ADVANCING PARTNERS & COMMUNITIES

COMMUNITY HEALTH SYSTEMS CATALOG COUNTRY PROFILE: AFGHANISTAN

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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	Unites 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	*A Basic Package of Health Services for Afghanistan 2010*	*Community-Based Health Care Strategy (2015-2020)*
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

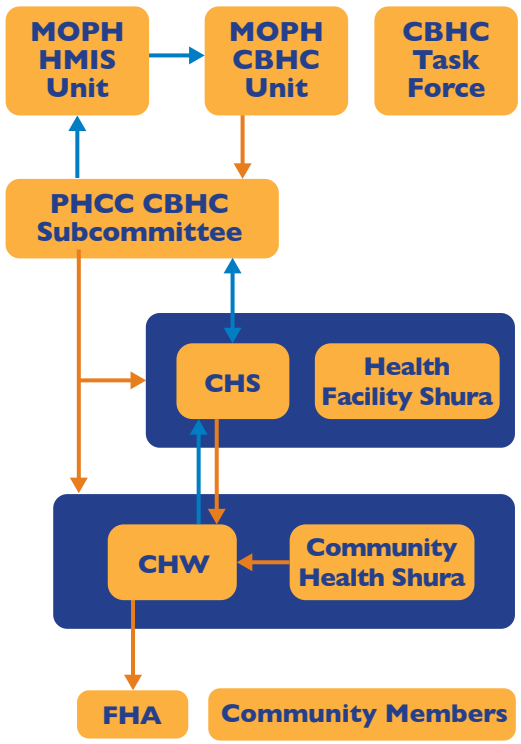
Community-level service delivery in Afghanistan is managed and coordinated across the national, provincial, district, and community levels. Each has a distinct role in supporting policy and program efforts as described below.

- 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 1. Health System Structure

Level	Managing Administrative Body	Service Delivery Point	Key Actors and Their Relationships*
National	MOPH (CBHC Unit) CBHC Task Force	Specialty Hospitals	
Provincial	PHCC (CBHC Subcommittee) NGOs*	Provincial Hospital	
District	CHS Health Facility Shura	Health Facility (DH, CHC, BHC, HSC, MHT)	
Community	CHW Community Health Shura	HP/CHW	



* 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.

Table 3. Community Health Provider Overview

	CHWs
Number in country	28,000
Target number	40,000
Coverage ratios and areas	1CHW : 1,000–1,500 people[1] Operate in urban, rural and peri-urban areas
Health system linkage	CHWs are volunteers that implement the CBHC program at the community level and provide the health services outlined in the *BPHS*.
Supervision	A CHS at the nearest health facility provides technical supervision for CHWs during monthly meetings and on-the-job training as needed.[2] Community health shuras oversee CHW interactions with the community and monitor their performance and community satisfaction with services.
Accessing clients	On foot Bicycle Public transport Clients travel to them
Selection criteria	Resident of the community 20–50 years old Interested in serving as a CHW Respected in the community and enjoys the support of community members Women should be encouraged to train as CHWs Basic literacy preferred
Selection process	CHWs should be selected by the community that they serve, with input from the community health shura. Further detail on what the selection process should entail is not provided.
Training	CHWs undergo training conducted in 3 phases over 4 to 6 months. There is a 4-week break between each training phase during which CHWs practice the skills they have learned under the guidance of a CHS. CHW knowledge is assessed at the beginning and end of each phase. CHWs are considered 'active' after the first phase of training but do not receive a completion certificate until they have completed all 3 training phases. CHWs must undergo a 5-day refresher training within 6 months of receiving their completion certificate. CHS provide monthly in-service training and additional refresher or updated trainings as needed.
Curriculum	*Community Health Worker's Training Manual* (2012) includes modules for each of the 3 training phases: Afghanistan health system, health promotion and prevention of diseases; improving maternal and child health (including FP services); and first aid and management of common diseases and situations.
Incentives and remuneration	CHWs are volunteers and do not receive a salary. They receive a mix of financial and non-financial incentives, including formal social recognition, respect from the communities they serve, and reimbursement for travel and other expenses. Previously, MOPH policy forbade regular payments for CHWs. However, in the updated *CBHC Strategy* in 2015, the MOPH promised to investigate the possibility of financial rewards for good performance and performance-based incentives.

[1] Equivalent to approximately 100–150 families.
[2] CHSs supervise a maximum of 15–20 HPs, which is equivalent to 30–40 CHWs.

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.

HEALTH SUPPLY MANAGEMENT

When CHWs begin service, the CHS gives them a kit that includes the medicines, supplies, and equipment necessary to maintain a HP. Supplies are replenished during monthly supervision meetings at the health facility. Policy does not describe a system for CHWs to acquire emergency backup supplies.

CHWs are trained on safe disposal of medical waste, including incineration, burial, and use of safety boxes for sharp waste materials.

The full list of commodities that CHWs provide is not available, but Table 4 provides information about selected medicines and products included in the *National Essential Medicines List of Afghanistan*.

Table 4. Selected Medicines and Products Included in the *National Essential Medicines List of Afghanistan* (2014)

Category		Medicine / Product
FP	☐	CycleBeads®
	☑	Condoms
	☐	Emergency contraceptive pills
	☐	Implants
	☑	Injectable contraceptives
	☑	IUDs
	☑	Oral contraceptive pills
Maternal health	☑	Calcium supplements
	☑	Iron/folate
	☑	Misoprostol
	☑	Oxytocin
	☑	Tetanus toxoid
Newborn and child health	☑	Chlorhexidine
	☐	Cotrimoxazole*
	☑	Injectable gentamicin
	☑	Injectable penicillin
	☑	Oral amoxicillin
	☐	Tetanus immunoglobulin
	☑	Vitamin K
HIV and TB	☑	Antiretrovirals
	☑	Isoniazid (for preventive therapy)
Diarrhea	☑	Oral rehydration salts
	☑	Zinc
Malaria	☐	Artemisinin combination therapy *
	☐	Insecticide-treated nets
	☑	Paracetamol
	☐	Rapid diagnostic tests
Nutrition	☑	Albendazole
	☑	Mebendazole
	☐	Ready-to-use supplementary food
	☐	Ready-to-use therapeutic food
	☑	Vitamin A

* Listed in the *BPHS* but not the Essential Medicines List

SERVICE DELIVERY

Afghanistan's *BPHS* includes eight service delivery packages for the community level, including maternal and newborn health (including FP), child health and immunization, public nutrition, communicable diseases, mental health, disability and physical rehabilitation, supply of essential drugs, and primary eye care services. CHWs provide some services within each package.

Table 5 summarizes the various channels that CHWs use to mobilize communities, provide health education, and deliver clinical services.

The *CHW Training Manual* guides CHWs on when and where to refer clients for some higher-level services, but does not provide comprehensive referral information for every health area that CHWs must address. For health areas not covered in the manual, CHWs use the *BPHS* as a guide for where to refer clients based on the type of service needed. CHWs track patient referrals to health facilities using referral sheets, each of which has two detachable slips for the patient to take to the health facility. After the patient receives treatment, s/he returns the completed referral slip to the CHW and receives any needed follow-up care. This system allows CHWs to track and report referral numbers.

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 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
	Mothers' or other ongoing groups
Community mobilization	Community meetings
	Mothers' or other ongoing groups

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 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

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
Child health and nutrition	Community integrated management of childhood illness	CHW	CHW	CHW	CHW
	De-worming medication (albendazole, mebendazole, etc.) for children 1–5 years	CHW	CHW[4]	Unspecified	Unspecified
	Exclusive breastfeeding for first 6 months	CHW		Unspecified	CHW
	Immunization of children[5]	CHW	No	CHW	CHW
	Vitamin A supplementation for children 6–59 months	CHW	CHW[6]	Unspecified	Unspecified
HIV and TB	Community treatment adherence support, including directly observed therapy	CHW	CHW[7]	CHW	CHW
	Contact tracing of people suspected of being exposed to TB	CHW	CHW	CHW	Unspecified
	HIV testing	CHW	No	CHW[8]	Unspecified
	HIV treatment support	CHW	CHW[9]	CHW	Unspecified
Malaria	Artemisinin combination therapy	CHW	No[10]	CHW	CHW
	Long-lasting insecticide-treated nets	CHW	CHW	Unspecified	Unspecified
	Rapid diagnostic testing for malaria	Unspecified	Unspecified	CHW	Unspecified
WASH	Community-led total sanitation	CHW	CHW		
	Hand washing with soap	CHW			
	Household point-of-use water treatment	CHW			
	Oral rehydration salts	CHW	CHW[11]	Unspecified	Unspecified

[1] Provide mini delivery kits for pregnant women.
[2] Provide iron/folate for pregnant and lactating women as well as non-pregnant women and girls.
[3] Trained to refer women experiencing postpartum hemorrhage to the nearest health facility, but specific medications for treatment are not mentioned.
[4] Provide deworming medication to people of any age.
[5] Provide information on and provide support during immunization campaigns, but do not administer immunizations. Immunization campaigns immunize newborns, children, and adults, and include BCG, oral polio vaccine, PENTA (diphtheria, whooping cough, tetanus, hepatitis B, type B influenza), and measles.
[6] Administer vitamin A to people of all ages.
[7] Only administer DOTS after the patient has completed the first phase of treatment at a health facility.
[8] Refer known TB patients to health facilities for HIV testing.
[9] Monitor, supervise, and support HIV treatment, but do not administer medication.
[10] Can treat cases of suspected mild to moderate malaria and refer serious cases to health facilities. They can only treat using pyrimethamine + sulfadoxine and chloroquine and cannot provide ACTs, which are reserved for laboratory-confirmed cases of malaria.
[11] Provide oral rehydration salts to patients of all ages.

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