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Women's and girls' right to health in Afghanistan

Report of the Special Rapporteur on the situation of human rights in Afghanistan, Richard Bennett*

Summary

In the present report, the Special Rapporteur on the situation of human rights in Afghanistan, Richard Bennett, provides an intersectional examination of women's and girls' right to the highest attainable standard of health in Afghanistan.

* The present report was submitted to the conference services for processing after the deadline so as to include the most recent information.

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I. Introduction

1. Taliban rule has ushered in a widespread and systemic attack on the rights of the people of Afghanistan, foremost women and girls, who are being subjected to an institutionalized system of gender-based discrimination, oppression and domination that permeates all areas of life, restricting their rights to education, work, freedom of movement, health, access to justice and to the freedoms of expression, association, assembly and participation in public life. This system amounts to crimes against humanity.

2. Health and health outcomes in Afghanistan have long been shaped by profound structural disadvantage, including decades of conflict, poverty, limited infrastructure, chronic underinvestment, corruption and aid dependence. The return of the Taliban has intensified these challenges, imposing new barriers that severely limit women's and girls' access to health systems and their capacity to make autonomous decisions about their bodies and their health. The discriminatory and gender-oppressive policies described in the present report systematically violate women's and girls' right to health.

3. These policies exacerbate a crisis brought on by massive cuts to international assistance that are severely undermining life-saving programmes and straining an already overstretched health system. For women and girls, the cuts are converting an oppressive framework into a health catastrophe, leaving millions without essential care.

4. Amid these conditions, Afghan health workers continue to serve their communities with extraordinary skill and dedication. Health remains one of the few areas where women can work. Their commitment underscores the critical need for support to restore and protect the rights of women and girls.

5. Without urgent and sustained international action, Afghanistan faces an alarming trajectory with immediate, cumulative and long-lasting consequences. Policies that discriminate against women and girls not only violate their rights, they also jeopardize the viability of the Afghan health system, with repercussions that will be felt across generations. Ensuring the right to health in Afghanistan is inseparable from restoring the rights of women, girls and all Afghans.

II. Mandate and methodology

6. The present report is submitted pursuant to Human Rights Council resolution 60/2, in which the Council requested the Special Rapporteur on the situation of human rights in Afghanistan to prepare a report on the situation of women and girls, adopting an intersectional approach. The focus of the report – women's and girls' right to health – was chosen following consultation with Afghan women human rights defenders, civil society activists and other stakeholders.

7. In preparing the present report, the Special Rapporteur conducted focus group discussions and one-to-one interviews with 137 Afghans of diverse backgrounds and identities, including individuals in 29 Afghan provinces.[1] They included current and former health workers, members of civil society organizations working in health or adjacent fields, and healthcare consumers. Input was obtained from people from or working with at-risk, vulnerable and marginalized groups, including women in remote and rural areas, persons with disabilities, LGBT+ persons, children and adolescents, and survivors of gender-based violence.

[1] The provinces were Badakhshan, Badghis, Baghlan, Balkh, Bamyan, Daykundi, Farah, Faryab, Ghazni, Ghor, Helmand, Herat, Jowzjan, Kabul, Kandahar, Kapisa, Khost, Kunar, Kunduz, Wardak, Nangarhar, Nimroz, Paktika, Paktiya, Panjshir, Parwan, Takhar, Uruzgan and Zabul.

8. The Special Rapporteur sought further input through a public call for submissions and received 17 submissions, including confidential reports and analyses. He also benefited from data and insights gathered as part of an independent survey of 8,085 women across 33 provinces, conducted by Bishnaw in November and December 2025,[2] and focus group discussions with 469 women in 28 Afghan provinces. Additional information was gathered through meetings with representatives of the United Nations, international and national non-governmental organizations and Afghan and international experts. The Special Rapporteur appreciates their cooperation.

9. As is his regular practice, the Special Rapporteur sought views and inputs from the de facto authorities in Afghanistan. In addition to requesting in writing information about efforts to ensure the highest attainable standard of health for women and girls, he shared an advance copy of the present report for comments on factual errors. At the time of submission, no response had been received. The Special Rapporteur also wrote to the Permanent Mission of Afghanistan to the United Nations Office and other international organizations in Geneva and he expresses his appreciation for the Permanent Mission's input.

III. Gender inequality and the right to health nexus

10. Health in Afghanistan has long been shaped by a complex mix of geography, socioeconomic status, conflict, political instability, traditional norms, poor infrastructure and limited institutional capacity. These factors have never affected all Afghans equally. Indeed, health outcomes have consistently reflected deep social inequalities, including along lines of gender, socioeconomic status, location, ethnicity, religion, literacy and ability/disability.

11. Gender – and gender inequality – is one of the most significant determinants of women's and girls' health in Afghanistan. Patriarchal norms, gender stereotypes and unequal power relations have long played a central role in determining how decisions about health are made, and under what conditions women and girls can access services. These dynamics shape women's autonomy, dignity and their ability to exercise their right to the highest attainable standard of health and other rights.

12. While these norms are often portrayed as culturally fixed, Afghan women have actively negotiated and contested them across generations, including though education, informal support networks and livelihood strategies, demonstrating that gender roles are socially constructed and dynamic.

13. Since returning to power, the Taliban have enforced an ideological system of governance rooted in patriarchal gender stereotypes designed to strip women of their rights and agency. These restrictions are imposed through discriminatory edicts, coercive measures, including physical violence, and ideological indoctrination. A highly repressive social order is being normalized, in which women's and girls' autonomy is progressively erased, with profound consequences for physical and mental health, health-seeking behaviour and survival.

A. Gender norms, family and household decision-making

14. Family structures play a central role in shaping women's health and health-related decisions. Afghan society has traditionally been organized around patriarchal structures in which men – particularly husbands and fathers – often hold primary authority over household decision-making. This includes decisions related to financial expenditure, mobility, marriage, reproduction and health-seeking behaviour. Women can – and do – exercise influence; however, in many households, their power to make independent decisions is limited, which has been exacerbated by Taliban restrictions on women's employment, job losses resulting from the economic crisis, and enforced dependence on male relatives. Young women and adolescent girls face compounded restrictions due to their age, position in the family and expectations of obedience.

[2] See https://bishnaw.com/access-to-health-for-women-and-girls-in-afghanistan/.

15. These dynamics are reinforced by gender norms and stereotypes that have long defined women's roles, primarily in terms of marriage, childbearing and caregiving for children, older relatives and relatives with disabilities. These norms influence the perception and prioritization of women's health, with their needs often seen as secondary, resulting in delays in seeking care until illnesses become serious.

16. Where women's health is addressed, it is often framed around a narrow subset of maternal and reproductive health. While essential, this focus obscures other unmet health concerns including chronic illness, mental health, ageing and preventive care. Discussions on sexuality, contraception and reproductive decision-making remain taboo, even within families, further limiting informed health choices. In many communities, it is considered inappropriate for a woman to be examined or treated by male health workers. Consequently, the availability of women doctors, midwives and nurses often determines whether a woman can seek care at all.

17. Women in Afghanistan explained that patriarchal gender norms and stereotypes are being entrenched and enforced under Taliban rule. Echoing sentiments express by others, a woman from Jowzjan Province explained, "Taliban restrictions have directly affected family mindsets … women are not given the right to choose, and even decisions about their own health are made by male family members."

B. Other determinants of women's and girls' health

18. Beyond family and social norms, broader factors – particularly access to education, employment, freedom of movement and participation in public life – play a critical role in shaping women's and girls' access to healthcare, health outcomes and overall well-being. For example, education equips girls and women to navigate healthcare systems and make informed decisions about their bodies, nutrition, hygiene, family planning and reproductive care. Higher levels of female education consistently correlate with lower maternal and child morbidity and mortality. As an Afghan woman from Daykundi Province said, "For women and girls in Afghanistan, being healthy means physical survival, mental stability, dignity, safety and access to basic services without fear, restriction or humiliation." Employment strengthens autonomy by providing the financial resources to independently access healthcare and support households. Meanwhile, women's participation in public life – including in governance, civil society and community decision-making – ensure their perspectives shape health policy, resource allocation and service design.

19. Following the Taliban's return to power, highly repressive and regressive policies have severely narrowed the social, economic and political conditions that enable women and girls to access healthcare and exercise autonomy.[3] Taliban authorities have suspended girls' education beyond grade six, restricted women's participation in many forms of paid work and effectively excluded them from public life. These policies violate women's and girls' fundamental rights, erode autonomy, restrict social networks, limit life opportunities and contribute to psychological distress. They also generate and intensify a range of interrelated abuses – such as child and early marriage – which have serious health implications.

20. Afghan women made clear to the Special Rapporteur that enjoyment of their fundamental rights is closely intertwined with their physical, mental and social well-being, freedom and dignity. Their right to health cannot therefore be separated from other rights and freedoms.

C. Multiply marginalized groups

21. Gender alone does not fully explain the identity-related barriers women and girls face in accessing healthcare in Afghanistan. It intersects with other axes of marginalization, including age, socioeconomic status, ability/disability, geographic location, ethnicity, religion, language and level of education, to create compounded barriers. Understanding

[3] See A/HRC/51/6, A/HRC/52/84, A/HRC/53/21, A/78/338 and A/78/338/Corr.1, A/HRC/55/80, A/HRC/56/25, A/79/330, A/HRC/58/80, A/HRC/58/74, A/HRC/59/25 and A/80/432.

these layered and cumulative challenges is essential to grasp the full scope of health inequities in the country. For example, women and girls in remote and rural areas have long contended with long distances to facilities, poor transport infrastructure and limited availability of services. For those from low-income households – the majority – constraints are magnified, particularly the cost of care. Women with disabilities face discrimination, accessibility constraints and insufficient specialized services. Displacement, returnee status and lack of personal identity documentation can prevent women from registering at facilities, receiving referrals or accessing humanitarian support. Meanwhile ethnic, religious and linguistic minority women have reported bias or discrimination within the health system.

22. Intersectional barriers are both cumulative and often transgenerational. Patterns of exclusion, poverty and limited access to healthcare are frequently passed from one generation to the next, perpetuating health disparities and other inequities across communities and generations. Intersecting forms of marginalization underscore the limits of "one-size-fits-all" approaches to health policy and service delivery. Indeed, health interventions that fail to account for these differences in experience risk reinforcing inequalities rather than alleviating them.

IV. Health sector in Afghanistan

A. Geographic, environmental and economic barriers

23. In Afghanistan, the mountainous terrain, weak transport infrastructure and dispersed rural settlements seriously constrain access to health services, a situation compounded by high transport costs and seasonal weather. Around 33% of the population lives in underserved areas.[4] The country's vulnerability to natural disasters – including earthquakes, floods and droughts – creates health-related emergencies, while limited access to safe and clean water contribute to preventable diseases and poor hygiene.

24. Affordability is another critical factor. Although public health is free in principle, in Afghanistan the health system relies heavily on out-of-pocket expenditure by households. Under the Islamic Republic, private household spending accounted for approximately 75% of total health expenditure, a figure estimated to have risen under the Taliban.[5] Access to care is heavily contingent on household income, a challenge intensified by the current economic downturn, forcing many families to delay treatment, rely on informal or traditional providers or forgo care altogether. Women and girls are disproportionately impacted.

25. The reduction in hostilities has led to improvements. Today, some survey data show high reported access to healthcare, although levels are lower for women than for men.[6] However, the picture is more complex as data also show that women's access is often contingent on compliance with Taliban-imposed restrictions – conditions which are increasingly normalized and therefore likely to be underreported.[7]

B. High reliance on donors

26. The health sector in Afghanistan has historically been heavily reliant on external financing. National budget allocations to health, whether under the former Islamic Republic or the current de facto administration, have consistently ranked well below security and other priorities. Under the Islamic Republic, approximately three quarters of public health

[4] Office for the Coordination of Humanitarian Affairs (OCHA), *Afghanistan: Humanitarian Needs and Response Plan* (December 2026), p. 52.

[5] Afghanistan, Ministry of Public Health, "Health financing strategy 2019–2023" (2019), p. 1, and confidential meeting.

[6] United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), *Gender Index 2024: Afghanistan* (2025), p. 19, and Bishnaw health survey.

[7] For example, around a quarter of respondents of the Bishnaw health survey identified Taliban restrictions as their main barrier to accessing treatment, while 80% of rural woman consulted by UN-Women reported being unable to reach a health facility without a *mahram*.

expenditure was financed by international donors.[8] This reliance was institutionalized by a contracting-out model which outsourced health service delivery functions to non-governmental organizations (NGOs). While this enabled rapid expansion of health services, infrastructure and workforce capacity, it also created a system deeply dependent on international aid and highly vulnerable to political and fiscal shocks.

27. Following the Taliban takeover, the withdrawal and redirection of external aid have had immediate implications for the health sector, particularly service continuity and staff salaries. Humanitarian and emergency-focused aid have replaced long-term development support, prioritizing short-term interventions over sustained public health programmes. A parallel challenge has been how to provide support without conferring legitimacy on the Taliban or breaching international sanctions.

28. United Nations agencies, other international organizations and civil society organizations continue to play a central role in health service delivery, while some States are also supporting efforts to expand health infrastructure.[9] However, significant reductions to international funding in 2025, notably by the United States of America, are having serious consequences. The scale and abruptness of the cuts have significantly impacted health and related services, including nutrition, water and sanitation, and food security. An estimated 445 health facilities have been forced to close,[10] while community awareness-raising initiatives, education programmes, referrals and protection activities have also been forced to scale back. The situation is critical. According to the 2026 Humanitarian Needs and Response Plan, some 21.9 million people in Afghanistan require humanitarian assistance, 14.4 million of them in health.[11]

C. Availability of health facilities, goods and services

29. Afghanistan faces long-standing challenges in the availability of health facilities, goods and services. This includes underinvestment in infrastructure, shortages of trained health workers – particularly women health workers – and imported medicines. Health workers from across the country consistently describe a chronic lack of health facilities, equipment and essential medications in addition to staff shortages and operational funding. Many facilities have closed or else operate at a reduced level.[12] Patients who can afford to do so seek private treatment or travel overseas if they can obtain visas.

30. Staff shortages are a critical concern, particularly regarding women health workers and health workers in specialized or emergency care. Significant outmigration of qualified personnel has been driven by economic factors and oppressive policies. Economic pressures in rural areas have reportedly pushed health workers towards urban centres, leaving rural facilities further understaffed.

31. Medicines and medical supply shortages remain critical. Domestic pharmaceutical production is minimal, leaving the health system dependent on imports, and cross-border disruptions continue to affect supply chains and availability. Health workers report high costs, increased use of poor-quality or expired medicines, and critical gaps in essential medications.

D. Leadership and governance

32. Under the de facto administration, health sector decision-making has become highly centralized. Senior officials appointed to the de facto Ministry of Public Health lack technical expertise or health sector experience, reflecting a broader pattern of appointments based on

[8] Afghanistan, Ministry of Public Health, “Health financing policy 2012–2020”, p. 2.

[9] Qatar News Agency, “Qatar Charity, Afghan health ministry sign MoU to build hospital in Kandahar”, 2 September 2025.

[10] Health Cluster Afghanistan, “Afghanistan: Health facilities suspended/closed due to funding gaps in 2025” (December 2025).

[11] OCHA, *Afghanistan: Humanitarian Needs and Response Plan*, p. 2.

[12] Jelena Bjelica, *Rural Women’s Access to Health in Afghanistan: “Most of the time, we just don’t go”* (Afghanistan Analyst Network, March 2025), p. 4.

political and ideological affiliation.[13] Many managerial roles in hospitals and health directorates are now held by individuals without health-sector training. Many women previously employed in managerial and administrative positions have been removed from their posts.

33. Allegations of corruption – a persistent concern under the Islamic Republic – continue under the Taliban, including bribery for the appointment of underqualified individuals, misuse of funds allocated to health projects, overcharging and inappropriate referral of patients to private health clinics. These concerns are exacerbated by the weakening or dismantling of previous governance, accountability and regulatory mechanisms, including grant management bodies, and independent monitoring.

34. Opportunities for meaningful redress of human rights violations, including discrimination in the health sector, remain extremely limited. The de facto justice system lacks independence and enforces the Taliban's ideology, while independent oversight mechanisms have been dismantled.[14] Severe restrictions on independent media prevent scrutiny and reporting of abuse and corruption.

V. Restrictions directly affecting women's and girls' health

A. Restrictions on movement

35. Among the most immediate restrictions limiting access to healthcare are those on women's freedom of movement: the *mahram* (male guardian) requirement and mandatory dress codes. Both requirements, imposed to varying degrees in provinces across Afghanistan since the Taliban retook power, were formally codified in August 2024 in the so-called law on the promotion of virtue and the prevention of vice.[15]

1. The *mahram* requirement

36. Physical access to health facilities often depends on women having a *mahram* who is willing and able to accompany them. This is especially challenging for those in women-headed households, widows, internally displaced and returnee women, separated or unaccompanied women and girls, those whose *mahram* has a disability and those who may not have family support, for example LGBT+ women. The requirement severely undermines women's ability to independently and confidentially seek care. It imposes additional financial burdens, including increased travel costs and lost income, which exacerbate challenges for those in remote rural areas or living in poverty. As an Afghan woman from Badakhshan Province noted, "In emergency situations, the need for a *mahram* becomes decisive; without one, women cannot visit health facilities."

37. The Special Rapporteur received multiple reports of women being unable to access medical care, including urgent care, because they did not have a *mahram*. This included being prevented from travelling independently or denied entry on arrival at health facilities. In Balkh Province, a woman was compelled to deliver her baby at the hospital gate after being denied entry without a *mahram*. Another could not take her 4-year-old son to hospital while her *mahram* was away; by the time she reached a hospital hours later it was too late and the child died. In Herat Province, a woman witnessed another woman being turned away from a dental clinic and left screaming in pain. Ambulance services, generally only available in large cities, are frequently inaccessible to women without a *mahram*, with some male dispatch operators who answer emergency telephone calls refusing to speak to women at all.

[13] A/HRC/59/25, paras. 30–32.
[14] A/HRC/59/25.
[15] A/HRC/58/74, paras. 41–54.

38. Islamic scholars explained that Islamic jurisprudence clearly prioritizes the preservation of life, health and well-being, and that in cases where life or health was at risk, rules such as the *mahram* requirement can be relaxed to prevent greater harm. Despite this, no such exceptions appear to be permitted under Taliban rule.

39. The *mahram* requirement also severely restricts women health workers' ability to work or travel to treat patients. In some provinces, a *mahram* must accompany a woman to and from her workplace, while in others he must remain nearby throughout her shift, particularly at night. Health workers also reported having to present marriage certificates or identity cards to prove their relationship to their *mahram*. This requirement is especially difficult when a son serves as a *mahram* but lacks a birth certificate or other identification. In some southern provinces, women workers are required to register their *mahram* and are issued with a verification card which they must carry. Implementation varies however, and in some areas the *mahram* requirement is not strictly enforced.

40. The *mahram* requirement has forced families of health workers into difficult trade-offs. Men may have to leave or reduce their own work so that women can continue theirs, resulting in a loss of household income. Some organizations are employing *mahrams* as community health assistants, which requires additional resources. Amid significant funding reductions, there are growing concerns that organizations may reduce or discontinue the employment of women.

2. Mandatory dress codes

41. Taliban-mandated dress codes further restrict women's access to healthcare. While once again, implementation varies across provinces – including what constitutes the "correct" hijab – both women patients and women health workers have been denied access to health facilities for non-compliance. In November 2025, de facto authorities in Herat barred female patients and staff from public hospitals for non-compliance, prompting an immediate 28% drop in admissions.[16] Despite a partial relaxation following public pressure, the threat of enforcement continues to create delays in seeking care and additional stress for women seeking treatment.

42. For women health professionals, mandatory dress codes hinder not only access to their workplaces, but also the ability to carry out their duties once there. Failure to comply has led to threats of dismissal, and in some cases, reported dismissals.

3. Monitoring and enforcement

43. De facto authorities conduct regular inspections in health facilities for compliance with *mahram* and dress code requirements, preventing women from accessing services and instructing staff at health facilities to bar access to non-compliant women or deny them treatment. Health workers report being subjected to frequent questioning, constant surveillance and meetings where they are warned against non-compliance. Enforcement is highly inconsistent, creating opportunities for arbitrary or abusive application. Fear of sanctions has also fostered overcompliance and anticipatory compliance among some health providers.

44. Fear of arrest, detention or harassment for perceived non-compliance leads some women to delay or avoid seeking care, while health workers report that colleagues have left their jobs for the same reasons. This is exacerbated by the intense stigma and perceptions of "dishonour" attached to women questioned or detained by the de facto authorities. Enforcement of the virtue and vice law and growing community and self-regulation amplifies this fear, leading some families to pre-emptively restrict women's movements to protect them from punishment.

[16] Médecins sans frontières, "New restrictions limit access to care for women in Herat", press release, 10 November 2025.

B. Restrictions on women working in the health sector

45. Healthcare has been one of the few sectors where women have been permitted to continue to work. However, this exemption is inconsistently applied, frequently subject to local interpretation, and vulnerable to sudden reversal. Health service providers explained that ensuring women's work in the health sector often requires continuous engagement with local de facto officials, community leaders and families, creating additional administrative, security and operational burdens for organizations.

46. Health service providers also report that staff retention is a critical challenge, as restrictive working conditions, surveillance and uncertainty drive burnout and attrition among women staff. Health workers also described compulsory religious orientation sessions, including questioning or testing on Islamic knowledge, with threats of dismissal for those deemed to lack the requisite understanding.

47. Men also reported being subjected to verbal abuse for "allowing" or otherwise supporting their female relatives to work in the health sector. A man in southern Afghanistan recalled an interaction with de facto officials: "They said, 'Aren't you ashamed to bring your wife here? Even if someone paid me one hundred thousand afghanis (US$ 1,500) per month, I would not allow my wife to go to work'."

48. The situation is exacerbated by restrictions on women working for local and international humanitarian organizations and for the United Nations. In December 2022, the de facto authorities banned women from working for NGOs, with limited exemptions for the health and education sectors. As a result, women's ability to participate in monitoring, field visits, needs assessments, training and community outreach has been severely constrained, impacting health service delivery. In September 2025, the de facto authorities banned Afghan women, including national staff and contractors, from entering United Nations premises.

C. Ban on medical education and training

49. In December 2024, the Taliban issued a directive banning women from attending medical and health training institutions. As a result, medical, nursing, midwifery, laboratory and other clinical programmes for women were forced to close, and women were prevented from taking the exit examinations required to enter the professional health workforce. The move has effectively halted the pipeline of new women health professionals entering the workforce. According to an Afghan woman in Kapisa Province, "We have doctor shortages because medical education is completely closed to women … in the coming years, we will face a big disaster." The Special Rapporteur reiterates that the ban is completely unjustifiable and that, unless it is reversed, it will lead to unnecessary suffering, illness and deaths and could amount to femicide.

50. The ban abruptly ended the educational trajectories of thousands of women who had devoted years to study and training, and removed the most critical entry point for women's participation in both education and employment in the health sector. In the current context in Afghanistan, a career in the health sector represented one of the few avenues for women to pursue a profession, earn an income and contribute meaningfully to their communities. Its closure has also had serious mental health consequences for those prevented from realizing their professional aspirations.

51. Mixed-gender training courses and workshops for women who continue to work in the health sector are prohibited, and training for women staff can be conducted only by female trainers, of whom there is a shortage. Where training courses do occur, they are monitored by de facto officials to ensure gender segregation.

D. Gender segregation in health facilities

52. As in other institutions, the Taliban enforce gender segregation in hospitals and health facilities. In many provinces, women and girls must receive care in separate spaces, and women health workers are segregated from their male counterparts. Where female patients need to consult a male doctor, they must be accompanied by a *mahram*, adhere to hijab requirements and communicate through their *mahram*. This seriously undermines their right to privacy and to seek care confidentially. People with diverse sexual and gender identities, who have long faced invisibility in the health system, face strict binary gender norms and expectations of appearance, which further restrict their access to safe, appropriate and non-discriminatory healthcare.

53. Gender segregation also impedes the work of women health professionals who are prevented from interacting with male colleagues, even by phone in some cases. As affirmed by an Afghan woman from Helmand Province, "We are not allowed to speak to hospital guards, drivers or men in general unless absolutely necessary. If we do, intelligence officials or *muhtasibs* come and interrogate us. The first time, they issue a warning; the second time, we will be dismissed from our jobs." These restrictions limit opportunities for consultation, peer review, supervision and professional development, with broader implications for quality of care.

54. Taliban officials actively monitor compliance with gender segregation, including through checks that have involved entering private and confidential patient spaces, further discouraging women from seeking care.

E. Restrictions on information and awareness-raising activities

55. Taliban restrictions have curtailed women's participation in public life and health education awareness-raising initiatives. Outreach programmes and community events are now severely constrained, meaning that access to information, including on maternal health, family planning, hygiene, nutrition and other life-saving topics, has been significantly reduced. The situation is further exacerbated by funding cuts.

56. Civil society organizations report persistent operational barriers. Projects have been rejected by the de facto Ministry of Public Health because they target women exclusively, while those organizations that are permitted to operate do so under strict conditions and constant risk of suspension. Sessions conducted for women frequently require prior approval, must be delivered in highly generalized terms or are curtailed altogether. Non-compliance may be met with threats and intimidation, as a health worker in northern Afghanistan explained, "We used to do training and awareness-raising activities in the districts. When the Taliban found out they came to question us. We had to promise we would not come again to talk about sexual or reproductive health."

57. Health workers also reported concerns about increasingly conservative attitudes in some areas and reliance on traditional or religious leaders for health advice, further reducing adherence to evidence-based health practices.

58. Online workshops and discussion groups provide one of the few spaces where women and girls can access information independently of male relatives. However, these opportunities are constrained by the need for devices, Internet connectivity and private spaces. An Afghan woman from Zabul Province asked, "When the doors of knowledge are closed to us, how can we have access to healthcare?"

F. Sexual and reproductive health and rights

59. Access to sexual and reproductive health services, always a sensitive issue in Afghanistan, is severely constrained under the Taliban, undermining women's autonomy and health. While modern contraceptive methods are technically available, supply shortages, closure of family planning services and inconsistent funding have drastically reduced availability.

60. In some provinces, de facto officials have ordered health centres and pharmacies not to supply contraceptives, sometimes confiscating stocks, driving up prices and reducing availability. Health workers report being warned not to provide family planning information or services. Estimates suggest that less than half of women who need family planning have access to modern contraception.[17]

61. Men exercise significant power over reproductive decisions. According to health workers, many contraceptive methods – especially long-acting options such as implants or injectables – typically require the husband's consent, curtailing women's autonomy over their reproductive choices. Family planning counselling is limited; unmarried women have almost no access to these services. Evidence from Afghanistan shows that education and household income are correlated with increased contraceptive use, illuminating how restrictions on women's education and work further reduce reproductive autonomy.[18]

62. Women and girls face major challenges maintaining menstrual health and hygiene. Poverty limits access to menstrual products, leading many to rely on unsuitable materials, increasing the risk of infection. Work is ongoing to expand clean water access and provide safe, sustainable menstrual hygiene options.[19] Programmes providing dignity kits have been scaled back, with specific impacts on displaced and returnee women and girls. Many women and girls experience shame linked to their inability to maintain hygiene, exacerbating social withdrawal and psychological distress.

63. Under the Islamic Republic, abortion was permitted only in very specific circumstances to save the life of the mother. Health workers report that abortions are still performed under extremely limited circumstances, often in private facilities and at prohibitive cost, forcing some women to resort to unsafe methods. Legal uncertainty (the Taliban have suspended all previous laws), social stigma and fear of repercussions deter timely care, increasing the risk of maternal morbidity and mortality.

64. Criminalization of sexual relations outside marriage (*zina*) and same-sex relationships continue to create further barriers. Unmarried women and women who engage in extramarital sexual relations – whether consensual or not – face harsh punishments amounting to torture, family reprisals and social ostracization, all of which discourage disclosure and access to services. Health providers, fearing sanctions, may refuse care or avoid counselling. LGBT+ persons report heightened risks of discriminatory treatment or being reported to the authorities, leaving them effectively unable to access safe and timely care.

VI. Impact and consequences

A. Long-term collapse of the health sector

65. Since August 2021, Taliban policies targeting women's education, work, mobility and participation in public life have been inflicting deep and lasting damage on the health system in Afghanistan. While women health workers continue to work, constraints, including the 2024 ban on medical education, have not only disrupted current service delivery but also fundamentally undermine the future viability of the health sector. There is already a critical shortage of women health workers: a recent analysis estimates that women make up just 27% of non-specialized physicians, 18% of specialized physicians and 29% of nurses. Today, only a fraction of Afghan women – estimated at 4.1 million out of approximately 15 million in 2024 – have reliable access to healthcare.[20]

66. By curtailing access to medical, nursing, midwifery and allied health education, the de facto authorities have effectively dismantled the pipeline of future health professionals. Existing women health workers are retiring, emigrating or being forced out of practice,

[17] UN-Women, *Gender Index 2024: Afghanistan*, p. 15.

[18] Central Statistics Organization, Ministry of Public Health and ICF, *Afghanistan Demographic and Health Survey 2015* (Kabul, Central Statistics Organization, 2017).

[19] See for example initiatives such as Safepad.

[20] Jelena Bjelica, *Rural women's access to health in Afghanistan*, p. 5.

leaving entire communities – particularly in rural and underserved areas – without trained personnel able to provide safe and acceptable care.

67. While other factors, including poverty, insecurity, infrastructure gaps and aid reductions, affect health outcomes, they do not sufficiently account for the current trajectory of the health sector. Rather, the cumulative effect of Taliban policies has been to deliberately design and implement a system that withholds essential healthcare from women and girls. The resulting outcomes – including rising maternal and child mortality, preventable complications and worsening chronic illnesses – are predictable consequences of a governance framework that institutionalizes gender discrimination, oppression and domination.

B. Maternal health and denial of reproductive autonomy

68. Afghanistan has long recorded one of the highest maternal mortality ratios globally. According to the World Bank, the number of maternal deaths per 100,000 live births fell from 1,311 in 2001 to 521 in 2023.[21] Since the Taliban's return to power, however, these gains appear to be reversing. While official data are limited, 2024 estimates place the maternal mortality ratio at 638 deaths per 100,000 live births.[22]

69. Health workers reported to the Special Rapporteur a perceived rise in maternal deaths and pregnancy-related complications. Shortages of essential medicines combined with insufficient numbers of trained staff, inadequate facilities, weak referral systems and a lack of women health workers, particularly in rural areas, are contributing to preventable maternal and neonatal deaths.[23] According to the United Nations Children's Fund (UNICEF), only 66% of women give birth with a skilled attendant, while just 33% receive four or more antenatal visits.[24] Even when death is avoided, women frequently experience long-term morbidity, including anaemia, obstetric fistula, hypertensive disorders and infection.

70. Health workers expressed concern about the number of pregnant and breastfeeding women arriving at clinics severely malnourished. Some 1.2 million women are estimated to be suffering from chronic and acute malnutrition.[25] In addition to posing health risks to the mother, this also undermines children's health, increasing the risk of neonatal death, stunting, wasting and developmental delays.[26] Neonatal mortality is alarmingly high, at 24 deaths per 1,000 live births.[27]

71. As noted above, Taliban policies systematically restrict women's autonomy and access to health services. They compound existing structural weaknesses in the health system, worsening maternal and neonatal outcomes. A foreseeable consequence of these policies is an increase in unwanted and high-risk pregnancies, and access to antenatal, delivery and post-partum care will be delayed or denied, placing women and newborns at risk of serious harm and preventable death.

C. Lack of access to emergency medical care

72. Taliban policies are seriously undermining women's and girls' access to emergency healthcare, directly threatening their right to life. Emergency care is inherently time-sensitive, and requirements that women be accompanied by a *mahram* delay or prevent timely treatment. Such delays can be fatal.

73. Shortages of women health workers, reduced operating hours, facility closures and weak referral systems – especially in rural areas – limit women's ability to seek care at all, particularly urgent services at night.

[21] See https://data.worldbank.org/indicator/SH.STA.MMRT?locations=AF (accessed on 27 January 2026).
[22] OCHA, *Afghanistan: Humanitarian Needs and Response Plan*, p. 13.
[23] Ibid.
[24] UNICEF, "Child food poverty: Nutrition crisis in early childhood in Afghanistan" (2025), p. 20.
[25] OCHA, *Afghanistan: Humanitarian Needs and Response Plan*, p. 55.
[26] UNICEF, "Afghanistan: Humanitarian situation report, 1–31 March 2025".
[27] UNICEF, "Child food poverty", p. 20.

74. Restrictions imposed on women health professionals by the Taliban have also weakened emergency responses, with severe consequences for women and girls, during crises, including the August 2025 earthquake in eastern Afghanistan and mass deportations of Afghans from the Islamic Republic of Iran and Pakistan. At the same time, disaster response has emerged as a rare area of pragmatic engagement between humanitarian organizations and the de facto authorities to facilitate humanitarian access. This highlights potential entry points for targeted interventions that could save lives.

D. Child and adolescent health

75. Afghanistan faces a long-standing crisis in child and adolescent health, driven by chronic undernutrition, weak healthcare systems and gaps in preventive services. Funding cuts, reduced humanitarian assistance and constraints on NGO operations have worsened these challenges. Moreover, reduced access to schools for girls has removed a vital protective environment where health risks, abuse and malnutrition could otherwise be identified early.

76. Child malnutrition is widespread: nearly 3.7 million children under 5 years of age are estimated to suffer from acute malnutrition,[28] while almost 90% live in food poverty.[29] Data from the past year consistently show that girls comprise the majority (57–61%) of children admitted for wasting treatment.[30] Poverty limits access to food, clean water and healthcare, entrenching stunting and anaemia.

77. Taliban restrictions on women's education and economic opportunity undermine families' ability to access health services, nutrition support and immunizations. Over time, limiting girls' education compounds these effects, restricting their knowledge, autonomy and capacity to adopt positive health behaviours and creating a self-reinforcing cycle with intergenerational impacts on child and adolescent health.

78. Despite a formal ban on forced marriage, many girls and young women continue to be coerced into marriage, exposing them to serious health risks, including those associated with early pregnancy. The United Nations Population Fund estimates a high adolescent birth rate of 62 for every 1,000 women and girls aged 15–19, driven largely by child marriage and early childbearing.[31] Early marriage also limits education and economic opportunities, reinforcing intergenerational cycles of poor health. Infants born to very young mothers face higher rates of stillbirth, early death and long-term developmental harm.

E. Survivors of gender-based violence

79. Survivors of gender-based violence in Afghanistan face profound barriers to accessing healthcare. Health workers, often the first point of contact, struggle to provide support. Specialist gender-based violence units, referral networks and specialized services – including trauma-informed care, dedicated care spaces, testing and treatment for HIV and sexually transmitted infections, safe houses and legal aid – have largely been closed or suspended. Chronic gaps in mental health and psychosocial support compound trauma.

80. As restrictions on women's movement, work and social engagement continue, Taliban policies are increasing exposure to family and intimate partner violence, reinforcing cycles of gender-based harm. The trajectory for women's and girls' protection is deeply concerning; the Taliban's new "criminal rules of courts", announced in January 2026, include provisions that effectively permit men to use physical violence against women, with criminal liability arising only in cases resulting in broken bones or obvious bruising. This reinforces impunity for perpetrators and further undermines access to protection and justice.

[28] Save the Children, "Afghanistan: More than one in three children facing crisis levels of hunger as winter starts", 16 December 2025.

[29] UNICEF, "Half of all young children in Afghanistan are experiencing severe food poverty: UNICEF launches ambitious 'First Foods Afghanistan' to reverse the crisis", press release, 16 June 2025.

[30] See 2025 Humanitarian Situation Reports, available at https://www.unicef.org/appeals/afghanistan/situation-reports.

[31] UN-Women, *Gender Index 2024: Afghanistan*, p. 7.

F. Mental health

81. Current restrictions on women's rights and freedoms have triggered a severe mental health crisis, particularly among young women. Many have seen their education, work and personal aspirations demolished, contributing to profound stress, anxiety, depression and suicidal ideation. Taliban policies also eliminate key coping mechanisms, including social interaction, outdoor activities, education and artistic expression. Health workers also report experiencing high levels of stress and burnout. Decades of conflict in Afghanistan had already caused widespread mental health challenges and trauma, including post-traumatic stress disorder, depression and anxiety, often with little access to support or care.

82. Access to psychosocial support remains extremely limited. Mental health remains heavily stigmatized and public services are virtually non-existent. Services provided by NGOs are constrained by operational restrictions, funding shortfalls and access barriers. Remote counselling exists but is often inaccessible due to privacy and connectivity challenges.

83. Mental health is also shaped by broader gendered pressures. People with diverse sexual and gender identities experience direct targeting, discrimination and violence, while cisgender men face social and economic pressures, including expectations to uphold and enforce restrictive gender norms.

84. Afghans in exile are also experiencing trauma associated with displacement, loss of country, "survivors' guilt" and ongoing concern for loved ones. Those in neighbouring countries, particularly the Islamic Republic of Iran and Pakistan, face precarious living conditions, limited access to protection, livelihoods and services, and the constant threat of forced return. Human rights defenders and journalists in exile face ongoing threats while documenting human rights violations from abroad.

G. Chronic, specialist and long-term health needs

85. Access to specialist care for chronic and long-term illnesses in Afghanistan remains severely limited, driven by economic barriers and shortages of trained medical professionals, specialized facilities and equipment. Many people cannot access care for conditions such as diabetes, cardiovascular disease and renal failure or for rehabilitation, leaving illnesses unmanaged and increasing the risk of preventable complications and deaths.

86. People with disabilities are disproportionately affected. Nearly one in four Afghans live with a disability, many requiring health and rehabilitation services.[32] Clinics frequently lack accessibility features, adapted examination facilities and sign language support. Essential services such as physiotherapy, assistive devices and rehabilitation are concentrated in a few urban centres, leaving rural residents and those with limited mobility particularly vulnerable. Medical information is rarely provided in accessible formats. Taliban restrictions on movement, combined with social stigma and limited household resources, further restrict care for women and girls with disabilities. Health workers also report that education gaps and shortages of essential medicines contribute to preventable disabilities in children.

87. Older women experience a pronounced form of invisibility within the health system. In the Bishnaw health survey, 46% of women aged over 60 reported being unable to reach a health facility when needed. Age-related health needs are often complex and extend beyond maternal or basic health services. For older women, untreated illnesses, poor nutrition and lack of preventive or regular care accelerate physical decline, increase the risk and impact of chronic illnesses, and contribute to earlier ageing and reduced life expectancy.

H. Women in detention and institutional settings

88. Women in detention and other institutional settings in Afghanistan face severe barriers to accessing healthcare. Detainees frequently lack timely medical treatment, a situation made more urgent given ongoing accounts of torture, ill-treatment and sexual violence in detention facilities. These risks are compounded by insufficient access to hygiene and menstrual

[32] United Nations Afghanistan, "UN Afghanistan statement on the occasion of International Day of Persons with Disabilities", press release, 3 December 2025.

products, leaving women particularly vulnerable to infections and serious physical and psychological harm. Information about the consequences for individuals subjected to corporal punishment – including their access to physical and mental healthcare – is extremely limited, particularly due to stigma and fear of reprisals.

89. Health concerns are further pronounced for women who use drugs – around 10% of drug users in Afghanistan, particularly in the north.[33] Under the Taliban, drug use is treated primarily as a criminal offence rather than a public health issue, and drug users can face corporal punishment, detention and forced treatment. Most drug treatment centres cater to men, with far fewer facilities for women, significantly limiting women's access to care. Funding cuts since 2021 have sharply reduced service availability: by 2023, approximately 44% of drug treatment centres had closed, while only 10% remained operational, many on severely reduced budgets.[34]

I. Erosion of public health capacity and disease surveillance

90. The public health system in Afghanistan is severely undermined by a lack of expertise, capacity and resources to effectively monitor, prevent and respond to disease outbreaks. Low routine immunization coverage for measles, polio and other vaccine-preventable diseases continued to enable recurrent outbreaks – just 51% of children aged 12–23 months are fully vaccinated.[35] The acute shortage of essential medical personnel – especially women health workers – has led to the systematic weakening of vital public health functions, including disease surveillance and emergency preparedness. This leaves the country ill-equipped to identify health threats early, respond to public health emergencies or ensure the timely delivery of essential interventions. It has also left the country vulnerable to both local outbreaks and cross-border transmission, posing regional and even global public health risks.

VII. Legal analysis

91. As a State Party to numerous international human rights treaties, Afghanistan is bound by obligations arising under those instruments that remain applicable irrespective of changes in government, the authority exercising effective control over the territory, or the question of international recognition.

A. International human rights law

92. Under international human rights law, every person has the right to the highest attainable standard of physical and mental health, without discrimination. This right extends to the underlying determinants of health, including food and nutrition. In addition to being a fundamental right, health is indispensable for and dependent on the exercise of other human rights, including the rights to non-discrimination, food, housing, work, education, life, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement.[36]

93. The International Covenant on Economic, Social and Cultural Rights, to which Afghanistan is a State Party, obliges States Parties to achieve the full realization of the right to health progressively and to the maximum of available resources (art. 2). However, certain obligations are immediate, including the duty to ensure non-discrimination, to prioritize the most vulnerable and marginalized groups in the allocation of health resources, and to allocate health resources equitably. Other core obligations include ensuring reproductive, maternal

[33] United Nations Office on Drugs and Crime, *Afghanistan Drug Insights, Volume 5: High-Risk Drug Use In Afghanistan* (2025), p. 5.
[34] Ibid., p. 12.
[35] UNICEF, "Child food poverty", p. 20.
[36] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health, para. 3.

and child healthcare, providing education and access to information, and providing appropriate training for health personnel, including education on health and human rights.[37]

94. Under international human rights law, Afghanistan is specifically obligated to respect, protect and fulfil sexual and reproductive health rights, which encompass the autonomous ability of individuals to make decisions about their bodies and reproduction free from coercion, discrimination and violence. Measures that restrict reproductive autonomy or deny individuals the capacity to make informed choices violate these obligations.[38]

95. Other treaties, including the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities, further reinforce the duty of Afghanistan to protect the health rights of women, children and other at-risk groups. The Convention on the Elimination of All Forms of Discrimination against Women includes specific provisions requiring States Parties to eliminate discrimination against women, including in the field of health (arts. 2 and 12). It also obliges Afghanistan to ensure appropriate services in connection with pregnancy and to ensure that rural women have access to adequate healthcare facilities, including information, counselling and services in family planning (arts. 12 and 14). The Convention on the Rights of the Child, meanwhile, guarantees a child's right to healthcare, with particular attention paid to maternal and child health (art. 24).

96. The realization of the right to health requires that health facilities, goods and services must be available, accessible, acceptable and of good quality. Accessibility encompasses physical accessibility, economic accessibility (affordability) and access to health-related information, without discrimination. In practice, this requires a functioning public health infrastructure, trained medical personnel, essential medicines and equipment, and public laws and policies that permit and facilitate non-discriminatory access. All health facilities, goods and services must respect medical ethics, be culturally appropriate and respect confidentiality. International law also requires that violations of human rights, including the right to health, are met with effective remedies.

97. While States themselves are responsible for ensuring the fulfilment of human rights, the Committee on Economic, Social and Cultural Rights has specifically called upon States Parties to take steps "individually and through international assistance and cooperation" to fully realize economic, social and cultural rights, noting that wealthier States should help facilitate access to essential health services in other countries and "provide the necessary aid when required".[39]

98. Since the Taliban assumed effective control, the de facto authorities have implemented policies that directly violate the international obligations of Afghanistan to ensure the highest attainable standard of health. Women and girls face systematic and discriminatory barriers to accessing healthcare, amid restrictions on other rights.

99. Deliberate measures taken by the de facto authorities described in the present report undermine the availability, accessibility, acceptability and quality of health services for women, girls and gender-diverse persons. They are deeply discriminatory and foreseeably result in avoidable harm, including violations of bodily autonomy, serious physical and mental suffering, and preventable deaths. The Taliban's retrogressive measures are intentional and cannot be justified by resource constraints or cultural considerations.

100. The violations stemming from these policies are driven and compounded by interrelated infringements of multiple other rights, including the rights to freedom of movement, education, work, privacy, family life, and equal participation in social, cultural

[37] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), paras. 43 and 44.

[38] Committee on Economic, Social and Cultural Rights, general comments No. 22 (2016) on the right to sexual and reproductive health, and No. 14 (2000).

[39] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000), paras. 38 and 39.

and political life. These policies also threaten the right to life and freedom from torture and other cruel, inhuman or degrading treatment or punishment.

101. Measures imposed by the de facto authorities strike at the core of women's and girls' bodily and reproductive autonomy, directly and indirectly undermining their ability to make free, informed and independent decisions about their sexual and reproductive health, including whether, when and how to have children. By conditioning access to essential services on male permission, denying or severely restricting access to contraception and abortion, and suppressing information and services related to sexual and reproductive health, Taliban policies systematically replace individual choice with coercion and control. This constitutes an intentional, discriminatory infringement on the rights to privacy, bodily integrity and family life, and the right to the highest attainable standard of health, including sexual and reproductive health and rights.

102. Taken together, these measures amount to systematic reproductive violence: a form of gender-based violence that targets reproductive autonomy through acts or omissions that interfere with reproductive rights, bodily integrity and decision-making capacity. The consequences – including preventable maternal deaths, lifelong health complications, psychological harm and intergenerational impacts on child health and survival – are foreseeable, preventable and reflect a sustained attack on women's and girls' bodily autonomy and dignity.

B. Crimes against humanity

103. The Special Rapporteur has previously concluded that the Taliban have imposed an institutionalized system of gender discrimination, oppression and domination that is both widespread and systematic, constituting crimes against humanity.[40] Further, he has concluded that the severe and intentional deprivations of women's and girls' fundamental rights amount to the crime against humanity of persecution on the grounds of gender.

104. This conclusion is reinforced by the findings in the present report, which demonstrate that the Taliban are systematically depriving women and girls of their rights to equality and non-discrimination, the highest attainable standard of physical and mental health, sexual and reproductive health and rights, freedom of movement, education, equal participation in economic, social, cultural and political life, privacy, family life and freedom from torture and other cruel, inhuman or degrading treatment or punishment.

105. Taliban policies described in the present report may constitute or be indicia of other crimes under international criminal law. They should compel further investigation, including rigorous examination of the intersectional, gender- and age-specific dimensions of harm and their cumulative impacts on individuals over their lifespan, and on communities.

C. Gender apartheid

106. Taliban violations of the right to health and related rights illustrate the complex, interlocking and mutually reinforcing system of gender oppression currently enforced in Afghanistan. These violations can accurately be described as gender apartheid.

107. While the existing international legal architecture prohibits gender-based crimes, including persecution on the grounds of gender, it does not fully prohibit institutionalized regimes of systematic gender oppression, such as the one currently imposed in Afghanistan. Consequently, the necessary tools to fully define such crimes, address their intentional and institutionalized nature, and hold both State actors and individuals accountable for the totality of violations are lacking. Recognizing and codifying gender apartheid as a distinct international crime is essential to close this accountability gap and ensure full recognition of the unique and intergenerational harms experienced by survivors.

[40] See A/HRC/56/25.

VIII. Conclusions and recommendations

108. **Afghanistan faces an escalating long-term health crisis, caused not only by a fragile health system, weakened over decades of conflict and underinvestment, but also by the Taliban's deliberate and systematic violations of the rights of women and girls. Policies limiting mobility, education, workforce participation and access to health services have intensified pre-existing inequities, creating a self-reinforcing architecture of gender oppression that systematically undermines women's and girls' capacity to safeguard their health. Over time, the cumulative effect of these violations threatens to destabilize the health system and perpetuate cycles of preventable disease, suffering and death. Policy changes and accountability are essential to halt violations and affirm the dignity and rights of women and girls.**

109. **The crisis is compounded by severe international funding cuts and operational constraints on health and humanitarian actors that are undermining life-saving programmes, seriously disrupting service delivery, and stretching an already fragile and externally dependent system to breaking point. Without urgent and sustained support, millions of Afghans will be left without essential care, with women, girls and gender-diverse persons disproportionately bearing the consequences. Greater international responsibility and action are required.**

110. **Supporting women and girls in Afghanistan – through safeguarding access to education, health services, professional opportunities and protection from violence – is critical both for their individual rights and well-being and the resilience and recovery of the health system. Strengthening women's role in healthcare, education and community leadership is essential to secure the health and future of Afghan society.**

111. **The Special Rapporteur reiterates his previous recommendations to the de facto authorities, which have been largely unimplemented. He further calls on the de facto authorities:**

(a) **To immediately lift the ban on medical education and training for women and allow women graduates to take their final examinations;**

(b) **To lift restrictions on the freedom of movement of women and girls, notably the requirement to be accompanied by a *mahram*;**

(c) **To ensure that women and girls have access to quality health services, including physical, psychosocial, and sexual and reproductive health services;**

(d) **To restore the right of women to work in all sectors and allow full and unimpeded access for women health and humanitarian workers to reach underserved communities and access United Nations premises;**

(e) **To lift the ban on secondary and tertiary education for girls and women, ensuring that schools impart knowledge that equips girls and boys with comprehensive, age-appropriate information about nutrition, hygiene, sexual and reproductive health and rights, and preventive care;**

(f) **To revoke all policies and practices that deprive women and girls of rights and fundamental freedoms and violate the international human rights obligations of Afghanistan, including those provided in the "law" on the promotion of virtue and the prevention of vice and the criminal rules of courts;**

(g) **To ensure the publication of State budgets, progressively increase funding for the public health system consistent with the World Health Organization benchmark of 5% of gross domestic product, and take steps to expand and improve primary healthcare facilities, especially in rural and underserved areas;**

(h) **To engage constructively with the Special Rapporteur and other United Nations human rights mechanisms and to facilitate visits by them to the country.**

112. **In order to provide support for Afghan women and girls, the Special Rapporteur calls upon States:**

(a) **To avoid normalization or legitimization of the de facto authorities until and unless there are demonstrated, measurable and independently verified improvements, including against human rights benchmarks, particularly for women and girls;**

(b) **To ensure the full, safe, equal and meaningful participation and inclusion of diverse groups of Afghans, in particular women, young people and members of minority and marginalized communities, in all deliberations concerning the country's future.**

113. **In order to support and strengthen Afghan civil society, particularly women-led civil society organizations, the Special Rapporteur calls upon States and donors:**

(a) **To ensure full funding of the 2026 Humanitarian Needs and Response Plan for Afghanistan;**

(b) **To increase support for non-governmental organizations operating in Afghanistan or working on the situation there, including in health and health-adjacent sectors, by committing to long-term and flexible funding, while ensuring that non-governmental organizations lead in identifying key areas of work and setting priorities;**

(c) **To increase support for training and education programmes for girls and women in health-related fields through scholarships, alternative learning programmes and by other available means;**

(d) **To consult actively, meaningfully and regularly with Afghan civil society organizations, ensuring the inclusion of diverse voices and perspectives, particularly those of women, children and young people, and members of minority and marginalized communities.**

114. **In order to tackle impunity for international crimes committed in Afghanistan, the Special Rapporteur calls upon States, especially Muslim-majority States:**

(a) **To ensure that the Independent Investigative Mechanism for Afghanistan is operationalized at the earliest opportunity and contribute to the voluntary trust fund so that it can begin its important work;**

(b) **To support the codification of gender apartheid as a crime against humanity;**

(c) **To ensure that the International Criminal Court has the resources and cooperation needed to investigate and prosecute those responsible for international crimes;**

(d) **To support ongoing efforts to hold Afghanistan to account for violations of the Convention on the Elimination of All Forms of Discrimination against Women.**

115. **The Special Rapporteur recommends that international accountability mechanisms ensure that violations of the right to health and all forms of gender-based violence, including reproductive violence, are included within the scope of their investigations.**