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Stakeholder's perspective: Sustainability of a community health worker program in Afghanistan

Said Ahmad Maisam Najafizada[a,*], Ronald Labonté[b], Ivy Lynn Bourgeault[c]

[a] Division of Community Health and Humanities, Faculty of Medicine, Memorial University of Newfoundland, Canada
[b] School of Epidemiology, Public Health and Preventive Medicine, University of Ottawa, Ottawa, Canada
[c] Telfer School of Management, University of Ottawa, Ottawa, Canada

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ABSTRACT

Objectives: The objectives of this study were two-fold: 1) to examine how different stakeholders define sustainability, and 2) to identify barriers to and facilitators of the sustainability of the Afghan CHW program.
Method: We interviewed 63 individual key informants, and conducted 11 focus groups [35 people] with policymakers, health managers, community health workers, and community members across Afghanistan. The participants were purposefully selected to provide a wide range of perspectives.
Finding: Different stakeholders define sustainability differently. Policymakers emphasize financial resources; health managers, organizational operations; and community-level stakeholders, routine frontline activities. The facilitators they identify include integration into the health system, community support, and capable human resources. Barriers they noted include lack of financial resources, poor program design and implementation, and poor quality of services. Measures to ensure sustainability could be national revenue allocation, health-specific taxation, and community financing.
Conclusion: Sustainability is complicated and has multiple facets. The plurality of understanding of sustainability among stakeholders should be addressed explicitly in the program design. To ensure sustainability, there is a need for a coordinated effort amongst all stakeholders.
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1. Introduction

Sustainability of health projects funded by international agencies is a major challenge both for donors and recipients in developing countries (Edwards & Roelofs, 2006; Sarriot et al., 2004). Sustainability could mean continuation of the project, sustaining the outputs, or maintaining the desired outcomes (Pluye, Potvin, & Denis, 2004). Scheirer and Dearing (2011) define sustainability as "continued use of program components and activities for the continued achievement of the desirable program and population outcomes" (p. 2060). Factors that contribute to sustainability of health projects include community involvement, organizational capacity building, and institutional integration (Sarriot et al., 2004).

Empirical studies on sustainability of health projects are growing. Studying Primary Health Care projects implemented by non-governmental organizations (NGOs), Sarriot et al. (2004) found that sustainability occurs through a strategic partnership between local institutions and implementing organizations, capacity building of local institutions, and ensuring financial stability. Studying a health project in China funded by Canadian International Development Agency (CIDA), Edwards and Roelofs (2006) found that strong and transparent partnership with local institutions, adequate organizational support, and preparation of a handover plan at the beginning were necessary elements to sustain the health project.

In a systematic literature review on sustainability of and scaling up CHW programs, Pallas et al. (2013) identified enablers and barriers at multiple levels. At the community level, selection of motivated people from and by the community was an enabler, while lack of community and family support was considered a barrier. At the management level, direct, consistent and standardized supervision was an enabler, while insufficient incentive (a major cause of attrition) and poor supervision were barriers to sustainability. Finally, integration of CHWs into the broader health system and being formally recognized as a human resource for health were enablers, while lack thereof was a barrier to program sustainability.

* Corresponding author.
E-mail addresses: snaja100@uottawa.ca (S.A.M. Najafizada), rlabonte@uottawa.ca (R. Labonté), Ivy.Bourgeault@uottawa.ca (I.L. Bourgeault).

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Most studies of sustainability have focused on small projects implemented in isolation from the health system. There is little knowledge on sustainability of national health projects within health systems funded, especially when funded primarily by international organizations. In this paper we explore stakeholder perceptions of sustainability in Afghanistan's national CHW program, which is part of the Basic Package of Health Services (BPHS).

In 2014, Afghanistan had a population of approximately 29.8 million people, with 46% below 15 years of age, and 4% above 60 years (Campbell et al., 2013; WHO, 2015). Life expectancy at birth was estimated to be 60 years, an increase from 47 in 2002 (WHO, 2015). Almost 76% of the population lived in rural areas, and over 60% of the population had improved drinking-water sources, but improved sanitation facilities remained as low as 30% (WHO, 2015). Women and children in Afghanistan had one of the lowest health statuses in the world. Maternal mortality ratio was 400 per 100,000 live births, compared with 170 regionally and 210 globally (WHO, 2015). Out of 1000 live births, 36 newborns died before reaching their first month, 73 before reaching their first year, and 101 before reaching their fifth year –i.e., one out of ten dies before reaching their 5th birthday (Campbell et al., 2013). The fertility rate of 5.1 in Afghanistan was double the global average of 2.5 and contributes to both high maternal mortality and under-5 mortality (WHO, 2015). Human resources for health remained scarce in most regions of the country in 2013. Overall, there were 1.9 physicians and 7.5 nurses and midwives per 10,000 people in 2013, most of whom were based in cities and big towns, with as high as 7.2 physicians per 10,000 people in cities, and as low as 0.6 physicians per 10,000 people in rural areas (Campbell et al., 2013). Midwives were also typically based in health clinics where they have the necessary medical equipment for service provision (Bick, 2007). In villages, where 76% of the people lived, CHWs were the first and often the only point of contact of villagers with the formal health system (Najafizada, Labonté, & Bourgeault, 2014). Traditional Unani and Greek medical doctors, religious healers, traditional birth attendants and drug dispensers worked informally both in urban and rural areas (Wilson, 2011). To tackle the discouraging maternal, neonatal and child health concerns and a chronic shortage of human resources for health, the Afghan Ministry of Public Health started deploying volunteer Community Health Workers in rural areas of Afghanistan in 2003. The CHW program, a component of a Basic Package of Health Services, had trained around 26,000 CHWs (8.7 per 10,000 people) until 2014 (Najafizada et al., 2014). Though some studies have looked into the Basic Package of Health Services, in general (Ameli & Newbrander, 2008; Newbrander, Ickx, Feroz, & Stanekzai, 2014); there is a knowledge gap on the CHW program in Afghanistan and especially on sustainability of the Afghan CHW program. As the CHW program is a core component of the Basic Package of Health Services, the two are sometimes discussed interchangeably.

The objectives of the study reported on in this paper were two-fold: 1) to examine how different stakeholders define program sustainability, and 2) to identify facilitators and challenges to the sustainability of the Afghan CHW program.

2. Method

An exploratory qualitative design was chosen, since this design can reveal contextual factors affecting the program that may not have been taken into account when the program was being designed or implemented (Sandelowski, 2010). Participants were selected purposefully using stratified sampling, a method that divides the population into separate subgroups, and then creates a sample by drawing subsamples from each of those subgroups (Morgan, 2008). Stratified sampling ensures that all subgroups within a population are represented in the sample, and purposive sampling ensures that stratified sampling is systematically implemented (Morgan, 2008). The lead researcher stratified the population for this research both hierarchically and horizontally (Table 1). Hierarchically, they were divided at policy level, management level, and community level. Horizontally, policy-makers were stratified into government, international agencies and donor agencies; implementing organizations were stratified into international NGOs, national NGOs, and provincial health departments; and communities were stratified into less remote and high remote areas where the CHW program was implemented.

In-depth interviews were conducted with policy makers in Kabul, health managers of NGOs implementing the program in provinces, and CHWs and community members in villages. The lead researcher (MN) selected policy makers based on their knowledge of the BPHS and its CHW component through consultation with Ministry of Public Health officials and researchers in Afghanistan National Public Health Institute. Once a number of potential participants were identified, the solicitation email was sent. Upon their agreement, a date and place were set with the participants and interviews were conducted. Most potential participants agreed to the interview. Lack of time was the main reason for policymakers not participating in the study. Health managers were selected based on the three types of implementing organizations (international NGOs, national NGOs, and provincial government health departments). First, the lead researcher contacted the implementing organizations and met with the director of the organizations to identify potential health managers who had good knowledge of the program. Then, the researchers sent a solicitation letter to the managers to ask them for their

Table 1
Hierarchical and horizontal classification in sampling.

Hierarchical	Horizontal		
Policy	Government	Donor agencies	UN agencies
• Policymakers			
Management	Public Health Departments	International NGOs	National NGOs
• Managers, • CHW supervisors, • CHW trainers,			
Community	Less remote communities		Highly remote communities
• CHWs • Community members			

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