

Leadership Management and Governance/Afghanistan Trip Report: Assessment of the Afghan Community Based Health Care (CBHC) Department of the Ministry of Public Health (November 7-30, 2014)

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February 9, 2014

The Leadership, Management and Governance (LMG) Afghanistan program will further strengthen the capacity of the Afghan Ministry of Public Health (MoPH) to lead, govern and manage the scale of access to and quality of the Basic Package of Health Services (BPHS) and the Essential Package of Hospital Services (EPHS), particularly for those at highest health risk. The project will also continue to support capacity building of the Ministry of Education (MoE). The LMG Afghanistan program is an 18-month intervention starting in September 1, 2012 and extending to January 31, 2014. Total budget for the 18-month period is \$25,400,800. In collaboration with USAID-Kabul, LMG-Afghanistan has received an 8 month extension of the project, with associated additional funding of ~\$4 million for the additional months of activities.

Leadership, Management, Governance, Health Systems Strengthening, Ministry of Health, Afghanistan

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Assessment of the Afghan Community Based Health Care (CBHC) Department of the Ministry of Public Health

February 9, 2014

EXECUTIVE SUMMARY

We (Dr. Iain Aitken and Dr. Steve Solter) were asked by the Leadership, Management, and Governance (LMG) project, which is implemented by MSH and funded by USAID/Kabul, to carry out an assessment of the stewardship role of the Community-Based Health Care (CBHC) Department of the Afghan Ministry of Public Health (MoPH). The assessment took place from November 7-30, 2013. During this period we visited Kabul, Nangarhar, Balkh, and Herat provinces in order to review the CBHC program at both central and provincial levels. We were able to interview key MoPH staff and consultants working in the area of CBHC as well as provincial health office officials, staff of NGOs implementing the Basic Package of Health Services (BPHS), representatives of donor organizations including USAID, LMG staff working on CBHC, and Community Health Workers, their supervisors, and others involved with CBHC in three provinces of the country. We were also able to review key documents, articles, survey results, and reports as well as Health Management Information System data.

The main objectives of the assessment were as follows:

- 1) Assess capability of the CBHC department in terms of effective leadership, sound management, and transparent governance practices required for support of smooth implementation of CBHC interventions in the country
- 2) Examine appropriateness of the selected CBHC interventions in light of the socio-cultural norms and health needs of the country
- 3) Assess the role of CBHC in the improvement of community access to quality health services
- 4) Identify existing gaps and challenges that the CBHC may face without external support

The main findings of this assessment include the following:

- 1) **On the appropriateness of selected CBHC interventions:**
 - a) The BPHS and its CBHC component were designed to serve the most vulnerable groups, women and children, and address the most important causes of morbidity and mortality for those groups with interventions that had been shown to be the most effective
 - b) The key innovation in this CBHC was the inclusion of women as CHWs
 - c) The later inclusion of Family Health Action Groups as a means of behavior change recognizes the importance of behavior change for health

2) On the role of CBHC in the improvement of community access to quality health care:

- a) The latest compilation of figures from the BPHS NGOs (February, 2014) suggest that in the ten years since starting the CBHC program 27,662 CHWs have been trained for 15,337 health posts. About half of the CHWs are women
- b) There is significant disagreement between the numbers of CHWs reported by NGOs, the numbers who have been actually registered, and the numbers submitting monthly reports
- c) The current numbers of CHWs are thought to be approaching the numbers estimated to cover the rural population in a ratio of one health post to 100-150 households, but there are still many health posts which cover a much larger or much smaller number of households
- d) HMIS data from the public sector show that numbers of sick people treated by the health services has continued to grow, and the contribution of the health posts has grown with that
- e) The presence of female CHWs in communities has been particularly important for access to modern contraceptives. Comparing health posts and public health facilities, 55% of the couple years of protection (CYPs) from short-term contraceptives are supplied by CHWs
- f) Concerns about the quality of care provided by any health workers are always present, and they are justified in the case of CHWs
- g) A second issue related to quality of care is the quality and frequency of supervision
- h) Supervision of female CHWs remains problematic

3) On the capability of the CBHC department in terms of effective leadership, sound management and transparent governance practices required for support of smooth implementation of CBHC interventions in the country:

- a) The CBHC Department has been very successful in developing and strengthening the structure and basic functioning of the CBHC system
- b) Probably the greatest achievement of the CBHC Department has been to advocate successfully for CBHC and for CHWs both nationally and internationally
- c) Associated with the advocacy has been the successful maintenance of morale and motivation among CHWs. This has been achieved in spite of the CHWs being volunteers
- d) An important part of the CBHC department maintenance of CHW morale has been its attention to preventing significant expansion of the CHW job description and workload
- e) The Department has been very successful in networking. The CBHC Task Force is the biggest and most active task force in the MoPH
- f) Successful advocacy and networking has led to additional funding from donors

- g) Urban CHWs and Nomad CHWs have been trained and deployed, thereby expanding the population covered by CHWs
- h) The CBHC Department is organized into two sections—one that focuses on Monitoring & Evaluation and one that focuses on Capacity-Building. However, members of each group frequently assist the work of the other group as appropriate and necessary
- i) The Monitoring and Evaluation role of the CBHC Department is beginning to focus on bigger picture issues (and less on checklists) but as far as we could see, the process has not yet addressed the issues of low CBHC coverage or utilization in specific provinces
- j) The Capacity-building work of the CBHC department has an impressive record of curriculum revision and training of trainers for training programs for CHWs, CHSs, FHA Groups, CBHC Officers and shura-e-sehies over the past three-four years

4) On existing gaps and challenges that the CBHC may face without external support

We have tried to emphasize in this report that the MOPH stewardship of the CBHC component of the BPHS involves a variety of other departments of the MOPH besides the CBHC Department. The donors supporting the health system also have a significant influence on the exercise of that stewardship, depending on which particular activities they support

- a) *Perhaps the first weakness of the CBHC Department may be the consequence of one of its main achievements.* Data have been used primarily to demonstrate the successes of the CBHC Program. At this stage, however, there is a need for the use of available data for a much more critical look at the CBHC system
- b) *The CBHC Department is first of all dependent on the GCMU* for assuring that agreed numbers of CHWs are selected and trained for the appropriate communities, that CHWs get travel expenses and sufficient medical supplies, that CHSs have a means of transport by which they can do their supervisory visits to health posts, and that money allocated for in-service training actually gets used for the training of CHWs. We have noted problems in all of these areas.
- c) *Where additional funding may be required, donors as well as the MoPH Planning Division may also be required*
- d) *Donor support will be required for significant unfinished business.* These funds may be supplied as project funds or in NGO BPHS budgets for specific purposes
- e) *There needs to be a more intentional and integrated approach to setting and working towards targets for public health programs by the MoPH, including the CBHC Dept.*
- f) The position of the CBHC Department in the MOPH Organogram, as a Sub-Directorate limits official and direct access to the leadership of other technical and management departments in the MOPH that are stakeholders in CBHC

- g) There is concern whether the “on-budget” process will result in a department that lacks the means and motivation to continue being effective

The main recommendations of this assessment include the following:

1. Introduction:

As already noted, over the past ten years, the CBHC department with USAID support through REACH, Tech Serve, HSSP, LMG and other projects has done a very impressive job of advocacy for CBHC and of developing and expanding the basic building blocks and processes of the CBHC system within the BPHS. The capacity of the departmental team has grown with the job and, in the current work plan, they are completing the consolidation of the work of the past several years.

A successful future role for the Department must look different. Rather than just supporting general expansion of the program, there will be greater need for attention to the varying rates of coverage and utilization of CBHC services in the provinces and districts. There will need to be greater attention to the performance and productivity of health posts and FHA Groups. And they will need to be able to build the capacity of NGO and PHO staff to do the same in their provinces. We believe that this new approach will require a change in thinking as well as some additional skills in the Department.

In the final year work plan for the LMG CBHC Program, the major time-consuming activities will be building on the accomplishments of the past two years (the review and revision of training courses and materials for all major CBHC players) through the training of NGO staff to implement the new curricula. These include CHWs, CHSs, Shura and the expansion of FHA groups. In view of the possible closing of the LMG Project later this year, as well as the anticipation of changes with SEHAT and the absorption of a reduced number of consultants into the MOPH “on budget”, these NGO capacity-building activities should be considered priorities.

1. CBHC LMG Workplan-related recommendations:

a. Objective 1: Expand Community-Based Health Services

i. 1.1. Scale-up FHA Groups

A sub-activity for this year should be the preparation of a plan and budget with GCMU for national expansion of FHA groups in a period of time that reflects their importance for health promotion and behavioral change

ii. Increase number of new CHWs

The CBHC department should work very actively with the HMIS department to assess the true needs for future new CHWs

b. Objective 2: Improve the quality of CBHC services

i. 2.4. Training of CHSs

An additional activity should be advocating for and developing a new policy for the numbers of CHSs at a health facility

ii. 2.6. Training of CHW trainers in the new CHW curriculum

A supplementary activity should be the planning and implementation of the completion of CHW training in C-IMCI.

iii. 2.5. Production of CHW training manual and job aids.

Production of essential CHW job-aids should be guaranteed as well as copies of the manuals

iv. 2.8. Monitoring visits to provinces.

Monitoring visits should emphasize the ‘big picture’ and strategic issues

v. 2.10. Gender equity

To improve the support of female CHWs, an evaluation should be made of Nangarhar’s initiative to have Community Midwives visit and hold mini-clinics at health posts together with the female CHWs

c. **Objective 3: Ensure sustainability of the CBHC system**

i. Maintain departmental technical staff for “on budget”.

Arguments for maintaining the current capacity of the CBHC Department should be made in terms of future, anticipated skills required for in-depth analyses and planning for improvements in coverage and performance of CBHC services as part of an integrated BPHS system

i. 3.2. Promotion of CBHC department to Directorate

As for 3.1, the argument will need to present a future role of the CBHC unit that will require organizational partnering with other key technical units with which there will need to be regular collaboration for mutual benefits of programs

ii. 3.4. Build capacity in strategic and operational planning

Each of the additional activities recommended above should be examined to identify any need for a specified capacity-building component for the CBHC staff.

iii. 3.5. Provincial CBHC Officers to the MOPH *tashkeel*

This is not a new recommendation, but an endorsement of this work plan activity. After seeing the potential of an effective provincial CBHC officer, we think it a very important role.

2. LMG Project Recommendations:

The two concept notes (Annexes B and C) requested by the LMG management in Kabul and the MSH head office have outlined the development and institutionalization of a BPHS Performance Improvement Program and process within the MOPH. This essentially addresses the stagnation of much health program performance in the BPHS and the lack of the necessary integration and collaboration of technical and management effort required to bring about improvements.

This recommendation is to the whole LMG Project, and not just to the CBHC Program. While the recommendation arose out of an assessment of the MOPH stewardship of the CBHC Program, and of the performance of the CBHC Department in particular, the problem is not primarily that of CBHC or the CBHC department. This is an issue for the stewardship of the whole BPHS program. The management of the BPHS is with the GCMU, and there is no clear, regular way in which the MOPH technical units or the PHOs can participate. The second concept note, “BPHS Performance Improvement through Active Management by Objectives” outlines the problem and the way in which effective management by objectives can be introduced and institutionalized

I. THE CONSULTANCY

Background: The Community-Based Health Care Department of the Afghan Ministry of Public Health (MoPH) plays an extremely important role in the implementation of the Basic Package of Health Services (BPHS) and in primary health care generally. In Afghanistan's rural areas, almost half of sick children are first seen by Community Health Workers (CHWs) at community level and about two-thirds of all family planning contacts take place in the village (with only one-third occurring in government health facilities). Afghanistan differs from many developing countries in the importance of its community-based health system; in most other developing countries CHWs play a less central role in primary health care.

Since 2003, MSH, as a strong partner of the MoPH and with funding from USAID, has provided technical support to build the MoPH's management, leadership, and public health capacity to improve the health of the people of Afghanistan. This has been achieved through a high-quality, accessible, sustainable, and equitable health system with a strong community component from the beginning. As part of its overall support to health system strengthening, MSH helped to create the CBHC Department in 2005 and, subsequently, build the department's capacity. It now has a strong technical team comprised of 11 consultants working in the central MoPH in Kabul. The additional consultants were hired and deployed in the Ministry in July 2008. Since 2003, MSH has supported the MoPH to produce all the critical policy, legislative and strategic documents needed to firmly establish health care at the community level as a vital part of the continuum of care and the CBHC Department in the MoPH. MSH has also been an essential player in all the technical developments of CBHC.

The LMG Project has continued support to the CBHC Department. As part of its scope of work in what it anticipates as its final year, LMG is assisting the MoPH in making the necessary arrangements for the migration of the CBHC Department consultants to become part of the MoPH formal structure to ensure sustainability of the CBHC program.

Purposes of the assessment:

This assessment of the Afghan CBHC department was requested by MSH's Leadership, Management, and Governance Project and the Scope of Work for the assessment can be found in Annex A.

Its goal was a) to assess whether the CBHC department of the MoPH is fully capable of playing its stewardship role and implementing its strategy and policy independently or with very limited external support; b) to identify any remedial activities to be done by LMG in this final year; and c) to identify and disseminate lessons learned from the assessment.

Specific objectives:

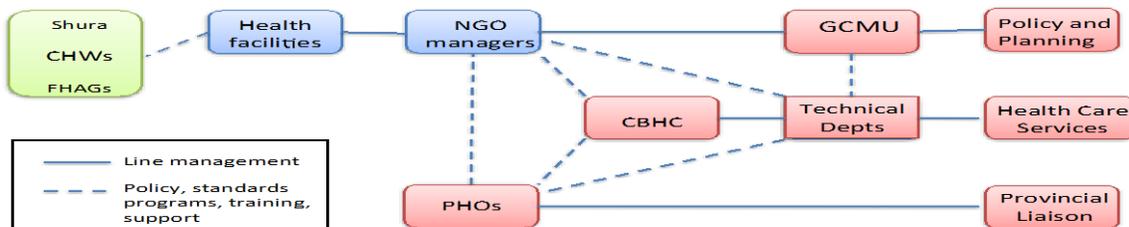
- Assess capability of the CBHC department in terms of effective leadership, sound management, and transparent governance practices required for support of smooth implementation of CBHC interventions in the country
- Examine appropriateness of the selected CBHC interventions in light of the socio-cultural norms and health needs of the country
- Assess the role of CBHC in the improvement of community access to quality health services
- Identify existing gaps and challenges that the CBHC may face without external support

APPROACH TO THE ASSESSMENT

Conceptual framework

The goal of the assessment is to define the MOPH governance system of the CBHC Program, to identify the special roles, responsibilities and authorities of the CBHC Department in that system, and assess how well it is performing those functions. (See Figure 1.)

Figure 1: Governance system of CBHC by the MOPH



In the MOPH there are four different groups of departments that are included among the stakeholders of Community-based Health Care.

- “Vertical” technical departments dealing with the content of health care programs at all levels of the health system, for example, Child and Adolescent Health, Reproductive Health, National TB Program, Health Promotion, etc.

- “Horizontal” health service organization departments like the Community-based Health Care Department (The Hospitals Department is similar, but not directly involved in CBHC)
- Line management departments: The GCMU together with the contracted NGOs it supervises, and the HMIS Department that monitors the health system
- Provincial Health Offices which play a stewardship role at provincial level; 26 of 34 PHOs have a CBHC officer playing a coordinating role

All these departments are stakeholders in CBHC, but have different roles, responsibilities and levels of authority. The stewardship roles include responsibilities and authority for policy setting, program design, and program implementation (Monitoring and evaluation is essential to all these activities.) The departments and organizations that are CBHC stakeholders all have different levels of responsibility and authority over policy, programming and implementation of the CBHC program.

Based on the SOW and this conceptual framework, our objectives in this assessment of the CBHC Department and Programs were to identify:

- a. The roles, responsibilities and authorities of the different stakeholders;
- b. The mechanisms by which these responsibilities and authorities are carried out;
- c. The mechanism(s) by which they are coordinated;
- d. The particular roles, responsibilities and authorities of the CBHC Department;
- e. How they are being carried out;
- f. How well they are being carried out;
- g. Performance data for the CBHC Program in evidence of the stewardship system of CBHC;
- h. How the overall system of MOPH stewardship of CBHC might be improved;
- i. How, in particular, the CBHC Department might be improved for its stewardship role

Activities:

1. Interviewing the following:

LMG

- Dr. Mubarak, Dr. Saleh and Dr. Mushfiq for overall briefing
- Dr. Mushfiq and Dr. Pardis for more detailed discussions

MOPH

- Dr. Arwal, CBHC
- Dr. Ahmad Shah and Dr. Masood, section heads within CBHC
- Child and Adolescent Health Department

- Reproductive Health Department
- National Tuberculosis Control Program / Dr Rashidi, TB-DOTS
- HMIS Department
- PCH – GCMU and follow-up with World Bank and EU

Provinces – Nangarhar, Herat and Balkh

- Provincial Health Directors
- Provincial Health Offices – CBHC Officer and Child Survival/Reproductive Health Officer
- NGO Program Manager
- NGO CBHC Officer
- NGO Trainers
- Group interviews with 5-6 CHSs
- Interviews with CHWs when possible

2. Data analysis

Trend analysis of HMIS data of selected service delivery activities by health post, health facility and total

II. THE STATE OF CBHC IN AFGHANISTAN: AFTER 10 YEARS OF COMMUNITY-BASED HEALTH CARE IN AFGHANISTAN, 2003 to 2013

1. State of CBHC – at 10 years

- a. **How did we get here?** (See Annex D: Detailed timeline of development of CBHC)

i. The start of the CBHC program

Following the many years of war, the Transitional Government of Afghanistan in 2003 adopted a Basic Package of Health Services (BPHS), prioritizing maternal and child health and disease control, as its approach to reconstruction of a relevant and effective health system. A key element of the BPHS was the Community-Based Health Care element. This was to consist of a village health post with one male and one female Community Health Workers (CHWs), supervised and supported by a community Shura-e-sehie and with technical supervision and supplies from the health facility in whose catchment area it lay. This strategy was intended to bring effective essential services and health education to communities especially to village women whose access to health facilities was restricted by cultural and security considerations.

Basic documents and plans were prepared in 2003 by the CBHC Task Force and training of CHWs commenced in 2004, implemented by the NGOs who were contracted to implement the BPHS.

A National CHW Sustainability Conference in August 2005 reviewed the situation and came up with three recommendations:

- That CHWs should not receive any regular payment, but should remain volunteers with support from communities;
- That a new position of Community Health Supervisor be created, based in health facilities, which would be dedicated to the support and supervision of the CHWs surrounding a health facility;
- That the CBHC Task Force be reconstituted and, among other tasks, prepare recommendations for the formation of a CBHC Department within the MOPH.

Revised Terms of Reference for the Task Force were approved and the CBHC Department was formed later in 2005.

ii. Role of projects

Much of the development of CBHC in Afghanistan over the next few years was achieved by donor-funded projects, predominantly with funds from USAID. These included:

- Family Health Action Groups (FHA Groups) as a women-based approach to behavioral change in the community. These are an adaptation of the Women's Action Groups formed under a USAID-supported project by Future Generations. Scaling up of the FHA groups has been slow up to now. Latest figures from the NGOs suggest that there are 1,189 FHA groups, less than 10% of all health posts.
- The Postpartum Family Planning (PPFP) project that improved the training program for family planning and included the provision of first injections of Depo Provera by CHWs. This has been implemented nationwide.
- The Community Integrated Management of Childhood Illnesses (C-IMCI) project was introduced to improve the case management of children by CHWs. It included the development of a pictorial version of the IMCI management algorithms together with charts on essential newborn care and infant and young child feeding and immunizations. Two training modules were developed with a focus on the disease patterns of the two main seasons. This program has been implemented in all but six provinces.
- Community TB screening and TB-DOTS have been developed and implemented nationwide.

All these projects have developed specific aspects of the agreed job description of the CHW. In some cases a CHW activity has been elaborated; in all cases an improved training program has been developed. All these activities are part of the BPHS.

The USAID-funded BASICS project (2008-2011) used the FHA Groups as the basis for implementing an Integrated Child Survival Package at community level. In addition to

the C-IMCI, this included community growth monitoring and nutrition counseling, essential newborn care and additional behavior change communication. This package has not yet been included in the BPHS but was implemented in most districts of USAID-supported provinces.

iii. Role of CBHC Department

The CBHC Department was formed in late 2005. It had a head and later received two support staff. Its initial role was mostly advocacy and a growing effort at coordination of community-based activities through the CBHC Task Force. Its main focus from the beginning has been the structure and functioning of the CBHC system: the CHWs, the CHSs, the Shura-e-sehie, FHA groups, etc. In general it has not played a significant role in the projects that have concerned themselves with the technical content of the CHWs' job. The main exception to this was the PPFPP project. Under this project, ten positions for consultants were created in the CBHC Department in 2008. These included the head of the department, a women's health coordinator and eight master trainers. The initial tasks of the master trainers were to provide the training and follow-up monitoring of the NGO trainers for the PPFPP program scale-up.

In the past three years, the CBHC department staff have focused their activities on continued monitoring of the CBHC program in the provinces, capacity-building of NGO staff and CHSs, and further consolidation of the CBHC program. Advocacy has continued to be very effective, and the CBHC program is now well known throughout Afghanistan. The CBHC Task Force is the largest and most active of all the MOPH task forces.

The needs of urban communities and nomadic groups have been addressed with the development of strategies to meet their special circumstances. Training of CHWs for these communities has commenced in the past two years.

As numbers of CHWs continue to increase and their volunteer status remains, a major concern has been with their motivation. This has been partly achieved by making sure that the CHWs' workload does not increase significantly. The other approach has been to promote their recognition in as many ways as possible. A major achievement of the Department was, therefore, the establishment of the National CHWs' Day on December 5th each year. This is recognized by large gatherings of CHWs in Kabul and provincial capitals each year.

In the past two years, the CBHC Department has consolidated much of the improvements achieved by the donor projects described above. This has included:

- A revised and simplified provincial CBHC monitoring instrument;
- Revision of the job description, guidelines and training of the Community Health Supervisors;

- Updating of the FHA Groups implementation guidelines;
- Revision of the CHW initial training curriculum to incorporate all the improvements developed through the projects;
- Revision of the guidelines and training manual for the Shura-e-sehie;
- Improved training module on eye care for CHWs;
- Development of an advanced in-service training module in first aid and management of trauma to meet the needs of CHWs working in districts where there is significant ongoing fighting with insurgent groups.

iv. Role of other MOPH technical departments.

Many of the technical directorates or departments in the MOPH are stakeholders in the CBHC program. Child and Adolescent Health, Family Planning, Nutrition, the National TB Program, Eye Care, the Red Cross and others have all participated in the various projects and some of the recent activities of the CBHC Department. (See Section III for further comments on the relationship between the CBHC Department and other CBHC stakeholders.)

b. Are CBHC interventions appropriate to the socio-cultural norms and health needs of Afghanistan?

The CBHC system was designed as part of the BPHS. Those involved in the design were those who were most familiar with the rural areas of Afghanistan, their socio-cultural norms and health needs. The goal was to provide evidence-based services that met the nutritional, infectious disease and reproductive health needs to the most vulnerable groups, namely women and children. Any significant changes to the BPHS over the past ten years have not reflected a change in the original assessment of priorities; they have been made possible through the establishment of a functioning health system and additional resources.

There have been additions to the activities of CHWs in the past ten years. These include initiating injectable contraceptives for families and the introduction of the FHA Groups. Neither enlarged the scope of the job description, but was an evidence-based intervention that improved the effectiveness of the CHWs' work in family planning or health promotion. Community growth monitoring and community-based essential newborn care are both interventions that have been partially implemented in Afghanistan so far. Both are becoming increasingly relevant in communities where child survival has improved and greater efforts in nutrition and newborn care become higher priorities.

The inclusion of CBHC in the BPHS recognized the serious issues of access to health care that existed both as a result of the destruction of the previous health services, and the more fundamental problems of communities being spread over large distances, difficult communications, especially in winter, and the special cultural and security

constraints on the movement of women from their homes. The special innovation in this CBHC design, therefore, was the introduction of female CHWs as partners to the male CHWs in the health posts. Data in the next section demonstrate how this improved access has made a special difference to the use of child health, birth spacing services, and the referral of very sick children.

Because women have central roles in pregnancy and childbirth, child nutrition and rearing, as well as the family diet and home hygiene, the promotion and adoption of healthy behaviors has to involve women and social norms among women. The Family Health Action Groups as an effective approach to changing social norms and family behaviors are especially important. Where they have been implemented with full support they have been very effective, so the slow implementation is regrettable.

The role of men in community and family leadership has been recognized from the beginning in the promotion and education of the community Shura-e-sehies. Regular communication and consultation with them has not been consistent, and the more recent formation of health facility shuras and the development of updated and improved guidelines for all shura are expected to help in maintaining better collaboration between communities and health facilities. Collaboration with religious leaders has been a special aspect of this. Their assistance has been sought in identifying those health messages specifically taught in Islam and emphasizing them in efforts at health promotion. This has been particularly effective in the area of birth spacing.

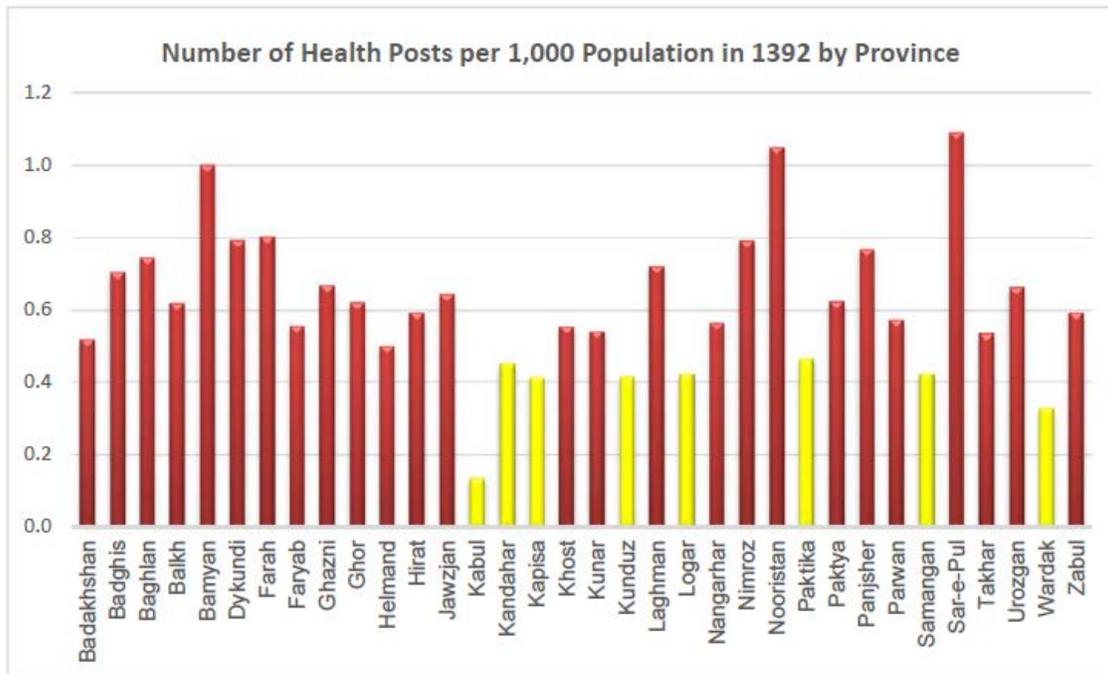
Finally, it has to be recognized that high levels of illiteracy exist in rural communities as a result of the years of war. Five years ago this was true of 70% of female CHWs and 20% of male CHWs. Training materials and job aids for CHWs and health promotion materials for communities have had to be carefully designed with that in mind. High quality and innovative pictorial materials have so far proved very acceptable and effective.

Two very important areas of health need in post-conflict Afghanistan are mental health and disabilities. Both are recognized in the BPHS, but significant programs are so far lacking. For mental health this reflects a lack of capacity and the absence of simple evidence-based interventions. CHW-training, therefore, only attempts to make CHWs aware of mental health problems and encourages them to refer cases to health facilities. Much of the need for assistance to people with disabilities has been met, with considerable success, by national and international NGOs. So far, CHWs have not been involved in these programs. Recently, there have been discussions on the CBHC task force about involving CHWs in a program of active case finding and referral of people with disabilities. This seems very appropriate in the growing maturity of both programs, but caution was emphasized at the Task Force lest the workload of the CHWs be increased significantly.

c. Health Outputs and Impacts of CBHC

i. *Expansion of CBHC system*

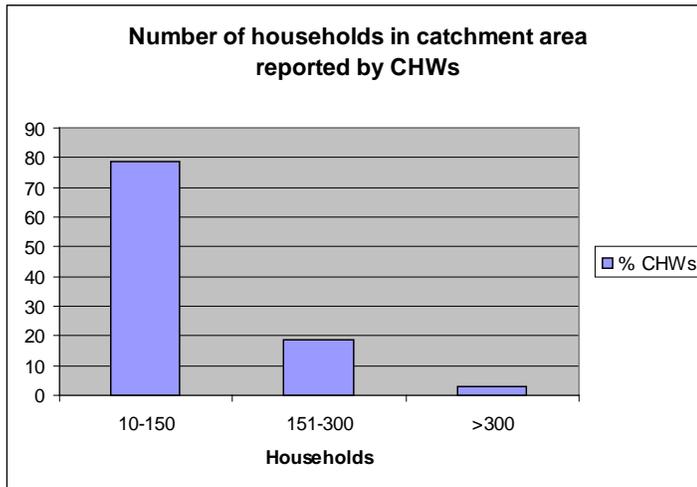
Government contracts with the NGOs implementing the BPHS have specified targets for expansion of the numbers of CHWs and health posts in each province. As a result, NGOs now (February 2014) report 27,662 CHWs and 15,337 health posts. Approximately half of all CHWs are still women. The actual number of CHWs is actually hard to specify. NGOs report on the numbers that they are regularly supervising, and that provides the largest numbers. The process of registration of CHWs is not yet complete and provides a lower number. The numbers of health posts reporting to the HMIS is the third source of information and varies from time to time.



Whether or not there are sufficient CHWs already trained is uncertain. The above chart from the 1391 HMIS Annual report indicates that there is considerable variation in the number of health posts available per population. A process of identifying the locations of all health posts with GPS locators is under way. Also, the CHWs are now involved in the regular CAAC community census exercises. These sets of information should in time help to identify where there are underserved populations or others where CHWs are attempting to care for an excessive number of households.

The issue of health posts with too many households was identified in some of our provincial interviews. (See in section III) The issue was already identified at a CBHC Consensus Workshop in November 2008.

Figure 1: Number of households in catchment area reported by CHWs



JHU 2007

Figure 1 shows that in 2007 more than 20% of health posts were caring for more than 150 households. Since that time, populations have certainly grown and the problem has probably increased.

As expansion of the CBHC system has progressed, the other continuing problem has been that of supervision. The CHSs as dedicated staff for CHW support and supervision have done a great job. Without them, little would have been achieved. There are currently about 1200 CHSs, and only 70 of them are female. Again, this problem was identified at the 2008 Consensus Conference. **Figures 2, 3 and 4** show the distribution of numbers of health posts supervised by BHCs, CHCs and District Hospitals.

Figure 2: Number of health posts supervised by BHCs

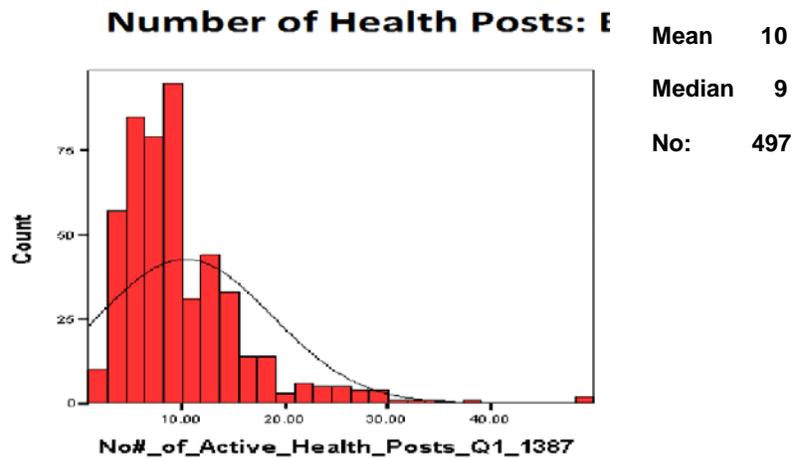


Figure 3: Number of health posts supervised by CHCs.

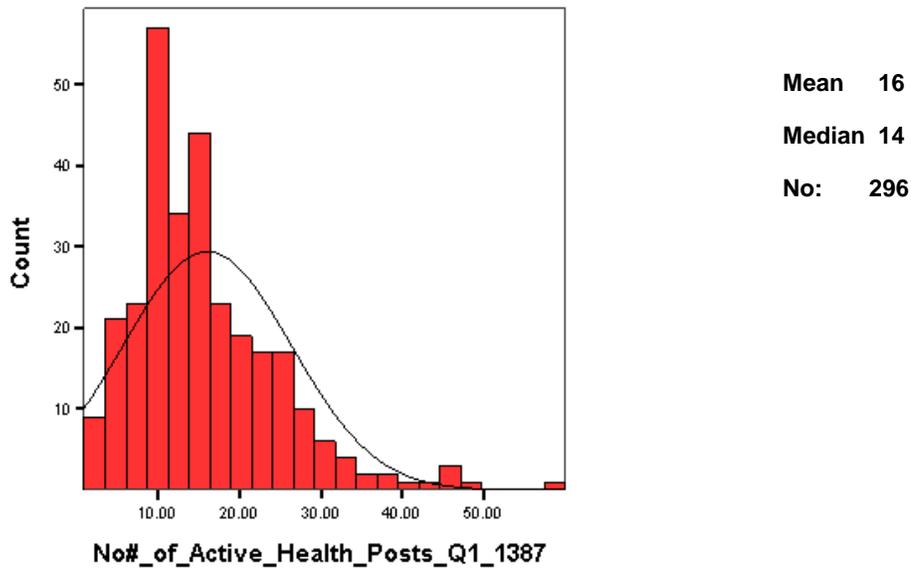
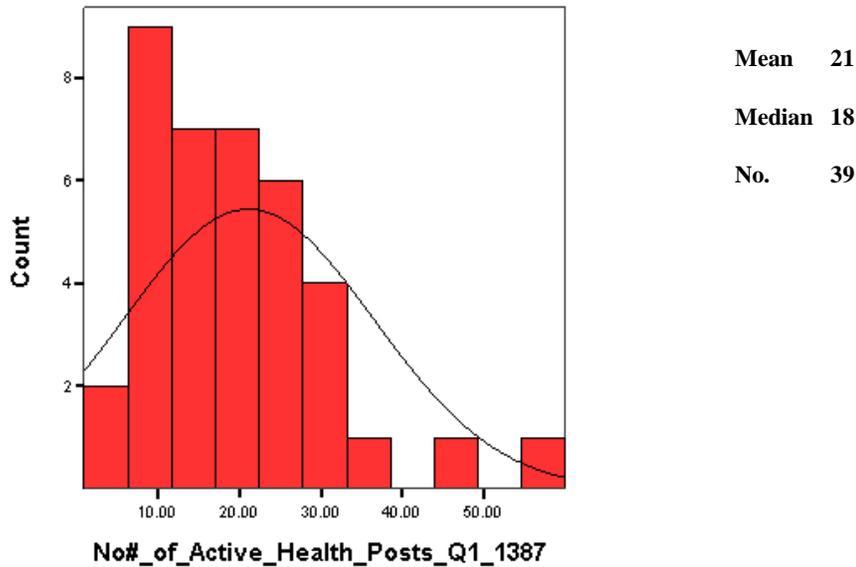


Figure 4: Number of health posts supervised by district hospitals.



From these charts we can see that about 15% of almost 500 BHCs are caring for 20 or more health posts, about 25% of almost 300 CHCs and about half of district hospitals are looking after 20 or more health posts. Significant numbers of CHSs are trying to supervise 30, 40 or more health posts. Clearly, this requires budgeting and recruitment for considerably more CHSs if supervision is to be physically possible and meaningful

ii. Specific CBHC outputs in child and reproductive health.

HMIS data make it possible to assess the specific outputs and contributions of health posts to aspects of child health and family planning. Many other health system outputs in immunization and maternal health have a clear contribution from the CBHC system, but these contributions cannot be quantified.

Children under five years are treated for cases of Acute Respiratory Infection (ARI) at both health posts and facilities. Cases of pneumonia are treated at both levels and severe cases may be referred from the health post to the facility. **Figure 5** shows the increasing numbers of cases of ARI treated at both health posts and facilities over the years 1389-1391, continuing a trend over ten years. **Figure 6** shows that there is a five-fold difference between the highest and lowest numbers of cases treated and referred between provinces. The reasons are not obvious but should be explored.

Figure 5: Cases of ARI treated at health posts and facilities, 1389-1391.

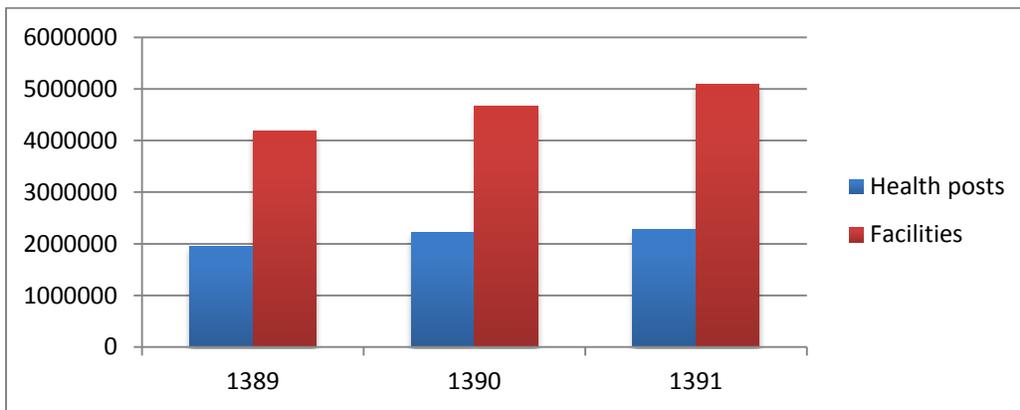
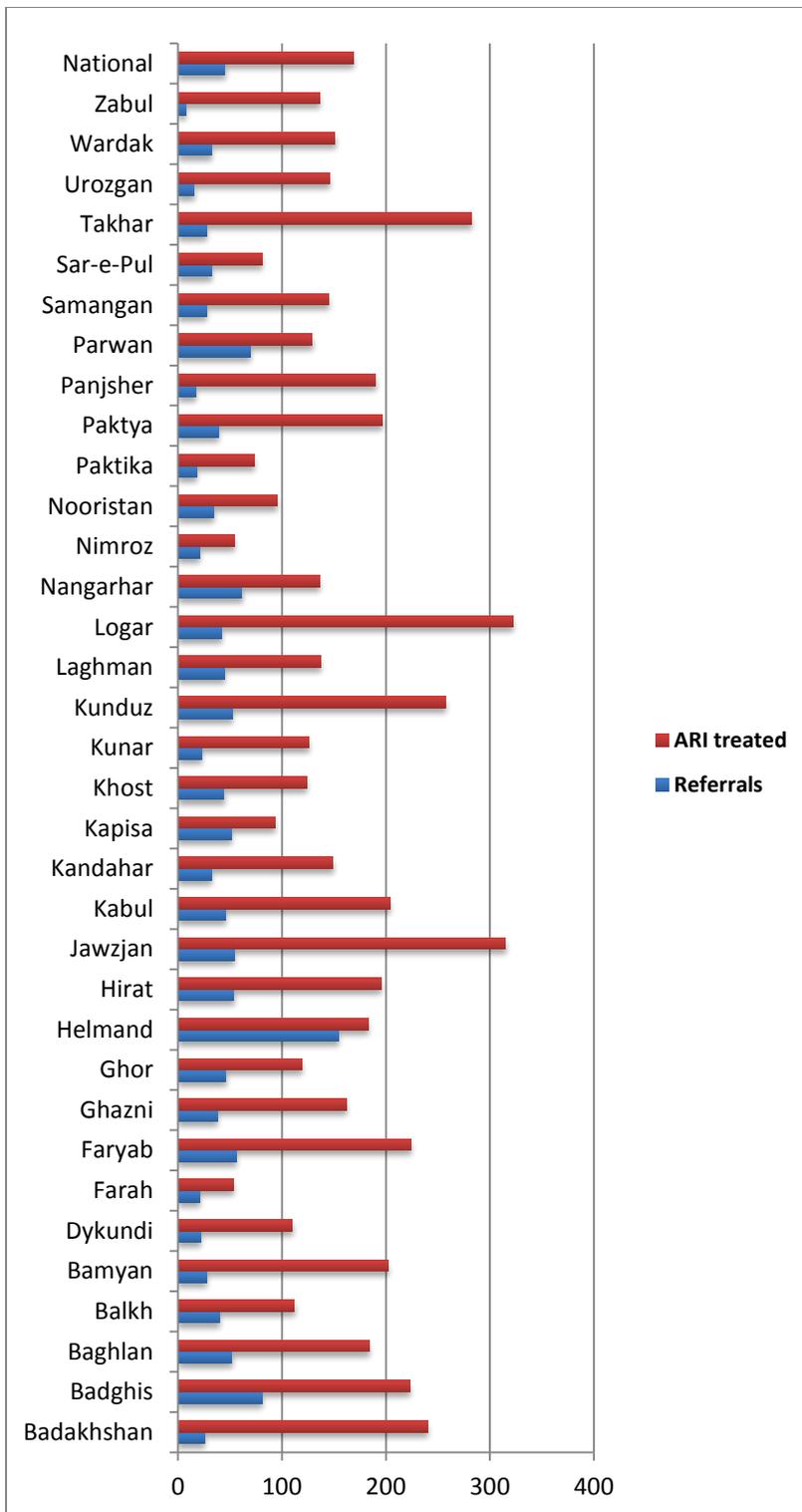


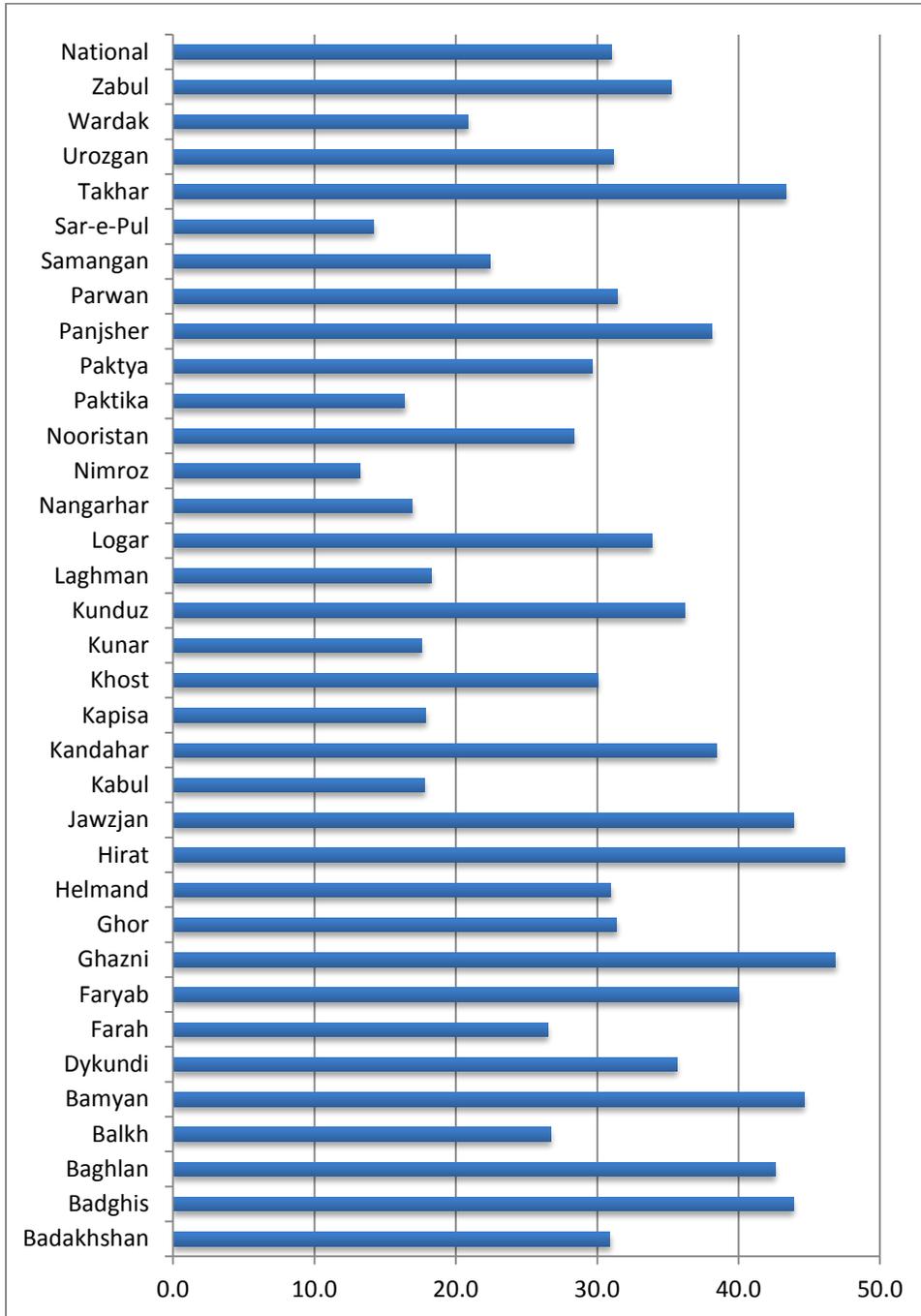
Figure 6: Average numbers of ARI cases treated and referred per health post, 1391.



Nationally an annual average of 170 cases of ARI are treated at a health post and 45 are referred. The average rate of referral is about 21%. The percentage of total cases of ARI treated at health posts by province is shown in **Figure 7**. Again there is nearly a fourfold difference between the

highest and the lowest percent, and the reasons are not obvious. Nationally just over 30% of ARI cases are treated at health posts.

Figure 7: Percent of total cases of ARI treated at health posts by province, 1391.



The situation for diarrhea is similar to ARI. **Figure 8 and 9** shows the numbers and percentages of cases of diarrhea treated at health posts and facilities..

Figure 8: Cases of diarrhea treated at health posts and facilities, 1389-1391.

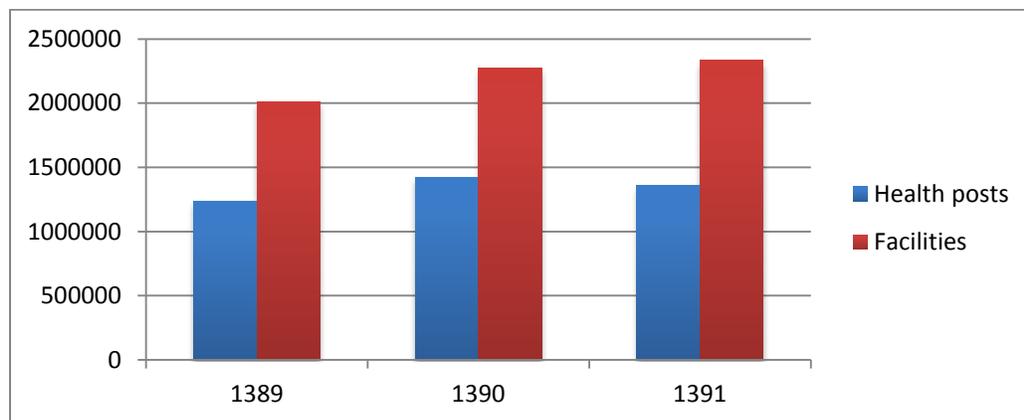


Figure 9: Percent of total cases of diarrhea treated at health posts, 1391.

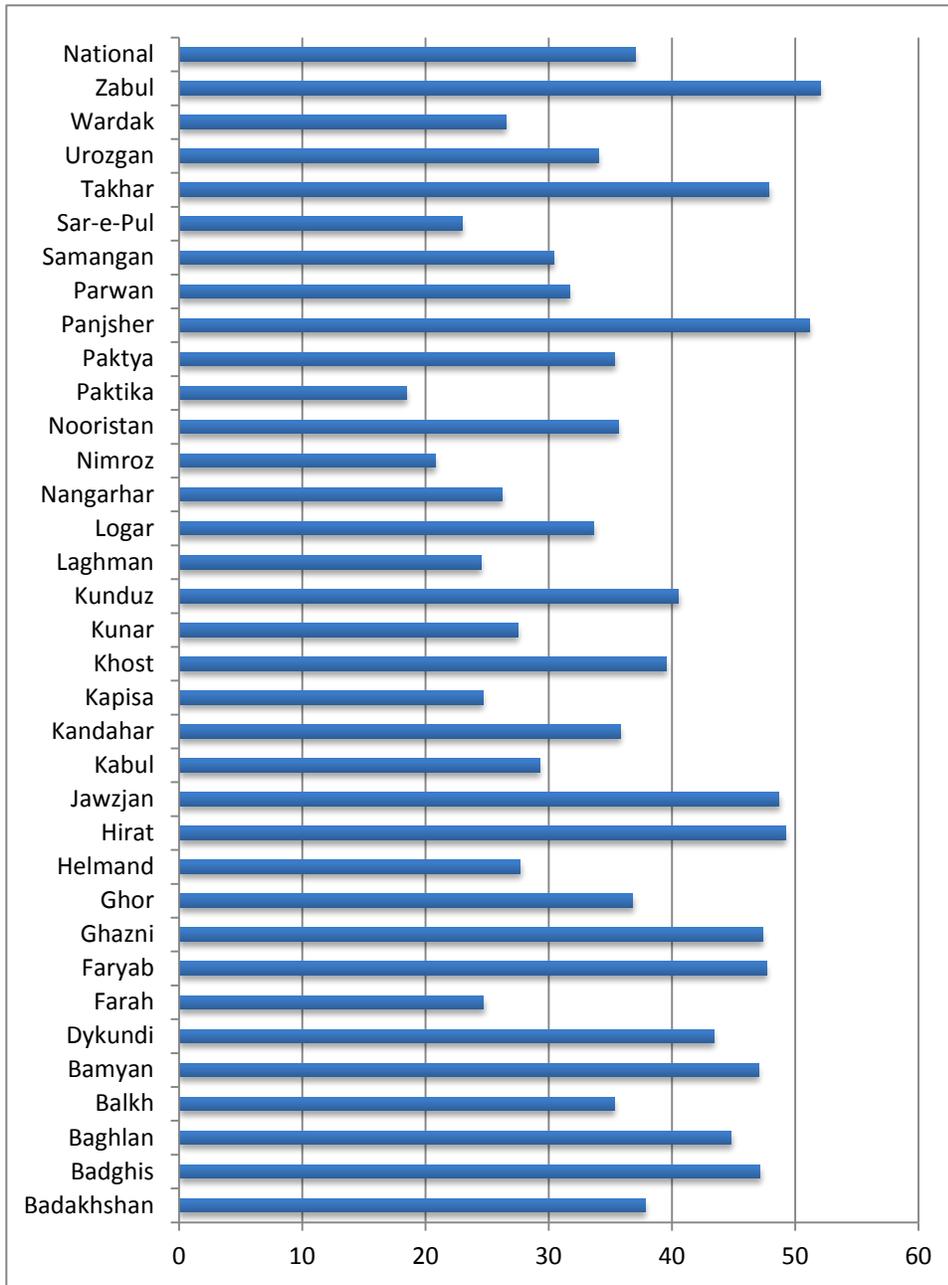
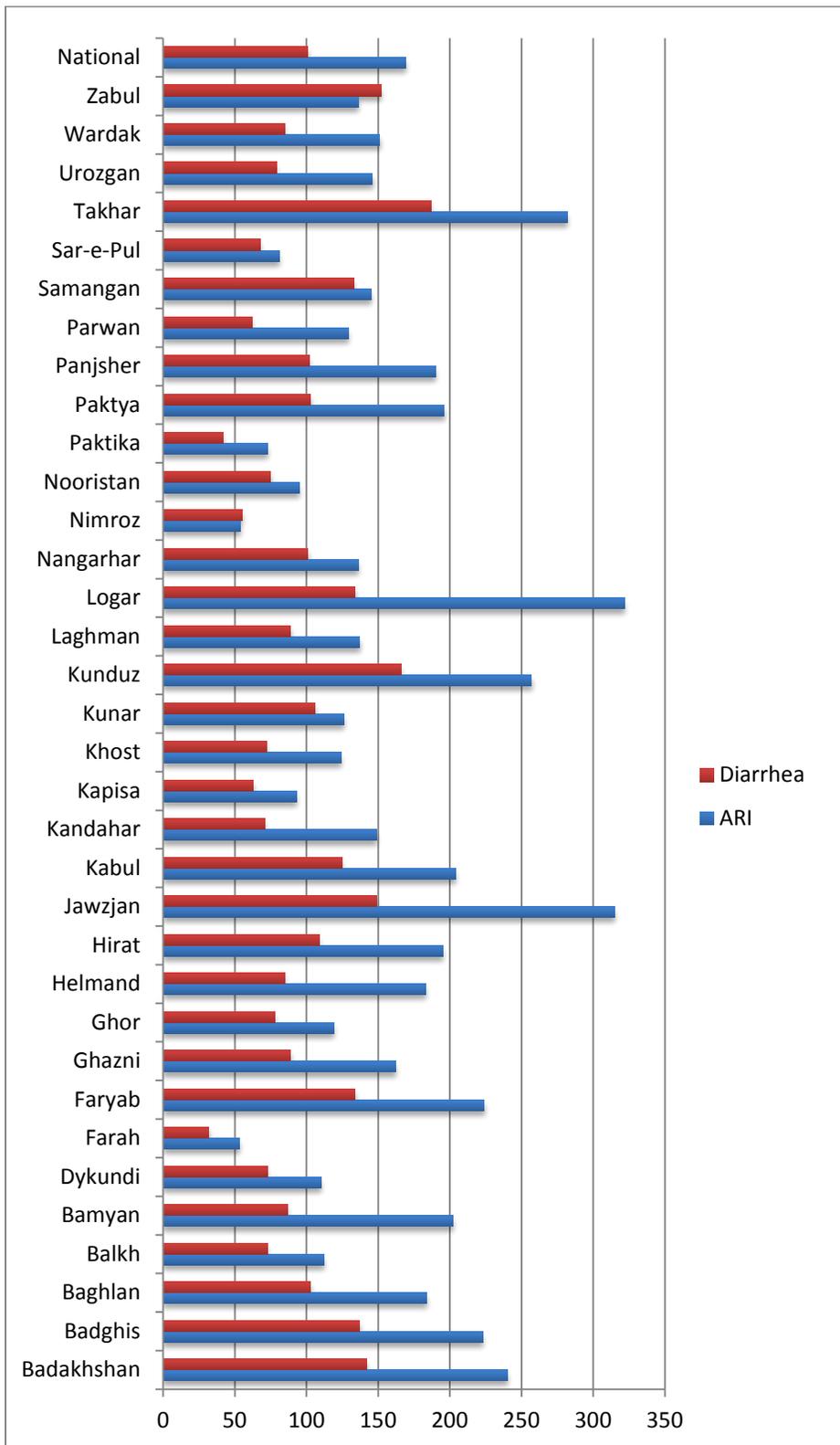


Figure 10: Average numbers of cases of ARI and diarrhea per health post, 1391.

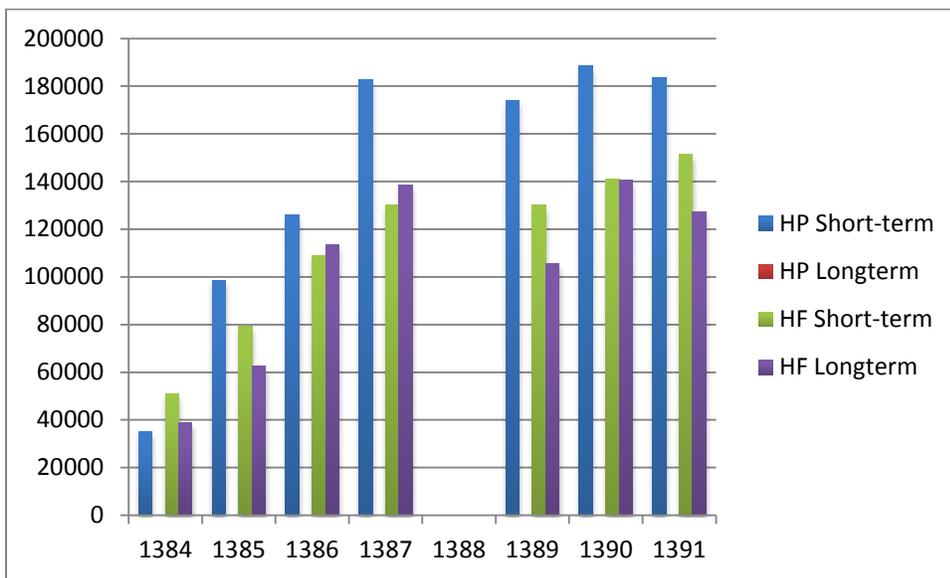


Comparing average numbers of cases of ARI and diarrhea treated at health posts (Figure 10), there is a clear relationship between low/high numbers of one and low/high numbers of the other. There is no pattern clearly associated with security, so other factors need to be identified and addressed appropriately.

Provision of contraceptives is the other service that can be clearly compared between health posts and facilities. The presence of female CHWs in communities has been seen as a great advantage to women wishing to use a modern contraceptive. In the following discussion, numbers of different types of contraceptives supplied to couples are converted to Couple Years of Protection (CYPs) to give a clearer picture of the outputs of health posts and facilities.

Health posts only supply short-term methods of contraception, while facilities supply both short- and long-term methods. **Figure 11** shows the contribution of each. Clearly health posts provide more short-term methods than facilities (55% of all short-term methods in 1391, but only 40% of total CYPs from long- and short-term methods.).

Figure 11: CYPs from short-term and long-term methods at health posts and facilities.

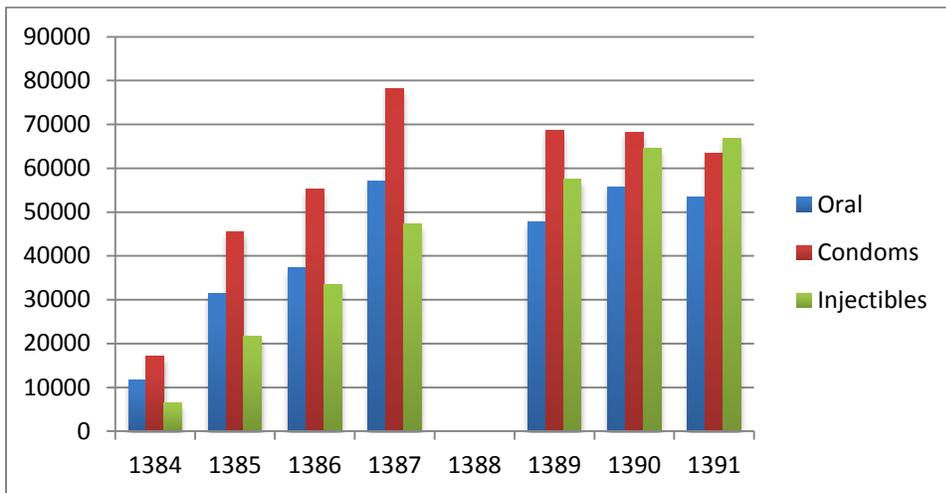


The CYPs contributed by different contraceptive methods at health posts at different times over eight years is shown in **Figure 12**. It shows the steady increase in use of all short-term methods until 1387. After that time there is a continued increase in the use of injectables while use of condoms and oral pills decline. This may be explained by the commencement of the scale-up

program of Postpartum Family Planning and initiation of Depo Provera by CHWs in 1388. In 1391, the proportions of total CYP by each method was:

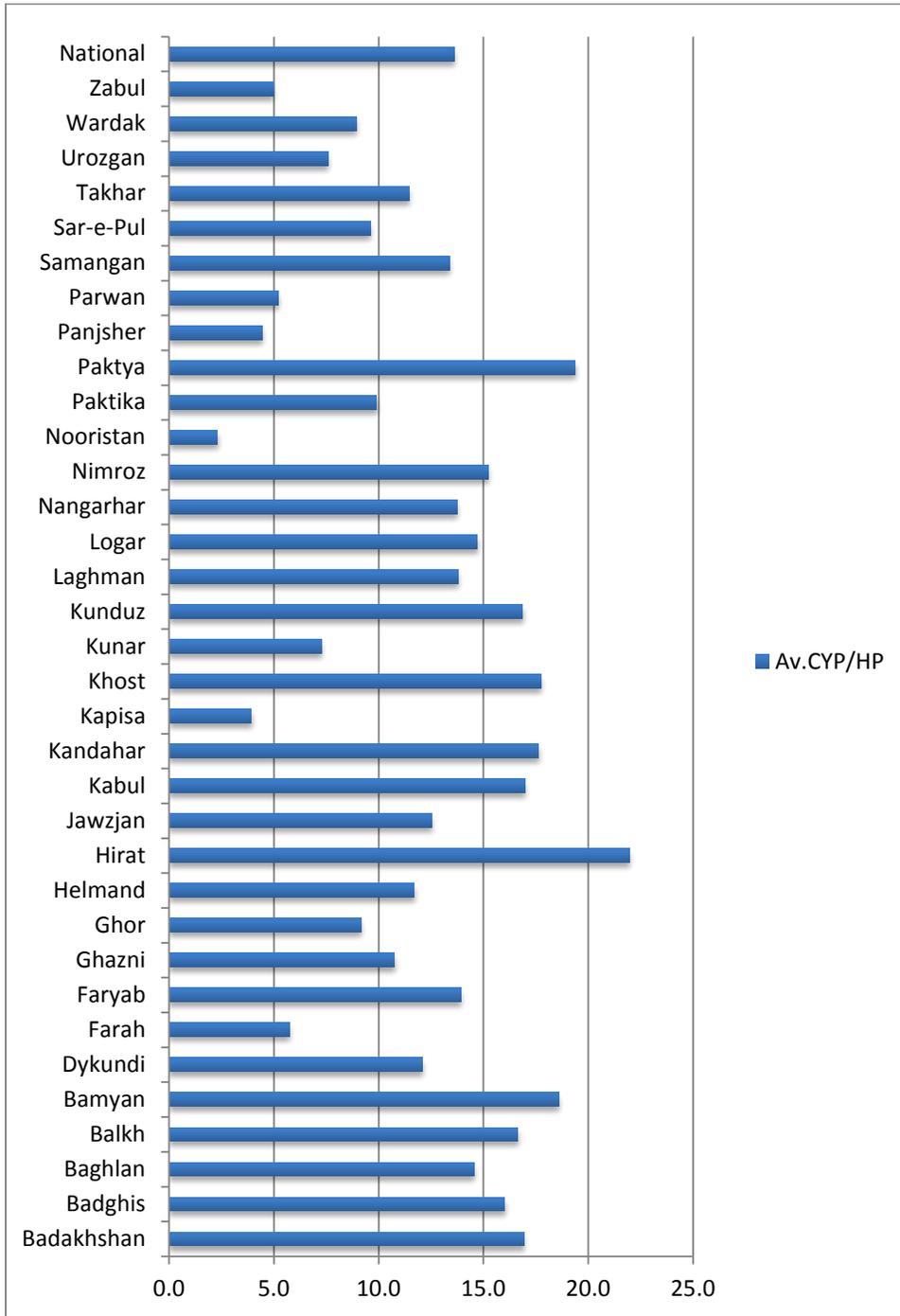
- Oral pills 29%
- Condoms 34%
- Injectables 36%

Figure 12: CYPs from different methods at health posts, 1384-1391.



The average number of CYPs supplied by health posts in each province is shown in **Figure 13**. The national average is 13.6 CYPs per annum in 1391. This might represent about 10% of the 150 households supposed to be served by a health posts. The variance among provinces is again striking, but resists any easy relation to regions of the country or the levels of insecurity. These differences may be better explained by the levels of support and training that birth spacing has received in the province.

Figure 13: Average CYPs per health post by province, 1391.



iii. Health outcomes and impacts to which CBHC has contributed.

Recent household surveys, including the 2010 Afghan Mortality Study and the 2010/11 MICS study, have shown considerable progress in a variety of health indicators. Over the last ten years improvements include an increased use of ANC from 8% to 68%, and of Skilled Birth Attendance from 14% to 34%. The Contraceptive Prevalence Rate (CPR) has risen from 8.5% to about 21%, and the Total Fertility Rate (TFR) has declined from 6.7 to 5.1. Estimates of the child mortality rate have declined from 257 per 1,000 to 105 per 1,000. The maternal mortality ratio has also declined from about 1600 per 100,000 to about a third of that.

What has been the contribution of CBHC to all those improvements? The connection between rates of community case management of childhood illnesses and the decline in child mortality is easily made. Similarly, the contribution of health post provision of contraceptives to the CPR and TFR is clear. That does not obviously impact the maternal mortality ratio, but it certainly reduces the overall maternal mortality rate. Health promotion by CHWs has almost certainly contributed to improved use of antenatal and delivery care at health facilities. Referrals of sick women and children have certainly increased. The scope for further improvement in use of health facility services is suggested by anecdotal reports from the implementation of FHA Groups.

III. CURRENT SITUATION OF THE COMMUNITY-BASED HEALTH CARE DEPARTMENT OF THE AFGHAN MINISTRY OF PUBLIC HEALTH

As has already been described in the previous section on the history and background regarding CBHC in Afghanistan, there has been a steady progression since 2003 regarding the scope of the program.

The CBHC Department: The CBHC Department of the MoPH was established in 2005. From its inception it has been headed by Dr. Sayed Habib Arwal. There are three MoPH regular staff and 10 consultants (including Dr. Arwal). During the eight years that the department has been operating it has made steady progress.

III.A A Few Highlights Describing the Current CBHC Program and the CBHC Department:

- 27,662 volunteer CHWs (about half women) have been trained, with a very low dropout rate
- CHW training in Afghanistan is longer and more comprehensive than occurs in most other developing countries where volunteer CHWs are being trained
- Numerous innovations regarding training, diagnostic screening, supervision, and reporting have taken place, including pictorial checklists for screening candidates for

DMPA, extensive training materials for non-literate CHWs, full-time CHW Supervisors based in health facilities, and pictorial tally sheets for reporting from communities

- Urban CHWs and Nomad (*kuchi*) CHWs have been trained and deployed, thereby expanding the population covered by CHWs
- The CBHC Task Force has greatly expanded and become more active over the years, so that coordination with other units of the central MoPH have significantly improved
- 26 out of 34 provinces have CBHC officers working in the Provincial Health Office
- The CBHC Department is organized into two sections—one that focuses on Monitoring & Evaluation and one that focuses on Capacity-Building. However, members of each group frequently assist the work of the other group as appropriate and necessary
- The CBHC Department and the CBHC program are increasingly seen as models in other countries; CBHC staff have gone on study tours (to Indonesia and Bangladesh, for example) and have participated in international conferences where the “Afghan model” has been seen as something to be emulated by other developing nations
- New donors have become interested in supporting CBHC in new initiatives. These include UNICEF, which has promised 500 Zareng ambulances for CHWs for emergency cases such as complicated deliveries, as well as 5,000 mobile phones to CHWs in five provinces with high maternal mortality
- Technical units of the Afghan MoPH have become increasingly aware of the importance of CHWs to the success of their own programs, including EPI and National Immunization Days, TB Control and Community DOTS, as well as Reproductive Health (family planning and safe deliveries)
- With the worldwide upsurge in interest in and support for CBHC, senior management in the MoPH have taken notice and are seeing CBHC in a new light, given the importance of CBHC to Afghanistan’s major health donors
- The concept of the “Family Health Worker” which involves teaching students the basic CHW curriculum (without providing them with medicines) throughout primary school and high school, could greatly expand practical knowledge and skills relevant to healthy behaviors among millions of schoolchildren

Current Concerns of the CBHC Department:

- Major concerns of the CBHC Department are the financial and operational consequences of the unit going “on-budget.” This proposes that the 10 staff who currently work as consultants (salary and operational expenses paid by USAID through MSH’s LMG Project) would become direct MoPH staff paid by the Afghan government with funds provided to the government by USAID. Their operational budget would need to come from the MoPH budget. The concern is that their salary and operational expenses would suffer the significant delays (3-6 months) typical of the rest of the MoPH
- Another concern of the CBHC Department is the possibility that the MoPH might want to transfer some of the consultants to another MoPH department, with fewer consultants

Given the size and complexity of the CBHC program in the country and the ongoing need for active coordination with other HQ and provincial departments, the unit feels that the entire complement of 10 consultants is needed by the CBHC Department

- The CBHC unit is well aware of the fact that it does not directly manage CBHC in the country—the direct line authority comes from the GCMU and the NGOs actually implementing the BPHS, including the work of the CHWs and CHSs; as a result, the unit has concerns regarding how CBHC will be managed in the future (with a new President there could be a new Minister of Health, which could mean changes in priorities), how the GCMU will respond to the new *Sehat* Project, etc. An uncertain future is always a source of concern
- Currently, the CBHC Department is a Sub-Directorate of the Directorate of Community Health Promotion (the other three Sub-Directorates are for Dental Health, Eye Care, and Disabilities), but the unit would like to become a Directorate on its own so it can be more effective and influential in its coordinating role within the MoPH
- Another issue of concern to the CBHC Department has to do with the salary and operational expenses of the 26 provincial CBHC officers who work in Provincial Health Offices. Currently, they are paid with money from the Global Fund but those funds are managed by the Afghan government, which must follow its own rules and regulations. Payments have been delayed for many months, making it difficult for CBHC officers to stay on the job. These payment delays appear to have made it very difficult to recruit the eight additional CBHC officers for the remaining provinces

III.B The CBHC Situation in the Provinces

CBHC is being actively implemented in all 34 provinces. Twenty-six provinces have CBHC officers assigned to the Provincial Health Office. In terms of coverage for CBHC, the Afghan population can be divided into the following basic categories:

- 1) The rural population of those provinces with NGOs contracted to implement the Basic Package of Health Services (including CBHC) funded by the World Bank
- 2) The rural population of those provinces with NGOs contracted to implement the Basic Package of Health Services (including CBHC) funded by the European Union
- 3) The rural population of those provinces with NGOs contracted to implement the Basic Package of Health Services (including CBHC) funded by USAID
- 4) The rural population of those provinces where the Basic Package of Health Services is managed by the Afghan government, funded by the World Bank
- 5) The urban population, including the urban poor, with partial coverage by NGOs implementing the BPHS (including CBHC) funded by various donors
- 6) The nomad population, with partial coverage by NGOs implementing the BPHS (including components of CBHC)

- 7) Those Afghans living in areas where NGOs provide services (not the complete BPHS or the complete CBHC component of the BPHS)
- 8) Those Afghans living in so-called “white areas” where the BPHS is not being provided

Most provinces have people from five of the above categories (one of the first four categories and then categories five through eight). The strategies needed to reach the population represented by each of the categories are quite varied, and differ from province to province. It is the responsibility of the CBHC unit, as it carries out its stewardship role, to do everything it can to make sure that CBHC is available to as much of the population as possible, and that the services provided are of high quality.

To achieve high levels of coverage of CBHC and to ensure that the quality of services is high, requires close cooperation from at least seven groups of major players. These include:

- The **CBHC department** of the MoPH in Kabul is responsible for coordinating the MoPH’s stewardship role regarding CBHC
- The **Grants and Contracts Management Unit (GCMU)** of the central MoPH is responsible for overseeing the grants and contracts given to NGOs to implement the BPHS and the EPHS
- The **technical departments of the MoPH**, especially the Child and Adolescent Health Directorate, the Reproductive Health Directorate, the disease control units (for controlling TB, malaria, and immunizable diseases) and other departments such as those responsible for nomad health, HMIS, Quality Improvement, HR, etc.
- The **Provincial Health Offices**, including the CBHC officer and other technical officers
- The **implementing NGOs** working in the provinces
- The **health facilities**, including BHCs, CBHCs, and district hospitals
- The **communities**, including the CHWs the health facility *shura*, and the Health Post *shura*

Please see Annex E for concise reports of our three provincial visits (to Nangarhar, Balkh, and Herat provinces). As can be seen from these reports, the situation regarding CBHC varies from province to province, but a few key observations can be made from the visits to Nangarhar, Balkh, and Herat Provinces regarding CBHC in those provinces (November 2013):

- The NGOs responsible for implementing the BPHS in the three provinces have done an overall good job of providing CBHC, in partnership with the PHO, the GCMU, the CBHC department of the MoPH, and the communities they serve
- The workload of CHWs remains an ongoing concern. In some of the more densely populated areas (in Nangarhar, for example), CHWs may be caring for up to 300 households. The original 100-150 households guideline remains the optimum number. Given the growth in community populations over the past ten years, each province should

make a review of health post workloads to assess the need for additional health posts or additional CHWs at health posts.

- Some CHWs complain that they run out of essential medicines and that busier health posts don't necessarily receive more medicines than health posts that are less busy. Several CHWs agreed that people in the communities are becoming more demanding about receiving medicines. The NGOs in the EU and World Bank-supported provinces purchase their own medicines for health facilities and health posts while in the USAID-supported provinces the medicines are procured through international vendors and provided in fixed amounts to implementing NGOs. A recent revision of the CHW kit policy increases the amounts of medicines supplied to CHWs, based on the needs indicated by their HMIS monthly reports.
- Provinces vary in the extent to which they are scaling-up the Family Health Action Group program. This program is critical for large-scale behavior change at household level for such important things as early and exclusive breastfeeding, handwashing with soap, infant immunization, appropriate weaning, family planning, etc. Although the rate of scale up varies, all the provinces visited are actively engaged in increasing the number of FHA Groups.
- In-service training of CHWs in essential life-saving skills is still an unrealized priority. Hirat is one of six provinces that has not been covered by the Community IMCI training program for CHWs. (We discovered no active efforts to find the money for this by GCMU, the Child and Adolescent Health Department nor the CBHC Department.) In Balkh province, casual conversations with CHWs revealed serious deficiencies or errors in case management of sick children.
- The supervision overload of CHSs has remained largely unaddressed since the studies and CBHC Consensus Workshop of five years ago. In each province there were CHSs who were attempting to support many more than 20 health posts. We learnt that the GCMU had made a very few exceptions to the one male CHS per facility guideline on account of the number of health posts. If health post supervision, especially for remote communities, is to be at all effective, there needs to be a general review of this policy at GCMU level and with each of the major donors.
- Supervision of female CHWs remains a major challenge. Fewer than 10% of CHSs are female, and new ideas are needed if female CHWs are to receive effective and timely supervision. It is noted in several places that where the male and female CHWs are related, supervision of them both by a male CHS is generally successful. However, it was noted that it is those reproductive health issues that are the special concern of the female CHW that cannot be discussed with a male CHS. It was particularly pleasing, therefore, to note the very successful initiative of the Provincial Reproductive Health Officer in Jalalabad. She has started a program of weekly or twice weekly visits by the facility Community Midwives to health posts. During these visits she is able to do antenatal and postnatal examinations and family planning consultations in collaboration with the

female CHW. This initiative has been very warmly received by all concerned. It is obviously limited by the distances that the CMWs can travel, but may prove to be the most effective model for combining supportive supervision to female CHWs with a coordinated approach to delivering reproductive health services between health facilities and health posts.

- The PHOs, in general, do not work as closely with the implementing NGOs regarding CBHC as they should. They meet during the monthly Provincial Health Coordinating Committee (PPHC) meetings but usually do not have regular meetings in addition
- Although the CBHC department of the MoPH makes regular monitoring visits to the provinces, they are not able to have enough such visits in all 34 provinces to have significant national impact on access and quality of CBHC services
- In the three provinces we visited, one had a very effective Provincial CBHC Officer, and a second had a CBHC Officer, who was less effective. Neither of these officers had received any salary for several months. In the third province, three attempts to recruit a CBHC Officer had produced no applicants. It was believed that the reason was the unreliability of the salary payments.
- In only one of the provincial health offices did there seem to be more than a superficial noting of the quarterly results of the ten key health indicators. Even then there seemed to be little attempt to analyze down to a district or facility level or to use the data to actively manage activities to overcome blockages or use opportunities for improvement.

IIIC. Findings from the central MoPH technical departments relevant to the CBHC Department:

Our discussions with the Child & Adolescent Health Department, the Reproductive Health Department, and the HMIS Department resulted in the following points:

- All three departments that we interviewed felt that the CBHC Department was doing a good job of coordinating with technical units of the MoPH
- The HMIS Department thought that the CBHC Department was more interested in using data than most other departments in the central MoPH. However, the data produced by HMIS were mostly used by the CBHC Department for reporting achievements rather than for the purpose of determining how CBHC could be better managed and have greater impact in the field
- Both the CAH and RH departments claimed that the CBHC Department coordinated well with them. Likewise the CBHC Department claimed good coordination with the CAH and RH departments. However, when trying to identify the products of coordination, they all seemed to be in the favor of the CBHC Department and in fulfillment of its agenda. The most recent example of this has been the revision of the CHW training manual, which has incorporated the improved training curricula developed for CHWs through

donor-supported projects like the Postpartum Family Planning scale-up and the Community IMCI training that were implemented with RH and CAH oversight.

- The Reproductive Health Department is clearly concerned about the contraceptive counseling skills of CHWs, but we were unable to identify any joint activities that had attempted to address that issue. The scaling up of the use of Misoprostol for prevention of postpartum hemorrhage at home deliveries is a major program initiative for the RH Department. The Misoprostol will be distributed by the CHWs. We detected no obvious enthusiasm or involvement by the CBHC department for this program which will need careful implementation but has great potential for saving women's lives.
- The Child & Adolescent Health Department, with support from the Global Fund and the BASICS Project invested a huge effort in the design and scale-up of the national Community IMCI program. The CBHC Department did not participate in that program and has not appeared concerned about the remaining six provinces that have not received the training. Likewise, the CBHC Department did not participate in the BASICS-supported development of community growth monitoring and essential newborn care.

IV. MAIN FINDINGS AND ISSUES

IV.A. On the appropriateness of selected CBHC interventions

- The BPHS and its CBHC component were designed to serve the most vulnerable groups, women and children, and address the most important causes of morbidity and mortality for those groups with interventions that had been shown to be the most effective. The interventions selected for CBHC were those that were most urgently needed by people and which were appropriate to the level of skills and resources available at community level.
- The key innovation in this CBHC was the inclusion of women as CHWs. This recognizes the special limitations on the movement of women from their homes for cultural and security reasons.
- The later inclusion of Family Health Action Groups as a means of behavior change recognizes the importance of behavior change for health and the need for doing so by changing social norms and not just by individual counselling.

IV.B. On the role of CBHC in the improvement of community access to quality health care

- The latest compilation of figures from the BPHS NGOs (February, 2014) suggest that in the ten years since starting the CBHC program 27,662 CHWs have been trained for 15,337 health posts. About half of the CHWs are women. There appears to have been a very low attrition rate in spite of the volunteer status of the CHWs.
- There is significant disagreement between the numbers of CHWs reported by NGOs, the numbers who have been actually registered, and the numbers submitting monthly reports.
- The current numbers of CHWs are thought to be approaching the numbers estimated to cover the rural population in a ratio of one health post to 100-150 households. Until the

current process of identifying the actual locations of all health posts and matching them with local population sizes from the CAAC, it will not be possible to identify the remaining unserved populations, mostly in remote areas. However, according to HMIS data supplied, there is considerable variation in the ratios of health posts to population between the provinces. In particular, there are several provinces with very low ratios suggesting that many more health posts are required. In addition, there are underserved populations, where the health posts now serve many more households than the 150 recommended. These are frequently in more densely populated areas closer to health facilities, so the exact needs for additional CHWs should be examined.

- HMIS data from the public sector show that numbers of sick people treated by the health services has continued to grow, and the contribution of the health posts has grown with that. Currently about a third of sick children are treated at health posts and two thirds at health facilities. This is a slight decline in the health posts contribution since five years ago, even though the actual numbers of children treated have continued to grow. However, the mean values hide a considerable variation by province in the number of cases treated per health post. Low rates are about a third of the higher rates. The reasons should be investigated.
- The presence of female CHWs in communities has been particularly important for access to modern contraceptives. Comparing health posts and public health facilities, 55% of the couple years of protection (CYPs) from short-term contraceptives are supplied by CHWs. Because health facilities provide long-term methods, this means that CHWs supply 40% of the total couple years of protection from all methods (long-term and short-term) of contraception. Overall CYPs supplied at health posts have remained static over the past 4-5 years. As with other programs, inter-provincial performance varies greatly, in this case by a factor of 7-8 times between the lowest and highest performers.
- Utilization rates for immunizations, antenatal care and skilled birth attendance have all improved. These are services that are supplied by health facility staff. While the increase in the number of female health workers at facilities has played an important part, the health promotion efforts of CHWs and FHA Groups have made an important contribution. The full extent of that contribution has probably not been realized, but could be so with greater integration of efforts.
- Concerns about the quality of care provided by any health workers are always present, and they are justified in the case of CHWs. The low levels of education of most of the CHWs has been addressed consistently through the provision of appropriate teaching methods and pictorial job aids. Nevertheless, deficiencies and errors in the procedures of care that have been regularly observed suggest deficiencies in training methods, especially for practical clinical skills and inter-personal communication, or a lack of follow-up monitoring and refresher training.
- A second issue related to quality of care is the quality and frequency of supervision. The general pattern of one CHS per health facility has remained since the CHS program was started in 2005. Survey data from 2007 suggested that 15% of all facilities were supervising more than 20 health posts, many of them much more. Requests for additional positions for CHSs seem to have been met with an inconsistent policy by the GCMU and/or donors. Some NGOs have been given additional positions; others have been refused. The situation requires further investigation and a clear policy.

- Supervision of female CHWs remains problematic. However, the finding that the CHWs at a health post are most frequently related, suggests that general supervision of a health post in the community can be achieved by a male CHS. What seems most difficult is the support and supervision of those reproductive health programs that most clearly involve the female CHWs, but which cannot be discussed with a male CHS. The initiative in Nangarhar to have Community Midwives do regular weekly health post visits to work with the female CHWs and her clients needs full evaluation. If feasible, the various stakeholders of the CMW program should be invited to see how best the program can be expanded.

IV.C. On the capability of the CBHC department in terms of effective leadership, sound management, and transparent governance practices required for support of smooth implementation of CBHC interventions in the country.

- The CBHC Department has been very successful in developing and strengthening the structure and basic functioning of the CBHC system. It has been good at strengthening and consolidating the implementation of interventions developed by MoPH technical departments under donor projects, but generally has not participated in the development and piloting of those interventions.
- Probably the greatest achievement of the CBHC Department has been to advocate successfully for CBHC and for CHWs both nationally and internationally. CBHC and its contributions are now well recognized throughout the health system and the MoPH.
- Associated with the advocacy has been the successful maintenance of morale and motivation among CHWs. This has been achieved in spite of the CHWs being volunteers. The establishment of National CHW Day on December 5th, the regular publication of Salamati Magazine for CHWs, and the development of a new newsletter for CHWs have all helped to maintain and promote CHW morale.
- An important part of the CBHC department maintenance of CHW morale has been its attention to preventing significant expansion of the CHW job description and workload. One important addition was doing the community census surveys for the CAAC. This has been very valuable to the health services overall.
- The Department has been very successful in networking. The CBHC Task Force is the biggest and most active task force in the MoPH, with regular attendance of all stakeholders. Department staff have been regular in participation in working groups or task forces organized by other departments or directorates.
- Successful advocacy and networking has led to additional funding from donors. UNICEF is supplying 500 Zarej ambulances for CHWs for emergency cases such as complicated deliveries, as well as 5,000 mobile phones to CHWs in five provinces with high maternal mortality. The Global Fund has provided money for the Provincial CBHC Officers' salaries.

- Policy and planning work has included the development of a CBHC Strategy and Policy document together with supplements covering CBHC in urban areas and for the nomad (Kuchi) population. Urban CHWs and Nomad CHWs have been trained and deployed, thereby expanding the population covered by CHWs.
- The CBHC Department is organized into two sections—one that focuses on Monitoring & Evaluation and one that focuses on Capacity-Building. However, members of each group frequently assist the work of the other group as appropriate and necessary.
- The Monitoring and Evaluation role grew out of the post-training monitoring visits during the implementation of the Postpartum Family Planning scale-up program in 2009-2010. Since then they have developed a more general CBHC monitoring tool for assessing the quality of CBHC programming in the provinces. They have responded to criticisms that this process was too focused on checklists and missed the big picture by modifying the tool and the overall approach. CBHC, in close collaboration of IQHC, also developed Harmonizing Approaches to Improve Quality in Community. However, as far as we could see, the process does not address the issues of low CBHC coverage or utilization in specific provinces.
- The Capacity-building role also grew out of the Postpartum Family Planning scale-up program, for which the consultants were originally hired as master trainers. Using their training and curriculum development skills, they have accomplished an impressive record of curriculum revision and training of trainers for training programs for CHWs, CHSs, FHA Groups, CBHC Officers and shura-e-sehies over the past three-four years.

IV.D. On existing gaps and challenges that the CBHC may face without external support

We have tried to emphasize in this report that the MOPH stewardship of the CBHC component of the BPHS involves a variety of other departments of the MOPH besides the CBHC Department. The donors supporting the health system also have a significant influence on the exercise of that stewardship, depending on which particular activities they support. Actual line management of CBHC is by the GCMU and the BPHS-implementing NGOs on the basis of the contracts agreed and budgeted. The CBHC Department has shown some effectiveness in managing this complex system, but needs to strengthen its approach to the GCMU and Planning Division in order to more effectively influence the management of CBHC in the provinces.

- 1) *Perhaps the first weakness of the CBHC Department may be the consequence of one of its main achievements.* Data have been used primarily to demonstrate the successes of the CBHC Program (These consultants have both done this in the past.) At this stage, however, there is a need for the use of available data for a much more critical look at the CBHC system. Data presented in this report suggest that there is considerable variance in the population coverage of health posts and in the use of services in populations that are covered by health posts. There is no evidence that the CBHC Department has been either

requesting or studying data to try and assess the extent or the causes of these serious inter-provincial variations, either at a central level or as part of provincial monitoring visits. We think that the Department probably requires assistance in learning to ask appropriate questions, working with the HMIS Department to obtain helpful analyses, and then working with GCMU and PHCCs to find ways of improving performance in the provinces.

- 2) *The CBHC Department is first of all dependent on the GCMU for assuring that agreed numbers of CHWs are selected and trained for the appropriate communities, that CHWs get travel expenses and sufficient medical supplies, that CHSs have a means of transport by which they can do their supervisory visits to health posts, and that money allocated for in-service training actually gets used for the training of CHWs. We have noted problems in all of these areas.*
- 3) *Where additional funding may be required, donors as well as the MoPH Planning Division may also be required.*
 - a) We have noted the need for additional CHWs or health posts in situations where current health posts are caring for up to 300 households - an excessive workload for volunteers. Documentation of current CHW workloads and an assessment of the needs for additional CHWs will need to be discussed with the donors for budgeting additional funds for training and supplies.
 - b) We have also noted the continuing lack of sufficient CHSs. Improving that problem by recruitment of additional CHSs for selected health facilities will require an updated survey on CHS workloads, a policy guideline on the maximum number of health posts to be supervised by one CHS, and a donor/GCMU plan for budgeting and recruitment of additional CHSs.
- 4) *Donor support will be required for significant unfinished business.* These funds may be supplied as project funds or in NGO BPHS budgets for specific purposes. It would seem important for all the key stakeholders (E.g. CBHC and CAH) to very clearly work together in advocating for an effective way to obtain and use these funds.
 - a) The Community IMCI training program and job-aids developed and implemented by the CAH Directorate with support from GAVI-HSS and the BASICS Project has still not been implemented in six provinces.
 - b) Family Health Action Groups have been implemented very slowly. Only 1189 out of the current 15,337 health posts have FHA Groups. It is the most effective approach to behavioral change available at present, and should be scaled up on a five year rather than an uncertain ten year plan.
 - c) The community growth monitoring and essential newborn care initiatives developed by the CAH Department and the BASICS Project and implemented in most USAID-

supported districts have received no further support. Given the great reductions in post-neonatal mortality achieved in the past ten years, these two interventions become central to any further significant improvements in child survival. Senior MOPH policy makers should decide the priority and timing of such a scale-up.

- 5) *There needs to be a more intentional and integrated approach to setting and working towards targets for public health programs by the MoPH.* Although a few technical departments, like EPI, do have targets, there do not seem to be focused and collaborative efforts by the technical departments with CBHC, GCMU, NGOs, etc. to energize everyone's efforts into solving problems or capturing opportunities.
 - a) While there have been improvements in the utilization of preventive health services as well as curative services, the rates of improvement are slowing. Future improvements will require focused situation analyses and performance improvement planning at provincial, district and facility level.
 - b) CBHC has developed an impressive coverage of Afghanistan's population with tools like the Community Map and community groups like the Shura and FHA Groups that could greatly enhance the effectiveness of public health programs IF they were specifically used as part of a coordinated effort with health facility staff to achieve greater use of specific services.
 - c) The HMIS Department and other researchers will need to help assess and understand the reasons for the very large variance in service performance of CBHC in different provinces before solutions can be developed for the low-performing provinces and districts.
 - d) There is a need for a formal BPHS performance improvement/management process that will integrate the MOPH technical departments and the PHOs with the GCMU and the implementing NGOs.
- 6) The position of the CBHC Department in the MOPH Organogram limits official and direct access to the leadership of other technical and management departments in the MOPH that are stakeholders in CBHC. We believe that the CBHC Department could be much more effective if it became a full Directorate. This seems appropriate to the scope of CBHC and the number of health workers involved.
- 7) There is concern whether the "on-budget" process will result in a department that lacks the means and motivation to continue being effective. The CBHC Department is currently a highly motivated and very productive team. This has been achieved with a combination of reliable and acceptable (but not high) levels of personal compensation, good leadership, sufficient and reliable funds to meet the needs of routine tasks of provincial monitoring and the equipment and supplies for their capacity-building role.

There have also been additional donor funds for scaling up essential and government-approved CBHC initiatives.

- a) The current status of the Provincial CBHC Officers provides a very acute warning to the CBHC staff. With funds from the Global Fund, the MoPH has employed these officers in 26 out of 34 provinces. Most of them have not received a salary for the past seven months. Other provinces cannot recruit CBHC officers because of this situation.
- b) The CBHC Department believes that it needs to keep the full complement of staff in order to maintain its output of effective work.
- c) At present the CBHC Department does not have a MoPH operating budget. The “on-budget” process should involve a negotiation for an operating budget for the CBHC Department

V. RECOMMENDATIONS

2. Introduction:

As already noted, over the past ten years, the CBHC department with USAID support through REACH, Tech Serve, HSSP, LMG and other projects has done a very impressive job of advocacy for CBHC and of developing and expanding the basic building blocks and processes of the CBHC system within the BPHS. The capacity of the departmental team has grown with the job and, in the current work plan, they are completing the consolidation of the work of the past several years.

A successful future role for the Department must look different. Rather than just supporting general expansion of the program, there will be greater need for attention to the varying rates of coverage and utilization of CBHC services in the provinces and districts. There will need to be greater attention to the performance and productivity of health posts and FHA Groups. And they will need to be able to build the capacity of NGO and PHO staff to do the same in their provinces. We believe that this new approach will require a change in thinking as well as some additional skills in the Department.

In the final year work plan for the LMG CBHC Program, the major time-consuming activities will be building on the accomplishments of the past two years (the review and revision of training courses and materials for all major CBHC players) through the training of NGO staff to implement the new curricula. These include CHWs, CHSs, Shura and the expansion of FHA groups. In view of the possible closing of the LMG Project later this year, as well as the anticipation of changes with SEHAT and the absorption of a reduced number of consultants into the MOPH “on budget”, these NGO capacity-building activities should be considered priorities.

Because most of our recommendations are actually variations or elaborations of items in the work plan, they will be presented as such. Other recommendations for the LMG project will be presented separately after that.

3. CBHC Workplan-related recommendations.

a. Objective 1: Expand Community-Based Health Services

i. 1.1. Scale-up FHA Groups

A sub-activity for this year should be the preparation of a plan and budget with GCMU for national expansion of FHA groups in a period of time that reflects their importance for health promotion and behavioral change. At present, less than 10% of health posts have FHA Groups. Expansion at the rate proposed in the work plan would take much too long.

The plan would identify those NGOs/provinces that already have the capacity to implement complete and effective FHA groups, and how much capacity-building in other provinces would be required. It should also estimate a feasible rate of annual scale-up in each province and then draw up a plan for complete expansion.

(This activity also relates to activity 3.4: Capacity-building of the CBHC Department staff in strategic and operational planning.)

ii. 1.2. Increase number of new CHWs

The CBHC department should work very actively with the HMIS department to assess the true needs for future new CHWs. Data presented in this report suggest that estimating the numbers of additional CHWs simply on the basis of so-called “white areas” seems inadequate. Provincial health post to population ratios are very varied, numbers of “active” CHWs are still not clear, numbers of ageing CHWs that will need replacing are unknown, and a significant number of health posts are serving much more than 150 households.

Completion of the MOPH HIS CHW database and renewed surveys on the number of households served by health posts are needed, as well as assistance given to the HMIS Department in completing the GPS survey of all health posts. Consideration of these data will help to make a much more accurate and sober assessment of future CHW requirements.

b. Objective 2: Improve the quality of CBHC services

i. 2.4. Training of CHSs

An additional activity should be advocating for and developing a new policy for the numbers of CHSs at a health facility.

In 2007 about 15% of facilities were supervising more than 20 health posts; many were trying to support far more than 20. This situation appears not to have improved, and the response from GCMU and the donors to requests for more CHSs has been very inconsistent.

CBHC should work together with GCMU and the NGOs to document the numbers of health posts being supervised by health facilities and reach a consensus on the number of health posts that can be effectively supported by one CHS. Working with the Policy and Planning unit of the MoPH, CBHC should advocate for a consistent and feasible policy that can be supported by the donors.

ii. 2.6. Training of CHW trainers in the new CHW curriculum

A supplementary activity should be the planning and implementation of the completion of CHW training in C-IMCI.

The CAH Directorate claims that C-IMCI has not yet been implemented in six provinces because of lack of funding. This problem can be overcome as a result of the training of trainers in the new CHW curriculum, since that contains the C-IMCI training curriculum. In anticipation of the completion of the ToTs in these provinces, CBHC and the NGOs should negotiate with GCMU for identification of sufficient additional funding for in-service training to cover the costs of completing the scale-up of this essential program. If necessary, the NGO trainers can be given the C-IMCI in-service training guidelines for the two 3-4 day courses to use with the existing CHWs in these provinces who have not been given that training.

iii. 2.5. Production of CHW training manual and job aids.

Production of essential CHW job-aids should be guaranteed as well as copies of the manuals.

CHW trainers are supposed to have sufficient quantities of CHW job-aids and IEC materials for all trainee CHWs at the time of their training. This is especially important for essential job-aids like the C-IMCI pictorial charts. This will be a significant requirement in those provinces catching up on C-IMCI training.

iv. 2.8. Monitoring visits to provinces.

1. Monitoring visits should emphasize the ‘big picture’ and strategic issues.

In addition to use of the new monitoring tool designed to facilitate strategic review, the monitors should have documents which show a review of the coverage of CBHC services and the utilization of

those services in the province, together with charts to show comparative performance with other provinces. These should be used to guide additional questions with CHWs, Shura, facility staff and provincial managers.

2. The monitoring tool and guidelines should also make full use of the set of community-based health standards based on the Harmonized QI approach

v. 2.10. Gender equity

To improve the support of female CHWs, an evaluation should be made of Nangarhar's initiative to have Community Midwives visit and hold mini-clinics at health posts together with the female CHWs. On the basis of this and any other similar efforts, a collaborative effort can be made with all stakeholders to develop guidelines for the different ways in which CMWs can work with female CHWs, particularly in support of reproductive health programs that need to integrate services at both facilities and health posts. For communities that are smaller or more distant, Herat's use of the cluster approach for CHW supervision by CHSs might be considered. Implications for the job description and training of CMWs should be examined.

c. ***Objective 3: Ensure sustainability of the CBHC system***

i. Maintain departmental technical staff for "on budget".

Arguments for maintaining the current capacity of the CBHC Department should be made in terms of future, anticipated skills required for in-depth analyses and planning for improvements in coverage and performance of CBHC services as part of an integrated BPHS system.

The probability that the total number of consultants will be reduced from 800 to about 450 means that a well-staffed unit like CBHC will need to make a very strong case for maintaining its level of capacity. A "business-as-usual" argument will not suffice.

ii. 3.2. Promotion of CBHC department to Directorate

As for 3.1, the argument will need to present a future role of the CBHC unit that will require organizational partnering with other key technical units with which there will need to be regular collaboration for mutual benefits of programs.

Claiming the size and complexity of the CBHC program in Afghanistan or its contribution to date will not be sufficient.

iii. 3.4. Build capacity in strategic and operational planning

Each of the additional activities recommended above should be examined to identify any need for a specified capacity-building component for the CBHC staff.

Many of the above additional activities are going to require skills in data analysis, evaluation, political negotiation and scale-up planning in which most of the CBHC staff have not yet participated. The Performance Improvement Program outlined in 3 (below) will require many of the same skills.

iv. 3.5. Provincial CBHC Officers to the MOPH *tashkeel*

This is not a new recommendation, but an endorsement of this work plan activity. After seeing the potential of an effective provincial CBHC officer, we think it a very important role.

4. LMG Project Recommendations.

The two concept notes (Annexes B and C) requested by the LMG management in Kabul and the MSH head office have outlined the development and institutionalization of a BPHS Performance Improvement Program and process within the MOPH. This essentially addresses the stagnation of much health program performance in the BPHS and the lack of the necessary integration and collaboration of technical and management effort required to bring about improvements.

This recommendation is to the whole LMG Project, and not just to the CBHC Program. While the recommendation arose out of an assessment of the MOPH stewardship of the CBHC Program, and of the performance of the CBHC Department in particular, the problem is not primarily that of CBHC or the CBHC department. This is an issue for the stewardship of the whole BPHS program. The management of the BPHS is with the GCMU, and there is no clear, regular way in which the MOPH technical units or the PHOs can participate. The second concept note, “BPHS Performance Improvement through Active Management by Objectives” outlines the problem and the way in which effective management by objectives can be introduced and institutionalized.

ANNEX A



Scope of Work

Community Based Health Care (CBHC) Department/Program Evaluation in Afghanistan

September 22, 2013

Duration: Estimated Date of Report Delivery: December 30, 2013

Estimated Dates of Field Work: 3 weeks (Nov 02-20, 2013)

Activity manager: Dr. Hedayatullah Mushfiq

Consultant Team: two consultants from within or outside of MSH

Background

MSH, as a strong technical partner of MoPH, has provided technical support to build the Ministry of Public Health (MoPH) management, leadership, and public health technical capacity to improve the health of the people of Afghanistan through a high-quality, accessible, sustainable, and equitable health system. As part of the overall support to health system strengthening, MSH built the CBHC department capacity, and strengthened the CBHC system to assist communities in promoting healthy lifestyles and behaviors through establishment of a strong technical team comprised of 11 consultants in July, 2008. MSH has supported the CBHC team to produce all the critical policy, legislative and strategic documents needed to firmly establish health care at the community part of the continuum of care. At this point all the critical documents exist and have been disseminated.

The present CBHC consultants have developed adequate skills to support and maintain high quality community-based health care at the community level with very little assistance from outside advisors. However, MSH assists the MoPH in making the necessary arrangements for

managing the migration of those consultants to formally become part of the MoPH to ensure sustainability of the CBHC program.

To make sure that the CBHC department is able to manage the program effectively, and identify the level of CBHC program contribution in the improvement of health status and decreasing mortality and morbidity among the people of Afghanistan, it is intended to conduct an informative evaluation of the CBHC program implemented since 2002. Information gained from the evaluation will be used to guide any remedial activities that may be required to improve the program and lessons learned will be used to improve on support of other programs at central and provincial MoPH.

Purposes

To assess whether CBHC department of MoPH is fully capable of playing its stewardship role and implement its strategy and policy independently with no or very limited external support, and to identify and disseminate lessons learned.

Specific objectives

- Assess capability of the CBHC department in terms of effective leadership, sound management and transparent governance practices required for support of smooth implementation of CBHC interventions at the country
- Examine appropriateness of the selected CBHC intervention in light of the socio-cultural norms and health needs of the country
- Assess role of CBHC in the improvement of community access to quality health services
- Identify existing gaps and challenges that the CBHC may face without external support

Scope of Work and Methodology

To have a comprehensive evaluation, considering security, ethnicity, geographical, literacy level, cultural, economic, challenges, donors support, cooperation of implementing partners, the following provinces are recommended to be evaluated:

1. Kabul
2. Bamyan
3. Nangarhar
4. Hirat, and
5. Balkh

The evaluation methodology will focus on participatory approaches with qualitative and quantitative methodologies that will be undertaken to answer required evaluation questions and provide a very basic plan for collecting and analyzing data. Evaluators will be conducting SWOT analysis sessions, review of the documents, and key informant interviews with relevant people

and stakeholders to review overall achievements, strengths, weaknesses, opportunities and threats to CBHC program at national level through:

- Key Informant Interviews with key project managers, and key stakeholders including policy and strategy implementers at the provincial level including CBHC Officers and Implementing NGOs representatives
- FGDs with CBHC stakeholders, CHSs, CHWs, Health shura members, community development shruras, religious leaders, FHA groups, health services providers and patient care takers, particularly mothers of under 5 children

Possible Activities for Addressing the SoW (in approximate chronological order)

	Activity	Responsible
1	prepare, in coordination with LMG Afghanistan project management team, a detailed workplan and itinerary	Assessment Team and LMG Management Team
2	Identify resources and logistical requirements , essential to implementation of the evaluation. This will include, but not limited to, schedule for each event, duration, number of participants, time allocation for processing and reflecting on data collected at reasonable intervals, travel times and transport plans and necessary services: translators, interpreters, drivers, data processors, facilitators, access to desk space and computers, printers etc.	LMG Management Team and Assessment Team
3	Develop consensus with key stakeholders , including MoPH, USAID, and implementing partners, on priority data generation, management, communication needs and further details of the assessments as required.	LMG Management Team and Assessment Team
4	Review documents, and conduct interview with key project informants and stakeholders as described above	Assessment Team
5	Conduct site visits to the health facilities and posts in target provinces to independently observe the status of project implementation, undertake the interviews and discussions outlined above	Assessment Team
6	Record, compile and analyze all data extracted from reports/documentation and all data collected through interviews and observations into a report format that meets the assessment requirements.	Assessment Team

	Activity	Responsible
7	Provide a preliminary overview presentation of the assessment findings to the LMG Afghanistan project management team. This will allow the evaluator to obtain initial feedback, ask any further questions and incorporate these into the first draft of the evaluation report.	Assessment Team
8	Prepare and present a report with the results of this analysis in a manner that can be easily considered and discussed by senior management in MSH, Ministry of Public Health and other stakeholders that would be involved CBHC. Include cost and human resource requirements of the options to the extent possible.	Assessment Team
9	Submit a preliminary evaluation report to LMG Afghanistan and home office within two weeks from the completion of the three-week evaluation period for review and comment. Feedback will be provided within one week and the evaluator will have an additional one week to make necessary revisions.	Assessment Team
10	Submit a final evaluation report between 20 and 25 pages of narrative plus appendices. Appendices must include data collection tools, additional tables, analyses and photos as appropriate	Assessment Team
11	Provide overall recommendations for CBHC system improvement as well as interventions and approaches which would be the most beneficial to address existing needs, gaps, and challenges, given the current state of health system development and capacity in Afghanistan.	Assessment team
12	Include next steps for the MOPH that would be necessary to take the ideas developed in Activity #11 to the next level.	Assessment Team
13	Translation of the report into Dari and Pashtu and share it with MoPH, USAID and other key stakeholders as appropriate.	LMG

Team Members

The Assessment Team will consist of 2-3 people, including the Team Leader and 1-2 consultants or MSH staff with different areas of expertise. Types of experience and expertise being sought through the involvement of this team of consultants include:

- Experience with community-based health care implementation in developing and transition country situations, including Afghanistan.
- Extensive experience with health programs in Afghanistan
- Excellent facilitation and team building skills
- Strong monitoring and evaluation background and previous experience successfully conducting similar evaluations
- Excellent writing skills
- Full time availability for this assignment
- Experience in health data recording, reporting and transmittal in developing countries
Systems and procedures for reporting health events and support requirements from communities to the appropriate level of the health service system.

Team Members

Team Leader: Dr. Steve Solter, Public Health Expert

Additional MSH Staff: TBD, HMIS Expert

Consultants: TBD, CBHC Expert

LMG Kabul Team

Dr Saleh, Dr. Mushfiq

LMG Cambridge Team

Calves, Stephanie

Deliverables

1. A comprehensive assessment report as defined in activity 10 above which includes annexes containing the outcome of the meetings, interviews, analyses and studies carried out. Attention will be paid to the following before submission and dissemination of the final report:
 - Preliminary overview presentation of the assessment findings to the LMG Afghanistan project management team
 - A preliminary evaluation report to LMG for review and feedback

- CBHC Governance and Management guidance in terms of recommendations on the policy, strategy, and management requirements for effective implementation of CBHC programs and further improvement of the CBHC system.
- 2. List of stakeholders consulted, including contact information and brief explanation of relevance
- 3. Trip report of the Team Leader

Duration and Approximate Time Period of the study

Two months commencing in November 2013, and completion of the assignment and report by December 30, 2013, including all activities cited above. A trip to Afghanistan will be planned for 3 weeks during this time period. Exact dates of the trip will be determined once the team has been formed in consultation with LMG, MoPH and USAID.

Level of Effort (LOE)

The Team Leader will dedicate approximately 40 days of LOE to the assessment. Another consultant (Assessment Team Member) will require 30 days of LOE, including travel days and weekends. The HMIS expert and additional MSH staff in both Kabul and Cambridge will be involved as necessary.

Technical Supervision

The technical content of this activity will be supervised by Dr. Hedayatullah Mushfiq as the Team Leader, in the LMG project in Kabul.

Charge Code

All expenses for this consultancy will be charged to A193/AFSU////.

ANNEX B

NEXT STAGES IN DEVELOPMENT OF CBHC DEPARTMENT CAPACITY

A Concept Note from the USAID LMG Project.

Community-Based Health Care: Phase 1 - the first ten years.

Development stage:

Implementation of the CBHC component of the BPHS commenced in 2004. Between 2007 and 2011 there were several important improvements to the program. These were developed under Tech Serve, HSSP, BASICS, the Quality Improvement Project and TB-Care. These include the Postpartum Family Planning program, improvement of the Community Mapping tool, Community IMCI, Community Newborn Care, Community Growth Monitoring and IYCN, the Family Health Action (FHA) Groups, Community TB-DOTS, and CBHC quality standards.

The CBHC Department was formed in 2004. It was expanded in 2009 with the addition of USAID-supported consultants to be master trainers for the national scale-up of the Postpartum Family Planning program. Since then, they have been involved in several of the other developments as trainers and monitors.

Consolidation stage:

During the last two years, The CBHC team has consolidated the gains of the previous years by revising national guidelines and training curricula for the Community Health Workers, the Community Health Supervisors, the community Health Shura and the Family Health Action Groups. The key activities of the final year of the LMG CBHC work-plan are the capacity building of provincial staff and the implementation of these new guidelines and training curricula.

Next steps: Phase 2 – Meeting the challenges of integration within the health system, and advancing health goals.

The CBHC Department and its program have reached levels of maturity that perhaps exceed that of most other departments. The CBHC team has demonstrated a competent capacity to promote and oversee the basic structure and functions of the CBHC components of the Afghan health system. It has been able to collaborate with other technical departments of the MOPH to accomplish this. What it has not yet done is to demonstrate a capacity to collaborate with these departments in the pursuit of their health goals to improve the quality, coverage and utilization of BPHS services.

Our observations during this assessment suggest that there is now a general lack of a ‘management for results’ mindset at both central MOPH and provincial levels. General levels of utilization of MCH services are still very poor. Even in those provinces where the ten key indicators are monitored regularly, there is a lack of in-depth application of challenge-identification and problem-solving in order to ensure improvement in the indicators because of a

lack of accountable targets. It is also possible that a diffuse attention to all indicators prevents an effective in-depth concentration on any particular priority indicator.

The CBHC department cannot by itself improve the integration of CBHC into the health system in order to improve the coverage and utilization of BPHS health services. This can only be achieved by a coordinated program involving all the stakeholders of the BPHS, pursuing common goals and targets, and led by the MOPH.

Proposal: BPHS performance improvement through management by objectives.

In the second half of the REACH Project, the provincial and NGO strengthening activity supported a successful management for results approach by using a scorecard of six key indicators to monitor health program performance, but selected only two programs, EPI and family planning, for a focused performance improvement process (PIP) supported by both REACH contract officers and technical staff.

Recommendation One is the introduction of this approach, which would include:

- Target setting in key BPHS programs for provinces and districts,
- Monitoring performance with a scorecard,
- Focusing on no more than two (new) indicators for a concentrated PIP,
- Use the process of regional Learning Collaboratives for mutual learning among provinces,
- Motivate through a combination of friendly competition and appropriate recognition of achievements.

Recommendation Two is the institutionalization of this process for the BPHS management in the MOPH. The goal of this is to create a mechanism whereby all parts of the MOPH with stewardship responsibilities for the BPHS can participate:

- Creation of a BPHS Performance Technical/Oversight Committee in parallel with the GCMU that reports to Policy and Planning.
 - It would consist of the technical departments in the MOPH that are stakeholders in the BPHS.
 - It would be advisory, and its recommendations on targets and the PIPs would be implemented through the GCMU.
- The PHCC would be the responsible body at the provincial level.

Full details of this proposal are found in a second concept note: “BPHS Performance Improvement through Active Management by Objectives.”

CBHC Competencies required for the performance improvement process.

The CBHC Department has a proven record of supporting the expansion and strengthening of the components of the CBHC system. What they have not demonstrated, but will require for the BPHS performance improvement process are the skills to assess performance and develop improvement strategies for:

1. Population coverage of CBHC services,

2. Utilization of CBHC services in covered populations,
3. CBHC promotion of preventive health services offered by health facilities,
4. Promotion of healthy behaviors in homes and the community.

They will need data analysis assistance from the HMIS Department for these tasks.

ANNEX C

BPHS Performance Improvement through Active Management by Objectives:

A concept paper.

Background

Over the course of the past ten years the capacity of the rural health system in Afghanistan has improved considerably. This has been designed to implement the Basic Package of Health Services (BPHS).

- A network of hospitals and health centres provides access to comprehensive primary health care and basic secondary care to the rural population. About 60% of health facilities now have a female health worker.
- More than 14, 500 health posts with 28,000 male and female Community Health Workers provide community case management of childhood illnesses, access to short-term contraceptive methods, health promotion and referrals to health facilities. Facility and community Shura-e-sehie and women’s Family Health Action Groups facilitate health promotion and behavioral change.

The problem

The growing health infrastructure has been effective in providing care for steadily increasing numbers of clients and patients at both facility and community levels. Utilization rates of preventive health services have also increased, but are still at disappointing levels. Much of these weak performances can be explained by the ongoing geographic, climatic, cultural and security constraints, but cannot be accepted as excuses for a management system that in general consistently fails to address them. Currently, there is no system-wide management approach that actively seeks to improve measurable performance in health outcomes.

Figure 1: Governance system of BPHS by the MOPH.



The BPHS has many stakeholders but a management system that restricts participation by many of them. (See figure 1.) Direct management of the NGOs that are delivering the BPHS in the provinces is by the GCMU by means of contracts with the NGOs and regular monitoring of performance under those contracts. In the original discussions of the “contracting-out” mechanism for the BPHS, there was consideration about the contracts being performance-based, with bonuses being provided for achieving agreed health outcome performance targets. In the end, this approach failed to gain consensus and the

NGOs are now paid for satisfactorily reaching targets of process outputs that are specified in the contracts.

The stakeholders with greatest concern for improving health outcomes and impacts are the technical units in the MOPH, like Child and Adolescent Health, the Expanded Program on Immunization, the National TB Program, and Reproductive Health. However, unless they are participating in a donor-funded program designed to improve performance in a particular area, they have no direct power or influence except through the GCMU. Likewise, those units in the MOPH that are concerned with health facilities and human resources like Hospitals and the Community-Based Health Care Departments have their own concerns for health care coverage and quality of care but have no direct management control. The third group of stakeholders that has very limited influence on health system performance is the provincial health offices. Their lack of resources and managerial authority means that their effectiveness is determined only by leadership skills and the mobilization of local political and financial resources.

In order to introduce a mechanism whereby the management of the BPHS can become more oriented to health outcomes and impacts, there need to be changes in the management structure and/or processes.

Suggested approaches

The following are not well thought-out proposals, but suggestions that should be better developed by those most familiar with the issues.

1. Management by objectives

a. Setting targets for provincial health programs

The monitoring of measurable indicators to determine progress towards a health program target is well proven as a means to guide and motivate teams of health workers to greater achievements. The performance improvement model (Challenge model) involves analysis of obstacles and opportunities to performance improvement, and the planning, implementation and evaluation of interventions to improve performance. At present, the MOPH is monitoring performance of ten key health program indicators, but has no management system of setting targets and working towards them.

Targets will need to be negotiated and set individually for each province, district and implementing NGO. The history, settings and circumstances of the provinces are different, and at present there is considerable variation in the levels of performance of many indicators between the provinces.

b. Starting selectively to learn the process

This process of setting targets and implementing the performance improvement model was one of the most successful activities of the second half of the USAID REACH Project. An important decision at the outset was to focus the process to two program areas rather than all the programs. The two were EPI and family planning. This meant that most people in the health system could be involved in some way, but that there was focus and concentration on only two targets.

These two programs were chosen because, while utilization levels were low, existing coverage of services at both facility and community levels were already quite high. These were not programs where services required by women and children were only available at facilities. What was mainly required was engagement of the community and promotion of the services, addressing myths and misunderstandings, and assuring convenient accessibility of the services.

Under the REACH Project, there was no time to begin expanding the process to other programs, but this would be a necessary and critical part of the MOPH program. The selection of one or

two more key indicators to the first two would depend upon the groups of health workers involved, who in the community would be involved and the nature of the behavioral changes required of both health workers and community members. By design or opportunistically, they might be chosen to coincide with the implementation of a technical assistance program in a particular health area.

An annual addition of programs or indicators does not mean that there is an expectation that each program only requires a year to “fix”. That would be most unusual. Work on the first two programs or indicators would need to continue after the first year. Clearly, every additional indicator involves an expansion of effort. That expansion can be more efficient if an additional indicator is associated in the same program as a previous indicator: for example, the addition of skilled birth attendance after previously working on antenatal care.

c. The scorecard

The provincial scorecard is a record of the quarterly results of the routine indicators used to monitor the progress of the health programs. REACH used six indicators; currently the MOPH is using ten.. Provincial offices and the NGOs have the capacity to monitor these at present, and to analyze and display results by district and facility. Results can be checked and comparative tables circulated by the HMIS Department to illustrate comparative progress of provinces towards their targets as well as their absolute performance. The HMIS Department can also help with preparation and presentation of useful indicators derived from the raw HMIS data. These might include percentage of children completely immunized under one year old or Couple Years of Protection for family planning, as was done under REACH.

d. A Learning Collective approach

Most of the challenges faced at a provincial level will be shared by at least several other provinces. There is, therefore, a great opportunity for sharing and learning from the experiences of different approaches tried in different provinces. This applies to the ways in which problems and opportunities are identified and examined. It also applies to the design and evaluation of interventions to overcome obstacles and take advantage of opportunities. Two or three meetings a year for this kind of sharing and documentation of different stages in the improvement program would be helpful. These can be most efficiently done by regional groupings and by using existing meetings of provincial and NGO staff.

e. Technical inputs and contractual oversight

Part of the success of the REACH program of performance improvement was the teaming up of project technical staff with the contract officers who were supervising the NGOs. These teams had regular meetings with the NGOs and PHOs to review the scorecards and participate in the different stages of the performance improvement cycle. The same approach can be applied in the present situation, whether in national or regional meetings as described above. The technical departments in the MOPH (E.g. Family planning and EPI) that are involved in the selected programs or indicators would work with the contract officers in the GCMU to lead the process. They will be most familiar with the relevant program standards, nationally approved resources and in-service training materials, innovations that have worked in similar settings, etc. They can continue to support the program through their technical officers in the PHOs.

For most programs there will be other stakeholders involved. The CBHC department would be required for most indicators to help with making the most of CBHC resources. Health Promotion would be a regular contributor to make sure that provinces were aware of all relevant promotional media or coordinate the development of new media products. Some programs might require

inputs from the hospitals and laboratory units. Professional associations like the Afghan Midwives Association could also be very helpful.

Appropriate teams can be formed to work with the PHO/NGO teams at national and regional meetings. This will have many benefits. It provides a very tangible way for the various stakeholders to be engaged with the BPHS implementers and managers; it makes possible the development of an integrated approach to problem solving; it becomes an opportunity for a lot of sharing and learning between all the groups; and it creates an important integration of the technical oversight of the BPHS with its contractual management.

2. *Accountability and motivation for reaching targets*

a. Conceptual issues

There is currently no accountability for performance of public health programs. As pointed out already, the BPHS implementing NGOs are accountable only for a variety of outputs that are specified in their contracts. Satisfactory completion of these is required for their payments. The inclusion of performance on public health program targets in the management of the NGOs raises a number of issues:

- How targets are negotiated and set,
- How performance indicators are to be routinely measured and independently verified,
- Whether or not financial or other material rewards or sanctions are to be attached to performance on these indicators,
- How those material incentives or sanctions are to be distributed among all the NGO staff participating in the program,
- Whether and how any incentives could be distributed among community volunteers that may be among the most critical contributors to performance success,
- Whether Provincial Health Office or other MOPH staff are to be included in any of the material incentives,
- What alternative forms of incentive or motivation are to be employed.

b. Practical considerations for the present time

The present arrangement whereby the withholding of payments to the NGOs principally affects the NGO management on the basis of whether they have demonstrated agreed process outputs. A system of accountability for health outcomes based on measurable health indicators involves all the NGO staff as well as community volunteers working together to achieve performance targets. Rewards and sanctions should, therefore, involve all of them. A full-scale performance-based financing process of this sort would involve major policy decisions and program reorganizations that are probably inappropriate at a time when the basic changes to the SEHAT are under way. They are also too involved to accomplish as an activity for the balance of the LMG Project.

This means that the primary motivation to be sought for a performance improvement program needs to be that of the professional rewards and satisfactions from achieving the improvements in specific programs and the knowledge that communities are healthier and safer than they were before. A second group of motivations can be supplied through friendly competition between provinces and particularly from appropriate recognition of achievements by provincial and national professional, civic and political authorities. If targets are set sensibly and feasibly, if appropriate moral, technical and material support is made available for the performance improvement process in all provinces, and if encouragement and recognition is quickly and reliably forthcoming, these incentives should be sufficient.

3. Institutionalized technical oversight

a. The need for a BPHS Technical/Performance Oversight Committee

Our understanding of the process by which the BPHS is managed includes:

- i.** Initial design and periodic review of the content by a collection of technical subcommittees under an oversight committee under the Directorate of Policy and Planning. The subcommittees are made up of appropriate stakeholders, including donor representatives.
- ii.** In preparation for renewal of the NGO contract cycles, Requests for Proposals and draft contracts are prepared by the GCMU, Policy and Planning, and donors. Actual contracts are prepared by the GCMU under the supervision of Policy and Planning.
- iii.** Supervision of the contracts is done by GCMU.
- iv.** Any significant alterations or additions to the contracts will be referred by the GCMU to Policy and Planning and, if significant budget additions are involved, the donors.

We have explained the need for an additional process of management by objectives that uses public health program outcome targets as the basis for a performance improvement program. If this is to become a long-term component of the BPHS management process it will be necessary to institutionalize the process within the MOPH structure.

b. The nature of the BPHS Performance Oversight Committee

Such a committee would need the following characteristics to be effective:

- It would be advisory in nature because: a) the rewards and sanctions associated with this process are not financial or material, and b) the managerial authority already rests with the GCMU, supervised by Policy and Planning.
- It should be convened by and responsible to Policy and Planning in order that its recommendations can carry the authority of Policy and Planning and be implemented by the GCMU.
- It should be independent of the GCMU and consist of representatives of the MOPH departments that are the key stakeholders in the BPHS. These will be the departments, which have responsibility for the programs whose indicators are being used for the performance improvement process, or who, like CBHC, are responsible for supporting key elements of the health system. The HMIS Department head would be a member of the committee and would coordinate the supply of data and information to the committee.
- Such a committee needs to be large enough to be inclusive of all critical stakeholders but small enough to be efficient. Perhaps an annual stakeholders' meeting could be called to hear reports of the year's progress and advise on the selection of additional indicators for the following year. Quarterly (or more frequent) meetings during the year should only have those directly concerned with the programs whose indicators are the subject of the performance improvement process.
- It would seem advisable for this activity to have its own budget for the most efficient management of the process. The funds can be used specifically each year to cover the travel needs of the people who are relevant to that year's program.

c. Provincial institutional management and accountability

The Provincial Health Coordinating Committees would be formally accountable for performance improvement. As at the central MOPH, this combines managerial political and technical components.

4. LMG inputs

The LMG investment in leadership and management training for many of the people who will participate in this performance improvement program provides a very strong foundation of understanding and skills. The integration of the Challenge/Performance Improvement model with the Learning Collaborative approach (being developed at LMG Boston) makes best use of two approaches already being applied in Afghanistan.

This proposal provides a platform by which the Stewardship role of the MOPH for the BPHS can be developed and strengthened. Each of the activities of leadership and management are exercised, but most importantly it provides a way to *focus* on public health outcomes and a mechanism to *align and mobilize* all those with stewardship responsibilities in institutions and processes that will facilitate integration and coordination of the contributions at both central and provincial levels that are required to achieve improved performance. There will need to be significant motivating and support for a number of the players, who may not initially appreciate the importance of the process or the benefits to their unit. The broad reach of the LMG staff across the MOPH will enable that support to be more easily provided.

Ultimately, the results of this intervention could be the best vindication of the benefits of the Leadership and Management approach in Afghanistan.

ANNEX D

Timeline of Development of CBHC 2003-2013

Date	CBHC Development activities	Organizational Development
2003	CBHC included as an integral part of the BPHS. Health post to have 1 male and 1 female CHW. One health post per 100-150 households. <u>CHW job description</u> includes: <ul style="list-style-type: none"> • Health Promotion: <ul style="list-style-type: none"> ○ Disease control ○ MCH, nutrition and family planning • Direct services: <ul style="list-style-type: none"> ○ Management of childhood illnesses ○ Counseling and provision of contraception ○ First aid ○ Screening for TB • Management: <ul style="list-style-type: none"> ○ Know families and keep Community Map ○ Report births, deaths and health post activities ○ Manage health post, its equipment and supplies. 	<ul style="list-style-type: none"> • CBHC Task Force formed. • CBHC policy and CHW job description developed.
2004	CHW training commences.	
2005	Formation and training of Shura-e-sehie commences.	1. National Workshop on CHW Sustainability. <ul style="list-style-type: none"> • Reaffirms that no regular payments will be made to CHWs, • Creates the position of Community Health Supervisor at the health facility, • Reconstitutes the CBHC Task Force with clear TORs. 2. Formation of CBHC Department in the MOPH.
2006	CHS selection and training commenced.	

<p>2008 to 2011</p>	<p>Several programs commenced and scaled up at different rates during this time:</p> <ol style="list-style-type: none"> 1. <u>Family Health Action Groups</u> were developed from an operations research project of Future Generations, funded by USAID. HSSP developed the operating manual for this program. The female CHWs selects a group of respected women in her community and leads them through a series of monthly training sessions. These women in turn demonstrate and pass on the lessons learned to the women of ten of her neighboring households. 2. <u>The Postpartum Family Planning (PPFP) program</u> was a scale up of an operations research project by MSH, funded by the Hewlett Foundation. It involved training and mentoring of CHWs in family planning, intensive family planning education with community and religious leaders, and the introduction of CHWs providing first injections of Depo Provera. HSSP developed a new training program on PPFP and on provision of injectables. 3. <u>Community Integrated Management of Childhood Illnesses</u>. This was an initiative of the IMCI section of the MOPH Child and Adolescent Health Directorate. Funding was secured from GAVI. Technical assistance was sought from the BASICS Project for the design of a two 3-day training modules and a set of pictorial charts with the C-IMCI algorithms, and with the design and budgeting of the scale-up. Implementation was through contracts with NGOs and the training staff of the BPHS NGOs. 4. <u>The BASICS Project</u> (2008-2011) included a major CBHC component. It worked in USAID-supported provinces and implemented the Integrated Child Survival Package. Building on the FHA Group model, they implemented community growth monitoring, the C-IMCI package, essential newborn care and behavioral change communication. This program was implemented and supported by Child Survival Officers at district level and by a MCH Committee at provincial level. 	<p>The management of the PPFP scale-up was a combined effort between the CBHC and Family Planning departments of MOPH, the REACH project and HSSP.</p> <p>The CBHC was expanded with ten consultants under REACH, including the Department Head and some master trainers for the PPFP program scale-up.</p> <p>The CBHC Policy and Strategy, 2009-2013 document was approved in December 2009.</p> <p>Two annexes were added in December 2010:</p> <ul style="list-style-type: none"> • CBHC for Nomadic People (Kuchi). • Urban CBHC Strategy.
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	<p>5. <u>Community TB DOTS</u>. The TB CAP and TB Care projects have been expanding the TB program throughout the country. This has included the introduction of supervised TB treatment by CHWs in the community.</p> <p>6. <u>The National CHW Day</u> was introduced in 2010. It is celebrated each year in Kabul and the provinces on December 5th.</p>	
2011-2013	<p>1. These two years have seen a process of consolidation:</p> <p>a. Continued <u>monitoring visits</u> to the provinces. Preparation of a revised and simplified monitoring instrument.</p> <p>b. <u>Community Health Supervisors</u>. There is now an updated job description, operational guidelines and training course.</p> <p>c. <u>Family Health Action Groups</u>. The implementation package has been updated.</p> <p>d. <u>Community Health Workers</u>. The CHW basic training course has been completely revised to incorporate all the developments of PFP, C-IMCI, C-TB DOTS, etc. Individual sections can still be used as in-service training modules for CHWs who have not yet completed those modules.</p> <p>e. <u>Shura-e-sehie</u>. An updated set of guidelines and a training package have been developed.</p> <p>2. Training of urban CHWs and Nomad CHWs has commenced.</p>	<p>The CBHC Department staff were divided into two teams:</p> <ul style="list-style-type: none"> • Provincial monitoring team. • Capacity-building team. <p>While this separates two key areas of responsibility, in fact all members participate in both areas of work.</p>

ANNEX E

Narrative report of CBHC program evaluation in Balkh province (this visit was similar to what occurred in Nangarhar and Herat provinces)

Reported by: Dr. Mohammad Anwar Rasooli

Period: 20 – 25 Nov. 2013

On Nov. 20, 2013 a team including Dr. Mubarak and Dr. Steve Solter came from Kabul to evaluate the CBHC program in Balkh province. For this visit, Dr. Rasooli, the PHSSC of Jawzjan province, also joined the team. The team arrived at 12:30PM in Mazar-e-Sharif. After a short break they went to the BPHS implementing NGO's—CHA— office in Karte Amani district of Mazar-e-Sharif and met with the CHA management team and about 25 CHSs from different HFs of Balkh province.

After a round of introductions of the team members, Dr. Mubarak spoke about the purpose of the team's mission in Mazar-e-Sharif, the selection of Balkh province for this evaluation, and also explained about the national CBHC program. In this meeting Dr. Steve Solter spoke about the important role and responsibility of CHSs and thanked all the participants for taking part in this meeting. Dr. Solter requested the CHSs to talk about their experiences regarding the CBHC program and what their main accomplishments have been.

After that; Dr. Mubarak requested the CHSs to introduce themselves, and tell us the number of HPs they were responsible for supervising, the distance of the nearest and farthest HPs from their HF and what they had done which was innovative regarding CBHC. The following table lists the CHSs at the meeting and what they said:

No	Name of CHS	Health Facility	Number of Health Posts	Duration of Work	Distance of Health Posts	Innovation
1	Nasibullah	Keshendah	7 HP	2 Years	7 – 10 Km	He standardized the latrines after communication with the Shuras and he exhorted the communities to keep the drinkable water sources far away from latrines
2	Mohammad Jawid	Chemtal	11 HP	2 Y	9 – 13 Km	He mobilized the people to consider the critical health messages and explained to the mothers how to make ORS for their dehydrated children
3	Zabiullah	Charbolak	10 HP	1.5 Y	7 – 15 Km	Encouraged the community to bring their pregnant women for safe delivery in the clinic
4	Namatullah	Shulgarah	9 HP	7 Y	10 – 15	Encouraged the people to use

					Km	the available family planning methods and practice birth spacing
5	Abdullah	Shulgarah DH	11 PH	2 Y	6 – 14 Km	Conducted regular Health Shura meetings and encouraged the CHWs to update their community (household) maps
6	Nasruddin	Khulm	11 HP	3 Y	5 Km	Submitted regular reports received from HPs to the HF
7	Najibullah	Shortapa	7 HP	2 Y	2 – 6 Km	Conducted health shura meetings and established new health shuras at the HP level
8	Mohammad Musa	Charbolak	17 HP	4 Y	7 – 16 Km	Supervised HPs and collected their reports
9	Noorullah	Shortapa	10 HP	3 Y	5 – 60 Km	Persuaded communities to dig water wells for obtaining safe drinkable water. Some communities were drinking river water and it was very dirty
10	Ghulam Qader	Balkh	24 HP	8 Y	10 – 20 Km	Eliminated swamps to reduce breeding of mosquitoes and reduced stagnant water to prevent malaria cases; also helped build places for children to safely play
11	Mohammad Naim	Balkh	20 HP	3 Y	1 – 7 Km	Improved the waste disposal process (from people's houses) and worked on behavior change of the community
12	Salik + 1 CHS	Balkh DH	39 HP	1.5 Y	1 – 15 Km	Encouraged parents to visit their children at school
13	Mehrullah	Dawlat Aabad	20 HP	2 Y	5 – 10 Km	Dug water wells through the NSP found and provided safe water for the community
14	S. Imaduddin	Dawlat Aabad	9 HP	3 Y	3 – 6 Km	Improved the referral system from HPs to HFs
15	Mohammad Sadeq	Qara ghulja	26 HP	3 Months	1 – 5 Km	Based on the high level of utilization at the existing HF, he encouraged the community to upgrade their HF from BHC to CHC
16	Ziadullah	Shortapa	10 HP	2 Y	2 – 7 Km	Encouraged the community to use safe water for decreasing the number of diarrhea cases

17	Niaz Mohammad	Chemtal	10 HP	6 Y	5 – 10 Km	Chlorinated water sources; set up a box in the HF for collecting relief funds and used the funds for providing transportation for poor and needy families
18	Sher Mohammad	Chemtal	23 HP	8 Y	5 – 18 Km	Improved TB case detection and treatment at HFs, especially among rich families
19	Mohammad Hassan	Shulgarah	14 HP	2 Y	3 – 18 Km	Provided an invitation letter for ANC clients to come to the HF for safe delivery
20	Said Murtaza	Shulgarah	12 HP	8 Y	1 – 15 Km	Supported behavioral change among the community to use safe water for drinking and made a barrier around the water sources to keep away animals from the water sources
21	Hussain	Shulgarah	7 HP	1.5 Y	3 – 12 Km	Met with families to ask them to pay about 50 Afs for a charitable donation and then use the money for emergency health problems
22	Mahmood	Maidan	20 HP	1.5 Y	5 – 10 Km	Established health shuras in each HP
23	Zabiullah	Charbolak	10	2 Y	3 – 4 Km	Conducted health awareness sessions among families
24	Habibullah	Charbolak	10	2 Y	6 – 8 Km	Increased the number of family planning users

After all the CHSs had spoken, Dr. Bahawuddin Baha, the CBHC officer of CHA in Mazar-e-Sharif, welcomed the team and spoke about the status of the CBHC program situation in Balkh province. Dr. Baha mentioned that there are 766 HPs in the CHA coverage areas in all 14 districts of Balkh province, 1439 CHWs and 55 CHSs. The CHSs have monthly 3-hour meetings with CHWs where they orient the CHWs about technical issues; for one hour they work on their HMIS data and analyze the data from hard copy reports. CHA supplies the HPs on a quarterly basis; the supply includes medical, non-medical and hygiene kits. When the evaluation team met with CHSs in the CHA office, the CHSs were completing a training course regarding the CHWs' new curriculum. According to Dr. Baha the methodology of the training included presentations, lectures and role play.

The CBHC officer at the CHA office in Balkh also mentioned several innovations of CHSs and CHWs in Balkh province:

- Preparation of invitation cards for pregnant women to come to the nearest HF for delivery. In the card they mentioned the EDD of the pregnant women and how their

families can prepare for the delivery in advance; this card was distributed to families by female CHWs

- CHWs took sputum samples and sent them to the HF for examination
- Development of good communication among CHSs, midwives and lab technicians for improving the CBHC program.
- Provision of furniture and carpets by health shura of Khulm district to their district hospital.
- In Zareh clinic the shura built a surrounding wall for HF, waiting room for the patients and planted trees at the HF.
- In Dehdadi district the HF was in private house, the community provided land for construction of the clinic and now they have standard HF building.
- In 33 HFs of Balkh the shuras made a charitable donation box and they use these funds for emergency health events; 16 HFs are planning to do something similar
- Planting of trees at Dawlat Aabad HF by shura.
- In Shar Shar clinic the shura extended a pipe for 150 meters from a spring to the clinic to bring safe water.

On Nov. 21, 2013; the CBHC evaluation team had a meeting with the acting PHD of Balkh; Dr. Mubarak explained the purpose of the mission to Balkh province. The team wanted to know how the PPHD of Balkh was involved in the CBHC program and its role as steward of the health sector in Balkh province; also, he said it's important to know the improvement of the health situation regarding the CBHC program during the last 8 or 9 years in Afghanistan especially in Balkh province.

Afterwards the acting PHD of Balkh welcomed the team to Balkh and briefly gave some information about CBHC program in Balkh province; he mentioned that about 2 years ago there was no CBHC officer on the PPHO team and now we have a CBHC office and most of the activities are coordinated by him. Eighteen months ago there were 6 urban HFs with 76 HPs handed over from CHA to PPHD. Now the supply and supervision of these CHSs and CHWs is managed by PPHO of Balkh. At the beginning of the hand over process they had problems with HR department of MoPH regarding certification of CHSs and now the problem has been solved by them and all of them have a P2 from the MoPH and a job description. He mentioned that the CHWs managed by the PPHO received a regular supply, although they are urban, but due to lack of salary about 50% of them are selling their medicine to the clients or patients. This issue was found by PPHO monitoring teams in the field, reported by DHOs and community elders/Shuras. The PPHO/CBHC officer had regular monthly subcommittee meetings with NGOs, according to Dr. Sharifi.

He mentioned some challenges such as:

- Lack of budget through MoPH channels for conducting of initial and refresher training for CHWs.
- No regular budget for providing of medical and non-medical supplies for CHWs
- No budget for transportation of CHSs to visit and supervise the HPs
- About 10% of CHWs resigned her/his job each year due to lack of salary
- Influence of community shuras during selection of CHWs; if the shuras select someone for a CHW position then they can not to do their jobs well because they choose them

based on their family rather than their commitment or intelligence. If we can't work with shuras for CHWs selection, then they can't support the program. This is a big challenge. Most of the shuras are doing this interference.

He said they sent an official letter to MoPH to get approval of the budget for PPHO/CBHC program or approval for handover of CBHC program from PPHO back to NGO. But still they haven't received any response from MoPH in this regard.

Suggestions for improving of the program which were mentioned by the acting PHD of Balkh:

- Solving of above mentioned challenges.
- Implementation of results-based financing system in CBHC program to provide some incentive to them based on their results regarding health indicators.

On Nov. 21, 2013 a second meeting was conducted with PPHOs and 4 DHOs of Balkh province. The below persons participated in the meeting:

No	Name	Position	Organization	District	Phone	Email
1	Dr. Asadullah Sharifi	Acting PHD	MoPH /PPHO	Mazar-I-Sharif	0799201818	Cdc_balkh@yahoo.com
2	Dr. Mohammad Hashim	HMIS Officer	MoPH /PPHO	Mazar-I-Sharif	0799163336	Hashemhakimi786@gmail.com
3	Dr. Halima	RH Officer	MoPH /PPHO	Mazar-I-Sharif	0781768682	Moon_happy99@yahoo.com
4	Dr. Basir Ahammad	REMT manager	MoPH /PPHO	Mazar-I-Sharif	0795978820	Dr_ahaliepi@yahoo.com
5	Dr. Attullah Tokhi	CBHC Officer	MoPH /PPHO	Mazar-I-Sharif	0700505043	Dr.tokhi_786@yahoo.com
6	Dr. Ghulam Nabi	DHO	MoPH	Charkent	0774403624	
7	Dr. Fridoon Shahzad	DHO	MoPH	Khulm	0799060960	Fraidoon1@yahoo.com
8	Dr. Asadullah	DHO	MoPH	Shulgarah	0798806160	
9	Dr. Ahammad Jawid	DHO	MoPH	Chemtal	0770008254	
10	Dr. Bahawddin Baha	CBHC Officer	CHA	Mazar-I-Sharif	0799143659	ostadbaha@gmial.com

At the beginning of the meeting Dr. Mubarak spoke about the mission of the team in Balkh province and that the team wanted to know about PPHO's role and the responsibilities of PPHOs and DHOs regarding the CBHC program. He also said each PPHO and DHO should present their ideas, achievements, and their role in the CBHC program and their challenges in this regard.

The REMT manager of Balkh mentioned that the role of CHWs is very important and CHWs supported the program in NIDs and routine EPI; also, they referred mothers and children for vaccination.

The District health officer of Khulm district said that the CBHC program is a successful program for improving the awareness of the shuras and communities about health, hygiene, strengthening of referral system from villages to HFs, improving mother and child health etc... Also he mentioned some challenges in this regard, such as no salary for CHWs, low knowledge of some of them, low commitment of some CHWs, insufficient supply of medical and non-medical items.

He suggested the following solutions for improving the CBHC;

- Hiring of some new CHWs and letting go CHWs if they are not committed to work or they are too old
- Increasing budget for supplying CHWs
- Paying incentives or remuneration for those CHWs when they had some good achievements

The CBHC officer of Balkh gave some information about the CBHC program situation in Balkh province; altogether they have CHWs=1591 (NGO=1439, MoPH=152), CHSs= 59 (NGO=55, MoPH=4) 9 of them female and 39 Male, HPs =802 (NGO=766, MoPH=76). The activities carried out by them include the following:

- Supervision and monitoring from HPs and HFs each month 3-4 times and use of relevant CBHC check lists
- Conducting CBHC subcommittee meetings on monthly basis
- Submitting of CBHC department monthly and quarterly reports to relevant departments
- Participating in PPHCC monthly meetings

Some suggestions and challenges also raised by provincial CBHC officers:

- Delay in monthly salary payment, processing of per diem and accommodation by central level of MoPH
- Sometimes lack of transportation for timely monitoring and supervision of HFs and HPs
- Delay in supplying of office items and stationery and also purchasing of some items through *Mustofiat* channel
- Lack of budget for conducting of refresher and initial trainings for CHSs and CHWs
- Lack of transportation costs or transport to CHSs for their supervision of HPs
- No opportunity for CBHC teams to make study tours to neighboring countries' CBHC programs
- Insecurity of some HF roads and HP coverage areas

On Nov. 21, 2013 the CBHC evaluation team including the CHA CBHC officer made a visit to Karte Noor Khuda CHC. The health facility was open; many patients and clients were in the HF. The CHS was female; her name was Humaira and presented her activities to the team, the CHC had about 13 HPs and 26 CHWs. All of the 13 HPs followed the FHAG program and she prepared a fine chart/table that showed the number of HPs, location and number of HPs and names of FHAG members. They conducted CBHC refresher training on a monthly basis and CHA paid 150 Afs for their transportation.

After visiting the HF, the CBHC evaluation team went to visit health post number 26171 in Karte Bughdi of MZR city. The CHW's name was Zarmina and she has worked more than 4

years as a CHW. This CHW was very capable in her job and she had a household map and was fully supplied with her CHW kit items. Her knowledge regarding treatment of ARI and diarrheal cases was good. During the visit the team asked her to role play and the CHS role was as a mother of the child. She (CHS) asked her what her complaint was regarding her child's health problem and she (CHW) played her role very well and gave correct messages to the mother of the child. Also during the CHW's home visit, Miss Turpikai, one of the FHAG members, came and joined in the visit. She was one of the active CHWs of this health post and gave some information about her job as a FHAG member. She shared her experiences and success stories about two cases (One TB suspected case and one malnourished child case which were referred through FHAG members and they were treated and they are getting well). Turpikai liked her job; she wants to improve in her work. The health post health service was free of charge.

The CHW also suggested per diems or any other kind of reward for her job. Also she requested transportation costs for transporting of quarterly health post supply from HF to HP.

On Nov. 23, 2013 the CBHC evaluation team visited 2 MoPH covered HPs; one HP was in Chughdak village and the CHWs' names were Zia Gul and Rahimah. They have been working about 7-8 years as a CHW. They were responsible for 150 families, 75 for each of them. Their knowledge was pretty good. The record and report of CHWs was not in the health post; their reports were in BHC Chughdak. Some challenges mentioned by them:

- Lack of supervision by their supervisors
- Lack of regular supply. During the last year the PPHO of Balkh did not supply the HP at all.
- Lack of trainings for improving their knowledge
- No appropriate places for HP in their house
- No box for carrying supplies from HF to HP
- No standard referral card for referring cases to HF

Thereafter the team went to Youlmarab village and visited one health post. The CHW's name was Suraya; she has worked about 8 years as a CHW; she was responsible for 150 families; the knowledge of the CHW was very good especially in treatment of ARI and CDD cases. She had a high level of commitment to her work. She said before establishing of the health post, the health awareness of the community was not good, but now it's much better. The reporting documents of CHWs were collected by the CHS in Youlmarab BHC. Some challenges mentioned by Suraya:

- No regular supply by PPHO (last time of supply was more than one year ago)
- Lack of supervision by their supervisors
- Lack of trainings for improving of their knowledge
- No box for carrying supplies from HF to HP
- No standard referral card for referring of the cases to HF
- No tally sheet or copy of their reports in the HP. The reports were kept by CHS in Youlmarab BHC.

On Nov. 24, 2013 the CBHC evaluation team had a meeting with PPHOs and acting PHD of Balkh. Dr. Mubarak introduced LMG to them, and described the implementation of CBHC by MoPH for changes of families' behavior, as well as standardizing the CBHC program among

different NGOs. The CBHC department in the MoPH is supported by MSH and it's one of the most successful departments. Also he shared their visit's findings and feedback to PPHO team. Fortunately after meeting with PPHOs, a PPHCC meeting was conducted and the CBHC evaluation team had the opportunity to attend the meeting. Some gaps were seen during conducting of the meeting:

- The chairman of the meeting didn't follow the ToR of PPHCC
- About 12 key members were absent
- The meeting agenda was not shared before the meeting with the members
- The meeting seemed like a reporting session and not a decision-making meeting

Some suggestion from my side for improving of CBHC program in Balkh province:

- The MoPH CBHC department should prepare an accelerated action plan for eliminating gaps in Balkh's CBHC program
- Conduct initial and refresher training for CHSs and CHWs, and regular supply of MoPH HPs
- The number of supervisory and monitoring visits to HF and HPs should be increased by the PPHO team.
- We need to think about Urban and Rural HPs (location, supply, supervision, training, reporting and service delivery)
- The new implementing NGO (BDN) should assist the Balkh PPHO team
- The recruitment of female staff as CHSs and CHWs has been very useful for the program; it's effective and has support
- Providing transport for CHSs is very important, because they have no regular transportation for carrying supplies and providing supervision of the HPs
- Recruitment of second female CHSs beside male CHSs is very important for improving the program, because the male CHS cannot have close contact with female CHWs
- Networking among PPHOs from neighboring provinces is good for exchanging their experiences and positive competition among PPHOs. (2 or 3 provinces, 1 or 2 times a year).
- Logistics for PPHOs, CBHC officers, CHSs and CHWs are very important; PLD and health partner NGOs should consider it
- Rewards and appreciation of the best performing CHSs, CHWs and HPs are among the best ways to improve the program
- FHAGs should be established in each HP by the new BPHS implementing NGO and now is a very good time for transition from CHA to BDN. And BDN should put it in the project action plan and estimate a budget for it. The process should be supported by the MoPH/CBHC department and PPHO CBHC officer.
- DHOs should be supported by the PPHO team and central MoPH team. They need more trainings, supervision, supply and links with PPHOs. The reports of DHOs should be reviewed by PPHOs and they should provide feedback to them
- Each department of the MoPH should conduct close supervision and monitoring of the Balkh PPHO and the PPHO needs more support from the central team

BRIEF SUMMARY OF A FIELD VISIT TO NANGARHAR PROVINCE TO REVIEW THE CBHC PROGRAM: November 18-19, 2013

We were able to visit Nangarhar province for two days and meet with provincial health officials, implementing NGO staff, CHSs, and CHWs in order to learn about the CBHC program in the provinces, including its challenges and successes. Our major findings were as follows:

- Dr Gul Habib Arwal, the CBHC officer for Nangarhar province, facilitates monthly meetings of NGOs including CHSs and CHWs to review progress and challenges regarding CBHC in the province; Dr. Arwal has been on the job for 18 months but has not received any transport allowance for the past year
- There are 911 Health Posts in the province, supervised by 79 CHSs, with many active Health Post shura
- Many challenges regarding funding: inadequate money for transport for CHWs to get to monthly meetings or CHSs to visit HPs; shortage of medicines in HPs, and so forth
- In our meeting with 6 CHWs, they mentioned a number of issues, including the fact that all of their HPs were responsible for more than 150 households, that they greatly need female CHSs to supervise female CHWs, that they need more supplies and medicines than what they are receiving (the main supplies they lack are bandages, first aid supplies, and analgesics)
- The CHWs felt that they needed more training to do an effective job
- In meeting with the Provincial Health Office staff (including the Child & Adolescent Health/IMCI officer, the CDC officer, the HMIS officer, the Pharmacy officer, the Reproductive Health officer, the EPI officer, the Nutrition officer, the PHC officer, the General Administration officer, and the CBHC officer) we learned that RH officer works closely with female shura in a number of villages, that there are performance-based incentives for CHWs that are currently being implemented (such as non-cash incentives for referring women to health facilities for delivery), and that the RH officer supports midwives doing outreach and provide technical support to female CHWs, especially where there is no female CHS
- We also learned from the RH officer that in 10 of Nangarhar's 22 districts there is support provided to female CHWs by facility-based community midwives; also, we learned that there are 74 FHA Groups in 3 districts, mostly formed in the past 10 months (the RH officer's opinion, which other officers agreed with, was that those villages with FHA Groups were clearly doing better than villages without FHA Groups, especially concerning key health behaviors, referral of suspect TB cases to health facilities, etc.)
- 40 midwives from Nangarhar have been trained in IUD insertion and removal and two midwives were recently trained in insertion of a contraceptive implant (Jadelle); this makes it easier for CHWs to refer women for long-acting methods when the local community midwife has the skill to insert IUDs or implants
- The PHO officers were very positive about the role of the central CBHC Department in Kabul and the support they've been providing to the PHO of Nangarhar
- The PHO staff recommended that next year National CHW Day should be celebrated at the District Level so that more CHWs can get recognition for the excellent service they provide.

Six male CHWs

	Time as CHWs	No. households	Kms from facility	Female CHW
1	8 mos	120	3	Cousin
2	8 mos	220	3	Aunt
3	6 yrs	> 300	6	Aunt
4	6 yrs	300	6	Wife
5	7 yrs	200	6	Aunt
6	6 yrs	270	7	Mother

- Note that 5/6 health posts have more than 150 households to care for.

Six male CHSs

	Years as CHS	Number of health posts	Distance of health posts (Km)
1	2	12	2 – 4
2	9 mos	10	4 – 12
3	3	10	5 – 12
4	4	17	5 – 15
5	3	12	3 – 8
6	2	10	5 - 9

FIELD VISIT TO HERAT PROVINCE TO REVIEW THE CBHC PROGRAM

Drs Aitken and Pardis, 21st to 23rd November 2013.

Meetings were held with the provincial health staff at the PHO and with staff, CHSs and CHWs from the NGOs, BDN and DAC at the BDN office.

Provincial Health Office

- No CBHC Officer. Have advertised three times. Believe that general knowledge that CBHC Officers do not receive salaries for months deters applicants.
- CBHC Focal Point in the PHO is the HMIS Officer who does not believe in CBHC.
- About 2,100 CHWs in Herat Province. Some, especially some of the female CHWs, are now getting old. There was clearly a problem with the selection criteria earlier, and some of the women selected were old TBAs.
- Also a problem of drop-outs. Apparently there is insufficient money to train new CHWs.
- 15%-20% CHWs caring for more than 150 households.
- CHWs have not been able to participate in the NIDs (and get allowances.)
- Some CHWs are said to be selling medications.
- Sometimes CHWs do not get expenses for meetings.
- Quite a number of the CHSs are supervising as many as 40-60 Health posts. PPHD has spoken to GCMU about this “many times”, but has had no action.
- FHAGs are said to be present in many communities (no data) and are said to be helping to improve use of services (no data analyzed).
- HMIS data are analyzed monthly and quarterly by district as well as province, reviewed at PHCC, and action taken on problems identified.

BDN Office: Meeting with CHWs and CHSs.

- Noted that on the BDN – Heart banner in the office hallway there was a list of the numbers of all the different facilities but no mention of health posts or CHWs.
- BDN – 831 HPs; DAC – 220 HPs; AIL – 20 HPs.

BDN CHWs.

Sex	Time as CHW (years)	Distance to facility (km)	Number of households	Relation to other CHW
M	6	3	95	Aunt
F	12	2.5	115	Relative
F	6	15	100	Relative
F	7	3	95	Nephew
M	10	10	103	Relative
M	5	7	181	Wife

- 1/6 CHWs has more than 150 households.

- Have at least one set of IEC charts for each program. Obtained from MOPH through the BDN Kabul Office.
- All CHWs and CHSs had postpartum family planning training. All giving DMPA without problems. (BDN and DAC)
- C-IMCI training has been given to CHWs at 25 health posts in each of 4 districts. (only BDN)
- FHA Groups at 157 BDN health posts. (125 also had C-IMCI) FHA Groups at 24 DAC health posts. Claim that more families are going to clinics, immunization has improved, and diarrhea cases have been reduced.
- Shura and female shura are supportive, but not as much as before.
- All health posts have and use community maps.
- Many communities assume that CHWs are paid. People can be very demanding, any time of day or night, and insisting on medicines.
- Many need replacements for kit boxes.
- Receive too many contraceptives but insufficient dressings.

BDN CHSs.

	Time as CHS (years)	Number of health posts	Kms to health posts
1	4	49	< 24
2	3	10	3
3	1.5	26	< 27
4	6	24	9-24 (< 75)
5	4	35	15 – 18
6	7	8	34
7	6	9	16 - 22

- BDN has negotiated with GCMU for an additional CHS in 3 facilities.
- DAC has 7 female CHWs. If >15 HPs, facility gets another CHS. One facility has 2 male and 1 female CHS.
- Attempt to do a monitoring and a report-collection visit to HPs each month. These may be bimonthly if too many.
- For distant HPs, arrange a cluster meeting in that region.
- CHSs travel by motor bike, but may not get enough fuel.
- Community leaders are not always supportive.

Meeting with Herat NGO Managers (BDN and DAC)

- Because DAC has no Kabul Office, gets only irregular information from CBHC Department.
- Monitoring visits from Kabul are not effective:
 - Very little assessment of strategic accomplishments or issues,
 - Long list of feedback on the basis of the long checklist, but no sense of priorities.

ANNEX F

PEOPLE CONSULTED

MSH.LMG Project

Dr. Mubarak Shah, Project Director

Dr. Hedayatullah Saleh, Principal Technical Advisor

Dr. Hedayatullah Mushfiq, Senior Technical Advisor, CBHC

Dr. Ahmad Shah Pardis, CBHC Technical Advisor.

CBHC Department, MOPH

Dr. Said Habib Arwal, Head of Department.

Dr. Ahmad Shah, Leader of CBHC Monitoring Team

Dr. Sayed Masood, Leader of Capacity-building Team.

Dr. Hamed Masood

Dr. Shahpoor

Dr. Karima Joyan Yosufzai

Dr. Sharif Ahmad

Dr. Atiqullah

Dr. Asadullah Nawabzada

Dr. Mohammad Sadiq.

Child and Adolescent Health Directorate, MOPH

Dr. S. Alishah Alawi, Director

Dr. Motawali, Leader, IMCI Unit

Dr. Hedayatullah Stanekzai, BASICS Unit.

Reproductive Health Directorate

Dr. Sadia, Director.

Dr. Nezamudin Jalil, RH Coordinator.

HMIS

Dr. Yacub Azimi, Acting Director.

Dr. Chris Bishop, HMIS and M&E Advisor

Dr. Sayed Ataullah Saeedzai, HIS Specialist.

GCMU

Dr. Massoud Mehrzad, Project Manager.

TB CARE

Dr. Khakerah Rashidi, Project Director.

MSH/SPS Project

Dr. Zafar Omari, Project Director.

Jalalabad

Dr. Baz Mohammad, Provincial Public Health Director

Dr. Habib Arwal, Provincial CBHC Officer

Dr. Zarmina, Provincial RH Officer.

Dr. Kamin Wali, Provincial HMIS Officer

Dr. Gul Habib, Provincial CAH Trainer.

Dr. Ajmal, Program Manager, HNTPO.

Dr. Hafez, CBHC Coordinator, HNTPO

Dr. Hamidullah, CBHC Trainer/supervisor, HNTPO

Dr. Farzana, CBHC Trainer/supervisor, HNTPO.

Herat

Dr. Rashad, Provincial Public Health Director
Dr. Matin, Provincial Health Advisor
Dr. Latifa Sadat, Provincial RH Officer
Dr. Zia, Provincial HMIS Officer and CBHC focal point
Dr. Rahimi, Provincial IMCI Officer.
Dr Faraidon Sultani, Project Manager, BDN
Dr. Mohammad Hasham, CBHC Officer, BDN
Dr. Ehsan Ahmad, Project manager, DAC.

Balkh Province

Dr. Asadullah Sharifi, Acting PPHD
Dr. Mohammad Hashim, HMIS Officer
Dr. Halima, RH Officer
Dr. Basir Ahammad, REMT Manager
Dr. Attullah Tokhi, CBHC Officer
Dr. Ghulam Nabi, DHO, Charkent
Dr. Fridoon Shahzad, DHO, Khulm
Dr. Asadullah, DHO, Shulgarah
Dr. Ahammad Jawid, DHO, Chemtal
Dr. Bahawuddin Baha, CBHC Officer, CHA.
Dr. Mohammad Anwar Rasooli, PHSSC of Jawzjan province.

USAID Health team.