

Overview

Afghanistan continues to face worsening acute food insecurity and malnutrition. The current analysis reports the highest acute malnutrition levels ever recorded for the period, and a deterioration in acute food insecurity since 2024. Economic pressures, weak purchasing power, unemployment, inflation, rising input costs due to the Middle East conflict, cross-border tensions with Pakistan, trade disruptions, and large-scale returns continue to strain large segments of the Afghan population. This is despite improved rainfall and agricultural production that improved food availability. Declining humanitarian assistance is reducing households’ ability to protect livelihoods and cope with shocks. Vulnerable groups—particularly landless households, casual labourers, returnees, and those with limited purchasing power—continue to face limited food access and deteriorating food security outcomes. Acute malnutrition remains a major and rising concern, driven by a combination of disease outbreaks, including acute watery diarrhoea (AWD) and cholera; inadequate water, sanitation and hygiene (WASH) conditions; food insecurity and a significant reduction in access to essential nutrition services following the closure or suspension of approximately one-third of nutrition sites.

For the Acute Food Insecurity (AFI) scale, during the current period (September–October 2026), an estimated 15.9 million people (32 percent of the population) are classified in Crisis or worse (IPC AFI Phase 3 or above), including 3.4 million people in Emergency (IPC AFI Phase 4) and 12.5 million in Crisis (IPC AFI Phase 3). Acute food insecurity in Afghanistan disproportionately affects poor and vulnerable households dependent on casual labour and agriculture, returnees, female-headed households, and women and girls, whose resilience is further constrained by a number of factors. Of the 47 units of analysis, 44 were classified in AFI Phase 3. Compared to the same period last year, the number of people facing AFI Phase 3 or above increased by approximately 2 million people. The situation is likely to worsen further during the first projection period (November 2026–April 2027), which coincides with the winter lean season, when 19.2 million people (38 percent) are likely to experience AFI Phase 3 or above, including 5 million people in AFI Phase 4 (10 percent). This represents 1.8 million more people in AFI Phase 3 or above and nearly half a million more in AFI Phase 4 than in the same period last year. Seven provinces are projected to face Emergency (AFI Phase 4) conditions: Daykundi, Ghazni Rural, Badakhshan, Samangan, Sar-e-Pul, Badghis and Ghor. The main drivers are the seasonal reduction in agricultural activity and labour opportunities during the lean season, limited income opportunities and declining purchasing power. Conditions are expected to improve seasonally during the second projection period (May–September 2027), reducing the number of people in AFI Phase 3 or above to 15.3 million (30 percent of the population analysed). However, Humanitarian Food Security Assistance (HFSA) remains insufficient to meet needs across all analysis periods.

For the Acute Malnutrition (AMN) scale, an estimated 4.04 million children aged 6-59 months are expected to need treatment for acute malnutrition between January and December 2027, representing a 9 percent increase from the previous estimate for the January to December 2026 time period. Cases of severe acute malnutrition (SAM) are expected to rise by 16 percent, from 942,000 to nearly 1.1 million. Moderate acute malnutrition (MAM) cases are expected to rise by 8 percent, from 2.74 million to 2.95 million. Of these, 824,000 are high-risk MAM and 2.13 million are early MAM. The number of pregnant and breastfeeding women (PBW) in need of treatment is projected to rise by about 7 percent, from 1.19 million women in 2026 to 1.27 million in 2027. With 3.9 million children aged 6–59 months stunted, the analysis shows a strong interrelationship between wasting and stunting. This is particularly concerning in Zabul, Hilmand, Nuristan, Kandahar and Uruzgan provinces, among others, where prolonged or recurrent wasting typically contributes to chronic malnutrition, highlighting the negative long-term consequences of repeated acute malnutrition episodes. The nutrition situation follows a different seasonal pattern from acute food insecurity, with the highest severity recorded during the current period (August–October 2026) and the second projection period (April–July 2027). Currently, ten provinces are in Critical (IPC AMN Phase 4), 11 in Serious (IPC AMN Phase 3) and ten in Alert (IPC AMN Phase 2). A slight seasonal improvement is expected in the first projection period (November 2026–March 2027), followed by a deterioration in the second projection period, with 14 provinces projected in AMN Phase 4, 15 in AMN Phase 3 and five in AMN Phase 2. This deterioration is expected to follow typical seasonal patterns, compounded by the likelihood of a steep decrease in health sector funding in 2027.

Preventing a further deterioration in both acute food insecurity and acute malnutrition will require a timely and well-coordinated scale up of multisectoral responses, including HFSA, improved access to health and nutrition services, WASH interventions and livelihood support, with particular attention to children, women and returnee populations.



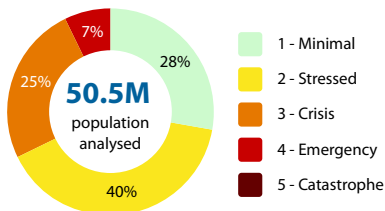
Current Acute Food Insecurity · September–October 2026



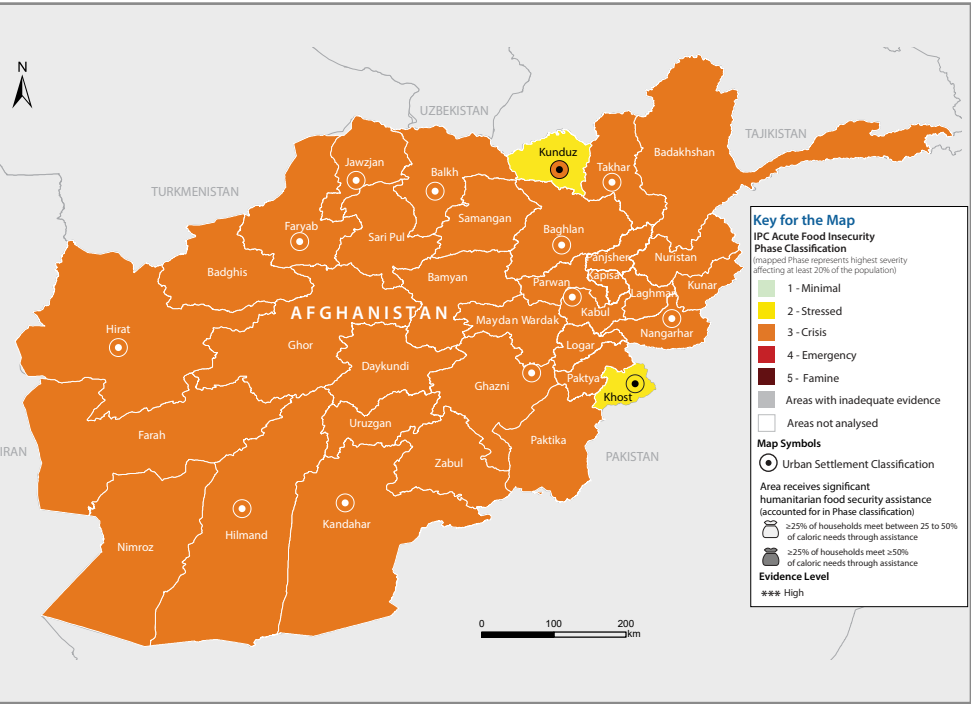
15.9 million

Around 15.9 million people in Afghanistan are experiencing high levels of acute food insecurity (IPC Phase 3 or above) between September and October 2026.

32% of the population is in Phase 3 or above



Current Acute Food Insecurity · September–October 2026



Key drivers of acute food insecurity



**Agricultural production and climatic conditions:** Favourable growing conditions supported a strong 2026 cereal harvest and seasonal labour opportunities. However, benefits were limited for landless and market-dependent households, and rangeland and livestock conditions remained under pressure in several areas.



**Macroeconomic shocks and market conditions:** Weak purchasing power, high input costs, limited livelihoods, high production and transport costs, trade disruptions with Pakistan and Iran, and restrictions on women's economic participation continue to constrain household food access and recovery.



**Returnees and border restrictions:** More than 1.2 million Afghans returned from Iran and Pakistan in 2026, increasing pressure on labour markets and services. Limited livelihoods, assets and land access leave many returnees highly vulnerable to food insecurity and intensify competition for scarce income opportunities.



**HFSA:** Planned and funded HFSA falls far short of the needs of the population in AFI Phase 3 or above. In the first projection period (November 2026–April 2027), assistance covering about 50 percent of daily kilocalorie needs is expected to reach only 1 percent of the population. Limited assistance is assumed in the current period, and no confirmed assistance is assumed in the second projection period. As a result, food consumption gaps are likely to widen and households will rely more on negative coping strategies.

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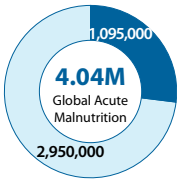


Acute Malnutrition · January–December 2027\*



4.04 million

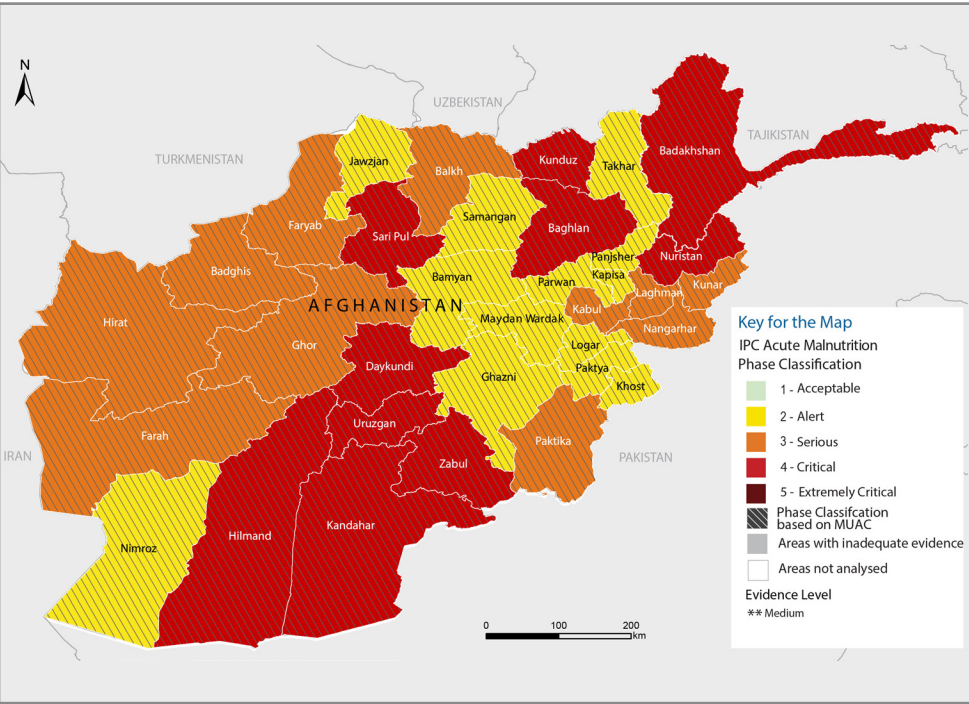
Around 4.04 million cases of acute malnutrition are expected among children aged 6–59 months.



1.27M pregnant or breastfeeding women will likely suffer acute malnutrition in the same period.

\*Caseload estimates were produced by the Nutrition Cluster and partners for the Humanitarian Needs and Response Plan (HNRP) and cover January–December 2027. The IPC AMN severity classification covers August 2026–July 2027.

Current Acute Malnutrition · August–October 2026



Contributing factors to acute malnutrition



**Poor child diets and food insecurity:** Poor child diets and food insecurity are key drivers of acute malnutrition. Only one-third of children achieve a minimum acceptable diet, while nearly 60 percent consume unhealthy food. High food insecurity among children across provinces further increases risks of wasting and nutritional deterioration.



**Disease outbreaks and high childhood morbidity:** Childhood morbidity remains high, with 61 percent of children reported sick. By August 2026, 3.3 million diarrhoea cases (2.6 million AWD and 721,000 dysentery) were reported, alongside 36 polio cases, 26,141 measles cases and 493 cholera cases in 2026. Low vaccination coverage (around 60 percent) further increases vulnerability to acute malnutrition.



**Poor WASH conditions:** Seasonal increases in AWD coincide with higher SAM admissions, while water insecurity (47 percent of households), poor water quality (38 percent) and inadequate hygiene increase disease exposure and nutritional deterioration.



**Women's malnutrition and maternal healthcare gaps:** Malnutrition affects one in five PBW and adolescent girls. Only 2 percent of pregnant women attend four or more antenatal care (ANC) visits. Limited antenatal, nutrition, breastfeeding and postnatal care further increase nutritional vulnerability, particularly among poorer and rural women and adolescent mothers.



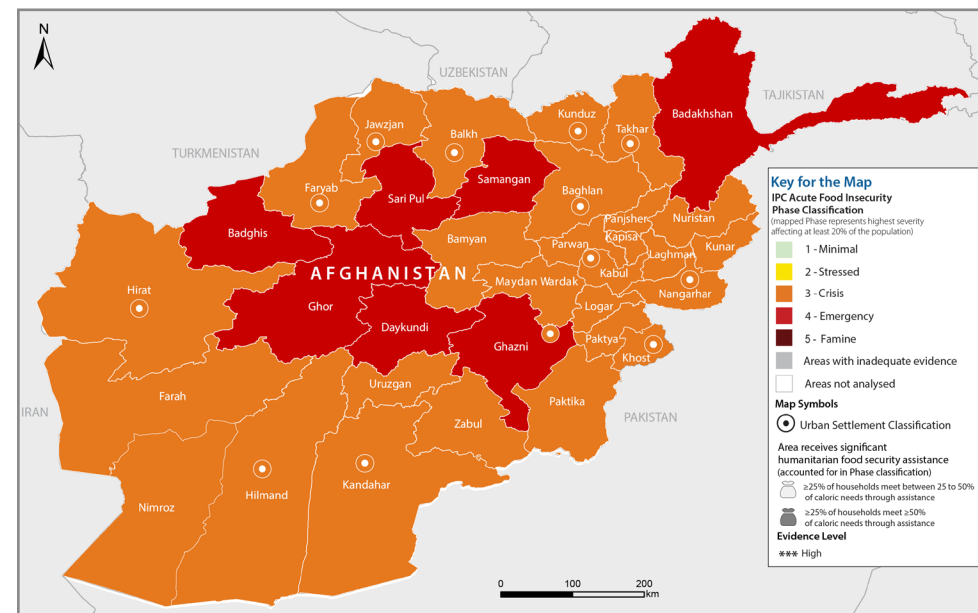
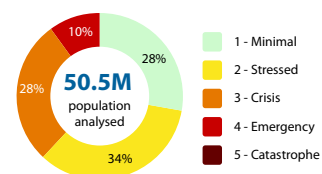
## Acute Food Insecurity 1<sup>st</sup> Projection · November 2026 – April 2027



**19.2 million**

Around 19.2 million people in Afghanistan are expected to face high levels of acute food insecurity (IPC Phase 3 or above) between November 2026.

38% of the population is in Phase 3 or above

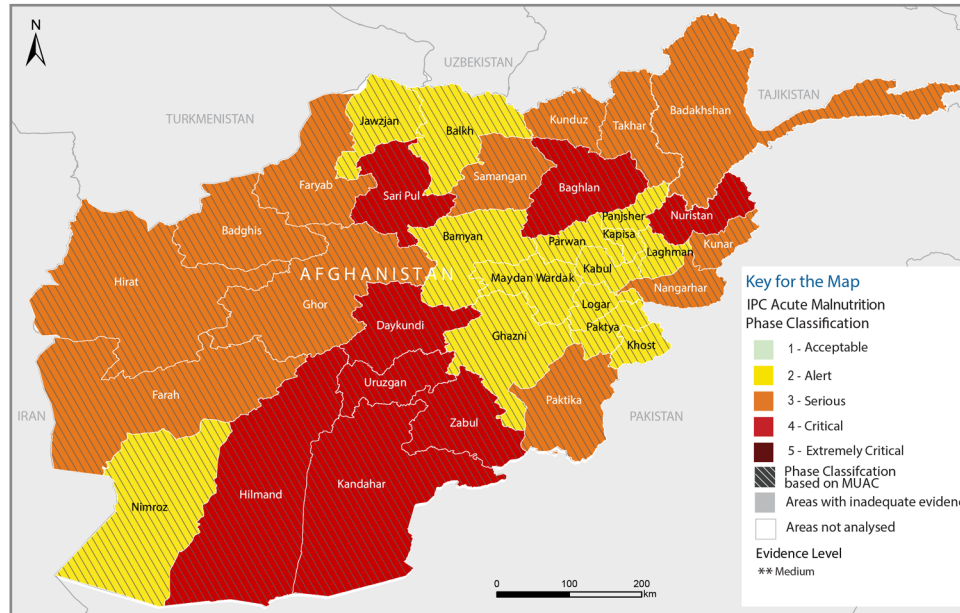
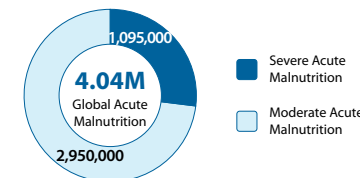


## Acute Malnutrition 1<sup>st</sup> Projection · November 2026 – March 2027



**4.04 million**

Around 4.04 million cases of acute malnutrition are expected among children aged 6–59 months. 1.27 million pregnant or breastfeeding women will likely suffer acute malnutrition in the same period.



## Linkages between acute food insecurity and acute malnutrition

Acute food insecurity and acute malnutrition in Afghanistan follow contrasting seasonal patterns driven by different underlying factors. Acute food insecurity is expected to peak during the lean season and winter months (November 2026–April 2027), when agricultural production declines, labour opportunities shrink, incomes fall and harsh weather limits physical access, particularly in remote areas. By contrast, acute malnutrition is expected to worsen through the current AMN period (August–October 2026) and second projection period (April–July 2027), even as food security is projected to improve after the harvest and as seasonal employment rises.

While food insecurity remains relatively widespread across the country, with most provinces classified in AFI Phase 3, acute malnutrition varies between provinces. Several central provinces remain in AMN Phase 2, reflecting household coping strategies that prioritise children's food consumption. Provinces in the south and parts of the north and east remain AMN hotspots due to the combined effects of disease outbreaks, poor dietary diversity, inadequate WASH conditions and declining access to health and nutrition services.

Acute food insecurity does not translate into acute malnutrition immediately. Nutritional deterioration often follows prolonged food insecurity and the erosion of household coping capacities. Provinces projected to deteriorate to AFI Phase 4 during the winter period may, therefore, see acute malnutrition outcomes worsen later in 2027. These trends underscore the importance of interpreting AFI and AMN classifications together while recognising their distinct drivers, seasonality and pathways of impact.

## Worsening food security and malnutrition call for early action

Acute malnutrition worsened during the August–October 2026 peak compared with the same period last year, with 10 provinces classified in AMN Phase 4 and 11 in AMN Phase 3. Conditions are expected to worsen further during the second projection period (April–July 2027), with 14 provinces projected as AMN Phase 4 and 15 as AMN Phase 3. This would leave 29 of 34 provinces requiring urgent emergency action. Early mobilisation of resources and preventive interventions ahead of the 2027 peak are essential to mitigate further deterioration and reduce the risk of increased SAM and child mortality, especially in Uruzgan, Hilmand, Nuristan, Sar-e-Pul, Daykundi, Zabul, Kandahar and Baghlan.

Food insecurity is expected to worsen during November 2026–April 2027, with Badakhshan, Ghor, Badghis, Samangan, Sar-e-Pul, Daykundi and Ghazni Rural projected to face AFI Phase 4, alongside populations classified in AFI Phase 3 or above. Rising food, fuel and fertiliser prices, declining employment and remittances, and disrupted trade and supply chains threaten to deepen food consumption gaps and push households into adopting emergency coping strategies. HFSA must reach communities before winter cuts off access. Timely agricultural inputs, livestock feed and veterinary services are critical to protect livelihoods, ensure households can sow in time for the next harvest and avert further loss of productive assets.



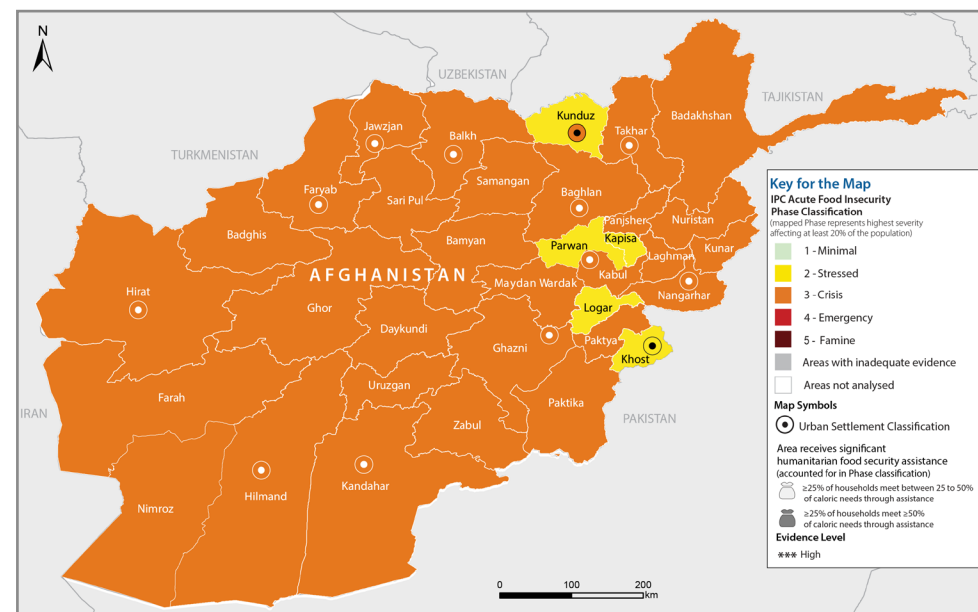
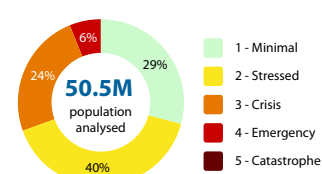
## Acute Food Insecurity 2<sup>nd</sup> Projection · May – September 2027



**15.3 million**

Around 15.3 million people in Afghanistan are expected to face high levels of acute food insecurity (IPC Phase 3 or above) between May and September 2027.

30% of the population is in Phase 3 or above



## Acute Malnutrition 2<sup>nd</sup> Projection · April – July 2027



**4.04 million**

Around 4.04 million cases of acute malnutrition are expected among children aged 6–59 months. 1.27 million pregnant or breastfeeding women will likely suffer acute malnutrition in the same period.

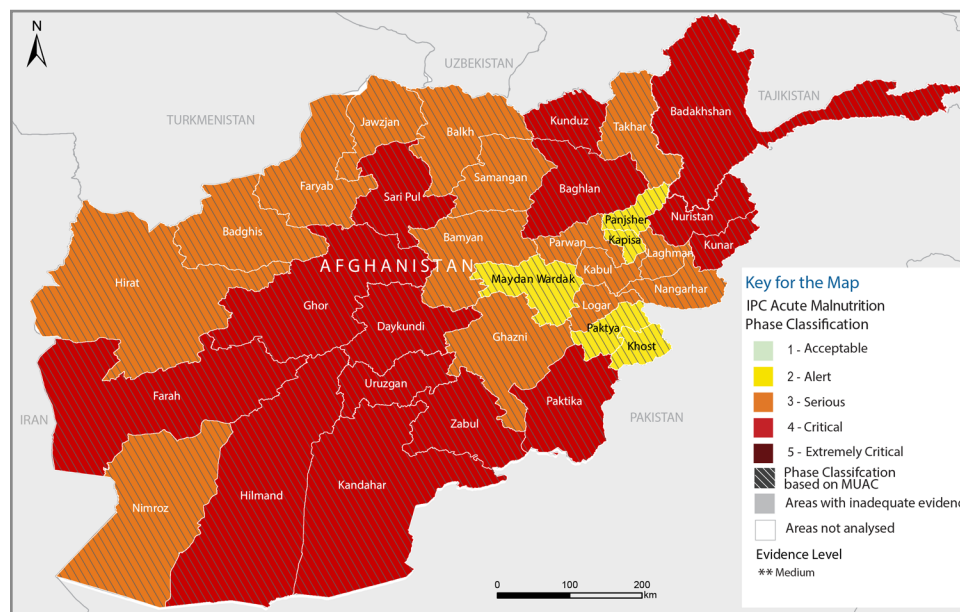
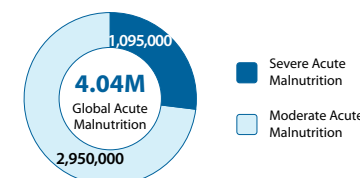
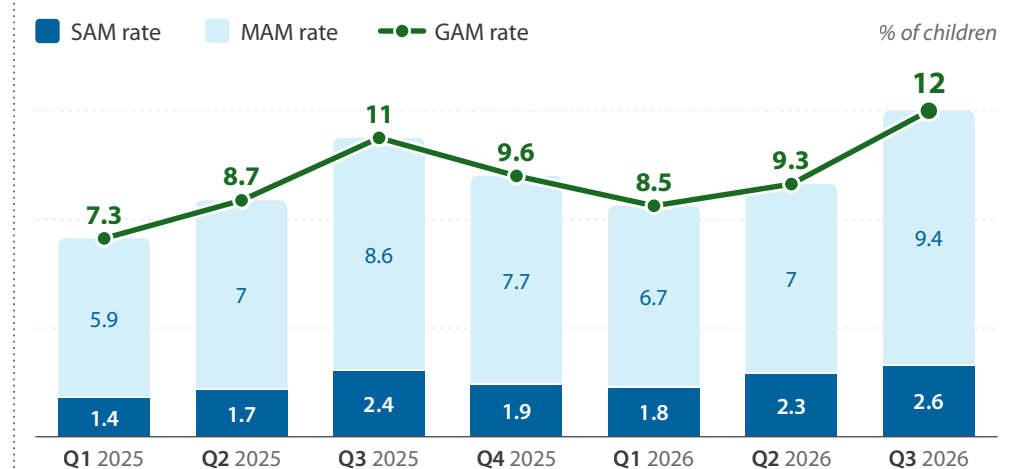


Figure 1: Proportion of children with GAM · Trends of GAM by mid-upper arm circumference (MUAC)



Source: Community Nutrition Sentinel Surveillance (CNSS)

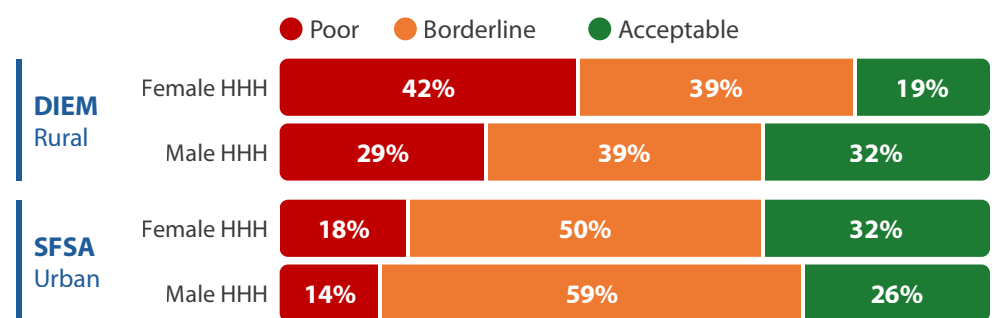
## Acute food insecurity and malnutrition among women and girls in Afghanistan

Women and girls remain disproportionately affected by both acute food insecurity and malnutrition in Afghanistan. Restrictions on women's participation in education, employment and public life continue to constrain income-generating opportunities and limit households' access to and utilisation of resources. **At the same time, declining access to health, nutrition and WASH services, including the closure or suspension of approximately one-third of health facilities, has increased the vulnerability of women and children to adverse nutrition outcomes and protection risks.** Evidence from the Whole of Afghanistan Assessment (WoAA), Seasonal Food Security Assessment (SFSA) and Data in Emergencies Monitoring (DIEM) consistently points to greater vulnerability among female-headed households, particularly in rural areas. Although differences in poor food consumption are not always statistically significant, female-headed households generally report worse food security outcomes, greater reliance on coping strategies, lower dietary diversity and higher levels of hunger than male-headed households. DIEM data show that rural female-headed households were twice as likely as rural male-headed households to experience moderate hunger (36 percent versus 18 percent), while the SFSA found that female-headed households reported the highest use of food-based coping strategies of any household group.

In addition, women and girls face limited healthcare utilisation and nutrition support, with ANC coverage low and showing substantial socioeconomic and access inequalities. ANC coverage among the wealthiest women (43 percent) is more than double that among the poorest (20 percent) and nearly double that among adolescent mothers (22 percent). Education shows an even stronger gradient, with coverage at 25 percent among women with no education versus 59 percent among those with more than secondary education. The urban–rural gap (40 percent versus 26 percent) points to persistent barriers to accessing maternal health services.

**Figure 2: Food Consumption Score - By sex of household head**

*Food security indicators consistently show female-headed households to be more vulnerable. Assessments found higher rates of poor food consumption and moderate hunger among female-headed households, with differences often more pronounced in rural areas.*



## IPC Analysis Partners (Acute Food Insecurity/Acute Malnutrition)



Publication date: 15 October 2026. \*IPC population data is based on OCHA population estimates for 2027. Disclaimer: The information shown on this map does not imply official recognition or endorsement of any physical and political boundaries.

Nearly 29 percent of PBW attended four or more ANC visits, below the World Health Organization (WHO) recommendation of eight antenatal contacts, while 67 percent of women who did not seek ANC cited "didn't think it was necessary" as the main reason. Only 28 percent of pregnant women independently decided where to deliver. Furthermore, just 57 percent of new mothers received postnatal care within two days of birth, while 46 percent of newborns and mothers received no postnatal care from a health provider. Nutrition counselling was also low, with only 15 percent of women receiving counselling on which foods and how much to eat and 14 percent receiving breastfeeding counselling. Although 71 percent received iron supplementation during pregnancy, these findings together highlight women's nutritional vulnerability and important gaps in maternal and newborn healthcare, nutrition counselling and micronutrient supplementation, underscoring the need to address barriers to care and strengthen integrated maternal nutrition and health services.

**Figure 3: Coverage of antenatal care by various characteristics - Afghan Health Survey 2025**

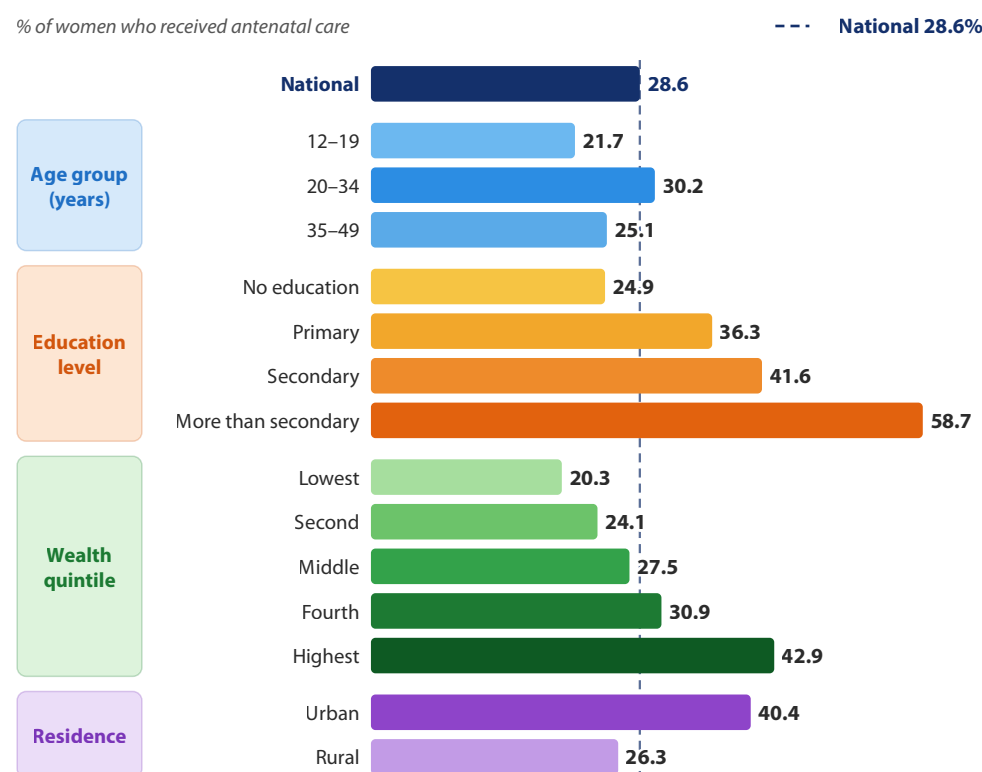
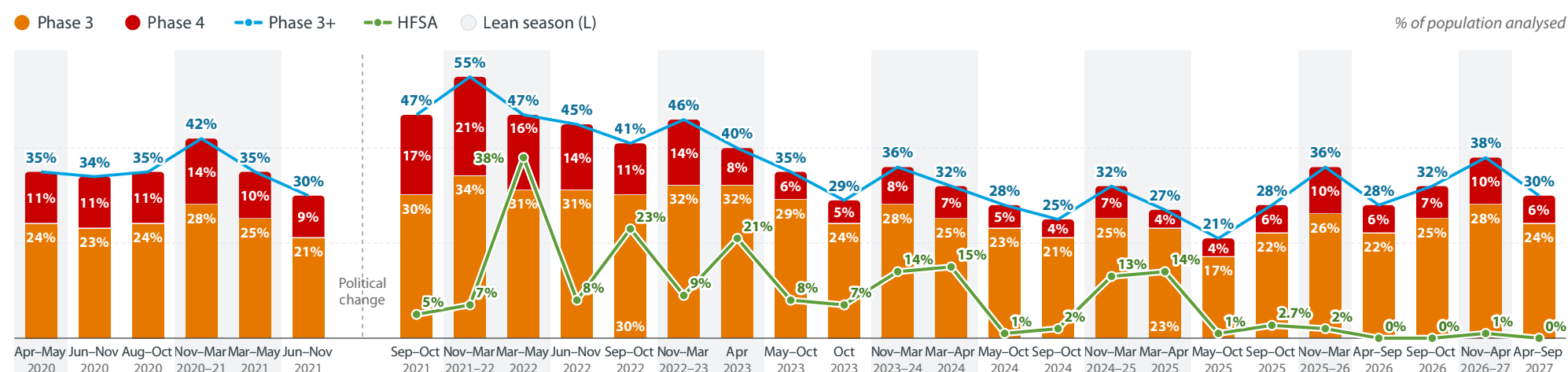


**Figure 4: Population in IPC AFI Phase 3 or above (%), harvest/post-harvest vs lean season - 2020–2027**



## Recommended actions

- Scale up HFSA and emergency agriculture support:** Expand real-time geographical and household-targeted food assistance and shock-responsive social protection during the winter and lean season, while providing timely agricultural and livelihood support to protect productive assets, sustain production, prepare for upcoming farming cycles and assist the most vulnerable households, including female-headed households.
- Enhance preparedness and response for returnees:** Strengthen monitoring, preparedness and response mechanisms for potential returnee influxes from Pakistan and Iran to ensure timely, integrated, area-based support that addresses immediate food needs; strengthens livelihoods, productive assets, skills and income opportunities; and reduces pressure on vulnerable host communities.
- Protect and adapt nutrition treatment services:** Maintain access to quality nutrition treatment services for malnourished children, PBW and adolescent girls by safeguarding treatment capacity in AMN Phase 3 and 4 areas. Explore and expand alternative delivery platforms, community-based approaches and cost-efficient models, such as simplified treatment protocols, to mitigate the anticipated drop in health sector and humanitarian funding while ensuring timely detection and treatment of cases.
- Strengthen prevention of acute malnutrition:** Scale up integrated prevention interventions for children under five and PBW, with a particular focus on improving diets. Promote access to affordable, nutritious and safe foods through coordinated food security, nutrition-responsive social protection, WASH, health and agriculture interventions. In high-risk areas, consider community-level approaches to improving child diets, including food- and supplement-based interventions for children aged 6–23 months.
- Prevent high disease burden among children and scale up WASH measures in priority areas:** Enhance disease surveillance, immunisation coverage and WASH conditions to prevent outbreaks. Prioritise high-risk, overcrowded and high-returnee communities, with preventive measures intensified ahead of and during the seasonal AWD peak, particularly in areas where AWD outbreaks coincide with seasonal increases in acute malnutrition.
- Sustain robust nutrition and food security surveillance and enhance linkages across early warning systems and anticipatory action:** Sustain surveillance and strengthen the use of climate, agricultural and nutrition early warning information to monitor risks, detect deterioration early and trigger timely anticipatory action and preparedness ahead of predictable shocks. Prioritise high-risk and worsening areas, including Zabul and Hilmand provinces and other food security and GAM hotspots, while protecting livelihoods and productive assets and strengthening linkages between early warning, anticipatory financing and local response planning.