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Solidarity Committee for Afghanistan

Policy Brief

Afghanistan's Maternal and Child Health at Breaking Point

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Key recommendations

1. Sustain funding for maternal and child healthcare in Afghanistan. Donors should increase support for essential health services to prevent further closures of facilities and improve access to safe deliveries. Private foundations and philanthropists can help offset declining official development assistance by funding high-impact interventions.
2. Strengthen frontline health providers. Channel support to organisations with a proven delivery record within maternal and child health, enabling them to scale mid-wife led and community-based services, and to provide training, supervision, and capacity support to frontline health workers.
3. Allow women to study and train as health professionals. Afghan authorities should restore women's access to education and professional health training. In the long term, this is the only viable solution to meeting the workforce needs required for reducing maternal and child mortality.

Introduction

Afghanistan's maternal and child health (MCH) system is at a critical juncture. After two decades of steady declines in maternal and child mortality, gains have stalled since the Taliban's return to power in 2021. The heavily aid-dependent health system now faces fragmented governance, and hundreds of health facilities have closed due to reductions in donor funding. Restrictions on women's education are further constraining the pipeline of future female health workers.

This brief provides an understanding of the critical role of MCH services in Afghanistan, particularly midwifery, in reducing mortality. It reviews past gains, assesses current risks, and identifies opportunities, arguing that urgent action is both necessary and feasible to prevent a rise in avoidable deaths among women and children.

Midwifery Scale-up and Health System Gains

In 2000, Afghanistan had one of the highest maternal mortality ratios globally, at approximately 1,800 deaths per 100,000 live births – far above the developing-country average of around 450 at the time (WHO, 2010). Under-five child mortality rates were similarly severe, with an estimated 132 deaths per 1,000 live births (UNICEF, 2024a). These outcomes reflected decades of conflict, very limited

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access to healthcare, and restrictive gender norms limiting women's mobility and care-seeking.

Following the establishment of a new Afghan government in 2001, international support enabled a rapid expansion of the health system through adopting the primary care Basic Package of Health Services (BPHS) in 2003 and the secondary and tertiary level Essential Package of Hospital Services (EPHS) in 2005. By contracting non-governmental organisations (NGOs) for service delivery while health authorities retained a stewardship role, a rapid scale-up was enabled. By the mid-2010s, over 3,000 health facilities were operational resulting in approximately 70% of the population being able to reach a health facility within two-hour travel time, compared with 10% in 2002 (Newbrander et al., 2014; Kim et al., 2020).

The central role of midwives: At the outset of health system expansion, the country's severe shortage of skilled birth attendants posed a major barrier. A 2002 assessment identified only 467 birth attendants with at least some formal midwifery training for a population of around 27 million (MSH, HANDS and MSH/E, 2002), and fewer than one in ten births were estimated to be attended by a skilled provider (Smith et al., 2008).

In response, a Community Midwifery Education programme was scaled nationwide by 2005, alongside the establishment of the Institute of Health Sciences midwifery programme and the Afghan Midwives Association (AMA). Two-year diploma courses focused on training women for deployment in remote areas where mortality rates were highest. As effectiveness hinged on community acceptance, rural trainees were prioritised, and village elders mobilised to support graduates to return to serve in their communities. Community engagement also proved essential in raising awareness of the live-saving role of midwives (Turkmani, 2024).

By the late 2010s, around 7,000 qualified Afghan midwives had been trained. Combined with expanded immunisation, improved child health services, and broader social gains in education, clean water, and women's and children's rights, Afghanistan achieved a 40–50% reduction in maternal mortality and over 50% reduction in child mortality between 2000 and 2020 (WHO, 2023; UNICEF, 2021). Afghanistan is widely cited as evidence that midwifery scale-up can deliver significant health improvements even in conflict-affected settings (Das et al., 2018).

Beyond their clinical roles, Afghan midwives play an important function in increasing trust in the health system, promoting sexual and reproductive health and rights, responding to gender-based violence, and advancing women's status (Turkmani et al, 2013). As respected professionals and income earners, they have gained influence and serve as role models within their local communities (Turkmani, 2024).

AMA plays a key role today in sustaining maternal health services under increasingly constrained conditions. Through its leadership and network of 3500 members across Afghanistan, AMA contributes to national coordination on reproductive, maternal, newborn, child, and adolescent health. It supports frontline providers by organising training, supervision, and mentorship, and also increasing delivers services by running midwife-led units in rural underserved areas.

Maternal and Child Health in Afghanistan Today: The Risk of Reversal

Since 2021, Afghanistan's health system has become increasingly fragile. In response to the Taliban takeover, donor countries suspended development funding to the unrecognised regime, triggering salary delays, supply gaps, and service disruptions across the heavily aid-dependent system.

THE AFGHAN MIDWIVES ASSOCIATION (AMA) is a professional body representing midwives in Afghanistan. Its mandate is to promote member's interests, strengthen the profession, contribute to health policy development, and support the standardisation of midwifery education and licensing.

Towards the end of 2021, services were partially restored through UN-managed funding mechanisms that contract NGO implementing partners. While critical in averting a system collapse, these off-budget arrangements bypass national structures as UN agencies – rather than health authorities – assume responsibility for policy, resource allocation, and contract management. This raises concerns over longer term sustainability, as domestic governance, capacity, and accountability remain fragmented in the context of continued international non-recognition of the regime.

The termination of USAID funding in 2025, alongside reductions from other donors, has dealt a further major blow to the system, pushing it towards breaking point. By the end of 2025, the Afghanistan Health Cluster reported 445 health facilities – around 15% of the national network – as suspended or closed due to funding shortages, disrupting access to essential healthcare for millions (Turkmani, 2025; WHO, 2025).

These pressures are further compounded by overlapping humanitarian shocks. Since 2021, the economy has contracted by roughly 25% (World Bank, 2023). In 2025, around 23 million people – almost half the population – required humanitarian assistance (Solidarity Committee, 2026, citing OCHA and IPC), while one quarter of the population faced high levels of acute food insecurity and nearly four million children suffered from acute malnutrition (Solidarity Committee, 2026). Large-scale refugee returns from Pakistan and Iran and regional instability have further disrupted health services and medicine imports (Save the Children, 2026).

As a result, health needs are sharply rising while the response capacity of the fragile health system erodes, leaving growing numbers of people without access to care. Even where facilities remain functional, women's access to services is constrained by travel distances, transport costs, restricted mobility due to the requirement of a male guardian, and inadequate deployment of qualified female health workers (HRW, 2024). A 2025 survey by EMERGENCY across 11 provinces found that three in four women faced difficulties accessing maternal care, with distances cited as the most common barrier. Conditions manageable at the primary level therefore often escalate into complications requiring emergency care, again constrained by transport barriers.

Taken together, these dynamics point to worsening MCH outcomes. UN projections anticipate a substantial rise in maternal and neonatal deaths in the coming years as more women give birth without skilled attendance or access to emergency obstetric and newborn care, while immunisation, paediatric services, and responses to malnutrition and infectious disease outbreaks continue to weaken (Turkmani, 2025).

Future Supply of Midwives

According to workforce modelling by UNFPA, WHO and ICM (2023), Afghanistan requires around 24,000 qualified midwives by 2030, yet only some 5,000 were in full-time service in 2021. Closing this gap, however, is not only a matter of training new cohorts. Since the 2010s, around 26,000 graduates have emerged from largely unregulated private midwifery institutes in Afghanistan. A 2018 Johns Hopkins University assessment found that only one in three of

these institutes met minimum standards, including at least 40 supervised births during training, while regulated midwifery programmes consistently met these benchmarks (UNFPA, WHO and ICM, 2023). This raises concerns about readiness for safe practice and limits employability within formal health services.

At the same time, deployment is constrained by the limited absorption capacity of the health system, shaped by outdated BPHS/EPHS policies and facility closures. As a result, a paradox persists: despite high maternal and child mortality, more than 80% of Afghan midwives with some form of training remain unemployed (UNFPA, WHO and ICM, 2023). This reflects not only a supply-demand imbalance but also structural constraints in certification and competency recognition.

The future pipeline is further threatened by restrictions on female education. Since 2022, authorities have barred girls from studying beyond grade six, and since late 2024, programmes for training female health professionals are suspended. While those already trained are permitted to work, the long-term supply of midwives will decline as new cohorts no longer enter the workforce. Given that social norms in most areas require female providers to treat women and girls, this decline, combined with an ongoing exodus of health workers due to poverty and repression, will have an increasingly negative effect on MCH services (Turkmani, 2024).

Opportunities Nonetheless

Despite these constraints, important opportunities remain.

Firstly, women remain permitted to work in the health sector. MCH services could therefore be strengthened by investing in existing female health workers. With adequate support, closed facilities could be reopened and new ones established, while proven models such as midwife-led care could be expanded in underserved areas, including so-called "white areas" previously inaccessible due to active conflict pre-2021.

Secondly, the existing pool of unemployed or underemployed women with midwifery training represent a significant potential that can be targeted for skills upgrading, certification, and deployment. Within current constraints, in-service training, supportive supervision, and mentorship, as for instance provided by AMA, alongside innovative approaches such as remote learning, telehealth, and cross-border collaboration, could be effective for strengthening competencies and improving workforce utilisation (Turkmani, 2024).

Finally, demand for MCH services remains strong, including in rural areas, driven by improved awareness, health literacy, and prior positive experiences of the health system. Demand is often reinforced by family members and community leaders, underscoring the central role of midwives as both essential clinical providers and trusted community actors. Evidence shows that women actively seek care when services are accessible, affordable, and delivered by female providers. Utilisation rates are therefore mostly related to matters of supply and access (UNICEF, 2024b; WHO, 2025).

Conclusions

The Afghan health system is under immense strain, posing a serious risk of reversing hard-won gains in maternal and child survival. Given that donor countries are hindered in supporting the response capacity of health authorities, there is an urgent need for the international community to mobilise resources and sustain engagement via established mechanisms – particularly for MCH services. With the low likelihood of resumed US funding, other bilateral and multilateral donors must

increase their contributions. Private foundations and philanthropists can help close critical gaps by funding high-impact interventions such as midwife-led units in underserved areas.

Funding should be channelled to organisations with proven capacity to deliver, prioritising community-based models centred on midwives and nurses. Given the limited capacity of health authorities, domestic and international MCH-related organisations operational on the ground play a key role in supporting the system and addressing critical service gaps.

Beyond service delivery, investment is needed in in-service training, supervision, mentorship, and innovative capacity building for existing frontline health workers. In the longer term, however, the only viable solution to meet future workforce needs is policy reform that restores women's access to education and professional health training.

Most maternal and child deaths in Afghanistan are due to preventable or treatable causes. Without urgent and sustained action, mortality will continue to rise, leaving the country among the most dangerous places in the world to be pregnant, a mother, or a baby. While the international community repeatedly affirms its commitment to supporting Afghan women and children, failure to sustain support for MCH services amounts to a betrayal of that commitment.

THE BASIC PACKAGE OF HEALTH SERVICES (BPHS) delivers primary care including maternal and newborn health, immunisation, family planning, treatment of common diseases, nutritional support, and health education, at community and district levels.

THE ESSENTIAL PACKAGE OF HOSPITAL SERVICES (EPHS) enables referral and provides emergency obstetric care, surgery, trauma care, and specialist treatment at district, provincial and regional hospitals.

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