

COMMUNITY HEALTH SYSTEMS CATALOG COUNTRY PROFILE: AFGHANISTAN

SEPTEMBER 2016



Advancing Partners & Communities

Advancing Partners & Communities (APC) is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-12-00047, beginning October 1, 2012. APC is implemented by JSI Research & Training Institute, Inc. in collaboration with FHI 360. The project focuses on advancing and supporting community programs that seek to improve the overall health of communities and achieve other health-related impacts, especially in relationship to family planning. APC provides global leadership for community-based programming, executes and manages small- and medium-sized sub-awards, supports procurement reform by preparing awards for execution by USAID, and builds technical capacity of organizations to implement effective programs.

Recommended Citation

Kimberly Farnham Egan, Kristen Devlin, and Tanvi Pandit-Rajani. 2016. *Community Health Systems Catalog Country Profile: Afghanistan*. Arlington, VA: Advancing Partners & Communities.

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ACRONYMS

APC	Advancing Partners & Communities
BHC	basic health center
BPHS	basic package of health services
CAAC	Catchment Area Annual Census
CBHC	community-based health care
CHC	comprehensive health center
CHS	community health supervisor/community health system
CHW	community health worker
DH	district hospital
DOTS	directly observed treatment short course
FHA	family health action
FP	family planning
GOA	Government of Afghanistan
HMIS	health management information system
HP	health post
HSC	health sub-center
IUD	intrauterine device
MCH	maternal and child health
MHT	mobile health team
MOPH	Ministry of Public Health
NGO	nongovernmental organization
PHCC	provincial health coordination committee
TB	tuberculosis
USAID	United States Agency for International Development
WASH	water, sanitation, and hygiene

INTRODUCTION

This Community Health Systems (CHS) Catalog country profile is the 2016 update of a landscape assessment that was originally conducted by the Advancing Partners & Communities (APC) project in 2014. The CHS Catalog focuses on 25 countries deemed priority by the United States Agency for International Development's (USAID) Office of Population and Reproductive Health, and includes specific attention to family planning (FP), a core focus of the APC project.

The update comes as many countries are investing in efforts to support the Sustainable Development Goals and achieve universal health coverage while modifying policies and strategies to better align and scale up their community health systems.

The purpose of the CHS Catalog is to provide the most up-to-date information available on community health systems based on existing policies and related documentation in the 25 countries. Hence, it does not necessarily capture the realities of policy implementation or service delivery on the ground. APC has made efforts to standardize the information across country profiles, however, content between countries may vary due to the availability and quality of the data obtained from policy documents.

Countries use a wide variety of terminology to describe health workers at the community level. The CHS Catalog uses the general term “community health provider” and refers to specific titles adopted by each respective country as deemed appropriate.

The CHS Catalog provides information on 136 interventions delivered at the community level for reproductive, maternal, newborn, and child health; nutrition; selected infectious diseases; and water, sanitation, and hygiene (WASH). This country profile presents a sample of priority interventions (see Table 6 in the Service Delivery section) delivered by community health providers and for which information is available.

APC regularly updates these profiles and welcomes input from colleagues. If you have comments or additional information, please send them to info@advancingpartners.org.

AFGHANISTAN COMMUNITY HEALTH OVERVIEW

In 2003, the Government of Afghanistan (GOA) formalized the country’s previously existing informal community health system and created a standardized structure to better integrate into the broader health system. Since then, health policies and strategies have been periodically updated to guide implementation of health services with an aim to develop and sustain a resilient health system that is able to recover from conflict and endure future challenges. Currently, community health in the country is guided by several main policy documents, along with supplemental health-specific strategies and implementation guides.

Afghanistan’s Ministry of Public Health (MOPH)¹ drafts policies and guidance and designs programs at the national level, while implementation is managed at the provincial level. The *National Health Policy (2015–2020)* is the overarching framework that provides general guidance for the health system, including the community level. It lays out the government’s goals of moving toward universal health coverage, balancing preventive and curative health services, improving governance, and decreasing corruption. In addition, the policy highlights the important role of community-level services in improving health outcomes, and promotes engaging and empowering communities to increase their ownership of the health system.

The MOPH is planning to shift how its health programs are implemented. Currently, the GOA and international donors contract with international and local nongovernmental organizations (NGOs) to provide health services in certain provinces. Over time, the MOPH will transition to government provision of health services nationwide.

Table 1. Community Health Quick Stats

Main community health policies/strategies	<i>A Basic Package of Health Services for Afghanistan 2010</i>	<i>Community-Based Health Care Strategy (2015-2020)</i>
Last updated	2010	2015
Number of community health provider cadres	1 main cadre : Community health workers (CHWs)	
Recommended number of community health providers	40,000 CHWs	
Estimated number of community health providers	28,000 CHWs	
Recommended ratio of community health providers to beneficiaries	1 CHW : 1,000–1,500 people ¹	
Community-level data collection	Yes	
Levels of management of community-level service delivery	National, provincial, district, community	
Key community health program(s)	CBHC Program	

¹ Equivalent to approximately 100–150 families.

¹ The MOPH may officially change its name to the Ministry of Health in 2016.

Community-level health service delivery is guided by the *Community Based Health Care Strategy (2015–2020)*, which provides structure for the Community Based Health Care (CBHC) program. The main goal of the CBHC program is to improve the health of communities and reduce morbidity and mortality, particularly among women of childbearing age, and children under five years of age. The program focuses on increasing awareness of healthy behaviors and preventive actions, community engagement and empowerment, and assuring access to health services. The CBHC program is implemented nationwide and managed at the provincial level, in some cases by NGOs. However, there are still some populations that have not been reached by the program, particularly nomadic populations and the urban poor. The most recent *CBHC Strategy (2015–2020)* prioritizes and outlines plans to reach these underserved groups with health services over the next five years.

Table 2. Key Health Indicators, Afghanistan

Total population ¹	33.4 m
Rural population ¹	73%
Total expenditure on health per capita (current US\$) ²	\$57
Total fertility rate ³	5.3
Unmet need for contraception ³	24.5%
Contraceptive prevalence rate (modern methods for married women 15-49 years) ³	19.8%
Maternal mortality ratio ⁴	396
Neonatal, infant, and under 5 mortality rates ³	22 / 45 / 55
Percentage of births delivered by a skilled provider ³	50.5
Percentage of children under 5 years moderately or severely stunted ⁵	59
HIV prevalence rate ⁶	<0.1%

¹ PRB 2016; ² World Bank 2016; ³ Central Statistics Organization, Ministry of Public Health, and ICF International, 2016; ⁴ World Health Organization 2015; ⁵ UNICEF 2016; ⁶ UNAIDS 2015.

A *Basic Package of Health Services for Afghanistan–2010 (BPHS)* establishes a community-level package of services across multiple health areas, including maternal and newborn health, child health, immunization, nutrition, and communicable diseases, and guides the CBHC Program overall. The *BPHS* indicates the type of health facility patients should access for their primary health care at the district and community levels, but allows flexibility in implementation to fit local contexts. A complementary service package—the *Essential Package of Hospital Services for Afghanistan (2005)*—outlines secondary care at the provincial and national levels. The two packages are linked, guided by national policy, and together form the bedrock of health service delivery in Afghanistan.

Afghanistan’s health policies acknowledge that gender is a barrier to health service access, and suggest strategies to mitigate gender discrimination, such as ensuring that half of community health workers are female and encouraging gender sensitivity training for all health workers.

The *CBHC Strategy* and *BPHS* are supplemented by several other health area-specific policies—all of which are implemented as part of the CBHC program. These include reproductive health, nutrition, child health, immunization and health management information systems (HMIS), among others.

The *CBHC Strategy* and the *BPHS* also guide Afghanistan’s only cadre of community health

workers (CHWs), who are volunteers. The CHWs constitute the community-level arm of the CBHC program. CHWs conduct health education sessions, promote healthy behaviors, facilitate community mobilization, and provide basic health care services for common and simple illnesses, with a general focus on maternal and child health (MCH), FP, and WASH. *The Community Health Worker’s Training Manual*, updated in 2012, provides additional and comprehensive guidance on the roles of CHWs, the services they provide, and how they fit into the broader community health system.

All MOPH policies and guidance recognize gender as a consistent barrier to accessing health services. To help ensure equitable access to services, the MOPH recommends that 50 percent of trained CHWs are female and encourages training in gender sensitivity for health workers at all levels of the health system.

Policy also guides the involvement of community groups in Afghanistan's community health system. Two types of community groups are integral to the operation of the health system at the community level: health shuras and family health action (FHA) groups. Health shuras are community advisory groups that strengthen the relationship between health facilities and the community. There are two types of health *shuras*. Health facility shuras advise health facilities on annual action plans, encourage community members to access health services, and provide other necessary support to the health facility. Community health shuras provide feedback on CHW performance, encourage community members to use CHW services, and take part in CHW selection. CHWs form and manage FHA groups, which comprise women from the community who are interested in promoting healthy behaviors, encouraging their neighbors to use CHW services, and supporting CHWs in community outreach.

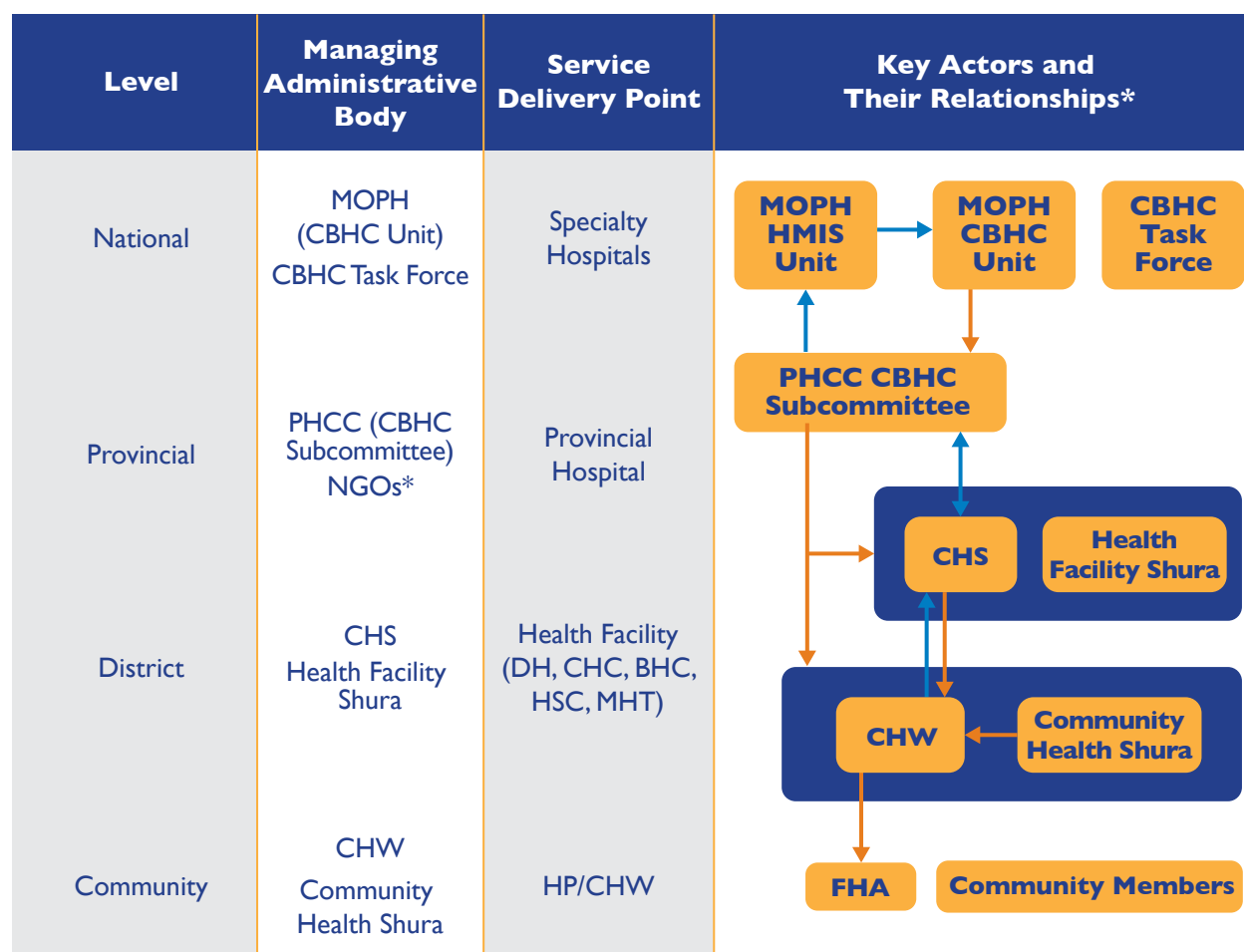
LEADERSHIP AND GOVERNANCE

Community-level service delivery in Afghanistan is managed and coordinated across the national, provincial, district, and community levels. Each has a distinct role in supporting policy and program efforts as described below.

- At the **national level**, the MOPH provides general oversight and structure through the development of health strategies and policies. The CBHC unit within the MOPH oversees and coordinates the CBHC program, develops CBHC-specific policies and strategies, and ensures the program is in line with broader MOPH guidance. The CBHC unit coordinates with other ministries, other MOPH units, UN agencies, and NGOs. Additionally, the CBHC unit evaluates the CBHC program based on HMIS data from lower levels. A CBHC Task Force provides technical support and guidance to the CBHC unit and comprises representatives from other MOPH units, implementing NGOs, technical assistance agencies, and partnering UN agencies.
- At the **provincial level**, a provincial health coordination committee (PHCC) oversees implementation of the CBHC program. A CBHC subcommittee ensures that national strategies and guidelines relevant to a particular province are followed, designs an annual provincial plan that guides implementation at the district and community levels, ensures that all community-level elements of the *BPHS* are implemented in an integrated manner, and oversees and provides feedback on work performed by community health supervisors (CHSs), CHWs, and health shuras. In some provinces, NGOs implement the CBHC program with oversight and guidance from the PHCC.
- Implementation of the CBHC program at the **district level** is overseen by CHSs, who supervise CHWs and are posted at each health facility, of which there are four types: district hospital (DH), comprehensive health center (CHC), basic health center (BHC) and health sub-center (HSC). Health facilities are supported by health facility shura, comprising members of the community. Mobile health teams (MHTs), consisting of a male and female health provider, vaccinator, and driver provide basic primary health care services in areas that do not have regular access to other health facilities.
- At the **community level**, CHWs implement the CBHC program through health posts (HPs) located in their homes and with oversight from CHSs. CHWs receive support from community health shura and FHA groups.

Figure 1 summarizes Afghanistan's health structure, including service delivery points, key actors and managing bodies at each level.

Figure I. Health System Structure




* In provinces where NGOs implement the CBHC program, the NGOs are supervised by the PHCC and in turn supervise all actors at the district and community levels.

Supervision →
Flow of community-level data →

HUMAN RESOURCES FOR HEALTH

Volunteer community health workers are Afghanistan’s sole cadre of community health providers. CHWs are the frontline of the CBHC program and provide services from an HP located in their homes. Two CHWs, one male and one female, are posted at each HP. They focus on health education, promotion of healthy behaviors, disease prevention, and treat basic common illnesses across a range of health areas including MCH, tuberculosis (TB), FP, and WASH, and refer to health facilities for more complicated treatment. They also assist with vaccination campaigns. While CHWs can be either men or women, the MOPH recommends that at least 50 percent of CHWs be women.

While there is only one CHW cadre, roles may differ depending on whether a CHW is based in a rural or urban location. Until recently, CHWs operated mostly in rural and peri-urban areas. In the updated *CBHC Strategy* of 2015, the MOPH included specific provisions for training CHWs to respond to health concerns in urban areas and within nomadic populations to accomplish the CBHC program goal of increasing access to primary health care services in underserved areas of the country.



CHWs are supervised by a CHS based at the nearest health facility and also receive guidance from community health shura. The community health shura provide feedback on CHW performance as well as their relationship with the community, mobilize the community to utilize CHW services, and take part in CHW selection.

CHWs also work closely with FHA Groups which are made up of female volunteers selected by CHWs, that are willing to adopt healthy behaviors, serve as model households, spread awareness of healthy behaviors amongst their neighbors, and report health occurrences such as pregnancies, births, and illness to CHWs. CHWs meet with FHA groups regularly to discuss a variety of health issues as well as how to better support families within their respective community to change behaviors for improved health outcomes.

Table 3 provides an overview of CHWs in Afghanistan.

HEALTH INFORMATION SYSTEMS

Community-level data is routinely collected and integrated into the national HMIS. CHWs collect community-level data using pictorial data recording and reporting tools that make the process easier for CHWs with low literacy. There is one community map per HP, which is updated daily and uses symbols and markings to identify and monitor the health status of the catchment area households, including which children have been immunized, which women have received antenatal or postnatal care, which women are interested in FP services, and which persons are undergoing directly observed treatment short course (DOTS) for TB. In addition, each HP has a pictorial tally sheet that is updated daily to record information about CHW household visits and the services they have provided.

Community-level data is an integral part of Afghanistan's HMIS. Pictorial data recording forms are used to make reporting easier for community health workers with low literacy.

CHWs also participate in data collection for routine community health surveys, such as the Catchment Area Annual Census (CAAC). CHWs use CAAC data to update the number of households represented on their community maps.

The supervising CHS at the nearest health facility helps the CHWs consolidate HP data from the community map and pictorial tally sheet into a monthly activity

report. The monthly reports from all HPs in the health facility's catchment area are then aggregated and submitted to the PHCC. The PHCC compiles the aggregated reports from all health facilities and submits them to the MOPH HMIS unit, which analyzes information on a core set of indicators on a quarterly basis to track program progress and shares the results with the CBHC unit.

The PHCC CBHC subcommittee also conducts preliminary data analysis and uses the results to improve coverage, inform the annual provincial plan, and improve quality of services. A summary report is shared with each health facility, along with written feedback that is intended to improve services. All CBHC-related policies encourage the use of data at the community level. Figure 1 depicts the flow of community-level data.

Using FP as an example, CHWs may provide postpartum FP services, information on lactational amenorrhea method, condoms, oral contraceptive pills, and injectable contraceptives. They may refer clients to:

- **HSCs, BHCs, MHTs, and CHCs** for the same FP services and products CHWs can provide, as well as intrauterine devices (IUDs).
- **DHs** for the same FP services and products available at lower level health facilities, as well as permanent methods.

Table 6 details selected interventions that CHWs deliver in the following health areas: FP, maternal health, newborn care, child health and nutrition, TB, HIV, malaria, and WASH.

Table 5. Modes of Service Delivery

Service	Mode
Clinical services	Provider's home
	Health posts or other facilities
Health education	Door-to-door
	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
Community mobilization	Mothers' or other ongoing groups
	Community meetings
Community mobilization	Community meetings
	Mothers' or other ongoing groups

Table 6. Selected Interventions, Products, and Services

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
FP	Condoms	CHW	CHW	CHW	CHW
	CycleBeads®	Unspecified	Unspecified	Unspecified	Unspecified
	Emergency contraceptive pills	Unspecified	Unspecified	Unspecified	Unspecified
	Implants	Unspecified	Unspecified	Unspecified	Unspecified
	Injectable contraceptives	CHW	CHW	CHW	CHW
	IUDs	CHW	No	CHW	Unspecified
	Lactational amenorrhea method	CHW		CHW	CHW
	Oral contraceptive pills	CHW	CHW	CHW	CHW
	Other fertility awareness methods	CHW		CHW	Unspecified
	Permanent methods	CHW	No	CHW	No
	Standard Days Method	Unspecified		Unspecified	Unspecified
Maternal health	Birth preparedness plan	CHW	CHW ¹	Unspecified	CHW
	Iron/folate for pregnant women	CHW	CHW ²	Unspecified	Unspecified
	Nutrition/dietary practices during pregnancy	CHW		Unspecified	Unspecified
	Oxytocin or misoprostol for postpartum hemorrhage	Unspecified	Unspecified	CHW ³	Unspecified
	Recognition of danger signs during pregnancy	CHW	CHW	CHW	Unspecified
	Recognition of danger signs in mothers during postnatal period	CHW	CHW	CHW	Unspecified
Newborn care	Care seeking based on signs of illness	CHW			CHW
	Chlorhexidine use	CHW	CHW	Unspecified	CHW
	Managing breastfeeding problems (breast health, perceptions of insufficient breast milk, etc.)	CHW		Unspecified	Unspecified
	Nutrition/dietary practices during lactation	CHW		Unspecified	Unspecified
	Postnatal care	CHW	CHW	CHW	CHW
	Recognition of danger signs in newborns	CHW	CHW	CHW	Unspecified

KEY POLICIES AND STRATEGIES

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