Nutrition Action for Systemic Change

Briefing Series: Nutrition Outcomes in Afghanistan

BRIEFING NOTE 1:
Restrictions on Women and Girls: Implications and Recommendations

KEY TAKEAWAYS

Repressive restrictions enforced by authorities are having a severe impact on the nutrition and health of women and children in Afghanistan.

- **Restrictions have significantly worsened nutrition-related challenges** with widespread adverse effects across various sectors, impacting women's and girls' health, education, wellbeing, economic empowerment, income, and decision-making abilities. Restrictions will lead to poorer diets, unhealthy practices, and reduced access to essential services for both women and children.
- Threats to the nutrition and wellbeing of women and girls in Afghanistan, related to increased restrictions, are very likely to **undo the progress made in reducing child and maternal mortality over the past 20 years.**
- **The ban on girls' education is devastating,** leading to increased child marriage and no future pipeline of female professionals in health, education and other important sectors.
- **Adaptive mitigating programming approaches are effective** in the short/medium term but carry financial and opportunity costs.
- **Evidence-based advocacy needs to be strengthened.**

Urgent action is needed to sustain funding, safeguard existing health and nutrition programmes, expand culturally appropriate, community-led solutions, and strengthen advocacy to ensure girls can return to school and women can work in health and other essential service sectors, including nutrition, and education.

WHAT IS THE **CURRENT SITUATION**

Since the political transition in Afghanistan in August 2021, restrictions imposed by the authorities have impacted women's right to education, employment, public participation and social inclusion, with the harshest effects in the Southern regions. Recognised globally as both rights holders and vital caregivers, women in Afghanistan now must have a male escort (mahram) to travel and face limitations on working outside the home. Despite these oppressive conditions, many female health workers persist under immense strain, and some health services remain accessible through local efforts. These restrictions limit women's mobility, reduce their control over household decisions, cut their income, and block their access to health, nutrition, clean water, education, and reliable information. This combination of barriers is harming maternal and child nutrition, increasing harmful practices and putting women's and children's health and wellbeing at serious risk. Widespread mobility restrictions and exclusion from formal education, health services and media have left many women reliant on informal, often unreliable, sources of health information.

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WHY IT **MATTERS**

Loss of household income, reduced autonomy in household decision-making, exclusion from secondary and higher education and reduced access to reliable sources of information will have both short and long-term effects on maternal, adolescent and child nutrition, wellbeing and development. Girls' exclusion from secondary and higher education leads to higher rates of early marriage and teenage pregnancy, which in turn increase maternal and child malnutrition and child mortality.

Failure to maintain access to vital services and to adapt programming will likely result in:

- A reversal of gains in maternal nutrition, with **increased maternal mortality and morbidity** due to teenage pregnancy, reduced access to care, and inadequate supplementation during and after pregnancy.
- An increase in all forms of child malnutrition and development issues as **the proportion of children born to mothers with lower education status inevitably rises.**
- **Increased anaemia among adolescent girls,** driven by reduced access to iron-folic acid and inadequate dietary intake, leading to significantly increased risk of death and poor outcome related to child-bearing for both mother and baby.
- **Increased difficulty in accessing clean water and health facilities** due to women's restricted movement, especially as the responsibilities for collecting water and promoting hygienic practices in the family fall disproportionately on women and girls.
- **Growing risks of misinformation and harmful practices** with restricted availability of, and access to essential health, nutrition, education and other basic services, and increased reliance on informal sources for health information, resulting in both short and long-term impact on well-being outcomes.

KEY FINDINGS

- In provinces such as Kandahar, Helmand, Urozgan and Paktika, enforcement of mahram requirements has adversely affected women's access to health clinics and community services.
- The banning of girls' education is devastating due to its direct and evidence-based relationship with increased rate of child marriage, (and related consequences), poor nutrition and child development outcomes and the complete disruption of a future pipeline of female health workers.
- Despite restrictions, mitigation strategies such as negotiations with local authorities, the use of mahrams for female staff and other measures have helped to maintain many services, though at great personal and financial expense.

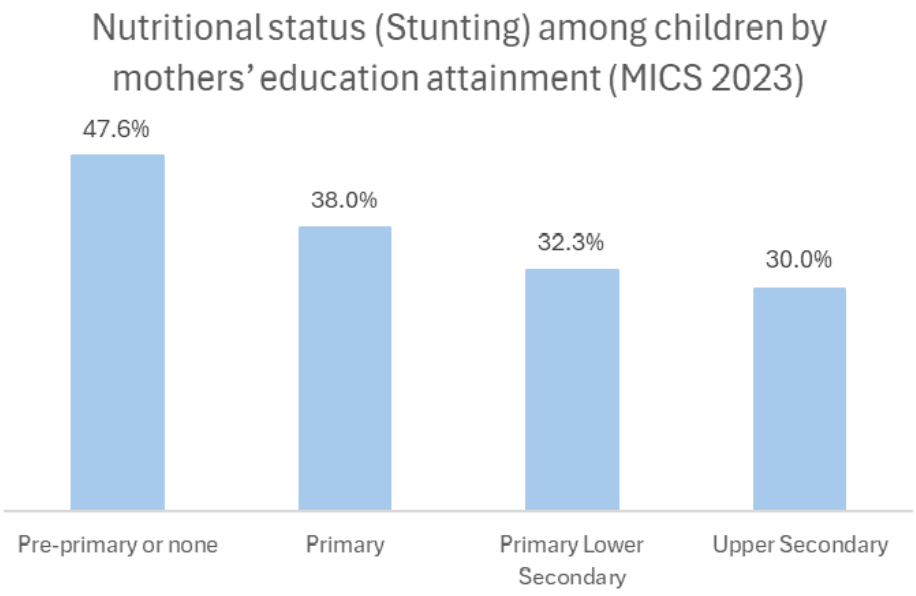
WHAT THE **EVIDENCE SHOWS**

- 70% of women say they struggle to access health and other basic services because of repressive policies from the authorities and lack of female staff.[1]
- Early marriage rates rose to 38.9% in 2023 (from 28% pre-restrictions), linked to teenage pregnancies with associated higher death and malnutrition risks[2].
- 56% of women-headed households lack basic knowledge of how or where to access assistance.
- Over 60% of women cite lack of information and female staff shortages as core barriers.
- School-based Weekly Iron and Folic Acid Supplementation essential for prevention of anaemia in adolescent girls, has been discontinued in most areas.
- Women and girls report being turned away from health and nutrition services due to lack of mahram.
- Female health workers report increased psychological stress and operational pressure[3].
- Closure of nutrition services and outreach efforts has reduced access to accurate nutrition information, as community sessions and school-linked Social and Behaviour Change (SBC) initiatives have been disrupted[4].
- Child food poverty is closely related to the mother's education level, exposure to media and number of ANC visits[5].

Current and future implications for Women's and Girls' Nutrition and Wellbeing

- More children will not achieve optimal growth and development (stunting) or face increased risk of death due to acute malnutrition. An increase in malnutrition among women and girls along with an increased number of early pregnancies will lead to increased maternal and infant mortality and morbidity, harming long-term human development in Afghanistan.
- Increased child mortality and illness from declining access to critical nutrition, health, Water, Sanitation and Hygiene (WASH), and food security interventions, as well as an increase in maternal, newborn mortality and stillbirths from lack of skilled female health workers for ante-natal care, delivery and post-natal care.
- Social and cultural norms, reinforced by recent restrictions are making it harder for women and girls to access care. Even when services exist, they often do not use them due to family restrictions, community pressure, and fear of damage to their reputation.
- Mitigation strategies require maintenance and scale-up but remain underfunded. Community-based solutions show impact such as the grandmother groups sustaining nutrition-related counselling and madrasas employing female educators have reintroduced adolescent girls to health and nutrition messaging.
- The ban on girls' education is driving long-term harm to women's health, nutrition, and workforce capacity. Girls who cannot finish school are more likely to marry and become pregnant early, leading to poor overall outcomes for themselves and their children. As the graph shows, children of mothers with little to no education are much more likely to be stunted (unlikely to reach physical or mental potential) Denying women education and jobs will permanently weaken the capacity of the health system to serve women and children, and over time will also erode women's knowledge and ability to provide good care and feeding practices for infants and young children.

[1]Women and Girls in Crisis: 2024 Gender Analysis of Humanitarian Sectors in Afghanistan (April 2025)
[2]Multiple Indicator Cluster Survey (MICS) – secondary Analysis, UNICEF, 2023
[3]Comparative Drought Analysis, REACH, September 2024
[4]Social and Behavior Change (SBC) FGD, UNICEF, July 2023
[5]Child Food Poverty – Nutrition Crisis in Early Childhood in Afghanistan, UNICEF June 2025



CALL TO ACTION

1. **Expand gender-adapted nutrition service delivery.** Urgently scale up proven approaches that remain feasible under current restrictions. This includes deploying mobile Community Health Worker (CHW) teams in mahram-compliant pairs, supporting women-only clinics, and using digital platforms for remote nutrition counselling. Partner with madrasas employing female educators to deliver nutrition messages in culturally accepted spaces.
2. **Support and safeguard the female health and nutrition workforce.** Prioritise sustained support for salaries, safe transport including mahram arrangements, and mental health services for female staff. Enable this through flexible budgeting within grant frameworks to prevent burnout and attrition.
3. **Improve gender-sensitive data and real-time monitoring.** Rapidly invest in the collection and use of disaggregated data to monitor access to nutrition services for women and girls. Invest in provincial and district-level systems to detect enforcement trends, emerging access barriers, and to evaluate which adaptation strategies are working.
4. **Embed gender equity into programme design and implementation.** Embed gender-specific Key Performance Indicators (KPIs), incentives, and participation strategies in all donor-supported nutrition and health interventions. Programme design should engage women – especially female-headed households – through both formal consultations and informal feedback mechanisms.
5. **Invest in women-led and women-serving local organisations.** Actively channel funding to Afghan women-led NGOs and local organisations with proven access and legitimacy. These groups are essential to delivering nutrition services in conservative and hard-to-reach areas, and to maintaining trust with affected communities.
6. **Engage in high-level advocacy to restore girls' access to secondary and higher education** and enable women's entry into health-related fields including midwifery, nursing and medical practice.

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