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Toward universal coverage in Afghanistan: A multi-stakeholder assessment of capacity investments in the community health worker system

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ABSTRACT

Global efforts to scale-up the community health workforce have accelerated as a result of the growing evidence of their effectiveness to enhance coverage and health outcomes. Reconstruction efforts in Afghanistan integrated capacity investments for community based service delivery, including the deployment of over 28,000 community health workers (CHWs) to ensure access to basic preventive and curative services.

The study aimed to conduct capacity assessments of the CHW system and determine stakeholder perspectives of CHW performance. Structured interviews were conducted on a national sample from 33 provinces and included supervisors, facility providers, patients, and CHWs. Formative assessments were also conducted with national policymakers, community members and health councils in two provinces. Results indicate that more than 70% of the NGO's provide comprehensive training for CHWs, 95% CHWs reported regular supervision, and more than 60% of the health posts had adequate infrastructure and essential commodities. Innovative strategies of paired male and female CHWs, institution of a special cadre of community health supervisors, and community health councils were introduced as systems strengthening mechanisms. Reported barriers included unrealistic and expanding task expectations (14%), unsatisfactory compensation mechanisms (75%), inadequate transport (69%), and lack of commodities (40%).

Formative assessments evidenced that CHWs were highly valued as they provided equitable, accessible and affordable 24-h care. Their loyalty, dedication and the ability for women to access care without male family escorts was appreciated by communities. With rising concerns of workforce deficits, insecurity and budget constraints, the health system must enhance the capacity of these frontline workers to improve the continuum of care. The study provides critical insight into the strengths and constraints of Afghanistan's CHW system, warranting further efforts to contextualize service delivery and mechanisms for their support and motivation.

1. Introduction

Community engagement has emerged as a paramount strategy for enhancing access to healthcare and optimizing efforts of the health system to achieve the Millennium Development Goals (MGDs) (Rosato et al., 2008; Bhutta et al., 2010; Perry and Freeman, 2009; Perry and Zulliger, 2012). Healthcare contexts present complex challenges arising from the diverse geographic, ethnic, and

Acronyms: BPHS, Basic Package of Health Services; CBHC, Community Based Healthcare Department; CHW, Community health worker; FGDs, Focus group discussions; MOPH, Ministry of Public Health; NGO, Non-Governmental Organization.

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sociopolitical factors that require appropriate service delivery architecture for community based healthcare. Community dynamics necessitate a multi-faceted approach to manage informal providers effectively and require a 'systems lens' to ensure capacity, quality and coverage of service delivery. CHWs are now recognized as integral members of the health care workforce, though their roles and functions vary among contexts. In many settings, they provide primary preventive and curative care and serve as the community's critical link to the formal health system. As health workforce crises escalate, they are increasingly filling human resource gaps through task shifting, with additional responsibilities for screening, curative care and health information systems. Despite the positive findings of research studies on programs integrating CHW services, the debates on optimal job descriptions and workload, quality assurance and continuity of care, compensation and motivation remain unresolved (Lehmann and Sanders, 2007; Bhattacharyya et al., 2001).

In Afghanistan, the deployment of volunteer CHWs by the Ministry of Public Health (MOPH) was a key and integral part of its Basic Package of Health Services (Afghanistan MOPH, 2003), implemented in 2003, to improve equitable access to healthcare for rural communities. Major postwar challenges included inadequate health infrastructure, workforce deficits, especially females, and geographic and socio-economic barriers, including cultural constraints on the mobility of women. Maternal and child mortality rates were estimated at 1600 per 100,000, and 172 per 1000, respectively (Bartlett, 2005, and Central Statistics Organization, 2003). The BPHS prioritized maternal and child health, birth spacing and disease control. One male and one female CHW were selected and trained for each village health post, serving up to 150 households. The CHW job description included treatment of childhood diseases, provision of contraceptives, health promotion, and demand-creation for preventive and maternal health services at the supporting health facility. Community health councils were established in 2005, and facility councils were introduced later.

In 2005, the MOPH established the Community Based Health Care (CBHC) Department with responsibility for policy and oversight of the national CBHC program. In 2009, the department expanded to manage the workload of monitoring provincial programs and the training and mentoring of provincial-level NGO trainers. CHW programs were being expanded and improved training modules for both pre-service and refresher training were being prepared. In 2005, the department oversaw the deployment of a facility-based cadre of Community Health Supervisors. It has also introduced various incentive systems and mechanisms to maintain CHW motivation. Recently it has implemented the women's Family Health Action Groups, based on the Care Group Model. Female CHWs engage 10–15 respected female volunteers to conduct health promotion activities for around ten neighboring households, resulting in improved health behaviors, utilization of services, and improved child survival (Edward et al., 2007; Ricca et al., 2014). During the last decade, 28,459 CHWs (49% female) were trained and deployed (NGO quarterly reports to the Grants and Contracts Management Unit.)

Data from the Central Statistics Organization (2014) indicate that 88.4% of the rural population report facility access (<2 h travel time). However, persisting barriers to access reinforce the importance of CHWs. Over 50% of women not attending antenatal care claimed that distance or transport was the reason (APHI MOPH et al., 2010). Security incidents have increased over the past five years and, in 2014, at least 58 districts experienced temporary or permanent facility closures (Safeguarding Health in Conflict, 2014).

Frameworks for enhancing community systems for healthcare, particularly for strengthening CHW performance, identify the key determinants of capacity, motivation and a supportive work environment (GFATM, 2014; Jaskiewicz and Tulenko, 2012). In Afghanistan, these critical factors as well as effective regulatory oversight depend upon targeted investments by a variety of stakeholders.

National-level assessments of Afghanistan's health system have been conducted annually since 2004, using the balanced scorecard strategy. The evidence has illustrated impressive gains in most performance domains, however, the scorecard does not include measures for community-based service delivery (Edward et al., 2011). A recent study on CHW systems, indicated improved referrals by trained CHWs (Newbrander et al., 2012), but aside from a previous operations research study (JHBSPH and IIHMR, 2007) no systematic assessments have been published on CHW services in Afghanistan. This study's main objective was to perform capacity assessments and examine stakeholder investments in the CHW system.

2. Materials and methods

In 2011, we conducted a mixed-methods study to determine systemic constraints in the CHW system and stakeholders' perspectives and investments at the national, facility and community levels. Assessments included both qualitative (key informant interviews, focus group discussions (FGDs) and quantitative methods (structured interviews) (Table 1). Employing multi-stage systematic random sampling, up to 25 health facilities were selected in each province for the national assessments. All supervisors (facility in-charge) of selected health facilities, up to five providers and up to two CHWs were selected randomly from each facility to participate in the survey assessments. Capacity assessments were also performed at the CHW health posts.

All national-level NGO managers involved in the design and/or management oversight of CHW programs were selected for interviews to determine the characteristics of the CHW system. Key informant interviews were conducted with policymakers, and FGDs were conducted with the technical advisory group members of the CBHC Department. Eight facilities from Bamyan and Takhar provinces were selected purposively and eight communities were selected randomly for conducting community and health council FGDs. Quantitative and qualitative data were collected from pretested validated structured questionnaires and FGD and KII guides. Survey teams were recruited based on past experience in quantitative and qualitative surveys and received training on technical content, survey techniques and ethical procedures and demonstrated competencies on pre-post tests. Survey teams comprised of male and female pairs conducted the qualitative assessments, and a five-member team conducted the health facility assessments.

The quantitative data were analyzed using STATA Version 12.0 (StataCorp LP, College Station, TX, USA), and descriptive statistics were employed to summarize results. Qualitative data were analyzed using thematic content analysis and summarized based on key themes evaluated. The study was reviewed and considered exempt human subjects research by the Johns Hopkins University Institutional Review Board, and also approved by the Afghanistan review board. Verbal informed consent was obtained from all study participants.

3. Results

Results of the capacity assessment and perceptions are reported for each stakeholder category and health system level.

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