Refugees International

AFGHANISTAN

NO ONE DIED?

New Frontline Evidence from Afghanistan on Maternal, Neonatal, and Child Deaths following the Withdrawal of U.S. Assistance

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About Refugees International

Refugees International advocates for lifesaving assistance and protection for displaced people and promotes solutions to displacement crises around the world. We do not accept any government or UN funding, ensuring the independence and credibility of our work.

Featured Image: An Afghan woman holds her one-year-old niece Maissa, as she waits with other women in the outpatient department of the underfunded district hospital of Andar on August 26, 2025, in Ghazni, Afghanistan. Photo by Elise Blanchard/Getty Images.

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Executive Summary

"No one has died because of USAID cuts." In May 2025, U.S. Secretary of State Marco Rubio defended the Trump administration's decision to terminate U.S. foreign assistance by asserting that there was no evidence linking aid cuts to preventable deaths. This new research by Refugees International presents frontline evidence from Afghanistan that directly contradicts that claim. The study reveals the avoidable deaths of hundreds of Afghan women and children whose lives could have been saved by specific health services that were shut down because of U.S. funding cuts.

Drawing on 555 survey responses by healthcare professionals across 30 out of 34 provinces in Afghanistan – 69.4 percent of whom were practicing midwives – and public health data acquired from more than 320 health facilities and hospitals across six provinces. Refugees International documents a high rate of neonatal[1] and maternal mortality[2] and a health system that has rapidly deteriorated following the termination of U.S. humanitarian and health assistance. While this research was not designed to estimate nationwide mortality, it provides robust quantitative and qualitative evidence that preventable deaths are occurring at a wider scale as essential health services have disappeared.

Using a conservative verification methodology designed to avoid duplication, the survey documents compelling frontline evidence of the human toll:

- At least **161 high-confidence, preventable deaths**, including **80 maternal deaths, 30 newborn or fetal deaths, 14 deaths among children, 26 adult deaths, and 11 unknown/unspecified deaths** were reported by survey respondents (See more in Annex 1).
- **More than two in five** respondents **reported personally knowing of individuals who had died because they were unable to access healthcare** that was disrupted by funding cuts.
- **Three in five** respondents reported knowing **patients who suffered severe health consequences** because clinics had closed, healthcare workers had been dismissed, or medicines had become unavailable.

1 Neonatal mortality rate (NMR) is calculated as the number of deaths from birth to 28 days postpartum divided by the number of live births. "Number of deaths during the first 28 completed days of life per 1,000 live births in a given year or other period. Neonatal deaths (deaths among live births during the first 28 completed days of life) may be subdivided into early neonatal deaths, occurring during the first 7 days of life, and late neonatal deaths, occurring after the 7th day but before the 28th completed day of life" [WHO GHO, 2026]. According to UNICEF data, neonatal mortality in Afghanistan in 2024 was 33 deaths per 1,000 livebirths. The SDG target is fewer than 12 deaths per 1,000 live births.

2 Maternal mortality ratio (MMR) is defined as the number of maternal deaths during a given time period per 100,000 live births during the same time period [WHO 2026]. Typically deaths from pregnancy through termination of pregnancy or 42 days postpartum are counted. This is the approach taken in the analysis below; however, it should be noted that the maternal deaths reported here are likely an underestimate of maternal deaths, as these data may capture only in-facility deaths; thus maternal deaths in the community or in transit between hospitals may be missing.

- **More than two-thirds of midwives** who responded reported they **lost their jobs following U.S. aid cuts.**

The survey findings are reinforced by hospital data collected directly from **more than 320 health facilities in six Afghan provinces.** A look at health facility data by province shows:

- In **Herat Province**, the data reveals a disturbing nearly **five-fold increase in the institutional maternal mortality ratio in the first six months of 2026** (+109%) compared with 2025 (22.5%).
- In six district hospitals in **Nangarhar**, **neonatal mortality rate increased by nearly 60%** in 2025 compared to 2024, and **perinatal mortality rate[3] rose by more than 28%** in the same period.
- In **Farah's provincial hospital**, institutional deliveries increased by nearly 15%, yet neonatal deaths increased by 167%, resulting in the **neonatal mortality rate increasing by 133%** in 2025 compared with 2024.
- In **Kunar Province**, **neonatal deaths due to asphyxia increased by 156%.**

The data clearly suggests that the quality and capacity of essential maternal and newborn care deteriorated despite continued demand for services. However, it should be noted that the deaths reported here are likely an underestimate as these data mostly capture only in-facility deaths; thus maternal and neonatal deaths in the community or in transit between hospitals may be missing.

Following the 2025 USAID cuts, increases in mortality are most evident at the highest levels of care (i.e. in provincial and regional hospitals that can take on higher risk cases); this may have to do with referral of complications and volume of patients at higher level care. Maternal mortality and newborn mortality are bellwethers of a health system and its quality of care. The majority of maternal and newborn mortality is preventable, and relies on the building blocks of the health care system. With the USAID cuts, changes in staff, supplies, systems, and structures were dramatic, altering the underlying health system.

Healthcare workers surveyed by Refugees International consistently described women dying not because their medical conditions were untreatable, but because the systems designed to save them had ceased to function. Mothers died from postpartum hemorrhage because blood transfusion services had stopped operating. Pregnant women died while trying to reach functioning hospitals after nearby maternity centers closed.

3 Perinatal Mortality Rate (PMR) is the combined number of stillbirths and neonatal deaths per 1,000 births.

Newborns died because oxygen plants were no longer operational, and children with treatable illnesses succumbed after delays in obtaining routine medical care. The evidence demonstrates that maternal mortality has been driven by multiple, simultaneous failures, including the closure of health facilities, shortages of skilled midwives, the collapse of referral pathways, and the loss of emergency obstetric services.

The U.S. funding cuts also precipitated a rapid collapse of parts of Afghanistan's primary healthcare system. Among 555 healthcare workers surveyed, 69% were midwives – 70% of whom reported losing their jobs. Nearly three in five (59%) said their health facility had already closed due to U.S. funding cuts, with another 12% reporting imminent closure. Reports of deaths were nearly twice as common among workers from closed facilities as among those from facilities that remained open (45% vs. 28%).

These findings emerge against the backdrop of one of the most abrupt reversals in U.S. humanitarian policy in modern history. For more than two decades, the United States was the single largest international investor in Afghanistan's health sector, helping build a nationwide primary healthcare system that was historically burdened by high maternal and neonatal mortality. From 2002 to 2025, the U.S. funding helped build, renovate, and modernize more than 600 healthcare facilities in Afghanistan. This investment placed a heavy emphasis on training midwives and strengthening maternal and neonatal care to combat the historically high mortality rates.

Medical doctor and surgeon Bibi Khadija Sadat completes a C-section in a provincial maternity unit, on August 27, 2025 in Ghazni, Afghanistan. Photo by Elise Blanchard/Getty Images.

Even after the Taliban seized power in August 2021, the United States maintained humanitarian aid and health programming in Afghanistan. Officials recognized that cutting funds would severely endanger women and children while exacerbating the Taliban's system of gender apartheid. But in January 2025, the Trump administration terminated more than $1.7 billion in assistance to Afghanistan, and approximately $736.6 million in annual humanitarian funding disappeared. At a time when Taliban policies had already imposed severe restrictions on Afghan women and girls, humanitarian funding helped preserve one of the few remaining lifelines for women's health through support for midwives, maternity services, and primary healthcare. While the Taliban bears responsibility for creating the system of gender apartheid that constrains women's access to healthcare, the evidence presented in this report indicates that the withdrawal of U.S. humanitarian assistance was a critical additional shock that accelerated and exacerbated the collapse of maternal and child health services and placed Afghan women, mothers, and children at significantly greater risk of preventable illness and death.

This research documents the lethal human cost of the termination of U.S. humanitarian funding in Afghanistan and makes an urgent call for its immediate reversal. Every day that life-saving assistance remains suspended places more Afghan women and children at risk of preventable death.

Methodology

This study employs a mixed-methods research design combining quantitative survey data with qualitative testimony from frontline healthcare professionals, the majority of whom are practicing midwives.

Refugees International received **555 survey responses**[4] from healthcare workers across Afghanistan through a combination of in-person interviews, telephone interviews, and secure online questionnaires. Respondents included midwives, physicians, nurses, administrators, and other healthcare personnel directly involved in delivering maternal, neonatal, pediatric, and community health services. The majority, 69% (383 of 555), identified as practicing midwives.[5]

Refugees International additionally conducted 15 qualitative in-depth interviews with midwives – some of whom lost their jobs – and also with families of people who died as a result of not being able to access timely healthcare services as a result of U.S. funding cuts.

Artificial intelligence was used as an analytical support tool to help identify, translate, classify, and verify mortality cases reported in the survey. The survey data was analyzed using two distinct AI softwares. The results were compared, and in addition were manually reviewed row by row. The objective was to establish a conservative, auditable minimum high-confidence mortality count from hundreds of qualitative survey responses in Dari, Pashto, and English. Reported deaths were subsequently reviewed using duplicate-screening procedures to distinguish unique cases from potentially overlapping reports. Only deaths assessed as high-confidence unique events are included in the documented minimum of 161 deaths presented in this report (See Annex 1).

The data on neonatal mortality from the survey was further corroborated by obtaining health data directly from health facilities and hospitals across Afghanistan – with a focus on analysing recorded maternal, neonatal, and perinatal mortality in 2025 in comparison to 2024 when U.S. assistance was still active. The data provided provides a look at facility-based mortality and underestimates the overall true mortality rates across Afghanistan.

4 The survey asked respondents whether they had lost employment due to funding cuts, whether facilities had closed, whether they knew patients who experienced serious health consequences because healthcare became inaccessible, whether they knew individuals who had died because of reduced healthcare access, and what they considered the most significant health consequences affecting their communities.

5 Midwives (69 percent of the respondents) serve as the primary providers of maternal and neonatal healthcare throughout Afghanistan, and therefore the respondent pool provides direct insight into changes affecting maternal mortality and reproductive health.

Background

Afghanistan's public health system has long depended on international assistance. After the fall of the earlier Taliban regime in 2001, donor financing helped build a nationwide primary healthcare system, expanding maternal care, childhood immunization, nutrition services, emergency obstetric care, mobile clinics, and the deployment of thousands of midwives. Although Afghanistan continued to face one of the world's highest maternal mortality burdens, these investments enabled millions of women to access antenatal care, skilled birth attendants, and facility-based delivery, including in previously underserved rural communities.

After the Taliban returned to power in August 2021, donors suspended most direct development cooperation with the authorities but continued humanitarian and health assistance through UN agencies and nongovernmental organizations. Afghanistan's health system – particularly services for women – consequently became even more dependent on aid financing. In 2024, the United States provided approximately $736.6 million, or roughly 43 to 45 percent of reported humanitarian funding, out of approximately $1.71 billion recorded by OCHA. That support contracted sharply in 2025. With the suspension of nearly all U.S. foreign assistance, the Trump administration terminated or froze more than $1.7 billion in assistance connected to Afghanistan. Total humanitarian funding reported to OCHA fell to approximately $1.16 billion, a decline of about $550 million, or 32 percent, from 2024. Although the European Union, Germany, Japan, the United Kingdom, Australia, India, the United Arab Emirates, and others continued or increased selected assistance, their contributions were often short-term, geographically targeted, or tied to specific emergencies and did not replace the scale of U.S. funding.

The consequences for the health system were immediate. The World Health Organization (WHO) reported that 167 health facilities had closed by March 2025, cutting off care for approximately 1.6 million people in 25 provinces. Later estimates indicated that at least 422 primary healthcare facilities and mobile health and nutrition teams had closed or suspended operations, affecting approximately 3.3 million people. Major providers were forced to reduce or terminate services. Save the Children reported the closure of 18 health facilities. The International Rescue Committee suspended or reduced health, vaccination, nutrition, water, education, and protection programs. Action Against Hunger halted U.S.-funded activities, including services for severely malnourished children. UNFPA lost support for reproductive health, maternal care, and midwifery programs, while WFP reduced food and nutrition assistance.

These were not isolated project closures. They disrupted an interconnected health system dependent on midwives, medicines, oxygen, blood banks, ambulances, referral pathways, laboratories, and functioning hospitals; making treatable conditions such as postpartum hemorrhage, eclampsia, obstructed labor, infection, and neonatal

respiratory distress potentially fatal. Respondents repeatedly described women dying after maternity wards closed, children dying because oxygen plants stopped functioning, patients with treatable illnesses being unable to reach referral hospitals, and families arriving at health facilities only to discover that no healthcare workers remained on duty.

Effects of Cuts on Afghan Women

The funding withdrawal has had especially devastating consequences for Afghan women. Under the Taliban, women and girls have been excluded from secondary and university education, barred from many forms of employment, restricted in their movement, and increasingly erased from public life. Healthcare remains one of the few sectors in which women continue to work in substantial numbers. Female doctors, nurses, midwives, vaccinators, nutrition counselors, and community health workers are indispensable because many Afghan women cannot receive care from male providers or travel freely to distant facilities.

The U.S. aid cuts materially reinforce the Taliban's system of gender apartheid. They remove services women need for survival, including antenatal care, assisted delivery, emergency obstetric treatment, contraception, nutrition support, and postnatal care. Restrictions on movement and male-guardian requirements already impede access; clinic closures force women to travel farther, at greater cost and risk.

The funding cuts also eliminate one of the last major sources of professional employment available to Afghan women. When clinics close or salaries disappear, female health workers lose both their livelihoods and their place in public life. Their families lose income, while communities lose the female personnel necessary for women to access care. This deepens women's economic dependence, poverty, food insecurity, and social isolation, further advancing the Taliban's exclusion of women from education, employment, and public participation.

Awa, a nurse specializing in malnutrition care, weighs four-year-old Shukuria, assisted by her mother Naziro on August 26, 2025, in Qala-e Nuri, a village of Andar district, Afghanistan. She works at the last mobile health clinic run by the NGO Première Urgence Internationale in Ghazni province, after its four others closed due to U.S. funding cuts. Photo by Elise Blanchard/Getty Images.

Research Findings

Key Finding

> **Afghan women and children are dying preventable deaths because health services became inaccessible after U.S. funding cuts forced facilities to shut down.**

1.1 Deaths reported by 555 survey respondents: Frontline healthcare workers across Afghanistan consistently reported preventable deaths following the withdrawal of U.S. humanitarian assistance. When asked whether they knew of anyone who had died because they were unable to access healthcare following the closure of health facilities or shortages of healthcare workers resulting from U.S. funding cuts, more than two in five respondents answered yes, and in those instances many provided narrative descriptions of those cases.

To better understand the nature of these reports, Refugees International systematically reviewed every death narrative submitted by respondents. After removing entries assessed as having medium or high risks of duplication, the survey documented a high-confidence minimum of 161 unique deaths associated with disruptions in healthcare access following the reduction in U.S. assistance. These documented deaths included:

- 80 maternal deaths
- 30 newborn/fetal deaths
- 26 adult deaths
- 14 infant deaths
- 11 unknown age/category deaths

Given that respondents represented only a fraction of Afghanistan's healthcare workforce and geographic coverage, the true mortality burden is likely substantially higher. Importantly, these deaths occurred through identifiable and preventable mechanisms. Maternal deaths represented the largest category, reflecting the severe disruption of emergency obstetric care following clinic closures and the loss of skilled midwives. Newborns died during childbirth after delayed referrals or because neonatal services were unavailable. Older children died from pneumonia, diarrheal disease, malnutrition, and other conditions that are normally treatable through functioning primary healthcare systems. Adult deaths included patients suffering from chronic diseases, trauma, and acute medical emergencies who were unable to obtain timely care.

Case example 1: A physician from Nangarhar Province reported that the closure of a USAID-supported oxygen plant and stoppage of maintenance for critical life-saving equipment such as ventilators resulted in the deaths of many children:

> **"Infants admitted to the hospital with pneumonia and children under five years of age don't have oxygen. Three to four percent of the children admitted [in Nangarhar Regional Hospital have died]. This oxygen plant is not functional anymore because of the USAID cuts."**
>
> **— Dr. Shah, Jalalabad**

1.2 The statistical findings are corroborated by qualitative interviews and consistent testimonies from healthcare workers across Afghanistan: The descriptive accounts by healthcare workers describe witnessing deaths that they believed were preventable and directly linked to the loss of health services.

Case example 2: Halima, who was in her final trimester of pregnancy, arrived at Ahmad Shah Baba Hospital seeking emergency obstetric care but found that the maternity unit had effectively ceased functioning after U.S. funding cuts. She was referred to another hospital, but died during transport before reaching medical care. The maternity unit at the Ahmad Shah Baba Hospital previously employed 52 midwives and served nearly 2 million people. Following the funding cuts, only one to two midwives remained responsible for approximately 100 births per shift, dramatically reducing the hospital's capacity to respond to obstetric emergencies.[6]

> **"She was in her last trimester and went to Ahmad Shah Baba Hospital, but there wasn't any medical personnel to attend to her; she was sent to Rabia Balkhi Hospital. On the way, her situation got worse, and she died before getting to the hospital."**
>
> **— Nazifa, Midwife, Kabul**

Case example 3: A 37-year-old mother of five in Kabul, pregnant with her sixth child, was unable to receive antenatal care after nearby health services became unavailable due to the funding cuts. According to the midwife who treated her, the woman had not received routine prenatal check-ups because of the lack of medicines and limited access to functioning clinics.

6 According to FIGO, "if a birthing center with no surgical facilities manages approximately 1,000 births per year, there should be a minimum of two – and ideally three – skilled maternal health personnel per shift. A surgical facility with the same number of births would require at least three non-surgical and one surgical member of staff."

By the time she arrived for delivery, she was suffering from severe anemia and exhaustion. Although the delivery itself was completed, she experienced postpartum bleeding and rapidly went into shock. Medical assessment revealed that her kidneys had failed. She died two days after giving birth. The attending midwife attributed her death to the cumulative consequences of the collapse of routine maternal healthcare—particularly the loss of antenatal services, shortages of medicines, and delayed access to skilled care.

Case example 4: A mother in Herat province experienced a ruptured uterus and severe postpartum hemorrhage after a normal delivery. The local health center lacked essential medicines and equipment to control the bleeding. She had to be referred to another facility. There was no ambulance, transportation was delayed, roads were poor, and the vehicle broke down. She died during transport before reaching definitive care.

Case example 5: Gull's sister was in labor in a remote village in the south western province of Nimruz. The nearest health center to their village had closed down because of aid cuts. By the time they took her to the provincial hospital that was hours away, she was in a serious condition. Upon arrival there was a delay in attending to her because of the shortage of medical staff. She died two hours later, and her twins were stillborn.

> **"My sister was sick and in labor. We transferred her to the health center, but it was closed. Then we found a vehicle with many difficulties and carried her to Nimroz Province. When we took her there due to the lack of professional healthcare services, we lost our sister after two hours. Our sick sister was pregnant with twins, and they handed them over to us stillborn."**
>
> **— Gull, Nimroz Province**

1.3 Corroborated mortality by analyzing health data from hospitals: Refugees International obtained health and mortality data from hospitals across the Nangarhar province. The data corroborated the findings from the survey showing a major increase in neonatal and perinatal mortality and significant increase in maternal mortality (See Annex 3).

Case example 6: Dataset for six district hospitals in Nangarhar, showed both neonatal and perinatal mortality rates surged significantly from 2024 to 2025, even though total institutional deliveries fell by 5.62% (dropping from 25,586 to 24,147).

Indicator	2024	2025	Change
Total Institutional Births	25,586	24,147	-5.62%
Neonatal Deaths (Total)	79	119	50.63%
NMR (per 1,000)	3.09	4.93	59.55%
Stillbirths (Total)	392	452	15.31%
PMR (per 1,000)	18.41	23.65	28.46%

Figure 1: Data from Six District Hospitals in Nangarhar Province

This data set shows a disproportionate spike in deaths: While total hospital deliveries dropped by more than 1,400 births, the actual volume of newborn deaths climbed drastically. The risk of a newborn dying in these facilities jumped by nearly 60% year-over-year. The data also shows a compounding crisis. Total stillbirths climbed from 392 to 452. When combined with neonatal deaths, the overall perinatal mortality rate rose by 28.46%, showing that conditions worsened both during late pregnancy/labor (stillbirths) and immediately after delivery.

The data from Nangarhar Province is striking and demonstrates (1) increases in maternal and newborn mortality from 2024 and 2025 across all levels of the health system and (2) notably higher mortality rates in provincial and regional facilities. It is not surprising that higher level facilities have higher rates given a referral pathway to that facility and high risk pregnancies/births; however, the shift from 2024 to 2025 is notable as there was a decrease in total births in 2025 in provincial level facilities, but more deaths. In the regional facility, which may serve several states, the birth volume was similar, but higher rates of mortality were observed in 2025 (See more in Annex 4).

Indicator	2024	2025	Absolute Change	Percent Change
New Patients / OPD	452,919	488,165	+35,246	7.8%
IPD Admissions	104,599	113,226	+8,627	8.2%
Institutional Deliveries	18,618	18,438	-180	-1.0%
Cesarean Sections	5,289	5,318	+29	0.5%
Maternal Deaths	6	8	+2	33.3%
Neonatal Deaths	730	867	+137	18.8%
Stillbirths	758	788	+30	4.0%
ANC Visits	12,662	12,862	+164	1.3%
First ANC Visits	6,062	5,474	-588	-9.7%
Fourth ANC Visits	1,642	1,891	+249	15.2%
PNC Visits	33,954	34,242	+288	0.8%

Figure 2: Data from Nangarhar Regional Hospital

Institutional deliveries were essentially unchanged, declining by only 1%, while neonatal deaths increased by 18.8% and maternal deaths increased by 33.3%. Stillbirths also increased by 4%. This means the increase in deaths occurred despite a nearly stable volume of hospital deliveries.

Indicator	2024	2025	Absolute Change	Percent Change
New Patients / OPD	200,000	280,550	+80,550	40.3%
IPD Admissions	50,215	90,520	+40,305	80.3%
Institutional Deliveries	10,200	8,500	-1,700	-16.7%
Cesarean Sections	3,000	1,516	-1,484	-49.5%
Maternal Deaths	2	6	+4	200%
Neonatal Deaths	520	640	+120	23.1%
Stillbirths	250	381	+131	52.4%
ANC Visits	8,003	6,710	-1,293	-16.2%
First ANC Visits	3,481	2,320	-1,161	-33.4%
Fourth ANC Visits	1,002	540	-462	-46.1%
PNC Visits	20,312	14,790	-5,522	-27.2%

Figure 3: Data from Nangarhar Provincial Hospital (Bibi Fatima Zuhra Regional Hospital)

The provincial hospital saw a 16.7% fall in institutional deliveries and a nearly 50% fall in cesarean sections, yet maternal deaths tripled from 2 to 6, neonatal deaths increased 23.1%, and stillbirths increased 52.4%. At the same time, first ANC visits fell 33.4%, fourth ANC visits fell 46.1%, and PNC visits declined 27.2%.

Indicator & Facility Type	2024	2025	2026 (January – June)
Institutional Deliveries Provincial Level (includes BPHS and non-BPHS)	57,734	71,211	41,210
Institutional Deliveries BPHS level (unaffected by U.S. funding cuts)	40,068	45,292	25,382
Institutional Deliveries Non-BPHS level (affected by U.S. funding cuts)	17,666	25,919	15,828
Maternal Deaths Provincial	16	16	45
Neonatal Deaths Provincial	292	373	160
Neonatal Deaths Non-BPHS	253	342	153

Figure 4: Maternal and Neonatal Health Indicators by Facility Type in Herat Province

Case Example 7: Comparative data across 241 health facilities in Herat province illustrates the stark contrast in terms of increase in maternal mortality rate (MMR) when comparing facilities impacted by U.S. funding withdrawals and those that remained supported. The BPHS facilities remain unaffected and supported by funding from the World Bank and Asian Development Bank, while the non-BPHS facilities are the ones bearing the brunt of the U.S. funding cuts.

The data reveals a disturbing five-fold increase (+109%) in the institutional Maternal Mortality Ratio during the first half of 2026 and signals towards deteriorating maternal health outcomes. This suggests that aid cuts are showing severe negative outcomes as the years progress.

The **Basic Package of Health Services (BPHS)** covers seven essential pillars of primary healthcare in Afghanistan, focusing on maternal and newborn health, childhood immunizations, and public nutrition. It also provides standardized diagnosis and treatment for widespread communicable diseases, basic mental health support, disability rehabilitation, and a reliable supply of essential medicines.

Non-BPHS healthcare in Afghanistan covers advanced secondary and tertiary hospital services regulated under the Essential Package of Hospital Services (EPHS), including complex surgeries, intensive care, and specialized diagnostic imaging. It also encompasses the private medical sector, which provides urban populations with specialized clinics, commercial pharmacies, and brand-name medications funded through out-of-pocket expenses. Additionally, it covers independent humanitarian initiatives and national programs targeting complex, long-term conditions like non-communicable diseases, cancer treatments, and major trauma care.

Indicator	2024	2025	Change
Institutional Deliveries	20,211	20,666	2.25%
Neonatal Deaths	93	137	47.31%
NMR (per 1,000)	4.6	6.6	43.48%
Maternal Deaths	11	14	27.27%
Stillbirths	438	497	13.47%

Figure 5: Health Outcomes in 59 Facilities Affected by U.S. Funding Cuts in Laghman Province

Case example 8: Laghman Province data covering 59 health facilities across seven districts shows a marked deterioration in maternal and newborn outcomes between 2024 and 2025. While institutional deliveries increased slightly from 20,211 to 20,666 (+2.3%), neonatal deaths rose by 47% (93 to 137), increasing the facility-based neonatal mortality rate from 4.6 to 6.6 per 1,000 births. Total maternal deaths increased by 27% (11 to 14), while stillbirths rose by 13.5% (438 to 497), indicating worsening outcomes despite continued utilization of health services.

Indicator	2024	2025	Change
Institutional Deliveries	525	610	16.2%
Neonatal Deaths	2	7	250%
NMR (per 1,000)	3.8	11.5	203%
Stillbirths	23	28	21.7%
Maternal deaths*	0	10	1000%

Figure 6: Maternal and Newborn Health Indicators in Nuristan Province
*Maternal deaths represent reported maternal deaths at home. An additional one facility maternal death due to prolonged/obstructed labour was reported at Want Waigal Hospital in 2025.

Case example 9: Data from three health facilities affected by the U.S. funding cuts in Nuristan indicate that despite a 16.2% increase in institutional deliveries between 2024 and 2025, maternal and newborn outcomes deteriorated substantially across the three reporting hospitals. Facility neonatal deaths increased from 2 to 7, causing the neonatal mortality rate to more than triple from 3.8 to 11.5 deaths per 1,000 institutional deliveries, while stillbirths rose by 21.7%. The data also shows that the perinatal mortality rates (stillbirths + neonatal deaths), increased sharply from 42 deaths/1000 to 63 deaths/1000; 74 to 61 and 98 to 107 from 2024 to 2025. At the same time, 10 maternal deaths at home were reported in 2025 compared with none in 2024, suggesting that access to timely emergency obstetric care and the quality of maternal and newborn services worsened despite continued utilization of health facilities.

Case example 10: Following the termination of U.S. funding in 2025, the three reporting hospitals in Kunar continued to receive increasing numbers of women seeking institutional delivery, yet newborn outcomes deteriorated markedly. Institutional deliveries increased by more than 14%, but neonatal deaths increased by one-third and stillbirths rose by 12.5%. Particularly concerning was a 156% increase in neonatal deaths attributed to birth asphyxia and a doubling of deaths associated with prematurity—conditions that are highly responsive to timely obstetric intervention, skilled birth attendance, neonatal resuscitation, and immediate newborn care.

Indicator	2024	2025	Change
Institutional Deliveries	8,984	10,260	14.2%
Total Neonatal Deaths	98	131	33.7%
Neonatal Mortality Rate (per 1,00 institutional deliveries)	10.9	128	17.4%
Stillbirths	375	422	12.5%
Deaths due to birth asphyxia	9	23	155.6%
Deaths due to sepsis	63	49	-22.2%
Deaths due to prematurity	13	27	107.7%
Deaths due to other causes	9	2	-77.8%

Figure 7: Neonatal Mortality Comparison in Kunar Province

Indicator	2024	2025	Change
Institutional Deliveries	23,334	26,744	14.6%
Neonatal Deaths	15	40	166.7%
NMR (per 1,000)	0.64	1.50	133%

Figure 8: Key Newborn Health Indicators from the Farah Provincial Health Management Information System

Case example 11: The Farah Provincial hospital that was affected by the U.S. funding cuts experienced a marked deterioration in newborn outcomes despite increasing utilization of maternity services. Institutional deliveries increased by nearly 15%, yet neonatal deaths increased by 167%, resulting in the neonatal mortality rate more than doubling. This divergence suggests that while women continued to seek care at health facilities, the capacity of those facilities to provide effective maternal and newborn services deteriorated.

1.4 Maternal mortality has increased through multiple simultaneous failures: The survey documents a conservative minimum of 80 unique, high-confidence maternal deaths. Respondents described overlapping failures contributing to these deaths, including postpartum hemorrhage, lack of blood and transfusion services, shortages of skilled maternity staff, delayed referral, and facility closures.

Figure 9: Maternal Mortality Has Increased Through Multiple Simultaneous Failures

These findings indicate that the reported 80 maternal deaths were associated not only with obstetric emergencies but also with multiple, concurrent failures in access to emergency obstetric care.

1.5 Children and newborns are increasingly at risk: The survey documents at least 30 newborn or fetal deaths and 14 deaths among older children. Respondents repeatedly describe newborn deaths associated with obstructed labor, delayed referral, stillbirth following prolonged transport, lack of oxygen, and absent neonatal services. It demonstrates that neonatal deaths were driven by the collapse of essential maternal and newborn health services rather than isolated medical complications. This data presented by the survey specifically on neonatal deaths was corroborated with the data received from hospitals.

Other Findings

Serious health consequences extend beyond mortality

Three in five respondents reported knowing individuals who suffered serious health consequences in the wake of U.S. aid cuts. These included interrupted treatment for tuberculosis, diabetes, hypertension, respiratory disease, and other chronic illnesses. Respondents also described widespread psychological distress among women who had lost access to counseling services, depression associated with deteriorating economic conditions, and increasing reports of trauma across communities. The interruption of routine healthcare has therefore produced substantial morbidity extending well beyond the documented deaths.

Case example 12: Fatima, a 30-year-old woman from Nawabad village in Ghazni province, regularly attended a Maternal and Child Health Center where she received both maternal healthcare and psychosocial counseling. Her healthcare providers described the clinic as a source of hope and emotional support that had significantly improved her mental well-being. After the facility closed following the U.S. funding cuts, Fatima lost access to both counseling and maternal health services. According to the healthcare worker, her psychological condition deteriorated substantially, illustrating how the collapse of community health services has left vulnerable patients without essential care.

The qualitative data from the survey demonstrates that suspension of nutrition programs has produced widespread concern regarding child and maternal malnutrition. Healthcare workers repeatedly linked closure of supplementary feeding programs to increasing rates of severe acute malnutrition among children under five years of age. Pregnant and breastfeeding women were also described as suffering deteriorating nutritional status because nutritional supplementation programs had ceased operating. Respondents warned that untreated malnutrition is increasing susceptibility to infectious disease while simultaneously reducing children's ability to recover from otherwise manageable illnesses.

Case example 13: A healthcare worker in Kandahar reported that children receiving treatment for severe malnutrition lost access to nutritional support after funding cuts forced reductions in health and nutrition services. Without continued treatment, many remained severely underweight and developed profound anemia. In several cases, their condition deteriorated to the point that they required emergency blood transfusions—demonstrating how the interruption of basic nutrition programs transformed treatable illnesses into life-threatening medical emergencies.

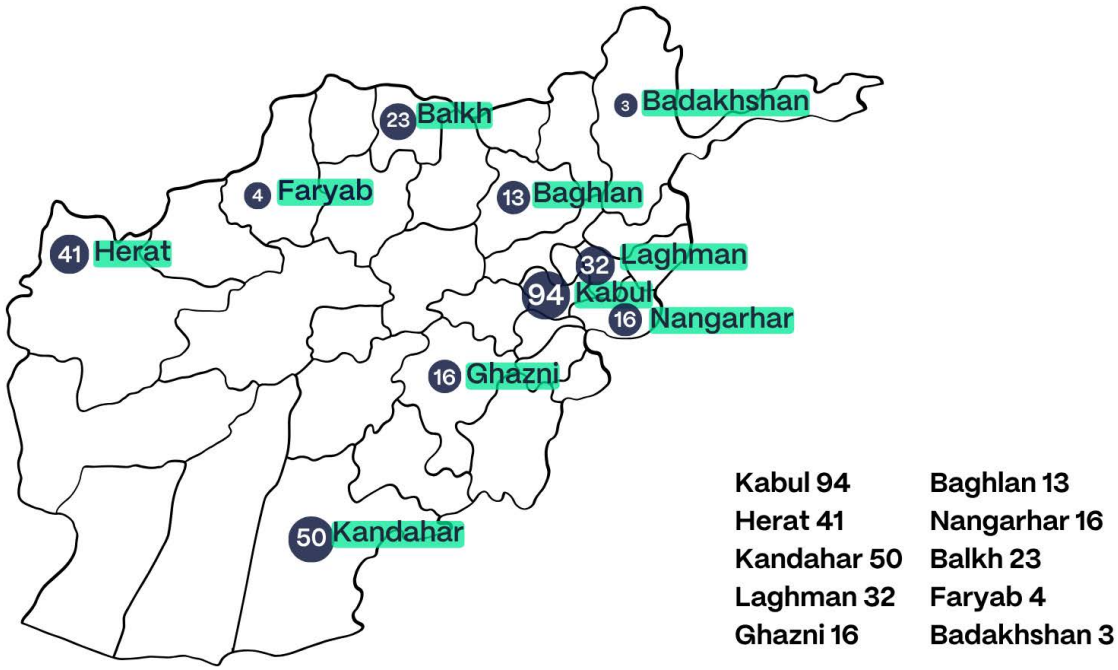
Collapse of Afghanistan's Primary Healthcare System

The survey findings surface at least four trends that collectively point to a rapid collapse of parts of Afghanistan's primary healthcare system following the suspension of U.S. funding.

The first trend is the loss of professional staff. Among the 383 midwives who responded, 260 (68 percent) reported losing their jobs. Among the 172 respondents in other occupational categories, 130 (76 percent) reported losing their jobs (See Annex 2).

The loss of female healthcare workers—particularly midwives—was repeatedly identified as having a disproportionate impact on women and girls, many of whom could no longer access culturally acceptable maternal and newborn healthcare. In addition to their patients, health workers who lost their jobs and their families also paid a high price.

Figure 10: Survey Reported Job Losses after U.S. Aid Cuts



Case example 14: A midwife from Faizabad, Badakhshan Province reported that the consequences of the U.S. funding cuts extended beyond patients to healthcare workers themselves. According to the respondent, one midwife died by suicide after losing his income and being unable to financially support his family.

> **"One midwife committed suicide because he had no income and was responsible for supporting his family financially."**
>
> **— Sharifa, Midwife**

Second, respondents also reported the closure of hundreds of health facilities across multiple provinces. Many described the complete shutdown of Basic Health Centers (BHCs), Comprehensive Health Centers (CHCs), Family Health Houses, mobile health teams, nutrition centers, and maternal and child health facilities. Among the 555 healthcare workers surveyed, 329 (59%) reported that the health facility where they worked had already closed due to the U.S. funding cuts, while another 66 (12%) reported that their facility was on the verge of closure.

As facilities closed, remaining health centers became overwhelmed, referral systems broke down, ambulances and transportation became unavailable, and shortages of medicines, medical supplies, oxygen, laboratory services, and essential equipment became widespread. Healthcare workers described the suspension of vaccination campaigns, antenatal and postnatal care, nutrition programs, tuberculosis treatment, mental health services, and outreach to remote communities.

Third, reports of death in the survey were almost twice as common among workers from closed facilities as among those whose facilities remained open. Most midwives and health workers reported staying informed about the health of their former patients and the communities they had served prior to the closure of their clinics. Among the 329 respondents whose facilities had closed, 147 (45%) reported knowing someone who died because healthcare became inaccessible. Among the 120 respondents whose facilities remained open, 33 (27%) reported knowing of such a death. At facilities nearing closure, 31 of 66 respondents (47%) reported knowing someone who had died.

Finally, the survey also demonstrates a dramatic contraction in access to parts of primary healthcare following the January 2025 U.S. funding cuts. Healthcare workers reported substantial reductions in the number of patients receiving care each day.

Taken together, these findings demonstrate that the funding cuts did not simply reduce healthcare capacity; they triggered a systemic collapse of frontline health services that left large segments of the population without access to essential, life-saving care.

Conclusion

Refugees International's new frontline evidence from Afghanistan on maternal, neonatal, and child deaths following the withdrawal of U.S. assistance not only proves the U.S. administration's claim that "no one died because of aid cuts" wrong; but the findings also point to an urgent policy imperative – the United States should immediately restore life-saving humanitarian and health funding to Afghanistan.

Reopening health facilities, re-employing midwives and healthcare workers, restoring maternal and newborn services, and ensuring access to essential medicines, nutrition, oxygen, and emergency obstetric care would save lives. At a time when Afghan women and girls already face unprecedented restrictions under Taliban rule, maintaining the suspension of humanitarian health assistance risks further preventable deaths among mothers, newborns, and children. The evidence presented here demonstrates that restoring U.S. humanitarian funding is not simply a policy choice—it is a life-saving humanitarian necessity.

Annex 1

To produce a conservative, evidence-based minimum estimate of documented deaths attributable to the collapse of health services following the U.S. funding cuts, survey respondents were asked whether they personally knew of individuals who had died because they could no longer access healthcare after the funding cuts.

Deaths were included only when:

- the respondent described a specific individual or clearly identifiable event;
- sufficient clinical or contextual information was provided to establish a plausible link between disruption of health services and death;
- duplicate reports describing the same individual were excluded;
- generalized statements (e.g., "many mothers died") without identifiable cases were excluded.

Deaths that could not be independently distinguished from other reports were intentionally omitted to avoid double counting.

Classification

Verified deaths were categorized according to clinical presentation:

Category	Key Factors
Maternal	Hemorrhage, labor obstruction, eclampsia, transport failures
Neonatal	Asphyxia, oxygen/referral/care gaps
Child	Pneumonia, diarrhea, vaccine/treatment delays
Adult	TB, chronic illness, trauma, untreated emergencies

Figure 11: Classification

Using this conservative methodology, the survey documented a verified minimum of:

- 80 maternal deaths
- 30 neonatal or fetal deaths
- 14 deaths among older children
- 26 adult deaths
- 11 of unspecified type

Total documented minimum: 161 high-confidence deaths

The report only counts high-confidence, unique deaths as reported in the survey and does not extrapolate deaths to the broader Afghan population. The resulting final mortality figure in this report is therefore a minimum high-confidence count of deaths explicitly supported by respondents' narratives, not an estimate of the total mortality attributable to the funding cuts.

Use of AI

Artificial intelligence was used as an analytical support tool to help identify, translate, classify, and verify mortality cases reported in the survey. The objective was to establish a conservative, auditable minimum high-confidence mortality count from hundreds of qualitative survey responses in Dari, Pashto, and English.

The process involved screening the data through two distinct AI softwares with similar command prompts. The results were compared, and in addition were manually reviewed row by row. In addition to manual review of the data by multiple individuals, AI was used for:

1. Cleaning and deduplication of the survey dataset: The original survey contained repeated submissions from some respondents. Two AI softwares were used to find duplicate responses, and then those were manually compared, and individually reviewed and removed as appropriate to finalise a dataset that was deduplicated.

2. Translation of Dari and Pashto narratives: AI was used to translate Dari and Pashto responses into English, while preserving the meaning of the original account.

3. Identification of specific death events: The final dataset was reviewed through two AI models to systematically review the qualitative narratives on deaths attributable to the funding cuts. The review did not rely solely on respondents selecting "Yes" to a question about whether they knew of such deaths. Each narrative was assessed to determine whether it described a sufficiently specific death event. A case was included in the high-confidence mortality count when the respondent described a specific person or patient who died; explicitly stated that one or more people died; provided a numerical number of deaths; or described multiple clearly distinguishable deaths within the same response.

4. Deduplication of death incidents: Many respondents described the same death in more than one survey question. AI was used to compare the narratives within each response. When more than one response clearly referred to the same person and event, the death was counted only once. Where the additional narrative added information—for example, identifying severe hemorrhage as the cause—it was treated as additional detail about the same death rather than a separate death.

Annex 2

Survey respondents who reported losing their jobs because of the U.S. funding cuts, by province. Counts reflect only the 555 unique respondents in the survey dataset, not all healthcare workers in each province.

Province	Job Losses / Responses	% Job Loss
Kabul	94 / 125	74%
Herat	41 / 41	100.0%
Kandahar	50 / 72	69%
Laghman	32 / 32	100.0%
Ghazni	16 / 21	76.%
Baghlan	13 / 16	81%
Nangarhar	16 / 19	84%
Balkh	23 / 26	88%
Faryab	4 / 10	40%
Badakhshan	3 / 7	43%

Figure 12a: Reported Job Losses

Annex 3

Facility Level	Year	Neonatal Deaths	Maternal Deaths	Births	NMR (per 1k)	MMR (per 100k)
District	2024	79	4	25,586	3.1	15.6
	2025	119	4	24,147	4.9	16.6
Provincial	2024	520	2	10,200	51.0	19.6
	2025	640	6	8,500	75.3	70.6
Regional	2024	730	6	18,618	39.2	32.2
	2025	867	8	18,438	47.0	43.4

Figure 13: Maternal and Neonatal Health Indicators by Facility Level in Nagarhar Province

Annex 4

Province	Responses
Kabul	123
Kandahar	72
Herat	42
Laghman	32
Ghor	25
Balkh	26
Nangarhar	21
Ghazni	21
Farah	19
Baghlan	16
Logar	16
Samangan	15
Faryab	10
Nimroz	9
Takhar	7
Bamyan	7
Badakhshan	7
Jawzjan	5
Helmand	4
Badghis	4
Kunduz	4
Nuristan	3
Parwan	3
Uruzgan	3
Kapisa	2
Maidan Wardak	1
Zabul	1
Daikundi	1
Paktia	1
Kunar	1
Province not properly noted	54

Figure 14: Survey Responses by Province

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