



UNFPA Afghanistan

flagship programme spotlight:

Family Health Houses

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FOREWORD

Despite the achievements over the last two decades to Afghanistan's public health system, particularly in regard to the expansion of the Basic Package of Health Services, the country is still struggling to ensure access to essential health services for all Afghans. Women, newborns, and children under 5-years-old in remote and hard-to-reach areas of the country are especially in need of health services.

Afghanistan introduced the Basic Package of Health Services in 2003 to improve health outcomes throughout the country, including dispatching Mobile Health Teams to remote and sparsely populated areas.

Nevertheless, small pockets of populations remain underserved or entirely unserved. These places—so-called 'white areas'—account for most of Afghanistan's maternal and childhood illnesses and deaths. Around 10% of the population live in white areas, which are over two hours walk from the nearest public health facility.

Midwives play a critical role in expanding lifesaving maternal and newborn health services to underserved areas; however, the need for midwives far outweighs the number of those currently trained. Indeed, much work remains to achieve Afghanistan's maternal, newborn, child, and adolescent health goals. At 638 maternal deaths per 100,000 live births, the maternal mortality ratio is the poorest in the region. Afghan women have the least access to many maternal health services in South Asia. Plus, a high unmet need for family planning services contributes to Afghanistan having the highest fertility rate in South Asia, and one of the highest in the world, at 5.1 children per woman.

Rapid progress is needed; and innovation offers the most promise to quickly reach the country's public health goals. Afghanistan's health system encourages innovative solutions to enhance the quality and expand the coverage of its services at low cost.

Accordingly, in 2010, the United Nations Population Fund (UNFPA), in collaboration with the Ministry of Public Health, introduced and piloted the Family Health House model. This creative, scalable, and sustainable programme increases vitally needed access to basic yet essential reproductive, maternal, newborn, child, and adolescent health services in underserved and unserved areas. Thereby, Family Health Houses reduce maternal and childhood illnesses and deaths.

The model has proven its success with expansion throughout the country over the last decade. The Ministry of Public Health plans to incorporate Family Health Houses within the Integrated Package of Essential Health Services—the latest package of public health services for Afghans. In doing so, Family Health Houses will become a public health facility, enhancing the programme’s sustainability and reach. However, further efforts are still needed to ensure full integration within the public health system. The Ministry of Public Health, UNFPA, donors, and partners urge policymakers to help bring this plan to fruition.

I am pleased to introduce the following window into the Family Health House programme. Here you will find details about how this transformative model works, its impact, anecdotes from communities it serves and partners with, and opportunities to bring Family Health Houses to more people in Afghanistan and beyond. In doing so, together we will advance the principles of many of the Sustainable Development Goals and move towards universal health coverage for all, starting with the furthest behind.

Dr. Abdul Qadir Qadir
General Director of Policy and Planning,
Ministry of Public Health – Afghanistan

PREFACE



UNFPA works tirelessly to ensure that the basic health needs of all reproductive-age Afghan women are met. When women go without essential reproductive healthcare, not only do they face great risk, but the detrimental impacts transcend society.

Through the Family Health House programme, UNFPA and its partners have developed a long-needed solution for women and their children in rural Afghanistan, where they far too often die in childbirth or suffer lifelong consequences of pregnancy-related complications.

The programme's adaptive, low-cost, and sustainable approach also helps women in remote communities plan the timing and frequency of their pregnancies so they are more prepared, physically and otherwise, for childbearing.

These services—while routine in many parts of the world—change the course of women's reproductive years. Instead of fearing for their lives, they can enjoy the magic of childbirth and make choices about having children like never before, thanks to Family Health House midwives.

UNFPA is honoured to work alongside its partners and the Family Health House host-communities so women and their young children have the best chance at living healthy, happy, and productive lives.

We invite you to read on about this inspiring and effective flagship programme.

Mr. Koffi Kouame
Country Representative, UNFPA Afghanistan

EXECUTIVE SUMMARY

Family Health Houses:

A Time of New Beginnings, Not a Time of Fear

The vast majority of maternal deaths are preventable with the right measures in place, but too many pregnant women, especially in poor, rural Afghanistan, lack access to basic and essential health care. These women—and their children—are at great risk of serious pregnancy-related and early childhood illnesses and death. Despite improvements in public health coverage within the past decade, as of 2017, the nearest public health facility was still further than a two-hour walk for 10% of the population.¹ While maternal and childhood mortality rates have fallen over the past decade, and access to family planning information and services has increased, considerable work yet remains to ensure women and their children receive quality care before, during, and after pregnancy in remote parts of Afghanistan.

To avoid these tragedies, an innovative programme called Family Health Houses has been developed by UNFPA and the Government of the Islamic Republic of Afghanistan's² Ministry of Public Health. Alongside UNFPA funding, Family Health Houses receive generous support from the Government of Canada, the Italian Agency for Development Cooperation in Afghanistan, and the United Nations Development Programme Global Fund Partnership.

The Family Health House model delivers life-saving reproductive, maternal, newborn, and child health care to some of the most un(der)served areas of Afghanistan. It does so by training women from rural parts of Afghanistan to become community midwives through the Ministry of Public Health's 26-month standardised curriculum, which includes a two month internship. Once certified, these midwives return home to serve their own communities in a simple health facility, called a Family Health House. Important to note is that these Family Health Houses are culturally appropriate, community supported and participatory.

Family Health Houses offer free, round-the-clock services before, during, and after pregnancy, including provision of basic yet essential care for children under 5-years-old, and family planning information and tools. Very importantly, community midwives screen for complications during pregnancy and proactively refer high-risk cases to better equipped public health facilities, C-EmONC facilities, and pediatrics wards; this referral system is the backbone of the programme model. In light of the global pandemic, Family Health Houses also raise awareness of COVID-19 prevention practices, and refer suspected cases to the nearest capable public health facility.

1 National Risk and Vulnerability Assessment 2011–2012, 2014 in Concept Note on Family Health Houses, 2018

2 Referred to as “the Government of Afghanistan” hereafter for brevity.



This model provides a crucial link between the public health system and rural women and young children who are often the furthest behind. The impact of Family Health Houses is felt across communities in Afghanistan, with 92,000 women having received sexual and reproductive health care, including over 30,000 deliveries by skilled birth attendants between 2015-2019. To-date, 80,000 young children have received health care from Family Health House midwives. Now, these rural communities see childbirth as a time of new beginnings, not a time of fear—sparing children the heartbreak of losing their mothers, and mothers of losing their children.

Family Health Houses are a desperately needed solution that can be scaled to reduce maternal, infant, and childhood morbidity and mortality while increasing access to family planning information and services across rural Afghanistan. Family Health Houses work to achieve numerous Sustainable Development Goals and advance multiple international and national frameworks, health policies and strategies.

UNFPA calls upon public officials, donors and the private sector, United Nations agencies, international and national non-governmental organisations, civil society, and South-South collaborators to join us in sustaining, scaling, and replicating Family Health Houses in Afghanistan and beyond its borders. Specific opportunities to save the lives of thousands of women and young children through this innovative community midwifery programme are suggested at the end of this document.



WHO SHOULD READ THIS?

This document shows readers the rationale and impact of UNFPA's flagship Family Health Houses programme. This document presents learnings related to an innovative and effective model which is providing basic yet essential reproductive and early childhood health care to remote communities of Afghanistan. Family Health Houses promote gender equality by empowering rural women through education, which taken together, helps alleviate poverty. UNFPA Afghanistan invites readers to learn about the landmark work underway to provide basic and essential reproductive health services to all Afghans, especially those located in Afghanistan's remotest regions.

We invite the following individuals and institutions to help increase the access and number of Family Health Houses throughout Afghanistan.

- **Public officials and other influencers** with the power to shape health policies and programmes in Afghanistan;
- **Donors and private sector partners** with the resources to scale the impact of the Family Health House model;
- **National partners** whose efforts dovetail the Family Health House model;
- **UN agencies** with capacity and mutual interest to leverage resources in support of shared objectives;
- **South-South collaborators** who can replicate Family Health Houses in other parts of the world and offer shared learning; and
- **Individuals interested in learning about innovative solutions** to maternal and child health in rural, impoverished and conflict-prone settings.

GAME-CHANGING PROGRAMMES IMPROVING PARTICIPATION, RIGHTS, KNOWLEDGE, HEALTH AND WELL-BEING

The Family Health House initiative is designed and managed by UNFPA Afghanistan—and is one of its flagship programmes changing the status quo in Afghanistan.³

Family Health Houses complement UNFPA Afghanistan's other flagship programmes:

- **Family Protection Centres**, which provide survivors of gender-based violence access to medical, psychosocial, and legal support, as well as referrals to other services; and
- **Youth Parliament, Youth Health Line, and Youth Health Corners**, which build youth leadership skills and empower young people with vital knowledge and services to improve sexual and reproductive health in Afghanistan and form healthy gender attitudes. The Youth Health Line and the Youth Health Corners also offer young people tools to prevent gender-based violence and get help when experiencing it. During the current COVID-19 pandemic, the Youth Health Line and the Youth Health Corner staff have been trained to provide guidance on awareness raising, prevention methods, and testing.

Together, these reflect the priorities of multiple international and national agendas and commitments. They also work towards UNFPA's Transformative Results of zero preventable maternal deaths, zero unmet need for family planning information and services, and zero sexual and gender-based violence and harmful practices against women and girls.

Sustainable Development Goals: Family Health Houses help achieve the following Sustainable Development Goals, in support of the *2030 Agenda for Sustainable Development*:



³ UNFPA Afghanistan's flagship programmes are innovative and successful initiatives currently being implemented that serve as prime models for scaling up and replication to support those furthest behind, especially vulnerable individuals with limited access to services and opportunities, and individuals in remote locations.

THE SITUATION

Emerging from decades of devastating conflict and unrest, Afghanistan continues to face political instability and a resulting fragile socio-economic state. A largely rural country with over half of the population living below the poverty line, people in Afghanistan have long struggled with insufficient infrastructure and access to education, gender inequality, and other challenges. These hardships are reflected in the historically poor state of the public health system.⁴

Less than half of married women in Afghanistan participate in decision-making regarding their own health care, and only 5% make these decisions independent of their husbands.⁵ When women do receive care, prominent cultural norms mandate that women must be treated by female health workers. This makes it more complex for women to access health care, especially in rural areas with fewer facilities. But thanks to improvements in public health policy and programmes, the situation is slowly improving.

Looking Back: A Grim Health Landscape

In 2001 when the Taliban regime collapsed, Afghanistan had one of the worst health indicators in the world and a health system in disarray. Infrastructure had been destroyed, and in 2002, 60% of Afghans had no access to basic health services. Contributing to and compounding this, 80% of the population lived in rural areas and less than 10% of the population lived within an hour walking-distance of a health facility. Reproductive-age women and children were particularly impacted, since two thirds of districts lacked maternal and child health services.^{6,7}

Consequently, between 1999 to 2002, Afghanistan had the highest-ever recorded maternal mortality ratio—estimated at 1,600 deaths per 100,000 live births who survived delivery.⁸ had the fourth highest infant and child mortality rates: An estimated 165 infants died per 1,000 live births and 257 children died per 1,000 surviving children.⁹

Looking Forward: Despite Progress, a Long Road Ahead

Investments in public health over the past decade have improved the situation considerably since 2001. But given the limitations and complexities of providing health services in Afghanistan—especially the widespread, remote, and conflict-affected villages—Afghanistan's public health facilities still do not reach substantial swaths of the country. Even today, many challenges lie ahead.

4 Afghanistan Living Conditions Survey 2016 - 17 Analysis Report, 2018

5 2015 Afghanistan Demographic and Health Survey, 2015, p. 254

6 Bartlett et al., 2005

7 2015 Afghanistan Demographic and Health Survey, 2015, p. 254

8 Bartlett et al., 2005

9 Afghanistan Statistical Yearbook 2018-19, 2019; Conceição, 2019

- **Health care for pregnant women is dangerously lacking in Afghanistan, particularly in rural areas and for women with lower educations and incomes.**¹⁰

As of 2017, the nearest public health facility was still further than a two-hour walk for 10% of the population.¹¹ Afghanistan's mountainous terrain and an absence of basic transportation infrastructure, its sparsely populated and scattered communities, security concerns, and restrictions on female movement continue to impede women's access to public health facilities.¹²

Between 2007-2017, less than 60% of women in Afghanistan had at least one preventative care visit during pregnancy, called 'antenatal' care. All other countries in South Asia—excluding India¹³ had better access to antenatal care during the same period, with an average of 87% of women in these countries receiving antenatal care at least once. In fact, Afghanistan was ranked third worst for antenatal care coverage in the world, of countries with available data, only marginally ahead of Chad and Lao People's Democratic Republic.¹⁴ In 2018, 20% of pregnant women had four antenatal care visits in Afghanistan, which is an important clinical milestone for the survival of both mother and newborn.¹⁵

From 2013-2018, less than 60% of births in Afghanistan were attended by skilled health personnel. This compares to an average of over 80% of births in other South Asian countries—excluding Sri Lanka—with Afghanistan having the second to lowest proportion of skilled birth attendance in the region, just ahead of Nepal. Globally, Afghanistan ranks in the bottom 10% of countries with skilled birth attendance and data collection.¹⁶

- **Far too many women and infants continue to die during childbirth in Afghanistan. Children under 5-years-old are at extreme risk as well.**

While the maternal mortality ratio has dropped by more than half since 2002, sadly, given the gaps in health care for pregnant women, an estimated 638 women still die in childbirth for every 100,000 who live.¹⁷ That is a very high number of preventable pregnancy-related deaths, for both regional and international standards.¹⁸

As of 2018, 60% of women did not receive postnatal care after delivering a baby in Afghanistan, which is important for preventing dangerous infections and other complications. In fact, the majority of global maternal deaths occur in the post-partum period, up to six weeks after birth.¹⁹

10 2015 Afghanistan Demographic and Health Survey, 2015

11 National Risk and Vulnerability Assessment 2011–2012, 2014 in Concept Note on Family Health Houses, 2018

12 Afghanistan Living Conditions Survey 2016 - 17 Analysis Report, 2018

13 Antenatal care data for India are not included in the Human Development Index global comparison. South Asian countries with available data are Afghanistan, Bangladesh, Bhutan, Islamic Republic of Iran, Maldives, Nepal, Pakistan and Sri Lanka (Conceição, 2019).

14 Ibid.

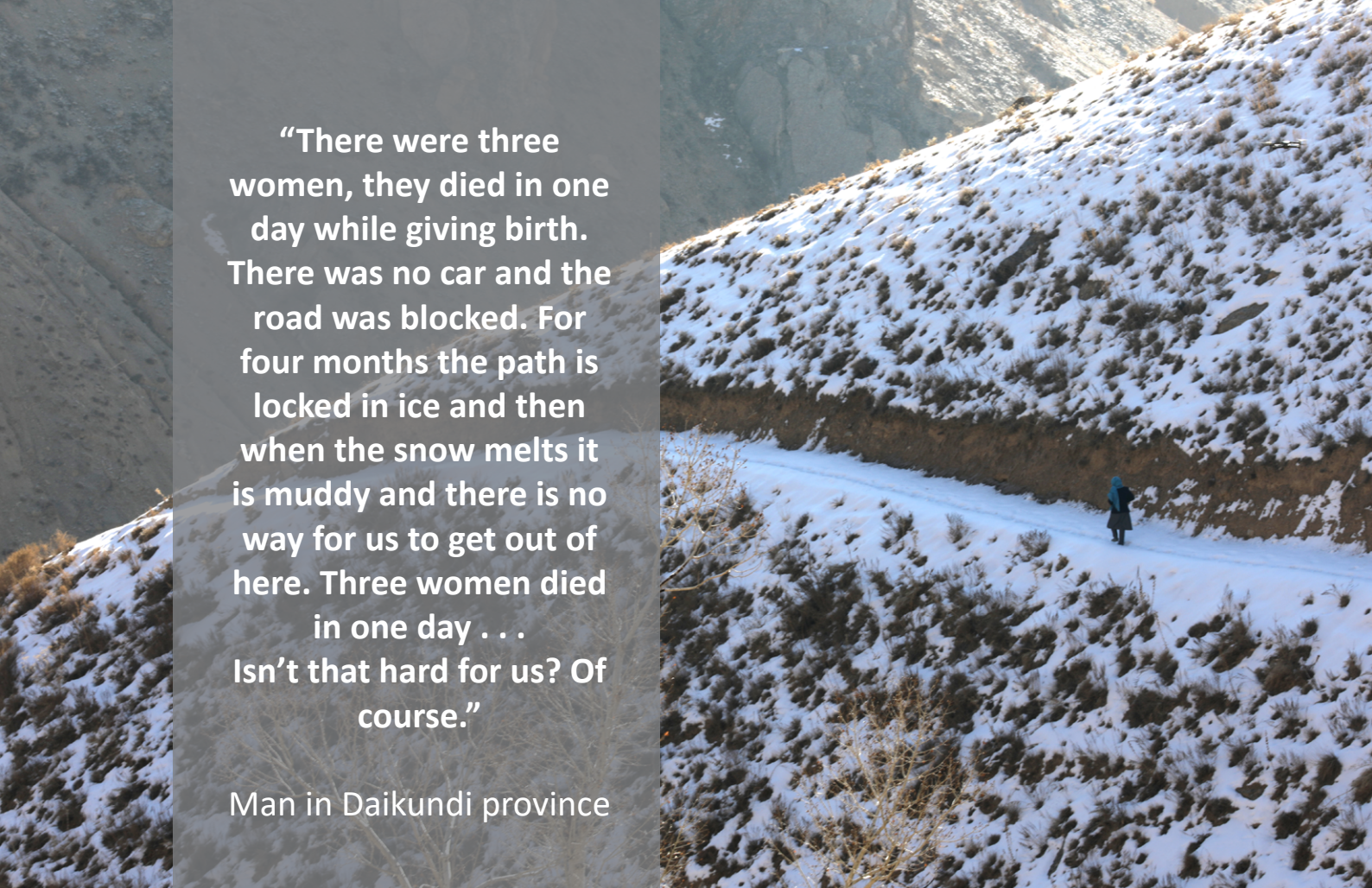
15 Afghanistan Health Survey 2018, 2019

16 Skilled birth attendance data for Sri Lanka are not included in the Human Development Index global comparison. South Asian countries with available data are Afghanistan, Bangladesh, Bhutan, India, Islamic Republic of Iran, Maldives, Nepal and Pakistan (Conceição, 2019).

17 Trends in Maternal Mortality 2000 to 2017, 2019, p. 34

18 Conceição, 2019

19 Afghanistan Health Survey 2018, 2019, pp. 54, 76



“There were three women, they died in one day while giving birth. There was no car and the road was blocked. For four months the path is locked in ice and then when the snow melts it is muddy and there is no way for us to get out of here. Three women died in one day . . . Isn’t that hard for us? Of course.”

Man in Daikundi province

And while childhood mortality has reduced over the past 15 years, according to 2018 data, there is still a long way to go. Of every 1,000 children born, 50 still die before their fifth birthdays—that equates to one in 20. Among the standard childhood mortality age categories, neonatal deaths have made the least progress in the past 15 years, with 23 of every 1,000 newborns dying within the first month of their lives—that equates to one in 43. While infant survival has improved more rapidly, it remains a significant challenge too, with 41 of every 1,000 infants dying before their first birthdays—or one in 24.²⁰

The majority of these maternal and childhood deaths could be avoided through abundant community midwifery and related health services, but in Afghanistan there are only an estimated 5,000 qualified midwives. That is less than a third of the estimated need for over 15,000 midwives to adequately serve the population, based on World Health Organization recommendations.²¹

In addition to an insufficient number of community midwives, low coverage of health services due to distance from health facilities is one of the leading causes of maternal and childhood morbidity and mortality in Afghanistan.²² There is a significant geographic imbalance with far more qualified health workers living in urban than rural areas.²³

²⁰ Ibid., p. 94

²¹ Concept Note on Family Health Houses, 2018; projected need for midwives in Afghanistan is calculated based on a standard formula in Workforce 2030, 2016, p. 40.

²² Afghanistan Health Survey 2006 in Concept Note on Family Health Houses, 2018

²³ National Health Strategy 2016–2020, 2016

- **A serious unmet need for family planning in Afghanistan persists, despite progress.**

Family planning education and tools are among the most effective global health and poverty reduction measures. When reproductive-age women have the knowledge and power to make choices about using contraception, drastic reductions in unplanned pregnancies and abortions are observed, as well as maternal and newborn deaths. Family planning is good for national budgets too—for every US dollar spent on family planning, 6 dollars are saved.²⁴

Between 2003 and 2010, the promotion, delivery, and utilisation of family planning services in Afghanistan drastically improved, with the use of modern contraception doubling to 20% in 2010²⁵ Since then, modern contraception usage has fluctuated between 15-20%, with 17% of ever-married women using modern contraception as of 2018.²⁶ This may seem surprising given that almost 70% of ever-married women are aware of some form of modern contraception, indicating a barrier to accessing family planning services.²⁷ Indeed, as of 2015 a quarter of reproductive-age, married women had an unmet need for family planning, as did a quarter of pregnant, married women in 2018. This means women are having more children than they want and/or they would prefer to space their pregnancies further apart.²⁸

Adolescents also have a high unmet need for family planning services.²⁹ Adolescent mothers, 15-19 years old, accounted for 7% of births in Afghanistan between 2015-2020 . That is almost twice the average adolescent birth rate among other South Asian countries, of which Afghanistan has the second highest rate after Bangladesh.³⁰

It must be noted that extreme variances in coverage and utilisation of sexual and reproductive health services exist between provinces, districts, and socioeconomic statuses, so in many parts of Afghanistan the situation is far worse than the aggregated data indicates.³¹

24 “What We Do: Family Planning Strategy Overview,” 2020

25 Modern contraceptive methods include female sterilization, intrauterine device (IUD), birth control pill, injection and condoms (Afghanistan Health Survey 2018, 2019).

26 Ibid., pp. 8, 82

27 Ibid. p. 83

28 2015 Afghanistan Demographic and Health Survey, 2015, p. 108; Afghanistan Health Survey 2018, 2019, p. 57

29 Afghanistan Health Survey 2018, 2019, p. 57

30 Conceição, 2019

31 2015 Afghanistan Demographic and Health Survey, 2015

MINISTRY OF PUBLIC HEALTH'S RESPONSE TO IMPROVE THE HEALTH SYSTEM

To mitigate the dire state of the public health system after the fall of the Taliban, the interim government's Ministry of Public Health established a *Basic Package of Health Services* (BPHS) in 2003. The BPHS, which was revised in 2005 and again in 2010, centrally governed, organised, standardised, and prioritised the public health system to make primary care accessible to as many people as available funding allowed. It also mandated that all Afghans requiring health care receive equal services, regardless of their ability to pay.³²

In 2005, the Ministry of Public Health developed a complementary *Essential Package of Hospital Services* to provide secondary, specialised, and in-patient care at the district, provincial, regional, and national levels. The district-level hospitals are the link to the Basic Package of Health Services; primary health facilities refer patients to the nearest district-level hospital for assessment, where they are treated or referred vertically for more specialised services.³³

In 2019, to enhance and streamline the two health systems, the Ministry of Public Health launched the *Integrated Package of Essential Health Services*. This redesigned integration of the two preceding packages better reflects the country's current epidemiological profile and health needs. In addition to policy interventions, the Integrated Package standardises nine primary and secondary health service areas. The highest priority is given to reproductive, maternal, newborn, child, and adolescent health since reproductive-age women and children are particularly in need of quality health care but vulnerable to restrictions in access.³⁴

The 2019 Integrated Package of Essential Health Services delivers the following health facility structure, listed in order of increasing service capacity, specialization, and geographic coverage. The targeted number of facilities for each type is in parenthesis.³⁵

³² Newbrander et al., 2014

³³ Ibid.

³⁴ IPEHS, 2019

³⁵ National Health Strategy 2016–2020, 2016; Newbrander et al., 2014

- **Total number of public health facilities in Afghanistan: 3,251**³⁶

LOCAL, BASIC COMMUNITY- BASED CARE

- **Mobile Health Teams (272):** Provide interim community-health services to Family Health Houses while community midwives are in training, on leave, etc., as well as humanitarian relief in areas facing natural disasters and security emergencies .
- **Community Health Posts (16,404):** Health posts are not facilities, but rather services provided by a duo of one female and one male community health worker offering basic medical care, including sexual and reproductive health services. These community health workers are important because they serve as a key referral link between Family Health Houses and the public health system.
- **Sub-Health Centres (1,030):** Staffed by one male nurse and one female community midwife.
- **Basic Health Centres (882):** Staffed by one male nurse, one female community midwife, and one laboratory technician.
- **Comprehensive Health Centres (435):** Have a moderately larger staff and more advanced equipment and services, including two physicians, one male and one female.
- **District Hospitals (88):** Have a slightly larger capacity than comprehensive health centres, including more capacity and advanced expertise and equipment.
- **Special Hospitals (31):** Provide specialised care, such as optometry or infectious disease, exclusively.
- **Provincial Hospitals (27):** Have enhanced capacity, expertise, and equipment.
- **Regional and National Hospitals (9):** Have the highest capacity and degree of expertise and advanced medical technology.
- **Other Types of Health Facilities (477):** Health facilities that are not included in the Basic or Essential Packages of Health Services; Family Health Houses fall within this category.

LARGER-SCALE, SPECIALIZED CARE

³⁶ Public health facility quantities as of mid-2020.

Family Health Houses: UNFPA Afghanistan helps bridge the public and private health sectors

To help alleviate the inequitable hardships shouldered by women in rural areas, UNFPA has developed a transformational flagship programme called Family Health Houses, in collaboration with the Ministry of Public Health. Family Health Houses aim to reduce maternal and childhood morbidity and mortality in the most remote communities through midwifery and family planning services. Family Health Houses bridge the gap between community health posts, which serve a population of 1,000 to 1,500 people, and sub-health centres, which serve between 3,000 and 7,000 people. These facilities are often located far from each other, scattered across a wide-range of geographic areas.

In alignment with the health packages described above, Family Health Houses are an important part of the *Afghanistan National Health Policy 2015-2020*, which notes that physical access to community health facilities will be improved in isolated rural areas through the innovative Family Health House model. Likewise, Family Health Houses address the *National Health Strategy 2016-2020* priority of reducing maternal and child mortality, especially in rural areas, by addressing the nationwide shortage of high-quality, accredited female medical personnel. *The National Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy 2017-2021* calls for an increase in the number of Family Health Houses serving remote communities.

“For us,
[the Family
Health House]
is like a gift
from God to
take us out of
this hardship.”

– Woman in
Daikundi province



FAMILY HEALTH HOUSES: THE MODEL

Why:

UNFPA, with the Ministry of Public Health, has developed a landmark programme that bridges the gap between the public health system and hard-to-reach villages to improve the health of reproductive-age women and children under 5-years who have been left behind for far too long. Now, these people's stories are changing, lifting a cloud of fear that had long accompanied childbearing.

Family Health Houses deliver community-based midwifery and family planning information and services to the furthest behind, moving the needle towards zero preventable maternal deaths and zero unmet need for family planning in Afghanistan. Alongside funding from UNFPA, Family Health Houses receive generous financial support from the Government of Canada, the Italian Agency for Development Cooperation in Afghanistan, and the United Nations Development Programme Global Fund Partnership.

What:

Family Health Houses are a life-saving solution for women and their children who live in un(der) served villages of Afghanistan, which are home to 10% of the population.^{37, 38} Each Family Health House is located at least 10 kilometres or three-hours walk from the nearest health facility and serves a population of 1,500-3,000 people. All services are free-of-charge, reducing families' out-of-pocket expenditures for health care and transportation-related costs.

³⁷ "Unserved" areas are more than 10 kilometres from a public health facility without access to a community health post, while "underserved" areas are also over 10 kilometres from a public health facility but are served by a community health post.

³⁸ National Risk and Vulnerability Assessment 2011–2012, 2014 in Concept Note on Family Health Houses, 2018

“

Before the Family Health House, there was no doctor here. We went through so much pain. If we still had destiny in this world, we would survive. This Family Health House opened recently and women are using it, and their problems are solved.

– Woman in Daikundi province

”

“

“I gave birth to a daughter. I was in so much pain. We didn't have a Family Health House and they wanted to take me to the doctor far away. We walked for a long distance. My daughter was born on the way there and died. I was unconscious, they were carrying me. When my baby was born, I didn't realize it.”

– Woman in Daikundi province

”

Each clinic is staffed by a female midwife who provides:

- Antenatal, delivery, and postpartum screenings, treatment and education, including newborn care, breastfeeding, hygiene, and sanitation practices.
- Basic health care for children under 5-years-old in the community, with efforts to offer vaccinations is underway.³⁹
- Screening and follow-up treatment for HIV, malaria, and tuberculosis.
- Family planning counselling and tools including contraceptives, since spacing pregnancies is essential for healthy gestation and safe deliveries, especially in impoverished settings where malnourishment is common.
- Basic psychosocial support for gender-based violence survivors and referrals to the nearest Family Protection Centre, which are one-stop clinics—and a flagship programme of UNFPA—for survivors to access comprehensive gender-based violence response services.
- Referrals to the nearest capable public health facility when the community midwives cannot provide the necessary care. In fact, one of the core functions of Family Health Houses is efficiently connecting rural women to the public health system; these referrals are the backbone of the programme.

Family Health Houses typically have four small rooms; examination and pharmacy room, delivery room, PNC room, storage, and toilet. Solar panels ensure the facility always has electricity, and a water supply is provided when possible; otherwise, community members provide clean water. Each Family Health House is located near the midwife's home for easy, round-the-clock emergency care.

Where:

As a result of their success, Family Health Houses continue to expand across Afghanistan. All Family Health Houses are overseen by the Community-based Health Care Department of the Ministry of Public Health.

Established Family Health Houses (191 in 8 provinces):

- 121 Family health Houses are financed by 58 in Daikundi by Canada, 56 (32 in Faryab, and 24 in Bamyan) from UNFPA's RR, and 7 by Italy
- 35 Family Health Houses operate in two provinces (Khost and Badakhshan), established by the Health Strengthening Department of the Ministry of Public Health with funding from United Nations Development Programme Global Fund Partnership.
- 35 new Family Health Houses operate in two additional provinces (20 in Herat and 15 in Ghor) since July 2020, with funding from the Government of Italy.

³⁹ Immunisations are not currently offered by Family Health House midwives because until 2014, Sub-health Centres did not provide this service due to Ministry of Public Health budgetary constraints. As bigger public health facilities serving a larger population than Family Health Houses (see earlier descriptions), it was determined that Sub-health Centres should offer immunisations first. Now that they do, Family Health Houses will be able to too; they are expected to receive authorisation to provide immunisations in the next iteration of the Integrated Package of Essential Health Services.

Future Family Health Houses (115 in five provinces):

- Plans for an additional 115 Family Health Houses in five new provinces (Badghis, Kandahar, Paktika, Nuristan, and Samangan) are underway with funding from the Government of Canada through Global Affairs Canada, with 15 opening in late-2020 and the remaining 100 by 2022.

How:

UNFPA and its partners support one young woman from each community with a planned Family Health House to become a certified community midwife. These women, who are nominated by community leaders and selected via a thorough and competitive process, train in the centre of each province or region for 26 months. This includes a two-month internship for on-the-job, practical coaching, health facility management, and community health training. The standard Community Midwifery Education programme and accreditation process is overseen by the Ministry of Public Health, with plans for the Afghanistan Midwifery and Nursing Council to facilitate accreditations for community midwives and Community Midwifery Education schools in the near future.

To qualify as a candidate for the programme, young women must be between 18-35 years old and have at least a grade 12 education, though exceptions are made in communities without access to secondary education. Once certified, the graduates return to their homes where they serve as the local Family Health House midwife, often for 5-10 years, as determined by contractual agreements. In the event that there is already a local, qualified midwife in the area, the Family Health House will still employ her.

The community midwives provide both reactive and proactive care; they are responsible for having a big-picture view of their local community's health status. This involves visiting homes of reproductive-age women who cannot or have not visited the Family Health House to ensure their sexual and reproductive health needs are being met, including following up with individuals who have missed appointments or stopped treatments.

The Family Health House model involves four components: the Family Health House itself, a health post, two family health action groups, and a community health shura.

- **Health Posts** are community-based health services for rural areas. They consist of two volunteer community health workers, one male and one female. Health posts provide villagers with three services:
 - Health education;
 - Referrals to Family Health Houses and public health facilities; and
 - Distribution of contraceptives and treatments for common diseases, such as oral rehydration salts.



- **Family Health Action Groups** are made up of 10-15 reproductive-age women who promote health messages and behaviours within their communities on a voluntary basis, primarily related to reproductive, maternal, newborn, child, and adolescent health. The volunteers also encourage use of Family Health Houses. Family health action groups partake in basic orientation and regular information sessions from the health posts' female community health workers.
- **Community Health Shuras** are organised groups of community elders, religious leaders, and other well-respected local figures in accordance with the Ministry of Public Health's community-based health care procedures and guidelines. In areas with a Family Health House, the community midwife chairs the local community health shura.

“

During delivery, they were bleeding, they didn't visit a doctor or a hospital. They don't use family planning methods so they give birth one after another. That's why most of their children become malnourished and the mothers are anaemic. But good changes have happened since [opening the Family Health House]. We can see changes in the [women's] behaviour and health. Their children's health has progressed well too.”

– Tahera Hussaini, Family Health House midwife, class of 2012

Community Ownership and Sustainability:

Family Health Houses are sustainable and locally led. The participatory approach ensures communities—albeit predominantly males and elders, as is customary in Afghanistan—have a say in the process.

From nominating community midwife candidates and determining where Family Health Houses are located, to outlining governance and operations procedures via the community health shuras, local voices are incorporated throughout the programme design, implementation, monitoring, and evaluation process. For example, the community is responsible for deciding and implementing responsible hazardous waste procedures, based on international best practices. The community also commits to protecting the security of the Family Health House and its midwife. For instance, when Family Health Houses have no water supply, the community is responsible for providing clean water.

The community bears a third of the cost of Family Health House development, giving them a stake and incentive to ensure the programme's success. Community-donated land is officially registered, and construction labour and traditional materials for building and repair is supplied by the community. Other materials, such as roofing, tiling, doors, windows, etc. are supplied by the implementing partner with UNFPA and donor support. The community also shares in the cost and responsibility for transporting clients to higher level health facilities when a referral is made.

Since the community midwives come from the villages they serve, they know the community and neighbouring settlements and are familiar with the local culture, customs and traditions, as well as the basic health needs.

Conversely, communities—including men—know and trust the midwives. The Family Health House programme empowers women to be agents of change in their communities. Ultimately, the Family Health House model contributes to women's economic and social empowerment in these typically conservative parts of the country.

The Family Health House midwives receive a modest salary commensurate with the community context. Even if international funding was no longer available, local community financing through cash and in-kind support could sustain the Family Health Houses given their low operational costs. Work is also being done to incorporate the Family Health Houses into the Government's BPHS services, which would secure a stream of funding for the midwives.

Want to know more? Watch our short documentary to see Family Health Houses in action.

<https://www.youtube.com/watch?v=tgeAOc48jNc>

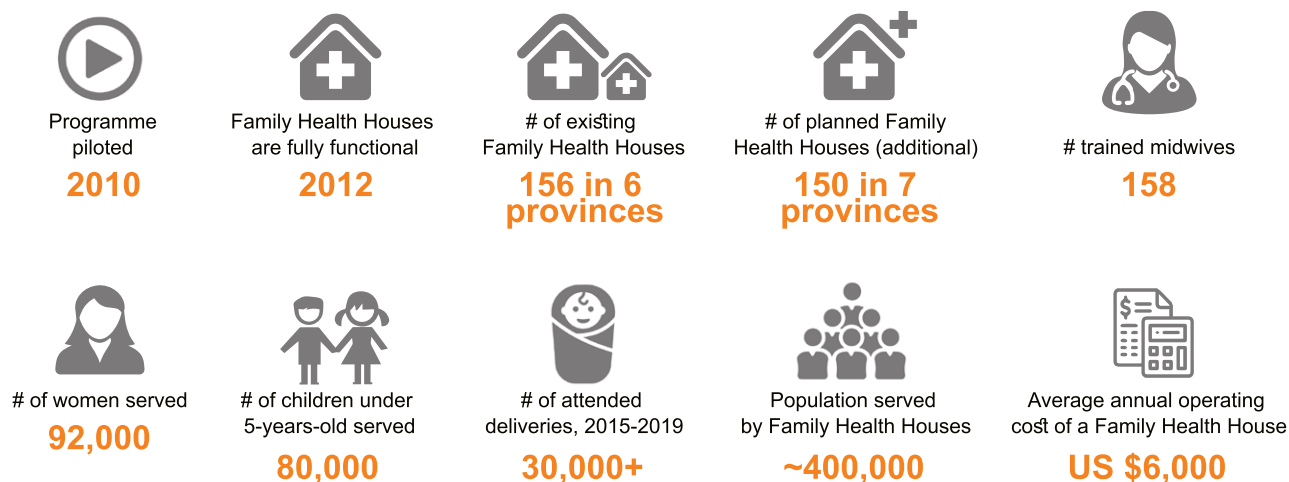
“

The students in this programme have been changed from a normal, common girl or woman to a person who plays a major role in identifying problems and helping communities and women with their deliveries.

– Dr Suraya Dalil, Minister of Public Health

”

Family Health House Investment & Impact (2010-2020)



COVID-19 Adaptations:⁴⁰

The following measures are being taken by Family Health Houses to help stop the spread of COVID-19 and to continue provision of reproductive, maternal, and child health services:

- Family Health House midwives are equipped with guidelines based on World Health Organization (WHO) recommendations to help prevent COVID-19, as well as educational materials for distribution within their communities. These materials were developed by the Ministry of Public Health.
- Midwives are encouraged to promote awareness regarding the toll-free COVID-19 information line (166) with clients.
- Family Health Houses are supplied with personal protective equipment as per WHO guidelines and other infection prevention control supplies such as hand sanitisers and soaps for use by the community midwives.
- Midwives refer suspected COVID-19 cases in their communities to the nearest applicable public health facility.

Donors:

Canada 

 ITALIAN AGENCY
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⁴⁰ COVID-19 adaptations may have evolved since time of writing in mid-2020.

HELP SUSTAIN, SCALE, AND REPLICATE FAMILY HEALTH HOUSES IN AFGHANISTAN AND BEYOND

Afghanistan has the highest fertility rate in South Asia, and among the highest in the world, at 5.1 children per person.⁴¹ While fertility is declining, the country's population continues to grow by over half a million people annually, and it is expected to double in 33 years.⁴² One of the many strains of population growth is an exponentially intensified demand for health care beyond available resources.⁴³ This, combined with decreasing foreign aid and a slowing economy, among other complexities, presents major challenges to sustaining and scaling up health services. Women and young children are particularly vulnerable to public health system gaps and disruptions. Their lives are especially dependent on the basic yet essential health services provided by midwives. Without an increased access to such services, Afghanistan cannot continue its trajectory of progress over the last decade, including the momentous improvements and expansions to maternal and child health care.

Family Health Houses are a proven solution for many of the most at-risk women and young children living in rural communities, addressing geographic, cultural, and economic barriers to health care. Family Health Houses have substantially contributed to Afghanistan's recent improvements in maternal and child health by providing round-the-clock care for reproductive-age and pregnant women and their children at the most crucial times—prior to, during and soon after childbirth.

But to sustain and grow the Family Health House model—and to continue saving lives and empowering vulnerable and marginalised women and their young children—we need your help.



⁴¹ Afghanistan Statistical Yearbook 2018-19, 2019; Conceição, 2019

⁴² Calculations based on Afghanistan Statistical Yearbook 2018-19 and standard 'doubling time' formula of $70/\text{population growth rate}$ (2.1).

⁴³ Afghanistan Statistical Yearbook 2018-19, 2019, p. 13

Calls-To-Action for Public Officials

- Ensure the life-saving Family Health House model is a permanent structure integrated within the public health system. Specifically, Family Health Houses should be included in the next iteration of the Integrated Package of Essential Health Services. The model's proven efficacy in reducing maternal, infant, and child mortality, as well as increasing critical family planning services, shows the undeniable value and return-on-investment to rural communities across Afghanistan, and ultimately, the public health system.
- Prioritise the generation of accurate population data, disaggregated by age and gender, at the community level. Such data is critical in order to properly assess service delivery coverage and needs across rural Afghanistan. This helps estimate the number of pregnancies and births at the local level, and therefore which districts have the greatest gaps between coverage and needs. Without this data, it is also difficult to precisely measure the impact of the Family Health Houses and other public health functions, and thus their ability to effectively deliver equitable services to the general population.
- Help enhance the referral system for more effective and efficient linkages between Family Health Houses and public health facilities. Raise awareness of Family Health Houses in public health facilities and create opportunities to build connections between these entities and their staff to facilitate strong relationships and mutually beneficial partnerships.

Seeking Funding Partnerships, Policy Support, In-Kind Support and South-South Collaborations

- Scale this innovative, cost-effective and game-changing sexual and reproductive health solution in Afghanistan. UNFPA seeks funding partnerships with donors and the private sector to establish new Family Health Houses in more parts of rural Afghanistan to save the lives of thousands of reproductive-age women and their young children who are the furthest behind.
- Provide technological solutions to strengthen referrals between Family Health Houses and the public health system. Private sector companies, such as telecommunications providers, are uniquely positioned to offer innovative solutions and in-kind devices and services such as mobile phones and Internet infrastructure to enhance the efficiency of the referral system, which is the backbone of the Family Health House model.
- Replicate Family Health Houses in other countries. UNFPA welcomes bilateral partnerships with donors, private sector, other UN agencies, international and national non-governmental organisations, and civil society to replicate the Family Health House model in countries facing similar challenges to Afghanistan, such as rural and post-conflict settings. Additionally, UNFPA invites South-South collaborations to share learnings and best practices from similar solutions in other countries.

REFERENCES

- 2015 Afghanistan Demographic and Health Survey. (2015). Central Statistics Organization, Ministry of Public Health and ICF.
- A Basic Package of Health Services for Afghanistan 2005/1384. (2005). Ministry of Public Health, Transitional Islamic Government of Afghanistan. [http:// www.msh.org/afghanistan/pdf/Afghanistan_BPHS_2005_1384.pdf](http://www.msh.org/afghanistan/pdf/Afghanistan_BPHS_2005_1384.pdf)
- Afghanistan health indicators: Fact sheet. (2008). Afghanistan Ministry of Public Health. <http://moph.gov.af/Content/Media/Documents/Afg-Health-Indicators-Factsheet-August20082812201014152812.pdf>.
- Afghanistan Health Survey 2006. (n.d.). Indian Institute of Health Management Research (IIHMR), Johns Hopkins University, Ministry of Public Health (Afghanistan).
- Afghanistan Health Survey 2018. (2019). KIT Royal Tropical Institute. <https://www.kit.nl/wp-content/uploads/2019/07/AHS-2018-report-FINAL-15-4-2019.pdf>
- Afghanistan Living Conditions Survey 2016—17 Analysis Report. (2018). Islamic Republic of Afghanistan Central Statistics Office. <https://washdata.org/sites/default/files/documents/reports/2018-07/Afghanistan%20ALCS%202016-17%20Analysis%20report.pdf>
- Afghanistan Statistical Yearbook 2018-19 (No. 40). (2019). Islamic Republic of Afghanistan National Statistics and Information Authority. https://www.nsia.gov.af:8080/wp-content/uploads/2019/11/Afghanistan-Statistical-Yearbook-2018-19_compressed.pdf
- Bartlett, L., Mawji, S., Whitehead, S., Crouse, C., Dalil, S., & Ionete, D. (2005). Where giving birth is a forecast of death: Maternal mortality in four districts in Afghanistan, 1992-2002. *The Lancet*, 365, 864–870. [https://doi.org/10.1016/S0140-6736\(05\)71044-8](https://doi.org/10.1016/S0140-6736(05)71044-8)
- Conceição, P. (2019). Human Development Report 2019: Beyond income, beyond averages, beyond today: Inequalities in human development in the 21st century. United Nations Development Programme. <http://www.hdr.undp.org/sites/default/files/hdr2019.pdf>
- Concept Note on Family Health Houses. (2018). UNFPA Afghanistan, Ministry of Public Health of the Islamic Republic of Afghanistan.
- Global strategy on human resources for health: Workforce 2030. (2016). World Health Organization. <https://apps.who.int/iris/bitstream/handle/10665/250368/9789241511131-eng.pdf?sequence=1>
- Integrated Package of Essential Health Services 2019. (2019). Islamic Republic of Afghanistan Ministry of Public Health. https://www.lshtm.ac.uk/sites/default/files/2019-09/IPHES_2019.pdf

- National Health Policy 2015-2020. (2015). Islamic Republic of Afghanistan Ministry of Public Health. [http://old.moph.gov.af/Content/Media/Documents/NationalHealthPolicy\(NHP\)2015-2020December2015endoured247201615435541553325325.pdf](http://old.moph.gov.af/Content/Media/Documents/NationalHealthPolicy(NHP)2015-2020December2015endoured247201615435541553325325.pdf)
- National Health Strategy 2016–2020. (2016). Islamic Republic of Afghanistan Ministry of Public Health. http://old.moph.gov.af/Content/Media/Documents/MoPHStrategy2016-2020_Final09September2016111201614508950553325325.pdf
- National Reproductive, Maternal, Newborn, Child and Adolescent Health Strategy 2017–2021. (2017). Islamic Republic of Afghanistan Ministry of Public Health. <http://old.moph.gov.af/Content/files/National%20RMNCAH%20Strategy%202017-2021%20English-Final.pdf>
- National Risk and Vulnerability Assessment 2011–2012 (Afghanistan Living Conditions Survey). (2014). Central Statistics Organization, Government of the Islamic Republic of Afghanistan. <https://www.undp.org/content/dam/afghanistan/docs/MDGs/NRVA%20REPORT-rev-5%202013.pdf>
- Newbrander, W., Ickx, P., Feroz, F., & Stanekzai, H. (2014). Afghanistan's Basic Package of Health Services: Its development and effects on rebuilding the health system. *Global Public Health*, 9(S1), S6–S28.
- The essential package of hospital services for Afghanistan 2005/1384. (2005). Islamic Republic of Afghanistan Ministry of Public Health. <http://moph.gov.af/Content/Media/Documents/EPHS-2005-FINAL29122010164126629.pdf>.
- Trends in maternal mortality 2000 to 2017: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. (2019). World Health Organization.
- Viswanathan, K., Becker, S., Hansen, P., Kumar, D., Kumar, B., Niayesh, H., Peters, D., & Burnham, G. (2010). Infant and under-five mortality in Afghanistan: Current estimates and limitations. *Bulletin of the World Health Organization*, 88, 576–583. <https://doi.org/doi:10.2471/BLT.09.068957>
- What We Do: Family Planning Strategy Overview. (2020, March 18). Bill & Melinda Gates Foundation. <https://www.gatesfoundation.org/What-We-Do/Global-Development/Family-Planning>



UNFPA Afghanistan

flagship programme spotlight:

Family Health Houses



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