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Empowering Female Community Healthcare Workers to Promote Maternal and Child Health in Afghanistan



Hannah Jo

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by **Hannah Jo** for *Annotations Blog*

The Backbone of Afghanistan's Healthcare System

When community healthcare worker (CHW) Khala Zarina answered a late-night call to assist a woman suffering from postpartum bleeding, she ultimately found herself in need of care. As she recalls, "[my] husband got so angry when someone came [knocking] at our door…But my husband abused him and started beating me. My hand fractured and [I] could not move it for a month." Khala's account lays bare a deeper reality of Afghanistan's fragmented healthcare system: female CHWs are the backbone of Afghanistan's maternal and child health services, yet they bear the brunt of risks intensified by the authoritative Taliban regime and widespread foreign aid withdrawals.

Although CHWs are unpaid volunteers without formal medical training, they deliver essential services to approximately 70% of the population. (**Community Health Delivery Partnership, 2021** (https://www.communityhealthdeliverypartnership.org/media/376/file/Afghanistan_Roadmap_ENG_Final_20211202.pdf.pdf)). According to UNICEF, female CHWs worked with over a million women and children from 16,300 health posts across the country for the past six months in 2025. CHWs manage common childhood illnesses (e.g., respiratory infections and diarrheal diseases), which remain among the leading causes of infant morbidity and mortality in Afghanistan. Beyond clinical interventions, CHWs contribute significantly to health education by disseminating information on hygiene, nutrition, and disease prevention.

However, female CHWs have increasingly become more vulnerable in the face of the Taliban's 2024 ban on midwifery education and the impact of ongoing international aid cuts (**Human Rights Watch, 2025** (https://www.hrw.org/news/2025/09/02/gender-apartheid-as-an-international-crime); **Executive Order 14169, Jan 20, 2025** (https://www.federalregister.gov/documents/2025/01/30/2025-02091/reevaluating-and-realigning-united-states-foreign-aid); **Forbes, 2025** (https://www.forbes.com/sites/globalcitizen/2025/02/25/foreign-aid-is-shrinking-what-happens-next/)). Particularly, under the Taliban regime, the *mahram* mandate—which requires women to be accompanied by a male guardian in public—has severely restricted the mobility of female CHWs. Reports indicate that female CHWs face harassment, violence, and even physical assault when attempting to

travel to work without a male escort. This has led to a decrease in the availability of maternal and child care, with nearly half of healthcare workers reporting a reduction in services and nearly half stating that conditions for providing care have worsened (**Conflict and Health, 2023** (https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-025-00663-3)).



Figure 2: A female community health worker provides medicine to a pregnant woman in the Herat province of western Afghanistan (Al Jazeera, 2023).

(**UNICEF/Mukhtar Nikrawa** (https://www.aljazeera.com/gallery/2023/9/19/photos-the-silent-bravery-of-afghanistans-healthcare-workers))

Policy Recommendation: The FHH Model

Afghanistan needs a health delivery model that aligns with its political and social constraints. The establishment of the Family Health House model (FHHs), coupled with the integration of digital health infrastructure, offers the most viable and sustainable solution. The concept of FHHs is inspired by the United Nations Population Fund's (UNFPA) Women & Girls Safe Spaces (WGSS) model in Syria. The FHH model focuses on alleviating barriers to healthcare access for Afghan women, especially in rural areas, by creating spaces where female CHWs can operate effectively within the mahram mandate (**International Journal of Health Planning and Management, 2023** (https://bmcprimcare.biomedcentral.com/articles/10.1186/s12875-024-02336-1)). By situating health services in the homes and neighborhoods of CHWs that are trusted by communities, non-governmental organizations should aim to address women's healthcare needs while reducing the risk of confrontation with Taliban enforcers. Engaging local leaders and male family members is crucial for legitimizing the presence of female CHWs and ensuring community support.

Assessment of the FHH Model

IMPLEMENTATION FEASIBILITY

FHHs address multiple barriers simultaneously by embedding healthcare services within the fabric of local communities. According to former Afghanistan Policy Lab associate Mustafa Basij Rasikh, initial efforts to establish FHHs may encounter resistance from conservative factions. Nevertheless, sustained community engagement and alignment with societal norms can secure their acceptance By prioritizing maternal and child health care, FHHs not only address urgent healthcare needs but also create a scalable and resilient framework for long-term health system strengthening.

FINANCIAL VIABILITY

By repurposing existing homes and spaces, FHHs offer a cost-effective alternative to traditional healthcare delivery models. Unlike mobile health clinics, which require significant infrastructural investments, FHHs leverage community resources to minimize start-up costs according to the UNFPA model. Financial support can be directed toward providing medical supplies, modest compensation for CHWs, and training programs. The localized nature of FHHs reduces logistical expenses, while community ownership fosters sustainability by minimizing dependency on external funding. Specifically, FHHs minimize reliance on centralized, resource-intensive solutions (e.g. mobile health clinics) and instead focus on repurposing local homes as health hubs. The decentralized nature of the model bridges the gap between socioeconomic inequities and healthcare access, aligning services more closely with local needs and reducing dependency on external resources.

SUSTAINABILITY

The long-term success of FHHs hinges on strong community ownership, robust monitoring systems, and integration into localized health networks. FHHs will be managed entirely by local community health committees, ensuring autonomy and reducing vulnerability to external political influence (**International Journal of Public Health, 2024** (https://pmc.ncbi.nlm.nih.gov/articles/PMC11180759/)). These committees, composed of respected local leaders and CHWs, will oversee daily operations, resource allocation, and conflict resolution. Furthermore, a robust monitoring and evaluation system is essential to track the impact and effectiveness of FHHs. Baseline health indicators, such as maternal and child mortality rates, antenatal care uptake, and immunization coverage, should be established during the initial phase. Monthly reviews of service delivery and community feedback will ensure continuous improvement, while participatory feedback mechanisms will empower women and CHWs to contribute to the model's evolution (**Health Policy and Planning, 2023** (https://pmc.ncbi.nlm.nih.gov/articles/PMC9923383/)). To further guarantee sustainability, FHHs should integrate with localized health networks, such as informal supply chains or regional NGO partnerships, to ensure the continuous availability of medical supplies and training resources (**BMC Health Services Research, 2023** (https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-023-09733-9)).

Conclusion

Afghanistan's female healthcare workforce shortage requires adapted, not imported, solutions. Unlike resource-intensive mobile clinics, FHHs prioritize minimal resources and community engagement. Above all, the FHH model offers a culturally-attuned and contextually-informed approach to mitigating the ongoing healthcare obstacles faced by women and children in Afghanistan. The Afghanistan Policy Lab at Princeton calls upon donor countries and international healthcare institutions to facilitate funds, resources, and coordination to logistically establish and maintain the FHH model throughout the country. Such an unprecedented healthcare crisis can be mediated through a maximally feasible model with precedent.



Meet the author: Hannah Jo

Hannah Jo is an undergraduate fourth-year student in the Neuroscience Department at Princeton University. Coupled with her ambition to practice medicine, Hannah is passionate in addressing global healthcare crises in conflict regions and low-income countries. She is a Senior International Policy Associate at the Liechtenstein Institute on Self-Determination.