صداهای زنان برای صلح همه‌شمول و پایدار
د ټول‌شموله او تلپاتي سولې لپاره د ښځو غږونه
Women's Voices for an Inclusive and Sustainable Peace

# WOMEN'S PEACE BRIEF

December 2025 – February 2026

# Access to Healthcare for Women and Girls in Afghanistan under Taliban Rule

## SUMMARY


A total of **8,805** women across all **34** provinces[1] of Afghanistan were surveyed on access to healthcare for women and girls.

While **51.5%** of respondents report being able to access a health facility when needed and a further **24.9%** strongly agreeing, these figures obscure a critical gap in the quality, safety, and adequacy of care.

Public hospitals and clinics serve as the primary point of care for respondents **(57.6%)** indicating a strong reliance on formal health systems, alongside clear evidence of structural barriers and coping strategies. This is followed by private facilities **(30.67%)**, NGO-run clinics **(3.66%)** and traditional medicine **(2.72%).** Notably, 0.74% of respondents report not seeking care at all, a small but critical group likely facing extreme and compounded barriers.

There is a clear and consistent demand for female healthcare providers. Female doctors are identified as the most urgent need by **41.88%** of respondents, followed by female midwives at **27.42%**. In comparison, female nurses are identified as a priority by only **4.67%** of respondents, while **4.24%** are unsure which type of provider is most needed.

There is also a strong demand for mental health providers, with psychologists identified as the third most needed provider category by **21.81%** of respondents.

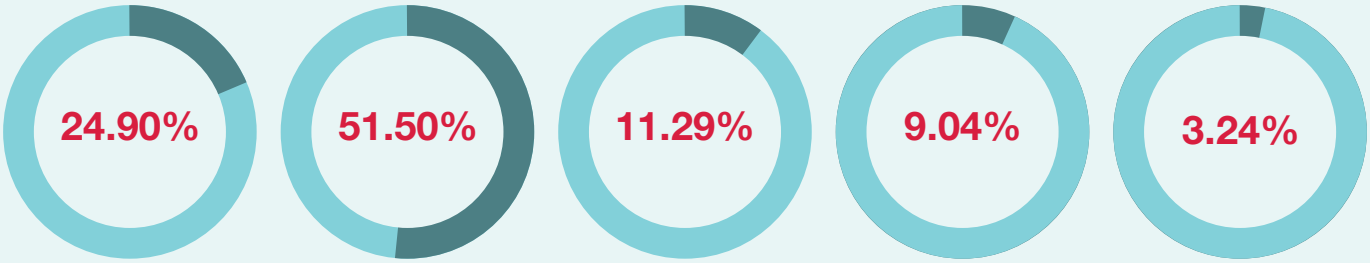
Cost is the single greatest barrier to healthcare access, cited by 38.06% of respondents followed by the lack of female health providers **(20.31%)**, lack of nearby facilities **(17.03%)**, and mahram requirements **(12.21%)**.

It is notable, that broader Taliban-imposed restrictions, beyond just mahram requirements, are identified by **12.40%** of respondents as a barrier. These include limitations on women's mobility, employment, and participation in service delivery, which collectively constrain both access to and provision of healthcare.

Taken together, these findings demonstrate that barriers to healthcare are not singular but overlapping and mutually reinforcing. Economic hardship, gender norms, security-related restrictions, and systemic underinvestment converge to limit women's access to even basic medical care. The prominence of cost as the leading barrier highlights the urgent need for subsidized or free healthcare services, while the continued significance of female provider shortages and movement restrictions underscores the structural nature of the crisis.

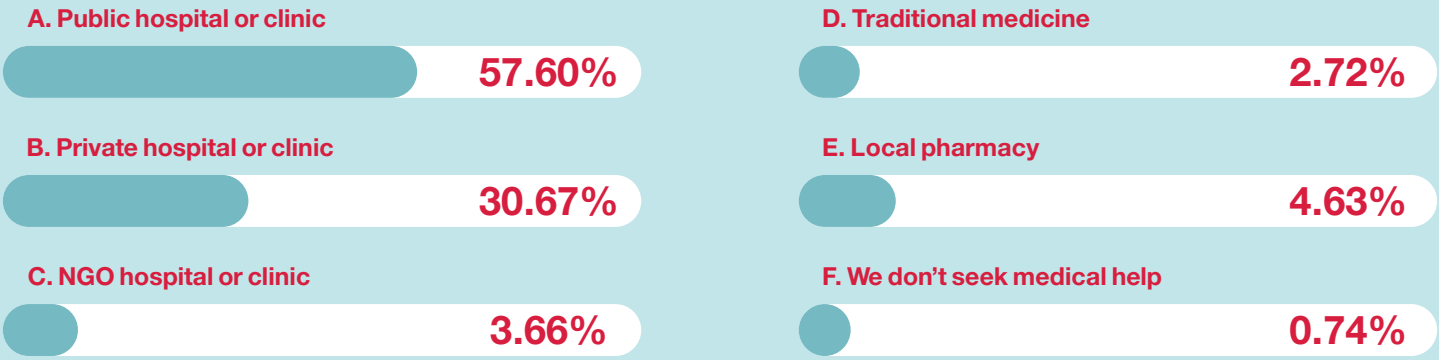

1. **Note:** Survey responses from Logar, Panjshir, Uruzgan, Wardak, and Zabul were 15 or fewer per province and have therefore been excluded from the aggregate findings presented in this brief

## Q1: Would you say you are able to reach a health facility when needed ?

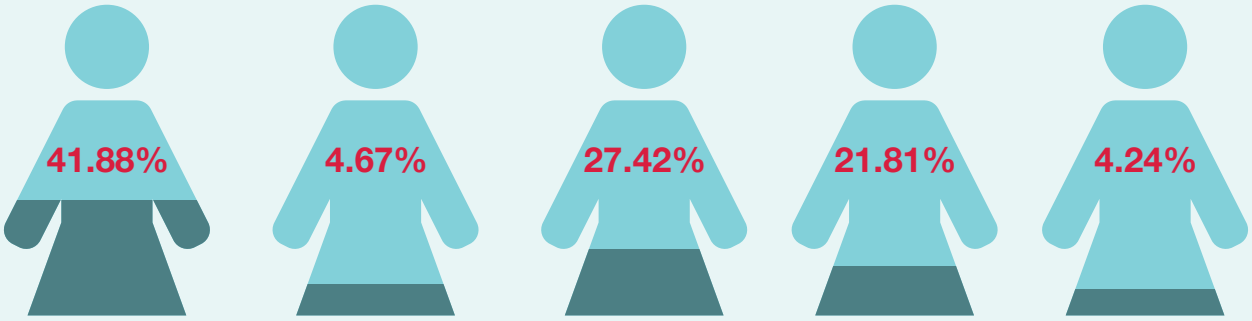



A. Strongly agree | B. Agree | C. Unsure | D. Disagree | E. Strongly disagree

## Q2: When someone in your household including you or another female member needs healthcare where do you go to first for medical help?

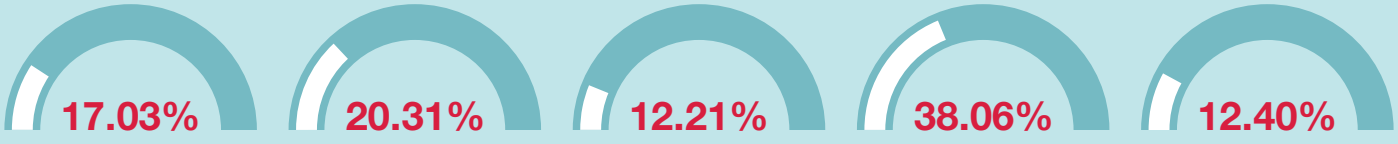



## Q3: Which type of female health provider is needed most in your community?




A. Doctor | B. Nurse | C. Midwife | D. Psychologist | E. Don't know

## Q4: What is the main difficulty that you or other women in your household face when trying to access medical treatment?




A. No medical facilities nearby | B. Lack of female health providers | C. Mahram requirements | D. Cost of treatment | E. Taliban restrictions other than mahram

# KEY INSIGHTS FROM BISHNAW'S WOMEN'S PEACE CIRCLES

**This analysis draws on focus group discussions conducted with Bishnaw's Women's Peace Circles across 27 provinces of Afghanistan, to examine women and girls' access to healthcare under current conditions. While healthcare facilities formally exist across many parts of the country, the findings reveal that access is neither equitable nor guaranteed. Instead, access is highly conditional and mediated by a convergence of gender restrictions, geographic isolation, economic hardship, and the declining capacity of the public health system. Across contexts, the gap between nominal service availability and women's actual ability to obtain care remains profound.**

## A System of Nominal Availability but Restricted Access

Across provinces, women described a health system in which services may formally exist, but access to them is highly conditional and often illusory in practice. The strongest national pattern is the gap between nominal availability and actual access. In provincial centers such as Kabul, Herat, Mazar, and parts of Badakhshan, women reported comparatively greater physical proximity to facilities, but even there access was constrained by overcrowding, low service quality, medicine shortages, and high costs. In rural and mountainous areas, by contrast, access often depended on whether a woman could secure transport, family permission, a mahram, and enough money to complete the journey and pay for care. As one participant in Badakhshan observed,

> **"When a patient is in critical condition, finding transportation is very difficult. Health services are limited, there are no female doctors, treatment costs are high, and services are poor. We have not seen improvements so far."**

## Geography Produces Deep Provincial Inequality

A second clear trend is the sharp urban-rural divide, which cuts across nearly every province. In places such as Badghis, Kunar, Nuristan, Daikundi, Samangan, and Sar-e-Pol, women described long journeys over poor roads, lack of ambulances, seasonal isolation, and facilities too weak to handle emergencies. These barriers were most severe in remote districts, where women often arrived late or not at all. Yet there were provincial differences in degree. Bamyan and parts of Balkh reflected relatively better urban access, while provinces such as Badghis, Nuristan, and Kunar reflected near-systemic rural exclusion. The common denominator, however, was that geography itself had become a determinant of survival. As one participant in Badghis stated,

> **"We have seen many women who reached health centers late and lost their lives."**

## Gender Restrictions Turn Delay into Danger

Across nearly all provinces, the Taliban's mahram requirement and related restrictions on women's movement emerged not as secondary obstacles, but as primary determinants of whether care could be sought at all. Women reported being unable to leave the house, board transport, enter facilities, or travel far or at night without a male escort. In some provinces, this was enforced through hospital practice; in others, through checkpoints, family restrictions, or fear of harassment. While the intensity varied, with Bamyan reflecting somewhat more indirect enforcement and Helmand, Khost, Ghazni, and Sar-e-Pol reflecting more explicit constraints, the overall pattern was consistent: mobility restrictions converted treatable illness into medical emergency. As one participant in Khost explained,

> **"When an emergency happens… and there is no man in the house, the woman cannot go alone to a clinic or hospital."**

## The Shortage of Female Health Workers is Now Structural

The shortage of female doctors, midwives, nurses, and mental health professionals was one of the most consistent findings across all datasets. This shortage is not only a service gap, it is a structural access barrier because many families will not permit women to be examined by male providers, particularly for reproductive, maternal, and gynecological care. In several provinces, women said that even where facilities existed, they remained functionally inaccessible because no female staff were available. This shortage was described as worsening since the return of the Taliban due to restrictions on women's education, blocked professional pathways, low salaries, resignations, and migration. While the need for female doctors and midwives was strongest everywhere, Takhar, Paktia, Sar-e-Pol, and Khost also revealed a growing demand for female psychologists, suggesting an important regional expansion from physical care needs into mental health. As one participant in Samangan put it,

**"In every hospital there is a Taliban guard, because without a mahram and without hijab, we cannot go out. Pregnant women, with all their bad physical condition, are forced to observe hijab. If they do not have proper hijab, they are not allowed to enter the hospital."**

## Poverty Determines the Care Pathway

Economic deprivation is the most pervasive cross-cutting factor shaping access. In nearly every province, women described a care pathway governed less by medical need than by household finances. Government facilities remained the first option for most because they were cheaper, but even these required out-of-pocket spending for tests, medicines, supplies, and transport. Private facilities were widely perceived as faster, cleaner, and better staffed, but accessible only to those with financial means. This has created a two-tiered system in which quality care is effectively rationed by income. Some provincial differences were notable. For instance, in Nimroz, the relocation of the government hospital outside of the city center increased transport costs so sharply that private facilities within the city became the default despite their high costs; in Khost, the introduction of new fees in public hospitals signaled a further erosion of affordability. Across provinces, however, the same conclusion held: poverty delayed care, narrowed options, and forced women into riskier choices. As one participant in Nimroz noted,

**"Now mostly people go first to private hospitals, then pharmacies, then traditional medicine."**

## Delayed Care, Home Treatment, and Informal Substitutes Have Become Normalized

Because women face simultaneous constraints of cost, distance, transport, permission, and staff shortages, the most common pattern of care-seeking is delay. Across provinces, women described first relying on home remedies, pharmacies, traditional healers, local midwives, or religious healers, and turning to formal care only when the illness became severe. This pattern was particularly visible in Kandahar, Nangarhar, Paktia, Paktika, Nimroz, and Sar-e-Pol, where families often postponed care until pain, bleeding, childbirth complications, or severe deterioration made delay impossible. This is one of the most important convergences across the country: women reach the best option last; they reach the nearest or cheapest option first. Women are forced to rely on the most accessible or affordable option, often seeking higher-quality care only when their condition becomes severe, and only if they can afford it. As one participant in Kunduz summarized,

**"When a woman needs health care, she usually goes to the nearest possible option, not the best option."**

## Public Health System Weaknesses Compound Every Other Barrier

Even when women overcome the barriers to reaching facilities, the quality and functionality of public health services remain deeply compromised. Participants across provinces described medicine shortages, lack of good doctors and diagnostic tools, long waits, poor referral systems, administrative favoritism,

informal payments, negligence, and disrespectful treatment. These problems were reported not only in remote clinics, but in provincial hospitals as well. Government facilities in most provinces were often described as only having the capacity to handle minor conditions, with more serious cases referred to hospitals in city centers like Kabul. In Samangan, Sar-e-Pol, Farah, and Takhar, women stressed that facilities often looked functional from the outside but failed to provide meaningful care once reached. As one participant in Balkh said,

**"People go with effort, wait for hours, and finally even one packet of medicine is not accessible."**

## Priority Changes to Improve Healthcare Access

Across all 27 transcripts, participants converge on a clear set of priorities for improving women's access to healthcare: the removal of gender-based restrictions on mobility and work, particularly the mahram requirement; the reopening of girls' education to rebuild the pipeline of female health professionals; and the urgent expansion of female staff, especially midwives, doctors, and increasingly mental health providers. These structural demands are reinforced by calls to reduce the cost of care, ensure the availability of medicines and equipment, and strengthen the overall quality and functionality of public health services. At the same time, participants emphasize the need to expand services into rural areas through local clinics and mobile health teams, and to address social norms that limit women's decision-making within households. Taken together, these responses underscore that improving access is not a single-sector issue, but requires coordinated action across rights, health systems, and economic barriers to enable women to seek and receive care in practice.

## METHODOLOGY

This brief presents data collected through the Bishnaw initiative. Using an online survey with four multiple-choice, closed-ended questions, we surveyed **4,814** respondents in **34** provinces. An additional **3,271** respondents were surveyed through key informant interviews (KIIs) conducted in **27** provinces[2]. The majority of these respondents were between the ages of **18** and **35**. Futhermore, to deepen the quantitative analysis, we also conducted focus group discussions with Bishnaw's Women's Peace Circles in the same **27** provinces mentioned above, involving **469** participants.

Bishnaw's methodology is designed to ensure the inclusion and participation of diverse women reflecting all demographic and regional backgrounds. As a result, in this survey, data from **15** provinces[3], surpassed the **90%** confidence level threshold for representativeness.

2. KIIs and FDGs were conducted in the following provinces: Balkh, Bamiyan, Daikundi, Farah, Faryab, Jawzjan, Herat, Kandahar, Nangarhar, Baghlan, Paktya and Badghis, Kabul, Badakshan,Takhar, Kunar, Samangan, Helmand, Nuristan, Kapisa, Nimroz, Sar-e-Pol, Ghazni, Kunduz, Parwan, Khost, Paktika. Balkh, Bamiyan, Farah, Daykundi, Faryab, Jawzjan, Herat, Kandahar, Nangarhar, Baghlan, Paktya, Badghis, Kabul, Nimroz, Badakhshan.

3. Balkh, Bamiyan, Farah, Daykundi, Faryab, Jawzjan, Herat, Kandahar, Nangarhar, Baghlan, Paktya, Badghis, Kabul, Nimroz, Badakhshan.

## ABOUT US

Bishnaw is a digital platform that captures the voices of women and girls in Afghanistan in real-time and on a diversity of topics. Reflected in its name, Bishnaw means 'listen' in Dari and was developed to ensure that the process of 'listening' to Afghan women is not seen as a one-off event but as an integral part of all national and international discussions, platforms, and decision-making processes.