Assessing the Community Health Worker Role in the Polio Eradication Initiative's Social Mobilisation Strategy

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Executive Summary

In 2015, Afghanistan's Polio Eradication Initiative (PEI) commissioned a Knowledge, Attitudes and Practice (KAP) survey to ascertain whether and how it could improve efforts to reach one hundred percent of Afghanistan's children and in so doing both achieve the goals of eradicating polio and strengthening Routine Immunisation (RI). One finding of the KAP is that an improved modality of work with the Community Based Health Care (CBHC) pillar of the Ministry of Public Health's (MoPH) outreach programme would increase PEI outreach, mainly because communities identified the female and male Community Health Workers (CHWs) mobilised by the CBHC as their most trusted source of health information. Communities also expressed some concern that the Frontline Workers (FLWs) they were encountering during PEI campaigns were unfamiliar to them and observed that the predominance of male FLWs acts as a constraint on the goal of inoculating every Afghan child against polio.

To identify whether the PEI should more actively engage with CHWs and to develop a clearer picture of the advantages and possible pitfalls of such engagement, the PEI commissioned an in-depth study. Working from the understanding that the CBHC and its CHW structure is immediately relevant for other high-impact child survival interventions, the study was designed to ascertain whether CHWs are potentially well positioned to engage in the PEI Immunization Communication Networks (ICNs) for increasing community awareness, promoting public health information and facilitating the vaccination of children who have been missed during campaigns. The study also investigated challenges arising because the PEI ICNs have been a largely parallel workforce to the CHWs and determined ways in which to overcome the disconnect between the Polio Programme and sustained approaches to improving vaccination coverage at large.

The study finds that CHWs are indeed a potential, but at present, largely untapped resource. While there are some challenges in aligning the already-established approach to mobilizing FLWs with the modality through which CHWs work, there are also important lessons to draw from that have the potential to strengthen Afghanistan's CBHC as a whole.

Part One

Introduction

Polio eradication cannot be achieved and sustained unless there is also a strong and sustained Routine Immunization (RI) programme working closely with community based structures. In Afghanistan, Community Based Health Care (CBHC) is the foundation for the successful implementation of the Basic Primary Health Services (BPHS) 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 public health system and the communities it serves. Its success depends upon community participation and support, and a partnership between community and health staff.

The implementation of CBHC recognizes that families and communities have always looked after their own health. Religion and cultural norms and beliefs play an important part in either enabling or preventing good health practices, and, based on these, families are making decisions to prevent illness, maintain health or care for illness every day. While healthcare decision-making may appear to be highly personal, it is in fact embedded in larger, although sometimes invisible or difficult-to-assess social structures that are likely to be influential on how decisions are made, and by whom. Community members both understand and determine or perpetuate the social dynamics at play in choosing health options, including who delivers health services, and may therefore have reliable information on local needs, priorities, and challenges. 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 exchange negative behaviors for more healthy ones. This process may necessitate assessing and tackling exclusionary social norms and behaviours that compromise fair and equal access to health services for all community members.
- To encourage the guidance and collaboration of communities in the implementation of health programs and the acceptable provision of health care, and enable them to identify and solve their own problems and broaden their health-seeking behaviours in sustainable ways.

Challenges and New Directions for the Afghan PEI

Not only the message must be localised and consistent – the messenger must be too.

Early in 2015, Afghanistan's Polio Eradication Initiative (PEI), a programme with the challenging mandate of eradicating polio in a country whose operating environment is among the most difficult in the world, began to analyse the findings of a "Knowledge, Attitudes and Practice" (KAP) survey to identify how Afghans receive and understand the Initiative's work.[1] Among the insights of the survey is that individuals see an unfamiliar workforce as the public face of the PEI. This is problematic because they report that they *most trust* polio prevention and other health messages given to them in a form already familiar to them, by people they already know (family, friends and community members).

[1] They survey was designed and conducted by Harvard University's Opinion Research Program in partnership with UNICEF.

This finding has to be carefully interpreted for the insights it gives into the effects of miscalculations already made by the PEI in understanding how family health can best be promoted in Afghanistan. The initiative's decision to over-rely on men as frontline workers (vaccinators and social mobilisers) is revealed not to be as appropriate and culturally responsive as thought, but as an enabling factor in permitting some men to dominate and misshape the PEI's purpose for their own ends. One result is that today, the goal of achieving one hundred percent uptake of the polio vaccine remains elusive.

As a result of existing siloes in the MoPH, the initial design of the PEI was not closely aligned with the CBHC basic health delivery system in Afghanistan and largely overlooked an established health workforce that is based in communities across the country. The KAP survey reveals what was not clear before: not only that already-mobilised and trusted community health workers (CHWs) could have provided significant support to the PEI, but that leaving them out has negative ramifications for polio eradication, for routine immunisation and for other related aspects of community-based healthcare. To put this problem in a different light, the perceived challenges of working in Afghanistan may have overly encouraged programme planners to believe that the PEI should be delivered as a humanitarian intervention rather than a mechanism to advance development goals. Aiming for a 'quick impact' in turn justified using a programme delivery format familiar from other countries rather than taking the time to investigate systems that were already in place, and then working judiciously to enlarge them. An analysis of the knock-on effects of these early decisions has become increasingly important as the PEI comes to the end of its mandate and begins to evaluate its legacy for Afghanistan's healthcare system. An elaboration of these points forms the backbone of this report.

Why Focus on CHWs?

From PEI's perspective, the CHW system has specific strengths: it is a nationally-implemented approach designed to reach the poorest, most marginal and most precarious in the population. While men play a crucial support role, the system's focus is squarely on women and their children.

Built in response to the country's appalling maternal-child mortality statistics, the CHW system was designed to provide families access to community-based healthcare. It operates at exactly the level needed if the PEI is to reach all Afghan children.

The CHW system has to function inside Afghanistan's severely constricting patriarchal system with its core emphasis on women's seclusion and constricted public movement. As a result, it has been built in such a way that it can get around some of the problems associated with accessing women and their children. It makes sense in its context and is trusted by Afghans, including in the very conservative parts of the country. As such, it provides an effective, if very basic, method to respond to the critical situation in women's health (and in the well-being of their children) that results from entrenched restrictions on their access to public space, including community-based health services. As multiple such constraints continue to affect women's health-seeking behaviours today,[2] the CHW

[2] Some Afghans still enforce a seclusion so complete that women never meet anyone outside their kinship network throughout their lives. It is important not to exaggerate the extent to which CHWs can reach such women, but the point is that those who can become direct beneficiaries of some healthcare are more easily reached by FCHWs than through any other means.

programme remains unusual and important in Afghanistan as it is able to operate through mobilising female capacities to work in women's interests.[3]

To overcome limitations on women's freedom of movement, the structure calls for a *mahram* male and female CHW pair,[4] elected by the village *shura*, to serve the community's basic health needs on a voluntary basis.[5] Women have long been able to serve community health needs as traditional birth attendants (TBA); so when Afghanistan followed WHO guidelines and disallowed TBA work in 2003, a large number of them elected to become FCHWs. They could only do this only if they were able to convince a male family member to act as *mahram*. In the early days of the CHW programme, then, recruitment appears to have been driven through *women* with some community reputation for dealing in family health concerns, not through men.

Numbering in the tens of thousands, CHWs were never intended to become official, salaried, or in any other way regulated workers within the MoPH. Importantly, the system's focus on women seems to be possible because it was always conceived of as voluntary, and while FCHWs do gain community recognition and status, it accrues to them privately as positive role models and influencers in their families and village networks, not through elevating them into publicly visible leadership roles.[6] Ironically, what was originally a financially prudent decision has proven to be an important factor in keeping women engaged and CHW work firmly focused on women's well-being. Women-to-women health service delivery remains possible not only because women can be comfortably associated with the care-giving aspects of health-related service, but because voluntary work is regarded as appropriately low-status enough that even women can join. The CHW system is also unlike other interventions that try to focus on promoting women's well-being, because it recognizes that men can be encouraged to support women and children if they can do so in ways they accept as culturally appropriate. Men's dominance can remain unchallenged because the MCHW's backing is essential for the FCHW to do her work, and he remains in control of the public aspects of CHW service such as writing reports and negotiating with other men when women need help beyond what the village health post can deliver. Within the constraints of the powerfully patriarchal political economy of Afghanistan, therefore, it can be argued that the existing CHW system offers an ingenious indigenous response to the problem of enabling women, and through them children, to access a basic level of healthcare service.

Crucially for the PEI, the basis of the success of the CHW system is that it is highly localized and draws on the voluntary support of community members who already enjoy a good level of respect. The importance of this fact cannot be over-estimated given Afghanistan's decades-long history of armed conflict, which has produced deep levels of suspicion of outsiders and hyper-vigilance about messages that try to instil new behaviours. The household level of their work is made possible

[3] At least at the delivery level where voluntary work is done. Women do not easily or often ascend the hierarchy into public, paid positions.

[4] In Afghan culture, a woman leaving her house must be veiled (in many parts of the country, she must be completely covered by a *chadari* or *burka*) and accompanied at all times by a male family member (father, brother, son, husband). The Taliban made attempts to curtail women's freedom of movement well beyond what was already considered culturally appropriate. Even since their fall, ongoing insecurity their legacy of conservatism and backlash against external efforts to 'liberate women' remain engrained.

[5] CHWs are not entirely unremunerated, as will be discussed in greater detail below.

[6] FCHWs tend to be very humble, mostly illiterate women. MCHWs, by contrast, tend to be literate men already in a public role such as school teacher.

because of the *mahram* pair approach, and communities highly appreciate that they are served by both a woman and a man in matters of basic health decision-making.[7]

Preference for *mahram* pairs and the implications for PEI

KAP survey respondents, while they largely remember encountering males in the course of polio campaigns, indicated that male-only health workers are unfamiliar to them in the context of community-based health delivery, especially for a health service that is delivered door-to-door. Respondents overwhelmingly indicate that they would prefer to receive health information and services from male and female *mahram* pairs.[8] This preference correlates highly with their rating of Community Health Workers (CHWs) as those they trust most highly in family health matters.

Significant questions are therefore raised by the KAP: are survey respondents indirectly asking why the PEI chooses to present its work as different from or outside what they accept as normative frameworks for basic health work? If so, how has this affected the successful uptake of the initiative and possibly shaped refusal and other expressions of suspicion about the intentions of the PEI? In what ways should the PEI modify its approach to build more trust and recognition in the communities it serves? Is the current communications approach, which relies more heavily on communication methods such as TV and radio slots, posters and announcements from religious leaders than facet-to-face communications, most effectively pitched to reach the broadest possible audience?

> *"…a scared, hungry, poor, uneducated person forgets messages easily. What people do remember is house-to-house visits from familiar people. Routine contact is good" (field interview)*[9]

Given the tightly-knit structure of Afghan society and hyper-vigilance resulting not only from direct experiences of conflict but also encounters with conflict-related disinformation, rumours, moral panics and propaganda, it is unsurprising that communities want to receive healthcare within structures and through formats they trust. However, contrary to what communities recognise and endorse, PEI work conducted to date has only peripherally engaged with the CHW system and failed to recognize the pitfalls of using predominantly male social mobilisers as well as male-only pairings of vaccinators to prepare communities and administer the oral polio vaccine (OPV) during National Immunisation Days (NID) campaigns.

The in-depth analysis that led to this report was commissioned to help PEI programmers understand whether, how and to what extent failing to engage CHWs may have been counter-productive to

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[7] The Knowledge and Practice (KAP) survey conducted for UNICEF by Harvard University in early 2015 revealed that CHWs are the most highly-trusted source of health information, with religious leaders and neighbours coming close behind them. This tells us that it is the *localization of the messenger* as much as the localization of the message that promotes better health-seeking behaviors.

[8] In Afghan culture, a woman leaving her house must be veiled (in many parts of the country, she must be completely covered by a *chadari* or *burka*) and accompanied at all times by a male family member (father, brother, son, husband). The Taliban completely curtailed women's freedom of movement but even since their removal from power, ongoing insecurity and cultural conservatism remain engrained and shape women's access to public space in profound ways.

[9] Field-level research for this report was conducted in Jalalabad, Kandahar and Kabul in August and September 2015. Findings were corroborated with key informants in Kabul.

achieving the PEI's goals.[10] Simply put, the research question was, through field-based discussions supplemented by secondary literature, to extrapolate the unanticipated negative consequences from the approach used by PEI to date; and to identify whether working more deliberately with CHWs might allow challenges in delivering the PEI to be overcome in the future. Recommendations derived from the research findings are elaborated below.

Identifying Key Concerns in the Operating Environment

A change in approach is timely and necessary

Afghanistan's Polio Eradication Initiative (PEI) is well-positioned to consider new approaches, not only to benefit from the findings of the KAP survey but also to reflect changing realities within programme delivery and support the evolving priorities of the Ministry of Public Health (MoPH) specifically its implementation of the Community Based Health Care approach (CBHC). The changes proposed here are intended to address overall challenges facing the PEI and issues on the ground in the low-preforming districts (LPDs) in some provinces, and also to strengthen the work of the MoPH more broadly by suggesting ways to address current overlaps in health delivery systems that may be draining scarce resources.

As is alluded to above, Afghanistan faces complex difficulties that affect the success of the PEI. A brief list illustrates how wide-ranging these are:

1) *Weak centralised governance and a perceived lack of transparency*:

The challenges of establishing a centralised and unified system of government in Afghanistan are well-documented. Even within Ministries, lack of coherence and siloes are affecting holistic delivery of public services. At the outset of this research, for instance, the CBHC director did not participate in the MoPH's unified PEI working group.

Beyond the capital, there are ongoing armed insurgencies and more-or-less constant struggles to claim or contest political power. A highly devolved provincial governance structure means that policy decisions made by the MoPH in Kabul may be unevenly accepted and implemented in the provinces. Some leaders in the Public Health Department (PHD) also expressed a belief that provincial structures are left to function on greatly reduced budgets. This affects the implementation of PEI, because it supports a perception that efforts to draw in Basic Public Health Services (BPHS) NGOs,[11] and specially, CHWs, is simply a ploy to get more work done for free, or at cost, in the provinces.

2) *Economic uncertainty and PEI as an 'income-generating activity'*:

The majority of Afghans face extreme impoverishment and very limited legitimate income-generating opportunities as a result of decades of war, and today's ongoing insecurity. In the LPDs, PEI's NID approach, which pays a wide network of people to deliver the OPV, is now regarded as a (fairly predictable) income source. Afghans may jokingly talk of 'polio and poppies' as the two economic activities available to them, and refer to NIDs as 'National Income Days', but this apparent

[10] In urban areas such as Jalalabad and Kandahar, communities have been exposed to female social mobilisers. Women were not engaged in urban areas, because of perceptions by programme implementers that women cannot move around giving health messages.

[11] Basic Package of Health Service (BPHS) NGOs are responsible for the training, supply and oversight of CHWs. They are managed exclusively by men.

levity disguises an uncomfortable set of practises that have arisen around the PEI as a well-resourced health initiative. Because money changes hands in the course of NID Campaigns, complex patronage networks appear to have evolved around who gains access to PEI assets.[12] As a result, some of those who are invited to 'volunteer' for NIDs may assume that their closeness to their employer makes them unaccountable. Some indifference and inefficiency seems to exist in the system, and may be contributing to the ongoing problem of children missed in polio campaigns. Most distressingly, the suspicion has been raised that obstructing the goal of eradicating polio is acceptable in order to keep the money associated with the PEI flowing.

3) *Culturally-sanctioned and justified exclusions*:

Because patronage networks may be over-determining recruitment and remuneration policies, the inefficient delivery of OPV can be easily excused as a 'necessary evil' because of cultural constraints on women's participation in public economic activity; and, unsurprisingly in Afghanistan, gender inequalities play a fundamental role in undermining the eradication of polio. Men, protecting male patronage networks, may (and do) argue that women cannot be deployed for NIDS for reasons they ascribe to Afghan culture. Yet it is demonstrably inefficient to send male-only pairs from household to household to deliver the OPV: men outside the family kinship network, who cannot enter the private space of an Afghan compound, cannot determine the number and age of children in the household. As (predominantly male) vaccinators are currently paid per number of households reached and try to achieve a daily quota, the evidence shows that inadequate effort is being made to reach sleeping, sick, absent or newborn children: i.e., children invisible to non-kin males. There are relatively elaborate checks-and-balances to record which children are missed during campaigns, but, when emphasis is placed on speed and numbers rather than thoroughness, households may not be properly revisited during campaigns.

> *Considering the established CHW* mahram *pair system and the level of outreach it seems to facilitate, it is puzzling that PEI frontline workers (FLWs) are not also deployed in male-female pairings and that NIDs do not draw in all registered CHWs.*

It is difficult not to conclude that existing best practice has been ignored because using it might undermine the male patronage networks discussed above, especially because there is good evidence that women, when they have been included, make a worthwhile contribution to advancing PEI goals. In those urban areas in which women are working during NIDs, there are extremely positive reports of their efficiency and determination to reach every child in every household, including accounts that they take time to win over reluctant caregivers and diligently revisit households in which children were missed. A re-thinking of the PEI approach from an informed gender analysis of the conditions for delivering an effective programme is therefore a necessity, not an external imposition, a distraction or an irrelevancy.

4) *Trust-building and positive caregiving*

[12] These resources are primarily a small daily wage for the five days of each NID campaign, although the 'big money' appears to be attached to payments made for the use of private vehicles to do campaign work.

An extremely high child mortality rate (a tragedy with multiple causes) may have produced a fatalistic approach to children's well-being in Afghanistan (childhood death is seen as 'the will of Allah' rather than something preventable). With this problem in mind, ascribing the low uptake of OPV and other RI solely to suspicion stemming from exposure to counter-productive messaging may be inaccurate, a finding corroborated by the KAP.[13] Other, more helpful directions of inquiry might be being overlooked as a result of an unnecessarily narrow focus on 'false messaging': is there fatigue at a message repeated too often? Are we approaching people in ways that they expect and support? Do we communicate PEI messages correctly and to the right audience? Even apparently mundane issues such as the colour of the ink used to mark a vaccinated child's finger might turn out to be affecting how NIDs are received, if only caregivers were asked![14]

Given the difficult operating environment, asking the baseline question, 'why is so much of the target population still evading this vital piece of preventive medicine?' is also critical: the KAP indicates a profound mistrust in a stressed population that any formal or government-backed interventions are positively intended, especially when those delivering them are paid to do their work, and an inability to believe that help is available without codicils or hidden prices. While such hyper-vigilance is unsurprising in a generationally wartorn society, this reality means that the PEI programme has to be as much a psychological, or perhaps philosophical endeavour, as it is a practical, scientific effort to eradicate polio in Afghanistan. From this perspective, a major concern of the PEI has to be *to build trust and optimism* among caregivers, as well as to give more thought to creating 'child-friendly' NIDs which demonstrate to caregivers that their children are more than numbers on a list and have the right to health.[15] A crucial strategy is to re-think the current communications modalities, to deliver more convincing messages to the right people, through the right channels and through appropriate and trusted messengers, to allay existing fears about 'externally-driven' health programming and to help to build positive, forward-looking health-seeking behaviours among Afghan decision-makers and caregivers.

Overall, there is a welcome congruence in concerns about the PEI and a positive environment in which to implement changes supportive of Afghanistan's national interests. Implementing the proposed changes also signals that a transition strategy for the PEI is now being put in place and gives advance notice that it will come to an end in only a couple more years. Planning to leave in place a legacy that strengthens and sustains community health services as a whole – including through rebuilding a focus on the 'end-game' approach – has become an urgent task.

[13] The KAP reveals 'suspicion' as underlying only 1-3% of refusal, a far lower figure than was expected and one which once more cautions PEI staff not to expect the same findings in Afghanistan as in neighbouring countries such as Pakistan and India where false messaging has played a serious part in convincing caregivers not to allow their children to receive polio vaccines.

[14] One key informant one informant did, in fact, ask why children's fingers are marked with black ink, an ominous colour in Afghan society, rather than something bright, cheerful and positive.

[15] More than one key informant, and several Afghans engaging in casual conversation with the researcher, commented that engagement with children themselves seems to be missing from the campaign. There are no efforts to draw them in through activities, songs, colour, etc., although slightly older children are reportedly quite proud of their finger mark and like showing it off. It might in fact be helpful to create a demand and interest in the work of NIDs among children themselves, especially since it often has to be an older child, in the absence of a senior male, who answers the door when FLWs do their rounds.

Wastage of resources: the PEI's biggest logistical challenge

The strongest finding of this research is that the vertical structure of the existing PEI has generated both a programme delivery modality and a human resources base focused exclusively on the elimination of polio – to the exclusion of other routine immunisation (RI) work in the Expanded Programme on Immunisation (EPI). While this narrow approach, which is in line with global policy, may have made sense early in the programme's life, it has had the unanticipated negative consequence in Afghanistan of wasting resources, including through over-concentrating them. This in turn seems to have created opportunities for duplicity. Both of these problems are now threatening the achievement of the programme goal not only to eliminate polio in Asia, and globally, but also to strengthen the health system more broadly.

Largely as a result of the importation of modalities that, having succeeded elsewhere, were expected to be applicable in Afghanistan with minor or no modification, a duplicate structure now exists, of PEI FLWs and CPHD CHWs, that is:

1) undermining efforts by the MoPH to encourage RI and build EPI capacity to tackle all other childhood illnesses;
2) contributing to the likelihood that scarce financial resources might be misused and/or misdirected;
3) inadequately contributing to producing the human resources needed for the country's health services;
4) doing little to produce behaviour change in caregivers or to enhance the levels of trust needed to produce child-centred decision-making and increased uptake of health-giving interventions, even painless ones such as the OPV.[16]

Challenges to PEI delivery tend to manifest differently in crowded urban and peri-urban areas, and in those that are scarcely populated, although the underlying issues of a lack of readily-accessible and well-staffed healthcare facilities, a mistrust of strangers and a suspicion of 'foreign' interventions are widespread. Different strategic approaches are needed to deal with a reservoir of polio virus in urban Kandahar that persists because of overcrowding and poor sanitary conditions, and with the most recent outbreaks of zero-dose polio cases that are associated with trucking and migration routes into remote rural areas across the country's long and porous borders. But the diversity of root causes for new polio infections in Afghanistan also means that strategic thinking is required about how to counter the impacts of the country's long history of both internally and externally-driven conflict and the extreme suspicion and solipsism it has produced, the ongoing problem of a lack of provincially-enforceable government policy, and the implacable marginalisation of women from decision-making.

[16] In interviews, informants stressed that children should not be subjected to anything that causes pain, or makes them unhappy or scared. This may be a key factor in caregivers' refusal to wake sleeping children or allow sick or newborn children to be vaccinated. Again, this opinion should be read as alert that decision-makers have not fully understood that the OPV is administered painlessly and does no harm to children.

Identifying Key Concerns in PEI

1: Duplication and Duplicity

Cost of NIDs to RI Goals

At present, short and intense PEI National Immunisation Days (NID) Campaigns are run several times a year, with the frequency varying from area to area based on need. Because of the significant human resources needed during NIDs, in the twenty years of its life, PEI has mobilised several thousand Frontline Workers (FLW) to work for a few days at a time during campaigns. FLWs are both recruited and managed by the MoPHs District Coordinators (DCs), who are employed full-time as vaccinators in the EPI Centre at Health Clinics (HC). DCs are accountable to the Provincial EPI Management Teams.

While DCs should work exclusively on RI, and should continue this work regardless of whether a PEI campaign is running or not, some DCs bend the rules: they 'double-dip' and work as vaccinators for the PEI. This is financially rewarding for individuals who take senior (supervisory) roles during NIDs, as they not only earn the daily wage of 350 Afs per day but may also use their private vehicle to move around.[17] During NIDs, then, some personnel who should work on RI, and are being paid a salary to do so, are absent from their post.

Cost of NIDs to BPHSs

While the MoPH runs health centres and hospitals at provincial level, it subcontracts a large amount of work to Basic Package of Health Services (BPHS) NGOs, which run the community-based health services that exist at district, sub-district and village level. BPHS NGOs train and manage around 29,000 voluntary community health workers (CHWs) who offer very basic health services at Health Post (HP) level, serving around 10-15 families each, and who also refer serious cases to HCs. BPHSs pay for full-time Community Health Supervisors (CHSs) to manage CHWs.

BPHS are not currently part of the process of preparing for or delivering EPI campaigns. However, they hire and manage experienced health personnel (qualified vaccinators) to work on RI. BPHSs report that some of their personnel, attracted by the resources on offer through PEI, make themselves available, in their personal capacity, to work during PEI NIDs. BPHSs complain that they lose an important part of their workforce, with no benefit to the BHPHs, every time NIDs takes place.

Again this is contrary to the directive of the MoPH and undermines the broader health system. The fact that many RI vaccinators abandon their post several times a year to benefit from working for the PEI may be one reason that RI rates are currently very much lower than the targets set.

Cost of PEI to CBHC: Exclusion of BPHSs and CHWs

The third reason why the current PEI NIDs are diverting resources from the health system as a whole is that they have mostly not mobilised the most basic healthcare providers, CHWs, a voluntary health workforce who are managed by the BPHS NGO sector. CHWs are not well-positioned to benefit from the package paid to individuals mobilised for NIDs. This means, in turn, that this cadre of established health education mobilisers is not gaining access to campaign training or gaining focused learning on polio prevention messages.

[17] An individual can earn a significant amount (perhaps even as much as USD 30-50 a day) in 'transportation' costs.

As they receive training on the basket of RI that children should receive, enjoy high levels of trust from the communities they work in, pass on EPI messages routinely as part of their work, recognise missed children, and are mobilised to assist in the routine delivery of basic health services, they are an as-yet unrecognised asset both to PEI and EPI.

Recommendations

Avoid reinforcement of the 'parallel work force' situation and reduce the potential for corruption

- PEI should move away from a 'campaign only' approach. While NID campaigns will remain an important strategy, there also needs to be a 'between-campaigns' modality/catch-up strategy for tracking and vaccinating missed children, including those not reached when they migrate back and forth across the borders, because of insecurity, or for any other reason
- To facilitate this more consistent approach, PEI should be incorporated into the TORs for CHWs and they should 1) gain predictable access to the workforce mobilised for NIDs (receiving the same incentive as other FLWs) so that they legitimately spend some of their mandated work time on supporting PEI (i.e. are not involved in subterfuge/taking time from routine work); and 2) take their learning from NIDs back into the community between campaigns in order to watch for and inoculate missed children (and be capacitated as first-line responders if an infection should occur). Their between-campaign 'catch-up' work should be seen as part of their regular RI work, and be differently incentivised from NIDs so that it is congruent with incentives they usually enjoy (monetary and non-monetary) as CHWs.
- BPHS NGOs, which currently take responsibility for RI (except polio) will also need changed ToRs that include them in PEI NIDS, so that they can extend their supervisory services to CHWs during and in-between PEI campaigns.
- Working with CHWs through BPHS will have the added advantage of strengthening an existing supervisory/accountability chain (MoPH-PHD-BPHS-CHW) that does not always work optimally at present and facilitate the extension of a necessary system of checks and balances that will improve CHWs service delivery as a whole.
- Tracking the efficacy of CHWs working in *mahram* pairs will provide valuable data for how to step up EPI across Afghanistan, even in hard-to-reach areas
    - It may also dispel currently popular stereotypes (that are mobilised in PEI delivery, but dispelled by the CHWs system) about whether women can contribute effectively to advancing community health
    - It will enable implementation of learning from the Harvard KAP survey
- A proposal should be made to consider some task shifting: can those CHWs who have the capacity/vocation to be trained in delivering vaccines via injection be considered for this work? Such a shift could go some way to addressing the current chronic shortage of vaccinators in the country.
- Any training offered to CHWs is a sustainable investment in delivering the CBHC mandate: this training will ready the CHW cadre to assist in all RI campaigns (including PEI as it winds down/monitors the eradication of polio over the next few years)
- This changed approach will address and resolve the problem that some staff is 'lost' to NIDs. [There is likely to be resistance to this, however: there will be financial implications for DCs

and BPHS vaccinators who will lose their access to extra PEI resources that they are not meant to be getting].

2: Costs of Social Exclusion

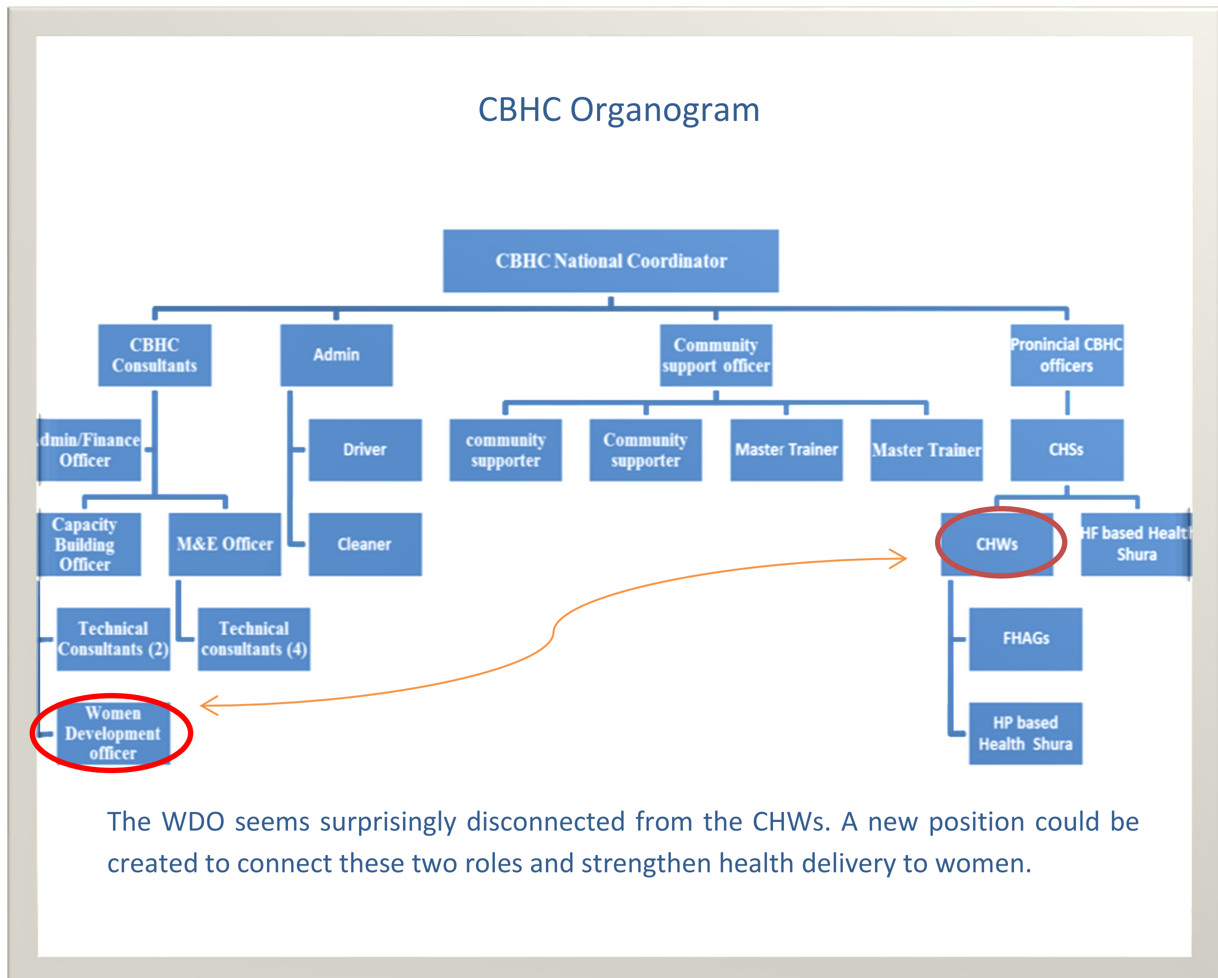
Lack of Coherence at Ministerial Level

The challenge of siloes and poor inter-Ministerial communication in the MoPH has been described above. Poor intra-Ministerial cooperation may also be a cause of concern to PEI as some of the community-based structures it should draw from, for instance, Community Development Committees (CDCs) have apparently not been factored into the programmatic approach to date.

Inside the MoPH, a high level of willingness to address the unintentional exclusion of the CBHC (and by implication, the channels through which CHWs can best be reached) was already demonstrated in September 2015, when the CBHC Director was included in weekly PEI discussions chaired by the MoPH for the first time.

The CBHC itself will need significant support in order to facilitate greater mobilisation of the CHW system to support the PEI. One area that needs further investigation and support is the CBHC-BPHS relationship. BPHS NGOs are currently selected by the MoPH through an annual bidding process. Part of their role is to devise and offer training packages constituting of basic training of 3 x 18 day sessions for new CHWs and regular refresher trainings for established CHWs each year. As CHWs receive a travel and subsistence allowance to attend training, predictable delivery is an important incentive for their continued engagement in public health. BPHSs are also responsible for stocking the 'CHW kit' of basic medicines and other necessities for the primary services offered by CHWs. In recent years, both training and kits have become inadequate as BPHSs re-define their budgets and undercut their bids to win government tenders. This problem requires urgent action and a coherent response from a health economy, management, oversight and accountability perspective .

The CBHC also currently seems to lack a coherent strategy, informed by careful gender analysis, to promote the health of women and their children. The diagram below illustrates one aspect of the problem:



Recommendations

To strengthen internal coherence and capacity within the CBHC section of the MoPH and between the CBHC and the PEI steering committee:

- Identify and appoint a (female) Afghan national officer at senior technical level to close the apparent organisational gap in the CBHC
    - The new officer will help strengthen and ensure that the best use possible can be made of the CHW system;
    - This person will also represent the CBHC in connecting PEI and EPI concerns
    - The gender analysis of the CHW system appended to this document should be consulted in determining the ToR and approach for this new position
    - Partners should support the MoPH with the identification, support and oversight of the new staff.
- Investigate funding modalities and decision-making: MoPH ↔ CBHC ↔ BPHS ↔ CHW especially as played out in the development of BPHS budgets and MoPH procurement and oversight of the services of these NGOs.

Duplications and Overlaps in Health Sector Personnel

There are important differences between the Frontline Workers (FLWs) currently engaged by the PEI, and CHWs. These are discussed comparatively here in order to tease out lessons learned in producing health workers in Afghanistan.

Contributions versus costs of FLWs

The modality of recruiting and managing PEI FLWs are quite complex and appear to create opportunities for division, imprecision in mandates and management, and corruption. FLWs are divided into a) vaccinators and their supervisory mechanisms (WHO leads), and b) social mobilisers (SM) and their supervisory mechanisms (namely, SMS, or Social Mobiliser Supervisors; UNICEF leads). There is a minimum literacy requirement for vaccinators but not for SM and, in a country whose women are largely non-literate, this shapes the composition of FLWs by sex, with the great majority of vaccinators being male. In urban areas, the majority of FLWs are literate.[18] Urban-based vaccinators and SM can be both women and men although male FLWs greatly outnumber women overall. Women have not been mobilised for either FLW role in rural areas.[19]

FLWs work in short-term roles: while this workforce is paid a daily rate for its efforts, and while many FLWs have supported NIDs from year to year, the expectation is that they form part of a temporary and unregulated workforce for three-to-seven day periods at a time.[20] Training is modulated accordingly, so that all FLWs receive the same training each time they work for a campaign even if it means individuals receive the same training several times over the course of their participation in NIDs. While all of those interviewed for this study expressed personal interest in health work, the great majority of FLWs are not engaged in any other form of health care promotion or provision and do not engage at all with health work in between NIDs.[21] This means that their training in communicating polio prevention messages or delivering OPV is dormant in between campaigns and their interest in health-related work is of necessity task-and-payment driven rather than sustained.

FLWs report varying challenges in completing their work at household (HH) level during NIDs:

- not being able to ask specifically to see all under-5 year olds (a problem faced by males);
- therefore missing newborn, sick, sleeping or absent children because outsiders don't know who lives in any particular household so children are not immediately visible to the FLW,[22]

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[18] Female SMs interviewed for this study are, by and large, high school and university students, although there are older women volunteers who are less literate.

[19] As WHO has not provided data on FLWs disaggregated by sex, this is surmised.

[20] Numbers cannot be precisely verified, but WHO estimates that around 10% of currently mobilised FLWs are also Community Health Workers in the CBHC health system. However, this is likely to be an over-estimation, especially when it comes to women.

[21] Of a total number of 19 female FLWs in Kandahar and Jalalabad interviewed for this study, only 3 (in Kandahar City) also worked on healthcare provision, two as CHWs and one as a midwife.

[22] In Afghan tradition, a mother and her newborn are not expected to leave the immediate confines of the house for 40 days after birth. Infants born in a health facility receive their initial OPV dose at birth; but despite efforts to institutionalize birth-giving, around 65% of babies are still born at home. Reaching newborns remains, therefore, a crucial goal for the PEI.

especially all-male teams who cannot enter a household or demand to treat very young children in the absence of a senior male;

- dealing with various refusals, sometimes because of negative rumours, but also because of fatigue around the PEI – householders are no longer open to hearing PEI messages;
- high levels of suspicion and questions about why strangers are at their door, which can expose FLWs to danger such as dogs being unleashed
- suspicion that FLWs are mobilised not because they believe in the importance of PEI but because they are remunerated to work on polio.

Observations

1) Training offered to FLWs is limited in scope and purpose. Retention rates of FLWs are high and they return to work as NID volunteers over a number of years when offered the opportunity to do so. While this is partly due to the fact that other opportunities for paid work are severely limited, especially in the case of women, they come back because being a FLW offers a rare opportunity to legitimately interact with outsiders to the family, learn new skills and contribute to community well-being. These advantages make for an engaged and motivated workforce. Yet there is no intention to build FLWs' incremental capacity through expanded training for multi-campaign volunteers, nor is there a programmatic approach to recruit FLWs into permanent work in the health sector. Whatever gains are made are therefore highly individualised and their knowledge is under-utilised or entirely dormant between campaigns.
2) This is particularly troubling because a significant number of FLWs (at least those working in urban areas) are female, literate and in family circumstances that permit them a certain amount of mobility.[23] They are all interested in healthcare delivery and with proper support could contribute to the longitudinal behavioural change necessary to make polio eradication possible. In the Afghan context, this makes them an a-typical and valuable cohort.

Suggestions for next steps

- Learn from the CHW system what modalities of healthcare delivery work best in Afghanistan: can FLWs be transformed into CHWs or can some other CHW-like role be developed in order to retain and develop an already mobilised pro-health workforce?
- The entrenched government policy of pairing male and female CHWs provides a positive example of how to position women health workers in Afghanistan and should be the basis of any intervention to expand FCHWs scope and authority;
- Investigate whether FLWs could play a more sustained and broader role in healthcare delivery beyond PEI NIDS. This is an especially relevant approach in urban areas, where the greatest concentration of populations – but also the greatest concentration of already-mobilised women – is to be found;
- Investigate whether existing curricula at midwifery schools in urban areas (which are producing an over-supply of urban-based midwives) could be broadened to introduce new

[23] In interviews, married female FLWs reported full family support for their participation, especially in cases where mothers-in-law were no longer around. From this we can conclude that more-qualified women might be available for recruitment into health services if strategies are set up: at present, almost 100% of health workers in paid roles of any kind (in Ministry or NGO positions) are men. This is usually explained away as reflecting 'a lack of qualified women' or 'a culture that restricts women's movement', two claims that do not bear weight in the presence of women FLWs.

areas of specialisation that are currently missing in Afghanistan's health system and therefore make access to health particularly difficult for women and their children. Identify whether existing FLWs are willing and able to enter more formal and engaged studies on healthcare so that they can serve communities in new and more sustained ways. Given the chronic shortage of vaccinators and extremely low levels of uptake of EPI, one area of focus could be the production of workers concentrating entirely on vaccine management and delivery. Women graduating from these institutions, because they are both literate and specialist trained, could become a cadre working under the CBHC's 'women development officer' as a new category of community health worker/community nurse.

Community Health Workers

At the same time as PEI has been ongoing, the MOPH has gradually increased its appreciation of a national CBHC and its contracted, provincially-based NGO partners, who manage the system of CHWs.[24] CHWs have been mobilised to bring a basket of very basic health services to their immediate communities (between 100-150 households). Male and female (M/FCHWs) work in 'Health Posts' (HPs, usually their own home) in both urban and peri-urban centres, and in the humblest and remotest communities in the country.

CHWs receive standardised training when they join the system and ideally also benefit from refresher training each year. They work within a tightly-defined ToR and can administer very basic drugs such as paracetamol or malaria prophylaxis. A large part of their work includes referrals to health clinics and preparing women for birth (which often involves MCHWs negotiating with male family members to prepare them to allow a woman to leave the home for an institutional delivery). FCHWs also establish and manage 'family health action groups' to support lactating mothers. As such, they have high levels of contact with infants in their first 23 months of life, when they need to receive the OPV. While very few have been mobilised to work for the PEI or received its specific campaign-based training, included in their tasks is basic health education on the importance of availing children of the 9 vaccines included in the EPI and in interviews, they were knowledgeable and confident about their task of raising awareness about the prevention of childhood disease. Also of interest to PEI is the work they do on promoting simple personal hygiene especially handwashing.

In general, where the systems that support them are functioning,[25] CHWs enjoy a high level of authority and respect in the community they serve. Becoming a CHW is expected to be a 'life-long commitment' and while a drop-out rate of between 5-10% is reported, a gratifyingly large number seem to take this commitment seriously and stay in the system for years. Because of this, they exert a constant and reliable influence on tightly-knit and closed communities that are suspicious of outsiders. This steady presence could offer crucial advantages to the PEI both because CHWs could regularly track newborn children and register or monitor their entry into the healthcare system, and

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[24] On paper, the MoPH claims there are 29,500 registered CHWs. Verifying how many of these are functioning was beyond the scope of this research, however, both anecdotal evidence and a study conducted by the U of Ottawa (2014) indicate that 'ghost' CHWs may be a sizable problem. The voluntary nature of their work makes both regulation and tracking of CHWs very difficult.

[25] Field research revealed that highly functioning CHWs are receiving regular refresher training and regular supplies for their kits, and are well-supported by a motivated Community Health Supervisor (CHS) based in the nearest Community Health Centre (CHC) to which pools of CHWs are attached. When this reporting line is weak, CHWs are demotivated and ill-prepared, and have a greatly reduced impact on their community's wellbeing.

consistently deliver accurate messages to caregivers. That CHWs have been largely overlooked in the course of identifying FLWs for PEI is surprising and counter-intuitive to the programme's community-based approach.

Observations

1) The CHW programme is specifically designed to extend better care to mothers and their under-5 year old children. As such, FCHWs are expected to keep track of women's health needs (especially when pregnant and lactating) and to encourage preventive health care protocols for young children, including EPI. They can easily move inside households as they are female and well-known to their community; as such they can access newborns and ensure they receive the zero dose OPV. MCHWs, for their part, are expected to encourage men to support their wives during pregnancy and plan for safe delivery, and to participate in active fathering such as decision-making on children's health including EPI.
2) As a consistent (if voluntary) work force in the health sector, CHWs ideally receive solid basic training and frequent refresher courses to supplement their knowledge and help them better address daily health concerns at community level.[26] They are eager to learn more and new things. Women CHWs particularly value the learning opportunities they receive as they are calibrated for non-literate women and build their skills and confidence in ways that are fairly exceptional in Afghan women's lives.
3) CHWs live and do their voluntary work in the community every day. As such, they are well-positioned both to track children missed during NIDs and to consistently offer encouraging advice to parents who doubt or refuse PEI.
4) Communities also trust CHWs because their work is voluntary so they are not associated with patronage networks or suspected of working against community interests.
5) CHWs (especially men) are surprised and disappointed to be excluded from NIDs. They ascribe this to their not being part of patronage networks run between powerful men and their beneficiaries. In other words, their exclusion is contributing in some measure to suspicion about the intentions of the PEI.

Suggestions for next steps

- Scale up contact with CHWs and bring them into a 'between campaign' PEI strategy to build confidence in broader EPI messages and contribute to changing negative caregiver attitudes to child health;
- Cross-reference with learning from working with FLWs to ensure that challenges, especially around the distribution of resources/payment to women, do not lead to the exclusion of FCHW in the future;
- Pay careful attention to maintaining and strengthening (broadening) CHW training, including investigating potential connections with existing midwifery schools to expand curricula and build capacity for basic community health approaches;
- *Do not overload* the existing CHW system, which is very fragile. It has to be carefully expanded from the ground to the MoPH.

[26] The great majority of FCHWs are non-literate. As no training courses were on offer during the course of this research, it did not attempt to assess how well-suited the training approach is to non-literate adult learners. However, in interviews FCHWs reported both enjoying the opportunity to learn and a desire for more (not least because attending training is associated with earning a small monetary incentive).

Research on CHWs illuminated the specifically gendered concerns that arise when working with this small group. As these findings go beyond the specific PEI focus of this paper, they are appended in an Annex which should be consulted before any scaled-up CHW work is undertaken, either in PEI or in any other area of community-based healthcare. Connections and lessons learned from mobilising female FLWs are also significant to consider before any adaptations are made to the PEI approach.

Part Two

An Exploration of the CHW System

Nurturing a 'Delicate Ecosystem'

In mid-2015 when fieldwork was conducted with CHWs, the female-focused structure of the appears to be both entrenched and delivering access to health, to a greater or lesser extent, to women and their children across the country. At this point, then, *female CHWs are the largest* (if unregulated) *mobilized group of women working for a public system in Afghanistan*. The exceptional status of FCHWs in Afghan society, and the challenges of not only preserving but enlarging and enhancing their status and efficacy as basic deliverers of community health, will be discussed in detail in this Annex.

A question raised in the field research for this analysis is whether the delicate balance in which the CHW system currently operates is beginning to change and might be too radically or rapidly modified as UNICEF and other organizations become more interested in working with CHWs. In particular, there are important concerns to consider before deciding how (and whether) to change the remuneration or incentives CHWs receive, or to scale up CHW work. At the base of the CHW system is a very delicate balance between what women and men do, and how their inputs and knowledge are valued. Given how patriarchal exclusion operates in Afghanistan, there is a very real danger that placing too much emphasis on CHWs, or appearing to overly enlarge the space they currently occupy, might in fact distort and undermine the purpose of CHW work, and even lead to women's exclusion from it in future.

It appears that some shift away from women as the centre of the CHW system has already begun. While the earliest FCHWs were recruited from the ranks of women who had served as Traditional Birth Attendants (TBAs), i.e., were regarded in community life as capable health-workers, it seems that new FCHWs are entering the system not through their own established interest in working on health issues, but because a male with whom they are *mahram* is elected by the village health *shura* as the MCHW. MCHWs, in this new paradigm, receive their appointment because of their relative literacy (many are schoolteachers)[27] or because they are in some way distinguished (a successful farmer or businessman), or merely because they are linked in a patronage relationship with the village headman and their CHW service enhances existing hierarchies of power.

In interviews, it was clear that F and MCHWs bring very different value systems to their work. MCHWs see themselves as the authoritative member of the CHW pair because they are both male and literate. The fact that non-literate FCHWs have to report information for them to pass on, in the view of MCHWs, appropriately places and maintains females in a deferential role. Even if they are not the primary contact point for women asking for health advice and support, the fact that a MCHW records any information that needs to be written down entrenches his sense of superiority: in the prevailing masculinist value system, being able to write down information is prized, but not the collection of the information itself, which is merely 'women's work.'

A similar dismissal of women is seen when MCHWs express their views on women as caregivers of children. Asked why they thought children were being missed in PEI NIDs, MCHWs were likelier to

[27] By contrast, all the FCHWs interviewed in the course of this study are non-literate.

blame women for 'being too ignorant' to avail their children of such healthcare services rather than to consider whether the messages or the approach of the campaign were improperly calibrated to reach all caregivers.

FCHW give very different answers to these questions. They defer to men's role as scribes but proudly report on their capacity to remember the names and ailments of people they treat, and value their memory for detail and their ability to recall and apply the information they learn in training courses. They appear to place little value in the written reporting that MCHWs do – this is just a detail for them; knowing what to do to help someone in distress is more important.

Asked about what makes caregivers miss getting their children vaccinated through campaigns, they were much more interested in interrogating the process than in blaming any individual responses. They tended to believe that caregivers (especially women) had simply not had enough time to internalise PEI messages or were not being helped to influence other decision-makers. Their insight is supported by reflections made by female FLW who also argued that some caregivers are simply not receptive to health interventions unless they are convinced through face-to-face dialogue about why they should subscribe.

Volunteerism Under Threat?

The growing prominence of MCHWs – if perhaps only, at this point, discursively – is leading to questions about whether the 'voluntary' basis of the CHW system should be maintained in the future. It is difficult to gauge the extent to which the monetised approach of PEI NIDs – which pay FLWs for their work – has brought about a changed perspective on the voluntary nature of CHW work, but it was clear from their responses that both M and FCHWs know that working for some health interventions brings in regular money. They feel confused, excluded and slighted because they are told that they should not expect money for the work they do, but also do not benefit from the money available through NID payments.

There are gendered differences in how they perceive working as unpaid volunteers. In interviews, MCHW made it clear that they expected better and more regular remuneration for their contributions. They stated that the low status they associated with 'voluntary work' makes it a burden for them to facilitate what FCHWs do.[28] Their opinion was shared by men in the more formal parts of the health system (within NGOs, at Public Health Department level and even at the MoPH), who took every opportunity available to urge the researcher to encourage remuneration for CHW work.[29]

WCHWs did not dwell to the same extent on money and were more likely to comment on the value of regular training and properly supplied kits as incentives for their work. They spoke of feeling respected as women with learning and reported satisfaction with their work as an expression of their active piety. Their response is quite possibly an expression of their knowledge about the severe

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[28] Focus group discussions with MCHWs were conducted separately from those with FCHWs and a female interpreter assisted in taking with women in the hopes that women-only spaces would allow for a freer exchange of information.

[29] It was carefully explained to anyone who made this suggestion that formalizing CHWs into the MoPh's paid labor force would be both unsustainable, as there are so many of them and funding cannot be provided by the MOPH; and undesirable because it would be likely to challenge women's currently central position in the system.

limitations within which Afghan women can operate, but it is probably also a warning that if CHW positions do become formalised or salaried, it may become increasingly difficult for women to be drawn into this work, or to operate with any of the autonomy they currently seem to enjoy.

With the introduction of attractive technologies such as *Zaranj*,[30] which are fully in the control of MCHWs even though their sole purpose is to transport women and their children to health facilities, and as more opportunities for remunerated/incentivized CHW work are put in place to improve CHW delivery, it should be anticipated that men will try to find ways to dominate the CHW system that are not available to them at present. Because there are no *socially-acceptable avenues* for women to move up in the CHW system (currently, all paid supervisory positions within the CBHC are held by men), there is a *major risk* that women's central role will become diminished and compromised. This fact has to be kept at the forefront of any efforts to expand or further systematize CHW work and it must remain the central focus of any new interventions that the CHW system delivers to women. Family health programmes will always have to be devised in such a way that they remain accessible to women. This means planners need to keep finding the best ways in which services can be delivered through women, with men offering important and socially necessary support but not dominating every aspect of the programme. Some of the specific concerns facing Afghan women workers are considered in greater detail below.

Afghan Women and Access to the Economy

For Afghan women, decades of war and the ongoing instability caused by armed insurgents and exaggerated by foreign military occupation, shape every aspect of life from birth to death. While a small group of elite women in Kabul and provincial capitals may have begun to experience incremental gains in status,[31] overall, and despite millions of dollars in aid and much rhetoric, the situation for women and many men has failed to improve. Indeed, in areas still dominated by armed groups and their subterranean and illicit war economies, the lives of the most impoverished women (and men) remain bleak and insecure. Particularly in conflict areas, even for men, access to paid work is severely restricted. This economic environment impacts severely on women, who are disproportionally excluded from paid work not only because of 'cultural' as well as pragmatic and security-focused constraints that keep them in seclusion, but because decades of poor or non-existent schooling for females has both re/produced and reinforced women's subordination.[32]

For religious and social reasons, women in Afghanistan do have limited rights to health seeking behaviours, and can claim such support as is available when the conditions for their access are calibrated correctly. In this framework, working as a FCHW appears to give some women a space in which to make a social contribution that does not disrupt cultural/social norms. Much less than the MCHWs interviewed for this research, FCHWs emphasized that the value they derive personally from their work is cultural and/or religious, and is therefore very rewarding to their sense of themselves as "good Muslim women" and "good wives, mothers, daughters and sisters". While they

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[30] *Zaranj* are tuk-tuk ambulances to be used by CHWs to bring pregnant and laboring women, or children needing vaccinations or other health care, to medical centers. UNICEF is currently piloting them in five provinces.

[31] This claim should be modified in light of the ongoing and apparently unpunishable violence against women who try to move into public spaces, including government institutions or the education system.

[32] This problem is central to Afghanistan's very poor record on maternal and child health, and its impacts on individuals and communities complicate every aspect of UNICEF's work, from nutrition to sanitation to protection to health.

liked receiving some payment for attending trainings, they placed far less emphasis on their CHW work as a potential source of income than MCHWs did. This does not mean that FCHWs should be unpaid or differently paid from men for what they do, but it exhorts us to look beyond money as the only reward system in which any value can be placed.

Also, lessons from other efforts to economically empower Afghan women teach that it is important not to overestimate the extent to which they can function as "autonomous economic agents" given that "investments in and loyalty to the family and community *matter for the security they can provide*" in the absence of a functioning state or regulated markets.[33] FCHWs never function outside of their *mahram* network and it is therefore important to calibrate any recognition they receive for their contributions within parameters that make sense to male family members and men in the broader community. To do otherwise would be to put them at risk.

With this in mind, it becomes clear that monetizing CHW work, while it may be advocated for by men and even appear to provide a good avenue to improve and regulate delivery of basic health services, may produce more than one negative effect. Firstly, finding the resources to provide salaries to a currently voluntary work force will be costly and will prove unsustainable when current levels of donor funding decline. Secondly, paid work has greater status: being paid more, and paid more regularly, would benefit men and enhance their social standing but in so doing, risks taking the focus off community health work as a primarily a women's health initiative. This problem is made likelier because voluntarism is seen as an enactment of personal religious convictions and a contribution to family honour and community well-being appropriate for women to make, but it will be difficult for women to occupy salaried roles without being constructed as competing with men for scarce jobs or moving into space that men see as belonging exclusively to them. Overall, the greatest loss may be to the currently uncontested fact that working as a FCHW is rewarding to the women who do it, and may allow a crucial contribution to be made – by women themselves – to reversing Afghanistan's extremely poor maternal-child health statistics.

Safeguarding Exceptional (if humble) Women

The question then is, what rewards lie beyond money for FCHWs (and this question can also be extended to PEI's FLWs) – why do they do what they do? What motivates this small of women to become exceptional in their culture as actors and public servants beyond the confines of the extended family, visible in the public sphere? How can we also continue to motivate the men who support them, without ending up with a male-focused system which would ultimately fail to deliver to the target group?

In the severely demarcated social and cultural space open to humble, impoverished and non-literate female Afghans, it should be recognized that access to interventions that afford women who can take them up a modicum of freedom of movement and thought, authority, the potential for personal expansion and intellectual growth, are *as gratifying and valuable* as the small measure of economic security currently afforded to CHWs for their work. With this in mind, future interventions with CHWs have to be designed not so much to accommodate, but also to carefully stretch, deeply embedded patriarchal norms about how a good Afghan woman should behave – norms that are

[33] Jo Grace and Adam Pain. "Rural Women's Livelihoods: their position in the Agrarian Economy," in *Land of the Unconquerables: The Live of Contemporary Afghan Women*, eds. Heath and Zahedi, U California P, 2011. p. 263. Emphasis added.

specifically regulated through how individual women accesses public space and resources, and contribute to one another's quality of life.

'Culture' as a rationalization for women's exclusion

The design and implementation period of all humanitarian and development initiatives in Afghanistan should entail lengthy debates about how to calibrate them to achieve the greatest possible social inclusion. This should be especially true when it comes to discussions about remuneration or incentives for participation. In this analysis of CHWs and other Social Mobilisers (SM) who have been drawn into the ongoing work of the PEI, an important disjunction was noticed: arguments, put forward by men, that participation in the paid, public work of NIDs is suitable only for men, do not tally with the actual on-the-ground presence of a number of women, particularly in urban areas, participating in implementing polio campaign goals.

Interviews with FLWs confirmed that women from a wide variety of backgrounds can find ways round apparently insurmountable blocks if they see an opportunity to do something that interests and benefits them and their family. They said they were working for polio because they had found opportunities to negotiate with male family members, because mothers-in-law were no longer exerting an influence on them, or because they were from relatively open families (usually as refugee returnees) and were educated. Many of them identified their family's relative poverty (and men's unemployment) as the reason they were allowed to do work that demands them to operate in public space: their families were simply too poor not to mobilise everyone who could find paid work. What this shows is that apparently entrenched Afghan social and cultural practices, can, in reality, "be transgressed by various factors, one of which is poverty" (2011, p. 265). Indeed, evidence from research on women's livelihood practices shows considerable adaptability in how extended families interpret social norms in order to earn much-needed resources. Women's roles change continuously as family fortunes rise and decline – despite rhetorical efforts to claim that they are set in stone.

When it is clearly understood than even an apparently-immobile cultural sphere is in fact continuously in motion, it also becomes evident that there is considerable elasticity in how men (and women) mobilize arguments about the 'cultural' reasons for women either to remain secluded or to enter public space.[34] It becomes crucial, especially as we look for opportunities to enhance FCHW's authority and presence in the broader CBHC system, to look beyond what men tend to say about what women can and should be allowed to learn and do; to be appropriately cautious about 'culture' as a legitimate reason for exclusion or marginalization; and with existing gendered structural inequalities in mind, to proceed carefully in determining how incentives for CHW work should be calculated and dispersed, including by focusing on ways to provide non-monetized forms of recognition for work well done.

Incentivizing CHWs' Efforts

To identify ways to incentivize and reward them, CHWs were asked in FGDs to reflect on the value of existing incentives for them to do their work. As has already been alluded to above, women and men do not always value, or value in the same way, the same things.

[34] UNICEF has observed just such elasticity in its analysis of how female Social Mobilisers (SM) have been identified and retained through its long-term PEI programme.

That men are uniformly focused on receiving monetary payment reflects their gendered sense of how men gain authority and respect – as providers and good earners. While their responses are equally gendered, women, by contrast, place more emphasis on opportunities they are given for new learning. Because their lives are so restricted, they also value the chance to travel for training, because by this means, they are given a legitimate reason to meet women outside their immediate extended kinship network and discuss new ideas. Like men, they appreciate the stipend given during training, but they do not appear to rank it as their primary incentive for being a CHW.

FCHWs also regard the 'CHW kit' they receive every quarter as a positive incentive, because dispensing drugs allows them to reinforce their reputation in the community as a valuable health worker. Both men and women say they are incentivized by the kit, and both complained of shortfalls between the community's level of need and the size of their health kit, stating that their inadequate supplies complicate their work and compromise their reputation as reliable helpers. A review of the kit's contents and its enlargement beyond the basic medications it currently provides could be a useful means to support and incentivize CHWs and improve efforts to converge initiatives: Vitamin A and folic acid (nutrition cluster), hand soap (WASH), health and vaccination information cards (health, education and PEI) – and more – could be considered for inclusion, and all could contribute to improving the overall well-being of mothers and their children, while tangibly strengthening the CBHC and its structures. It might also be possible to combine small income-generating activities (food gardening or soap-making?) with CHW outreach efforts. There are already some health centres that have begun to explore an expansion of CHW work in areas such as improved nutrition, and these provide helpful guidance on what is possible for broader CHW work in the future.

Money Questions

The exchange of money for CHW work seems at present to be somewhat arbitrary and unpredictable, and this is a concern in the larger context of good development practice as it means CHWs have difficulty estimating the amount of time they can afford to give to their work and are restricted by their poor ability to find a planned balance between their income-generating and their voluntary activities. Both male and female CHWs seem to have developed pragmatic responses when they do receive cash: they reported that they try to save their training stipend if possible (they will walk to the training venue if possible rather than spending money on transportation and they bring food rather than buying it). They report that what they save gets spent on their household needs, and both sexes feel this payment, especially when it is predictable, is a fair way to offset giving up other work in order to serve as a CHW.[35] Unsurprisingly, then, both sexes indicate that they would prefer regular trainings to be delivered: both so that they can plan to include the time needed for training when they estimate their monthly workload and so that they might more easily be able to regard stipends as a reliable source of income.[36] In other words, while they may initially reflect differently on how they rank remuneration, receiving money is registered by both sexes as an important way of supporting and enabling the work they do.

[35] Walking to a training session, however, is counter-productive, as participants arrive exhausted and unready to learn.

[36] All CHWs are meant to receive 'refresher training' once a month, and to regularly be trained in new areas of health delivery. However, due to problems with disbursal of funds from the MoPH, the training programme is reported to be erratic.

What this seems to indicate is that support for CHWs can also be packaged as a livelihood strategy. If this idea is explored further, it might be useful to consider a more intra-Ministerial and cross-agency approach (perhaps including the Ministry of Rural Rehabilitation and Development and other relevant UN agencies?).

Learning from the PEI research also shows the crucial importance of a standardized approach to devising incentives: word tends to travel fast about discrepancies in how work is rewarded. In the PEI analysis, it quickly became obvious that both FCHWs and MCHWs were unhappily aware that when Front-Line Workers (FLWs) are mobilized for PEI NIDs, they are paid for their three days of work. CHWs themselves are rarely afforded the opportunity to participate in NIDs and earn this money, even though they offer advice on polio and other vaccinations in their everyday work. This practice is, unsurprisingly, perceived as unfair to them as people who regularly contribute to the well-being of their communities. It was noted by all CHWs as a disincentive and source of discouragement. A similar duplication (effectively, the temporary creation of a parallel work force) should definitely be avoided in the future.

There appears to be some vagueness within UN agencies themselves about how CHW remuneration should work. In interviews, UNICEF and WHO staff and CHW Supervisors at Community Health Clinics reported that CHWs are sometimes incentivized with small amount of cash, for the return of correctly-filled in forms for various activities, for attending *ad hoc* trainings or other meetings. As this system of reward currently seems to be driven by individuals rather than a systematic policy, more investigation is needed into wherever it is possible and useful to combine predictable incentives with more effective monitoring of the outcomes of CHW contributions to health initiatives. An often-reflected problem at present is that the voluntary nature of CHW work makes it difficult to insist on the achievement of measurable results, impose standards, or regulate the amount and quality of the work CHWs do. Budgets for the small incentives they are currently paid are rather *ad hoc* at present, so no-one who was interviewed for this research appeared to have a well-regulated or standardized approach to questions about how much is paid, when, and for what deliverables.

It is worth exploring, by revisiting the generic Terms of Reference given to all CHWs at present, how a standardised remuneration package could be developed. If this approach is taken, it is necessary to identify which CHW outputs (such as driving) can only be performed by men, and which (such as visiting pregnant women and accompanying them to birthing centers), are need women in the lead. Incentives given for each of the types of work undertaken by CHWs should be of equal value. On this point, Grace and Pain (op. cit.) offer evidence that when women have entered work spaces from which they were previously excluded, due to increased demands for labour, they "have been able to negotiate comparable wage rates to men" (2011, p.265). Their observation should inform decision-making on all compensation for CHW work of whatever kind and skill-level required.

Observations on CHW Learning and Training

Women and men had different perspectives on the quality of the training they receive, and differently valued its impact. Women were considerably more vocal than men in counting training as an important and valuable issue in its own right and, significantly more than men, expressed a desire for more regular training on a wider variety of topics. This finding is also not surprising in the context

of Afghanistan, where there are very few learning opportunities afforded to poor women, especially in insecure areas that have a poor history of providing educational services for females of any age.

Given the uneven history of access to education in Afghanistan, it is essential not to attach too much value to the level of literacy of individual CHWs, especially as this tends to be starkly divided along gender lines. Because women's inability to access formal learning is often mobilized as an excuse by men to treat their capacities, insights and contributions as less valuable than those of 'educated' men,[37] de-emphasizing skills in reading and writing, or adapting training opportunities and reporting mechanisms to suit non-literate workers remain important strategies to ensure that women are being supported in ways that are appropriate to the limited and liminal space they inhabit.

While recognizing that there will be a gendered division of labour that may require additional specialized learning, it is important that both male and female CHWs continue to receive the same basic training so that each understands, and can monitor and support, the expected deliverables of the other. This advice is not idealistic, but is important to overcome current operating constraints: delivery of training programmes is strictly segregated along gender lines.[38] As women and men are forbidden to learn together, for example through role-play, each has to learn the responsibilities of the other in order to ensure that they can transfer the abstraction of their learning in the training room into efficiency when they work in their community in their *mahram* pair. This requires a well-resourced strategy to be developed, however: reports from the field indicate that current training budgets are much too low.

It was beyond the scope of this research to consider whether there are other training opportunities or avenues available in Afghanistan at present that could be helpful for expanding CHW capacity, especially that of FCHWs. However, it may be possible that already-established midwifery schools in urban centres might be one such space. At present, midwife training in Afghanistan does not appear to be standardised possibly because it is a focus of a number of INGOs and local organisations. The research did not ascertain the extent to which the MoPH or the CBHC itself controls and directs midwife training. This report recommends that more research should be conducted on this area.

[37] The refrain, "women are ignorant" was often heard in discussions with MCHWs and FLWs, especially when they were asked to why they think systematic problems occur. It was always easiest for men to invoke this stereotype and blame mothers/women for problems.
[38] For the most part, however, 'master' trainers seem to be men. It would be helpful to develop a modality using 'senior female' and 'senior male' trainers.

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