



Islamic Republic of Afghanistan
Ministry of Public Health
General Directorate of Preventive Medicine
Community Health Directorate
Community Based Health Care Department

Community Based Health Care Strategy
2015-2020

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Acronyms and Abbreviations

AMS	Afghanistan Mortality Survey
ANDS	Afghanistan Nutritional Development Strategy
BHC	Basic Health Center
BECC	BPHS-EPHS Coordination Committee
BPHS	Basic Package of Health Services
CAH	Child Adolescent Health
CBHC	Community Based Health Care
CDC	Community Development Council
CHC	Comprehensive Health Center
CHD	Community Health Department
CHS	Community Health Supervisor
CHW	Community Health Worker
C-IMCI	Community – Integrated Management of Childhood Illnesses
CSC	Community Scoring Card
CTA	Call to Action
DOTS	Directly Observed Treatment short course
DHCC	District Health Coordination Committee
EC	European Community
EPHS	Essential Package of Hospital Services
EPI	Expanded Program on Immunization
FHA Group	Family Health Action Group
HEFD	Health Economics and Financing Directorate
HNSS	Health and Nutrition Sector Strategy
GCMU	Grants and Services Contract Managing Unit
GDHR	General Directorate of Human Resources
GDPM	General Directorate of Preventive Medicine
GDPP	General Directorate of Policy and Planning
GIHS	Ghazanfar Institute of Health Sciences
HMIS	Health Management Information System
HP	Health Post
IARCSC	Independent Administrative Reform and Civil Services Commission
IEC	Information, Education and Communication
IQHC	Improvement Quality Health Care
KMU	Kabul Medical University
LMG	Leadership Management and Governance
MAAR	Monthly Aggregated Activity Report
MCH	Maternal and Child Health
MoE	Ministry of Education
MoF	Ministry of Finance
MICS	Multiple Indicators Cluster Survey
MoiHA	Ministry of Irshad, Haj and Awqaf
MoHE	Ministry of Higher Education

MoPH	Ministry of Public Health
MRRD	Ministry of Rural and Rehabilitation Department
MoWA	Ministry of Women Affairs
MSH	Management Sciences for Health
NGO	Non-governmental organization
NHNP	National Health and Nutrition Policy
NIDs	National Immunization Days
NRVA	National Risk Vulnerable Assessment
PHCC	Provincial Health Coordination Committee
RMNCH	Reproductive Maternal and Neonatal Care Health
TB	Tuberculosis
TFR	Total Fertility Rate
ToRs	Term of Reference
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United State Agency for International Development
WB	World Bank
WHO	World Health Organization

FORWARD

I am very pleased to present the Ministry of Public Health's Community Based Health Strategy 2015-2020.

This strategy is different from the first Community Based Health Care Strategy 2009 to 2013 in that initiatives those have been successfully piloted and have officially been included for scaling up country wide. The initiatives are family health houses, school health and the use of community score cards. During the development of this strategy there was also more rigorous questioning about the sustainability of current and proposed interventions, the feasibility of quality implementation and whether there should be priority geographical areas where the community based health (CBHC) system should be strengthened. The latter is with the intention of improving access and equity.

There is no doubt that many of the planned outputs and outcomes in the national health strategy will only be achieved through a sound CBHC system. CBHC is for example, the foundation for the successful implementation of the basic package of health services (BPHS).

I would like to thank the General Directorate of Preventive Medicine and the Community Based Health Care Department for leading the development of this revised CBHC strategy and other stakeholders for their technical support.

Many thanks also to UNICEF, UNFPA, WHO and USAID/MSH who supported the Ministry of Public Health technically and financially.

Finally, I would like to take this opportunity to urge all our partners to support this strategy and align their resources to ensure effective implementation.



Dr. Ferozuddin Feroz
Minister of Public Health
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ACKNOWLEDGMENT:

I thank everyone who contributed to the development of the CBHC strategy 2015-2020. I would like to acknowledge all members of the CBHC strategy revision Working Group: Dr. Said Habib "Arwal"(MoPH-CBHC), Dr. Stephanie(MoPH), Dr. Saida Jan "Yousefzai" (GDPP), Dr. Hedayatullah "Mushfiq" ,Dr. Hedayatullah "Salih" ,Dr. Evon Smith and Dr. Ahmad Shah "Pardis" (MSH-LMG), Dr. Ahmadullah "Mollakheel" (NUFPA), Dr. Shirin Varkey, Dr. Depika "Attygalle" and Dr. Khaksar "Yousefi" (UNICEF), Dr. Sharifullah "Haqmal" (WHO), Dr. Azim "Omid" (GCMU), Dr. Ghulam Ahmad "Mateen" (SAF), Dr. Ahmad Shah" Abdurahimzai ", Dr. Sayed Masoud "Sadat" ,Dr. Hamed Masoud "Nawabi" Dr. Karima "Joyan" ,Dr. Asadullah ,Dr. Mohammad Sadiq "Ahmadzai" and Dr. Shah Poor "Hakimi" (CBHC-MoPH).

I am also very thankful to all directors and managers of the MoPH and individual experts for their contributions.

The process of developing the CBHC strategy was very participatory. In addition to the CBHC Strategy Working Group holding regular meetings, they solicited technical input from representatives of other MoPH directorates. Individual meetings were re-convened with most of the MoPH directors and managers to obtain their final inputs; also assessment at provincial level was done from 12 provinces of the country. Beside of that, a national consensus building workshop for stakeholders was held on 30 November 2014 to review the draft strategy to obtain suggestions and build consensus. The document was shared with CBHC task force meeting, the Technical Advisory Group (TAG) on 6 January 2015 to enrich the document and obtain approval. The final version of the document was presented to the MoPH Executive Board for final review and comments. The Board endorsed this document on 18 April 2015.


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Ministry of Public Health

Preface:

As MoPH /CBHC Program National Coordinator I am pleased that under my leadership, revision of the CBHC strategy has been undertaken.

This strategy has two aspects. The first is how to support successful implementation of the BPHS in community Level and the second is how the CBHC department can enhance its stewardship role in all over of the country program.

The main focus of this strategy is that communities actively participate in health system to contribute in reduction of maternal and child mortality and morbidity through provision of quality health care services, empower community to identify their own health needs and find local solutions for them, adopting healthy behavior promote their lifestyle.

For a successful revision of strategies it is needed to be evidence based therefore during revision process we assessed the implementation of previous CBHC strategy at central and field level, did a desk review of documents of the balanced score card and community based researches reports. We tried to ensure that our most important national health and disease strategies, priorities, activities and resources are reflected in this document.

Experts from WHO, UNICEF, UNFPA and MSH, have provided their technical inputs and shared the experiences for enrichment of this strategy. The success of this strategy document belongs to all of the CBHC Partners.

Let me to thank once again from WHO Afghanistan for supporting to print this important document.

I would like to thank the MoPH leadership, especially His Excellency Dr. Ferozuddin "Feroz", Dr. Najebullah Safi Acting Director of General preventive medicine directorate, Dr. Stephanie Simmonds advisor for MoPH, MSH team, UN agencies, The Director for CHD, CBHC strategy revision working group members and CBHC Task Force members who supported us in developing this revised strategy.

For best health of all Afghans,

Dr. Said Habib Arwal
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1. INTRODUCTION

1.1. Background

In 2002 the Ministry of Health (MoPH) determined its priorities for rebuilding the national health system, to lay the foundations for equitable, accessible, acceptable, and quality health care. The Ministry outlined the ways forward for dealing with challenges based on the knowledge and experience of staff and other stakeholders and on surveys and studies. As a priority the MoPH focused on the provision of essential health services that have the greatest impact on the major health and disease problems are cost-effective and equally accessible to both rural and urban populations.

The concept of working with communities to improve access of the community to core health services while empowering those communities has been entrenched since those early days and is emphasized in all in the MoPH national health policies and strategies¹. However, CBHC is not new to Afghanistan. It existed prior to the many years of war and conflict. It has been adapted over the years to the specific socio-cultural context of Afghanistan

The 2003 Basic Package of Health Services (BPHS) and the 2005 Essential Package of Hospital Services (EPHS)² were developed by the Ministry to help increase the coverage of health services close to the community. The CBHC program is the foundation for the successful implementation of the BPHS.

The implementation of CBHC activities recognizes first that families and communities have always looked after their own health. Religion and cultural norms and beliefs play an important part in health practices, and families are making decisions to maintain health or care for illness every day. In addition, community members understand and have better information on local needs, priorities, and dynamics in addition to the available local resources to promote health within their own community. The partnership of health services with communities therefore has two key aspects:

- To welcome and accept the guidance and collaboration of communities in the implementation of health programs and the acceptable provision of health services, and encourage them to identify and solve their own problems.
- To persuade families and communities to make appropriate use of formal health services, and where necessary to change behavior and life styles

The main purpose of the CBHC program is to increase community awareness about importance of promotive and preventive measures and to reduce treat common causes of mortality and morbidity, particularly among children and mothers, who, in Afghanistan are the most vulnerable of any community. A major advantage of community engagement in local health planning and implementation of health related interventions is that it can help ensure sustainability of the

¹ See the latest examples e.g. the 2015 Revised National Health Policy 2012-2020, the current National Health Strategic Plan 2011-2015 and the new National Health Strategy 2016-2020

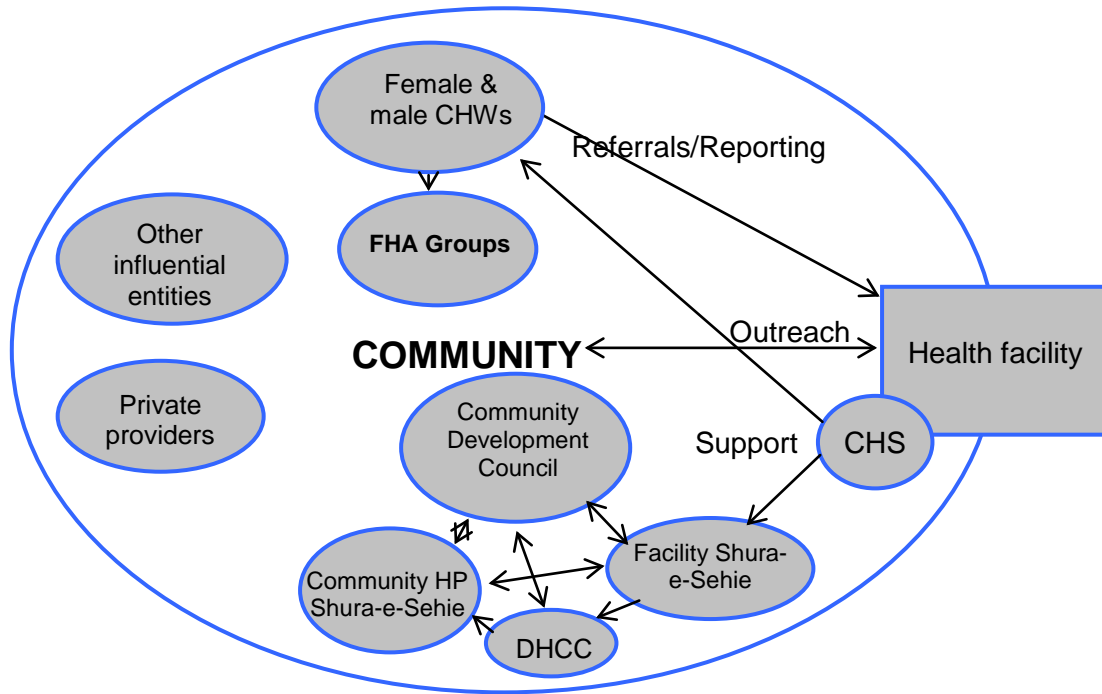
² See annex A for some brief notes about both packages

interventions. Also Call to Action for renewing commitment to reducing preventable deaths among women and children follow Kabul Declaration highlights priority targets for 2020 including:

- Reduce unmet need for FP by 10%
- Increase quality SBA to at least 60%
- Increase essential and emergency care of sick newborns to at least 50%
- Increase national vaccination coverage to at least 90%
- Increase coverage of interventions for prevention and management of pneumonia and diarrhea to at least 60%
- Increase treatment of acute malnutrition to at least 50%
- Ensure accountability through quarterly review on performance of RMNCH using CTA score card.

1.2 Community Based Health Care Situation Analysis

Community Based Health System, Afghanistan



The Afghan CBHC system is shown in the above figure. This emphasizes the dynamic nature of the system. Key stakeholders include:

1. Community health workers
2. Community health supervisors
3. Health shura (Shura-e-Sehie)
4. Family health action groups

Community health workers (CHWs)

CHWs are important members of the health system working as they do with the community. A CHW has to be from the same area he/she is serving so that she/he is familiar with the culture and language of the community; the community they serve should also select them.

A CHW provides basic health services from his/her home, which is recognized as a health post. Usually, both a female and a male community health worker staff a health post. In the case of the unavailability of both a male and a female CHW, just one CHW may work at the health post but this not an ideal situation. A health post is responsible for a catchment area for 1,000 to 1,500

people, equivalent to between 100 - 150 families. The coverage of a health post can be changed according to a geographical area .g. In a mountainous area, to maybe one CHW for 30-40 families).There are urban CBHC program for the poor urban populations in Kabul and a nomad CBHC program has been started but needs more CHWs to extend the coverage. Overall, there are still many areas of the country not covered by CHWs. At present in 2015 there are over 28,000 CHWs serving rural populations in Afghanistan.

CHWs are trained for between four- six months to deliver basic health services. The main responsibilities of community health workers are as follows:

- Health education, the promotion of health and changing the health habits of the community
- Referral of patients to health facilities when needed
- Provision of first aid
- Treatment of common and simple illnesses e.g. ARI. Diarrhea and malaria based on the C-IMCI treatment protocol
- Mother and child health
- Community mobilization for health actions
- Follow-up of TB-DOTs
- Participation in national immunization days and other relevant campaigns
- Community based rehabilitation awareness.

The MoPH takes the motivation of CHWs very seriously as they are volunteers. Recognition of their role in the health system, respect, honor, updating their knowledge, and supportive supervision are important types of compensation. The MoPH also recognizes the importance of different types of incentives, including reimbursement of expenses, rewards for good performance or performance based financing to keep CHWs in their volunteer role. The Ministry continues to explore affordable, sustainable mechanisms that will benefit all CHWs on an equitable, equal basis.

Community health supervisors

CHWs are supervised and monitored by a community health supervisor from the nearest health facility. A community health supervisor is member of the health facility. S/he is the main link between the facility and the communities in the catchment area of the facility. S/he supervises all the CHWs in the catchment area of the health facility, and guides them on the delivery of the basic health services. Community health supervisors conduct monthly supervisory meetings with CHWs and ensure the regular replacement of materials in the CHW kits. In addition, a community health supervisor collects and processes all monthly reports from CHWs and helps them in their practical work. They also evaluate the performance of CHWs and identify the need for their further training. In the course of their work the supervisors follow their term of reference, supervisory checklist and standard guidelines.

Health shura

There are two types of health shura in the CBHC program:

1. A health shura at the health post level

2. A health shura at the health facility level.

The health shura at the health post level supports health related activities in the community and selects, helps and monitors the CHWs. It encourages families in their catchment area to make full use of the health services and they work with the CHWs to promote healthy behavior and health related interventions using local resources and abilities. The health shura at the health facility level works with CHWs and BPHS staff to adapt health related services to community needs and ensure improved quality of services and the satisfaction of patients and clients who have used a health facility

The MoPH CBHC team has developed health shura guidelines and a manual for community health shuras and facility health shuras in consultation with health shura leaders. The purpose of the guideline and manual is to assist the health shura members in discharging their role and responsibilities in an effective, efficient, transparent and accountable way. The CBHC team pilot tested the guidelines and manual in 24 health facilities and health post shuras in 8 provinces. The pilot health shura successfully applied the guidelines, and improved their performance. The MoPH therefore approved the guidelines and manual for nationwide application³.

Family Health Action Group (FHA Group)

An FHA Group is a support group for female CHWs whose aim is to improve the life style of mothers and appropriate use of health services by mothers and children. With the formation of these groups from community members, various communication channels are used to spread health awareness and key health messages among mothers. This is with the intention of resulting in healthy homes and healthy lifestyles and an increase in the use of available health services.

Female CHWs select a group of 10-15 women as activists/volunteers with young children, respected within their community, and improve their knowledge about health related actions. These women activists/volunteers in turn promote adoption of healthy behavior among the families in their neighboring households. It is expected that this will make the work of the CHWs more effective and more efficient, maybe helping reduce their workload.

Health and disease context

Since 2002, significant progress has been made in the health sector, which is reflected in significant changes in key health indicators. Yet, in spite of major achievements in the health sector the country still lags behind other countries in the region with respect to key health outcomes. This is particularly so in the areas of maternal, infant and child health. Internal conflict, emergencies and security issues combined with socio-cultural factors are major factors.

High maternal and child mortality due to preventable reasons is one of the major public health problems in Afghanistan. According to recent data from Afghanistan mortality survey (AMS 2010), the pregnancy-related maternal mortality ratio is approximately 327 per 100,000 live births, which means that every two hours a woman dies in Afghanistan from pregnancy-related causes. Despite relatively good awareness about use of contraceptives among women (91%

³ Health Shura Training Guideline and Manual on 16 August 2014.

women have heard about any contraceptive method), access to family planning services remains low, with only 22 percent of women using some type of contraceptives, and the total fertility rate is 5.1 that is among highest in the region. The infant mortality rate is 74 per 1,000 live births and the under-five mortality rate is 102 per 1,000 live births (MICS 2010/2011, Afghanistan Central Statistics Office and UNICEF).

Communicable diseases account for 60 to 80 percent of all curative outpatient visits and for more than half of all deaths in Afghanistan. Tuberculosis (TB) is one of the main public health burdens. TB prevalence (all cases per 100,000 populations) is 358, while it is 169 globally (WHO Global TB report 2013).

The 2011-2012 Afghanistan multiple indicator cluster survey (MICS) found that 18 percent of children were suffering from acute malnutrition and the prevalence of chronic malnutrition among under-five years old children (stunting) was 55 percent. According to the national nutrition survey, carried out by the MoPH in 2013, micronutrient deficiencies are widespread in Afghanistan. Anemia (Hb levels <11.99gm/dl) is common in women of reproductive age (40.4 percent) and among children 6-59 months of age (44.9 percent). Vitamin A deficiency (< 0.70 µmol/l) is markedly more common in children 6-59 months of age (50.4 percent). Iodine deficiency was fairly common among both women of reproductive age and children 7-12 years of age, with a prevalence of 40.8 percent and 29.5 percent respectively. The majority of women of reproductive age (95.5 percent) and children 6-59 months (81.0 percent) are deficient in vitamin D (<20.0 ng/mL). Afghanistan also has significant environmental health issues such as unsafe drinking water, inadequate sanitation facilities, improper solid and hazardous waste management, chemical contamination, poor air quality and insufficient food hygiene practices. Forty-six percent of the Afghan population use improved drinking water sources and only 8 percent of household use improved sanitation facilities (NRVA 2011- 2012).

Afghanistan is in a state of transition, having recently experienced the handover of security responsibilities from international forces to the Afghan government. This transition process, which is associated with a decline in military and civilian aid, is characterized by considerable political and security uncertainty. The security transition could result in increased security threats, which can further undermine effective governance and delivery of basic services, and increased limitations on movement, at least in the short term. This could undermine access of the people to health services and inhibit their travel to seek medical advice from the health facilities.

Despite the challenges such as insecurity, the turnover of staff particularly at provincial level, illiteracy, and inadequate transportation facilities for community health supervisors, the shortage of female supervisors, and the irregular supply of CHWs kit, the CBHCC department has had considerable successes with the CBHCC strategy 2009 – 2013. Key quantitative and other outputs of the CBHC strategy include, but are not limited to:

- An increase in the number of CHWs from 18,939 to 28,250 (based on information taken from the HMIS)
- 4,447 FHA groups established (CHWs HR database and NGO reports)

- CBHCC department has supported the recruitment of 219 more community health supervisors
- The department has revised the CHW training curriculum which has been used for training of 13,559 CHWs in 29 provinces
- CBHCC department created position of provincial CBHC officers, and hired qualified staff for mentioned position in 26 provinces since 2012.

The CBHC program has not been formally evaluated and so it is not possible to give the outcomes, impact and quality of the CBHC program.

2. CBHC Vision, Mission and Values

The following vision, mission, values and working Principles of the CBHC program have been developed within the framework of the MoPH national vision, mission and values⁴.

Vision

Working with communities on primary health care to benefit all Afghans close to their homes throughout the country

Mission

The mission of the community based health program is to contribute to the reduction of morbidity and mortality rates, particularly among mothers and children. Through implementing evidence based health activities with members of the community as close to people's homes as possible and promoting a healthy lifestyle through community engagement and empowerment.

Values

While following all laws and regulations of the government of Afghanistan, the implementation of this strategy will respect the following ethical guiding principles:

- Treating all people with **dignity, honesty and respect**, and considering a healthy life to be a **basic right** of every individual.
- Ensuring **equitable access** to and provision of basic, essential, good quality health services for all individuals independent of gender, socio-economic status, age, race, religion and ethnicity.
- Ensuring optimum level of health for both men and women in full consideration of **gender equity and gender mainstreaming**.

Working principles

- Giving priority to groups in greatest need especially women, children, the disabled, and those living in poverty
- Improving the effectiveness, efficiency, and affordability of health services at the community level
- Promoting healthy lifestyles and discouraging practices that are proved to be harmful to health of the individuals and community
- Being honest, transparent and accountable
- Making evidence-based decisions through enhancing community engagement and ownership to better understand the health needs of the communities to ensure relevant, acceptable, user friendly health services and activities
- Promoting a results oriented culture among CHWs and their supervisors
- Recognizing health workers for their high quality performance
- Improving the quality of community based health programs and services that respond to client and patient needs, are safe, affordable, acceptable, accessible, client-centered and

⁴See the 2015 Revised National Health Policy 2012-2020

ensure continuity of care, conform to standards and protocols, and are continually being improved

- Creating sustainability services that are supported and owned by the community
- Strengthening partnership and collaboration with a wide range of stakeholders both within the health sector and with other sectors at the community level

3. CBHC Goal, Objectives, interventions and Actions

Goal

The goal of the CBHC Department is to make a significant contribution to the mission of the Ministry of Public Health to improve the health and nutrition status of the people of Afghanistan. This will be achieved through community based support of the basic package of health services and other community approaches mainly focusing on the two most vulnerable groups, women of child bearing age and children under 5 years of age, especially in under-served areas of the country.

Objectives

1. To scale up CBHC services and initiatives to 90% of uncovered and underserved areas in rural setting and 60% of poor urban and nomad population by 2020
2. To improve the quality of community based primary health care services at household level
3. To empower communities to identify their own health needs and take initiatives to solve identified health problems
4. To enhance the governance of CBHC programs at all levels of health system

Key interventions and actions

3.1 Objective1: To scale up CBHCC services and initiatives to 90 % of uncovered and underserved areas in rural setting, and 60% of poor urban and nomad population by 2020

Intervention 1: increased coverage of community-based health care services in white areas in a rural setting, ensuring the establishment of 6,000 health posts and 10,000 family health action groups through basic package of health services implementer NGOs in close coordination with the MoPH Grant and Contract Services Management Unit (GCMU)

Actions:

- Advocate with Grant Contract Services Management Unit to include recruitment 12, 000 new CHWs (at least 50% female) in uncovered and underserved area in the contract of BPHS implementing partners to meet shortages of CHWs in the provinces.
- Work with GCMU and NGOs to follow and to include the establishment of 10,000 new FHA Groups, as a component of CBHC mentioned in BPHS, in their annual plan in order to support community health workers (especially female CHWs).

- Ensure appropriate selection and coverage of unreached and underserved areas in line with set criteria
- Work with Policy, Planning and Evaluation Directorate to ensure appropriate selection of priority geographical areas for new CBHC program
- Ensure implementation of NGOs annual plan for establishment of FHA groups.

Intervention 2: Increase coverage of community based health care services for nomads through provision of technical support to the Nomad Health Directorate for the establishment of 1,000 health posts and health shuras in nomad settings.

Actions:

- Work with the Nomad Health Directorate to recruit select and train 2,000 CHWs (among nomads and let them to move with nomads) at least (50% female) for nomad through advocacy with GMCU and other technical departments.
- Ensure proper selection, standardized training and the regular supply of nomad CHWs.
- Develop/adapt a separate specific training package for nomad CHWs according to their needs.
- Develop a specific job description for nomad CHWs
- Ensure availability of a need-based training package for nomad CHWs.
- Print and distribute the training package to all nomad CHWs
- Conduct training of trainers for CHWs trainers
- Develop a medicines kit for nomad CHWs
- Assist the Nomad Health Directorate in the establishment and functioning of health shura for nomad health posts
- Ensure regular monthly meetings of health shura for nomads are conducted.

Intervention 3: Expand CBHC urban program for urban poor to first to five large cities in the country through the provision of technical support to the urban health unit at MoPH based on lessons learned from the current urban health program in Kabul and then to the rest of the country.

Actions:

- Document lessons learned from the current Kabul urban CBHCC project.
- Advocate for expansion of the Urban CBHC Program to Herat, Mazar, Jalalabad, Kundoz and Kandahar.
- Ensure proper selection, standardized training and the regular supply of urban CHWs.
- Ensure availability and implementation of a need-based, specific training package for urban female CHWs.
- Revise the training package for urban CHWs according to the needs of poor urban settings.
- Provide ToT training for CHWs trainers and CBHC officers in urban settings.
- Print and distribute the training package to all urban CHWs.

- Revise the job description for urban CHWs.
- Revise the urban CHWs kit for urban CHWs.
- Assist the Urban Health Unit in the establishment of health shura at urban health facilities.
- Ensure regular monthly meetings of the urban health shuras are conducted.
- Assist the Urban Health Unit in the establishment of FHA Groups to support urban community health workers
- Ensure proper selection and training of FHA group members, based on standard CBHCC-MoPH selection criteria which is mention in their ToR in the annexes

3.2 Objective 2. To improve the quality of community based primary health care services at household level

Intervention 1: Strengthen the capacity of CBHC elements and related structures (MoPH-CBHC) Organogram.

Actions:

- Develop and implement guidelines, training packages, treatment protocols and standards for service provision.
- Update existing CBHC documents.(CBHC protocol, training guidelines and manual)
- Introduce new low cost and high impact intervention to reduce maternal and child mortality
- Conduct ToT trainings on developed or updated documents for target staff.
- Organize periodical on-the-job mentoring of community health care providers addressing quality measures and standards.
- Ensure the replication of relevant training at the community level.
- Ensure need based initial and in service/ refresher trainings are conducted at the community level through BPHS implementing NGOs in close collaboration with GCMU, to improve CHWs performance
- Develop the capacity of BPHS implementers in the implementation of community based interventions through need based orientation and training workshops.
- Assess community satisfaction and proportion of usage through available CBHC tools for services on periodical basis.

Intervention 2: Ensure supportive supervision, monitoring visits and advocacy for the CBHC program

Actions:

- Strengthening monitoring and supervisory tools ensuring quality health care services are in place in the health facilities regarding of CBHCC program

- Advocate with GCMU to ensure that provincial CBHCC focal person ,CHSs, heads of health facilities and community midwives supervise the performance of relevant element of CBHC in a supportive manner
- Work with GCMU to ensure that NGO staff (central and provincial) supervise health posts, health facilities, health shuras, and FHA Groups in a supportive manner
- One CHS for 15- 20 health posts, will be hired which seems to be the maximum number that can be adequately supervised by a CHS, assuming that the health posts are not far from a health facility.
- Work with GCMU and NGOs to hire female CHSs where appropriate and needed
- Work with GCMU to make sure that CHSs receive transportation costs for conducting supervisory visits
- Coordinate with stakeholders, including the MoPH M&E Department, PPHOs and NGOs to ensure that CBHC activities are jointly monitored at provincial, district and community levels
- Strengthen the monitoring mechanism in CBHC programs through receiving reports and sending feedback to monitors and provincial CBHCC focal person
- Promote mechanisms for reporting shortages of supplies by CHWs and feedback to NGOs to minimize stock-out

Intervention 3: Promote the implementation of quality improvement tools through advocacy with, and encouragement of stakeholders to make sure that care provided by CBHC elements are according to harmonized quality improvement approaches

Actions:

- Coordinate with the MoPH improvement quality health care for advocacy on applying quality standards in accordance with the Harmonized quality improvement tool at the community level
- Coordinate with the BPHS implementer to strengthen follow up of IQHC recommendations for the implementation of quality improvement tools
- Advocate with GCMU, in coordination with the IQHC to include implementation of the harmonized QI tools in BPHS implementers’ contracts

Intervention.4: Establish national, provincial and international networking of CBHC to exchange knowledge, share experiences, and identify best practices to be scaled up to other areas

Actions:

- Conduct on-the-job mentoring for health posts in the health facilities
- Conduct on-the-job mentoring for CHSs in the nearest health facilities
- Design exposure visits and study tours for CBHC central and provincial staff both inside or outside the country
- Hold annual, biannual or quarterly CHSs coordination meetings in the provinces
- Conduct annual health shura meetings at district and provincial levels

3.3 Objective 3: To empower communities to identify their own health needs and take initiatives to solve identified health problems

Intervention 1: Enhance active community participation through capacity development of the health shura members strengthen the relationship between health facilities and the communities, involving the community in decision making about their own health issues, promoting women’s participation in the health system and mobilize community resources to support health programs and generate increased demand at the country level to accelerate national scale-up of low cost and high impact interventions

Actions:

- MoPH CBHC department will develop and implement capacity building plan for the health shuras, in close collaboration with the BPHS implementing NGOs. To strengthen the governance and stewardship role of shura, CBHC department developed new health shura guideline which still shura not received any kind of trainings
- Health shura guidelines and health shura manual will be introduced nationwide in a phase wise manner. Health shuras will be oriented and trained in the use of the guidelines and manual in improve their performance and better serve as a link between the community and health system. MoPH CBHCC department will develop, update and deliver training programs based on health shura guidelines and health shura manual, for health shura members. CBHCC department will conduct these training on a regular basis in collaboration with the BPHS implementing NGOs. To strengthen the governance and stewardship role of shura, CBHCC department developed new health shura guideline which still shura not received any kind of trainings
- Central and provincial MOPH authorities, PPHCC members, Provincial CBHCC officer, District health officer, DHCC members and implementing NGO officials will make monitoring visits to the health shuras.
- Health post shura, facility health shura, district hospital shura, provincial hospital community board, district health coordination committee, and provincial public health coordination committee will work closely with each other. Shuras will be supported in developing and implementing their annual action plan.
- The head of the health facility and director of the district hospital will be responsive to health shuras in their catchment area. They will actively coordinate with health shuras. Shura will have authority to monitor the performance of the health facility as per standard shura guideline by using the M&E developed tool for shura members.
- Identity cards will be issued to the health shura members for their well identification to all health providers. CBHCC department will design and distribute ID cards to health shura members through provincial CBHCC officers.
- The contributions of high performing shuras and shura members will be recognized, through providing appreciation letter and incentive to them.
- Provide technical support to the BPHS implementer on improving community/facility linkages through regular meetings and interactions, by PPHO team at provincial level

- Strengthening follow up of the existing mechanisms for the maintenance of on-going dialogues between community and health facilities such as shura monthly meeting at health facility and health post level
- Provide technical support to NGOs through to establish health shura in all health facilities and health posts
- Assist BPHS implementers in developing and implementing a capacity building plan for shura members on community leadership and governance
- Establish a mechanism that enables health shura members to oversee provision of health services at the health facility and health post levels
- Support health shura in developing the annual health plan and tracking implementation of planned activities as per guidance of standard health shura guideline
- Strengthen facility/community shura coordination and collaboration as describe in the health shura guideline as per guidance of standard health shura guideline
- Establish women health shura at both health facility and health post levels as describe in the health shura guideline
- Involve and encourage health shuras to participate in the decision making process of health related issues as describe in the health shura guideline
- Assist health shura to identify local resources to contribute to the support of the health system as describe in the health shura guideline
- Promote practical approaches for community members' active participation in health problem solving as describe in the health shura guideline
- Assist in developing linkages between communities and external resources through collaboration with different existing for a, such as CDC, VDC, etc., at the community level as describe in the health shura guideline
- Revise the ToRs of both health facility and health post shura to ensure that they consider their responsibilities as describe in the health shura guideline
- Increase health care seeking behaviors in the community through conducting community events and campaigns involving health Shura and religious leaders

Intervention 2: Incorporate new initiatives/best practices with community based health care program at the country level

Actions:

- Coordinate with Reproductive Health Directorate to advocate with MoPH, donors and partners for the expansion of the establishment of Family Health Houses(FHH),considering documented lessons learned from the current FHH project, across the country
- Coordinate with Reproductive Health Directorate to ensure implementation of NGO plan for the establishment of FHH projects
- Provide technical support to the Child and Adolescent Health(CAH)Directorate to expand implementation of the school health initiative program across the country through facilitating the establishment of health posts at schools
 - Establish a mechanism for involving CHSs in supervising and supplying of kit and IEC materials school health posts to ensure proper selection, training and effective implementation of the initiative

- Assist CAH directorate in developing a training manual for school health workers
- Continue community scoring card (Future health systems round 2) project, as It's a community base project (FHS2) which was piloted by Johan's hapkinse university in three provinces ,the main focus of this project is how to mobilize community leader to mobilize resources and to take part in improvement of health services if the resources and donor available

3.4 Objective 4: To enhance the governance and stewardship of the CBHCC program at all levels of the health system for further effectiveness and efficiency through strengthening of coordination, established a monitoring mechanism and enhance capacity of CBHCC staff at central and provincial level

Intervention 1: Build the capacity of the CBHC department on management, leadership and governance through the institutionalization of sound management, effective leadership, and transparent governance practices to fulfill the stewardship role of the department at central and provincial levels

Actions:

- Increase managerial, governance and leadership knowledge and skills of CBHC staff at central and provincial levels by taking advantage of all opportunities for training, mentoring, coaching and networking

Convince GDPM, GDHR and IARCSC to include the CBHC consultant team (They are the MoPH-CBHC department team, which they were hired through competitive process in the MoPH by financial support of MSH-LGM project until end of September 2015) in the MoPH Tashkeel, through conduct advocacy orientation meetings with them which already mentioned in the implementation action plan of this strategy

- Advocate with donors to maintain and increase their technical and financial support the CBHC program
- Enhance the linkage between the CBHC program and other programs of MoPH and relevant stakeholders through GCMU to include CBHC interventions in line with the revised CBHC strategy in the contracting out process of BPHS with implementer NGOs
- Persuade GCMU to involve the CBHC Department in the implementation and monitoring of contractors related interventions
- Strengthen coordination with other related MoPH departments through available forums such as CBHC task force meeting, EPHS and BPHS coordination meeting
- Convince technical departments/programs of MoPH to use CBHC standard guidelines during the implementation of community based activities , through conducting of advocacy orientation meetings
- Convince the MoPH authorities to allocate CBHC appropriate funding in the MoPH budget, through conducting of advocacy orientation meetings
- Develop strategic and annual operational plans for the CBHC program and submit them, with an estimated budget, to the MoPH leadership

- Enhance coordination with GCMU to strengthen CBHC oversight on NGOs CBHC related reports
- Establish a review and feedback mechanism for CBHC reports, channeling them through HMIS and GCMU
- Strengthen coordination at provincial level through regular conducting of CBHC sub-committee meetings as a part of PHCC at the provincial level by support of provincial CBHC focal person
- Share CBHC update information with all stake holders via MoPH websites
- Develop a motivational mechanism for CHWs to maintain their volunteer role through recognition of highly performing CHWs, appreciation for their work, introducing them to the community and conducting special recognition events such as celebration of the national CHWs Day
- Convince the EPI Program to involve CHWs and CHSs in NID and other vaccination campaigns
- Advocate with MoPH for the establishment of a performance based system of incentives
- Advocate with UNICEF and other donors to scale up distribution of community ambulances to CHWs all over the country
- Advocate with GCMU to include regular compensation to CHWs in NGOs contracts
- Enhance collaboration with line ministries such as the Ministry of Higher Education, Ministry of Women Affairs, Ministry of Irshad, Haj and Awqaf through comprehensive coordination mechanisms, through conduct regular coordination meetings and seminar with them
- Advocate with MoHE and MoPH to include CBHC concept in the curriculum of higher education institutions and the Ghazanfar Institute of Health Sciences(GIHS)
- Work with MIHA (Ministry of Irshad, Haj and Awqaf) to recognize CHWs in Friday Khutba and invite people to work voluntarily for their health
- Advocate with MoWA to encourage educated females to work as CHSs at health facilities
- Advocate with the MoPH authorities for the integration of community midwives and community nurses to the CBHC program
- Advocate for the integration of community midwives and nurses with the CBHC network
- Strengthen the CBHC program partnership and coordination through supporting a participatory decision making environment with partners and stakeholders
- Strengthening the involvement of religious leaders through their involvement in the selection of CHWs, and working with health shura members
- Strengthen the coordination of CBHC with existing councils working for community development through the establishment of a network with them.
- Conduct studies to assess distribution of health posts , and overall CBHC program implementation effectiveness in Afghanistan
- Conduct advocacy meetings with private sector to raise their awareness about CBH program
- Strengthen the coordination of CBHC with private sector through inviting them in the CBHC related meetings and vice versa

4. IMPLEMENTATION, MONITORING and Evaluation

4.1 Implementation

Successful implementation of the CBHC strategy depends upon close collaboration between all partners and stakeholders. This includes relevant departments of the MoPH, donors, UN agencies, NGOs, the private sector, parliament, line ministries such as MoE, MoHE, MoWA, MoHaj, MRRD, MoF and the community, especially religious leaders and the various community councils.

Considering its governance function, CBHC will focus on developing a regulatory framework that refers to a spectrum of rules, procedures, a code of conduct and standards, and ensures tools for implementation; monitoring and evaluation, including generating and analysing data, and assuring the quality of services; formulating a strategic direction for partners; and strengthening coordination and building partnerships with the private sector, in line ministries, technical departments of the MoPH, UN agencies, NGOs and the community.

The CBHC department will develop the capacity of its staff in management, leadership and governance so that they are able to scan their environment (see what is going on and what has changed); focus attention and resources (decide what people should pay attention to); align and mobilize other people and resources (connect other people and resources in the move forward); and inspire others (arouse and sustain people's commitment to new goals) ensuring accountability and transparency at central, provincial and community levels.

CBHC will place great importance on putting community involvement at the heart of community health interventions to increase health services impact at the community level. Formation, capacity building and oversight of health shura at health post and health facility levels will enhance the value of their responsibility to promote and adopt healthy lifestyles and behaviours at home and in the general environment, and actively participate in all programs relevant to their health and health care.

These health shura also strengthen community-facility linkages e.g. referrals, outreach activities, priority setting; mobilizing local resources, assessing health needs and client satisfaction, and providing feedback on CHWs and health facility performances; promoting collaboration with CDCs to facilitate addressing health problems in communities; supporting the scale up of establishing FHA Groups to help community health workers (especially female CHWs); advocating for an increased number of CHWs and female CHSs; and ensuring the provision of culturally and gender sensitive services

Close coordination with BPHS implementing partners will be a key factor for success of the strategy as it reinforces community health facility relations at sub, basic and comprehensive health centres as well as district hospitals, and paves the way for improved community engagement and support, in and to, the health services provided to the community.

At the provincial level, the CBHC focal point will represent the CBHC department in the Provincial Health Coordination Committee (PHCC) and other coordination in order to:

- Strengthen and maintain close coordination with BPHS implementing NGOs, health facility staff and other partners including community health supervisors
- Assist with the implementation of national policies, strategies and protocols related to community based health care
- Oversee community health workers, community health supervisors and health shura work and provide them with required technical support and timely feedback.

CBHC will build up provincial CBHC sub-committees to enhance its decentralized coordination and its partnership with (PPHOs) Provincial Public Health officers and other partners; oversee implementation of the national CBHCC strategy and relevant guidelines and protocols; and support CBHC elements and interventions as an integrated part of BPHS at provincial level. The CBHC sub-committees in turn receive support from them.

At the national level, CBHC will strengthen coordination and collaboration with GCMU and technical departments of the MoPH for the implementation of integrated community-based interventions mainly focusing on maternal and child health. In its governance role, the CBHC Department will oversee, coordinate and advocate for the development of a sustainable, integrated and effective CBHC system, providing accessible and quality health care and health promotion in a way that addresses community health needs and is acceptable to communities. It will also coordinate closely with the BPHS and EPHS Coordination Committee (BECC).

The CBHC Department has established a strong task force to provide focused technical input on specific topics. BPHS implementing partners, supporting partners, UN agencies, and the MoPH technical departments are members of the task force who work collectively and in needs based specific working groups to provide recommendations on developing and revising documents, implementation guidelines, and relevant strategies and approaches.

In addition, the CBHC Department will advocate with high authorities and donors for a balanced expansion and enhancement of the CBHC system, an upgrading of the department to a higher level, and the transition of CBHC consultants to the MoPH Tashkeel, and in strengthening its coordination with the private sector, NGOs, UN agencies and line ministries (named above) on the smooth implementation of relevant interventions.

An implementation plan has been developed by the CBHC at national level. It focuses on advocacy, coordination, capacity building, and the oversight and monitoring of CBHC progress on implementation the strategy at central, provincial and community levels. The plan specifies actions and activities to be taken within a specified timeframe and determines responsibilities for implementation. It also identifies the necessary resources (Please see annex H).

Each provincial CBHC officer will also develop a provincial annual plan to support the strategy at provincial and community levels. This will be supported from the central level through coaching, mentoring, and networking to contribute to achieving national CBHC targets and objectives. BPHS

implementing partners develop their own annual action plans to contribute to the achievement of the provincial plans.

4.2 Monitoring and evaluation

In close coordination and collaboration with the MoPH HMIS, M&E, IQHC and relevant technical departments, including the PPHO teams, CBHC is implementing joint routine and short term monitoring at central and provincial (in each monitoring visit will be last for one week in each province). This routine monitoring involves compiling information on quarterly basis for a core set of indicators. The short term monitoring is done for a limited period of time to track new activities and collect information to help solve recurrent problems. This close collaboration will allow adequate monitoring and evaluation of the strategy at central and provincial levels.

At the provincial level, the CBHC department will ensure the involvement of relevant (PPHOs) Provincial Public Health officers and NGOs in the monitoring process on monthly and quarterly bases. After provincial level health staff has been briefed on the targets of the program, a comprehensive monitoring plan for measuring indicators will be developed. A national monitoring checklist and IQHC standards will also be used during joint monitoring visits from the health posts and facilities by CBHC central team, GCMU, M&E directorate and PPHO team.

Provincial data will be analysed in the field and the results shared with the CBHC department. The provincial CBHC focal person will be trained to do the preliminary data analysis and use the analysis for improving their coverage, their activity plan, and the quality of services. The staff will be trained to produce charts, graphs and tables from the HMIS data and use it as a discussion point for their meetings. Efforts will aim at creating a system for regular collection; analysis and feedback of collected data (please see the M&E framework in (annex I)

Evaluation:

It is vital to evaluate what has worked, and what has not. It is essential for the CBHC department to evaluate Implementation action plan at the end of each year to assess the coverage, quality of health services which is provided by CBHC network, the evaluation of this strategy will be done by third party.

Indicators

The suggested key indicators that will allow tracking progress of the strategy implementation are:

1. Number of new health posts established during the last year
2. Number of new FHA Groups established during the last year
3. Number of new health posts established for Kuchi population in a year
4. Number of new CHWs trained in urban settings in a year
5. Number of Female CHSs recruited in line with set criteria in a year
6. Number of cities/provinces run CBHC program for poor urban setting in a year
7. Proportion of CHWs received need-based revised supply kit

8. Proportion of health posts supervised by CHSs and other health facility staff on monthly bases
9. Number of health Shuras trained about the community governance guidelines in a year
10. Number of Central CBHC team members included in MoPH Tashkeel in a year
11. Percentage of target provinces visited by the CBHC monitoring team in a year
12. Number of advocacy meetings conducted for up gradation of CBHC unit to directorate level or above in a year
13. Percentage of Afghan population receive PHC services in a year
14. Percentage of Afghan population changed their health seeking behavior through CBHC interventions in a year

Indicators are set for activities listed in the implementation plan at input, process, output, and outcome level to enable the CBHC monitors to track progress on set targets, objectives and activities on a regular annual basis. Report of the monitoring findings will be shared with partners within and outside the ministry to take corrective actions and change priorities as needed.

Annex A. Brief notes about the BPHS and EPHS

In March 2002, the Afghan Ministry of Health began a process to determine its major priorities for rebuilding the national health system, and which health services were so important for addressing the greatest health problems that they should be available to all Afghans, even those living in remote and underserved areas. It was decided to call these crucial services a Basic Package of Health Services (BPHS). The key elements to include in the BPHS were (1) those services that would have the greatest impact on the major health and disease problems, (2) services that were cost-effective in addressing the problems and (3) services which could be delivered to give equal access to both rural and urban populations.

The BPHS provides a comprehensive list of services, including maternal and newborn health, child health and immunization, public nutrition, communicable diseases, mental health, disability, and the provision of essential drugs. This is done through four standard levels of health facilities within the health system: the health post, basic health center, comprehensive health center, and district hospital.

To complement the BPHS, and promote a health referral system that integrates the BPHS with hospitals, the MoPH developed an Essential Package of Hospital Services (EPHS). It requires functioning hospitals where all health conditions can be treated to reduce maternal and child mortality rates. The EPHS also gives a standardized package of hospital services at each level of hospital, and provides a guide for MoPH staff, the private sector, NGOs, and donors on how the hospital sector should be staffed and equipped.

Hospitals are classified into three groups according to size of the referral population, number of beds, workload, and complexity of patient services offered:

- District hospitals (part of the BPHS)
- Provincial hospitals
- Regional hospitals
- Another group of hospitals, specialist hospitals, are referral centers for tertiary medical care and are located primarily in Kabul.

Four core clinical functions should exist in each of the three levels of hospitals: medicine, surgery, pediatrics, and obstetrics and gynecology. Mental health and dental health are predominantly provided as outpatient services at various levels.

Annex B. Job Description for the Community Health Worker (CHW), revised 2014

The community health worker (CHW) is a person (female or male) selected by the community according to selection criteria. The CHW promotes healthy lifestyles in the community, encourages appropriate use of health services, and treats and refers common illnesses.

Job Description of CHWs

The CHW is a person (male or female) selected by the community according to selection criteria mentioned above. The CHW promotes healthy lifestyles in the community, encourages appropriate use of health services, and treats and refers common illnesses.

The CHW is accountable to the community health shura for performance and community satisfaction and is technically accountable to the community health supervisor (CHS). The CHW has the following responsibilities:

A. Community Collaboration and Health Promotion

General Responsibilities

1. Actively participates in community meetings and major community events.
2. Actively works with mothers' groups to promote healthier homes and maternal and child health.
3. Encourages and mobilizes family/community participation in the immunization of children and women of childbearing age.
4. Supports national initiatives at the village level and actively participates in all campaigns/activities e.g., national immunization days and surveillance for acute flaccid paralysis.
5. Promotes good nutrition practices and encourages early breastfeeding and exclusive breastfeeding of children less than six months of age.
6. Promotes use of oral rehydration salts (ORS) and other homemade rehydration fluids for home management of diarrhea and dehydration.
7. Promotes hygiene and sanitation, and the preparation and use of safe drinking water.
8. Encourages couples to practice birth spacing and receive family planning services.
9. Promotes psychosocial wellbeing and mental health in the community and raises awareness about prevention and identification of disabilities.
10. Creates awareness within the community and provides information on the dangers of addictive substances such as tobacco, naswar, opium, hashish, and alcohol.

B. Direct Services

1. Identifies and manages acute respiratory infections, diarrhea, malaria, and other common communicable diseases according to national protocols. Treats mild to moderate cases and refers complicated cases to the nearest health center.
2. Counsels patients on correct use of medications included in the CHW kit.
3. The CHW should create awareness among the community on how to prevent TB and should refer or accompany suspected cases to a health facility. Following completion by a tuberculosis patient of the first phase of treatment at the health facility, the CHW should

ensure compliance of TB patients with the second phase treatment course in the community, based on DOTS.

4. Communicates the importance of antenatal and postnatal care. Distributes micronutrients and anti malarial to pregnant women according to national policy. Encourages the community to make regular and timely use of maternal child health (MCH) services.
5. Encourages the use of skilled birth attendants, where possible, and helps families make birth plans. Provides and teaches the use of a mini-delivery kit (see Annex C for kit contents). Teaches family members to recognize the danger signs of complications of pregnancy and childbirth, and assists them in making preparations for emergency referral.
6. Distribution of 7.1% chlorhexidine digluconate; for pregnant women in last trimester and ensure application of it immediately after cutting the cord to the tip of the cord, the stump and around the base of the stump. And repeat application once daily through the first week of life or until the cord separates.
- 7.
8. Distributes oral contraceptives and condoms to willing members of the target population according to national policy. Promotes (LAM) lactation amenorrhea method together with exclusive breastfeeding for the child's health during the first six months of a child's life. Administers first and follow-up injections of Depo Provera. Encourages interested families to seek long-term family planning methods at a health facility.
9. Provides first-aid services for common accidents at the family and community level.
10. CHWs provide community-growth monitoring promotion (C-GMP) services to children less than 2 years of age.

C. Management

1. Meets regularly with the shura to develop, implement, and monitor community action plans for health improvement.
2. Meets regularly with the community health supervisor to review reports and action plans, receive supplies, and for in-service training.
3. Regularly completes and submits the monthly tally sheets to the CHS for the HMIS.
4. Collaborates with and supports community midwife activities in his/her catchments area, including health promotion and pregnancy-related referrals.
5. Develop a community map of the catchment area, knows the members of the community who are eligible to receive the health services.
6. Reports all deaths and informs the health facility of any disease outbreaks.
7. Manages the health post, maintaining supplies and drugs given to CHWs and reporting utilization of drugs and supplies.
8. Helps the CHS to form Shura-e-Sehie at the health post level.

Annex B1: Urban Community Health Worker Job Description

Overall Responsibilities

The urban CHW promotes healthy lifestyle in the community, encourages appropriate use of health services, and refers ill people to health facilities. The urban CHW is accountable to the CHS technically and for overall performance.

1. Main responsibilities

Urban CHWs are responsible for providing health education to the community/ family on the prioritized topics:

- The importance of antenatal and postnatal care
- Regular and timely use of MCH services
- The use of skilled birth attendance
- Teach family members to recognize the signs of complications of pregnancy and childbirth, and the need to make preparations for emergency referral; identify high risk pregnancies to refer a suitable health facility.
- EPI for young children and TT vaccination for young ladies and women
- Raise the awareness of utilization of health services including location and relocation of HFs
- Different FP methods

2. General Responsibilities

1.1 Actively conduct/ provide health education to the community/ family on the below topics;

- Hygiene and sanitation
- The use of safe drinking water
- The use of oral rehydration salts (ORS)
- Good nutrition practices for young children and pregnant women
- Family planning

1.2 Refer cases that need consultation or treatment by doctors/ midwives.

1.3 Counseling and providing family planning

1.4 Following completion of the initial phase of treatment at the health facility, ensure compliance of TB patients with their course of treatment, based on direct observation of treatment short-course (DOTS), and create awareness among the community regarding the prevention of TB

1.5 Collaborate with and support other community based health care providers in their catchment area, including health promotion and pregnancy related referrals

1.6 Actively participate in the community meeting and major community events

1.7 Support actions for national initiatives at the community level and actively participate in all campaigns/ activities

1.8 Provide first aid services for common accidents at the family and community level

● Management

1. Know the members of community and develop a map of the eligible families and the services used.

2. In collaboration with community health shura, CHWs fill the community map and tally sheet

3. Report timely on activities implementation and progress to community health supervisor.
4. Maintain their CHW kit and report utilization of kit contents.

Annex C. Job Description of Community Health Supervisor (CHS)

Reports to head of the health facility (BHC/CHC/DH)

Qualifications:

- Graduate of high school. Professional qualification in health is preferred (a male or female).
- Respected, self-motivated resident of the local community
- Strong communication skills.
- Experience in community development, health care or management experience will be an advantage.
- Working knowledge of Pashto or Dari and fluent in local language if not Dari or Pashto
- Able and willing to travel to all parts of the area extensively

Overall Responsibility:

A community health supervisor will be posted at all BPHS health facilities.

The CHS will supervise all community health activities, not only CHW activities. He or she will assist in training, supporting and supervising CHWs and will also supervise public health programs and promote collaboration between the facility and the community. He or she also assists in the formation and linkage of community health committees (Shura-e-Sehie) with the CHW program and health facilities. He or she is responsible for supporting the community in identifying and addressing their health problems.

Training:

- Assists in practical training during CHW training courses, including supervising the practical experience of the CHWs in the community during their training
- Provides on-the-job mentoring and monthly in-service training to CHWs during debriefing day
- Reviews and evaluates the performance of the CHWs and identifies need for further training, and then consider refresher training for them.

Support and supervision:

- Assists the staff of the health facility in making plans for the community health programs in the facility and its catchment area.
- Implements, supervises and evaluates the community health program activities in the catchment area of the health facility.
- Identifies and reports immediately to the head of the health facility any problems that may interfere in achieving program objectives
- Guides the CHWs in the development and implementation of their action plans.
- Conducts monthly supervisory meetings with CHWs.
- Ensures regular replacement of supplies in the CHW kits.
- Conducts regular visits to the CHWs in their communities to assess and assist their work.

- Encourages team work among CHWs, especially when they are working in the same catchment population
- Provides regular reports on the CHWs to the head of facility

Health Management Information System:

- Supervises the quality of the pictorial registers and community maps maintained by the CHWs and assists the CHWs where needed.
- Supervises completion of the MARs monthly activity report by CHWs and the completion of the facility MAAR.
- Consolidates the MARs monthly aggregative activity report and assists the head of the health facility in preparing consolidated monthly reports and assists in maintaining graphs to monitor the facility health programs.
- Assists in supervising any required community health survey
- Uses the reporting system and information received from village health committees (Shura-e-Sehie) to monitor health conditions and submits findings to the person in charge of the health facility.

Facility community collaboration:

- Assists formation of community health committees (Shura-e-Sehie)
- Provides orientation session on BPHS and on health topics of concern to the community Shura
- Guides information & implementation of community-based health activities
- Promotes support for CHWs
- Provides feedback from community to head of the health facility.

Annex C1: Community Health Supervisor Job Description Urban CHS

1. Qualifications:

1. Graduate of high school. A university degree relevant to health is preferred, male or female (a female is preferred).
2. Respected, self-motivated resident of the local community
3. Strong communication skills.
4. Experienced in community development, previous PHC and management experience and being a Nurse or Midwife will be an advantage.
5. Good reading and writing skills in Dari or Pashto.

2. Overall Responsibility:

A Community Health Supervisor (CHS) will be posted at CHCs both without delivery and with delivery services in urban Kabul. The CHS will supervise all community health activities, not only Urban CHW activities. She will assist /conduct training to Urban Community Health Workers (CHWs) and support and supervise them. CHSs also supervise public health programs and promote collaboration between the facility and community. She also assists in the formation and linkage of Community Health Shura (Shura-e-Sehie) and the Urban CHW program/ health

facilities. She is responsible for supporting the community in identifying and addressing their health problems.

3. Training:

1. Assist CHW trainers to conduct the theoretical training courses for Urban CHWs, and supervise the activities of the Urban CHWs during their practices in the community
2. Provides on-the-job and monthly in-service training to Urban CHWs
3. Assists in identifying Urban CHW training needs.
4. Designs and implements plans to upgrade the skills of both Urban CHWs and members of the community Health Shura, as needed.

4. Support and supervision:

1. Assists the staff of the health facility in making plans for the community health programs in the facility and its catchment area.
2. Implements and supervises the community health program activities in the catchment area of the health facility.
3. Identifies and reports immediately to the head of the health facility any problems that may interfere in achieving program objectives
4. Guides the Urban CHWs in the development and implementation of their action plans.
5. Conducts monthly supervisory meetings with Urban CHWs
6. Ensures regular replacement of supplies in the Urban CHW kits.
7. Conducts regular visits to the Urban CHWs in their communities to assess and assist their work.
8. Encourages team work among Urban CHWs, especially when they are working in the same catchment population

5. Health management Information System:

1. Ensures the quality of the Tally sheets and community maps maintained by the Urban CHWs and assists the Urban CHWs where needed.
2. Completes the appropriate Monthly Activity Reports (MAR) and completes the facility Monthly Aggregated Activity Report (MAAR) in coordination with the HF in charge.
3. Uses the reporting system and information received from Urban CHWs to monitor health condition and submits findings to the in charge person of HF.

6. Facility-community collaboration:

1. Assists formation of Community Health Shura (shura-e-Sehie).
2. Provides orientation to Community Health Shura (shura-e-Sehie) on health related topics.
3. Guides information & implementation of community health plans.
4. Promotes support for Urban CHWs.
5. Provides feedback from community to health staff.
6. Supports referral system from community to HFs.
7. Solves and reports the problems which Urban CHWs are faced with to HFs.

Annex D. Roles and Terms of Reference of Community and Facility Shura

There are two levels of health shura,

1. Community Health Shura at health post level
2. Health Shura at health facility level.

Clearly defining the policy roles and responsibilities of the Shuras are essential to ensure the orderly implementation of CBHC activities.

D. 1 Shura-e-Sehie at the Health Post Level

1.1: Community/health post level shura formation:

The existing shura in the communities will be considered for the community health shura for BPHS activities. However, the existing shura may be reorganized to ensure more responsive to community health needs. The decision of selection/election of the shura members will be depending on community opinion. Health Facility/Health post will facilitate dialogue with different levels of people and beneficiaries of BPHS programs to select/elect community health shura members. Members for the shura may vary from 6-9 depending on community size and opinion. The shura composition will be:

- Chairperson: 1
- Member 5 – 8
- One third of the members to be women if possible.

The concern Trainer or supervisor will act as member secretary of the shura. The member secretary will be responsible for recording and maintaining meeting minutes. At least attendance of two-third members is essential for meeting quorum taking any decision.

The shura members will be selected /elected on the basis of the following criteria:

- Resident at the health post catchments area of the community
- Well known/reputed/influential/authentic formal and informal leaders from community (i.e. like malik, mullah, teacher, etc.) and members from other development program (i.e. credit program, Water Sanitation program, etc.)
- Ensure representation from all cucha (neighborhood)/mosque/corners/section/ of the community
- Beneficiaries of the health program
- Ensure female representation in the shura

A separate female shura may frequently be considered depending on community opinion and culture. The same criteria for selection/election of members will be followed in case of separate female shura.

1.2: Roles and responsibilities:

- Be knowledgeable on selected BPHS, CBHC policies and CHW's job description

- Review monthly progress/performance of CHWs’ activities including his/her updating community maps, completion of the monthly Tally Sheet, and referral clients to health facilities, and give feedback to the CHS or CHWs regarding their performance.
- Develop, implement and review progress of annual action plan for popularizing BPHS activities,
- Support the CHWs in the promotion of healthy behaviors and appropriate use of health services at community and facility level,
- Support outreach activities from the facility and mobilize the community to participate,
- Mobilize local resources for strengthening and sustaining BPHS activities
- Conduct monthly meetings and ad hoc emergency meetings
- Giving ideas and active participation in selection/election of CHWs
- Giving ideas and active participation in selection/election of Family Health Action / Mother’s Support Groups

D. 2 Shura-e-Sehie at Facility Level

2.1: Shura-e-Sehie formation:

The staff of each level health facility will facilitate the establishment of facility level “Shura-e-Sehie”. The Shura-e-Sehie involves different users groups in the management of the health facility and also promotes community-based activities which aim to improve the health status of the population living in the catchments area of the health facility. The Shura-e-Sehie members will be selected /elected from the community health shura at health post level as well as the catchment’s area of respective facility. Members for the shura may vary from 13-15 depending on community size (population and geographical distribution) and opinion. The shura composition will be:

- Chairperson: 1
- Member 12 – 14
- One third of the members should be women if possible.

The shura members will be selected /elected on the basis of the above mentioned criteria for HP Shura

Roles and responsibilities:

- Be knowledgeable on selected BPHS, CBHC policies and CHW’s job description
- Write and sign a constitution of the facility level shura. The constitution will record the names and gender of the members and their location of origin (to ensure equitable representation of the communities within the catchments area), the name of the elected chairperson and member secretary. The facility in-charge will act as member secretary of the shura. The member secretary will be responsible for recording and maintaining meeting minutes.
- Facilitate a health need assessment with the facility level shura members. The need assessment should focus on the major health related problems perceived to be faced by the community.

- Based on BPHS and the health problems perceived by the communities they represent will develop an annual action plan.
- In case of possibility organize an “open door event” (a specific day like Bazaar day, for visiting the health facility to know about services provided and getting an idea of ownership and trust to people) at the health facility for public in every 6 month
- Mobilize local resources for strengthening and sustaining BPHS activities
- Support facilities and community health shura in performing their responsibilities
- Conduct monthly meetings and maintain meeting minutes
- Monitor monthly performance of the facility and satisfaction of clients
- Review implementation status of annual action plan

2.3: Discontinuation of shura membership:

- A member will notify the respective shura if she/he wants to discontinue as a member of the shura. The shura will replace her/him in consultation with people under catchments area.
- The shura may cease any member for the following reasons:
 - Absent from 3 consecutive meetings
 - Mentally/physically unable to perform his/her responsibilities
 - Involved in activities, which may cause harm or against the BPHS activities.

Annex D.3 Roles and Terms of Reference of Community Health Shura for Urban Health

Community Health Shura (Shura-e-Sehie)

CHSs will orient and update these shuras about health issues and health policies. The shura at health facility level should meet every month.

Formation:

The Director and CHS of each health facilities will facilitate the establishment of health shura at their facility level. The Shura-e-Sehee members will be selected /elected from the community living in the healthy facility catchment area. Members of the shura may vary from 15-20 depending on community size (population and geographical distribution) and local opinion. The shura composition will be:

- Chairperson: 1
- Member 14 – 19
- One third of the members should be women if possible.

The shura members will be selected /elected on the basis of the following criteria:

- Resident of the health facility catchment area of the community
- Well known/respected/influential/authentic formal and informal leaders from the community (i.e. malik, mullah, teacher, etc.)
- Ensure representation from all cucha (neighborhoods)/mosques/corners/sections/ of the community
- Beneficiary of the health program

- Ensure female representation in the shura

A separate female shura may frequently be considered depending on community opinion and culture. The same criteria for selection/election of members will be followed in case of separate female shura.

Roles and responsibilities:

- Be knowledgeable on urban BPHS, CBHC activities and Urban CHW’s job description in urban Kabul
- The CHS will act as secretary of the shura. The secretary will be responsible for recording and maintaining meeting minutes.
- The attendance of at least two-thirds of members is essential for having a quorum and for making any decisions.
- Write and sign a constitution of the facility level shura. The constitution will record the names and gender of the members and their location of origin (to ensure equitable representation of the communities within the catchment area), the name of the elected chairperson and member secretary.
- Facilitate a health needs assessment with the facility level shura members. The needs assessment should focus on the major health related problems perceived to be faced by the community.
- Based on urban BPHS and the health problems perceived by the communities the shura members will develop an annual action plan.
- Try to organize an “open door event” (for community members visiting the health facility to know about services provided and getting an idea of ownership and trust) at the health facility for public participation every 6 month
- Mobilize local resources for strengthening and sustaining urban BPHS activities
- Support selection of Urban CHWs in the community
- Conduct monthly meetings and maintain meeting minutes
- Monitor monthly performance of the facility and satisfaction of clients
- Review implementation status of annual action plan

Discontinuation of shura membership:

- A member will notify the respective shura if she/he wants to discontinue as a member of the shura. The shura will replace her/him in consultation with people within the catchment area.
- The shura may terminate any member for the following reasons:
 - Absent from 3 consecutive meetings
 - Mentally/physically unable to perform his/her responsibilities as mentioned in approved BPHS and previous CBHCC strategy
 - Involved in activities which may cause harm or against BPHS policies such as inform people about the myths and rumors against family planning services at the health facility and health post level

Annex E. Terms of Reference for Family Health Action Groups (FHA Groups)

Selection Criteria:

- Women with young children (<5y)
- Women who are respected in their communities
- Women who are trusted by the female CHW
- Women who are willing to volunteer their time for this group
- Basic literacy or basic education skills among some members would be an advantage, but not necessary.

Process of selection of FHA groups

The process is expected to vary in detail among different communities, but the following activities should be considered:

- The CHS and/or another member of the health facility staff should explain the proposal to the CHWs, and discuss the whole process of the formation of FHA Groups with both the female and male CHWs at a monthly CHW meeting. Specific issues that may be important in particular communities will be raised and discussed by the group.
- In each health post community, the CHS and the CHWs will meet with both the male and female shuras in that community to explain the proposal to them and answer their questions.
- Using the community map, the CHWs should then divide the households up into neighborhood groups of 10-15 related families, and work out which women in each of those groups of households are the ones that best fit the selection criteria.
- The female CHW meets with the female leaders of the community to discuss the proposed list of women for the FHA Group.
- The female CHW invites the selected women to participate and explains what their roles will be.
- The female leaders and the CHWs, separately or together, will inform the men of the shura of their decisions

One FHA Group member for 10-15 nearby households in her part of the community

Role and responsibilities:

FHA Group members will be responsible for the following activities:

- Implement healthy practices in their own homes and then demonstrate these practices to the women living in her neighborhood group of households.
- Spread health awareness and key health messages among mothers

- Improve the life style and appropriate use of health services for reduction of the mortality rate of mother and children.
- Talk with her neighbors and promote other healthy practices.
- Promote appropriate use of curative and preventive care from the CHW and the nearest health facility.
- Inform the female CHW about pregnancies, births, and sick women and children who need care.
- Encourage families to follow the CHW's recommendation for referral when necessary.
- Provide wider contact with the men of the community, through men of their own families, to encourage their participation in health improvement activities

Training:

CHWs will meet with their FHA Group members regularly (every 2-4 weeks depending on the season). At these meetings, CHWs will share and discuss health problems and health practices that are appropriate to the season of the year or of concern to the women and their families.

Annex F. Terms of Reference of the Community Based Health Care Unit, MoPH

Overall responsibilities:

As the MoPH department charged with responsibility for community based health program, it will oversee and coordinate the development of a sustainable, integrated and effective CBHC system, providing accessible and quality health care and health promotion in a way that is acceptable to communities.

Specific responsibilities:

1. Receive and monitor regular and periodic reports from the HMIS, HEFD and other sources regarding the performance of the CBHC system and the numbers and training of CHWs and CHSs to ensure the most effective implementation of CBHC.
2. Develop and maintain CBHC policies and strategies that are consistent with national development policies and goals.
3. Prepare and implement annual work plans to implement the CBHC strategies with activities prioritized according to the current needs assessment.
4. Participate in the development of all MoPH policies and strategies that apply to or affect CBHC and ensure that they are compatible and consistent with overall CBHC policy and integrate well with existing policies.
5. Ensure that other MoPH departments and all international and non-governmental stakeholders are familiar with MoPH CBHC policies and strategies, and provide technical

support to these partners for the development of guidelines and programs to ensure that they are consistent with current CBHC policies and strategies.

6. Promote, oversee and evaluate operations research and innovative approaches to CBHC in both rural and urban areas of Afghanistan and then the adoption and scaling up of those that are both effective and cost-effective.
7. Promote and support the active inclusion of CBHC in the design and implementation of provincial health programs by provincial and district public health office staff.
8. Promote the highest possible levels of responsibility of communities and households for their own health through the formation and training of health shuras and community action groups (male and female) and through respectful consultation and collaboration with them by health services staff.
9. Ensure that the job descriptions, performance protocols, essential competencies, training programs and job aids of CHWs and CHSs follow evidence-based interventions, and are appropriate to the priority health care needs and cultural settings of Afghanistan and to the capacities of the CHWs.
10. Promote the implementation of policies and strategies that support the motivation of CHWs through maintaining a feasible work load, and through appropriate training, supportive supervision, regular medical supplies, compensation, incentives, and recognition and job satisfaction.

Annex G. Terms of Reference for the CBHC Task Force

Overall Responsibilities:

The CBHC Task Force is a regular forum for stakeholders of community based health to provide support, information, experience and technical advice to the MoPH and the CBHC Department in particular on all matters concerning CBHC in Afghanistan.

Membership of the Task Force

The CBHC Task Force is an open forum for all stakeholders of CBHC. Regular participation is encouraged from representatives of other MoPH departments, NGOs implementing the BPHS, NGOs implementing special CBHC projects, technical assistance agencies, and partnering UN agencies.

Specific responsibilities:

1. Provide a forum for the MoPH CBHC program and its partners to discuss issues and make recommendations concerning CBHC policies, strategies, programs, standards and new initiatives, and any challenges and opportunities arising in their implementation.
2. Share information about experiences of implementing the BPHS – successes, challenges and new opportunities.
3. Discuss and make recommendations to other MoPH departments about their policies, strategies, standards and programs that involve CBHC.
4. Assist the CBHC Department in conducting situation analyses and developing annual work plans for the CBHC Department and the Task Force.
5. Assist in promoting a better awareness of and support for the role and contribution of CBHC in the health services of Afghanistan.
6. Contribute to the membership of ad hoc technical working groups.

Annex H. CBHC Strategy Revision Participants List

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