Islamic Republic of Afghanistan
Ministry of Public Health

Community-Based Health Care Policy and Strategy 2009 - 2013

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Table of Contents

List of Acronyms……………………………………………………………2

Foreword…………………………………………………………….……3

Acknowledgment……………………………………………………………4

Preface……………………………………………………………………….5

1. Background and Rationale ………………………………….………..6
2. Situation Analysis ……………………………………………………7
3. CBHC Vision, Mission and Values ………………………….....…..12
4. CBHC Goal and Objectives …………………………..….…………12
5. Policy Priorities and Strategic Approaches ……………………..……...13
    - 5.1. Increase Coverage of CBHC Services ……………………………13
    - 5.2. Improve Quality of CBHC ………………………….……...…14
    - 5.3. CHW Capacity-Building ………………………...…………..15
    - 5.4. CHW Technical Support and Supervision …………………..……16
    - 5.5. Financing and Sustainability of CBHC …………….…………..17
    - 5.6. Community Responsibility and Participation ……………………18
    - 5.7. Health Promotion ………………………………………………19
    - 5.8. Institutional and Program Development and Coordination ……….20
6. Partners ……………………………………………………….……..22
7. Implementation of the Strategy ……………………..………………22
8. Monitoring and Evaluation ……………………………….……………23

Annexes:

A. Job Description of the Community Health Worker ……………………24
B. Job Description of the Community Health Supervisor ……..………..…26
C. TORs of the Community and Facility Health Shuras …………………..28
D. TORs of the Family Health Action Groups ……………………………31
E. TORs of the CBHC Unit ……………………………….…………33
F. TORs of the CBHC Task Force …………………………..……………34

List of Acronyms

BCC	Behavioral Change Communication
BHC	Basic Health Center
BPHS	Basic Package of Health Services
CBHC	Community-based Health Care
CHC	Comprehensive Health Center
CHS	Community Health Supervisor
CHW	Community Health Worker
C-IMCI	Community – Integrated Management of Childhood Illnesses
DH	District Hospital
DOTS	Directly Observed Treatment short course
EPI	Expanded Programme on Immunization
HEFD	Health Economic and Financing Directorate
GDHCS	General Directorate, Health Care Services
HCS	Health Care Services
HMIS	Health Management Information System
HNS	Health and Nutrition Strategy
HP	Health Post
IEC	Information, Education and Communication
LAM	Lactation Amenorrhea Methods of Contraception
MAAR	Monthly Aggregated Activity Report
MAR	Monthly Activity Report
MCH	Maternal and Child Health
MoPH	Ministry of Public Health
NGO	Non-Government Organization
NID	National Immunization Day
PPFP	Postpartum Family Planning
SM	Strengthening Mechanism
TTBA	Trained Traditional Birth Attendant

Foreword

Acknowledgment

Preface

1 Background and Rationale

The concept of working with communities to improve the reach of government health services while empowering those communities is entrenched in the over-riding strategies of the MOPH:

"Increase the active participation of communities in the management of their local health care services through developing strong, active participatory links with shura (community committees) and training and supporting community health workers." National Health Policy, Page 2: ANDS Page 109.

"The goal of the Health and Nutrition Sector (HNS) is to work effectively with communities and development partners to improve the health and nutritional status of the people of Afghanistan, with a greater focus on women and children and under-served areas of the country." HNSS: Page 1.

"The structure of the HCS in Afghanistan is traditional. At the most peripheral level, community health workers (CHWs) who are non-health professionals with limited but highly targeted training are the initial point of contact for individuals seeking HCSs." HNSS: Page 10.

"Health Post (HP): At the community level, basic HCS will be delivered by CHWs from their own homes, which will function as community HPs. A HP, ideally staffed by one female and one male CHW, will cover a catchment area of 1,000-1,500 people, which is equivalent to 100-150 families." HNSS: Page 10.

In regard to institutionalized health care provision, these commitments can best be described in the internationally recognized community empowerment model known as Community-Based Health Care (CBHC).

In Afghanistan, CBHC is the foundation for the successful implementation of the BPHS implementation package. While the BPHS does not address the inter-sectoral or the private sector linkages of community health, it does provide the context for a comprehensive interaction between the health system and the communities it serves. Its success depends upon community participation and a partnership between community and health staff.

The implementation of CBHC 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. The partnership of health services with communities, therefore, has two aspects:

- To persuade families and communities to make appropriate use of scientific health services, and to change certain behaviors and social norms for more healthy ones,
- To accept the guidance and collaboration of communities in the implementation of health programs and the acceptable provision of health care, and encourage them to identify and solve their own problems.

While there is no universally accepted definition of CBHC, global experience has identified three consistent components of CBHC:

- Partnership between the community and the health facility staff,
- Appropriate and good quality care by community-based providers,
- Promotion of healthy practices and life styles.

(Community Integrated Management of Childhood Illnesses [C-IMCI] is a very large and important part of CBHC; it consists of the same three components.)

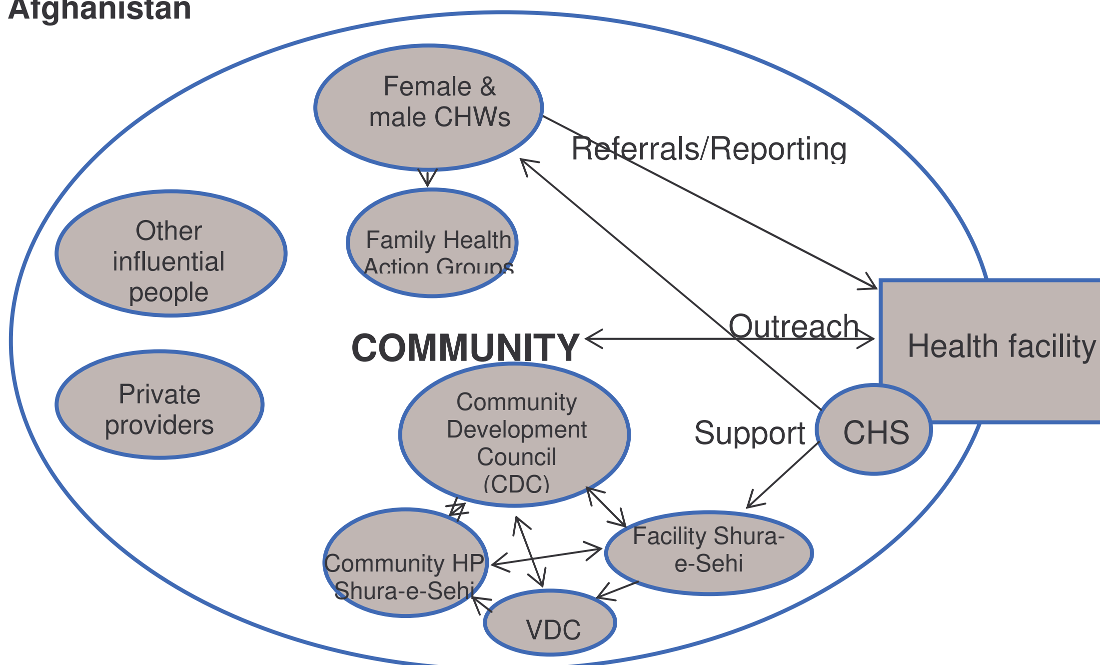
Experience of the implementation of these components has produced a set of global principles of CBHC:

- CBHC focuses on major health problems for which evidence-based, cost-effective solutions exist.
- A service should be provided by the lowest-level health worker who can provide the service at an acceptable standard of quality.
- Health workers are locally identified and recruited.
- Health workers are trained incrementally, a few skills at a time.
- An established list of drugs and supplies is used.
- Supervision is regular and supportive.
- The health worker is accountable to the community.
- The community makes a financial or in-kind contribution for the services.

2 Situation Analysis: The CBHC System of Afghanistan

2.1 Overview

CBHC is not new to Afghanistan; it existed prior to the many years of war and conflict. However, in this post conflict period, Afghanistan has reviewed these international concepts and developed an Afghanistan-specific form of CBHC, which was adopted by the Ministry of Public Health following a national conference on CBHC in September 2002. Additions and modifications have been made since then.



The Afghan CBHC system is shown in the figure. This emphasizes the dynamic nature of this system. The components of this system include:

2.2 Health facility

The facility provides many case management, midwifery and preventive services that are not available at the health post. Facility staff should work with community leaders and CHWs to optimize use of these services by the community. At the end of 2008 there were 1,546 health facilities. An estimated 50% of the population is within 10 km of these facilities. However, antenatal care is used by only 32% of pregnant women, and only 16% of women deliver with a skilled attendant at a health facility. This emphasizes that access for women and children is also determined by geography, climate, culture and security issues.

Many facilities also provide outreach services to communities with poor access to the facility. EPI is the main program delivered in this way because of the importance of achieving herd immunity. The proportion of children fully immunized is 70%.

2.3 Facility Shura (See details in Annex C.)

The facility shura works with facility staff to assure the relevance of services to community needs, quality of care and patient satisfaction. At present, 1,701 facilities (90%) have shura. Of these, 5% have women who participate. While the shura membership is supposed to represent the whole catchment area, it more often only represents communities near to the facility.

2.4 Community Health Workers. (See Annex A for Job Description.)

CHWs are community volunteers. A health post has one male and one female CHW to serve a population of 100-150 households (700-1,300 population)[1], or fewer in sparsely populated areas. All CHWs should be selected by communities in close coordination with the BPHS project staff, according to agreed criteria. CHWs are trained to provide high impact primary care in rural communities and to refer severely sick patients and those needing preventive services or delivery care. They also promote healthy behaviors and lifestyles in the community. CHWs maintain records of their activities and provide monthly reports to the HMIS system. (The monthly reporting rate from health posts is 98%)

Two types of communities that have little or no coverage with CBHC are urban populations and nomadic communities. A few projects have implemented different approaches to BHC for both these types of population, but there is a need to learn from earlier experiences to develop more standardized approaches.

2.4.1 Numbers of CHWs

In 2004, when implementation of the BPHS started, there were about 2,500 CHWs, most of whom were men. By the end of 2008, there were almost 20,000 CHWs, 49% of whom were women. Together they provide services at 10,075 health posts in all parts of the country. During these five years, the drop-out rate of CHWs has been only 2.5%, mostly among the men.

[1] Since the original policy was developed, it has become clear that the average household size is 6.8. 100-150 households, therefore, represent a population of 700-1,300 rather than 1,000-1,500.

A health post with one male and one female CHW should generally serve a population of 100-150 households. Over 20% of health posts have more than 150 households in the catchment area. Many communities still have no health post. Using a ratio of one health post to 1500 population, about half of the provinces have sufficient health posts; the other provinces have varying shortages of health posts.

2.4.2 CHWs' contribution to health services

CHWs provide care to an average of 27% of the total number of outpatients seen in the health system (2008). The numbers have grown with the number of health posts, but over the past two years, the numbers seen per health post have increased by 50%. Unlike at health facilities, there is no decline in visits during the winter months. More significantly, 40% - 45% of childhood illnesses are managed by CHWs and 66% of visits for birth spacing methods are to CHWs. However, surveys show that appropriate care-seeking occurs for only 40% of sick children.

Referrals to health facilities of severely sick children and pregnant women have all increased steadily. 75,000 sick children are referred monthly. However, only 32% of pregnant women attend the clinic for even one antenatal care visit and only 16% of women deliver at a health facility. These low utilization rates largely represent the combined effects of distance, climate, culture and security problems. CHWS do provide iron and folic acid tablets to pregnant women and education on healthy pregnancy, birth preparedness and safe home delivery. They can also successfully distribute clean delivery kits and train families to use Misoprostol to prevent postpartum hemorrhage. There is a good potential for CHWs to provide significant antenatal care and birth preparedness if some of these activities were appropriately programmed during pregnancy.

2.4.3 Quality of care

No formal evaluation of CHWs by observation of their work has been possible, but regular monitoring visits and surveys that ask about their knowledge and practice suggest that there are deficiencies in their management of sick people. Health post standards have been prepared for the standards-based management approach to quality improvement, and the quality collaborative approach is being applied to the CBHC component of maternal and newborn care.

Up to now, no major in-service training courses have been developed for CHWs. Starting in 2009, courses in Community IMCI (C-IMCI) and newborn care with pictorial job-aids to help illiterate CHWs, and in postpartum family planning are both being implemented with national targets.

2.4.4 Workload

In general, CHWs do not complain about their workload or a lack of time for their routine work. This only seems to become a problem when there are new or special projects that involve them. However, there is still concern that the pressure for inclusion of additional activities in the CHW's job description is going to distract from effective performance of priority preventive and promotive activities to all the families in their communities. Twenty percent of health posts serve more than 150 households. It is not known if all of these households are equally well served.

2.4.5 Motivation

Because CHWs and health shura are all volunteers, recognition and expressions of appreciation are very important parts of their motivation. Surveys of CHWs suggest that the amount of recognition and support they get from communities and shura is very variable, but generally poor. The lack of recognition is one of the reasons why CHWs frequently ask about financial compensation for the work they do. Another reason is the frequent failure to reimburse them for the expenses they have in fulfilling routine aspects of their work like making monthly visits to the health facility to bring reports and collect drugs and supplies. The inclusion of a standard monthly allowance for travel expenses for the CHW in the latest BPHS revision should address this need, but will need to be evaluated to be sure that it is adequate in all situations.

The National CHW Conference in November 2008 and the establishment of an Annual CHW Day provide recognition and encouragement to all CHWs.

2.4.6 Behavioral Change Communication approaches are not yet effective

Some excellently designed and produced IEC/BCC materials have been produced on most of the key health promotion topics required. These have been used both as flip charts and posters in communities. Doubt remains about how well these are distributed in the provinces they were made for and whether the CHWs actually received instructions on how best to use them. Certainly, there is great variation in the availability of high quality IEC materials around the country.

Healthy behavior change is still slow. Behavior change communication approaches using women's groups have been successful in changing behaviors and social norms, with a large recorded impact on child mortality in small operations research projects. Scale-up of these approaches is being planned as Family Health Action Groups.

2.5 Family Health Action Groups (FHA Groups)

The FHA Groups aim is to utilizing community members to spread health awareness and key health messages, especially among mothers. This will result in healthier homes and lifestyles and increase the use of available health services. It will build a strong information and referral system within the community that will help CHWs attend to pregnancies, births, and cases of illness. Female CHWs select a group of 10-15 women with young families, respected within their community, and shares with them what she has learned. These 10-15 women in turn promote adoption of healthy behaviors among the women in their ten neighboring households. It is expected that this will make the work of the CHWs more effective and more efficient, even reducing their current workload.

2.6 Community Shura-e-sehie (See details in Annex C.)

The community shura provides leadership and support to all health-related activities in its community. Shura members select, support and supervise the CHWs in the community; they monitor the community map with the CHWs to be able to encourage families to make full use of preventive health services including outreach services; they provide leadership in the adoption and promotion of new behaviors and social norms. It is reported that 90% of health posts have shuras, and of these 5% have women participating in some way. What is less easy to determine is

how active are all these shuras, how well they are being supported with information about health and health programs, and how well they fulfill their different roles as shura members.

As well as the Shura, there are many other important gatekeepers in rural communities. Mullahs, community elders, older women including regular village birth attendants, other traditional healers and school teachers all play different roles as community leaders or opinion leaders.

2.7 Community Development Councils (CDCs)

In support of the National Solidarity Program (NSP), CDCs provide much needed services to local communities until such time as local governments are capable of providing comprehensive support to the local population. Throughout all provinces and districts, CDCs should be encouraged to provide leadership for intersectoral projects in education, food security, water and sanitation, etc, that can improve some of the most important determinants of health in the community.

2.8 Community Health Supervisor *(See job description in Annex B.)*

Community Health Supervisors are members of the health facility staff. They are the main links between the facility and the communities in the catchment area of the facility. They support and supervise all the CHWs, collect and process all monthly reports from CHWs, meet regularly with Shura, and manage all community-based health programs.

Community Health Supervisors (CHSs) have been part of health facility staff only since late 2005. Supervision of CHWs and support to shura-e-sehie remain a problem:

a. Only about 75% of healthy facilities have a CHS.
b. Only about 10% of all CHSs are women. The result is that female CHWs get very little direct support.
c. Many health facilities have more health posts than can be supervised by one CHS or even a male and female CHS together. Fifteen health posts seems to be the maximum number that can be adequately supervised by a CHS, assuming that the health posts are not far from the health facility. This is generally not a problem for BHCs, where the average number of health posts is 10. For CHCs the average number is 16 and for district hospitals the average is 21. This implies that about half of all CHCs and DHs should have additional CHSs.
d. Lack of transport or funds to pay for transport are important constraints on the ability of CHSs to make regular visits to villages and health posts in their catchment areas.
e. There is no standard training program for CHSs. They have received a variety of training courses, but these have been so far deficient in clinical skills. This naturally inhibits them in their role as supervisor when many CHWs are better trained and more experienced than they are.

2.9 Private health practitioners

Pharmacists, dispensers, drug sellers and other traditional practitioners are founds in most communities and are frequently the first stop when people seek care. Increasing numbers of the pharmacists and dispensers have been trained and included in social marketing programs. Mostly, the training has covered contraceptive methods and the prevention and treatment of diarrhea.

3 CBHC Vision, Mission, Values

3.1 Vision

Better physical, mental and social health for all Afghans

3.2 Mission

The mission of the Ministry of Public Health is to improve the health and nutritional status of the people of Afghanistan through quality health care services and the promotion of healthy life styles in an equitable and sustainable manner.

The mission of CBHC is to reduce mortality and morbidity rates, especially among mothers and children, by providing evidence based health care as close to people's homes as possible and promoting a healthy lifestyle through community engagement and empowerment.

3.3 Values and guiding principles (adopted from MoPH)

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.
- 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.
- Promoting healthy lifestyles and discouraging practices that are proved to be harmful.
- Being honest, transparent and accountable.
- Making evidence-based decisions.

4 CBHC Goal and Objectives

4.1 Goal

The goal of the MOPH is to work effectively with communities and development partners to improve the health and nutritional status of the people of Afghanistan, with a greater focus on women and children and under-served areas of the country.

The CBHC Unit's goal is to make a significant contribution to the MOPH's overall goal 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 (BPHS) and other community-based approaches mainly focusing on the two most vulnerable groups, women of child bearing age and children, especially in under-served areas of the country.

4.2 Objectives

1. To expand coverage of CBHC services to 90% of the population of Afghanistan by the year 2013.

2. To improve the quality of health care (curative, preventive) services at the community and household level.

3. To strengthen the capacities of communities to initiate and implement activities that promotes their own health.

4. To support its partners in building the capacities at all levels of the health system for further strengthening of CBHC.

5 Policy priorities and Strategic approaches

Objective 1: To expand coverage of CBHC services to 90% of the population of Afghanistan by the year 2013.

5.1 Increase coverage of CBHC Services

5.1.1 Policy priorities: Increasing coverage of CBHC Services

5.1.1.1 Health posts should be created in all rural communities where it is possible to supply and support the CHWs.

5.1.1.2 Recognizing that a large proportion of women and children have limited access to facilities for preventive care services, all health care programs should have an integrated approach to implementation between the health facility and the health posts in its catchment area. This is to ensure that services that are within the competence of the CHW are provided in the community, with clear indications for referral when necessary.

5.1.1.3 Appropriate approaches to the implementation of CBHC will be developed for urban and periurban communities and for nomadic populations.

5.1.2 Strategic approaches: Improve coverage of community-based services

5.1.2.1 Work with HEFD to ensure that the grants and contracts of NGOs implementing the BPHS require plans to train a total of 10,000 new CHWs to meet shortages of CHWs in the province and ensure the coverage of unreached areas.

5.1.2.2 Liaise with the relevant MOPH technical departments to develop clear protocols for preventive MCH and disease control activities by CHWs and their better integration with preventive activities at health facility level, especially for the benefit of mothers and infants that cannot access the facility.

5.1.2.3 Current urban CBHC projects will be monitored and evaluated to document best practices in urban CBHC as a first step towards developing a specific urban CBHC strategy.

5.1.2.4 Work with Department of Nomads to develop an effective approach to CBHC for nomadic populations.

Objective 2: To improve quality of health care (curative, preventive) services at the community and household level.

5.2 Improve quality of CBHC

5.2.1 Policy priorities: Improving the quality of CBHC

5.2.1.1 In order to avoid an excessive work load, services provided by CHWs should be restricted to those interventions that address the priority health needs identified in the BPHS, with special focus on women and children and the control of priority communicable diseases.

5.2.1.2 Care provided by CHWs should be according to evidence-based standards, appropriate to that level of care, and delivered in a way that is acceptable to the community.

5.2.1.3 Promote mechanisms to ensure that CHWs are able to provide services equitably and efficiently to all households in the community without excessive workload for the CHWs.

5.2.1.4 Supply of essential equipment and medicines in the CHW's "kit" should be regular, reliable and sufficient to address the needs of the community.

5.2.1.5 Care provided by pharmacists/dispensers and other private sector providers at community level should be according to evidence-based standards and delivered in a way that is acceptable and affordable to the community.

5.2.1.6 People who require services for severe illness or preventive care not available at a community level should be referred to an appropriate health facility, and communities should be encouraged to facilitate this where possible.

5.2.1.7 International experience has shown that trained Traditional Birth Attendants (TTBAs) have not been successful in reducing maternal mortality without very close integration into a health system. Existing TTBAs should be encouraged to become CHWs. The remaining trained TTBAs should be supervised by the midwife at the health facility. (Note: Supervision of deliveries is not a part of the CHW job description.)

5.2.2 Strategic approaches: Improve the quality of CBHC

5.2.2.1 Support and use GDHCSP organizational mechanisms to monitor and coordinate ongoing development of MOPH programs that involve CBHC to:

- Ensure that the CHW job description does not get overloaded with non-priority activities and tasks.
- Ensure that evidence-based best practices are implemented into CBHC in a coordinated and integrated way, appropriate to that level of care and in keeping with CBHC policies.

5.2.2.2 Support establishment of FHA Groups to help community health workers (especially the female CHWs) with outreach activities, spread awareness of preventive behavioral practices, promote healthier lifestyles, increase use of available health services, and strength the referral system in the community.

5.2.2.3 Monitor the performance of quality improvement approaches at health posts and facilities and promote expansion of those that prove effective.

5.2.2.4 Work with the HEFD and the NGOs to strengthen mechanisms to monitor health post medical supplies and minimize stock-outs.

5.2.2.5 Promote the widest possible participation of pharmacies at community level in training and accreditation programs with social marketing and other agencies.

5.3 CHW Capacity building

5.3.1 Policy priorities: CHW capacity building

5.3.1.1 The training of CHWs should be in a manner to produce the core competencies, skills and changes of attitude required by the job description. Training methods and job aids for CHWs should be designed to match their educational levels and language abilities.

5.3.1.2 The training should be modular, sequential, and be conducted in a minimum of three phases over a period of several months. There should be competency testing at the end of each phase. (Appropriate changes in the implementation of the training are allowed for seasonal, security or other relevant local reasons.)

5.3.1.3 A certificate will be provided on satisfactory completion of training.

5.3.1.4 Refresher training should be regular and should meet needs identified by supervisors and the health workers themselves.

5.3.2 Strategic approaches: CHW capacity building

5.3.2.1 Revise and update the preservice CHW training curriculum, manual and facilitators' guide regularly. This should incorporate adaptations of effective recently implemented in-service training materials. Evaluated job-aids for CHWs and teaching learning

materials will be consolidated into a complete set for use by MOPH and NGO implementers.

5.3.2.2 Liaise with HEFD to ensure that grants and contracts include adequate funds for regular in-service training of CHWs. When major new in-service training packages (like C-IMCI, PPFP, and TB-DOTS) are adopted as MOPH standards, ensure that funds in NGO grants are adequate to train all CHWs.

5.3.2.3 Support the national implementation of the GAVI-HSS-funded Community IMCI and Newborn Care training. Work with stakeholders to find a way to support the extension of the Scaling up Success in Family Planning program beyond the USAID-supported provinces

5.3.2.4 The CBHC Department will work with the Ministry of Education to advocate for preferential inclusion of CHWs in literacy classes

5.4 CHW Technical Support and Supervision

5.4.1 Policy priorities: CHW Technical Support and Supervision

5.4.1.1 Community Health Supervisors and other health facility staff should provide regular supportive supervision and mentoring to all CHWs in their catchment area.

5.4.1.2 The numbers of male and female CHSs (or alternative technical persons) posted to a facility should be sufficient to provide direct support and supervision to all CHWs in the catchment area.

5.4.1.3 Where appropriate women are available, they will be trained and appointed as CHSs. When possible, CHSs should be married couples. Special consideration will be given for couples (each one appointed to different but nearby facilities) to work for 15 days in one facility and for the remaining 15days in their spouse's facility located nearby.

5.4.1.4 Information collected in the HMIS should represent indicators of priority activities.

5.4.1.5 HMIS data should be used on a regular basis to guide CHWs in understanding health needs and successes in the community.

5.4.2 Strategic approaches: CHW Technical Support and Supervision

5.4.2.1 Promote the development of a new policy proposal on CHS staffing of health facilities. This will review current CHS workloads and performance, and make proposals on:

- Effective ways to support female CHWs,
- An appropriate method to determine the number of CHSs required at a health facility to effectively support all health posts.

5.4.2.2 Promote the design and testing of innovative and effective ways in which the Community Midwife at the facility can work with CHWs (females especially) to plan and manage integrated maternal, newborn and birth spacing programs in the health facility catchment area.

5.4.2.3 Develop an updated job description for CHSs and a standardized, formalized preservice training curriculum.

5.4.2.4 Work with the M&E and HMIS departments to incorporate regular reporting of CHS activities, and collaborate with them in the updating of the Tally Sheet to highlight priority activities.

5.4.2.5 Promote the use of standardized supervisory checklists for CHSs and for regular HEFD monitoring in all parts of the country.

5.5 Financing and Sustainability of CBHC

5.5.1 Policy priorities: Financing and Sustainability of CBHC

5.5.1.1 A standardized equipment and medicine kit will be supplied to and maintained for CHWs for free dispensing to clients.

5.5.1.2 CHWs should be adequately compensated for all legitimate expenses (For example: transport and food) when working outside their communities.

5.5.1.3 The opportunity of financial incentives for particular services should be equitable for all CHWs (Male and female, those living far from a facility and those living close to the facility.) Incentives should first cover expenses (For example: travel with a referral) and then for extra time and dedication (For example: NIDs or completing DOTS for a patient with tuberculosis).

5.5.1.4 The MOPH will not make regular payments to CHWs from the MOPH budget and does not recommend that donor's resources be allocated for regular payments to CHWs because such a policy is financially unsustainable.

5.5.1.5 Communities will continue to be encouraged to support, compensate (Cash or in kind) and recognize CHWs in traditional ways.

5.5.1.6 Central and provincial health authorities should enhance the recognition of CHWs and express appreciation to CHWs in order to increase their motivation

5.5.2 Strategic approaches: Financing and Sustainability of CBHC

5.5.2.1 Promote the careful monitoring and evaluation of recently introduced regulations for the payment of CHWs' travel expenses (contained in the 2009 BPHS revision) and other operations research on payment of other kinds of incentives to CHWs to make sure they are adequate and appropriate, and implemented in all parts of the country.

5.5.2.2 Promote and evaluate innovative approaches to improve community support, compensation (Cash or in kind) and recognition of CHWs in traditional ways.

5.5.2.3 Work with provincial as well as central health authorities to make the best impact of the National CHW Days both for the motivation of CHWs as well as the promotion of better health through CBHC services.

Objective 3: To strengthen the capacities of communities to initiate and implement activities that promotes their own health.

5.6 Community Responsibility and Participation

5.6.1 Policy priorities: Community Responsibility and Participation

5.6.1.1 Communities will be encouraged to form a Shura-e-sehie in association with all health posts. They should all be encouraged to include the participation of respected women of the community in a way that is culturally appropriate. Shura members will be given orientation to CBHC and the BPHS and be given any training required to help them understand and approve the integrated community-based health care program and manage their activities in an appropriate and effective manner.

5.6.1.2 Health facility staff should invite representatives of community shuras to participate in a facility shura to help communication between facility and communities.

5.6.1.3 CHSs will meet regularly with community shuras to hear reports and advise and encourage them in the development and implementation of their work plans.

5.6.1.4 CHWs are accountable to the community shura for their work in the community and should receive support and recognition for their work.

5.6.2 Strategic approaches: Community Responsibility and Participation

5.6.2.1 Promote best practices in the partnering of facilities with health shuras at community and facility levels, including the participation of women in health shuras. Use the findings to develop improved guidelines on working with shuras for BPHS implementers.

5.6.2.2 Promote community-facility linkages, including outreach activities, and enhance behavior change communications as well as reinforce community mobilization to

create/increase demand for health services and healthy behaviors. Increase the utilization rate of BPHS faculties and health posts

5.6.2.3 Health facility staff should be encouraged and helped to work with both the health facility shura and community shuras in the planning, implementation, and monitoring of services in the facility catchment area so that communities develop a sense of ownership for their health services.

5.6.2.4 Promote and enable facility/community shura coordination and collaboration with CDCs to address health problems in communities. This should include:

- Provision of in depth information on health needs and problems in the community by health shuras.
- Identification and promotion of projects that could address those needs and problems by shuras, BPHS-implementing NGOs, and the provincial health office.
- Provision of required financial and technical support by CDCs

5.6.2.5 Integrated community-based initiatives such as Basic Development Needs (BDN) and models used by the National Solidarity Program (NSP) need to be carefully and formally evaluated to identify which lessons learned can best be applied in the context of existing MOPH and other sectoral ministries' policies.

5.7 Health promotion

5.7.1 Policy priorities: Health promotion

5.7.1.1 All CHWs should be supplied with a complete set of the IEC materials required to help them implement the health promotion activities in their job description and advised on the best ways of using them.

5.7.1.2 CHWs and shuras should be supported in using community maps to help them identify families and individuals needing immunizations and other preventive maternal and child care services or birth spacing advice.

5.7.1.3 Behavior change strategies should include approaches that encourage participation of groups of men and women in the community and that will promote the change of social norms.

5.7.2 Strategic approaches: Health promotion

5.7.2.1 The CBHC Department to collaborate with the MOPH Healthy Behavior Promotion Department and the relevant technical departments to:

- Ensure that health messages to be promoted by CHWs remain those concerned with priority health problems and interventions to avoid CHW job overload.
- Ensure that health messages and graphic materials are evidence-based, culturally appropriate, and harmonized with other IEC/BCC materials used by CHWs; and designed so that they can easily be used by both literate and illiterate CHWs.
- Ensure that approved high quality IEC materials are made available to all CHWs and that they get training in the appropriate use of them.

5.7.2.2 Ensure that any new or refresher training programs proposed by MOPH departments or partner agencies all have appropriate training to strengthen the counseling and interpersonal communication aspects of the services.

5.7.2.3 HEFD to ensure that use of community maps is encouraged in the implementation of BPHS, and that CHSs and CHWs are provided suitable training in their use.

5.7.2.4 Support the implementation and evaluation of Family Health Action Groups by NGOs in order to promote a community-wide approach to behavioral change.

Objective 4: To support partners in building capacity at all levels of the health system for further strengthening of CBHC

5.8 Institutional and Program Development and Coordination

5.8.1 Policy priorities: Institutional and Program Development and Coordination

Because an effective CBHC system is the foundation of the Afghan health system and integrates the community aspects of all priority health programs:

5.8.1.1 The CBHC Department will work with the M&E and HMIS Departments to ensure regular monitoring and evaluation of the role and contribution of CBHC in the health system, and regularly present developments and accomplishments to colleagues in the MOPH;

5.8.1.2 The CBHC Department will monitor all developments in other MOPH departmental programs that affect CBHC to ensure they are in keeping with CBHC policies and are incorporated into the CBHC program in a way consistent with the effectiveness of the whole program.

5.8.1.3 The CBHC Department will promote and support the capacity of Provincial Public Health Offices to plan and implement MOPH/CBHC policies and strategies in their provinces.

5.8.1.4 The CBHC Department will collaborate with counterparts in other government ministries to promote appropriate intersectoral activities that support the health and development of communities.

5.8.1.5 The MOPH will promote recognition of CHWs and their contribution to health services;

5.8.2 Strategic approaches: Institutional and Program Development and Coordination

5.8.2.1 The CBHC Department will call regular meetings of the CBHC Task Force to assist it in fulfilling its mission, policies and strategies. (See Annex D. for Terms of Reference.)

5.8.2.2 CBHC Department will regularly participate in the Task Force meetings of key MOPH technical departments, especially Child and Adolescent Health, Reproductive Health, Communicable Disease Control and Healthy Behavior Promotion to become aware of and contribute to developments affecting CBHC policies and programs.

5.8.2.3 The CBHC Department will take every opportunity to improve its own capacity so that it can better implement its responsibilities.

5.8.2.4 The CBHC Unit will work with the provincial health offices to address all CBHC related issues by all members of the provincial teams, especially the PHC Officer; in addition, the unit will promote the creation of a position for a CBHC focal point in the provincial health offices in the long run.

5.8.2.5 The CBHC Department will work together with partners to provide technical assistance to Provincial Public Health staff in making and implementing CBHC plans for the province.

5.8.2.6 MOPH will observe an annual National CHWs Day on first day of Jawza.

6 Partners

6.1 Ministry of Public Health

The immediate partners of the CBHC Unit are other technical units in the GDHCS. In particular, they are the units most concerned with the priority health issues being addressed through CBHC: Reproductive Health, Child and Adolescent Health, Control of Communicable Diseases, Nutrition, EPI, Mental Health and Disabilities. Other technical units include Malaria, National TB Program, Healthy Behavior Promotion, Monitoring and Evaluation and HMIS, the Department of Nomads and the Office of Private Sector Coordination. The Provincial Public Health Offices are key partners.

6.2 Other Partners

Other partners include the NGOs implementing the BPHS, and international technical support agencies including WHO, UNICEF, Tech Serve, HSSP, Future Generations and Johns Hopkins University. All the donors supporting the BPHS are partners, but USAID is providing special support to the CBHC Department through Tech Serve.

6.3 CBHC Task Force

The CBHC Task Force and the smaller CBHC Working Group have been active for more than three years and provide support and advice as well as a forum for consensus development.

7 Implementation of the Strategy

The stewardship role of the CBHC Unit in the implementation of this strategy includes two broad sets of responsibilities: oversight and support of the implementation of CBHC programs and the further development and improvement of CBHC programs.

7.1 Basic Package of Health Services

CBHC is an integral part of the basic package of Health Services. As such, the implementation of CBHC is through the MOPH and its implementing partners, the NGOS. The CBHC Unit works with the Monitoring and Evaluation and HMIS departments and HEFD to monitor progress of CBHC in the provinces, and the HEFD, PHOs, NGOs and technical support agencies to ensure the appropriate support and supervision of CBHC implementation.

7.2 Development and improvement of CBHC programs

This Strategy in support of the improvement and further development of CBHC is implemented by the CBHC Unit and its partners under the supervision of the Preventive medicine and PHC or GDHCS in which the Unit is placed. In particular, it will work with the technical units responsible for priority health programs to ensure that the CBHC aspects of new developments in those programs follow CBHC policies and are well integrated into other aspects of CBHC.

7.3 Work plan

On the basis of this Strategy, a five year work plan and annual work plans are being developed.

8 Monitoring and Evaluation

The monitoring of this Strategy will be through two mechanisms:

8.1 Monitoring the Work plan

The implementation of this Strategy of development of the CBHC system will be by monitoring of the Work plan. This will be supervised by the Privative Medicine and PHC or GDHCS.

8.2 The implementation of CBHC as part of the BPHS

The implementation of CBHC as part of the BPHS and the effects of improvements that are introduced will be monitored through the usual mechanisms: the HMIS quarterly score card, HEFD monitors, the annual national health services survey balanced score card and other household surveys that are done from time to time. Some early activities will include discussions with those responsible for these monitoring and evaluation mechanisms to ensure that their coverage of CBHC activities is improved and more comprehensive.

A priority for the CBHC Unit is to obtain, analyze and disseminate information on the performance of CBHC on a regular basis.

Annex A: Job Description for the Community Health Worker (CHW)

Revised by the MOPH Community-Based Health Care Task Force, March 2005. Updated for the BPHS 2009 Revision, February 2009.

The community health worker (CHW) is a person (female or male) selected by the community according to selection criteria reflected in the Policy on Community Health Workers (June 2003). 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 local *Shura* for performance and community satisfaction and technically accountable to the community health supervisor (CHS) assigned by authorities from the nearest health facility.

General Responsibilities

A. Community Collaboration and Health Promotion

1. Actively participate in community meetings and major community events.
2. Actively work with mother's groups to promote healthier homes and maternal and child health.
3. Encourage and mobilize family/community participation in the immunization of children and women of child-bearing age.
4. Support national initiatives at the village level and actively participate in all campaigns/activities e.g., National Immunization Days and surveillance for acute flaccid paralysis).
5. Promote good nutrition practices and encourage early breastfeeding and exclusive breastfeeding of children less than six months of age.
6. Promote use of Oral Rehydration Salt (ORS) and other homemade rehydration fluids for home management of diarrhea and dehydration.
7. Promote hygiene and sanitation, and the preparation and use of safe drinking water.
8. Encourage couples to practice birth-spacing and receive family planning services.
9. Promote psychosocial well-being and mental health in the community and raise awareness about prevention identification of disability.
10. Create awareness within the community and provide information on the dangers of addictive substances such as tobacco, *naswar*, opium, hashish, and alcohol.
11. Establish and support WHAGs to spead up behavior change including health care seeking behavior.

B. Direct Services

1. Identify and manage acute respiratory infections, diarrhea, malaria, and other common communicable diseases according to national protocols. Treat mild to moderate cases and refer complicated cases to the nearest health center.
2. Counsel 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. Communicate the importance of antenatal and postnatal care. Distribute micronutrients and antimalarials to pregnant women according to national policy. Encourage the community to make regular and timely use of Maternal Child Health (MCH) services.
5. Encourage the use of skilled birth attendants, where possible, and help families to make birth plans. Provide and teach the use of a mini delivery kit (see Annex C for kit contents). Teach family members to recognize the danger signs of complications of pregnancy and childbirth, and assist them in making preparations for emergency referral.
6. Distribute oral contraceptives and condoms to willing members of the target population according to national policy. Promote LAM together with exclusive breastfeeding for the child's health during the first six months of a child's life. Administer first and follow-up injections of Depo Provera. Encourage interested families to seek long-term family planning methods at a health facility.
7. Provide first-aid services for common accidents at the family and community level.
8. Ensure administration of vitamin A to children aged six months to five years during NIDs.

C. Management

1. Meet regularly with the *Shura* to develop, implement, and monitor community action plans for health improvement.
2. Meet regularly with the community health supervisor to review reports and action plans, receive supplies, and for in-service training.
3. Collaborate with and support community midwife activities in the catchment area, including health promotion and pregnancy-related referrals.
4. Regularly complete and submit the monthly Tally Sheets to the CHS for the HMIS.
5. Know the members of the community, and develop a community map of the eligible families in the catchment area and the services they have used.
6. Report all deaths and other activities included in the report form of the health post. Inform the health facility of any disease outbreaks.
7. Manage the health post, maintaining supplies and drugs given to CHWs and reporting utilization of drugs and supplies.

Annex B: 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 and monthly in-service training to CHWs
- Reviews and evaluates the performance of the CHWs and identifies need for further training

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 by CHWs and the completion of the facility MAAR.
- Consolidates the MAARs 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 in formation & implementation of community-based health activities
- Promotes support for CHWs
- Provides feedback from community to head of the health facility.

Annex C: 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.

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 very 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

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-Sehee 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: Terms of Reference for Family Health Action Groups (FHA Groups)

a. *Who will be selected as FHA Group members?*
- 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.

b. *How many FHA Group members to be allocated for households?*
- 1 FHA Group member for 10-15 nearby households in her part of the community

c. *Who selects FHA Group members?*
- CHWs in consultation with the male and female leaders in the community. (Female health shura if present.)

d. *How will FHA Group members be selected?*

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.

e. *What will FHA Group members do?*

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.
- 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.

f. *How will FHA Group members be prepared or trained?*
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.

g. *What sort of a program will they have?*
- Following the meetings with the CHW, FHA Group members will arrange meetings and gatherings with her neighborhood families to share what she has learned and show how she has changed the way she does things in her own home.

h. *How does a FHA Group differ from a women's shura?*
The women of the shura support the CHW and promote health in the community by using their authority as respected women in the community to influence the male leadership of the community and other older women (mothers-in-law) in families. They can provide leadership in promoting good health practices and can help to solve problems or conflicts. The FHA Group members are younger women with families, who are responsible for all the domestic activities that determine the health of a family and for raising their children. Their role is to share good household and health practices with the young mothers in neighboring households.

Annex E: Terms of Reference of the Community-Based Health Care Unit, MOPH, Afghanistan

Overall responsibilities:
As the MOPH department charged with responsibility for community-based health care, 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 Policies and 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, recognition and job satisfaction.

Annex F: Terms of Reference for the CBHC Task Force.

Overall Responsibilities:
The CBHC Task Force is a regular forum for stakeholders of Community-based Health Care 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 running special CBHC projects, technical assistance agencies, and partnering UN agencies.

Specific responsibilities:
1. Provide a forum for the MOPH/CBHC 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 which 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 care services of Afghanistan.

6. Provide the membership of technical working groups that are formed for special projects from time to time.