Family Health House (FHH) Model in Afghanistan

An Impact Assessment

March 2026

Contents

Table of Tables

Abbreviations

AFGA	Afghan Family Guidance Association
ANC	Antenatal Care
BPHS	Basic Package of Health Services
CEI	Client Exit Interview
CHW	Community Health Worker
FHH	Family Health House
FP	Family Planning
GESI	Gender Equality and Social Inclusion
IDI	In-Depth Interview
IPPF	International Planned Parenthood Federation
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MNCH	Maternal, Newborn, and Child Health
OPD	Outpatient Department
PNC	Postnatal Care
PSS	Psychosocial Support
SARO	South Asia Regional Office
SPSS	Statistical Package for the Social Sciences
SRH	Sexual and Reproductive Health
UNFPA	United Nations Population Fund

Executive Summary

The Family Health House (FHH) model, implemented by AFGA with support from IPPF and partners, is a community-based approach to expanding access to integrated sexual and reproductive health (SRH) and maternal and child health (MCH) services in underserved areas. It focuses on delivering essential health services at the community level to reduce disparities, improve access to care, and strengthen health outcomes for women and children in Afghanistan.

The aim of this study is to assess whether the Family Health House model is effective for improving health outcomes. This report presents the findings of an independent impact assessment of the Family Health House (FHH) model in Afghanistan, conducted in late 2025, across six provinces using a mixed-methods approach. The evaluation assessed the model's performance in improving access, client experience, and community trust in sexual and reproductive health (SRH) and maternal and child health (MCH) services, while also identifying operational barriers and sustainability risks. The purpose is to inform practical program recommendations and future planning.

Overall, the assessment finds that the FHH is a well-utilized and highly trusted community-based platform. Service utilization data shows a strong focus on core SRH needs, **with antenatal care (36.8%) and family planning (24.5%) together accounting for 61.3% of all client visits**. Client-reported experience indicators are exceptionally positive, with universal reports of respectful treatment, clear communication, and maintained privacy. This positive experience is reflected in strong client loyalty, with **95.3% of interviewed clients reporting repeat visits and 100% stating they would return to and recommend the FHH.**

Hence, findings show that the Family Health House (FHH) model delivers high-value, community-trusted SRH and MCH services in a fragile context, with exceptionally strong client satisfaction and loyalty. Clients report near-universal satisfaction and a strong willingness to return and recommend services, positioning FHHs as a preferred and credible point of care. Findings suggests that FHHs are viewed as important community assets that reduce time and financial burdens and promote timely care-seeking for women and children. A key contribution of the model is improved access to essential services, particularly for women facing barriers related to distance, cost, and social constraints, with FHHs serving as trusted first points

of care even for urgent maternal health needs. This proximity strengthens client confidence and supports sustained service utilization.

The impact is further reinforced by the model's strong community embeddedness and sustained engagement with local structures, which enhances awareness, increases service uptake, strengthens referral linkages, and reinforces local legitimacy. Strategically, the evaluation highlights the FHH model as a strong proof of concept for task-sharing, with midwives effectively leading service delivery and consistently providing respectful, confidential, and clinically appropriate care, sustained through trust-building and continuous community presence. Midwives' narratives further reflect professional empowerment grounded in increased confidence, community trust, and visible client outcomes, often expressed as pride when clients leave satisfied and when women feel safe sharing sensitive concerns, while also illustrating the transformative impact of timely midwife-led care, including safe deliveries in difficult circumstances and improved wellbeing through family planning services.

The model demonstrates strong success in reducing key access barriers for most clients. Geographic proximity is a major advantage, with 74.5% of clients living within one km and 82.1% walking to the facility. The 24/7 availability for urgent maternity care is highly valued, with all clients reporting that service hours are convenient. Clinically, reported adherence to core processes is high, including 100% informed consent and 98.1% receiving a health history assessment during consultations. However, some access and service readiness constraints persist. A notable proportion of clients reported barriers such as long distances (22.6%), poor road conditions (27.4%), and weather-related disruptions (21.7%). Socio-cultural norms also remain significant, with 50.0% of respondents who knew someone unable to access care citing family restrictions as the main barrier. Qualitative feedback from midwives further highlights availability of medicines—particularly non-SRH supplies—and infrastructure limitations, such as inadequate waiting areas, which affect client comfort and privacy.

The assessment identifies operational pressures that could impact service quality and staff retention over time. Midwife narrative interviews describe **high client load**, reported in some locations as ranging between approximately **20 and 60 clients per day**, which require careful management within the standard staffing structure of one midwife and one PSS counsellor per FHH. The model includes a provincial-level backup midwife who provides coverage when a midwife is absent or on leave; rotational deployment of additional midwives is not standard practice. KIIs do not indicate that demand systematically exceeds capacity; however, peak days and infrastructure limitations were noted as operational considerations. The report does not quantify a specific remuneration gap, as this would require a separate HR and market benchmarking exercise; however, stakeholder interviews emphasize that long-term midwife retention is linked to adequate working conditions and support systems.

A critical finding is the model's heavy dependence on external donor funding, which stakeholders identify as the foremost threat to its sustainability. This financial uncertainty was reflected in a temporary reduction in operational sites during 2025, when the number of FHHs decreased from 85 to 67 following US funding cuts; however, **with new funding secured in Q4 2025, operations expanded to 91 FHHs**, surpassing the 2024 level. Without a clear and financed transition pathway, the substantial gains in community trust and access are at risk. The evidence regarding health outcomes is primarily based on client and provider perceptions of improved access and timely care; this assessment does not measure population-level health impact, and statements on outcomes should be interpreted as reported pathways of contribution rather than definitive proof of changed mortality or morbidity rates.

Based on the evidence, the report recommends practical actions to consolidate strengths and address existing challenges. Key priorities include strengthening supply chains for non-SRH medicines, where applicable, through improved use of facility-level data; enhancing workforce planning and supportive supervision systems; and reinforcing security and safety protocols, including staff safety procedures, coordination with local councils, and contingency planning for remote or disaster-affected settings. Additional priorities include investing in essential infrastructure and formally documenting caseloads to optimize allocation of support staff. Most critically, stakeholders should develop a detailed sustainability

roadmap that aligns community demand with realistic scope and cost considerations and integration with national systems, while preserving the community-based and trusted nature of the FHH model.

Key Findings

1. **Primary SRH Service Profile:** FHHs are primarily used for SRH services, with ANC (36.8%, n=39/106) and Family Planning, including contraception method-related visits (32.1%, n=34/106) together accounting for 61.3% of reported visits. Other SRH-related reasons included gynaecological services (12.3%, n=13), PNC (10.4%, n=11), and delivery/labor (3.8%, n=4).

2. **Strong Client Retention and Trust:** Client continuity is high. 95.3% (n=101/106) of respondents were repeat visitors, indicating continued use of and trust in services.

3. **Willingness to Return and Recommend:** Client loyalty is very strong. 100% (n=106/106) stated they would return to the FHH and would recommend it to friends and relatives.

4. **Quality of Care:** Clients consistently reported positive interaction with staff, including 100% (n=106/106) reporting respectful treatment and those providers demonstrated care/empathy, additionally 99.1% (n=105/106) reporting they felt supported and comfortable during the visit.

5. **Consultation Completeness and Clinical Practice:** Clinical process indicators reported by clients indicate adherence to standard consultation procedures. 100% reported that providers asked for consent before examination, provided clear explanations, and conducted appropriate examination. Importantly, 98.1% (n=104/106) reported that providers asked about their health history/background during the consultation.

6. **Physical Accessibility:** For most clients, access is relatively close. 74.5% (n=79/106) live within 1 km of the FHH, 82.1% (n=87/106) walk to the facility, and 83.0% (n=88/106) reported travel time under one hour.

7. **Persistent Access Barriers (Geography and Infrastructure):** Despite overall proximity for many, a notable proportion still reported barriers. 22.6% (n=24/106) cited long distance, 27.4% (n=29/106) cited road disrepair, and 21.7% (n=23/106) cited weather-related disruption as access constraints.

8. **Socio-Cultural Barriers Remain a Key Constraint:** Social constraints affect women's access. Among respondents who knew someone unable to obtain care, 50.0% (n=10/20) cited restrictions by family members as the main reason highlighting dependency on household permission/support.

9. **Safety and Security:** Clients reported strong perceptions of safety, with 100% (n=106/106) stating they felt safe during their visit. Reported protective features included facilities located in walled or protected areas (84.9%, n=90/106) and restricted unauthorized entry (83.0%, n=88/106). Security guard presence was reported by 57.5% (n=61/106), based on client observations during their visit.

10. **High Value Placed on 24/7 Availability:** The 24/7 operational model is strongly valued. 100% (n=106/106) reported that FHH hours are convenient for the community, supporting availability of urgent SRH needs.

11. **Medicines:** high receipt, but availability concerns persist. Nearly all clients were prescribed medicines (97.2%, n=103/106). Among those prescribed, 4.7% (n=5/106) reported they did not receive all prescribed medications. Qualitative feedback also points to periodic medicine availability challenges.

12. **Community Demand for Additional Non-SRH Services:** Over half of clients (55.7%, n=59/106) requested expanded services beyond the current SRH package, particularly non-SRH services such as vaccination, lab tests, and treatment for minor illnesses.

13. **Proof of Concept for Midwife-Led, Community-Based SRH Care:** The model demonstrates a practical, midwife-led approach to SRH and MCH service delivery. Midwives were reported as the primary provider for 88.7% (n=94/106) of client interactions, supporting the feasibility of decentralized SRH care delivery in fragile settings.

14. **Sustainability is the Major Strategic Risk:** Long-term continuity remains a central concern due to heavy dependence on external donor funding. Stakeholder feedback highlights sustainability as a priority area and reported program trends indicates temporary fluctuations in operational sites due to funding volatility. While the number of FHHs decreased from 85 in 2024 to 67 during the 2025 evaluation period following U.S. funding cuts, new funding secured in Q4 2025 enabled expansion to 91 operational FHHs, surpassing the 2024 level. This fluctuation underscores the model's sensitivity to external funding and reinforces the need for clear sustainability and transition pathway.

15. **Community Perception of Value:** Clients overwhelmingly perceive FHHs as essential: 88.7% (n=94/106) rated the model as "Very Important" for accessing SRH/MCH services. Qualitative findings include provider/community narratives describing perceived life-saving benefits through reducing delays and improving access to skilled care; however, this assessment does not measure maternal mortality outcomes directly, so mortality-related statements should be presented as stakeholder/provider perceptions supported by reference quotes, not as measured impact.

1. Introduction

1.1. Background and Context

Afghanistan continues to face a complex, protracted humanitarian crisis driven by economic decline, recurring climate-related shocks, population movements, and severe operational constraints for service delivery. The 2025 Humanitarian Needs and Response Plan projects that around **22.9 million people will require humanitarian assistance[1].** Within this context, access to essential health services remains fragile: the Health Cluster has reported that **14.3 million people require healthcare services in 2025**, with partners targeting delivery of essential health services to approximately 9.3 million people[2]. These pressures are compounded by uneven geographic coverage, facility closures and under-resourcing, shortages of skilled health workers particularly female providers alongside access barriers linked to distance, transport costs, and social restrictions affecting women's mobility.

Maternal health remains a critical concern. Recent UN inter-agency/World Bank modelled estimates indicate Afghanistan's maternal mortality ratio is approximately **521 deaths per 100,000 live births (2023)**, which remains high by global standards[3]. This report therefore treats maternal health and SRH access as **priority concerns** in a system where many communities continue to face delayed care-seeking and limited availability of skilled, gender-appropriate services. Afghanistan continues to face **one of the highest maternal mortality burdens in the region,** with access to skilled birth attendants and reproductive health services remaining uneven across rural and remote areas[4]. Afghanistan's context for delivering maternal and reproductive health services differs substantially from that of other South Asian countries. Decades of conflict, geographic isolation of rural populations, and significant barriers to women's access to health services continue to shape the health service delivery environment. According to the World Health Organization, Afghanistan faces persistent shortages of skilled health workers, particularly female providers, and limited health infrastructure in rural and remote areas, which significantly affects access to maternal health services[5]. In addition, humanitarian and socio-cultural constraints influence women's mobility and their ability to seek care independently. The World Bank notes that Afghanistan has some of the most challenging service delivery conditions in the region due to fragile institutions, poverty, and limited health system capacity[6]. These contextual factors make the Afghanistan health service environment distinct from many other South Asian countries and require locally adapted models—such as **community-based service delivery approaches**—to ensure women can access essential maternal and sexual and reproductive health services.

National reproductive and primary healthcare priorities: Afghanistan's primary healthcare approach is structured around the Basic Package of Health Services (BPHS) and related essential service packages, which prioritize reproductive, maternal, newborn, and child health outcomes and emphasize equitable access at community level. Within this policy intent, models that bring skilled female health providers closer to communities are particularly relevant in contexts where women's access to facility-based care is constrained by distance, cost, and sociocultural norms.

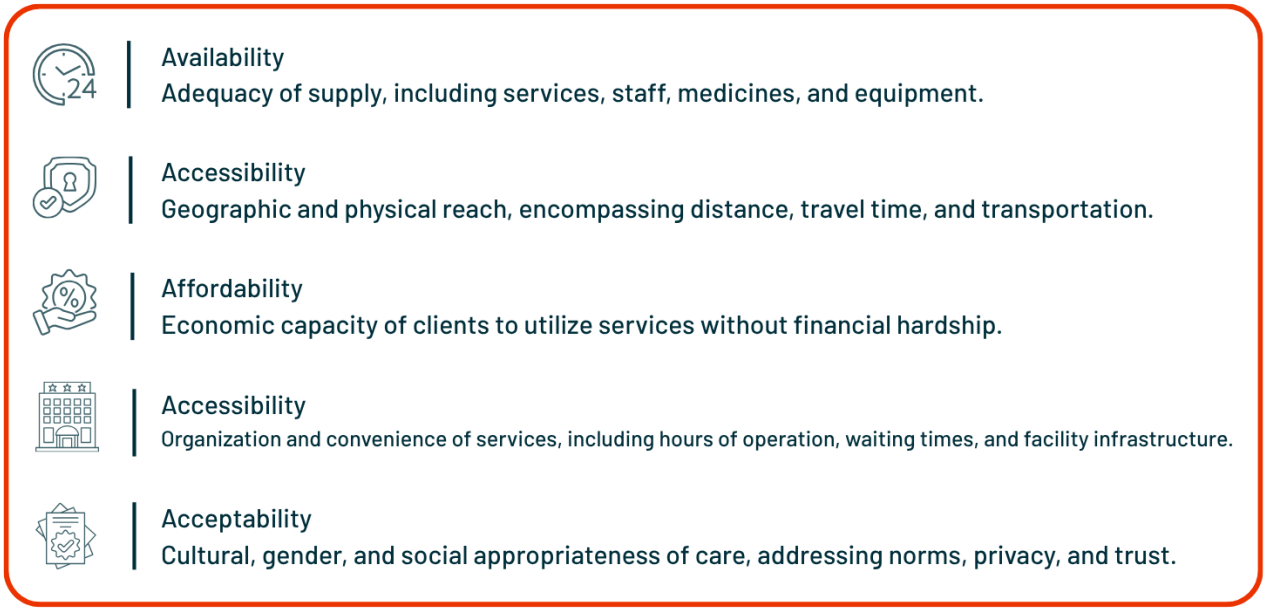
The Family Health House model and its evolution: The **Family Health House (FHH) model** implemented by the Afghan Family Guidance Association (AFGA) with support from IPPF and other partners is designed as a community-embedded service delivery approach to expand access to sexual and reproductive health (SRH) and selected maternal/newborn services in remote and underserved areas. Core services commonly described by providers include antenatal care (ANC), postnatal care (PNC), delivery care, family planning (FP), PSS, counselling/health education, and related client support. In some sites, providers also reported delivering non-SRH services, reflecting community demand and operational realities. The model's

1 Afghanistan Humanitarian Needs and Response Plan 2025 (December 2024) [EN/PS/Dari] | OCHA
2 Afghanistan Humanitarian Needs and Response Plan 2025 (December 2024) [EN/PS/Dari] | OCHA
3 Maternal mortality ratio (modeled estimate, per 100,000 live births) - Afghanistan | Data
4 UNFPA Afghanistan Country Programme https://www.unfpa.org/afghanistan
5 World Health Organization. 2023. Afghanistan Health System Overview https://www.who.int/countries/afg/
6 World Bank. 2023. Afghanistan – Health Sector Challenges https://www.worldbank.org/en/country/afghanistan/overview

intended contribution is to reduce delays in seeking and receiving skilled SRH and maternity care by placing trained female providers within or close to communities. Qualitative interviews illustrate this pathway through reported community trust and timely access to delivery care providers described pride in supporting safe deliveries and healthy newborn outcomes, while also emphasizing the constraints they face in maintaining consistent service availability. In parallel, stakeholders also emphasized that the model's broader goal includes contributing to reductions in maternal mortality through improved access to skilled care. In terms of scale, AFGA program figures indicate that the model expanded to a peak footprint across multiple provinces and later experienced contraction linked to funding constraints and operational challenges. The updated operational numbers for 2025 and the operational FHH count" timeline (e.g., 85 → 67 → any later rebound) and as a result, by the last quarter of 2025, the number of FHHs **increased to 91**.

Rationale and scope of this assessment: This assessment was commissioned to examine how the FHH model is functioning across selected provinces, focusing on service access, perceived quality, client experience, and operational constraints relevant to sustainability and scale. The assessment also applies to gender and inclusion lens, given that the model's value proposition depends heavily on acceptability, privacy, and women's ability to access care safely. Analytically, the report is structured using recognized frameworks to support clarity and comparability: (i) the "5 As" access framework (availability, accessibility, affordability, accommodation, acceptability), and (ii) selected elements of the WHO Quality of Care approach (distinguishing experience of care from provision of care). These frameworks are used to organize evidence; they do not replace outcome measurement and should not be interpreted as proof of population-level health impact without corroborating routine health information system or longitudinal outcome data.

Figure 1: The 5 As of Access Framework



1.1. Objectives

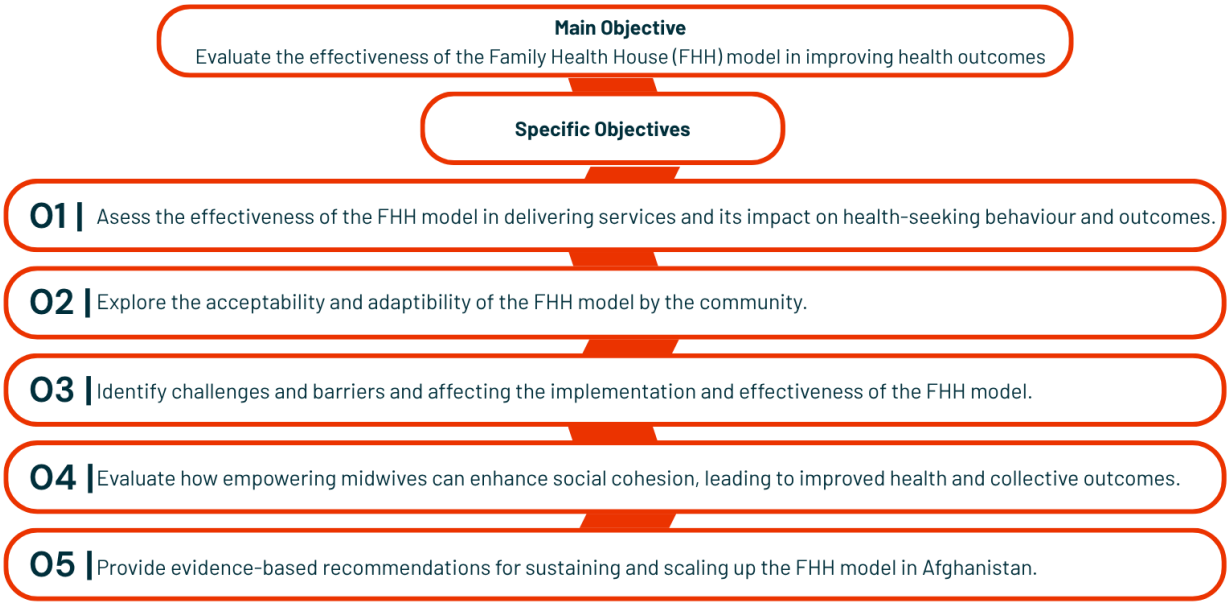
1.2.1 Main Objective

To provide an evidence-based assessment of the Family Health House (FHH) model's performance in improving access to and quality of SRH services, client experience, and community trust, and identify priorities for sustainability and scale-up.

1.2.2 Specific Objectives

1. Assess the FHH model's performance in delivering SRH/MCH services and its contribution to timely care-seeking and service utilization, based on client-reported experience and stakeholder perspectives.
2. Examine the acceptability, trust, and community relevance of the FHH model, including gender and socio-cultural factors affecting uptake.
3. Identify operational barriers and implementation constraints influencing service consistency and equity (e.g., access constraints, staffing/workload, supplies, infrastructure, security).
4. Explore how midwife-led, community-based care influences communication, client comfort, and community engagement, and how this supports continued utilization of SRH services.

Figure 2: Objective of the Study



2. Methodology

2.1. Study Design

This evaluation employed a mixed method design to generate a comprehensive assessment of the Family Health House (FHH) model, combining quantitative and qualitative evidence to compare findings across methods and strengthen validity. The approach was selected to capture not only descriptive patterns in service utilization and client experience, but also the contextual and operational factors explaining these patterns.

The study was conducted across **six provinces: Balkh, Herat, Kapisa, Laghman, Logar, and Parwan** selected to reflect geographic and contextual diversity. The sampling framework followed a multi-stage purposive approach: first, provinces were selected in consultation with AFGA/IPPF based on program presence and operational feasibility; second, within each province, three functional FHHs were selected (total 18 FHHs) to ensure variation in catchment characteristics (e.g., more remote vs. more accessible settings) and typical service delivery conditions. Within selected FHHs, Client Exit Interviews (CEIs) were conducted using an on-site systematic approach (e.g., selecting every nth eligible client after service completion) to reduce selection bias and ensure coverage across service days. Qualitative interviews were conducted using purposive sampling to ensure representation of key stakeholder categories, including midwives/service providers, community leaders, and implementing/partner stakeholders.

Enumerator training and ethical measures were implemented prior to data collection. The field team comprising trained female enumerators with relevant health or social research backgrounds received structured training covering: study objectives and tools, interview techniques, informed consent procedures, safeguarding and respectful engagement (including gender-sensitive interviewing), confidentiality and privacy protocols, and daily quality assurance routines (supervisor checks, spot-checks, and debriefs). A pilot/field test was undertaken to validate tool clarity, sequencing, and timing, followed by refinements prior to full deployment. Ethical practice was ensured through voluntary participation**,** informed consent, and anonymity in reporting. No personally identifying information was included in analysis outputs. Interviews with women clients were conducted by female data collectors to support cultural appropriateness and privacy, and participants were informed they could skip any questions or stop the interview at any point of time without any consequence for their access to services.

The study uses a stratified sampling framework across **six provinces** (Balkh, Herat, Kapisa, Laghman, Logar, and Parwan) to ensure geographic and contextual diversity, with data collection including 102 client exit interviews (17 per province), 18 narrative interviews with midwives, 18 facility observations, and 16 key informant interviews with stakeholders such as **IPPF, AFGA, UNFPA**, **and community leaders**. To ensure data quality and ethical integrity, the research teams received structured training covering the FHH model, research ethics, qualitative and quantitative data collection techniques, and field testing of tools, with all female enumerators selected to enhance cultural appropriateness and trust. Ethical measures are applied throughout the study, including informed consent, confidentiality protocols, gender-sensitive approaches **aligned with GESI principles and adherence to Do No Harm standards** to protect vulnerable participants and ensure respectful, secure, and inclusive engagement.

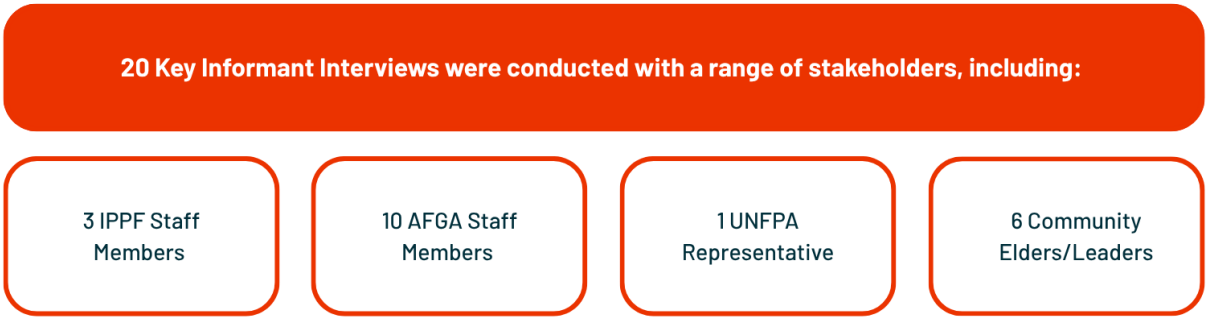
2.2. Data Collection

Client Exit Interviews (Quantitative Data Source): A total of **106 client exit interviews** were conducted (17 per province) with clients who had just received SRH services at the Family Health House (FHH) during the data collection visit. The exit interview tool captured information on client demographics, SRH service utilization, access and affordability, experience (including respectful care, communication, consent, and privacy), perceived quality of care, and overall satisfaction with services received.

Narrative In-Depth Interviews with Midwives (Qualitative Data Source): To complement the client exit interviews and better understand service delivery realities, the assessment conducted **18 narrative in-depth interviews with FHH midwives** (three per province). These interviews explored midwives' practical experiences of providing SRH services, including service delivery processes, client demand and expectations, referral practices, workload and staffing, supply and medicine availability, community trust and acceptability, and perceived strengths and improvement priorities for the FHH model. In addition, the narrative interviews covered midwives' motivation to continue in their role, professional empowerment gained through working within the FHH model, perceptions of support and supervision (and whether they felt empowered and supported in practice), and "most significant change" stories illustrating instances where their care, counselling, or support made a clear difference in women's lives. The narrative approach was used to capture detailed, field-based insights that help explain patterns observed in the quantitative findings.

Key Informant Interviews (KIIs) (Qualitative Data Source): In addition, **20 Key Informant Interviews (KIIs)** were conducted with a range of stakeholders to capture programmatic and community perspectives on the FHH model. These interviews included representatives from implementing partners, program management staff, donor stakeholders, and community elders/leaders. KIIs focused on implementation and coordination, perceived service acceptability and quality, sustainability and financing considerations, key operational challenges and risks and recommendations to strengthen implementation and guide decisions on the model's future direction.

Figure 3: Qualitative Data Source



2.3. Data Analysis

A structured and transparent analytical approach was applied to both quantitative and qualitative datasets to ensure internal consistency, credibility, and clear alignment between evidence and findings. The analysis was conducted in three interconnected stages: quantitative analysis, qualitative analysis, and integration of results across data sources.

Quantitative Analysis (Client Exit Interviews): Data collected through KoBo Toolbox were cleaned and exported to SPSS for analysis. Data cleaning included checks for completeness, logic consistency (e.g., skip patterns), range validation, and removal of any duplicate or incomplete submissions. The analysis primarily used descriptive statistics frequencies, percentages, and basic cross-tabulations to summarize client characteristics, SRH service utilization patterns, access and barriers, experience-of-care indicators and satisfaction measures. Where relevant, cross-tabulations by province were conducted to explore geographic variation in selected indicators; results are presented as descriptive comparisons and do not imply causal differences. Given the sample size (n=106) and the non-probability nature of facility selection, findings are interpreted as indicative of the assessed sites rather than statistically generalizable to all FHHs nationally.

Qualitative Analysis (Narrative Midwife Interviews and KIIs): All narrative interviews with midwives and KIIs were transcribed and translated into English for analysis. Qualitative data were analysed using thematic analysis through a combined coding approach. A coding framework was developed using (i) deductive codes aligned with the study objectives and analytical frameworks (e.g., access and barriers, acceptability, quality of care, safety, sustainability), and (ii) inductive codes emerging from the data (e.g., locally specific constraints, contextual drivers of trust, operational bottlenecks). Codes were applied systematically across transcripts to identify recurring patterns, convergent and divergent perspectives, explanatory narratives, and implementation realities influencing service delivery.

Integration and Triangulation of Findings: Findings from the quantitative and qualitative data were integrated through systematic comparison of evidence from different sources to strengthen interpretation. Areas of agreement between datasets were highlighted as stronger evidence, while differences between quantitative and qualitative findings were examined to identify contextual explanations, implementation variations, or data limitations.

2.4. Program Establishment and Evolution of the FHH Model

The Family Health House (FHH) model was established to rebuild a women- and girls-focused health delivery system in Afghanistan's protracted crisis context by providing accessible, affordable, lifesaving maternal, newborn, and sexual and reproductive health (SRH) services in remote and conflict-affected areas. The model was designed as a community-based, digitally enabled service platform to improve access to respectful SRH/MCH care where facility coverage was limited. In 2021–2022, the Afghan Family Guidance Association (AFGA), with support from international partners, **designed and implemented the FHH intervention model across six provinces: Herat, Logar, Balkh, Parwan, Kapisa, and Laghman**. A total of 75 Family Health Houses were established in coordination with the Ministry of Public Health (MoPH) and Provincial Health Directorates, following UNFPA and national guidelines. Site selection was undertaken in consultation with health authorities to ensure geographic coverage in underserved and hard-to-reach communities.

Each FHH was set up within the community in a rented facility consisting typically of one to two rooms, including an outpatient consultation (OPD) area and a delivery room equipped with essential medicines, equipment, and supplies. The service delivery model centered on a trained and skilled midwife, supported remotely by obstetricians through a digitally enabled Midwifery Helpline and call center. Three obstetricians provided regular remote supervision and consultation via audio and video platforms, particularly for high-risk pregnancies and complex SRH cases. This support mechanism strengthened clinical oversight while allowing services to remain community based. The model incorporated digital innovations to strengthen monitoring and quality assurance. Midwives were equipped with handheld digital devices and self-diagnostic kits to support community-based antenatal, postnatal, and other SRH services. An Android-based DHIS2 client-level application was adopted for real-time data recording and service tracking, with customized dashboards enabling continuous performance monitoring and feedback. Regional offices were established to support logistics, commodity supply, training, and quarterly coordination meetings.

Over time, the geographic footprint of the model evolved in response to funding conditions. In 2024, 85 FHHs were operational. During the 2025 evaluation period, this number **temporarily decreased to 67 due to external funding cuts**. However, with **new funding secured in Q4 2025**, services expanded to additional provinces, bringing the **total number of operational FHHs to 91,** surpassing the 2024 level. This trajectory shows the model's capacity to expand and its sensitivity to external financing conditions. Overall, the FHH model evolved from an emergency-focused intervention into a structured, digitally supported community health delivery platform, characterized by localized service provision, remote specialist support, structured supervision, and strong engagement with provincial health authorities.


AFGHAN FAMILY GUIDANCE ASSOCIATION
انجمن رهنمای خانواده افغان
دافغان کورنۍ لارښوونې ټولنه
Afghan Family Guidance Association
آشیانه صحی گردنه قیمچاق
دگردنه قیمچاق روغتیایی خاله
Gardna Qem chang Villg Family Health House
سال تاسیس ۱۴۰۱

3. Findings

Based on the mixed-method assessment conducted across six provinces, findings indicate that the Family Health House (FHH) model is widely regarded as a trusted and accessible service platform for delivering SRH services, particularly for women in settings where distance, cost, and socio-cultural constraints limit access to facility-based care. Client exit interviews portrayed strong repeat utilization and positive client experience indicators, while qualitative interviews provided additional context on the drivers of trust, operational challenges, and sustainability risks. Findings also highlight persistent constraints related to geographic access, medicine availability, infrastructure gaps, and longer-term financing, which should be addressed to protect service quality and continuity.

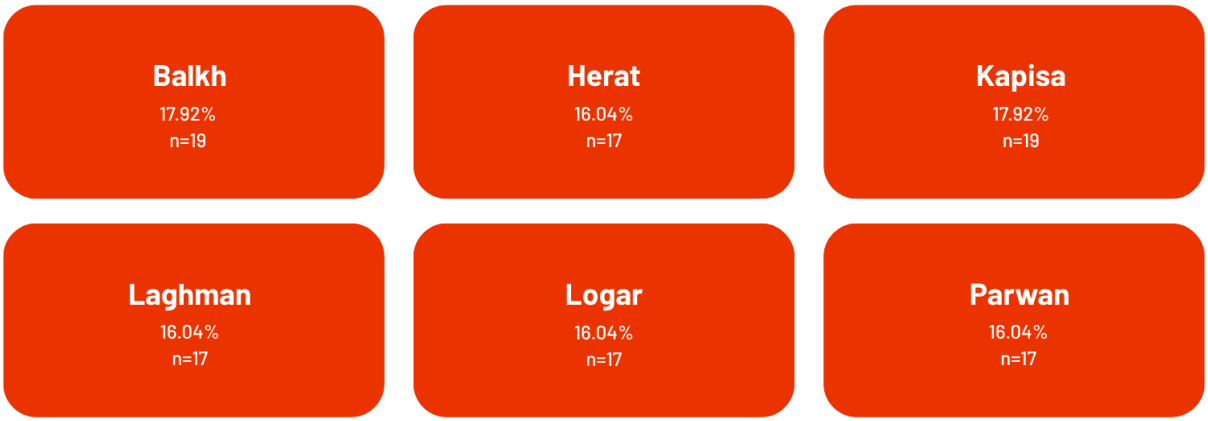
3.1. Client Profile and Service Utilization

This section presents the demographic profile of clients interviewed during facility exit visits and summarizes key patterns of SRH service use. Findings are drawn from 106 client exit interviews conducted across Balkh, Herat, Kapisa, Laghman, Logar, and Parwan.

3.1.1 Demographic Characteristic of Clients

Province-wide distribution of respondents (N=106): Client exit interviews were conducted across six provinces to ensure geographic spread. Respondents were distributed as follows: Balkh 17.9% (n=19), Kapisa 17.9% (n=19), Herat 16.0% (n=17), Laghman 16.0% (n=17), Logar 16.0% (n=17), and Parwan 16.0% (n=17). This distribution reflects the planned sample allocation per province.

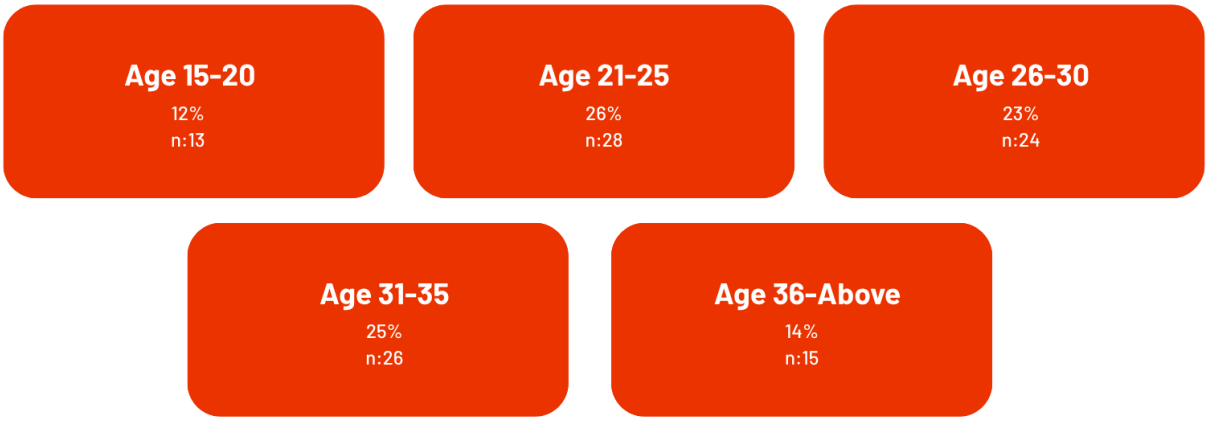
Figure 4: : Province-Wise Distribution of Respondents



Age Profile of Clients

Clients interviewed represented a broad range of reproductive age groups. The largest proportion of respondents were aged 21–25 years (26%, n=28), followed by those aged 31–35 years (25%, n=26) and 26–30 years (23%, n=24). Adolescents and younger clients aged 15–20 years accounted for 12% (n=13), while clients aged 36 years and above represented 14% (n=15). Overall, the age distribution indicates that the majority of service users were within the reproductive age range, aligning with the FHH focus on sexual and reproductive health (SRH) services.

Figure 5: Age Profile of Clients



3.2. Service Utilization Patterns

3.2.1 Primary Reasons for Visiting the FHH

Analysis of the client exit interviews (N=106) represented that the Family Health House (FHH) is primarily accessed for SRH/MNCH services, with Antenatal Care (ANC) as the most frequently reported reason for the visit (36.8%, n=39). Family Planning (FP) was also a leading reason for visits. Other SRH-related reasons for visiting included gynaecological services (12.3%, n=13) and postnatal care (PNC) (10.4%, n=11). A smaller proportion of respondents reported visiting for delivery-related care (3.8%, n=4) and pregnancy-related problems/complications (2.8%, n=3).

Overall, the pattern suggests that FHHs are mainly used for routine ANC and FP services, alongside other SRH/MNCH needs. At provincial level, utilization patterns vary. ANC was the leading service in most provinces, and FP-related services were also prominent in multiple sites. Gynaecological services were particularly concentrated in Kapisa, indicating a higher reported demand for gynaecological consultations in the assessed FHHs in that province. These variations likely reflect differences in community demand, local referral practices, and how clients describe the services they receive.

Table 1: Primary Reasons for Visiting the FHH

Reasons for your visit to this facility today?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
ANC (Antenatal Care)	42%	8	24%	4	21%	4	29%	5	59%	10	47%	8	37%	39
Family Planning (including contraceptive methods)	32%	6	41%	7	16%	3	47%	8	24%	4	35%	6	32%	34
Gynaecology	0%	0	0%	0	63%	12	0%	0	6%	1	0%	0	12%	13
PNC (Postnatal Care)	11%	2	12%	2	0%	0	24%	4	12%	2	6%	1	10%	11
Delivery & Labor	11%	2	0%	0	0%	0	0%	0	0%	0	12%	2	4%	4
Pregnancy Problems / Complications	0%	0	18%	3	0%	0	0%	0	0%	0	0%	0	3%	3
Child Health	5%	1	0%	0	0%	0	0%	0	0%	0	0%	0	1%	1
Other Health Issues	0%	0	6%	1	0%	0	0%	0	0%	0	0%	0	1%	1
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

The qualitative evidence from midwife narrative interviews supports the quantitative pattern that most client demand relates to ANC and Family Planning, followed by PNC and occasional delivery-related support. Midwives described providing a continuity of SRH/MNCH care from pregnancy through the postnatal period, with counselling delivered as part of routine ANC/PNC and FP services.

One midwife explained:

> ***"We mainly provide ANC, PNC, and family planning services. Women usually visit the facility for routine pregnancy check-ups, postnatal follow-up care after delivery, and counselling related to maternal and reproductive health needs. Additional guidance and support are provided whenever necessary to address individual concerns and ensure continuity of care."***
> *(Midwife narrative interview)*

3.2.2 Services Received During the Visit

This subsection summarizes the services clients reported receiving during their visit to the Family Health House (FHH). Since a single client visit includes multiple services (e.g., a clinical consultation combined with counselling, screening, or referral), responses are multiple-choice and percentages do not sum to 100%. Findings are based on Client Exit Interviews (N=106) across six provinces.

Overall, reported services underscored a strong concentration on the core SRH/MNCH package, complemented by selected supportive and non-SRH services. Family planning services were the most frequently reported service received (61%, n=65/106), followed by antenatal care (ANC) (54%, n=57/106) and postnatal care (PNC) (40%, n=42/106). Two supportive service components nutrition screening/counselling (36%, n=38/106) and referral to a higher-level facility (36%, n=38/106) were also commonly reported, suggesting that many visits include additional screening and care-navigation

beyond the primary SRH service. In addition, treatment for minor illness (a non-SRH service) was reported by 35% (n=37/106) of clients, while delivery services were reported by 25% (n=26/106). Psychosocial support services were reported by 23% (n=24/106) of clients, indicating that some visits include psychosocial support or counselling alongside SRH/MNCH services. Psychosocial Support Services (PSS) are provided at Family Health Houses as part of the broader service package supporting women's reproductive and maternal health needs. Exit interview findings indicate that **23% of clients (n=24/106) reported receiving psychosocial support during their visit.** Midwives highlighted that emotional reassurance and listening to clients' concerns are important components of care.

> ***"Many women come to the facility feeling anxious about their pregnancies or facing family-related challenges. We first take time to listen to their concerns and provide reassurance, helping them feel calmer, supported, and more confident before receiving further care and counselling."***
> *(Midwife narrative interview)*

At sites where a counsellor is present, psychosocial counselling complements clinical services provided by midwives and allows clients to discuss sensitive issues more openly:

> ***"Some clients arrive feeling anxious about their health conditions or the pressures they face within their families. By listening carefully to their concerns and offering emotional support, we help them feel understood, reassured, and more comfortable continuing with their care and treatment."***
> *(PSS counsellor interview)*

Provincial patterns indicate clear variation in the service mix received during visits. Kapisa shows very high reported coverage of multiple SRH/MNCH and supportive services, including ANC (100%, n=19/19), PNC (89%, n=17/19), family planning (84%, n=16/19), and high levels of nutrition screening/counselling and referral (68%, n=13/19 each), alongside delivery services (68%, n=13/19). Logar demonstrates the highest reported provision of several supportive components, including family planning (100%, n=17/17), psychosocial services (88%, n=15/17), and nutrition screening/counselling and referral (82%, n=14/17 each), together with ANC (59%, n=10/17) and PNC (47%, n=8/17). In Balkh, service delivery shows a more mixed between SRH and non-SRH components, with family planning (53%, n=10/19) and treatment for minor illness (53%, n=10/19) both commonly reported, alongside PNC (37%, n=7/19) and delivery services (26%, n=5/19) Laghman shows a relatively balanced service mix, including family planning (53%, n=9/17), ANC (47%, n=8/17), PNC (35%, n=6/17), and moderate reporting of supportive services (nutrition screening/counselling and referral at 24%, n=4/17 each). In Herat, reported services were concentrated mainly around ANC and family planning (41%, n=7/17 each), with lower reporting of additional services (e.g., PNC 18%, n=3/17; delivery services 18%, n=3/17). Parwan similarly shows a service mix primarily centred on family planning, ANC, and delivery-related care (FP 35%, n=6/17; ANC 47%, n=8/17; delivery 12%, n=2/17), while other supportive services were reported at comparatively lower levels. The variation across provinces likely reflects differences in local needs, how services are bundled during visits, and site-level operational realities.

Table 2: Services Received During the Visit

What services did you or your child receive today at the FHH?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Family planning services	53%	10	41%	7	84%	16	53%	9	100%	17	35%	6	61%	65
Antenatal care (ANC)	26%	5	41%	7	100%	19	47%	8	59%	10	47%	8	54%	57
Postnatal care (PNC)	37%	7	18%	3	89%	17	35%	6	47%	8	6%	1	40%	42
Nutrition screening or counselling	16%	3	18%	3	68%	13	24%	4	82%	14	6%	1	36%	38
Referral to a higher-level health facility	16%	3	18%	3	68%	13	24%	4	82%	14	6%	1	36%	38
Treatment for minor illness (e.g., cough, fever, diarrhoea)	53%	10	0%	0	53%	10	24%	4	71%	12	6%	1	35%	37
Delivery services	26%	5	18%	3	68%	13	18%	3	0%	0	12%	2	25%	26
Psychosocial services	16%	3	0%	0	5%	1	24%	4	88%	15	6%	1	23%	24

The midwives' narrative interviews reinforce the quantitative findings by describing how services are commonly delivered as a package during one visit particularly for women seeking routine SRH/MNCH care. Midwives explained that daily service delivery typically prioritizes ANC, PNC, and family planning, with supportive elements such as nutrition counselling integrated where needed, and follow-up care provided after delivery.

3.2.3 Repeat Visit or First-Time Use

Client exit interview data indicates a high level of repeat use of FHH services across the assessed sites. Overall, 95.3% of respondents (n=101/106) reported that they had visited the facility before, while 4.7% (n=5/106) stated that this was their first visit. This pattern indicates consistent service use and community familiarity with the FHH model in the assessed locations.

Table 3: Repeat Visitation or First-Time Use

Have you ever visited this facility before today?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Yes, visited earlier	100%	19	94%	16	100%	19	100%	17	100%	17	76%	13	95%	101
No, this is the first time	0%	0	6%	1	0%	0	0%	0	0%	0	24%	4	5%	5
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

3.3. Quality of Care and Client Experience

3.3.1 Service Delivery Process

This section examines key aspects of the service delivery process at the Family Health House (FHH), including adherence to scheduled service delivery, the primary cadre(s) providing services during client visits, and client waiting times. Findings are based on Client Exit Interviews (N=106) and are complemented by midwife narrative interviews to provide context operational realities and constraints.

Adherence to the Scheduled Appointment/Planned Time of Service: All clients interviewed (100%, n=106/106) reported that they received services at the originally planned/scheduled time. This suggests consistent service reliability on the assessed sites. While midwife narrative interviews did not explicitly reference "scheduled appointments" as a formal system, the interviews repeatedly emphasized the operational principle of continuous availability, particularly for maternity-related needs, which explain why clients reported full adherence to planned timing.

> ***"Our Centre provides services around the clock, including on Fridays, to ensure women can access care whenever it is needed. Women arrive at all hours, particularly for delivery services. When a woman in labour comes to the facility, the gate remains open and I am always prepared to provide immediate care and support."***
> *(Midwife narrative interview, Herat)*

Healthcare Staff Providing Services: Client responses indicated that the FHH model is primarily midwife-led. Overall, 88.7% (n=94/106) of clients reported that a midwife provided their services during the visit, while 11.3% (n=12/106) reported receiving services from a counsellor. Provincial variation is notable: counsellor-provided services were reported more frequently in Logar (29.4%, n=5/17) and Parwan (23.5%, n=4/17) than in other provinces. These findings suggest that some sites integrate psychosocial support more visibly into service delivery (A The current exit interview question is designed to capture a single response to the query "who provided the services." This structure does not account for scenarios where multiple providers, such as a midwife and a counsellor, are involved in a client's care during a single visit).

Table 4: Service Delivery Process[7]

Who provided you the services at the FHH?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Midwife	89%	17	100%	17	95%	18	100%	17	71%	12	76%	13	89%	94
Counsellor	11%	2	0%	0	5%	1	0%	0	29%	5	24%	4	11%	12
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

[7] Single-response question; does not capture visits where both midwife and counsellor contributed.

Client Waiting Times: Findings highlighted that for most clients (82.1%, n=87/106) waiting time was less than one hour after arrival, while 13.2% (n=14/106) waited one to two hours. Overall, 95.3% (n=101/106) reported being served within two hours. A small proportion (0.9%, n=1/106) reported waiting two to four hours, observed only in Parwan (5.9%, n=1/17).

Table 5: Client Waiting Times

How long did you wait to receive assistance after you arrived at the FHH?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Immediately get the services	5%	1	0%	0	0%	0	0%	0	18%	3	0%	0	4%	4
Less than one hour	84%	16	82%	14	95%	18	100%	17	76%	13	53%	9	82%	87
One to two hours	11%	2	18%	3	5%	1	0%	0	6%	1	41%	7	13%	14
Two to four hours	0%	0	0%	0	0%	0	0%	0	0%	0	6%	1	1%	1
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Although most clients reported relatively short waiting times, midwives described the operational strain required to maintain this level of responsiveness particularly in periods of high client flow and when staffing is limited. One midwife from Herat highlighted that client volume can be difficult to manage when the provider is working alone:

> ***"The main challenge is the heavy workload. A large number of clients come to the Centre, and I am often responsible for providing services on my own. Sometimes working alone makes it difficult to manage and maintain the flow of care."***
> *(Midwife narrative interview, Herat)*

This qualitative insight helps contextualize the quantitative finding on waiting times. It suggests that timely service delivery is sustained through considerable individual effort by midwives, underscoring the importance of adequate staffing support and workload monitoring to protect service quality and provider's well-being.

3.3.2 Quality of Care

Respectful and Caring Treatment: Client exit interview findings portrayed a consistently positive client experience. Across all provinces, 100% of respondents (n=106/106) reported that FHH staff treated them or their child in a caring and respectful manner. This suggests that respectful interaction and courteous behaviour are strong features of the client experience in the assessed FHHs. Qualitative narratives from midwives reflect a deliberate emphasis on professionalism and ethical conduct as the foundation for building and maintaining community trust.

A midwife from Balkh linked community satisfaction to honesty and ethical practice:

> ***"In our work, we are guided by honesty, professional ethics, and a strong commitment to gaining the trust and satisfaction of the community. We always strive to provide the best possible services and ensure that clients receive respectful and quality care"***
> *(Midwife narrative interview, Balkh)*

Demonstration of Provider Empathy: Clients also consistently reported empathic engagement during consultations. Across the six provinces, 100% of respondents (n=106/106) stated that the service provider demonstrated empathy during the interaction. This finding suggests that the FHH environment supports compassionate communication, which is a key element of quality SRH service delivery and helps strengthen continued utilization.

Feeling of Support and Comfort: Nearly all clients reported feeling supported and comfortable while receiving care. Overall, 99.1% (n=105/106) responded positively. The single negative response was recorded in Parwan (5.9%, n=1/17).

Table 6: Feeling of Support and Comfort

Did you feel supported and comfortable while receiving care from the FHH staff?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Yes	100%	19	100%	17	100%	19	100%	17	100%	17	94%	16	99%	105
No	0%	0	0%	0	0%	0	0%	0	0%	0	6%	1	1%	1
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Qualitative findings further help to explain why clients reported such high levels of comfort. They described creating a welcoming and confidential environment through listening carefully, maintaining privacy, and communicating respectfully particularly important in conservative contexts where women otherwise hesitate to discuss SRH concerns.

"Here, we do not have male doctors; only female staff provide services. This allows clients to discuss their health concerns more openly and comfortably in a supportive and culturally appropriate environment."
(Midwife narrative interview, Logar)

"I build the trust of women and their families through truthfulness, honesty, respectful care, and consistent follow-up on their health conditions. Maintaining good communication and showing genuine concern for clients helps strengthen their confidence in the services provided."
(Midwife narrative interview, Laghman)

Respect for Client Privacy

Client responses showcased a strong attention to confidentiality during service delivery. Across all provinces, 100% of respondents (n=106/106) reported that their privacy was respected during the consultation. This finding is particularly important for SRH/MNCH services, where privacy and confidentiality are central to building trust and enabling clients especially women to seek care comfortably.

Qualitative narratives reinforce this result and provide context for why privacy is a defining feature of the FHH model in conservative settings. Midwives described confidentiality as a core professional practice and highlighted the importance of a women-staffed environment in facilitating open communication about sensitive SRH concerns. A midwife from Logar explained that the presence of female staff and a confidential setting make it easier for women particularly those with mobility restrictions to access care and speak freely. Together, these findings indicated that consistently high reports of privacy are not incidental; they reflect a service culture that prioritizes confidentiality and respectful engagement, which in turn supports trust and sustained use of FHH SRH services.

3.3.3 Clinical Quality of Care

This section presents client-reported indicators related to clinical care processes at the Family Health House (FHH), including informed consent, history taking, examination and communication practices, and medicine prescribing and dispensing. Findings draw on Client Exit Interviews (N=106) and are complemented by midwife narrative interviews to provide practical context on how care is delivered in practice. The quantitative results describe patterns reported by clients at the assessed sites and should be interpreted as evidence of reported service processes and experience during consultations, rather than as verification of clinical outcomes. Informed consent before examination or treatment was reported consistently across the assessed facilities. All interviewed clients (100%, n=106/106) stated that they were asked for consent before examination or treatment, indicating strong adherence to consent practices in routine care. Midwife narratives also emphasized the importance of following clinical protocols and being prepared to manage urgent situations when they arise. One midwife in Balkh described responding to a critical case and stabilizing the client through immediate care and close monitoring before onward action. This account provides qualitative context on provider readiness to manage complications.

> ***"A woman arrived at the facility in a critical condition. We provided immediate care to control the bleeding and closely monitored her for several hours until her condition stabilized and she was out of danger."***
> *(Midwife narrative interview, Balkh)*

Health history assessment also appears to be a routine component of consultations. Overall, 98.1% of clients (n=104/106) reported that the provider asked about their health history and background, while 1.9% (n=2/106) reported that this did not occur. At provincial level, history taking was reported as universal in Balkh (100%, n=19/19), Kapisa (100%, n=19/19), Laghman (100%, n=17/17), and Logar (100%, n=17/17)

Table 7: Comprehensiveness of Patient History Assessment

Did the health service provider(s) ask you questions about your health history & background?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Yes	100%	19	94%	16	100%	19	100%	17	100%	17	94%	16	98%	104
No	0%	0	6%	1	0%	0	0%	0	0%	0	6%	1	2%	2
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Clients also reported very strong performance on communication and consultation practices. All respondents (100%, n=106/106) stated that providers gave clear explanations about their health situation, and 100% (n=106/106) reported that providers took sufficient time to answer their questions and address concerns. In addition, 100% (n=106/106) reported that the examination conducted was appropriate for their health concern. These results indicate high client satisfaction in consultation processes in the assessed facilities. Regarding medicine prescribing, 97.2% of clients (n=103/106) reported that they were prescribed medicine during the visit. Prescribing was reported as 100% in Balkh (n=19/19), Kapisa (n=19/19), Laghman (n=17/17), and Logar (n=17/17), with slightly lower levels in Herat (94.1%, n=16/17) and Parwan (88.2%, n=15/17).

Table 8: Prescription of Medicine

Were you prescribed any medicine?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Yes	100%	19	94%	16	100%	19	100%	17	100%	17	88%	15	97%	103
No	0%	0	6%	1	0%	0	0%	0	0%	0	12%	2	3%	3
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

On receipt of prescribed medicines, 95.3% of clients (n=101/106) reported receiving all prescribed items at the facility, while 4.7% (n=5/106) reported not receiving all medicines. Shortfalls were reported in Balkh (10.5%, n=2/19), Kapisa (10.5%, n=2/19), and Logar (5.9%, n=1/17). No shortfalls were reported in Herat, Laghman, or Parwan during the assessment visits. Midwife narratives provide context that intermittent shortages can influence community dissatisfaction.

"When medicines are not available, community members become dissatisfied, and this negatively affects their perception of the centre and their willingness to seek services."
(Midwife narrative interview, Kapisa)

"We do not face major challenges most of the time; however, at times there is a shortage of medicines, which affects service delivery."
(Midwife narrative interview – Service Provider)

The assessment did not capture an item-level list of stockout medicines; therefore, identifying which specific medicines were unavailable would require verification through facility stock records. Additionally, among those who were prescribed medicines (n=103), 100% (n=103/103) reported receiving clear instructions on dosage and how to take the medicines. This indicates consistent counselling on medicine use during consultations.

Table 9: Receipt of Prescribed Medicines

Did you receive all the prescribed medications?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Yes	89%	17	100%	17	89%	17	100%	17	94%	16	100%	17	95%	101
No	11%	2	0%	0	11%	2	0%	0	6%	1	0%	0	5%	5
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

3.3.4 Met and Unmet Services Expectations

Client exit interview findings presented that the FHHs are generally meeting clients' expectations for SRH services at the point of care. Across all assessed provinces, 100% of respondents (n=106/106) reported that they received the SRH services they expected during their visit. This consistent response indicates close alignment between client expectations and services delivered during the consultation. While this finding reflects very high reported satisfaction with the completeness of services received on the day of the visit, it should be interpreted as a client-reported process indicator. It indicates that, from the client perspective, the FHH model provides services that matches expressed SRH needs and supports continued trust and use of the model in the assessed sites.

3.3.5 Midwife Empowerment and Motivation (Narrative Interviews)

Narrative interviews with midwives reinforce the FHH model as a practical empowerment platform for midwife-led primary healthcare in fragile settings. Midwives repeatedly linked empowerment to three connected pathways: (1) visible impact on women's lives, (2) professional learning and applied skills, and (3) recognition and trust from clients and communities. In Parwan, one midwife described as being able to respond when women trust her enough to disclose sensitive concerns:

> ***"I mainly empathize with clients. I try to understand their feelings and concerns, and I maintain their confidentiality, becoming someone they can trust and confide in."***
> *(Midwife narrative interview, Parwan)*

In more fragile operating conditions, midwives emphasized that community acceptance and safety are enabling factors for retention:

> ***"The support of the people, encouragement, and security."***
> *(Midwife, Parwan)*

Motivation among midwives is largely driven by the emotional reward of service delivery and the visible, positive outcomes of their care. A midwife in Parwan explained that her motivation comes from trust-based interactions with clients:

> ***"My main motivation is that when a woman can easily share her problem with me and I can help her."***
> *(Midwife, Parwan)*

Another midwife noted that her decision to enter the profession was influenced by both a desire to serve the community and the need for financial independence:

> ***"I mostly wished to serve the community and also be able to support myself."***
> *(Midwife, Parwan)*

FHH model empowers midwives professionally: Midwives described professional empowerment as growing confidence through practice, results, and client feedback. In Parwan, one midwife explained that client trust and satisfaction strengthen her commitment and professional identity. *"The trust and satisfaction of my clients have made me... in love with my work"*. Another linked confidence to successful service encounters and positive outcomes: *"When a patient is discharged... satisfied, I am very proud of myself"* (Midwife, Parwan). These narratives suggest that empowerment is not only skill-based, but also relational rooted in trust, respectful communication, and the ability to support women through sensitive health needs.

Midwives feel empowered and supported in the FHH: Midwives reported feeling empowered when they can use their skills and see results. Support was described as both technical and social. Midwives valued supervision when it is constructive and quality-focused; *"Supervisors do supervision and they pay more attention to quality"* (Midwife, Parwan). They also highlighted practical enablers such as medicines and community backing: *"Access to medicine and the support of the community and people is more impactful"* (Midwife, Parwan). Recognition and appreciation also function as a motivator and a form of institutional support midwives noted that appreciation "makes me more motivated to serve people" and reinforces the value of their work. At the same time, interviews also signal the importance of strengthening support systems over time, particularly through regular refresher training and improved working conditions, which midwives identified as critical to sustaining performance and retention.

Midwife stories where care made a big difference: Midwives shared success stories illustrating how timely midwife-led care can be life-saving and transformative. In Parwan, one described: *"They brought a woman in a cart to the facility. The delivery was successfully conducted, and both the mother and the child were healthy afterward."* Others highlighted counselling as a pathway to improved wellbeing and healthier decisions: *"A woman came to the facility experiencing multiple closely spaced pregnancies. After receiving counselling and follow-up support, she now reports feeling satisfied and more comfortable with her situation."*

Stories where care made a big difference: Midwives shared credible, practice-based stories illustrating how timely midwife-led care can be life-saving and transformative:

- **Emergency response and rapid action:** One midwife described an emergency in which a woman experienced severe bleeding after delivery; "quick and precise actions" helped stabilize the situation and reinforced the importance of emergency readiness at FHH level.
- **Counselling that changes life decisions:** Midwives described clients whose "attitude and behaviour change" after counselling, resulting in better health decisions and improved wellbeing
- **Emotional support as a clinical outcome:** A midwife recalled a post-delivery moment where supportive communication strengthened a mother's self-confidence and sense of resilience (a key pathway through which respectful maternity care improves overall outcomes)

These narratives align with the quantitative picture of strong client satisfaction and loyalty and help explain why "provider behaviour" is consistently one of the top reasons clients choose the FHH. Because Family Health Houses operate primarily as midwifery-run facilities, task sharing plays an important role in ensuring effective service delivery and community outreach. Qualitative findings indicate that while midwives provide maternal and reproductive health services—including antenatal care, delivery support,

postnatal care, and family planning, other actors such as community health workers (CHWs), counsellors, and community groups support complementary functions such as health education, psychosocial counselling, community awareness, and follow-up with families. This collaborative approach allows midwives to focus on clinical care while strengthening preventive education and community engagement.

> ***"We work with community health workers (CHWs) and a Family Health Action Group composed of women from the surrounding villages. We hold regular meetings with them, and they play an important role in informing the community about available services and encouraging people to seek care at the facility."***
> *(Midwife narrative interview)*

3.4. Accessibility and Security

3.4.1 Geographic and Physical Access

Proximity and geographic accessibility: Client exit interviews show that the assessed FHHs are geographically accessible for most respondents. Overall, 74.5% of clients (n=79/106) reported that the FHH is located within less than 1 km of their home, while 19.8% (n=21/106) reported a distance of 1–5 km**.** A smaller proportion reported traveling 6–10 km (4.7%, n=5/106) or more than 10 km (0.9%, n=1/106)**.**

Table 10: Proximity and Geographic Accessibility

How far is the FHH from your home?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Less than 1 km	68%	13	71%	12	100%	19	94%	16	82%	14	29%	5	75%	79
1-5 km	16%	3	29%	5	0%	0	6%	1	18%	3	53%	9	20%	21
6-10 km	11%	2	0%	0	0%	0	0%	0	0%	0	18%	3	5%	5
More than 10 km	5%	1	0%	0	0%	0	0%	0	0%	0	0%	0	1%	1
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

In provinces where proximity is high, leaders described access as straightforward and linked this to the location of the FHH within or near the community. For example:

> ***"Access to the facility is easy, as people from this village and nearby communities come here because it is the closest centre available to them."***
> *(KII, Community Leader, Herat)*

> ***"Access to services has become much easier for our families. When we need care, we can reach the facility quickly without difficulties."***
> *(KII, Community Leader, Logar)*

In contrast, leaders in provinces where distance or terrain is more challenging pointed to practical barriers such as road conditions and transport availability/costs:

> ***"It is not easy for everyone, as the road is far. In winter, flooding worsens conditions and the road becomes difficult to use. In addition, some people do not have access to transport."***
> *(KII, Community Leader, Balkh)*

> ***"Access is not very easy because many families live far away, transport options are limited, and some households cannot afford travel costs."***
> *(KII, Community Leader, Kapisa)*

> ***"For some people access is easier, but for others it remains difficult because the clinic is located on the outskirts and far from the main road."***
> *(KII, Community Leader, Laghman)*

Transportation modes and physical access: Consistent with the proximity data, most respondents reported walking to the FHH. Overall, 82.1% (n=87/106) reported arriving on foot. Walking is universal in Kapisa (100%, n=19/19), Laghman (100%, n=17/17), and Logar (100%, n=17/17), and is also the most common mode in Balkh (73.7%, n=14/19) and Herat (64.7%, n=11/17). In Parwan, only 52.9% (n=9/17) reported walking, with higher reliance on paid transport such as hired cars (35.3%, n=6/17) and minimal use of private vehicles.

Table 11: Transportation Modes and Physical Access

How did you get to the FHH today?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Walked	74%	14	65%	11	100%	19	100%	17	100%	17	53%	9	82%	87
Motorbike	26%	5	24%	4	0%	0	0%	0	0%	0	6%	1	9%	10
Hired Car	0%	0	0%	0	0%	0	0%	0	0%	0	35%	6	6%	6
Private car	0%	0	6%	1	0%	0	0%	0	0%	0	6%	1	2%	2
Public Transportation (including rikshaws)	0%	0	6%	1	0%	0	0%	0	0%	0	0%	0	1%	1
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Travel time to the FHH: Most respondents reported reaching the FHH within a short travel time. Overall, 83.0% (n=88/106) reported travel time of less than one hour, while 14.2% (n=15/106) reported one to two hours, and 2.8% (n=3/106) reported two to four hours.

Table 12: Travel Time to Health Facilities

How long would/did it take you to get to the FHH today?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Less than one hour	74%	14	82%	14	95%	18	100%	17	88%	15	59%	10	83%	88
One to two hours	26%	5	18%	3	5%	1	0%	0	12%	2	24%	4	14%	15
Two to four hours	0%	0	0%	0	0%	0	0%	0	0%	0	18%	3	3%	3
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Transportation cost: Consistent with high rates of walking, most respondents reported no transport cost. Overall, 84.9% (n=90/106) reported paying nothing to reach the FHH, while 15.1% (n=16/106) reported incurring transport costs. Costs were most commonly reported in Parwan (35.3%, n=6/17), Herat (29.4%, n=5/17), and Balkh (21.1%, n=4/19), which corresponds to provinces where motorized transport is used more often.

Table 13: Transportation Costs for Clients

Do you pay for transportation to commute to the FHH?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
No	79%	15	71%	12	100%	19	100%	17	94%	16	65%	11	85%	90
Yes	21%	4	29%	5	0%	0	0%	0	6%	1	35%	6	15%	16
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Convenience of operating hours: All interviewed clients (100%, n=106/106) reported that the FHH operating hours were convenient for their community. Midwife narrative interviews provide additional context for this response, with providers describing flexibility beyond standard hours, particularly for urgent SRH/MNCH needs.

"We provide services beyond official working hours and remain available whenever women arrive for delivery or urgent care."
(Midwife narrative interview, Logar)

"Women come whenever they need services, including outside regular hours, and we make every effort to respond and provide the necessary care."
(Narrative interview, Midwife, Herat)

Access to SRH services when needed: All interviewed clients (100%, n=106/106) reported that they were able to access the SRH services they needed when they came to the FHH. This indicates close alignment between client expectations and service availability at the point of care in the assessed sites. Midwife narratives suggest that access is supported by the presence of female providers within communities and by the perceived acceptability of the FHH environment for women seeking SRH care.

Security and operational adaptations: KIIs with AFGA staff emphasized that service delivery in remote and conservative areas requires context-sensitive strategies to community acceptance and staff security. Reported measures included recruiting midwives from local communities and adopting culturally appropriate practices to maintain acceptance and safe service delivery. *(KII, AFGA staff).*

3.4.2 Barriers and Obstacles to Access

Obstacles to Accessing Health Services

Reported obstacles to reaching the FHH: Most respondents reported that they were able to reach the FHH without difficulty. Overall, 77.4% (n=82/106) stated that they did not face any obstacles in getting to the facility. However, a smaller share reported barriers that were strongly location specific. The most frequently reported obstacle was road disrepair (27.4%, n=29/106), followed by long distance (22.6%, n=24/106) and flooding or other weather events (21.7%, n=23/106). A small proportion reported concerns related to safe passage (2.8%, n=3/106).

> ***"Clients who come from farther villages face difficulties because the roads are unpaved and travel is not easy, especially in bad weather."***
> *(Midwife narrative interview, Parwan)*

Table 14: Obstacles to Accessing Health Services

Did you face any obstacles in getting to the FHH?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
I did not face any obstacles.	63%	12	71%	12	84%	16	100%	17	94%	16	53%	9	77%	82
The roads leading up to the FHH are in disrepair	26%	5	24%	4	84%	16	0%	0	6%	1	18%	3	27%	29
The FHH is a long distance away from home	32%	6	29%	5	5%	1	0%	0	18%	3	53%	9	23%	24
There has been flooding or other weather events in the area	21%	4	0%	0	100%	19	0%	0	0%	0	0%	0	22%	23
Other members of the community or other communities are impeding or hindering safe passage to the FHH	5%	1	0%	0	11%	2	0%	0	0%	0	0%	0	3%	3
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

A community leader in Kapisa similarly pointed to the combined impact of distance, road damage, and transport costs on access:

> ***"Clients who come from farther villages face difficulties because the roads are unpaved and travel is not easy, especially in bad weather."***
> *(Midwife narrative interview, Parwan)*

Service capacity and service readiness constraints

Several midwives and community leaders also raised issues related to service capacity and facility readiness such as limited staff, limited space, and periodic shortages of supplies. These concerns affect the overall service experience and the ability of facilities to meet demand, but they should be interpreted primarily as service readiness and capacity constraints rather than geographic access barriers.

One midwife in Kapisa described high demand relative to available staffing and service capacity:

> ***"Demand for SRH services is high, and with the current staffing and services available, it can be difficult to respond to all needs."***
> *(Midwife narrative interview, Kapisa)*

Midwives also cited limited facility space as affecting client comfort and privacy during busy periods. A midwife in Balkh noted:

> ***"One challenge is limited space, including the lack of a waiting area, which affects client comfort and privacy."***
> *(Midwife narrative interview, Balkh)*

Perceived unmet access needs in the community: Most respondents (81.1%, n=86/106) reported that they did not know anyone who needed services but could not reach the FHH. However, 18.9% (n=20/106) stated that they were aware of individuals who needed assistance but were unable to access the facility. It reflects respondents' awareness of cases they personally know about and therefore represents perceived access barriers rather than a direct measurement of how many people in the community were unable to access services.

Table 15: Perceived Awareness of Others Unable to Access the FHH

Do you know of anyone who needs this assistance but was not able to get to the FHH?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Yes	68%	13	71%	12	68%	13	100%	17	94%	16	88%	15	81%	86
No	32%	6	29%	5	32%	6	0%	0	6%	1	12%	2	19%	20
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Reasons people are unable to access services: Qualitative interviews highlighted that barriers to access are not limited to physical factors. Several respondents described household-level restrictions, social norms, and limitations in women's mobility as factors that can prevent women from seeking SRH services, even when services exist within a reachable distance. A midwife in Herat described how community trust and peer influence can support outreach to women who are initially hesitant or restricted:

> ***"Some women were initially hesitant to use the services. However, by sharing information through other women in the community, we were able to encourage them to visit the facility. After receiving care, they later expressed satisfaction with the services provided."***
> *(Midwife narrative interview, Herat)*

Table 16: Reasons for Inability to Access Care

Reasons for not being able to come to the FHH	Balkh		Herat		Kapisa		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n
Not permitted by men in the family	33%	6	60%	10	67%	13	100%	17	0%	0	50%	53
Long distance	33%	6	20%	3	0%	0	0%	0	50%	9	20%	21
Lack of transportation	33%	6	0%	0	0%	0	0%	0	50%	9	15%	16
Financial constraints	0%	0	20%	3	0%	0	0%	0	0%	0	5%	5
Shortage of Medicines at the Centre	0%	0	0%	0	17%	3	0%	0	0%	0	5%	5
Road Situation	0%	0	0%	0	17%	3	0%	0	0%	0	5%	5
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**89**

Midwife narrative interviews offer additional insight into the socio-cultural and geographic factors that can limit access to SRH services, and the practical strategies providers use to reduce these barriers. Several midwives described how household-level restrictions particularly limitations on women's mobility and reluctance to seek care in mixed-gender settings can delay or prevent timely care seeking. They also emphasized that the women-staffed nature of the FHH model can mitigate these constraints by offering a setting where clients feel culturally safe and able to speak openly.

One midwife in Balkh shared an account illustrating how delayed permission to seek care can lead to severe consequences:

> ***"I once supported a woman whose family did not allow her to seek care at a facility. She ended up delivering at home, but the placenta was retained. Her condition deteriorated, and she was brought to me two days later in a critical state. This experience has stayed with me, as it clearly demonstrated how dangerous delays in seeking care can be."***
> *(Midwife narrative interview, Balkh)*

Midwives also described proactive approaches to overcome these barriers through community-level engagement, counselling, and trust-building with families and influential community members. A midwife in Herat explained how satisfied clients can help encourage other women especially those initially hesitant to seek services:

> ***"Some women were discouraged at first, but through other women we shared information about the services available, and they later returned and were satisfied."***
> *(Midwife narrative interview, Herat)*

3.4.3 Security and Safety

Facility security arrangements reported by clients: Client exit interviews represented that FHHs are generally perceived to have basic security arrangements. The most frequently reported measures were that the facility is located within a walled/protected compound (84.9%, n=90/106) and that unauthorized entry is restricted (83.0%, n=88/106). In addition, 57.5% (n=61/106) of respondents reported the presence of a security guard at the gate at the time of their visit or interview. Lower reporting of guard presence likely reflects variation in guard availability at the time of visits or interviews, rather than the absence of a designated guard position at all FHH sites.

Table 17: Physical Security Measures at the FHH

Measures considered to ensure security at the FHH	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
The FHH was established inside of a walled/ protected area	58%	11	100%	17	68%	13	100%	17	100%	17	88%	15	85%	90
Unauthorized entry was not allowed to the FHH	68%	13	100%	17	100%	19	94%	16	100%	17	35%	6	83%	88
Security guard was present at the gate	84%	16	47%	8	84%	16	94%	16	12%	2	18%	3	58%	61
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Perceived safety within the service environment: Across all assessed provinces, 100% of respondents (n=106/106) reported that they felt safe while receiving services at the FHH. This indicates a consistently positive perception of safety within the facility environment during the assessment period.

Travel-related safety and timing of visits: All respondents (100%, n=106/106) reported expecting to return home during daylight hours. This finding likely reflects common mobility and risk-management practices in the community (e.g., preference to avoid travel in the evening) rather than a direct measure of facility scheduling or service availability. From an SRH access perspective, it nonetheless underscores the importance of service models that enable women and families to seek care within safe travel windows particularly in settings where night-time mobility is constrained by security concerns, distance, or limited transport options.

Community perspectives on women's mobility and accompaniment: Key informant interviews with community leaders suggest that women's ability to access SRH services is shaped by both social norms and practical travel considerations. Leaders in several provinces including Herat, Laghman, and Logar described that women can generally visit the FHH without major cultural constraints and do not require a male companion for routine visits. However, a more nuanced pattern was also reported: some leaders noted that accompaniment is preferred or considered necessary in specific circumstances, particularly when travel is required after daylight hours, when routes are perceived as unsafe, or when a serious medical situation requires travel to higher-level services. Community leaders also linked mobility and safety to structural factors especially distance, road conditions, and transport availability/costs which can affect whether and how women reach services in certain catchment areas. This supports the broader access findings that, in some provinces, safety and access are closely interconnected, and that improving safe and affordable transport options can directly strengthen SRH service utilization.

3.5. Community Perceptions and Impact

3.5.1 Awareness and Information Channels

Most clients reported that they were aware of the services available at the Family Health House (FHH) before arriving. Overall, 86.8% (n=92/106) indicated that they had been informed about FHH services prior to their visit, reflecting generally effective community-level information sharing.

Awareness was universal in Kapisa (100%, n=19/19) and Laghman (100%, n=17/17) and remained high in Herat (88.2%, n=15/17) and Logar (88.2%, n=15/17). Lower levels of awareness were reported in Parwan (70.6%, n=12/17) and Balkh (73.7%, n=14/19), which showcased clients arrived without prior knowledge of available services suggesting a need to strengthen outreach and communication in these locations.

Table 18: Prior Knowledge of FHH Services

Were you informed about the services available at the FHH before your visit?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Yes	74%	14	88%	15	100%	19	100%	17	88%	15	71%	12	87%	92
No	26%	5	12%	2	0%	0	0%	0	12%	2	29%	5	13%	14
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Qualitative interviews provide insight into how community awareness is generated and sustained. Midwives described proactive, continuous community engagement including health education, counselling, and structured meetings with local actors to build trust and increase understanding of SRH services over time.

> ***"When I first arrived, people had very limited information about health services. We provided health education, counselling, and awareness sessions to address this gap. Over time, the situation has improved a lot. We now hold monthly meetings with local council members, and we also work with a Family Health Action Group, whose members help raise awareness and share information within the community."***
> *(Midwife narrative interview, Herat)*

Community leaders likewise demonstrated a clear understanding of the FHH's role, most commonly describing it as a trusted point for SRH services particularly antenatal care, delivery care, postnatal care, and family planning and, in some cases, related MCH services such as child nutrition support.

"This Centre provides antenatal and postnatal care, delivery services, as well as counselling on family planning and birth spacing."
(KII, Community Leader, Herat)

"Women especially come here for delivery services, and we are very happy that this Centre has been established in our area."
(KII, Community Leader, Logar)

Clients reported learning about FHH services through several channels, with strong provincial variation. Overall, Community Health Workers (CHWs) were the most frequently cited primary source (27.4%, n=29/106), especially in Logar (86.7%, n=15/17) and Parwan (41.2%, n=7/17). Friends and neighbours were another common source (15.1%, n=16/106), particularly in Balkh (36.8%, n=7/19) and Parwan (41.2%, n=7/17). Formal outreach channels were dominant in specific provinces: awareness sessions were the leading source in Kapisa (78.9%, n=15/19), while posters were overwhelmingly reported in Laghman (94.1%, n=16/17). Community elders/leaders played a key role in Herat (58.8%, n=10/17), reinforcing the importance of local gatekeepers in SRH information dissemination.

Table 19: Channels of Service Information

How did you learn about them? (e.g., poster, CHW, friend, radio, awareness sessions)	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Community Health Worker	14%	3	27%	5	0%	0	6%	1	87%	15	42%	7	27%	29
Poster	0%	0	0%	0	21%	4	94%	16	0%	0	0%	0	22%	23
Awareness Session	7%	1	0%	0	79%	15	0%	0	0%	0	17%	3	20%	21
Friends and Neighbours	36%	7	13%	2	0%	0	0%	0	13%	2	42%	7	15%	16
Community Elders	14%	3	60%	10	0%	0	0%	0	0%	0	0%	0	12%	13
Men in the Family	29%	5	0%	0	0%	0	0%	0	0%	0	0%	0	4%	5
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

3.5.2 Reasons for Choosing the FHH

Clients' decisions to use the Family Health House (FHH) were primarily shaped by two factors: the quality of interpersonal care and the convenience of location. Overall, 83.0% (n=88/106) reported that they chose the FHH due to providers' behaviour, and 79.2% (n=84/106) cited that the facility is close to their home. Community-level endorsement was also a strong driver, with 68.9% (n=73/106) indicating that they chose the FHH because most people in the community come here, reflecting strong community trust and normalization of service use.

Table 20: Reasons for Choosing the FHH

Why did you choose this facility for healthcare?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Provider's behaviour	84%	16	71%	12	100%	19	100%	17	100%	17	41%	7	83%	88
Close to house	63%	12	71%	12	100%	19	100%	17	94%	16	47%	8	79%	84
Most people in the community come here	32%	6	65%	11	95%	18	94%	16	100%	17	29%	5	69%	73
Good experience	95%	18	6%	1	32%	6	100%	17	94%	16	35%	6	60%	64
Privacy	79%	15	0%	0	5%	1	94%	16	47%	8	6%	1	39%	41
The health intermediary asked me to come here	21%	4	0%	0	0%	0	76%	13	0%	0	12%	2	18%	19
Family member suggested	42%	8	0%	0	5%	1	24%	4	0%	0	12%	2	14%	15
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Midwives repeatedly described the FHH as reducing delays that previously led to serious risks for pregnant women, and they linked community satisfaction to both accessibility and how clients are treated at the facility.

"Women feel comfortable coming here because other clinics are far and difficult to reach. Before this Centre was established, some women delivered on the way or experienced serious complications due to delays in accessing care. People are very satisfied that this Centre is now available."
(Midwife narrative interview, Balkh)

"Our Centre provides services 24 hours a day, including Fridays. Unlike other facilities with limited operating hours, when a woman in labour arrives, the gate is open and we are ready to provide immediate care."
(Midwife narrative interview, Herat)

"Other clinics are far, and people often need two to three hours of walking to reach services. Community members are generally satisfied with the care provided here and encourage others to come to the facility."
(Midwife narrative interview, Kapisa)

Taken together, the findings underscored that the FHH model is chosen not only because it is physically accessible, but because it is perceived as dependable, respectful, and embedded in community trust factors that are particularly critical for SRH service uptake in fragile and conservative contexts.

3.5.3 Perceived Value and Impact

Importance of the FHH for Individual and Community Health

Clients placed very high value on the presence of the FHH in their communities for accessing SRH services. Overall, 88.7% (n=94/106) rated the FHH as "Very Important", while the remaining 11.3% (n=12/106) rated it as "Important", indicates that this model is valued across all locations, the intensity of perceived importance vary by context and local access conditions.

Table 21: Importance of the FHH for Accessing SRH Services

How important is having this FHH in your community for accessing SRH services?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Very Important	95%	18	94%	16	95%	18	100%	17	88%	15	59%	10	89%	94
Important	5%	1	6%	1	5%	1	0%	0	12%	2	41%	7	11%	12
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

"People's awareness has improved compared to before. In the past, some women were unable to seek care due to family permission issues. Through counselling and health education, we try to support families, and we have observed gradual positive changes over time"
(Midwife narrative interview, Balkh)

"Previously, there was no nearby facility, and women faced serious difficulties during childbirth. Now that the clinic is available, women can access care earlier and more safely."
(Midwife narrative interview, Logar)

"With the establishment of this Centre, community awareness has increased, and women and children are at reduced risk because essential services are now available nearby."
(KII, Community Leader, Balkh)


AFGHAN FAMILY GUIDANCE ASSOCIATION

3.5.4 Confidence in Accessing Care

The presence of the FHH was also associated with strong confidence in being able to obtain care when needed. Overall, 83.0% (n=88/106) reported feeling "Very Confident", 14.2% (n=15/106) reported "Confident", and 2.8% (n=3/106) reported feeling "Neutral."

Table 22: Confidence in Accessing Care due to the FHH

Do you feel more confident about getting care when you need it because the FHH is here?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Very Confident	100%	19	100%	17	100%	19	100%	17	82%	14	12%	2	83%	88
Confident	0%	0	0%	0	0%	0	0%	0	18%	3	71%	12	14%	15
Neutral	0%	0	0%	0	0%	0	0%	0	0%	0	18%	3	3%	3
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Perceived impact on health-seeking behaviour

All clients interviewed (100%, n=106/106) stated that the services received at the FHH had helped improve their own or their family's health. This result is best interpreted as a consistent measure of client-reported benefit and satisfaction, rather than as clinical verification of outcomes. Nevertheless, it provides strong evidence that communities consider the FHH services useful, responsive, and relevant to their needs particularly for routine and time-sensitive SRH care.

Community leader interviews also indicate perceived shifts in health-seeking behavior, especially among women and girls. Respondents commonly described earlier care-seeking, increased uptake of SRH services (including ANC/PNC, delivery care, and family planning), and greater willingness to use facility-based care due to proximity, trust, and the availability of female providers. These observations are echoed in midwives' narrative interviews, which link increased use of services to reduced delays in receiving SRH care particularly for childbirth and pregnancy-related needs because services are now available closer to communities and at more convenient times.

Community Perceptions of Improvement

Client responses represented that the FHH is widely perceived as making access to SRH services easier and more reliable at community level. The most commonly reported benefit was improved access and proximity (34.9%, n=37/106), suggesting that having services available closer to home is a major reason clients feel conditions have improved. This theme was particularly prominent in Parwan (58.8%, n=10/17) and Herat (52.9%, n=9/17), where respondents frequently associated the FHH with reduced travel burden and easier care-seeking. A second major theme was perceived improvement in health outcomes and service quality (33.0%, n=35/106), these findings indicated that communities perceive the FHH not only as a service delivery point, but also as a mechanism that reduces practical barriers to SRH care and improves the overall experience of seeking care.

Table 23: Community Perceptions of Improvement

In what ways has FHH made things easier or better for your community?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Improved Access & Proximity	21%	4	53%	9	32%	6	24%	4	24%	4	59%	10	35%	37
Improved Health Outcomes & Service Quality	21%	4	29%	5	47%	9	24%	4	65%	11	12%	2	33%	35
General Satisfaction & Happiness	5%	1	0%	0	0%	0	35%	6	6%	1	0%	0	8%	8
Comprehensive Service Range	11%	2	0%	0	21%	4	6%	1	0%	0	0%	0	7%	7
Contrast: Past Difficulty vs. Present Ease	11%	2	12%	2	0%	0	12%	2	0%	0	0%	0	6%	6
24/7 Availability & Timely Care	0%	0	0%	0	0%	0	0%	0	6%	1	24%	4	5%	5
Severe Past Hardship & Mortality	21%	4	0%	0	0%	0	0%	0	0%	0	0%	0	4%	4
Women's Empowerment & Permission	0%	0	6%	1	0%	0	0%	0	0%	0	6%	1	2%	2
Financial Relief & Reduced Costs	5%	1	0%	0	0%	0	0%	0	0%	0	0%	0	1%	1
Solving Previous Transportation Problems	5%	1	0%	0	0%	0	0%	0	0%	0	0%	0	1%	1
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Some midwives also described community willingness to support continuation of services, including through local contributions, which reflects strong perceived value of the model.

> ***"The community values this Centre highly, to the extent that some people have even expressed willingness to provide land if needed to ensure that services continue to remain available in the area."***
> *(Midwife narrative interview, Kapisa)*

Enhancing Access for Women, Children, and Vulnerable People

Client responses Highlighted strong improvements in the accessibility of FHH services for women, children, and other vulnerable community members. The most frequently selected response category was general satisfaction with improved access (51.9%, n=55/106). This response was concentrated in Laghman, Logar, and Parwan (100% in each province), suggesting that in these locations, respondents most commonly described improvement in broad, overall terms rather than through a single specific mechanism. Overall, the findings indicate that perceived accessibility gains are multi-dimensional: in some provinces, respondents emphasize the *experience* of improved access (general satisfaction), while in others they emphasize *why* access has improved (proximity, service range, and perceived quality). This

variation is important for interpretation and programming, as it points to context-specific access constraints and differing community expectations across provinces.

Table 24: Enhancing Access for Women, Children, and Vulnerable People

Accessibility of FHH to women, children, and vulnerable populations?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
General Satisfaction & Happiness	5%	1	18%	3	0%	0	100%	17	100%	17	100%	17	52%	55
Improved Access & Proximity	47%	9	47%	8	11%	2	0%	0	0%	0	0%	0	18%	19
Improved Health Outcomes & Service Quality	32%	6	29%	5	21%	4	0%	0	0%	0	0%	0	14%	15
Comprehensive Service Range	5%	1	0%	0	68%	13	0%	0	0%	0	0%	0	13%	14
Contrast: Past Difficulty vs. Present Ease	5%	1	6%	1	0%	0	0%	0	0%	0	0%	0	2%	2
Financial Relief & Reduced Costs	5%	1	0%	0	0%	0	0%	0	0%	0	0%	0	1%	1
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Midwives described outreach approaches that aim to reach women and vulnerable groups who might otherwise remain disconnected from services, including community groups and engagement with community health workers.

> ***"We work with community health workers and a local women's group. They help raise awareness in surrounding villages and encourage women to come for services."***
> *(Midwife, Herat)*

In some locations, midwives linked improved access to the availability of integrated services at one place, which reduces repeated travel and makes it easier for women to complete the SRH care pathway.

> ***"Providing a range of services in one place including ANC/PNC care, family planning, delivery support, and health education has made it easier and more convenient for women to seek care. This integrated approach has also strengthened community trust and accessibility of the services provided."***
> ***(Midwife narrative interview, Laghman)***

Additionally, midwives reemphasized the importance of a female-staffed environment for women who face restrictions on visiting mixed-gender facilities, which can be a key access enabler in conservative settings.

Perceived Improvements in Access After FHH Establishment

Client responses point to a clear improvement in access to services after the establishment of the FHHs, particularly in reducing distance- and transport-related barriers. The most frequently cited change was improved access and proximity (34.0%, n=36/106), indicating that for many respondents the presence of a nearby facility has made it easier to seek care when needed. This perception was especially strong in Kapisa (89%, n=17/19) and Herat (47%, n=8/17), and was also notable in Balkh (37%, n=7/19). A substantial proportion of respondents described the change primarily as a shift from past difficulty to present ease of access (22.6%, n=24/106). This theme was most prominent in Laghman (47%, n=8/17) and Logar (41%, n=7/17), indicating that in these provinces the perceived value of the FHH is strongly linked to relief from previous constraints, even when respondents did not attribute the change to a single factor such as proximity or cost. Respondents also highlighted economic and logistical improvements related to reaching services. Solving previous transportation problems was reported by 16.0% (n=17/106) overall and was concentrated in Parwan (59%, n=10/17) and Logar (24%, n=4/17). Financial relief or reduced costs was reported by 10.4% (n=11/106) and was most frequently noted in Laghman (41%, n=7/17) and Parwan (24%, n=4/17). These patterns align with earlier accessibility findings showing higher reliance on hired transport and longer travel distances in some settings, particularly Parwan.

Table 25: Comparison with Past Healthcare Access

Did you receive all the prescribed medications?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Improved Access & Proximity	37%	7	47%	8	89%	17	6%	1	18%	3	0%	0	34%	36
Contrast: Past Difficulty vs. Present Ease	16%	3	24%	4	0%	0	47%	8	41%	7	12%	2	23%	24
Solving Previous Transportation Problems	16%	3	0%	0	0%	0	0%	0	24%	4	59%	10	16%	17
Financial Relief & Reduced Costs	0%	0	0%	0	0%	0	41%	7	0%	0	24%	4	10%	11
Improved Health Outcomes & Service Quality	16%	3	18%	3	11%	2	0%	0	12%	2	0%	0	9%	10
Severe Past Hardship & Mortality	11%	2	12%	2	0%	0	0%	0	0%	0	6%	1	5%	5
General Satisfaction & Happiness	5%	1	0%	0	0%	0	6%	1	6%	1	0%	0	3%	3
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Community Ownership and Support

Findings highlighted that community ownership of Family Health Houses (FHHs) is strong and expressed mainly through practical, non-financial support. Across provinces, communities commonly contribute by helping maintain a safe environment around the facility, supporting referrals (including arranging transport where possible), and mobilizing women to use services. Direct financial contributions are limited and inconsistently reported, largely due to widespread economic constraints. However, several respondents described "in-kind" contributions such as providing space for the clinic, helping with basic maintenance, and supporting clients who travel long distances with water, food, or temporary shelter. Community advocacy particularly through mosques, local councils, and community meetings was repeatedly noted as a key mechanism for sustaining trust in the FHH and encouraging service uptake.

Community leaders describe their support as active and ongoing, particularly around security, referrals, and mobilization. A leader in Laghman mentioned that the community provides "security support, helps in referring patients, and mobilizes women to visit the Family Health Centre… [and] cooperates to transfer them to the [higher-level] centre when needed." A leader in Logar explained that community messaging is often conducted through mosques, stating: "We tell everyone in the mosque that anyone who require care/services can come to this health centre… We guide our women to this health centre."

Interviews also underscored that collaboration between community leaders and midwives is an important pathway for responsiveness and social acceptance of services. Leaders described acting as a bridge between families and the FHH sharing concerns, helping address misunderstandings, and supporting outreach. In several cases, leaders cited examples where community feedback contributed to operational adjustments (e.g., extending service hours or facilitating outreach to harder-to-reach households), reinforcing the perception that the FHH responds to local needs. One leader described this role in practical terms: leaders collect feedback from families and communicate it to staff to ensure services remain aligned with community priorities. At a broader level, some stakeholders reported instances where communities advocated to protect the continuity of services such as objecting to closure or relocation of an FHH suggesting that in certain settings the facility is viewed as a valued community resource.

3.5.5 Community Views and Suggestions

General Community Perceptions of the FHH

Client responses suggested that communities generally view the Family Health House (FHH) positively, with trust emerging as the most frequently reported theme. Nearly half of respondents (49.1%, n=52/106) described the prevailing community view in terms of *positive perception and trust*, indicating that the FHH is widely regarded as a credible and reliable source of SRH-related services. A further 34.0% (n=36/106) described the community's view in terms of *general satisfaction and positive opinions* about the facility and the staff, while 11.3% (n=12/106) highlighted *improved access and proximity* as the key reason the community values the FHH. A smaller subset (5.7%, n=6/106) specifically emphasized *timely care or 24/7 availability*, suggesting that in some locations the ability to receive services promptly especially during urgent needs shapes community confidence in the model. Qualitative accounts from community leaders align with these quantitative patterns and help explain what "trust" and "satisfaction" in practice.

Some leaders also described the FHH in broad terms as providing "all sections" or a wide range of services. This is best interpreted as a reflection of strong overall confidence in the facility, rather than a precise description of service utilization. In several provinces, the exit interview data show that service use is concentrated in core SRH services (notably family planning, ANC, and PNC), with selected additional services (e.g., nutrition counselling, referral, psychosocial support) varying by location. This suggests an opportunity to strengthen communication on the full-service package that is available at each FHH so community understanding remains aligned with consistent service delivery and any referral pathways for services not offered on-site.

Table 26: General Community Perceptions of the FHH

How do people in your community generally view the FHH?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
24/7 Availability & Timely Care	0%	0	0%	0	32%	5	0%	0	0%	0	0%	0	6%	6
General Satisfaction & Positive Emotion	53%	10	0%	0	0%	0	100%	17	0%	0	53%	9	34%	36
Improved Access & Proximity	11%	2	18%	3	37%	6	0%	0	0%	0	0%	0	11%	12
Positive Perception & Trust	37%	7	82%	14	32%	5	0%	0	100%	17	47%	8	49%	52
Total	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Most Appreciated Aspects of the FHH Model

Client responses indicate that the strongest driver of satisfaction with the FHH model is the way services are delivered, not only what is delivered. The most frequently appreciated aspect was staff conduct and behaviour (38.7%, n=41/106), reinforcing that respectful interaction, professionalism, and supportive communication are central to how communities experience and accept SRH services. Two additional aspects were ranked equally by respondents: privacy and security (17.0%, n=18/106) and quality of care and services (17.0%, n=18/106). Together, these findings indicate that trust in the FHH model is closely linked to: (i) how clients are treated, (ii) whether confidentiality and safety are maintained, and (iii) whether the care provided is perceived as appropriate and effective. Smaller but still notable proportions of clients highlighted facility and infrastructure (8.5%, n=9/106) and improved access and proximity (7.5%, n=8/106), indicating that physical conditions and geographic convenience matter, but are generally secondary to interpersonal and quality-related factors.

Table 27: Most Appreciated Aspects of the FHH Model

What do you like most about the FHH model?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Staff Conduct & Behaviour	58%	11	12%	2	95%	18	0%	0	29%	5	29%	5	39%	41
Privacy & Security	11%	2	88%	15	0%	0	0%	0	0%	0	6%	1	17%	18
Quality of Care & Services	26%	5	0%	0	5%	1	0%	0	65%	11	6%	1	17%	18
General Satisfaction & Positive Emotion	0%	0	0%	0	0%	0	59%	10	0%	0	0%	0	9%	10
Facility & Infrastructure	0%	0	0%	0	0%	0	0%	0	0%	0	53%	9	8%	9
Improved Access & Proximity	5%	1	0%	0	0%	0	29%	5	6%	1	6%	1	8%	8
Request for Development/Expansion	0%	0	0%	0	0%	0	12%	2	0%	0	0%	0	2%	2
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Balkh - Why Community-Embedded SRH Services Matter: To complement the quantitative findings on access, trust, and perceived impact, the following field narrative from Balkh illustrates the underlying vulnerabilities that continue to shape women's and children's health outcomes in remote and underserved settings. The narrative highlights why the Family Health House (FHH) model is particularly relevant in contexts where poverty, limited infrastructure, restrictive social norms, and weak referral pathways can transform otherwise preventable health risks into severe complications and, in some cases, life-threatening situations.

FHH model is reducing risk and improving outcomes through several practical pathways:

- **Reducing delays in care** by placing services closer to households, making early care-seeking more feasible for ANC/PNC, family planning, and complication screening.
- **Providing a trusted, female-staffed entry point** that improves acceptability and confidentiality for women in conservative settings.
- **Strengthening prevention and early identification** through routine counselling, screening (including nutrition-related counselling where relevant), and timely referral decisions.
- **Improving referral readiness** by guiding families on when and where to seek higher-level care, especially where transport and road access are limited.
- **Building community trust and social acceptance** via continuous engagement with community structures, which can gradually reduce restrictions and improve service use.

3.6. Service Gaps and Future Needs

3.6.1 Identified Challenges and Barriers

Client-Reported Challenges in Using Services

Most clients reported a smooth experience in using FHH services, with 74.5% (n=79/106) stating they faced no barriers. However, 25.5% (n=27/106) described constraints that can limit timely use or reduce satisfaction particularly in provinces where distance, transport options, or facility readiness remain challenges. Among the reported barriers, transportation and physical access was the most common issue (16.0%, n=17/106), indicating that despite overall proximity some clients still face difficulty reaching the facility when roads are poor, weather disrupts movement, or transport costs are unaffordable. A smaller but important proportion of respondents highlighted medical supply and service gaps (6.6%, n=7/106), reflecting situations where clients did not receive the medicines or services they expected at the point of care. Facility and infrastructure constraints were reported less frequently (2.8%, n=3/106) but remain relevant because they directly affect dignity, privacy, and client comfort during consultations.

Table 28: Client-Reported Challenges in Using Services

What challenges or barriers have you or others faced in using the FHH services?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
No Barriers Reported	53%	10	88%	15	100%	19	100%	17	76%	13	29%	5	75%	79
Transportation & Access	42%	8	12%	2	0%	0	0%	0	6%	1	35%	6	16%	17
Medical Supply & Service Gaps	0%	0	0%	0	0%	0	0%	0	18%	3	24%	4	7%	7
Facility & Infrastructure	5%	1	0%	0	0%	0	0%	0	0%	0	12%	2	3%	3
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Midwives' accounts support the client-reported barriers and help explain why some challenges persist even when overall satisfaction is high.

"Most people ask for more medicines, but the available supply is limited. When clients come from distant areas, we are not always able to provide the quantity or type of medicines they expect. As a result, some clients leave dissatisfied because certain medicines are unavailable or insufficient to meet their needs".
(Midwife, KII, Logar)

Our main challenge relates to the facility infrastructure. There is no proper waiting area, so women often must wait outside in the sun, which affects their comfort. In addition, limited space makes it difficult to ensure full privacy during service delivery. These conditions can negatively influence women's overall experience while accessing care."
(Midwife/KII, Balkh)

"The challenge is limited space, especially when many clients come. We have requested a waiting room because it becomes difficult to manage the flow and keep everyone comfortable."
(Midwife/KII, Herat)

Overall, the quantitative and qualitative findings indicate that while the FHH model is functioning well for most clients, service optimization will depend on targeted improvements in (i) transport/access support in Balkh and Parwan, (ii) medicine supply reliability and expectation management in Logar and Parwan, and (iii) basic facility infrastructure (waiting area/space) in higher-volume sites, which directly influences privacy, comfort, and service flow.

3.6.2 Recommendations for Improvement

Client and Community Requests for New Services

Clients highlighted on additional services show clear, location-specific priorities alongside a broader desire for general improvement. As shown in Table 29, most respondents provided general suggestions rather than naming a specific new service (79%, n=59/75). This pattern was particularly strong in Herat (100%, n=15/15) and Logar (100%, n=17/17), and remained high in Kapisa (93%, n=13/14) suggesting that communities in these provinces are generally satisfied with the service direction but want overall strengthening rather than a specific new service line. At the same time, 16% (n=12/75) explicitly requested expanded medical services, with demand concentrated in Parwan (47%, n=8/17) and Laghman (43%, n=3/7).

Table 29: Client and Community Requests for New Services

Are there any services you think the FHH should add?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Request for Expanded Medical Services	0%	0	0%	0	7%	1	43%	3	0%	0	47%	8	16%	12
General Suggestion/Request	20%	1	100%	15	93%	13	57%	4	100%	17	53%	9	79%	59
Request for Vaccination Services	80%	4	0%	0	0%	0	0%	0	0%	0	0%	0	5%	4
Total	**100%**	**5**	**100%**	**15**	**100%**	**14**	**100%**	**7**	**100%**	**17**	**100%**	**17**	**100%**	**75**

Client Suggestions for Service Enhancement

Beyond "new services," clients also described concrete improvements needed for FHHs to better meet community expectations (Table 30). The most frequent recommendation was strengthening infrastructure and resources (33.0%, n=35/106). A similarly strong share of respondents requested expanded medical services (31.1%, n=33/106). Taken together, this suggests that communities want either a broader clinical scope or a stronger referral support mechanism that makes "more services" realistically accessible. Smaller but programmatically important suggestions were also recorded, including sustainability (4.7%, n=5/106, mainly in Herat and Laghman), staffing (2.8%, n=3/106), and vaccination services (6.6%, n=7/106), which appeared mainly in Balkh (31.6%, n=6/19).

Table 30: Client Suggestions for Service Enhancement

What improvements would you suggest for the FHH to better meet your healthcare needs?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Request for Infrastructure & Resources	21%	4	24%	4	100%	19	47%	8	0%	0	0%	0	33%	35
Request for Expanded Medical Services	32%	6	41%	7	0%	0	12%	2	65%	11	41%	7	31%	33
Request for Development/Expansion	0%	0	0%	0	0%	0	0%	0	0%	0	53%	9	8%	9
Request for Medicine & Supplies	16%	3	0%	0	0%	0	18%	3	12%	2	0%	0	8%	8
Request for Vaccination Services	32%	6	0%	0	0%	0	0%	0	6%	1	0%	0	7%	7
General Suggestion/Request	0%	0	0%	0	0%	0	18%	3	18%	3	0%	0	6%	6
Request for Sustainability	0%	0	24%	4	0%	0	6%	1	0%	0	0%	0	5%	5
Request for Staffing	0%	0	12%	2	0%	0	0%	0	0%	0	6%	1	3%	3
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Community Leaders' inputs provide a practical and action-oriented roadmap for strengthening Family Health Houses (FHHs). Across provinces, leaders consistently emphasized operational enablers particularly referral capacity, facility readiness, and reliable supplies alongside a clear demand for expanded service availability. Overall, their recommendations focus less on minor adjustments and more on closing foundational gaps that affect access, quality, and continuity of care.

1) Priority improvements highlighted by community leaders

Leaders most frequently identified referral transport and infrastructure as urgent needs. Requests centred on the lack of ambulances for timely referral and the need for additional rooms or expanded space to manage client flow, maintain privacy, and improve service quality. As one leader in Herat noted: *"One of the needs of this centre is an ambulance. The number of rooms should also be increased."* A second dominant theme was the desire to expand clinical services beyond the current package, including vaccination and diagnostic services. A leader in Logar stated: *"We don't have vaccination here, and laboratory examinations should be added."* Leaders also raised concerns about the absence of additional clinical cadres (e.g., medical doctors), reflecting a broader expectation that trusted FHHs should evolve into more comprehensive primary health service points. Leaders also repeatedly emphasized the need for consistent medicine and equipment availability, noting that stock limitations can undermine community confidence even when staff conduct and responsiveness are strong.

2) Implementer's perspectives on service demand and operational constraints

KIIs with AFGA implementation staff support these priorities and clarify that community expectations are increasingly shifting toward service expansion. Staff reported frequent requests for:

- Vaccination services**,**
- non-SRH clinical services
- internal medicine/medical doctor availability, and
- nutrition services, particularly for moderate malnutrition**.**

Staff noted that this rising demand reflects a positive development: the FHH model has built trust and increased utilization, revealing broader unmet health needs. At the same time, these requests can create expectation gaps that require consistent communication about what the FHH can currently provide and what requires referral. Implementation staff also described persistent infrastructural gaps that directly affect quality of care and staff working conditions. These included delivery spaces, unreliable electricity (including solar functionality), inadequate heating/cooling, and in some locations lack of access to clean drinking water.

3) Workforce sustainability and midwife well-being

A third theme emerging from KIIs is workforce sustainability. Staff reported that midwives face logistical hardships in remote postings, including difficult travel conditions and limited access to basic needs. Concerns about low remuneration were repeatedly raised and linked to morale and retention risks. Given that midwives are the primary service providers across the FHH network, these concerns represent a sustainability vulnerability for the model if not addressed through appropriate support measures (financial and non-financial).

4) Accountability and feedback loop functioning

M&E-related findings underscored that community feedback is collected through multiple channels (e.g., complaint boxes, community discussions, client exit interactions), but the processing and closure of feedback is not consistently standardized. Staff indicated that feedback escalation and follow-up occur, but not always through a formal, documented mechanism. This presents a risk to accountability and responsiveness particularly as community demand becomes more specific and service expectations rise.

3.7. Recommended Actions

3.7.1 A) Phase service expansion based on demand and feasibility

A strategic, phased approach is recommended grounded in the most frequently requested services and aligned with feasibility, staffing, and health system coordination:

1. **Introduce or strengthen vaccination linkages/services**
    - Where feasible and aligned with the health system, integrate vaccination or establish reliable outreach/linkages with fixed EPI services. This is repeatedly requested and strongly linked to community perceptions of "comprehensive care."
2. **Add a basic package for common non-SRH services**
    - Where programmatically appropriate, consider limited outpatient support for minor/common conditions (with referral protocols), responding to community demand while maintaining a clear mandate and avoiding unsafe scope creep.
3. **Strengthen nutrition services**
    - Expand beyond severe cases by integrating screening and structured referral/support for moderate malnutrition where demand is documented and partners/health actors can support the pathway.
4. **Strengthen referral capacity**
    - Prioritize referral transport solutions (ambulance access, transport agreements, emergency transport funds, or community-supported mechanisms), particularly in locations where distance and road conditions remain significant.

B) Establish a simple, closed-loop feedback mechanism

To strengthen accountability and community responsiveness:

- **Standardize collection:** Use a uniform register/log across all FHHs to record feedback, complaints, and service requests (including those raised via leaders and councils).
- **Define escalation pathways:** Develop a one-page flowchart clarifying who receives which type of feedback (e.g., conduct issues, medicine stockouts, infrastructure needs, service expansion requests), escalation levels, and expected response timeframes.
- **Close the loop:** Require documented follow-up so communities are informed of actions taken. This "closure" step is essential for sustaining trust and demonstrating that feedback drives improvement.

Proposed Changes to Increase Community Acceptability

Client feedback points to a clear set of practical improvements that would strengthen community acceptability and extend the impact of the Family Health House (FHH) model. The most frequently cited recommendation was expansion of the model (26.4%, *n*=28/106), reflecting strong community interest in scaling services to additional locations and/or increasing the capacity of existing FHHs. In addition to expansion, clients emphasized the need for strengthening enabling conditions for quality service delivery. This includes requests for improved infrastructure and basic resources (17.0%, *n*=18/106), expanded medical services (11.3%, *n*=12/106), and more consistent availability of medicines and supplies (9.4%, *n*=10/106).

Key provincial patterns

Provincial results show that priorities differ by context, suggesting the value of location-specific improvement plans:

- Expansion/development was most prominent in Herat (88.2%), and also important in Laghman (41.2%) and Parwan (17.6%).
- Infrastructure and resources were prioritized in Kapisa (57.9%) and Balkh (31.6%), indicating basic facility readiness gaps.
- General Medicines and supplies were a notable concern in Balkh (26.3%) and Laghman (23.5%), consistent with broader narratives about stock reliability shaping satisfaction.

Respondents in Logar (47.1%) particularly highlighted the importance of the existing 24/7 availability of services, reflecting strong community value placed on immediate access, especially for delivery-related needs. Overall, these findings suggest that community acceptability is already strong but can be further improved through a combination of strategic expansion, facility and supply strengthening, and targeted service quality improvements tailored to the constraints and expectations within each province.

Table 31: Proposed Changes to Increase Community Acceptability

What changes would make the more acceptable to more people in your community?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Request for Development/Expansion	5%	1	88%	15	11%	2	41%	7	0%	0	18%	3	26%	28
Request for Infrastructure & Resources	32%	6	0%	0	58%	11	6%	1	0%	0	0%	0	17%	18
Request for Quality of Care & Services	0%	0	0%	0	0%	0	0%	0	6%	1	71%	12	12%	13
Request for Expanded Medical Services	21%	4	12%	2	21%	4	12%	2	0%	0	0%	0	11%	12
Request for Medicine & Supplies	26%	5	0%	0	5%	1	24%	4	0%	0	0%	0	9%	10
Request for 24/7 Availability & Timely Care	0%	0	0%	0	0%	0	0%	0	47%	8	6%	1	8%	9
General Satisfaction & Positive Emotion	16%	3	0%	0	0%	0	6%	1	24%	4	0%	0	8%	8
Improved Access & Proximity	0%	0	0%	0	0%	0	0%	0	18%	3	0%	0	3%	3
General Suggestion/Request	0%	0	0%	0	0%	0	12%	2	0%	0	0%	0	2%	2
Request for Staffing	0%	0	0%	0	5%	1	0%	0	0%	0	0%	0	1%	1
Request for Sustainability	0%	0	0%	0	0%	0	0%	0	0%	0	6%	1	1%	1
Staff Conduct & Behaviour	0%	0	0%	0	0%	0	0%	0	6%	1	0%	0	1%	1
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Recommendations for Community and Male Engagement

Findings from community leader interviews indicate that male engagement is a decisive enabler of women's access to SRH services, particularly in settings where mobility, transport, and household decision-making are shaped by men. Leaders consistently emphasized that the most practical and immediate support men can provide is facilitating access through overall support, accompaniment when needed, and creating a respectful environment for women to seek care. Importantly, leaders framed this as a supportive and responsibility-based role, rather than one of control.

"Male community members can support women's access by offering encouragement, accompanying them when needed, and helping create a safe and respectful environment."
(Community Leader, Balkh)

"It is every man's responsibility to encourage his wife to visit the centre—or accompany her himself—and never prevent her from seeking care."
(Community Leader, Herat)

"Men can support women's access by allowing them to visit the centre and by showing respect toward the female staff."
(Community Leader, Parwan)

Shared decision-making and respectful support within families: Beyond logistics, leaders emphasized the importance of men engaging constructively in family health decisions, in a way that respects women's choices and privacy and promotes timely care-seeking.

"Men should take part in family health decisions alongside women, while respecting their choices, and privacy."
(Community Leader, Balkh)

"Effective approaches include educating men, encouraging them to support women and girls, and promoting constructive involvement in decision-making."
(Community Leader, Laghman)

Structured community education and engagement of influential actors: Leaders unanimously identified community education as foundational for strengthening acceptance and sustained use of the FHH. They recommended structured awareness activities through community councils, mosques, religious leaders, and respected male leaders, who can help legitimize SRH services and reduce lingering social hesitancies.

"Regular meetings should be organized through councils and mosques."
(Community Leader, Kapisa)

"Holding sessions, workshops, and awareness-raising for the public has an impact."
(Community Leader, Herat)

"Support can be strengthened through awareness-raising, male participation, and religious and cultural support."
(Community Leader, Balkh)

Partnership Structures That Enable Community Support

KIIs with implementation staff confirm that the effectiveness of the FHH model depends heavily on strong, continuous relationships with local community leadership and health actors, particularly local councils, elders, and Community Health Workers (CHWs). These actors play an operational role in:

- mobilizing communities and increasing awareness,
- addressing local concerns and resolving misunderstandings,
- supporting referrals and problem-solving, and
- strengthening staff safety through local legitimacy and rapid response.

implementers described routine coordination mechanisms such as regular meetings, shared contact networks for urgent issues, and collaboration with councils on security incidents and referral support. Collectively, this reflects that community structures are not peripheral, they are core enabling systems for access, acceptance, and continuity of services.

Ensuring Sustainability and Future Growth

A consistent and urgent message from community leaders is the recommendation to expand the FHH model geographically, particularly to underserved areas where women and children face long travel distances and limited-service availability. Leaders repeatedly emphasized expansion to remote, deprived, mountainous areas and Kochi (nomadic) communities, where gaps in SRH and MCH services remain severe.

> ***"Expanding FHH centres in deprived villages is essential, because women in those areas have limited access to health services."***
> *(Community Leader, Balkh)*
>
> ***"Deprived areas with the greatest need for a clinic should be prioritized."***
> *(Community Leader, Laghman)*

Leaders also clearly linked expansion to prevention of avoidable deaths and unmet SRH needs, specifically citing the value of pregnancy care, safe delivery, family planning, vaccination, and health education.

Strategic Risk: Financial Sustainability

KIIs at the strategic level reinforce that expansion is both justified and demanded, with strong acceptance from communities and authorities. However, these KIIs also highlight financial sustainability. While the model has proven effective and community ownership is strong, leadership flagged continued funding uncertainty as a major risk to both current operations and future growth. In response, some stakeholders are exploring innovative sustainability approaches, including piloting models that transition greater operational responsibility to midwives and counsellors, potentially supported through minimal, context-appropriate user fees or other community-supported mechanisms, while maintaining equity safeguards. This represents a shift toward more resilient delivery options, but it will require careful assessment of feasibility, affordability protections, and strong governance to avoid excluding vulnerable clients.

(KII insight): A sustainability option being explored is gradual transition toward a locally managed model where services are supported through minimal fees, alongside measures to protect access for low-income households.

Implication for programming: The evidence supports a two-track approach (1) planned expansion to high-need areas, and (2) a realistic sustainability pathway that protects access for vulnerable groups while reducing over-reliance on uncertain donor funding.

3.8. Overall Client Satisfaction

3.8.1 Satisfaction Metrics

Rating of Service Quality

Client ratings indicate consistently high perceived service quality across the Family Health Houses (FHHs). Overall, 81.1% (n=86/106) rated the services received as "Very Good," and an additional 17.0% (n=18/106) rated them as "Good." Taken together, 98.1% (n=104/106) of clients provided a positive assessment. This strong pattern is seen across most provinces.

Table 32: Rating of Service Quality

How would you rate the quality of services you received at this facility?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Very Good	95%	18	88%	15	95%	18	100%	17	100%	17	6%	1	81%	86
Good	5%	1	12%	2	5%	1	0%	0	0%	0	82%	14	17%	18
Fair	0%	0	0%	0	0%	0	0%	0	0%	0	12%	2	2%	2
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Overall Satisfaction with Treatment Received

Client satisfaction with treatment received was similarly strong. Overall, 81.1% (n=86/106) reported being "Extremely Satisfied," and 16.0% (n=17/106) reported being "Satisfied," resulting in a 97.2% (n=103/106) positive satisfaction rate. This level of satisfaction is consistent across several provinces, including Balkh, Kapisa, and Laghman (100% "Extremely Satisfied"), and remains very high in Herat (94.1%) and Logar (82.4%).

Table 33: Overall Satisfaction with Treatment Received

Overall, how satisfied are you with the treatment you or your child received at this FHH today?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Extremely Satisfied	100%	19	94%	16	100%	19	100%	17	82%	14	6%	1	81%	86
Satisfied	0%	0	6%	1	0%	0	0%	0	18%	3	76%	13	16%	17
Neutral	0%	0	0%	0	0%	0	0%	0	0%	0	18%	3	3%	3
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

Strategic Finding: FHH as a Proof-of-Concept for Task Sharing: Beyond satisfaction metrics, the findings point to a broader strategic contribution of the FHH model: demonstrated task sharing in a fragile context. The model shows that midwives can effectively lead community-level delivery of primary SRH and MCH services, which is particularly significant in Afghanistan where female doctors are in limited supply, especially in rural and conservative settings.

This strategic value was reinforced in stakeholder reflections, including endorsement of the model's task-sharing approach as a key regional outcome:

One important achievement is the task-sharing approach, where midwives are providing essential services. From a regional perspective, this represents one of the strongest strategic outcomes and serves as a successful model.

This reinforces that the model's reliance on skilled midwives is not only operationally feasible but a core strength that supports service continuity, efficiency, and replicability.

Ease of Accessing Services

Perceived access is also high. Overall, 75.5% (n=80/106) rated access as "Very easy," and 12.3% (n=13/106) as "Easy," meaning 87.8% (n=93/106) reported a positive access experience.

Table 34: Ease of Accessing Services

How easy is it for you to access services at the FHH?	Balkh		Herat		Kapisa		Laghman		Logar		Parwan		Grand Total	
	%	n	%	n	%	n	%	n	%	n	%	n	%	n
Very easy	95%	18	71%	12	79%	15	100%	17	100%	17	6%	1	75%	80
Easy	5%	1	12%	2	16%	3	0%	0	0%	0	41%	7	12%	13
Neither easy or difficult	0%	0	18%	3	5%	1	0%	0	0%	0	47%	8	11%	12
Difficult	0%	0	0%	0	0%	0	0%	0	0%	0	6%	1	1%	1
Total	**100%**	**19**	**100%**	**17**	**100%**	**19**	**100%**	**17**	**100%**	**17**	**100%**	**17**	**100%**	**106**

3.8.2 Future Intentions

Willingness to Return to the FHH: Client loyalty and intent to reuse services are very strong. All respondents (100%, n=106/106) reported they would return to the FHH if care was needed in the future. This indicates that clients view the FHH as a reliable local source of care.

Willingness to Recommend the FHH: Similarly, 100% (n=106/106) stated that they would recommend the FHH to friends or relatives. This level of endorsement reflects high trust in the service model and suggests strong social acceptability. Such word-of-mouth recommendation is particularly important in community-based service delivery, as it supports utilization and contributes to longer-term sustainability.

4. Conclusion

Findings underscored that the Family Health House (FHH) model delivers high-value, community-trusted SRH and MCH services in a fragile context, with exceptionally strong client satisfaction and loyalty. Clients reported near-universal endorsement of service quality and intent to revisit and recommend the model, demonstrating that FHHs have become a preferred, credible point of care within their communities. This acceptance is reinforced by qualitative evidence portraying that communities increasingly view FHHs not simply as facilities, but as protective assets that save time, reduce financial burden, and normalize timely care-seeking for women and children.

A key contribution of the model is improved access to essential services, particularly for women who previously faced long-distance travel, cost barriers, and social constraints. FHHs are reaching clients close to where they live, serving as trusted points of care, including for urgent maternal health needs. This proximity strengthens client confidence and supports continuity of service utilization.

The impact is further reinforced by the model's strong community embeddedness and sustained engagement with local structures, which promote awareness, increase service uptake, strengthen referrals, and enhance local legitimacy. Strategically, the evaluation highlights the FHH model as a strong proof-of-concept for task sharing: midwives effectively leading service delivery, providing respectful, confidential, and clinically appropriate care, and sustaining trust through relational quality and consistent presence.

Midwives' narrative interviews revealed that professional empowerment is grounded in increased confidence, community trust, and visible client outcomes—often expressed as pride when clients leave satisfied and when women feel safe sharing sensitive concerns. These narratives also illustrate how timely midwife-led interventions and services can be transformative, including enabling safe deliveries under difficult circumstances and improving wellbeing through family planning services. Together, these experiences underscore the model's practical contribution to improved health outcomes.

At the same time, the findings also identified some operational constraints that limit perceived quality, equity, and the model's ability to meet community expectations. Barriers related to distance and transportation continue to exclude some remote households, while gaps in medicines, supplies, and the current scope of services—particularly vaccination, diagnostics, and management of certain illnesses—were highlighted by the communities. Infrastructure limitations, including space, electricity disruption, and inadequate water supply, further undermine the overall quality of care.

These challenges are not peripheral; they directly influence perceived quality, provider performance, and the model's credibility over time. Looking forward, the model presents clear opportunities for expanded impact through phased, needs-informed scale-up and stronger institutionalization of enabling conditions. Community leaders emphasized the need to extend FHHs to underserved areas, including remote, deprived, mountainous, and Kochi communities, explicitly linking expansion to the prevention of avoidable maternal and child deaths and the reduction of persistent SRH/MCH service gaps.

However, the most significant strategic risk remains financial sustainability. Leadership-level KIIs acknowledged that continuation of the model is uncertain under current budget constraints, despite strong demand and high levels of community ownership. Encouragingly, several sustainability pathways are being explored, including transitioning selected facilities toward a locally managed, minimal-fee social enterprise model led by midwives and counsellors if designed with appropriate safeguards for equity and access, this approach could reduce dependence on shrinking donor resources.

Taken together, the evidence positions the FHH model as an effective and socially accepted centre for protecting the health of women and children, while demonstrating the feasibility of midwife-led task sharing and community-embedded service delivery. To sustain current gains and responsibly expand impact, the next phase needs to prioritize:

- stabilizing core operational inputs, including infrastructure, water and power supply, medicines, and referral pathways and transport
- strengthening midwife motivation and retention as the foundation of service quality and performance
- expanding services in a phased manner aligned with documented community needs and operational feasibility
- advancing a realistic sustainability and scale-up pathway grounded in community ownership, government coordination, and diversified financing.

5. Recommendations

The Family Health House (FHH) model demonstrates strong acceptability and performance as a midwife-led, community-based SRH/MNCH service delivery platform, with midwives serving as the primary provider in most client interactions, confirming the model as a viable task-sharing approach in fragile settings. The recommendations below focus on actions that protect and strengthen the core mandate (SRH/MNCH), improve quality and continuity, and respond to community priorities through feasible, phased adjustments that reinforce referral pathways rather than expanding FHHs into hospital-like facilities.

- **Strengthen the availability of medicines and commodities**: Gaps in the availability of more medicines and related supplies were identified as operational constraints and sources of client dissatisfaction, undermining both trust and service effectiveness. A practical response would involve strengthening inventory management at the FHH level through measures such as establishing minimum stock thresholds, maintaining simple bin cards or stock registers, and implementing routine consumption reporting. These efforts should be linked to provincial supply hubs and supported by a rapid escalation mechanism for stockouts, enabling midwives to sustain uninterrupted delivery of ANC/PNC, family planning, infection prevention, and essential newborn care services.
- **Standardize and strengthen referral pathways. Referral systems should be strengthened as a core component of the FHH model's expanded capacity:** Community leaders and facility staff identified transport limitations and referral coordination as barriers to timely higher-level care. Rather than expanding into hospital-level services, FHHs need to focus on improving their ability to identify, refer, and follow up on cases requiring specialized care. Key actions include establishing clear referral criteria, standardized referral documentation, referral tracking systems, and formal linkages with nearby higher-level facilities. Strengthening communication, follow-up mechanisms, and practical enablers such as transport coordination and community health worker support would improve timely access to advanced care and enhance the overall effectiveness of the FHH model within the broader health system.
- **Introduce feasible, phased "add-on" services that remain within a primary care and referral framework based on expressed demand:** Qualitative findings highlighted repeated community requests for: vaccination (in some locations), basic laboratory examinations, access to doctors/internal medicine support, and broader treatment for common illnesses; staff also reported demand for nutrition services for moderate malnutrition and other non-SRH services.
- **Strengthen youth-responsive health education and counselling:** Service utilization patterns suggest that many clients under 25 primarily access FHHs for antenatal care, family planning, pregnancy testing, care and menstrual or gynaecological concerns, highlighting the need for more youth-responsive health education. Tailored counselling and education sessions on early pregnancy awareness, birth spacing, menstrual health, and contraceptive knowledge could help more in addressing knowledge gaps among younger clients. Strengthening confidential counselling, youth-friendly communication, and targeted community awareness activities would further support informed reproductive health decision-making and promote preventive health practices among young people.
- **Strengthen Community Social Networks for Awareness and Psychosocial Support:** Beyond clinical services provided at Family Health Houses (FHHs), community social networks play an important role in increasing awareness and providing informal psychosocial support to women and families. Women often rely on trusted community actors such as family members, community leaders, community health workers, and peer networks for information, reassurance, and encouragement to seek health services. Strengthening engagement with these community networks through outreach activities, women's groups, and health education sessions can improve

awareness of maternal and sexual and reproductive health services, reduce stigma around seeking care.

- **Strengthen supportive supervision and continuous skills development as cost-effective investments in quality:** A practical approach would include regular supportive supervision visits using concise quality checklists, structured feedback mechanisms, and periodic refresher coaching focused on ANC/PNC, delivery readiness, newborn danger signs, family planning counselling, infection prevention, documentation.
- **Protect the workforce enabling task-sharing through retention, wellbeing, and enabling conditions for midwives:** Qualitative findings highlight persistent challenges affecting morale and sustainability, including difficult access in remote postings, high workload, and benefits. A realistic retention strategy should combine non-financial recognition, professional development pathways, and more support for staff in remote settings and improve compensation and benefits where feasible.
- **Institutionalize a simple, closed-loop community feedback mechanism used consistently across sites:** While multiple channels exist, the process for logging, escalation, action-tracking, and closure was described as inconsistent and sometimes ad hoc. A feasible solution is a standardized feedback register, a basic escalation flow, and mandatory closure communication to complainants/community councils, so the model remains demonstrably client-responsive without creating heavy administrative burden.
- **Deepen community engagement in ways that remove access barriers and protect women's service use:** Community leaders emphasized that men could enable access through, accompaniment, support, and joint decision-making, and that structured awareness through elders/religious leaders and mosques is central for norm change and legitimacy. This should be operationalized through scheduled community dialogues with leaders and religious stakeholders, clear messaging on FHH scope and referral pathways, and targeted communication to address social restrictions that limit women's mobility.
- **Respond to community-demanded services:** Community consultations and qualitative interviews show strong appreciation for FHH services alongside demand for expansion. Priorities include enhanced maternal and reproductive health services, better management of pregnancy-related complications, basic laboratory testing, continued family planning counselling and methods, as well as nutrition and child health support. Communities also emphasized the need for stronger referral mechanisms for cases requiring advanced care.
- **Address sustainability as a strategic priority given documented funding vulnerability:** Sustainability remains a key risk due to reliance on external funding and observed reductions in sites over time, underscoring the need for a clear transition pathway. A pragmatic strategy should combine stronger government alignment for core functions, reinforced community ownership and a phased diversified financing that prioritizes protecting essential SRH/MNCH and referral services.

ACKNOWLEDGMENTS:
The International Planned Parenthood Federation, South Asia Region (IPPF SAR) acknowledges all respondents and partners who contributed to this study. We thank Adroit Associates Consulting Services for conducting this study and recognize and the active contribution of Afghan Family Guidance Association (AFGA). IPPF SAR further extends its appreciation to all whose efforts made this study and this report possible. IPPF SAR also acknowledges the financial support provided by NORAD

CONTRIBUTORS:
Arpita Das, IPPF SAR
Tayyaba Khatoon Shaikh, IPPF SAR
Mohammad Naqib Saber, AFGA
Najibullah Samim, AFGA
Manish Mitra, IPPF SAR
Tomoko Fukuda, IPPF SAR

DESIGN AND LAYOUT BY:
Purnima Singh


SARO
PPF