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# Universal Health Coverage (UHC) through midwifery-led family health houses in rural, hard-to-reach areas of Afghanistan

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Thirty-two percent (32%) of the Afghan population lives in remote, rural, mountainous and insecure areas call white areas with no access to essential RMNCH services. Access to RMNCH services is further constrained by costs, few female health workers and cultural dictates. Using mobile health teams to serve the white areas is expensive and does not offer 24-hour maternity care. As such, RH indices for rural areas such as Skilled Birth Attendance, institutional deliveries and use of FP have been low. We propose the Family Health House (FHH) model as a community-owned and community-based intervention to increase access to quality essential RMNCH services for every 1,500-3,000 population living in white areas. The model has five components: (1) Community engagement: To provide land, building materials and labor for FHH construction and maintenance; ensuring oversight and security of FHH and midwives; (2) 26-month community midwife education: Through bonded scholarships for identified female students, complemented with literacy and numeracy studies and child care for those with babies; (3) Provision of 24-hour MNCH services: In equipped and stocked FHH supported by home visits and referrals; (4) Social mobilization and health education: By 123 community health Shura's and 246 family health action groups that motivate and guide mothers on birth planning and use of RMNCH services and mobilize households/communities to support RMNCH programs; and (5) Supervision and monitoring: Integrated into public sector, including field visits, telephone consultation; catchment area census and data/information management through provincial health authorities. 123 FFHs constructed and staffed with community midwives in the white areas of Bamyan, Daikundi, Herat and Faryab provinces increasing national health care coverage by 15% and serving 216,705 people. With annual operations cost of $6,500, each FHH was constructed at the US $5,000 with community contributing 27% of the cost. In the 3 years, there was no drop out at midwifery school and only 0.0125% attrition rate of community midwives deployed in the FHHs. Annually, there is an increase in uptake of RMNCH services in these areas, with an average of 6, 485 deliveries and the same amount of neonatal care per year. Women accept the service because of having female midwives, no transportation cost and low social costs. The female members of the health Shura's have been empowered and now move out of their homes without seeking male permission and confidently talk to community leaders contrary to traditional dictates. The community midwives are seen as role models for girl-child and midwifery education, influencing girl child enrolment and retention in schools. Community leaders' negotiated unconditional releases of six health workers over 3 years, demonstrate community acceptance, ownership and valuing of the project in insecure areas. The FHH model offers the opportunity to increase equity in access to RMNCH services for remote, rural and un-served populations with cultural and in some cases security sensitivities in Afghanistan. Its community acceptance and ownership; and link with the public health system for referral, supervision and reporting offers opportunities for integration into government-led health care delivery. Such integration needs to balance considerations for cost-efficiency and equity in access.

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