

Community Mapping Assessment Report: Coordination of Humanitarian Assistance in Herat Province, Afghanistan

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October 2004

This report was made possible through support provided by the US Agency for International Development, under the terms of Contract Number EEE-C-00-03-00021-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the US Agency for International Development.

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Community Mapping Assessment Report

Coordination of Humanitarian Assistance, Herat Province



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USAID/Management Sciences for Health
Contract Number C-00-03-00021-00**



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ACRONYMS

ANC	Anti-natal Care
BPHS	Basic Package of Health Services
CHA	Coordination of Humanitarian Assistance
CHW	Community Health Worker
CM	Community Map
CMT	Community Mapping Tool
ELCO	Eligible Couple
FGD	Focus Group Discussion
FP	Family Planning
IEC	Information, Education and Communication
NGO	Non-Government Organization
PNC	Post-natal Care
REACH	Rural Expansion of Afghanistan's Community Based Health Care Program
TA	Technical Assistance
TAI	Technical Assistance Inc.
TB	Tuberculosis
TBA	Traditional Birth Attendant
TOT	Training of Trainers

EXECUTIVE SUMMARY

“Community Map is the mirror of our BPHS program in the field”

Dr. Waqfi, Acting Executive Director, CHA

The community map (CM) and household survey components of the Community Mapping Tool (CMT) were introduced to key staff of Coordination of Humanitarian Assistance (CHA) during a REACH-sponsored Training of Trainers (TOT) activity in Kabul, Afghanistan in September, 2003. These trainers in turn trained Community Health Workers (CHW) and oriented *shura* (community leaders) members in three districts of Herat Province. The CM is a management tool designed to assist CHWs in maintaining health service delivery records and identifying households needing follow-up for specific health services. The tool was pilot tested from September 2003 to March 2004 to determine the efficacy of CM for improvement of the Basic Package of Health Services (BPHS) throughout the country. REACH conducted a qualitative assessment of this pilot experience in three districts (Zindajan, Ghorian and Kohsan) of Herat Province in April, 2004.

This report presents the results of the assessment which used qualitative methods of focus group discussions (FGD) with CHWs and *shura* members; individual assessments using 9 questions about health knowledge with each CHW; and individual interviews with CHA’s program managers, master trainers, field trainers, and supervisors. During the 5-day assessment visit, a total of 15 FGDs were held with 138 participants in five village clusters. These discussions were followed by assessments of individual CHW’s health knowledge, and interviews were held with 13 CHA staff.

The assessment findings indicate that it is possible for CHWs to undertake household surveys and to use the resulting community maps as an effective management tool. They use the maps to identify family planning (FP), antenatal care (ANC) and postnatal care (PNC), and immunization status at the household level and to plan their day to day activities. The supervisors felt that the maps assist them in understanding the CHWs’ field activities and, accordingly, they are able to guide the CHWs more specifically and plan with them the appropriate strategies for reaching difficult clients. In general, CHWs also had retained health knowledge imparted during their training. The *shura* members find the CM to be a useful resource to enhance their knowledge of the community’s health status which also enables them to provide necessary support and encouragement to CHWs.

The major areas for further improvement in using the household surveys and community mapping, which were identified during the assessment, are mentioned below:

- Regular supervisory visits could further enhanced CHWs’ skills in providing BPHS in their community.
- CHWs do not follow a standard client visitation schedule.
- CHA does not provide CHW kits to the female CHWs as they are felt to need additional training to reliably use the kits.

- *Shura* members have limited skills in conducting meetings, recording meeting minutes, and in follow-up and monitoring of field activities.
- Where they exist, female *shura* members are functioning without any formal orientation on CM. An orientation on CM and BPHS can further accelerate their effective role in managing community health.
- *Shura* members in all districts recommended providing financial incentives to CHWs as they are poor.
- The CHWs reported that sometimes they face difficulties in using pink and red colors for identifying and recording pill users and pregnant women, respectively, as they can not easily differentiate between these two colors.
- In many cases in Kohsan district CHWs were prohibited, largely by the husbands, from recording some female clients' names in the register. However, they have resolved this challenge by listing the client as "wife of Mr. X".
- The female CHWs do not have a good sense of how to estimate the age of those clients who are not aware of their ages. Additional coaching or training in how to estimate age of clients would be useful.
- The assessment team was unable to determine if CHWs are disseminating correct information to their clientele.

The major recommendations are:

- Regular supervisory visits combined with on-the-job and in-service training can be useful for further increasing the CHWs' level of knowledge.
- CHA should develop and implement a standard client visitation schedule so that CHWs can visit and provide BPHS on a regular basis.
- CHA should investigate how to make CHW kits available to all male and female CHWs in their project areas and should also ensure adequate and proper drug supplies are available in the CHW kits.
- Training should be arranged for both male and female (where they exist) *shura* members on their roles and responsibilities to enhance their active participation in community health activities.
- Policy makers should review and decide on the recommendation of *shura* members to provide incentives for CHWs.
- CHWs should be provided with the knowledge of interpersonal communication skills and standard IEC materials should also be provided to them for motivation and recruiting clients.
- The REACH team should resolve the common problem in using pink and red colors for recording pill users and pregnant women, respectively.

- Innovative approaches and adaptations, such as the use of “wife of X” instead of recording the woman’s name in register where there is resistance from the husband or society, should be continued and taught in CM training elsewhere.

Above all, this pilot test demonstrates that CHWs were able to acquire skills in drawing community maps and in using the maps effectively to serve the clients in their assigned areas. Thus it is strongly recommended that Community Maps be adopted in all REACH sites in a phased manner.

BACKGROUND

Under the Rural Expansion of Afghanistan's Community-based Health (REACH) Program in Afghanistan, the Community Mapping Tool (CMT) is the basic tool for planning, monitoring, evaluating and managing the implementation of the Basic Package of Health Services (BPHS) at the community level. The CMT links the efforts of the community health worker (CHW) with the reference health center. The CMT, when fully implemented, consists of four components—the community map (CM), a household survey, a pictorial register, and training in the use of data for decision-making. The CM, based on an initial household survey of the community, is the component of this larger tool designed to assist CHWs in maintaining health service delivery records and identifying households needing initial and follow-up services for specific health needs. This mapping technique gives field level health workers, most of whom have limited literacy, a simple way to keep records and report their results. The maps are easy to use and update. The CM methodology has been used for two decades with demonstrated success in several countries, notably Bangladesh, India, and Indonesia. Based on the Eligible Couple mapping technique used in Bangladesh and India, CM was adapted for the Afghan context.

The CM and household survey components of the CMT were introduced to Coordination of Humanitarian Assistance (CHA), an Afghan non-governmental organization (NGO), during a REACH-sponsored 6-day Training of Trainers (TOT) course for 20 key CHA staff held in Kabul in September 2003. The training was designed to acquaint staff of CHA with the techniques of CM in preparation for improved delivery of the BPHS at the community level and to develop their skill in conducting CM training for their respective CHWs so that they will be able to prepare community maps for their working areas. Between September 2003 and March 2004, CHA-trained CHW undertook household surveys and prepared and used CM on a pilot basis in three districts (Zindajan, Ghorian and Koshan) of Herat Province. An assessment of this pilot experience was undertaken in April 2004. See Annex 1 for more details about the CM training approach.

OBJECTIVES OF THE ASSESSMENT

REACH conducted an internal assessment of the CM experience in the three districts of Herat Province to determine the relevance, adequacy and progress of CM implementation and to determine its effectiveness, impact, and potential for wider replicability. The emphasis in this assessment was placed on practical implementation issues rather than on impact and outcome measures.

METHODOLOGY

The REACH assessment team for this activity included the following REACH staff members: Sallie Craig Huber, Abu Sayeed, S.K.Zaman, Miho Sato, Nassim Assefi, Wahiduzzaman Chowdhury, Masood Arzoiy, and Khalid Rahim representing the Planning, Monitoring and Evaluation Unit and several technical program units of the project. Some had direct experience with the implementation of the CM activity while others gained their first exposure to this initiative during the field visits. The team was joined for two of the five field assessment days by a team from the U.S. Embassy and USAID who were observers of the process.

Sites were not randomly selected for this assessment due to the security situation in Afghanistan; several areas of the pilot districts are known for drug smuggling and the roads are reported to be unsafe for travel after nightfall and thus could not be reached to collect assessment data in the allotted time due to distance from Herat city. The REACH assessment team carried out a total of 15 focus group discussions (FGD) with 138 individuals in 5 village clusters of three districts in Herat Province as noted in the following table.

District Name	Village Cluster	Female CHWs	Male CHWs	Shura members	Total FGD participants
Zindajan	Shada	8	12	10	30
	QaliYadgar	8*	10	12**	26
Ghorian	Zangeh Saba	10	---18--- ***		28
	Ahmad Abad	6	5	15	26
Kohsan	Sarkal ha	8	7	13	28
TOTAL					138

* Three of these female CHWs were elected to the *Shura* after they began work as CHWs; however, they were not interviewed as part of the *Shura* FGD in this instance.

** This FGD also included four male CHWs who were not double-counted in the total for Qali Yadgar as they also participated in the male CHW FGD.

*** This was a combined FGD with both male CHWs and *Shura* members

See Annexes 2 and 3 for the CHW and *shura* FGD guides.

In addition to these FGDs, the CHWs were interviewed individually to determine their retention of nine basic health messages or data elements from their CM training. See Annex 4 for these questions. The team also held 13 individual or paired interviews with program managers, trainers, and supervisors of CHA. The findings of these interviews are summarized in the Lessons Learned section. See Annexes 5 and 6 for the staff interview guide. The assessment team also reviewed program documents including action plans, maps, and relevant materials developed and used by CHA.

Two female members of the assessment team visited homes of clients to verify information contained in the community maps. Their findings indicate that the CHWs captured information about the clients and their health status in the community map and information appears to be reliable and up to date.

FINDINGS

Capacity building at the community level is a key element of the REACH program. Training, use of management tools like CM, and empowerment of *shura* members puts information in the hands of CHWs and community members to support significant project action at this level. Since the initiation of REACH, the involvement of the community in planning, implementation and regular monitoring/evaluation of community level activities were a high priority. Accordingly, CHA built a cadre of 209 CHWs, who are providing selected BPHS services to nearly 33,600 households in Zindajan, Kohsan and Ghorian districts of Herat Province. The local informal community health committee known as the *shura* is involved in planning, monitoring and providing necessary support to CHWs and to CHA for effective implementation of the project in these geographic areas. In a relatively short period of time (September 2003 to March 2004), through the introduction of CM, the skills and capacity of

CHA program staff, master trainers, field supervisors and CHWs to carry out their respective roles and responsibilities related to the delivery of the BPHS have improved significantly. CHW have retained health knowledge taught in their original training and, through the use of CMs, they are able to analyze and target BPHS needs in the community. Field level supervisors are now better able to provide need-based support to CHWs and CHA managers now can effectively monitor field level performance and plan for further improvement.

PROVIDERS

Profile of CHWs

Based on the recommendations from the village *shuras*, CHA recruited a total of 209 CHWs in Zindajan, Ghorian and Kohsan districts of Herat province. Fifty-two percent of the CHWs are females and forty-eight percent are males. The average age of female and male CHWs is 52 and 36 years, respectively. Traditional Birth Attendants (TBA) were selected as female CHWs, in many instances, due to their reputation, easy access to each household, and familiarity with women's health issues. All the female CHWs were illiterate and the average education of male CHWs is grade seven. The profile of CHWs working with CHA in Herat is presented in the following table:

Characteristics		Zindajan	Kohsan	Ghorian	All Disticts
No of Trained Female CHWs		41	18	51	110
No of Trained Male CHWs		40	17	42	99
Percentage of Female CHWs		50.6	51.4	54.8	52.3
Percentage of Male CHWs		49.4	48.6	45.2	47.7
Average Age	Female CHWs	49	56	51	52
	Male CHWs	35	34	39	36
Average Education	Female CHWs	Illiterate	Illiterate	Illiterate	Illiterate
	Male CHWs	6	6	8	7
Avg No of Children	Female CHWs	3	5	7	5
	Male CHWs	4	3	5	4

Focus group discussions with male CHWs

All CHWs reported they had received a six-day basic training and two days of refresher training every two months on community mapping. The CHWs brought along their CMs and selected CHWs presented their CM revealing that the maps were well prepared and CHWs could speak knowledgably about them. CHWs were able to identify and understand each item in the map. They were able to identify the name of each homeowner from the community map. For example, one injectable contraceptive user was noted in one FGD. The responsible CHW was able to point out which person that was on the map and he mentioned that he noted the date she reported receiving her first injection so he could remind her when it was time to go for the next injection. Also, a few sterilizations have been done in this province at the hospital in Herat and these are so noted on the appropriate CMs.

One village map is used to guide the work of the team of one male and one female CHW serving each village. They reportedly worked together to collect the household survey information initially and to create the map. Thereafter, they make independent visits to the households. To update the CM, the information is provided by female CHWs after each household visit. The male CHWs do the actual map update as they are generally more literate than the female CHWs.

CHWs provided details on the advantages of the CM for their own work. CHWs realized that through the maps the general quality of their services improved as they were able to:

- Know their clients and their individual health service needs better
- Identify non-FP method users in their assigned areas
- Identify FP method switchers and drop-outs easily
- Identify pregnant women
- Know the status and need for ANC/PNC and immunization
- Identify clients to be referred for services beyond the CHWs' capabilities
- Plan for day to day activities more efficiently with regard to targeting pregnant women and children in need of referrals for ANC and immunization, non-users of FP, counseling for long-term methods, commodities to carry on a visit, and the general planning of the route
- Prepare better to provide appropriate health counseling by couple types and their needs
- See FP method mix and patterns of use
- Easily explain their maps to their supervisors and *shura* members for reporting and seeking required support

“Every day our performance increases due to these community maps. Every day, our life in the village is better.”

CHW, Zindajan District

The CHWs recognized that the *shura* members have selected and introduced them in the community. The CHWs have good contact with *shura* both during their regular fortnightly meetings and at other times when consultation and assistance is required. *Shura* members regularly monitor CHWs' activities and provide support for improving the health status of their community as well as helping to resolve local problems.

Focus group discussions with female CHWs

In CHA/Herat, most female CHWs were selected by *shura* members based on their experience as TBAs. These female CHWs report a good relationship and direct communication with *shura* members. As for the male CHWs, the female CHWs also received six days of training on CM six months prior to the assessment, followed by refresher training for two days every alternate month.

The female CHWs demonstrated good familiarity with CM and could answer all questions about their maps posed by the assessment team, including what to do with the CM if a man had two wives, and how to follow a woman through pregnancy and indicating what changes would happen to the CM following the pregnancy, (i.e. the circle would change from red to black, then eventually be coded for FP, entries for PNC, and immunizations for the baby).

A review of the community maps by the female CHWs revealed that they are very conversant with the meaning of the symbols on the map, even though they are not the ones who draw or complete the new entries on the map. One CHW demonstrated the meaning of the various colors on the map by showing the appropriate colored markers to the assessment team.



The CHWs detailed the advantages of the CM for their own work indicating that it provides lots of information regarding service data, difficulties of providing services for women and children, and it enables them to provide appropriate health education for FP, vaccination for the children, and referring women to the clinics in case the clients face any complications.

“It (the CM) helps me to promote contraceptive use in my community. I teach them how to use condom, which is against my culture, but now some people started using it.”

Fatema, Female CHW, Ahmedabad Cluster, Ghorian District

Regarding the CHWs’ role in providing of BPHS services, they were able to mention all the expected activities outlined in the CHW job description. One CHW mentioned that she refers her clients to the clinic when they are in need of attention from a medical doctor, the CHW also accompanies them to the clinic in most cases, if necessary. One female CHW reported:

“It is my responsibility to take pregnant women to the clinic as I am considered the mother of the village.”

Female CHW, Sakalha Cluster, Koshan District

The female CHWs demonstrated clean hand-washing techniques for safe deliveries very well. They discussed and demonstrated cutting of nails, removing jewelry, putting on an apron, washing of hands with soap, not drying hands with towel, keeping hands up in the air for drying. They also demonstrated how to boil the thread, and discussed the importance of using the razor blade only once, no longer allowed the husband to step on the umbilical cord, etc.

Challenges of Male and Female CHWs

- A few CHWs could not differentiate between red and pink colors for recording (or coding) pill users and pregnant women in the maps.
- In many cases in Kohsan district CHWs were prohibited, largely by the husbands, from recording some female clients' names in the register. However, they have resolved this challenge by listing the client as "wife of Mr. X".
- It was recorded from the discussion that the female CHWs do not have a good sense of determining a client's age, and menopause is the only sign when CHWs stop providing contraceptives to a client. When asked about how long an IUD could prevent pregnancy, most gave the answer of at least 3-5 years.
- One male CHW described participating with the female CHW for his village and another female CHW who was trained as a vaccinator in the recent tetanus vaccination campaign for all women of reproductive age. He noted that although they vaccinated 100% of the women in his village, this information was not recorded on the CM.
- CHWs do not seem to follow a standard visitation schedule to the clients in their assigned area and thus may miss providing services in a timely fashion.
- All FGDs mentioned distance from the nearest clinics as a significant constraint to the delivery of the complete BPHS. One cluster in Ghorian district reported that their *shura* helped to organize a rented car to take a group of mothers and children to the nearest (24 km) clinic for vaccination. Each family contributed for the car rental. FGD participants agreed that this would be difficult to organize as often as needed.
- The assessment team observed that CHA does not provide CHW kits to the female CHWs. Female CHWs get their supplies from the male CHWs. CHA management informed the assessment team that this is because female CHWs need additional training to reliably use the CHW kits. Inadequate supplies of some essential drugs in the kits was also reported.

Recommendations for CHWs

- The CHA team should resolve the common confusion regarding the use of pink and red colors for recording pill users and pregnant women, respectively. CHA could change the color scheme.
- Innovative approaches like use of "wife of Mr. X" instead of female clients' names in the household survey and register when there is resistance from husbands or society should be continued.
- Regular supervision combined with on-the-job and in-service training can further improve CHWs' knowledge about all aspects of delivering the BPHS at the community level.
- CHA should develop and implement a standard CHW visitation schedule to ensure regular client visits and provision of required services.

- A vaccination campaign day was organized in Zindajan district but performance was not recorded on CM. CHA, in consultation with the REACH team, should determine how to handle this situation as more of these campaigns may affect the accuracy of community maps and related service statistics.
- Community-initiated travel arrangements to send women and child to clinics should be encouraged and replicated in other areas. CHA may organize similar types of campaigns for vaccination and other services in their project area. CHA may also consider organizing regular satellite sessions to minimize travel problems of couples who are residing far away from clinics. When organizing special camps and satellite clinics, CHA should coordinate with the local *shura* to ensure their active support and promotion of these services.
- CHA should ensure adequate and proper drug supplies are available in the CHW kits and also ensure that female CHWs are well oriented in the use of these supplies so that they can be issued kits.

CHW's Health Knowledge

It was evident from the question and answer sessions with individual CHWs and from the assessment team's observations during the field visits that the CHWs have adequate knowledge about using the different codes for recoding individual couple status and recording changes in health status. Some of the CHWs interviewed as part of the assessment were asked specific question (data elements) about maternal health, family planning (FP) and child health issues (see Annex 4). Three questions were asked about each of these three BPHS components. A total of 92 CHWs, including 52 males and 40 females, were interviewed using these questions. Most of the CHWs were able to answer seven or more of the nine questions correctly and well over one-half (58%) correctly answered all nine.

CHWs' Knowledge of Health Facts

Data Element	Male CHWs	Female CHWs	Total
9 correct responses	25 (48%)	28 (70%)	53 (58%)
8 correct responses	12 (23%)	4 (10%)	16 (17%)
7 correct responses	14 (27%)	8 (20%)	22 (24%)
6 correct responses	1 (2%)	--	1 (1%)
TOTAL	52 (100%)	40 (100%)	92 (100%)

Recommendations on CHW Health Knowledge

- For the purpose of accreditation of CHWs, the above technique (verbally asking the definition of selected BPHS elements) to test CHWs' knowledge could be widely introduced.
- Regular on-the-job training can be useful to further increase CHWs knowledge level.

COMMUNITY

Focus group discussions with *shura* members

CHA clearly laid a solid foundation for the introduction of the BPHS, in general, and for CM, in particular, by consulting all community-level stakeholders, particularly the *shura* members. *Shura* membership includes local opinion leaders nominated by the community. Local mullahs were selected as *shura* members in few villages. Prior to introduction of the CM tool in these districts, *shura* members were oriented to the BPHS and to community mapping. Surprisingly, in a conservative Muslim community, the assessment team found the existence female *shura* members in Zindajan district who are playing an important role in their work with the female CHWs. Female *shura* members were not found in any other districts. CHA formally oriented five *shura* members from each CM site so that they could provide oversight for the health activities performed by CHWs. Other community leaders (maliks) of these villages were provided informal orientation on the CM by local CHA supervisors.

Shura members reported that they were consulted by CHA from the inception of the REACH program. Initially, they were consulted about the health situation and needs of the community, the scope of work of the REACH program, health service delivery mechanisms, and expectations of the *shura* to support the BPHS program in the area. *Shura* members noted that they were gathered by CHA in order to select CHWs in accordance with the preset criteria and introduce them to CHA. CHW selection criteria are that they be trusted by *shura* members and among the villagers in general. They must possess good manners, be acceptable to the community, preferably literate, and committed to providing the BPHS to their neighbors. CHWs must not discriminate against anyone in providing BPHS in the community.

Shura member are now involved in local level planning and overseeing implementation of the BPHS in their villages. They noted that they were requested by CHA to select and introduce more female CHWs. *Shura* members said that prior to introduction of CM, they had many difficulties in their understanding of the community's health status as they had no information on mortality and morbidity. Now they claim to have a good understanding of prevention and other health issues and several cited the importance of *shura* members setting an example to use healthy practices in their own families.

"I have ten children and only one wife so I want to stop; preferably, I want sterilization services to be available."

Male *Shura* Member, Zindajan District

Shura members correctly demonstrated the use of CM in the FGDs. They use the CM as a tool for overseeing the activities of CHWs. They arrange a meeting with the CHWs fortnightly to review the progress of their performance. They conduct the review based on changes of color codes in the CHWs' community maps. The FGD revealed that they can easily count the changes in family health and can compare findings with the previous month's performance.

As noted, the assessment team found that in the Zindajan district there are some female *shuras* who oversee the activities of female CHWs and monitor their performance by reviewing their community maps. These female *shura* members have received no formal training neither were they interviewed in the FGDs of this assessment. The assessment team was told that in this district, male and female *shuras* coordinate their activities in formal monthly meetings between chiefs of the female and male *shuras*. They also consult informally as issues arise. When asked whether they have any problems interacting with female CHWs in the community, male *shura* members answered that as they are living in the same village and they are close relatives of one another it is easy for them to meet female CHWs.

The male *shuras* mentioned one benefit of CM is helping the CHWs to improve the health of women and children in the community. Other effects of CHW training and CM, in particular, that were mentioned are the reduction in tetanus among newborns, increased vaccination coverage, increased awareness of the need for sterile procedures during vaccinations, better environmental sanitation, more attention to safe (unexpired) drugs and contraceptives, and safer food handling practices.



Health talks and information shared with the *shura* were found in several FGDs to be preached in the local mosques and shared in other local gatherings for the benefit of all villagers. *Shura* members reported that they are selected and supported by the community and the program. One indicated the role of health *shura* members to be ...

“... on call to provide health care to members of the community without apology; they can give no excuses for not serving community members whenever the need arises.”

Male *shura* member, Zindajan District

Shura members are very committed to rendering their support for encountering any problem in the community.

“We are in charge; it’s our job to supervise or oversee the work of the CHW.” If a CHW faces a problem in visiting a particular house, for example if the family doesn’t want to talk to the CHW about family planning, the CHW can come to consult me about this issue and I go to talk to the head of the household.”

Shura Member, Saadka Cluster, Zindajan District.

Challenges of *shura* members

- A planned program of more formalized participation of *shura* members could further improve community based BPHS activities. In particular, regular meetings with CHWs and supervisors, recording of meeting minutes, and follow-up and monitoring of field activities.
- The female *shura* members in Zindajan district are functioning without any formal orientation on CM or BPHS.
- According to *shura* members in Zindajan district, community members are interested in sterilization service but due to poor economic conditions and lack of accessible facilities, they are unable to have this procedure done.
- One *shura* in Ghorian district requested the establishment of a clinic in their locality as the nearest clinic is located 30km away from the village. Moreover, the villagers have to cross a river to reach this clinic which is very difficult during the rainy season.
- *Shura* members in Koshan district reported that many people in the community were suffering from tuberculosis (TB) but no treatment is provided by CHA. People of the community would be benefited if CHA could introduce TB drugs in the program.
- *Shura* members in all districts recommended providing financial incentives to CHWs as they are poor.

Recommendations for *shuras*

- Training about the roles and responsibilities of *shura* members will further accelerate community involvement in BPHS activities. The training must focus on the role of the *shura* in BPHS planning, implementation and evaluation. Specific training areas could be how to conduct meetings and maintain meeting records, CHWs performance analysis, providing feedback to CHWs, and coordination with CHA.
- CHA, in consultation and with support from REACH, should arrange a formal CM and BPHS orientation session for the female *shura* members of Zindajan district and should take other steps for the further enhancement of female roles in managing community health, both in Zindajan and other districts in which they work.
- CHA should take necessary actions to fulfill local service needs like sterilization and TB services for the community.
- CHA should try to increase access of clinical services for the community located a long distance from existing clinics by providing satellite clinic services and assisting these communities to arrange local transportation. CHA should also communicate with concerned authorities in this regard.
- CHA should communicate with policy makers about the recommendation of *shura* members regarding incentives for CHWs.

ORGANIZATION (CHA)

Views of Program Managers

Interviews with CHA's trainers, supervisors and program managers were conducted about the background, current and future status of CM in CHA (see Annexes 5 and 6 for interview guides). Dr. Rita Skandari and Dr. Ghoty Sadeq, CHA Master Trainers, participated in the MSH/TAI-sponsored study tour to visit the Local Initiatives Program in India in February-March, 2003. Upon their return they reported to Dr. Wakfi, then Medical Coordinator of CHA, about their findings. They recommended introducing CM to CHA's health programs in Afghanistan. Without any external funding CHA immediately translated the CM training guide into Dari for use within the organization. This tool has been shared with MSH and elsewhere.

CHA decided to develop its own strategy for CM as part of a training plan for TBAs and village health workers (CHA's old title for CHWs), even though they were not sure how this would be funded. This strategy for an integrated community based training approach which incorporated CM was included in proposals to Christian Aid and the World Bank.

Using the Dari training manual, CHA conducted training in CM for 14 trainers and supervisors from Herat and Ghor provinces during June 2003. This activity was funded as part of an MSH/REACH bridge grant. CHA considers the current work in Herat Province to be a pilot test of CM. Assuming the current assessment results in positive findings, CHA is ready to expand the CM approach to Farah and Faryab Provinces with World Bank and REACH funding, respectively. In Ghor Province, CHA had already introduced CM in their project funded by the European Commission, however the couple who were doing training of CHWs there have left the Province and have not replaced.

"Community Map is very important for the Community Based Health Care in Afghanistan. CHA is planning to expand community mapping in Farah and Ghor provinces."

Dr. Zahir Ayubi, Health Training Coordinator

CHA's National Training Center in Herat was just notified in early 2004 that it has received funding for the coming year from Christian Aid. We discussed the possibility of this training center becoming a training resource for other provinces interested in the introduction of CM. This could be strong possibility with adequate funding and human resources. This training center already provides training for other organizations on a tuition basis.

In general, all CHA staff were enthusiastic in their praise for CM and felt that it has enhanced the work of their community-based workers in delivery of the BPHS.

"Community Health Workers now have information they need to do their work better. Before we introduced community mapping, they were working and giving adequate services, but they didn't have the necessary information to direct their work."

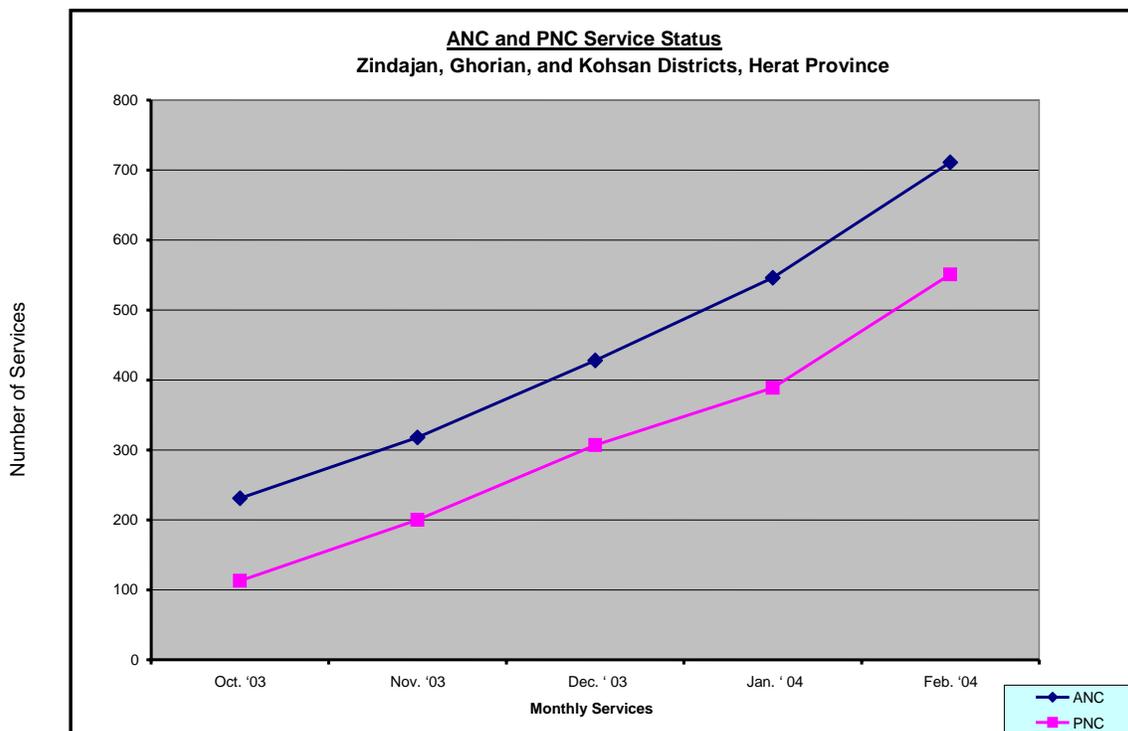
Dr. Waqfi, Acting Executive Director, CHA

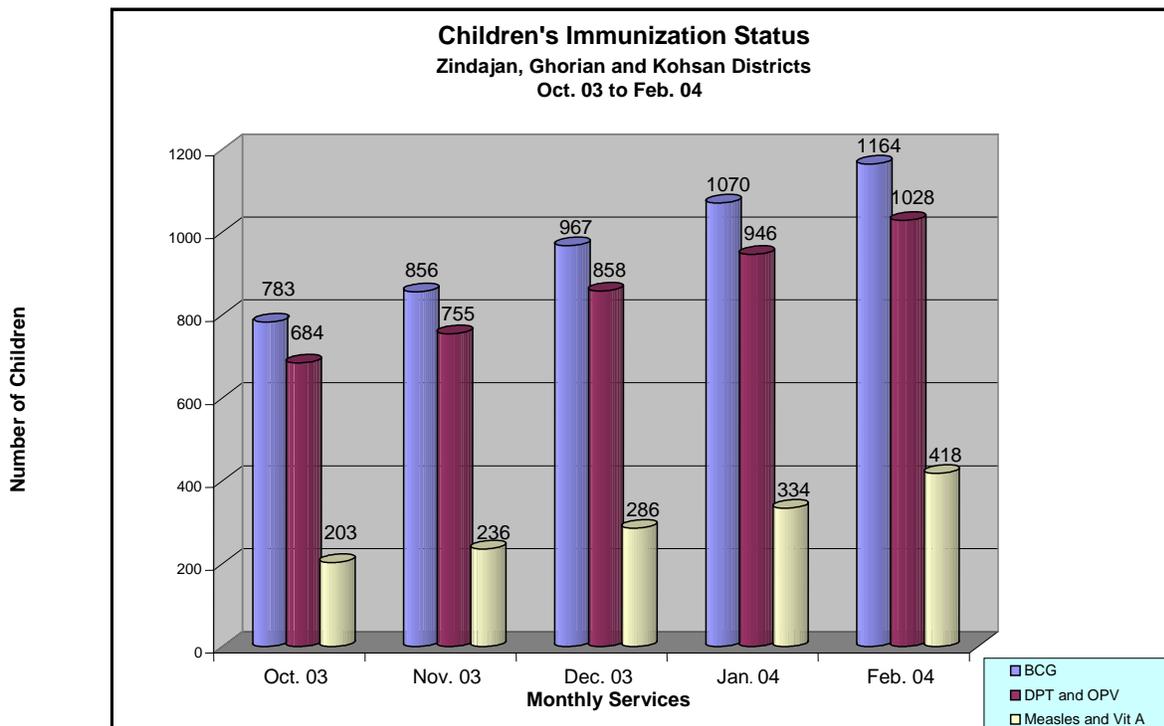
See Annex 7 for a sample of additional quotes from the FGDs and interviews undertaken in this assessment.

CLIENTS

While this assessment was not designed to be a quantitative evaluation of the impact of CM on health indicators, the pilot initiative developed a temporary data summary form to collect service statistics in the absence of an agreed-upon Health Management Information System tally sheet. (The latter was under development during the period of this pilot and will soon be introduced into this area and elsewhere throughout Afghanistan). Using data collected in this data summary form, there is little doubt that health indicators are beginning to improve in the project area. The CM pilot has had great effect in this regard as it helped CHWs to identify individuals and families in need of specific services and accordingly undertake initiatives for provision of these services. Though it was not a purpose of this assessment to address the impact of CM, it became evident from interviews with CHWs and *shura* members, as well as brief discussions with a few clients in the project areas, that health seeking behavior has started to improve. The following graphs demonstrate that the number of services for maternal health, child health, and family planning have increased over the first five months of the CM pilot initiative.

Maternal health indicators seem to be in improving each month with the number of ante-natal care (ANC) and post-natal care (PNC) services increasing each month. A similar trend continues with child immunization. According to CHA field staff, the regular planned field visits based on CM has contributed to these increasing volumes of service in the pilot areas.





The CHWs distribute pills and condoms during their field visits and they refer clients to clinics for other contraceptive methods. The number of contraceptive users is increasing and oral contraception is the most popular method in the project area. While the use of IUDs and sterilization more than doubled over this five-month period, the overall numbers of users of these clinical methods are not large yet. Distance to clinics and social restrictions on women's mobility may explain these relatively low numbers. It was also evident from the FGDs with both the CHWs and *shura* members that injectable contraceptives are popular and use would increase if CHWs were trained and able to provide injections in the community.

Contraceptive Use: Cumulative Numbers and Percentage Increase
October 2003-February 2004
Zindajan, Ghorian and Koshan Districts, Herat Province

Month	Cumulative Number of Contraceptive Users by Method					
	Orals	Condom	IUD	Injections	Sterilization	Norplant
October 2003	600	55	10	173	10	0
November	731	60	20	169	20	1
December	785	68	22	161	22	1
January 2004	832	83	24	168	22	1
February	892	101	26	154	22	1
Percentage increase	49%	84%	160%	-11%	120%	100%

LESSONS LEARNED AND CONCLUSIONS

From the foregoing results it is clear that the CM pilot was a success in the CHA districts in Herat. The objective of imparting skills and actual utilization of the maps was achieved. The CHWs, *shura* members, and CHA management staff found the CM a useful tool for improving the effectiveness of their work. The enthusiasm shown by the CHA staff in implementing the maps is an indication that the maps were well accepted by the field staff, community leaders and CHA management staff. It is suggested that the challenges faced in the pilot implementation phase be addressed during refresher training and replication of the CM in other REACH areas. The major lessons learned in this pilot of the CM in REACH are:

- Appropriate training which includes the development of an implementation action plan is very effective for developing skills of NGO staff. A participatory training methodology which includes adequate classroom exercises and village field based field practice as well as regular refresher and in-service training will further enhance capabilities of marginally literate field staff.
- A training guide in local language is useful for developing local NGO staff skills in CM and for ready reference following training.
- A management tool like the CM is an important adjunct to developing the confidence of local leaders to oversee program activities and creates an enthusiasm to be part of activities to improve the community's health status.
- An organization like CHA becomes receptive to external technical assistance (TA) when they feel that the TA includes the introduction of the CM tool which is applicable and easy to implement in their own situation.
- An organization like CHA takes ownership of tools like CM and takes the initiative to replicate it in their other project areas and is also willing to extend TA in the use of this tool to other interested agencies.

In conclusion, based on the findings of this assessment, it can be said that CM helps in building the capacity of institutions (NGOs), the community (*shura*), providers (CHWs), and clients in a short period of time. The assessment team strongly feels that this CM initiative is a successful intervention that should be replicated in all REACH areas. Other interested agencies may also be beneficial by implementing CM in their project areas.

ANNEXES

Annex 1

Methodology for Community Mapping Training

Trainers Training

REACH organized a training of trainers (TOT) for twenty trainers and supervisors of CHA from Herat and Farah provinces for six days in September, 2003. The training was designed to acquaint staff of this Afghan NGO with the techniques of preparation and use of the Community Map (CM) for improved delivery of the BPHS and to develop their skills in conducting CM training for their CHWs.

To enable the trainers to provide training to the field level workers and volunteers, a “trainer’s guide” has been developed. This guide contains step-by-step training instructions on CM preparation for field workers, the methodology and process of undertaking a household survey, and developing and maintaining maps. This guide also includes instructions on transferring field information from maps to client registers and analyzing monthly performance of the field workers. The training guide was translated into Dari for their easy understanding and use.

During the TOT an action plan was developed for six months to ensure timely CM training for CHWs and including three days in each cluster to undertake household surveys. The major outputs of the TOT were improved quality in the action plan and a translation of the training guide from English to Dari.

Community Health Worker Training

The CHA trainers in turn conducted six days training for 99 male, 110 female CHWs and one day orientation for 152 *shura* members on CM. The major training methodologies were participatory classroom sessions and field practice. In the classroom session participants were taught the purpose of using a map in delivering the BHPS; introduction to the community map and its components; benefits of mapping; experiences in other countries; how to conduct household surveys; techniques of preparing, updating and maintaining the CM; and how to use the CM to improve program management and decision making in the BPHS program. The trainees practiced drawing a hypothetical general map. These activities were supplemented by the use of case studies.

After two days of classroom training, the participants were taken to an actual project field site for two days of field practice. At the on-set of the field training the participants take a short tour of their assigned area to observe the geographical features and major landmarks of the area. The participants were then divided in to several groups and they worked in the villages to conduct a household survey as well as drawing a general geographical shape of their assigned area showing all important major land marks. On the following day, each group shared their experience in conducting the household survey as well as their mapping experience. Each participant was assigned to draw a CM based on their household survey data. The participants then analyzed their maps in accordance with a set of map analyses questions. Each group presented their maps to other participants, including an analysis of the field situation and recommendations for a future course of action.

The training was considered to be useful and practical. The community mapping training guide was used along with other important mapping tools such as pens, colored pencils, large poster paper, etc. Follow up training is conducted as a refresher for CHWs for two days every two months. During this refresher training, they highlight key points in CM techniques and review any problems the CHWs may be facing.

With assistance from their supervisors, the CHWs prepare monthly action plans for their own work based on their training in action planning training during the CM course. CHWs use the maps in planning for their visits to provide couple-specific counseling and services; distribute appropriate contraceptives, medicine and other materials; and refer clients to health facilities.

The trainers supervised CHWs weekly for initial first six months just after the training using a checklist for these visits. Supervisors also use the checklist for their bi-monthly supervision visit. Supervisors review maps during their visits, identifies issues or problems and advises the CHWs about possible solutions, and provides necessary on-the-job training. The CM is used for preparation of the monthly report that supervisors are required to submit to CHA. In addition to the data reported, there is also opportunity to report any problems and make suggestions to CHA.

Annex 2

FOCUS GROUP DISCUSSION GUIDE COMMUNITY HEALTH WORKERS (CHW)

Part I: (General understanding of CMT and its use)

1. How long have you been working as a CHW?
2. What is the level of your education?
3. Who is the *Shura* head of your village?
4. What is the role of the *Shura* in selecting you?
5. When did you receive training on CMT? For how long?
6. How important is CM for your work?
7. What type of services do you provide?
8. What is your role in providing BPHS?
9. Did you receive any training on your job?

Type: _____ Days: _____

Type: _____ Days; _____

10. On the review of the map, what strengths and weaknesses you can identify? Has the map been prepared in accordance with the CMT preparation guidelines?
11. Do you know how to update CM?

[Brief profiles (i.e., education/occupation/income/reasons for work as CHWs etc.) of CHWs will be collected prior to conducting FGDs]

Annex 3

FOCUS GROUP DISCUSSION GUIDE

SHURA MEMBERS

1. How long have you been involved in *Shura*?
2. How you were involved with community health activities in your area?
3. What is your role in selecting CHWs in your village?
4. What are the criteria used to select the CHWs?
5. Did you receive any training on CMT? How long? Who conducted the training?
6. What you learned from the training?
7. How do you use you new skill on CMT?
8. Do the local *Shura* arrange any meeting to review the community health activities in your area? How frequently? What do you discuss?
9. How do you use CM in your meeting?
10. Is CM beneficial for reviewing your community health status? If yes, what and how it is beneficial?
11. How do you communicate with female CHWs?
12. How do you communicate with CHA?
13. What types of support do you provide to CHWS? How?
14. What challenges do you face as *Shura* members?
15. Do you have recommendation for further improvement of CMT and BPHS activities in your village?

Annex 4

DATA ELEMENTS/CHW KNOWLEDGE QUESTIONS

Maternal Health

1. When is the best time to talk a woman about pregnancy complications?
2. How many TTs are provided to a pregnant woman during her pregnancy period?
3. When do you refer a pregnant woman to the nearest hospital/clinic?

Family Planning

1. Who are eligible couples?
2. Name two temporary methods of contraceptives.
3. On which day should a pill client start taking her pills?

Child Health

1. When is the second DPT due?
2. When is the BCG provided to a child?
3. What does “fully immunized” mean?

Annex 6

INTERVIEW QUESTIONS FOR PROGRAM MANAGERS

1. How many staff persons from your organization attended the Community Mapping Training held at MSH office in September 2003?

Name	Title

2. On completion of this TOT, did they debrief you/your organizational management team regarding the outcome of this training

Yes	No

3. What are the major outcomes that they have mentioned? Was this training useful?
4. Did they inform you that they agreed to introduce this tool (Community Mapping) in your program? How?
5. Did you conduct any CM training?
If Yes, please answer the following:

<i>For whom this training was conducted</i>	
<i>For how many days</i>	
<i>When this training was held (Dates)</i>	
<i>Where this training was held (Place)</i>	
<i>How many people attended this training</i>	
<i>Whether any curriculum prepared (If "Yes" Please review the curriculum)</i>	
<i>Who provided the training</i>	
<i>Whether any materials developed in Dari (If "Yes" Please review the materials)</i>	
<i>What is your general recommendation for this training</i>	

6. What is your future plan for introducing community mapping in your program?

Annex 7

QUOTES FROM FOCUS GROUP DISCUSSION

MALE CHWS

“Before introduction of community maps, we were not well aware of service gaps in our community. With the community maps we can easily identify who needs vaccination, contraceptives, ANC, PNC or any other services.” - *Abdur Rob, Male CHW, Shada Cluster, Zindajan District*

“Now we can identify children who need vaccination and it will help to reduce child mortality”. - *Nesar Ahmed, Male CHW, Zangi Sabah Cluster of Ghorian District*

“This map is an overall picture of our community’s health status”. - *Abdur Rasul, Male CHW, Sarkalha Cluster, Kohsan District*

“Community mapping is not only helping us to manage my case load but also helps me but also helps monitors, supervisors, managers to get information about our community’s health status by just viewing the map”. - *Joma Khan, Male CHW, Yadgar Cluster, Zindajan district*

“Advantage of community mapping is that now we can easily understand the health status of the families in our community and can link them with the services”. - *Abdullah, Male CHW, Ahmedabad cluster, Ghorian District*

FEMALE CHWS

“It is a very good tool because it helps me to easily identify service gaps and accordingly I can provide necessary services”. - *Sakina, CHW, Sarkalha Cluster, Kohsan District*

“It helps me to promote contraceptive use in my community. I teach them how to use condom, which is against my culture, but now some people started using it”. - *Fatema, CHW, Ahmedabad Cluster, Ghorian District*

“The advantages of the community mapping are it provides lots of information regarding service gaps -- difficulties of pregnant women and providing of services for children”. - *Bibi Jan, CHW, Shada Cluster, Zindajan District*

“Now it’s very easy for me to identify vaccination status of children and method of family planning used at each household. - *Sahib Jan, CHW, Zangi Sabah Cluster of Ghorian District*

“Community mapping gave us an opportunity to increase our interaction with male CHWs as well as families”. - *Kimia, CHW, Yadgar Cluster, Zindajan District*

SHURA MEMBERS

“After introducing community mapping -- the health statuses of our people improved significantly.” - *A Shura member, Shada Cluster, Zindajan District.*

“We had many difficulties in understanding of community health status as we had no information on mortality and morbidity. After introduction of community mapping, now we understand what to do”. - *A Shura member, Yadgar Cluster, Zindajan District*

“We are ready to deploy more female CHWs as they seems to be more effective in providing health services”. - *A Shura member, Ahmedabad Cluster, Ghorian District*

“Community mapping is useful in identifying and targeting community members in need of specific health services”. - *A Shura member, Zangi Sabah, Cluster, Ghorian District*

“Community mapping enhanced relationship among male CHWs, female CHWs, *Shura* member, CHA staff and community people”. - *A Shura member, Sarkalha Cluster, Kohsan District*

CHA STAFF

“Community Map is used as a guideline for planning, implementing and assessing progress of our health activities”. - *Mr. Alim, CHW Trainer*

“The training of trainers (TOT) on community mapping provided by UASID-REACH was good and useful. We usually have training that after the training, nothing is useful. However, the workplan that we developed during the training was good. It changed the overall picture of the health training system of CHA”. - *Dr. Zahir Ayubi, Health Training Coordinator*

“Community Map is the mirror of our field level performance”.
- *Dr. Waqfi, Acting Executive Director, CHA*

“CHA is planning to expand the community mapping tool in Farah and Ghor province”. *Dr. Rita Skandari, Master Trainer*

“Community mapping is helping CHWs for developing their skill in planning and providing services more effectively”. - *Dr. Farid Farahmand, Master Trainer*

“Community mapping is helping CHWs to improve the health status of women and children in the community”. - *Mr. Abdul Majid, Supervisor, Kohsan District*