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# **Involving Women in Afghanistan's Community Health Committees: Some Lessons Learned**

**June 2006**

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## Background

Women and children are the prime target groups for the Afghanistan Ministry of Public Health. This has been asserted in the national policies and strategies as noted in Afghanistan's current National Health Policy:

The mission of the Ministry of Public Health is committed to ensuring the accelerated implementation of quality health care for all the people of Afghanistan, through targeting resources especially to women and children and to underserved areas of the country, and through working effectively with communities and other development partners.

Afghan National Health Policy 2005 – 2009, page 18

The Rural Expansion of Afghanistan's Community-based Healthcare (REACH) program, funded by USAID, has promoted involvement of women throughout all program components of the Basic Package of Health Services (BPHS) which, for example, requires that "at least 40% of Community Health Workers (CHW) are female". A community Health Post (HP) should have one male and one female CHW. All REACH non-governmental organization (NGO) grantees have strived to achieve this target and women now comprise 53% of more than six thousand CHWs in 14 REACH-supported provinces. Stakeholders of REACH should celebrate this achievement in overcoming the security, socio-cultural barriers and low level of literacy among rural women.

While CHWs provide basic services to the rural population, REACH has also promoted the establishment of community health committees (*shura-e-sehi*)<sup>1</sup> at both HP and health facility (HF) levels to enhance local ownership and oversight of the BPHS program. The basic functions of both health post *shura* and health facility *shura* are similar. At the HP level, the members focus on community-level health issues including the performance of CHWs, whereas, at the HF level, members are engaged in the review of the management of the health facility as well as community-outreach activities in the area. (Annex 1 provides a comparison of the characteristics of two kind of *shura*).

REACH has promoted the involvement of women in community health *shuras*, but this is a new idea to most Afghan communities. Traditionally, a *shura* is a local council formed to deal with many issues affecting the community and consisting of male representatives (those who are so-called *mui safed* or white-haired) of all lineages and/or extended families of a village or tribal group.<sup>2</sup> It is a customary self-governance body to resolve conflicts occurring in the village. Therefore, *shura* membership or any kind of public/formal community decision-making is considered to be a "male" activity.<sup>3</sup>

For health facilities, one of the standards of the Fully Functional Service Delivery Point (FFSDP) quality management methodology, introduced through REACH, requires that each facility has a health committee and that at least one-third of the members are women. When the baseline evaluation took place among 214 health facilities between February and July 2005, none of the facilities met this standard. By the third external FFSDP evaluation undertaken between August 2005 to February 2006, 46 (54%) of 85 health facilities assessed achieved the standard.<sup>4</sup>

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<sup>1</sup> The terms community health committee, *shura-e-sehi*, or *shura* are used interchangeably throughout this paper.

<sup>2</sup> Boesen, Inger W. *From Subjects to Citizens: Local Participation in the National Solidarity Programme*, August 2004, AREU. Page 6.

<sup>3</sup> It is worth noting, however, that women who are wives and mothers of male representatives informally influence the decisions to be made. This paper intends to illustrate women's visible role in taking part in public/formal decision making body rather than influencing "behind the scenes".

<sup>4</sup> Data extracted from REACH FFSDP database on 2 March, 2006

The REACH Community Leadership (CL) Program supported REACH NGO grantees in the training of two *shura* members from each health post in leadership skills. After three years of the REACH program, more than 3,500 HPs were activated. To date, 5,732 *shura* members, including 1,207 (21%) women, have been trained in community leadership at HP level.<sup>5</sup> Eighty-five percent of all HPs have health *shuras* and about one-quarter of these include women participants. Out of 22 BPHS programs that report the number of CL trainees, 11 programs trained both men and women whereas 11 programs trained only men<sup>6</sup>.

The goal of REACH is not to see a mere increase in the number of women in the community health committee meetings. REACH advocates for substantial women's participation in the community in which women take an active role in community health activities, from household service delivery by female CHWs to decision making in the community health committees.

This paper reports on a qualitative study of a sample of NGO BPHS programs and to comment on lessons learned from REACH's experience with incorporating women in health *shuras*.

The objectives of this study were to better understand:

- The effect on health care and health promotion of having female *shura* members in the community,
- The different ways in which women participate in *shuras* and how they relate to male *shura* members, and
- The factors that determine the formation of female *shuras* in communities.

### Study methodology

The study used a qualitative approach. The results reported are based on semi-structured interviews and focus group discussions (FGD) with women of the following categories: CHWs, CHW trainers, Community Health Supervisors (CHS), and *shura* members. Focus group discussions generally lasted one-hour. In total, interviews took place with over 90 women. The author was assisted in each case by a female NGO staff member who was familiar with the local women.

The list below indicates the provinces and the NGOs where the field visits took place between July and December 2005.

No.	Date	Province/District	NGO	Purpose of the visit
1	July 20-21, 2005	Baghlan/Baghlan-e-Sanati	BDF	Monitoring the CL program
2	August 4, 2005	Baghlan/Dana-e-Ghori	AKDN	Visit to the Community Development Committee of the National Solidarity Programme
3	October 20, 2005	Takhar/Khwaja Ghar	CAF	Visit to <i>shura-e-sehi</i> at HF and HP levels
4	November 22, 2005	Kabul/Farza	STEP	Evaluation of the CL programs
5	November 24, 2005	Herat/Kushk Robot Sangi	NPO/RR AA	Evaluation of CL programs

<sup>5</sup> According to REACH HF and CHWs weekly updated report on 25 May, 2006

<sup>6</sup> In total, there are 28 BPHS programs in 14 provinces.

No.	Date	Province/District	NGO	Purpose of the visit
6	November 26, 2005	Herat/Kushk Kona	NPO/RR AA	Evaluation of the CL program
7	November 27-28, 2005	Heart/Karukh	CoAR	Evaluation of the CL program
8	December 4, 2005	Jawzjan/Mardean	Save the Children UK	Evaluation of the CL program
9	December 7-8, 2005	Ghazni/Khwaja Omari	BDF	Evaluation of the CL program
10	December 14-15, 2005	Paktya/Gardez and Sayed Karam	Ibn Sina	Evaluation of the CL program

The study sites were selected to achieve representation of national and international NGOs and different geographic areas and ethnic groups. The first three study visits were made by REACH Gender unit staff alone. The next six study visits were done in collaboration with a team from the REACH Community Mobilization Unit, who were conducting an evaluation of the Community Leadership Training Program.<sup>7</sup> The final visit was conducted by the Community Mobilization Unit alone.

This study relies heavily on the findings from the FGDs with female shura members. The FGDs conducted with male shura members collected general information on women's involvement, however, there was not enough qualitative information from the men in relation to the subject matter to enrich the overall findings.

### **Findings and Key Lessons Learned**

#### **The effect on community health care and health promotion of having female *shura* members.**

It appears that female *shura* members provide an important support group to female CHWs. The importance of this can be seen in two particular circumstances:

According to the BPHS, CHWs are supposed to care for 100-150 families. In urban areas, this number of families can be found in a couple of streets, however in rural settings, 150 families may be spread out over a very large area. It may, therefore, take a CHW up to one month to visit all households in his/her catchment area. Because female *shura* members live in different parts of the community, they are enhancing the CHWs' work by referring the sick to the health post and by conducting health education sessions.

Some communities have chosen CHWs who are literate but young and unmarried. These CHWs face challenges in promoting health messages related to pregnancy, delivery, and birth spacing due to their age and marital status. It has been observed that *shura* members, who are usually older women, can persuade female clients and their mothers or mothers-in-law to accept the suggestions of the CHWs.

<sup>7</sup> See: REACH: Community Leadership Assessment Report. June 2006.

Collaboration between CHWs and *shura* members can also be effective when they are all mature women and neighbors, as illustrated by the following example:

**Example 1 – Collaboration in Baghlan.**

As they live close by, CHW and *shura* members meet weekly. Whenever social gatherings for women take place (celebration of newborn baby, wedding, engagement party, funeral, *nazr*-religious and social ceremony, etc), a female CHW and a *shura* member conduct a health education session. They are a team; a CHW or a *shura* member alone does not carry out a health session. They always conduct these sessions together.

The collaboration between CHWs and *shura* members and its effect on health behavior is also well described in the quotations below:

“Without *shura*, CHWs’ work does not go ahead.”

“... (*shura* members and CHWs together) make better cooperation.”

- A female *shura* member in Ghazni

“People have become more knowledgeable. Previously, people did not breastfeed newborn babies for the first three days. Now CHWs and the female *shura* encourage mothers to nurse their babies right away because the first milk provides protection from diseases.”

- A female *shura* member in Kushk Kona, Herat

“*Shura* members support the CHWs when they have difficulties. If mothers-in-law won’t accept the use of family planning methods by their sons and daughters-in law, *shura* members go to talk to them.”

- A female *shura* member in Khwaja Omari, Ghazni

“A pregnant woman in our village would not take a CHW’s advice that she should have a Tetanus Toxoid (TT) vaccination. She was afraid. A *shura* member went to the woman to tell her the benefits of TT vaccine, and she got the vaccination.”

- A female *shura* member in Karukh, Herat

“Changes have occurred since the female *shura* was organized. There is better hygiene in the community, more use of family planning, increased vaccination, and acceptance of CHWs and antenatal care. And people are going from using ‘homemade medicine’ to visiting the clinic. “

- A female *shura* member in Khwaja Omari, Ghazni

When speaking of a *daia* or traditional birth attendant who is a member of one *shura-e-sehi* at HP level, we learned that she helps the CHW to tell pregnant women to have antenatal care and even encourages facility-based delivery.

“People listen to her better and accept what she says.”

- A female CHW in Karukh, Herat

**The different ways in which women participate in *shuras* and how they relate to male *shura* members,**

Various forms of community health committees exist in REACH project provinces. In one community, women and men hold health committee meetings together, another community in the same province can have separate committees for women and men. In another province, women and men are in the same room having a monthly *shura-e-sehi* meeting but they are divided by a curtain to observe *purdah*.<sup>8</sup>

<sup>8</sup> Seclusion of women, which is practiced in Muslim communities

Examples below demonstrate different patterns of women's participation in community health committees.

**Example 2- Mixed *Shura* to Separate *Shura* in Ghazni**

In this community, most of CHWs (both female and male) are literate. In the health facility, a mixed community health committee of women and men was established. Once the agenda of the committee's meeting was on family planning. After this meeting, women reported that they felt uncomfortable in discussing this topic with their male counterparts. In order to enable members to discuss all things freely, the committee has been re-organized separately for women and men. Nonetheless, minutes of the meetings are exchanged so that each group understands what has been discussed by the other group. Also, the male Community Health Supervisor (CHS) of this facility plays the role of intermediary between the two committees.

**Example 3 – An Exclusively Female *Shura* in Takhar**

The NGO which runs a Comprehensive Health Center (CHC) located in the capital of this province decided to establish a women's *shura* considering that the facility offers services mainly for women and children and it is better to have women to form the *shura*. NGO staff members visited a local girls' high school to discuss the matter. Finally, twelve teachers agreed to serve on the committee. After the orientation on the BPHS, particularly on the importance of family planning and vaccination, some of the members volunteered to have TT vaccination. Being teachers, they identified the need of TT vaccination among students thus they have organized a one-day campaign for eligible female students to have TT vaccine. As a result, 105 students were vaccinated. *Shura* members are actively involved in promotion of the use of family planning methods and the number of FP clients in this facility has increased markedly since the *shura* was formed.

It is worth noting that women leaders of the community recognize the importance of their new role in promoting the health of women in their community and they are conveying the voices of women.

"In our villages, there are more problems of women. Men do not know them. Where there are more problems of women, women's voice should be higher."

"(With the community *shura*) women's rights have come alive."

- Female *shura* members in Karukh, Herat

Women's involvement in health committees has not only had an impact on health, it has also increased community women's self confidence. During a discussion of communication between the male and female *shura* at HP level in Herat, one participant said "*Rui push nadaram*" (I do not cover my face). In addition to this comment, one CHW mentioned that after she was selected as a CHW, her community became "*kam azatar shod*" (a little bit more liberal) and "*Rui push kam shud*" (fewer women cover their faces).

**The factors that determine the formation of female *Shuras* in communities.**

**Commitment of NGO staff** Although REACH reports indicate that only half of all NGO grantees have women participating in any of their health *shura*, all ten of the study sites had women health *shura* members. This produced a limited perspective.

An important observation by the REACH Community Leadership Training team was that following the teacher training courses run by the unit for NGO trainers, only male *shura* members were initially recruited and trained by the NGOs. Only after follow up visits and further discussion of the importance of recruiting women did the NGO staff begin to encourage communities to identify women for training as health *shura* members.<sup>9</sup>

**Approval and support of male community members** NGOs have been successful in selection and deployment of female CHWs, but involving more women in community health committee activities has been a challenge for many. Nonetheless, some NGOs have succeeded in involving women in all community health committees at both HP and HF levels. As in the selection of female CHWs, having approval and support from male community leaders is the key in organizing women's *shuras*. Recruitment and deployment of female CHWs is key to women's involvement in *shura* activities.

In most cases, male community leaders were responsible for selecting female CHWs or approving a selection done by others. In several situations, where female CHWs are active, they, in collaboration with their trainers and supervisors, organize their support group composed of local influential women who are known to be supportive of the CHWs. These women may then be recognized by the male *shura* as the women's *shura*.

The examples below illustrate different processes of establishing a female *shura* at HP level:

**Example 4 -Separate *Shura* for Women in Baghlan**

In the formation of this women's *shura*, the male CHW trainer first talked with the male community leaders to obtain their agreement to establish a women's community health committee. The next step was that the female CHW trainer and female CHWs identified and invited respected women who were known to be supportive of the CHW to become *shura* members. After *shura* members were selected, CHWs trained them on health education topics and asked them to help refer women to CHWs. *Shura* members also received community leadership training from the CHW trainer.

**Example 5 -Separate *Shura* for Women in Paktya**

In a BPHS project site in Paktya, there are eight HPs which are staffed only by female CHWs. The NGO discussed the possibility of establishing a women's *shura* at each HP with male village elders/leaders. Then they selected the members of women's *shuras* who are close relatives of CHWs and/or village *shura* members. In the areas where only male CHWs are working, there are no female *shuras*.

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<sup>9</sup> Personal communication by Mr. Wahiduzaman Choudhury, Community Mobilization Advisor, REACH, March 2006.

**Example 6 -Male *Shura* First then Separate Female *Shura* in Herat**

A male *shura-e-sehi* without female membership had been established in this community. The person in-charge of CHW training (male) for this NGO approached the male community leaders as he had done for the recruitment of female CHWs. He used examples of the Prophet, e.g. that his wife was educated and participated in social affairs equally with men. The Prophet always consulted with her in making decisions. The CHW trainer also reminded the men of the changes in women's health status before and after female CHWs became active.

Finally the male community leaders decided to establish a separate female *shura-e-sehi*. The female *shura* members are relatives or family members of male *shura* members in the community. Therefore, they do have informal communication with each other. For example, the head of the female *shura* meets with the head of the male *shura*, who is her uncle, to discuss any issues raised by the female *shura*. Male and female *shura* meetings take place in the same room but they are seated separately, without any curtain or compartment. Whenever the male *shura* makes a decision, they ask for the women's opinion.

The next example shows how women became involved in a *shura-e-sehi* at a HF:

**Example 7 - Male *Shura* First then Separate Female *Shura* at a HF in Takhar**

The NGO which runs the facility invited representatives from the Department of Women's Affairs and female school teachers for a meeting between the members of *shura-e-sehi* at this facility and the Gender Unit team from the REACH Program. When the meeting took place, the committee did not have any female members. The REACH team reminded all the participants of the high maternal mortality rate of Afghanistan. They suggested that one of the causes is that women are less represented in society and that therefore their voices are not heard. One mullah, who was a member of the *shura-e-sehi* said "I agree that women participate in *shura-e-sehi*. However, men and women should have separate committees according to Islam. It is also better for women (to have a separate committee) because they can't talk freely in front of men."

After this meeting took place, this NGO started involving women at the HF level. Gradually they plan to establish women's committee at HP level as well.

**Building on other activities involving women** Where women are already active in community affairs or activities, it has been found easier to form a women's *shura*. CHWs have already been selected by community leaders, and where they have been effective in the community, they have been the best argument for involving other women in a women's health *shura*. A female CHW, who was selected by the community leaders, visits house to house daily to take care of women and children's health. Her activity is visible to the community members and her service has been appreciated by the community. This visible presence of women may have a significant impact in bringing a change in perception of women at the community level, among women and men, old and young.

**Other influences on women's involvement** Two other activities have been found to facilitate the formation of women's *shuras* or have the potential for doing so among REACH communities:

Learning for Life (LfL) is an integrated health and accelerated literacy program. It is part of the REACH Program, and is implemented in more than 360 communities in 12 REACH-supported provinces. During the course of this nine-month program, women not only gain literacy and numeracy skills, but change health practices in their own homes and throughout their communities. They gain a lot of support and approval from the men of the community at the same time. The facilitators and participants of LfL classes, all of whom are women, have in a few cases been selected from the community to be the members of *shura-e-sehi* at HP level.

The Ministry of Rural Rehabilitation and Development (MRRD) has implemented a National Solidarity Programme (NSP) nationwide since mid-2003 with the objective "to lay the foundations for strengthening community-level governance, and to support community managed sub-projects that improve rural communities' access to social and productive infrastructure and services."<sup>10</sup> The facilitating partners of the NSP first try to organize Community Development Committees (CDC) in their target districts. Block grants will be provided to CDCs in order to implement development projects that were decided by the members of the CDC.

The major difference between the CDC and community health committee is that CDC members are elected by secret ballot cast by the community residents (both men and women) whereas the members of the community health committees are oftentimes appointed by consensus of the community leaders, who are mostly men.

It is high priority for the NSP to have participation of women. The facilitating partners of the NSP take culturally appropriate measures in order to have women vote and participate in specific women's projects.

In March 2005, REACH identified 53 out of 111 REACH-supported districts as having NSP activities<sup>11</sup>. In these districts, some people serve on both a Community Development Committee (CDC) and a community health committee. In the communities where NSP and BPHS co-exist, different forms of coordination have taken place. For example, the CDC will collaborate with health promotion activities and the *shura-e-sehi* exchange the list of CHWs or provide health education sessions at CDC meetings.

## Reflection

The title of this paper is "Involving Women in Community Health Committees" and not establishing female community health committees. The ultimate goal is to make women's voices heard, and to have women participate equally in decision making, in particular for – but not limited to- decisions pertaining to their own and their children's health. Many rural communities of Afghanistan require more time to achieve this goal.

Observations from this study indicate that starting with separate *shuras* for men and women seems to be accepted in many REACH-supported communities. This process legitimizes a women's forum as part of community decision-making.

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<sup>10</sup> Boesen, Inger W. Page 2

<sup>11</sup> Sources: USAID-REACH Estimated Targets for Services dated 12 January 2005, REACH Program and National Solidarity Programme Implementation Progress as of December 31, 2004, National Solidarity Programme.

While the principle of equal participation is the goal, it must be recognized that there are pragmatic advantages and disadvantages to both mixed and separate meetings of *shura*. The author made the following observations from the abovementioned visits to various forms of female *shura-e-sehi*.

**Advantages and Disadvantages of Mixed Versus Separate *Shuras* for Men and Women: Some Observations**

Type of <i>shura</i>	Advantages	Disadvantages	Solutions
Mixed	<ul style="list-style-type: none"> <li>• Transparent decision-making process</li> <li>• Both men and women give input.</li> </ul>	<ul style="list-style-type: none"> <li>• It may take some time to put into practice as this form did not exist before in many areas.</li> <li>• If not facilitated properly or if women are not ready to participate, women's opinions may be neglected</li> <li>• Men/women may not feel comfortable in talking about certain issues (e.g. FP/RH) in front of the opposite sex</li> </ul>	<ul style="list-style-type: none"> <li>• Engage women in discussions if they do not speak up</li> <li>• Make everyone feel that everyone's opinion is valued</li> <li>• Depending on the nature of the topic, be flexible about having mix/single-sex meetings with appropriate feedback at the end</li> </ul>
Separate	<ul style="list-style-type: none"> <li>• Issues such as FP/RH are discussed freely (particularly for women)</li> <li>• Require less time to reach consensus</li> </ul>	<ul style="list-style-type: none"> <li>• Discussions and decisions made without feedback of opposite sex</li> <li>• Decisions from women's <i>shura</i> may be underestimated</li> <li>• Men and women may have separate activities in an uncoordinated manner</li> </ul>	<ul style="list-style-type: none"> <li>• Introduce formal means of exchanging communication in which the minutes of the committee are exchanged and there is room for discussion</li> <li>• Have an official process to exchange minutes of the meeting (<i>shuras</i> are supposed to take minutes), which are then conveyed by an acceptable intermediary to communicate between male and female <i>shuras</i> to coordinate activities and offer opportunities for the other group to make inputs</li> </ul>

In summary, the activities of female *shura* members include:

At Health Post level

- Referring patients to the CHWs
- Assisting the work of the CHWs by jointly or separately conducting health education sessions
- Collecting information on non-acceptors of health services encouraging them to go for services
- Monitoring CHW activities by regularly holding meetings with CHSs or CHW trainers

At Health Facility level

- Bringing the concerns of female clients as well as female providers to committee's attention
- Providing inputs to the discussion from the perspective of women
- Supporting each other as female members of the committee (the female members of health committee are usually female staff of the facility, teachers, or female students. They should take advantage of being together and discuss mutual issues for concern because it is usually difficult for women of different backgrounds to get together in one place)

REACH grantees hold monthly meetings of CHWs at a health facility. Some NGOs conduct community health committee meetings after the monthly meeting with CHWs. Female CHWs have difficulty in participating in a monthly meeting due to long travel from their own villages. It is envisaged that female CHWs will have more opportunity to meet with health facility staff, particularly with female providers so that their working relationship will further improve.

These activities are similar to those of male *shura* members. The issues such as establishment and management of community emergency funds, planning for community action (e.g. National Immunization Days), construction of community facilities, are more likely to be discussed at male *shura-e-sehi* meetings.

## Some Lessons Learned and Recommendations:

The following lessons learned are summarized from the observations on various forms of women's *shura-e-sehi*.

- In communities where both male and female members alike feel the need to involve women, their involvement can be achieved slowly and steadily with the constant encouragement of outsiders, such as clinic/NGO staff.
- NGO field staff are convinced of the necessity of women's participation in *shura-e-sehi* and know that it is possible. This is a prerequisite for involving women. If the staff has already succeeded in having the communities select female CHWs, they should continue working to involve women in *shura-e-sehi*.
- The presence of active female CHWs facilitates the process of involving women. This is a natural process. Female CHWs benefit from having female *shura* members in terms of increased performance.
- Involving women in community health *shuras* enables better decision making practices. For example, the perspectives of both male and female community members are considered. This, in turn, supports the process of helping the community make better decisions for its people.
- Female *shura* membership is a springboard to enhance women's empowerment and increase their leadership roles in the community: This is a breakthrough in Afghan history where women take a visible leadership role at the community level in partnership with men.
- While the approaches to women's involvement may vary depending on the community, some successful examples include using Islamic teachings and anecdotes, pointing out the fact that they have already selected female CHWs, and noting female CHWs' positive contributions to the health of the community.
- Those who completed Community Midwifery education as well as LfL are regarded as leaders in the community, thus they are expected to take leadership roles in the community.

In addition to these lessons learned, this small assessment of women's involvement in health *shuras*, leads also to the following recommendations:

- Encourage women's participation in community health committees at all levels, but without force.
- Involve female CHWs in selection of female *shura* members.
- Identify the approaches used successfully to convince men to allow women's participation and make them available to others.
- Target those NGOs which trained only male *shura* members on community leadership for special technical assistance to encourage and guide them to involve women in community health committees.
- Track the number of female members of combined and separate *shuras* as well as specific health outcomes or practices in relation to these different *shuras* to further assist in the analysis of the contributions of women to *shura-e-sehis*.
- Monitor areas where Community Midwives are posted and areas where LfL classes took place to determine the impact of these programs on female participation in *shura*. The data collected in this regard will indicate whether the connection between various REACH-supported training initiatives and increased female participation in *shuras* took place or not at the community level and provide further guidance.
- Monitor the FFSDP standard of "at least 1/3 of members of a *shura-e-sehi* should be women" as a good initiative, but it also provide careful supervision

and support to ensure that NGOs do not take it as token representation of women or women “participating” on paper. An effort needs to be made to ensure joint decision making even if *shuras* are separate.

- Enhance collaboration among existing programs such as NSP, female literacy training, activities NGOs, Ministry of Public Health, and Ministry of Women’s Affairs at the community level through sharing lessons learned and linking all existing programs to bring synergy to overall women’s empowerment in Afghanistan.

## ANNEX 1

### Comparison of *shura-e-sehi* at Health Post and Health Facility Levels<sup>12</sup>

	Health Post	Health Facility
Aim	<ul style="list-style-type: none"> <li>To be more responsive to community health needs</li> </ul>	<ul style="list-style-type: none"> <li>To improve the health status of the population living in the catchment area of the health facility</li> </ul>
Membership	<ul style="list-style-type: none"> <li>6-9 people depending on community opinion</li> <li>One third of the members are preferably women</li> <li>A separate female <i>shura</i> may be considered depending on community opinion</li> </ul>	<ul style="list-style-type: none"> <li>People representing different users of the health facility who are motivated to cooperate with the health facility staff in community-based health related activities</li> <li>At least one third of the committee members are women (FFSDP Standard 7.1-b).</li> </ul>
Facilitators to establish <i>shura</i>	<ul style="list-style-type: none"> <li>NGO</li> </ul>	<ul style="list-style-type: none"> <li>Health Facility staff</li> </ul>
Secretary	<ul style="list-style-type: none"> <li>Trainer or supervisor from NGO</li> </ul>	<ul style="list-style-type: none"> <li>The facility in-charge</li> </ul>
Roles and responsibilities	<ul style="list-style-type: none"> <li>Be knowledgeable about the BPHS and Community-based Health Care policies and CHW's job description</li> <li>Develop, implement and review progress of annual action plan</li> <li>Mobilize local resources for strengthening and sustaining BPHS activities</li> <li>Conduct monthly meetings and ad hoc emergency meetings and maintain meeting minutes</li> <li>Review monthly progress and performance of CHWs including updating community maps and referral of clients to health facilities</li> </ul>	<ul style="list-style-type: none"> <li>Be knowledgeable about the BPHS and Community-based Health Care policies and CHW and CHS job description</li> <li>Develop, implement and review progress of annual action plan</li> <li>Mobilize local resources for strengthening and sustaining BPHS activities</li> <li>Conduct monthly meetings and maintain meeting minutes</li> <li>Monitor monthly performance of the facility and client satisfaction</li> <li>Write and sign a constitution of the facility level <i>shura</i>.</li> <li>Conduct a health needs assessment</li> <li>Organize an "open door event" at the health facility for the public every 6 months</li> </ul>

<sup>12</sup> Sources: Roles of Community and Facility Shura. REACH. April 2005