

Health Care Must Reach People, Not Just Plans: Reform Without Retreat

NGO & CSO Position Paper for the Afghanistan Coordination Group (ACG) Meeting, Doha (20–22 October 2026)

Executive statement

Afghanistan's health system is being restructured, refinanced and reprioritised at the same time. Donor funding for health is declining across almost every source, while the Ministry of Public Health is consolidating the lower levels of primary health care. While each process has its own logic, together—and without coordination—they are closing services faster than alternatives can be put in place. About 740 health facilities were suspended or closed between 2025 and mid-2026 [2]; one in four BPHS facilities is not on the funded list for 2027 [3]; households already pay about three-quarters of all health spending [2]; and no woman has been allowed to train as a health worker since December 2024 [8]. The cost of this transition is moving to Afghan households, in a country where 521 women die for every 100,000 live births [2].

National and international health NGOs and civil society organisations support evidence-based reform, the rationalisation of the health network, and fair burden-sharing. We ask the ACG to judge every decision in Doha by one practical test: **will a woman in a remote village reach proper health care, without new barriers or extra out-of-pocket costs?**

Our key asks

1. **No gap between contracts, and no closure without a plan.** Agree on a contingency arrangement so that no facility closes because a funding decision is delayed. Before any closure, merger or reclassification, require an access check and a documented continuity-of-care plan.
2. **Keep the doorstep link for women and children.** Retain health posts and community health workers, more than half of them women, until staffed community health centres are within reach.
3. **Protect and rebuild the female health workforce.** Retain the women now working, deploy qualified midwives who are without work, and agree a time-bound path to reopen training for women.
4. **Share the burden; do not shift it to families.** Show the true decline in funding, make multi-year commitments that cover the real cost of services, seek a published domestic commitment, and keep primary care free of user fees.
5. **Finance health and nutrition together,** including the paediatric care that malnourished children with complications need.
6. **Engage health NGOs as partners in decisions,** uphold humanitarian principles, and use the ACG's collective weight for an enabling operating environment.

The full set of twelve asks, with owners, is in section 9.

1. Who we are and why we write now

We are national and international health NGOs and civil society organisations providing primary health care, maternal and child health, nutrition, trauma care, mental health and community health services across Afghanistan's provinces. We work through BPHS and EPHS contracts, humanitarian funding and our own programmes. We are usually the first to see a clinic close, a referral fail or a midwife leave.

We write now because three decisions are converging in October 2026:

- **The 2027 health funding envelope and the 2028–29 outlook**, now under discussion among health partners and in ACG Session 3. A financing gap is opening in early 2027, and rural services carry most of the risk.
- **Facility selection under the new funding scenarios**. Our concern is that choices are being made on cost and facility tier rather than on who loses access to care.
- **Burden-sharing with the de facto authorities**, the subject of the health case study in ACG Session 4. On the ground, the burden is already moving to households that cannot afford it.

2. Multi-layered shocks and the state of health

Afghanistan's health indicators were among the weakest in the world before the current funding cuts. Infectious diseases still account for a large share of illness and death, because safe water, sanitation and vaccination coverage remain low [2]. The present shocks fall on this baseline.

Area	Latest evidence
Maternal and child survival	Maternal mortality 521 per 100,000 live births; WHO cited 620 in 2025 [2, 8]. Under-five mortality 56 per 1,000 live births [2].
Immunisation and outbreaks	DPT3 coverage 56%, unchanged for years. 36 wild polio cases in 2026, against 21 in 2025 [2]. 26,141 measles cases and 3.3 million diarrhoea cases by August 2026 [1].
Tuberculosis	203 per 100,000, up about 20% [2].
Health workforce	10.3 health workers per 10,000 people, including 2.4 midwives, less than a quarter of the WHO benchmark of 44.5 [2].
Facility closures	About 740 facilities suspended or closed between 2025 and mid-2026, across 33 provinces, affecting about 6 million people [2].
Cost of care	Households pay about 75% of all health spending; domestic public financing is about 4% [2]. Median six-month household health spending rose 29%, and 50% of households say treatment is too expensive [4].
Access	53% of rural households, and 41% of women, report two or more kinds of barrier to care [2]. 17% of households cannot afford transport to a facility [4].
Childbirth	7% of births happen at home nationally, 13% in rural areas and over 60% in Nuristan and Badghis. A third of women who gave birth outside a facility could not afford facility delivery [4].
Quality	Client satisfaction in monitored facilities fell from 76% in 2025 to 67% in 2026 [2].
Food security and nutrition	19.2 million people projected in Crisis or worse during the 2026–27 lean season. 4.04 million children will need treatment for acute malnutrition in 2027 [1].
Returns	More than 6 million Afghans have returned from Iran and Pakistan since September 2023 [9], over 1.2 million of them in 2026 [1]. Half of returnees report no meaningful access to health services [9].
Public financing	Health received 2.6% of government spending in FY2025, against 48% for the security ministries [8].

3. The realities the ACG must see

The health system looks very different from a conference room in Doha than it does from a remote Afghan village. Coordination reports count facilities, contracts and people reached. Families count hours of travel, the cost of transport, and whether a woman health worker will be there when they arrive.

What the reports say	What the ground shows
“Every district has a hospital or referral point.”	In 2025, 297 of about 400 districts had any health facility. Kapisa alone has 20 “white areas” of 10,000 or more people with no service within 10 km [8].
“Referral systems are available in 95% of BPHS facilities.”	Only 55% of facilities in returnee areas offer emergency care, and 90% of CHCs have no inpatient beds [6, 7]. Furthermore, in winter, many referral routes are completely blocked by snow.
“Health posts reported 95% medicine availability.”	MoPH spot checks confirmed medicine supply in only 1 of 22 health posts [5].
“Service volumes are holding up.”	Only at the facilities that remain, as patients from closed facilities travel further [2].
“Midwives are available in 99% of BPHS facilities.”	63% of facilities report a shortage of female doctors [6], and no woman has been allowed to train as a health worker since December 2024 [8].
“Services are free at the point of use.”	Households pay about three-quarters of all health spending, mostly for medicines and transport [2]. Field teams report that winter transport in mountain areas costs 40–60% more [10].
“Needs are falling.”	One-third of nutrition sites have closed or been suspended as funding fell [1].

Case stories from the field

Kolaba, Kabul Province: winter isolation and a maternal death. During heavy snowfall, the road to Kolaba was blocked. A young mother went into complicated labour and needed emergency obstetric care. Without local emergency transport she could not reach a referral facility in time, and she and her newborn twins died. The nearest basic health facility had no emergency maternal transport funds and no resuscitation kit. This happened in Kabul Province, not a distant border district [10].

Arabkhel, Kapisa Province: cut off by floods. When the river floods, the path to the main road disappears. Sima, expecting her ninth child, described it simply: “There was no help. I just prayed to God.” A two-room clinic run by two local midwives on her side of the river is now the only care point that stays reachable during floods [8].

Badakhshan: a training pipeline interrupted. In 2024, thirty young women from three remote districts began a three-year midwifery course. After one term, training for women was stopped. None has graduated, and they are now training as community rehabilitation workers instead [8].

Diagnostics: a gap the private sector can fill, if regulated. Many basic health centres have no laboratory, and low-income patients skip tests they cannot afford. Some NGO referral programmes now pay selected private diagnostic centres at agreed rates, so patients are diagnosed without facing unaffordable charges [10].

Returnee host districts: primary care under strain. Facilities serving returnees report heavy caseloads of diarrhoea, respiratory and skin infections and malnutrition, made worse by cold-chain failures and

immunisation gaps in temporary settlements. Disease surveillance exists in only 33% of these facilities, while AWD alerts have come from 332 districts in 2026 [7].

4. Two transitions at once: funding retrenchment and PHC restructuring

Two changes are happening at the same time. Development and humanitarian funding for health is falling, and the Ministry of Public Health is restructuring primary health care. Where an expiring donor contract meets a facility merger, communities can lose their nearest service altogether, and new “white areas” appear.

The funding picture. International support for health in Afghanistan is declining and becoming less predictable. Development and humanitarian partners are working with tighter budgets, and few are yet able to make firm commitments beyond 2027. Domestic public financing accounts for only about 4% of health spending, while households pay about 75%, largely for medicines and transport [2]. When external funding falls and public financing does not rise, the difference is either paid by families or paid in the form of forgone care. The IPC itself warns that a likely steep fall in health funding in 2027 will deepen the malnutrition crisis [1].

Under the facility selection for 2027, about one in four BPHS facilities is not on the funded list. Every reduction in the number of funded facilities carries a cost in maternal, newborn and child lives, with newborns most at risk [3]. The facilities that drop out are mostly the small ones closest to women: basic health centres, sub-centres and Family Health Houses [3].

The restructuring. Under the proposed PHC model, health posts, Family Health Houses and sub-health centres would be merged into Community Health Care Centres serving 3,000 to 10,000 people, and “medical professionals would replace the non-medical professionals” [6]. The mapping that informed this proposal covered 16,657 health posts and 32,849 community health workers, 52.4% of them women [5]. The proposed staffing of the new centres does not include community health workers [6].

Four consequences need the ACG’s attention:

- **Receiving facilities will be overloaded.** Patients from facilities that lose funding will move to the facilities that remain funded, without additional staff. Midwives and other staff in those facilities may be overburdened, and quality may fall.
- **Open is not the same as functioning.** A facility can remain open on paper with no medicines or staff, and no one is systematically tracking the difference.
- **Women lose their first point of contact.** Around 17,000 women community health workers could be removed before trained replacements exist, at a time when women cannot train as the professionals meant to replace them.
- **Costs may move to families.** The BPHS monitoring report recommends introducing “nominal user fees” for applicable services [6]. With households already paying about three-quarters of all health spending, user fees would add to the burden on the poorest.

We recognise the weaknesses that motivate reform. Half of community health workers lack initial training, supplies are unreliable, and supervision is weak [5]. The same mapping also shows that 96.4% of health posts are active and over 90% have basic screening equipment, “a foundation to build on” [5]. The case for removing health posts rests partly on a spot check of just 22 records [5]. The answer is to train, pay, supply and supervise community health workers, and to sequence the change, not to remove the network before an alternative exists.

5. Women and girls: structural barriers to health

Restrictions on women's education, work and movement are not temporary shocks. They are lasting barriers that shape health outcomes every year:

- Only 10% of adult women earn an income; 58% cite a lack of jobs and 51% a lack of education [4].
- 43% of children aged 6–18 attend no education programme, and girls are out of education at twice the rate of boys (58% against 28%) [4].
- 17% of households report that no female member has civil documentation [4].
- Since December 2024, women have not been able to train as midwives, nurses or other health workers [8]. The share of women among nurses has fallen from 29% to about 24%, midwives have declined by about a fifth, and up to 5,400 female health workers could be lost by 2030 if restrictions continue [2].

For women, a facility is usable only if a female provider is there and the journey is possible. Deploying qualified women already in the country is an essential interim measure, not a solution. Without reopening education and training for women, the health system cannot be sustained.

6. Working with health NGOs and the operating environment

Why engage health NGOs. Since 2003, Afghanistan's basic and hospital health packages have been delivered largely through national and international NGOs. NGOs employ much of the female workforce that still reaches women, and their work with community health shuras gives them trust and access in remote districts. Decisions on reform, facility selection and burden-sharing taken without their evidence risk failing at the point of delivery.

How to engage them. NGOs are not only implementers or sources of data. They should take part in decisions on funding priorities, facility selection and the transition process, alongside national and women-led organisations. Coordination with the de facto authorities is necessary, but in line with humanitarian principles NGOs must keep their operational independence and the ability to negotiate access.

Health NGOs also see the operating environment as a growing constraint on services. Structured engagement with the authorities before a programme starts helps them understand its planning and priorities. High-level donor–authority discussions should be communicated systematically to line ministries, including MoPH, MoEc and MoF, and to provincial directorates. A lighter, more predictable framework for approvals, including MOU processes and lengthy audits, would allow services to start on time while remaining aligned with national priorities. Conducting a periodic joint review of the operating environment would show whether conditions are genuinely improving. Efficiency reviews should look at the number of contracting layers; savings must not come at the cost of quality of care, staff safety, safeguarding or the real operating costs of local partners. Multi-year commitments matter, but so do timely contracts and clear transition arrangements, with no gaps between contracts.

7. Questions for the ACG

We raise these to find solutions together. We are not opposed to change; we want it to work for the people who depend on these services.

1. **Who serves the people who lose access in 2027?** About one in four BPHS facilities is not on the 2027 list. For each, which facility will serve its population from January, and what happens if contracts are delayed?

2. **Who is carrying the burden today?** Households pay about three-quarters of health spending, and the government about 4%. Will the burden-sharing proposal move costs towards the authorities, or towards families?
3. **How will facility selection measure access?** Will the final list show how many women and children move beyond reach of care, and what receiving facilities will need?
4. **What is the plan for women health workers and community health workers?** Is there a funded plan to retain female staff, deploy qualified midwives, keep community health workers until replacements exist, and agree a path to reopen training?

8. Our position and principles

We do not argue that the old system should remain unchanged. Monitoring shows real weaknesses: many community health workers are untrained, medicine supply is unreliable, supervision is weak, and service quality varies widely across provinces. We do not oppose reform. We oppose reform that trades access for structure. Nine principles guide our position:

Principle	What it means in practice
1. Access before architecture	Effective coverage—meaning who can reach and afford care—must be the measure of reform, not the number or tier of facilities.
2. The hospital is the referral destination, not a substitute for primary care	The leading causes of death and illness, including diarrhoea, respiratory infection, malnutrition and maternal and newborn complications, are prevented and treated close to home.
3. Women are the equity test	If a reform makes care harder for a woman who needs a mahram, transport money and a female provider, it has failed, whatever else improves. Only 28.6% of pregnant women attend four or more antenatal visits [1].
4. Burden-sharing, not burden-shifting	A rising domestic share; donor funds targeted to rural and women's services on multi-year terms; household costs falling, not rising.
5. Reform in sequence	Fix medicines, staffing and referral first. Pilot changes before national roll-out. Keep community health in place while it is professionalised.
6. The private sector adds capacity; it does not replace public care	Diagnostics, specialist services and logistics, contracted under agreed tariffs, quality standards and patient protection.
7. One system, mapped	Map every health and nutrition platform before restructuring, so investments fill gaps rather than overlap.
8. No gaps between funding windows	People should not fall through the gaps between humanitarian, basic human needs and development financing.
9. NGOs as partners in decisions	Health NGOs and CSOs, national and international, take part in funding, facility selection and transition planning, while keeping their operational independence under humanitarian principles.

9. Asks to the ACG

We ask all ACG members and donors to take collective ownership of these asks and to review progress at each ACG meeting. They are listed in the order in which action is needed.

#	Ask	Owner
1	Make the gap visible. Publish the 2027 health envelope by source, province and facility, including the facilities left unfunded, and show the decline in funding on a like-for-like basis.	HN-JP Secretariat, World Bank, ADB, UNICEF
2	No gap between contracts. Establish a pre-agreed bridge or contingency window so that no facility closes because a funding decision or contract is delayed. NGOs cannot cover such gaps from their own resources.	ACG donors, MDBs, humanitarian donors
3	No closure without an access check and a continuity plan. Before any closure, merger or reclassification, assess catchment, travel time and women's access, and agree a documented continuity-of-care plan covering the receiving facility, referral transport, medicines and staff. Fund additional staff at receiving facilities and winterised mobile health and nutrition teams.	World Bank, ADB, UNICEF, WHO, with MoPH
4	Keep the doorstep link. Retain health posts and community health workers until staffed community health centres are within reach; professionalise them; and fund proven community models such as midwife-led clinics, Family Health Houses and winter waiting homes.	ACG co-chairs, UNICEF, UNFPA, WHO, with MoPH
5	Protect and rebuild the female health workforce. Retain all female cadres, including doctors, nurses, midwives, vaccinators and nutrition counsellors, with mahram support allowances; map and deploy at least 500 qualified midwives who are without work; support practical apprenticeships; and include a time-bound path to reopen education and training for women in the ACG Engagement Strategy on Gender.	ACG co-chairs, UN Women, UNFPA, WHO
6	Finance health and nutrition together. Create an integrated funding window for paediatric inpatient care and treatment of severe acute malnutrition in the provinces the IPC identifies for urgent action.	London Compact partners (FCDO, UNICEF, WFP)
7	Predictable, multi-year financing. Make 2027–29 commitments that cover the full cost of delivery, including local partners' overheads; agree common facility costing; explore a pooled BPHS/EPHS basket; and plan now for 2028 and beyond. Furthermore, review fund flows and reduce contracting layers so that more of every dollar reaches people in need, without cutting quality of care, staff safety or safeguarding.	ACG donors, MDBs, MDB+ Platform
8	Burden-sharing, not burden-shifting. Seek, through coordinated engagement, a published and rising domestic health commitment, and keep primary care free of user fees.	ACG co-chairs (Session 4 follow-up)
9	A regulated private-sector role. Establish tariff-capped referral for diagnostics and specialist care, with quality standards, patient protection and cash for health where appropriate.	MoPH, Health Cluster, World Bank, ADB, UNICEF

#	Ask	Owner
10	An enabling operating environment. Use collective policy dialogue to agree an accountable framework for structured engagement with the authorities before programmes start, with streamlined approvals and MOU processes. Communicate high-level agreements systematically to line ministries (MoPH, MoEc, MoF) and provincial directorates, and align investment plans with national health and nutrition strategies. Review the operating environment jointly and periodically, including approval times, audits and administrative barriers.	ACG co-chairs, Kabul Based Group, HN-JP co-chairs
11	NGOs as partners, on principle. Include national and international health NGOs, including women-led organisations, in decisions on funding priorities, facility selection and transition, in line with localisation commitments. Uphold humanitarian principles, NGOs' operational independence and their ability to negotiate access.	ACG co-chairs, HN-JP co-chairs, humanitarian donors
12	Track and account. Establish a joint monitoring and corrective-action mechanism for medicine availability, staffing, quality and continuity of services, and a quarterly joint gap report prepared with NGOs, included in the extended ACG Joint Framework.	Health Cluster, HN-JP co-chairs, ACG co-chairs

10. How we will all know it is working

We propose that health partners and the ACG track a short set of indicators that reflect conditions on the ground, disaggregated by sex, age, disability, returnee status and remoteness.

Indicator	Latest baseline	Direction sought by end-2027
Facilities suspended or closed for lack of funding	About 740 (2025 to mid-2026) [2]	No closure without a continuity plan
BPHS facilities funded	About three in four for 2027 [3]	Rising towards full coverage
Household out-of-pocket share of health spending	About 75% (NHA 2024) [2]	Falling
Domestic public share of health spending	About 4% (NHA 2024) [2]	Rising, and published
Households saying treatment is too expensive	50% (2026) [4]	Falling
Women who could not afford facility delivery	33% of those who gave birth outside a facility (2026) [4]	Falling
Women community health workers in post	About 17,000 (2024–25) [5]	Maintained until trained replacements are in place
Qualified midwives deployed under the interim plan	Not tracked	At least 500
Client satisfaction in monitored facilities	67% (2026) [2]	Rising
Closures preceded by a documented continuity-of-care plan	Not documented	100%

Indicator	Latest baseline	Direction sought by end-2027
Facilities with confirmed financing for the following year, published three months ahead	Not published	100%

Closing statement

The ACG has rightly moved from emergency response towards sustainability, burden-sharing and reform, and civil society supports that direction. A transition that is underfunded, rushed or measured only through financial metrics, however, will be paid for with preventable maternal and child deaths, outbreaks detected too late, and the lasting loss of women's health capacity.

The choice before the ACG in Doha is not whether to support the transition of Afghanistan's health system. It is whether to finance it early and strategically, or to pay later for its failures. Health NGOs and civil society organisations see the consequences first, in the communities they serve. We urge the ACG to make sure that plans agreed in Doha become care that people can reach.

Endorsing organisations:

1. Agency For Assistance and Development of Afghanistan (AADA)
2. Afghan Alfouz Innovational Welfare Organization (AAIWO)
3. Afghan Health & Development Service (AHDS)
4. Afghanistan Center for Training and Development (ACTD)
5. Afghan Youths Services Organization (AYSO)
6. Bakhtar Development Network (BDN)
7. Bu Ali Rehabilitation and AID Network (BARAN)
8. Care of Afghan Families (CAF)
9. Coordination of Humanitarian Assistance (CHA)
10. HealthNet TPO
11. Human Management & Leadership Organization (HMLLO)
12. INTERSOS
13. Medical Management and Research Courses For Afghanistan (MMRCA)
14. Move Welfare Organization (MOVE)
15. Organisation for Human Welfare (OHW)
16. Organization for Community Coordination and Development (OCCD)
17. Solidarity for Afghan Families (SAF)
18. Terre des Homes Foundation (TdH)
19. The Johanniter International Assistance (JUH)
20. The Tashabos Educational Organization (TEO)
21. Union Aid
22. World Vision International (WVI)
23. Youth's Assembly for Afghanistan Rehabilitation (YAAR)

References

1. IPC Afghanistan. *Acute Food Insecurity and Acute Malnutrition Snapshot, August 2026–September 2027*. Published 15 October 2026.
2. WHO Afghanistan. *Voices from the Field: Status of Afghanistan's Health System*. Presentation, 13 October 2026. Draws on the National Health Accounts 2024, REACH 2026, WHO health workforce data and the WHO Gender Analysis Report 2026.
3. World Bank, ADB and UNICEF. *Health Impact of Funding Scenarios and Facility Selection*. Presentation, October 2026.
4. REACH Initiative. *Whole of Afghanistan Assessment 2026: Preliminary Findings*. 23 September 2026.
5. Ministry of Public Health, CBHC Department. *Afghanistan CHW and Health Post Mapping Exercise 2024–2025: Findings and Implications for PHC Reform*. Health Cluster coordination meeting with the Minister of Public Health, 3 September 2026.
6. Ministry of Public Health. *BPHS/EPHS Revision: PHC Reform, and Comprehensive BPHS Monitoring Report 1404*. Health Cluster coordination meeting with the Minister of Public Health, 3 September 2026.
7. Afghanistan Health Cluster. Returnee health-service assessment and AWD situation update. Health Cluster coordination meeting, 3 September 2026.
8. Clark, K. and Foschini, F. *Holding the Line in Afghanistan: Women's Health in Crisis and One NGO's Response*. Afghanistan Analysts Network, 17 May 2026. Includes data from the World Bank Afghanistan Economic Monitor (March 2026) and the WHO Health Cluster Bulletin (July 2025).
9. International Organization for Migration (IOM), Displacement Tracking Matrix. *Afghanistan: Returnee Resilience Overview, Round 2*. June 2026.
10. *Voices from the Ground 1: Health Services*. NGO field note, October 2026, with field accounts from AYSO and Johanniter International Assistance.