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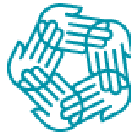
World Health
Organization



global health
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*Health workers for all
and all for health workers*

National HRH Consultative Forum
Secretariat: Ministry of Public Health

Afghanistan National Health Workforce Plan 2012-16

Islamic Republic of Afghanistan

2011

Prepared by the General Directorate of Human Resources, in collaboration with General Directorate of Policy and Planning, with support from WHO Afghanistan and the Global Health Workforce Alliance

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Foreword

This Plan is agreed by the Human Resources for Health Consultative Forum, which comprises representatives from the Ministries of Public Health, Higher Education, Finance and Civil Service Commission, as well as major private sector organisations, donor and civil society organisations, and professional associations.

It sets the framework for improving human resources for health in Afghanistan, both numbers and quality. The implementation of the Plan will be closely monitored by the Consultative Forum, and amendments made as required to improve health service delivery in Afghanistan

Dr Suraya Dalil
Acting Minister for Public Health and Chair of the HRH Consultative Forum

?Minister for Higher Education
?Deputy Chair

(date)

Acknowledgements

Monetary assistance has been provided through WHO Afghanistan, from the Global Health Alliance, to assist in the development of this Plan, and especially the employment of Ms Caroline Fitzwarryne, as a consultant to work with the Ministry of Public Health to facilitate the Plan.

Advice on the framework for the Plan, so as to be consistent with Plans in other countries, was provided by Dr Muhammad Mahmood Afzal, from WHO.

Considerable assistance has been provided by many staff and colleagues of the Consultative Committee members, so that the Plan can be both practical and visionary.

Executive Summary

Development of a 5 Year National Human Resources for Health Plan: The HRH Consultative Forum comprises representatives from the Ministries of Public Health, Higher Education, Finance and Civil Service Commission, as well as major private sector organisations, donor and civil society organisations, and professional associations. It has set the framework for improving human resources for health in Afghanistan, both numbers and quality.

Background:

Health Profile: Afghanistan is ranked 155 out of 169 countries for its human development index. Life expectancy at birth for Afghans is 46, and under 5 mortality is 161 per 1000 live births.

Human Resource numbers**:** The ratio of all qualified workers in the health sector, including management/technical support, is 22 per 10,000, however this includes 7.43 volunteer community health workers. WHO states that the minimum number of doctors, nurses and midwives (combined) required per 10,000 population is 23. Afghanistan has 7.26 which is one third of this. Despite a considerable increase in training of nurses and midwives scheduled for the next 5 years, the ratio of doctors/nurses/midwives to 10,000 population will only increase to 9.12.

Female health workers**:** Female workers make up 28% of the workforce (including unqualified support staff). Other than 100% midwives and 50% community health workers being female, only vaccinators and university educated groups of doctors, dentists and pharmacists have about 20% female. Technicians are between 5-10% female. However, the training that is now occurring, or scheduled, is much more gender balanced, with a number of courses having 50% female. But doctors, IHS-trained nurses, and laboratory and X-Ray technicians have 1/4 or less females in training.

Regional Variations**:** There are 16.7 public health workers (including unqualified support staff) in rural areas, compared with 36 per 10,000 in urban areas. Most qualified private health workers are in urban areas. Only 22.6% of the population live in urban areas, and most provinces are 90% rural. Of the seven regions, Southern has ¼ the ratio of health workers to population of Central Region. However, an increase in training (of nurses, midwives, doctors, physical therapists and psychosocial counsellors) is now occurring in regional centres, with the aim of keeping graduates in those regions. Degree courses for dentists, pharmacists and nurses are still only in Kabul, as are technician courses for laboratory, X-Ray, Dental, Pharmacy and Anaesthetic Nurses.

National Human Resources for Health Policy, Objectives, and 5 Year Strategies and Targets:

Policy: To produce, deploy and retain a well-trained gender-balanced health workforce, possessing the skills needed to deliver affordable and equitable health services to the population of Afghanistan.

Objectives, Strategies, Targets:

1. By end 2016 to have increased qualified and gender-balanced health workers from 22 to 39 per 10,000, and (within this number) doctors/nurses/midwives from 7 to 13. Target population of health staff will be 119,951 by end 2016 (60,366 staff more than current – much more than 2.3% population increase each year).

2. By end 2016 to have courses established and operational in regional centres for degrees in Nursing, Pharmacy and Dentistry by MoHE, and for diplomas by Institutes of Health Sciences (IHS) for Laboratory, X-Ray, Dental and Pharmacy Technicians and Anaesthetic Nurses.
3. To develop new curricula and produce 100 graduates by end 2016 in each of three new MoHE degree courses: medical engineering, medical technology and environmental health; and establish an agreed category of Psycho-social counsellor and train 700 through IHS.
4. To provide a Secretariat for the MoPH/MoHE Coordinating Joint Committee so that by end 2016 it can: assess/accredit all private sector training courses; establish database for Legislation Enforcing Directorate of MoPH of registered private health workers, and capacity build staff, so workers are qualified and monitored; establish Medical Council; establish overall Health Professions Council including membership from other Professional Councils which it will help groups establish.
5. To update and establish agreed curricula for all MoHE/MoPH training courses for trainees in medical specialities, provide training to trainers, and accredit trainers by end 2016.
6. To increase pre-service training (over and above that scheduled for next 5 years) by 7000 nurses, 6000 midwives, 800 physical therapists, 600 psychosocial counsellors, and 20,000 volunteer community health workers, so they are trained in their own regions and bonded for employment locally by 2016 (if CSC/MoF increase salaries ceiling).
7. To develop curricula for in-service update courses for nurses and technicians, and implement in-service training regionally for all those whose skills are inadequate by 2016.
8. To attract and retain qualified staff in both private and public sectors, by establishing agreed remuneration standards which are equitable across the civil service, NGO and private sectors, through advancing the following actions by 2016: CSC to work towards amending Civil Employees Law to allow higher salaries for specialist staff; CSC and MoF to work towards employing contracted-out staff as civil servants, with equitable salary and allowances.
9. To upgrade MoPH database so that it also includes MoHE and private sector data, and links with CSC, and through internet transfer with provinces in MoPH, with pay, deployment and attendance data – all by 2016.
10. To undertake required aspects of institutional development of MoPH HR Units (GDHR, GIHS and APHI) and, so as to ensure institutional structures, procedures, equipment, facilities, infrastructure, and employment and capacities of staff, including in provinces, are adequate to undertake their functions effectively in both central and regional locations by end 2016.
11. To have an Independent Health Complaints Office established and operational by end 2016, and the Transparency Working Group will have produced four annual reports on its progress by end 2016.

Financing the Plan: There are four financing components:

- The first is the remuneration of additional staff, and staff paid higher specialist salaries. This could be in the order of xxx.
- The second is training and skill development which is $191.55 M.
- The third is institutional development and management capacity building, which is $29.58M.
- The fourth is research and development which is $3.4M.

It is expected that much of the MoPH component of the plan, and some of the MoHE components will be funded initially from the Kabul Conference HR Cluster proposals which are now part of a New Policy Proposal. However these were only for 3 years and this Plan is for 5 years so some supplementation is required. The aspects relating to remuneration and specialist category salary increases were not costed in that proposal, nor private sector developments. There will need to be considerable advocacy by the HRH Consultative Committee to attract these additional funds.

Review

The HRH Consultative Committee will monitor progress at its 3 monthly meetings, and undertake an annual review. A third-party review will be undertaken prior to the end of the 5 years.

Abbreviations

AFD	French Development Agency
AKDN	Aga Khan Development Network
ANDS	Afghanistan National Development Strategy
APHI	Afghan Public Health Institute
BPHS	Basic Package of Health Services
CEL	Civil Employees Law
CF	Consultative Forum
CSC	Civil Service Commission
CTAP	Civilian Technical Assistance Program (USAID)
DAFA	Development Assistance Facility for Afghanistan (AusAID)
EPHS	Essential Package of Hospital Services
EU	European Union
GDHR	General Directorate of Human Resources
GDPP	General Directorate of Policy and Planning
GIHS	Ghazanfar Institute of Health Sciences
HCFD	Health Care Financing Directorate
HNSS	Health and Nutrition Sector Strategy
HRH	Human Resources for Health
GCMU	Grants Coordination Management Unit
HDI	Human Development Index
HMIS	Health Management Information System
HSSP	Health Services Support Project, affiliate John Hopkins University.
MDG	Millennium Development Goals
MoF	Ministry of Finance
MoHE	Ministry of Higher Education
MoPH	Ministry of Public Health
MSH	Management Sciences for Health
NGO	Non Government Organisation
PHO	Provincial Health Office
SWAp	Sector-Wide Approach
UNFPA	United Nations Population Fund
WB	World Bank
WHO	World Health Organisation

1. Introduction

Background, Rationale, Structure and Process of developing the plan

Afghanistan is ranked 155 out of 169 countries for its human development index (0.349), a composite measure of three basic dimensions of human development: health, education and income. Life expectancy at birth for Afghans is 46. Under-five mortality is 161 per 1,000 live births. The maternal mortality ratio in 2002 was 1600 for 100,000 live births. However, the situation is improving, albeit slowly. 55.9% of children have been immunised against measles. 83% of the population now has access to medical facilities, and 57.4% of those who are able to access services can do so within a two hour walking distance. Since 2000, the prevalence rate of tuberculosis has been cut in half to 231 per 100,000. The tuberculosis detection rate under directly observed therapy (DOTS) is 70% (2007) compared with 12% in 1998, and the treatment success rate under DOTS is 89% (2007) compared with 33% in 1998. (Ref: latest available figures in Afghanistan Health Indicators, Fact Sheet March 2010, MoPH)

Considerable planning for public Human Resources for Health has been undertaken by the Ministry of Public Health over the last few years. This has included an approved HR Policy 2010-2013, and a Strategic Plan and Indicative Plan to Implement Priority Activities 2008-2010.

The first costed Workforce Plan for the Public Health Sector was completed in December 2009 by the Ministry of Public Health (MoPH) utilizing its own HR Database and data from training institutions (including from MoHE and CSC). This was developed in collaboration with key stakeholders from MoPH, MoHE, CSC, MoF, NGOs and donors.

The Global Health Workforce Alliance (GHWA), an international partnership hosted by WHO, provided financial support so MoPH could produce its first Human Resources for Health (HRH) Afghanistan Profile (Health Workforce Observatory) in January 2010. The Profile included data from the MoPH Workforce Plan and extended it a little. This profile is an analysis of available data which is used for workforce planning.

Sixteen HRH Activity Proposals were developed by MoPH as part of the Human Resources Cluster submission to the Kabul Conference 20 July 2010. Some of these were developed collaboratively with the MoHE, and discussions were held in their development with CSC and MoF. Following discussion at the Conference with donors, they now form part of the New Policy Proposal being put forward by MoPH, in which some aspects are collaborative with MoHE.

An HRH Coordination Meeting was co-hosted by WHO/MoPH in June 2010 and terms of reference for a National HRH Consultative Forum (CF) were developed with key stakeholders in August/September 2010, and endorsed by the Acting Minister for Public Health, HE Dr Suraya Dalil in November 2010.

The Forum is a permanent mechanism to advise the Minister for Public Health and other interested Ministries on all issues relating to development and deployment of human resources for health in Afghanistan both in the public and private sectors. It is planned it will have four meetings a year and be supported through a WHO-supported Secretariat in GDHR. Members will provisionally be twenty three and comprise: 7 from MoPH, 3 MoHE, 1 MoF, I CSC, I USAID, I WB, I EU, I WHO, 2 NGO, 4 professional associations (one private hospital, one public health, one nursing and one midwifery), and 1 from a Civil Society Organisation (Integrity Watch Afghanistan).

The goals of the Forum are to:

- Advise on HR issues and problems and identify measures for their correction;
- Set HR priorities;
- Ensure the National HRH profile and 5 Year Workforce Plan are updated each year, and that feasible private sector data and planning are included together with public sector data;
- Assess the Plan and advise on:
  - Whether it is adequate to meet national and international goals to which the Afghan government has committed;
  - The adequacy of HR resources proposed to implement the Workforce Plan;
  - The reasonableness of the timeline for phased implementation; and
  - Financing mechanisms which are not dependent on donor funding.
- Advocate with Government and Donors for required resources;
- Ensure monitoring processes are in place to track the implementation of the Plan, and that this is reported annually; and
- Ensure there is a third party evaluation undertaken of HR in the public and private sector periodically, against the objectives and timeline within the Workforce Plan.

Working Groups and Sub-Committees will be established to further the goals of the Forum, and report to the Forum at its quarterly meetings. One of these will be a *Nursing and Midwifery Health Workforce Planning Sub- Committee* (TORS in Annex).

The development and implementation of this National Workforce Plan, with the support of the HRH Consultative Forum, will fulfil national HRH policy goals and objectives.

The Plan will summarise the current situation, issues, problems and challenges. Then it will identify strategies and actions to address them over the next five years. In short, it will operationalize the National HRH Policy. It will set targets together with expected results – what is to be produced or achieved – together with costs. Proposals will also be made for how implementation can be financed, allowing for flexibility in implementation as a result of review and adjustment processes. The timeline will incorporate actions which can be included in individual agency annual operating plans.

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financed, allowing for flexibility in implementation as a result of review and adjustment processes. The timeline will incorporate actions which can be included in individual agency annual operating plans.

2. National Policy Implications

National Development Policies, National Health Policy.

National Development Policies

The Afghanistan National Development Strategy 2008-2013 has set out to *strengthen democratic processes and institutions, human rights, the rule of law,* ***delivery of public services*** *and government accountability. And, to improve human development indicators and make significant progress towards the Millennium Development Goals (MDGs). Among the 10 challenges recognized by the strategy facing population health, 3 pertained to health workforce in particular. The challenges are:* (1) inadequate financing for many of the key programs; (2) reliance on external sources of funding; (3) inadequately trained health workers; (4) lack of qualified female health workers in rural areas; (5) dispersed
population, geographical barriers and a lack of transportation infrastructure; (6) low levels of utilization for certain health services, especially preventive services; (7) variable levels of service quality; (8) insecurity in some provinces, making it difficult for program implementation, recruitment and retention of staff, expansion of service coverage and monitoring by the provincial and central levels; (9) lack of effective financial protection mechanisms for poor households to receive the care they need without experiencing financial distress; and (10) lack of mechanisms for effective support to and regulation of for-profit private sector clinics and pharmacies. Indeed, the strategy clearly addressed 3 major challenges as related to health workforce in Afghanistan, namely: low production of trained HW, maldistribution and weak retention and remuneration.

Human Resources Development, Research
and Administration Programs in health are to be addressed as follows:

- The MoPH will work closely with the Civil Service Commission to implement the National Priority Reform and Restructuring competitive recruitment processes for placing the most highly qualified Afghan health professionals in established posts throughout all levels of the health system.
- Efforts will be made to promote a culture of quality throughout the sector, especially in health facilities, through leadership and good examples set in day-to-day work, strengthen the use of quality standards, and promote frequent supportive supervision. A Quality Assurance Committee has been established to promote improvements in service within public sector facilities.
- Once effective regulatory mechanisms are developed and can be enforced, the MoPH will address quality issues in the private-for-profit sector, especially pharmacies and drug sellers.

- A comprehensive approach to human resource development will be developed to produce, deploy and retain where they are needed an appropriately trained health workforce possessing the variety of skills needed to deliver affordable, equitable and quality health care services.
- Further develop and maintain a health care worker registration system and a national testing and certification examination process (in collaboration with the Ministry of Higher Education) will be established standards for accreditation of training institutes and programs.
- There will be a significant Expansion of the community midwife training program model to other cadres of health workers, with particular emphasis on recruiting, training and deploying couples to work together in health facilities in their community after graduation.

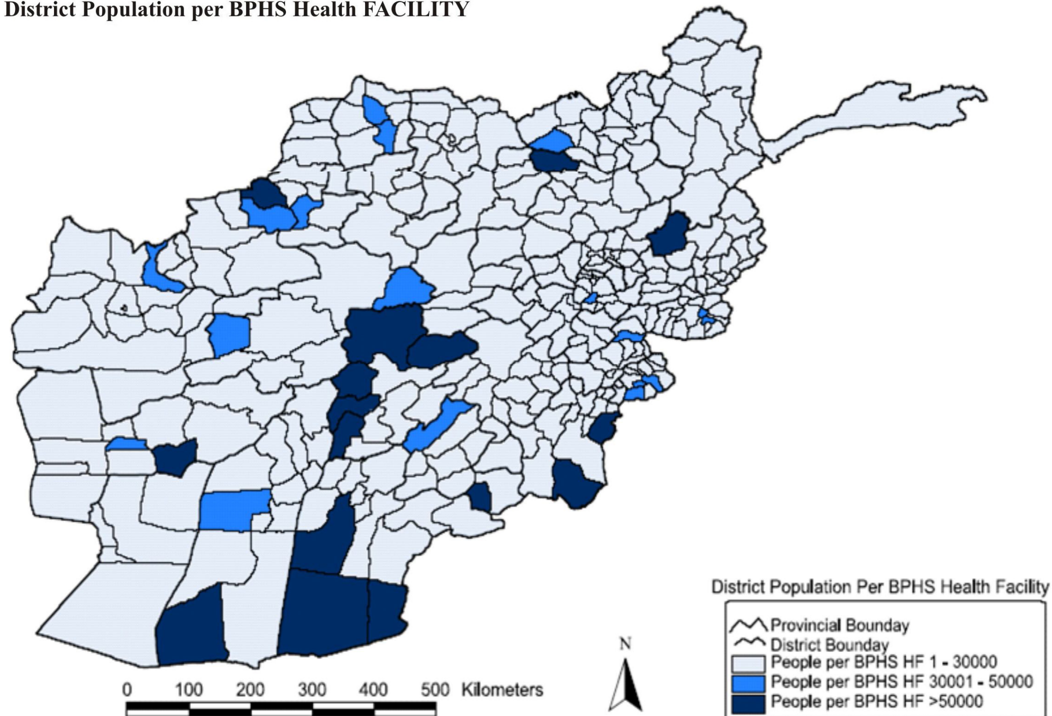
National Health Policies

Health and Nutrition Sector Strategy 2008-2013

The strategy aims at ensuring that 90% of population with nearby access to PHCSs by 2013. The 2000 benchmark is only 9%. To achieve such target, there should be a great deal of planning to scale up the production of appropriate HRH to staff such PHC facilities. The coverage of country regions, especially rural parts is major task and challenge facing HRH production (see below map).
As strategic directions, the strategy aims at:

- Strengthening organizational development and management at central and provincial levels to ensure the effective and cost-efficient delivery of quality HCSs;
- Further developing the capacity of health personnel to manage and better deliver quality HCSs and to facilitate evidence based decision making through coordination of relevant and useful research;

As Strategy 7.1 on Human Resources Development indicates, the HNS is committed as a top priority to using a comprehensive approach to HRD in addressing the issues of how to produce, deploy and retain an appropriately trained health workforce possessing the variety of skills needed to deliver affordable and equitable packages of HCSs as the basis for health care.
The selection, training, deployment and retention of staff in rural areas, particularly female staff is important to the HNS.
Recognizing the detrimental effects of more than twenty years of conflict on health professional education, the HNS will assess the capacity and training needs of existing staff to raise quality performance. (Note: HR Management – HRM - including PRR recruitment will be through Administration.



Source: Afghanistan Health and Nutrition Strategy 2008-2013

Afghanistan HR Strategies.

A number of attempts to set out to define an HRH national strattegise have been in action since 2002. In April 2006 Médecins du Monde-France (MdM-F) has been implementing the first HR programme in Afghanistan. This programme is located in Kabul and aims to contribute actively to define an Afghan HR strategy in order to halt and reverse the spread of HIV/AIDS.

Smith *(Source: Joyce Smith.* Guide to Health Workforce Development in Post-Conflict Environments. *Geneva: World Health Organization, 2005.) identified the following 7 interventions as early as 2005 as the most Important Human Resource Functions for Rebuilding and Supporting a Health* Workforce in Afghanistan:

- Formulating and implementing national HRH policies
- Planning the national health workforce
    - Ascertaining current health workforce size and composition
    - Defining desired future health workforce size and composition (given health needs and the financial envelope)

- Defining health worker roles, competencies, and minimum educational standards
- Developing and implementing HRH strategies to shift toward the desired future state
- Assessing financial feasibility of the strategies
- Monitoring and evaluating the implementation of the strategies

- Developing, implementing, and evaluating HRH standards
    - Minimum staffing standards for health facilities
    - Training standards
    - Clinical standards
- Developing and/or supporting the development of training capacity for key health worker cadres
- Developing and implementing a registration/certification system for health workers
- Developing and implementing a system for accrediting health training institutions
- Managing the health workforce
    - Hiring, firing, and transferring health workers
    - Defining and modifying compensation and incentive packages
    - Negotiating with labour unions over salaries and incentives
    - Paying salaries and incentives
    - Defining and applying disciplinary measures
    - Providing legal support in cases of alleged malpractice
    - Administering routine personnel matters
    - Evaluating health worker performance
    - Developing health personnel (career development and training)
    - Managing health worker motivation

However, despite the fact that all above 7 interventions are still needed, the emphasis on scaling up production to overcome the HRH crisis and match with the massive expansion of health services especially in rural areas plus the urgency to implement a functioning CCF are among other evolving important interventions.

3. Situation Analysis

Health Care System, Current Situation of HW in Afghanistan, Health Workers Stock and Trends, Health Workers Migration, Distribution profiles of HW (Gender, Age, Geographic, Health Facility and Sectors

distribution), HRH Systems and Governance: HRH Planning, HRH Production (Pre-service, Postgraduate and In-service development), HRH Utilization (Recruitment, Deployment & Distribution Mechanism, Remuneration and Performance Management), HW Data, Financing of HRH, Key HRH Partners and Stakeholders. Current National Projections and Gaps, SWOT Analysis, Main Problems and Challenges.

Afghanistan Health Care System and Services

Afghanistan is ranked 155 out of 169 countries for its human development index. Life expectancy at birth for Afghans is 46, and under 5 mortality is 161 per 1000 live births. The general health situation of the Afghan people remains overwhelmingly poor and is exacerbated by the dismally deficient determinants of health; vector caring mosquito, inadequate water supplies, poor sanitation and hygiene practices, security issues, lack of public policy on harmful goods (cigarettes, unfortified flour, non-iodized salt,), unsafe public places, uncontrolled waste disposal, air and noise pollution, unsafe drug practices, poorly designed houses, food insecurity, substance abuse and HIV potential. According to recent data, LEB at birth is a distressing 47 years for men and 45 years for women. Mortality rates for children and for women are unacceptably high – U5MR was estimated to be 257 deaths per 1,000 live births in 2000 (1379) – more than one in four children died before reaching their fifth birthday. The MMR was estimated to be among the highest in the world - 1,600 per 100,000 live births, with estimates in some provinces ranging much higher.

The structure of the HCS system in Afghanistan is traditional. At the most peripheral level, community health workers (CHWs) who are non-health professionals with limited but highly targeted training are
the initial point of contact for individuals seeking HCSs. The BHC, a formal structure maintained by the MoPH, is staffed by health professionals and provides, at a minimum, all of the services that comprise the BPHS. Comprehensive Health Centres (CHCs), the next level of the system, provides the BPHS and additional services including minor and essential surgery. The District and Provincial Hospitals offer a broader array of more sophisticated medical care and, at the pinnacle of the HCS pyramid, tertiary hospitals in the major urban areas provide the most sophisticated care available in Afghanistan's public HNS. There is a large private and traditional HCS sector in Afghanistan as well, about which relatively little is known. The MoPH is in the process of developing regulation and process to fulfil its stewardship
role this aspect of the NHCS as well.

Types of Health Facilities at 9 levels of health care delivery include:

(1)Health Post (HP): At the community level, basic HCS will be delivered by CHWs from their own homes, which will function as community HPs. A HP, ideally staffed by one female and one male CHW, will cover a catchment area of 1,000-1,900 people, which is equivalent to 100-150 families.

(2)Sub-Centre: Sub-centres will be established to cover a population from 2,000 to 15,000. The MOPH decision is to establish these sub-centres in the private houses and try to avoid construction. A Sub-Centre is staffed by one male nurse and one community midwife (CMW).

(3)Basic Health Centre (BHC): The BHC is a small facility offering the same services as a HP but with more complex outpatient care. The BHC will supervise the activities of the HPs in its catchment area. The ervices of the BHC will cover a population of 15,000-30,000 people, depending on the local geographic conditions and the population density. The minimal staffing requirements for a BHC are a nurse, a CMW, and two vaccinators. Depending on the scope of services provided and the workload of the BHC, up to two

additional Health Care Workers (HCWs) can be added to perform well defined tasks.

(4)Comprehensive Health Centre (CHC): The CHC covers a larger catchments area of 30,000-100,000 people, offering a wider range of services than the BHC. The facility will have limited space for inpatient care, but will have a laboratory (lab). The staff of a CHC will also be larger than that of a BHC, including both male and female doctors, male and female nurses, midwives, and lab and pharmacy technicians.

(5)Comprehensive Health Centre plus (CHC+): This type of health facilities aim to provide maternal health care services particularly Comprehensive Emergency obstetrics Care services. These facilities have 10 beds.

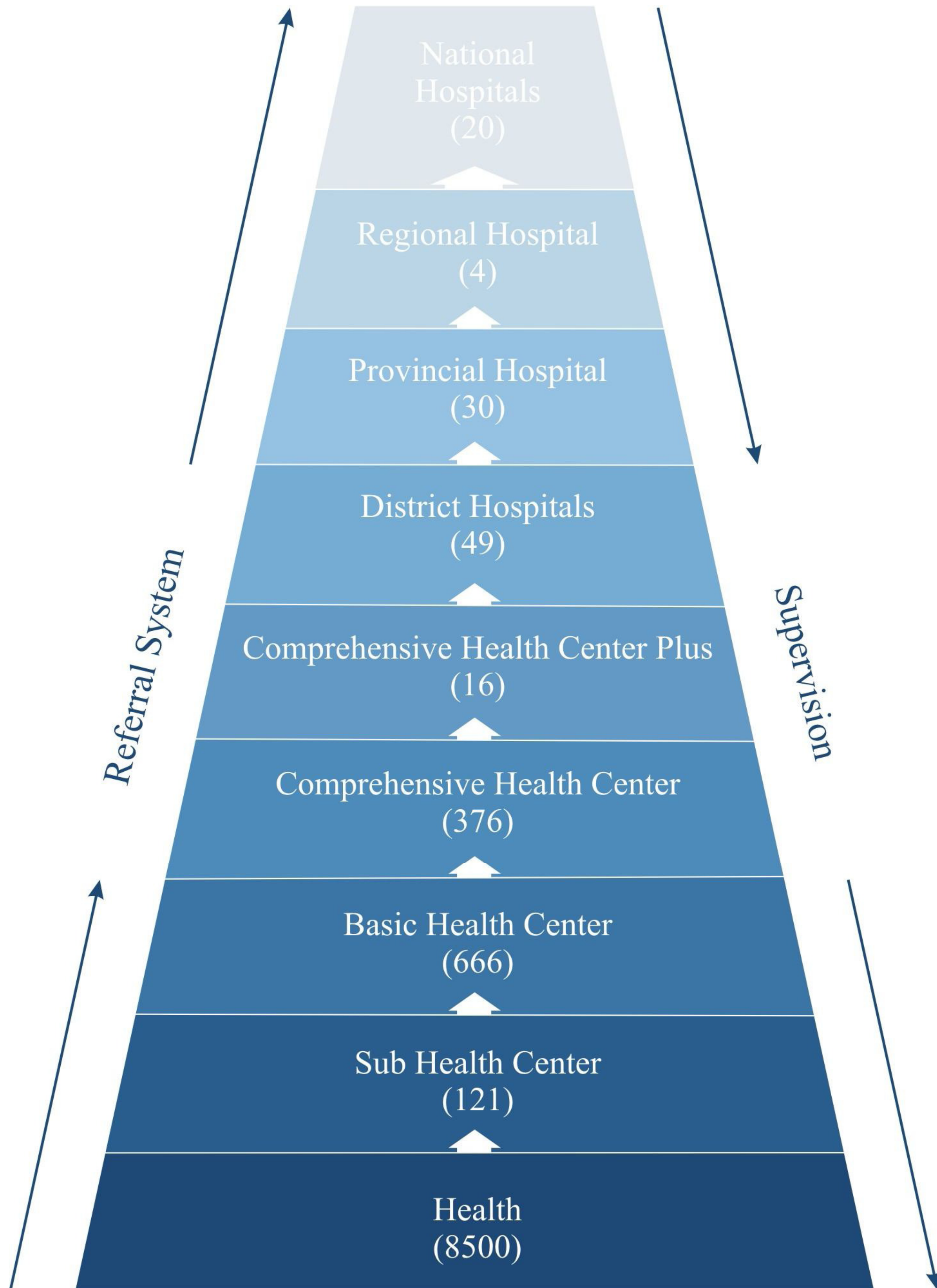
(6)District Hospital (DH): At the district level, the DH will handle all services in the BPHS, including the most complicated cases. The hospital will be staffed with doctors including female obstetricians / gynaecologists; a surgeon, an anaesthetist and a paediatrician; midwives; lab and X-ray technicians; a pharmacist; and a dentist and dental technician. Each DH will cover an approximate population of 100,000-300,000 people in one to four districts.

(7)Provincial Hospital (PH): The PH is the referral hospital for the Provincial Public Health (PPH) Care System. In essence, the PH is not very different from a DH: it offers the same clinical services and possibly a few additional specialties. In most cases, the PH is the last referral point for patients referred from the districts. In some instances, the PH can refer patients to higher levels of care to the regional hospital or to a specialty hospital (SH) in Kabul.

(8)Regional Hospital (RgH): The RgH is primarily a referral hospital with a number of specialties for assessing, diagnosing, stabilizing and treating, or referring back to a lower level hospital. The RgH provides professional inpatient and emergency services at a higher level than is available at DHs and PHs, yet the overall objective remains the reduction of the high MMR, IMR, and U5MR, and of other diseases and conditions responsible for Afghanistan’s high mortality and morbidity.

(9)National Hospitals (NH): NHs are referral centres for tertiary medical care and are located primarily in Kabul. They provide education and training for HCWs and act as referral hospitals for the PHs and RgHs.

Figure 1.2: Types and number of Health facilities in Afghanistan (**Source:** HMIS/MoPH (2007)



Current Situation of HW in Afghanistan

Afghanistan has taken a devastating toll during more than the past two decades with the human and socio-economic indicators still hovering near the bottom of international indices. Human resources (HR) in health have been decimated, leaving behind scarce qualified health professionals, who are predominantly male where it is more difficult to employ qualified female staff in districts/remote areas. Life expectancy at birth (LEB) is 47 years for Afghan men and 45 years for women, slightly more than half that of the wealthiest countries of the world.

The ratio of all qualified workers in the health sector, including management/technical support, is 22 per 10,000, however this includes 7.43 volunteer community health workers. WHO states that the minimum number of doctors, nurses and midwives (combined) required per 10,000 population is 23. Afghanistan has 7.26 which is one third of this. Despite a considerable increase in training of nurses and midwives scheduled for the next 5 years, the ratio of doctors/nurses/midwives to 10,000 population will only increase to 9.12.

Health Workers Stock and Trends

Health Workforce Data: At May 2011, 45,042 qualified staff were employed in the public health system, of which about 60% were civil servants and about 40% were employed through contracting-out mechanisms with NGOs, and a few contracted-in to MoPH. Doctors, dentists, pharmacists, laboratory and X-Ray technicians (and some other health workers) who are employed in the private health sector, are registered through the MoPH, but the records have never been computerised, and are very out-of-date. Estimates are provided in the table below, with assistance of professional groups, which have been adjusted to avoid double counting, as it is estimated that about 4/5 of those who work in private clinics also work in the public sector until 4pm.

WHO states that the minimum number of doctors, nurses and midwives (combined) required per 10,000 population is 23 (WHO Global Atlas of the Health Workforce, August 2010). The Afghanistan public health sector has 5.6, which is a quarter of this, and 7.26 including the private sector and MoHE hospitals.

As can be seen in Table 1 below, despite a considerable increase in training of nurses and midwives scheduled for the next 5 years, the ratio of doctors/nurses and midwives to 10,000 population will only increase from 7.26 to 9.12. This is because the estimate of population increase per year is 2.3% in the absence of a Census. Many more front-level staff are required.

The database in MoPH (which includes only the public sector) was the first such database established in a Ministry in Afghanistan and is very good, linking with the HMIS on Access (supported by USAID). However, considerable enhancement is required with a better platform - currently there is no link with Provincial Health Offices, the pay system, deployment data, attendance data, and training data (including for short overseas courses).

There also needs to be links with the private sector and MoHE data, so there can be a national HR database. (Activity 1 ANDS HR Cluster). The CSC is committed to ensuring links with its proposed HR database.

Health Workers Migration

Gender Profile Female workers make up 28% of the workforce (including unqualified support staff). Other than 100% midwives and 50% community health workers being female, only vaccinators and university educated groups of doctors, dentists and pharmacists have about 20% female. Technicians are between 5-10% female. However, the training that is now occurring, or scheduled, is much more gender balanced, with a number of courses having 50% female. But doctors, IHS-trained nurses, and laboratory and X-Ray technicians have 1/4 or less females in training.

Female workers make up 28% of the public health workforce. Other than 100% of midwives being female, and support staff (mainly unqualified) making up 36%, only vaccinators and the university educated groups of doctors, dentists and pharmacists have above 20% female. Technicians are between 5-10% female. The aim is always to have females comprising 50% of community health workers, but this does not always occur. However, the training that is now occurring, or scheduled, is much more gender balanced, with most courses having 50% female students. But doctors, laboratory and X-Ray technicians have only 1/4 or less females in training, and nurses doing the IHS general nurse training.

Age Profile

HRH Category Distribution: The ANDS HR Cluster Proposal prioritised the need for new training in bio-medical engineering, environmental health, medical technology, and psycho-social counselling.

- There is no bio-medical engineering program currently provided in Afghanistan, and qualified applicants cannot be found in Afghanistan. Equipment has to be sent overseas for repair when maintenance contracts expire.
- Although there are many laboratory technicians in the public sector, they are under-skilled. Medical technologists are required who are specialised, including in laboratory science, radiography, blood bank and anaesthetics.
- The Sanitarian training program has been discontinued due to its inadequacy. An environmental health officer training is required.
- Kabul University is now training psychologists and some need to be employed in MoPH. There have been one year pilot trainings and employment in BPHS vacant positions (such as nurses) of psycho-social counsellors, in some provinces, and some 2 week in-service trainings of other health workers. Although evaluation shows the skills have been used well, a long-term solution is required to provide mental health support after decades of conflict and insecurity.

Geographic Distribution There are 16.7 public health workers (including unqualified support staff) in rural areas, compared with 36 per 10,000 in urban areas. Most qualified private

health workers are in urban areas. Only 22.6% of the population live in urban areas, and most provinces are 90% rural. Of the seven regions, Southern has ¼ the ratio of health workers to population of Central Region. However, an increase in training (of nurses, midwives, doctors, physical therapists and psychosocial counsellors) is now occurring in regional centres, with the aim of keeping graduates in those regions. Degree courses for dentists, pharmacists and nurses are still only in Kabul, as are technician courses for laboratory, X-Ray, Dental, Pharmacy and Anaesthetic Nursing.

Of the seven regions, the Southern region has one quarter the ratio of health workers to population of the Central Region. Western is the next most disadvantaged followed by North Eastern. Analysis of the 34 provinces is in the Afghanistan HRH Profile March 2011. Only 22.6% of the population live in urban areas. Most provinces are at least 90% rural. There has been a great improvement in public sector health workers (including unqualified) in rural areas in the year to October 2010, from 4.5 per 10,000 population to 16.69. This compares with 32 in urban areas in 2009 compared with 35.73 in 2010. This is still way under the 23 per 10,000 of just doctors/nurses/midwives proposed by WHO. However, an increase of training (of nurses, midwives, physical therapists, psychosocial counsellors) is now occurring in regional centres, with the aim of keeping graduates in those regions. Degree courses for dentists, pharmacists and nurses are still only in Kabul, as are technician courses for laboratory, X-Ray, Dental, Pharmacy and Anaesthetic Nurses. Unfortunately there has been a 70% increase in medical students in Kabul in the last two years. Less than 1/5 (616) of the students to graduate in the next 5 years are in regional centres.

Distribution per Health Facility

(**COULD NOT FIND RECENT DATA ON DSTRIBUTION PER SECTOR THAN 2005)**

This is very important to see how HRH are deployed and how equitable distribution can be achieved in the plan.

Hospital Human Resources:

There has been institutional development and capacity building in three regional and seven provincial hospitals funded by donors through EPHS, however the National Hospitals have remained very run down. They do however have large numbers of staff, as many qualified staff will not agree to being posted out of Kabul. There is a great need to undertake institutional development and planning in these hospitals, a similar program to that undertaken in the regional hospitals, so as to determine staffing needs relating to speciality services provided, and improve management and clinical standards. This proposal was in Activity 6 ANDS HR Cluster, but was $94.5M as it included total hospital reform activities. Limited HR activities, including in-service training of current nurses, midwives and technicians would be one component of this. This needs to link with the planned training in hospital management being supported by DAFA (AusAID)

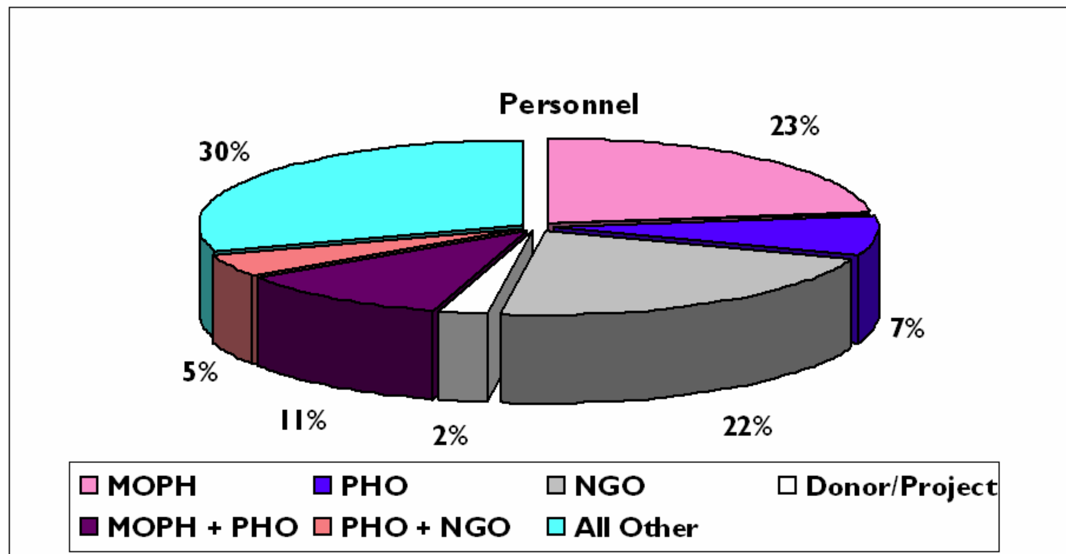
Enticing Health Workers to Work in Rural/Remote Areas:

As health workers are often not keen to work in rural areas, staff turnover at the provincial level is very high, especially in insecure provinces. They prefer to move to Kabul and other regional centres where there is better security, food, employment, better health care and education for their children. It was proposed in the 2009 Workforce Plan that the issue of working in insecure provinces could be dealt with through rotation schemes with families based in regional or large provincial centres. Various policies will need to be investigated with the clear aim that each professional staff member should spend part of their time in rural/remote areas. Also the hardship and hazard allowances in the Civil Employees Law need to be implemented for all staff, with budget allowance provided for this to occur. This issue links with the remuneration and allowances issue discussed above.

Distribution per Sectors

Need to have some figures on maldistribution among sectors like public, private, NGO, other government sectors...etc

Graph (may be outdated but something similar will be needed) : showing agreement among stakeholder groups on who has responsibility or authority, Afghanistan health sector, 2005 (Source Smith 2005)

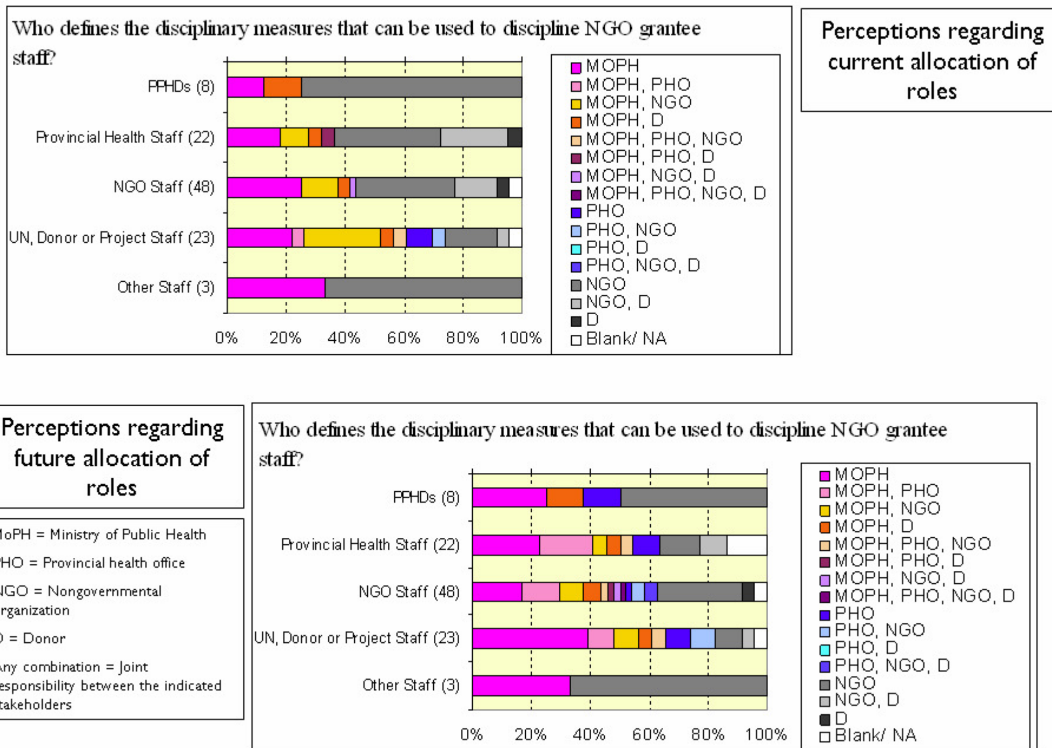


Afghanistan, 2005

Explanation: "MOPH" was 23% of the total number of answers, when stakeholders were asked who currently has responsibility or authority over Personnel (i.e. HR) functions; "PHO" was 7%, and so on.

(COULD NOT FIND RECENT DATA ON DSTRIBUTION PER SECTOR THAN 2005)

HRH Systems and Governance: The Afghanistan findings revealed considerable confusion and lack of agreement regarding HRH roles and responsibilities at all levels. The General Director of HR considered these findings a crucial help to strengthening overall organizational development, and insisted that they be widely shared with senior MOPH staff, MOPH departments (which previously covered individual HRH areas), various HR task forces and working groups, and relevant multilateral agencies. The RAMP findings provided fruitful input to discussions among senior government officials and their partners. It is, however, too early to assess their long term impact, due to recent changes in senior MoPH managers, including the General Director of HR.



(Source Smith 2005: Ministry of Public Health (MOPH); Provincial Health Office (PHO); NGO Donor (or donor funded project); and any combination of the above

The General Directorate of Human Resources in MoPH requires considerable institutional development which includes training of its officers in HR both centrally and in Provincial Health Offices (PHOs), and provision of computers for management purposes –There is currently some work being undertaken through the Development Assistance Facility of Afghanistan (DAFA) through AusAID to improve record management, and some computerisation at central level is occurring through the Civilian Technical Assistance Program (CTAP) funded by USAID, but computerisation is essential for form and data transfer to and from the provinces as well.

Also employment of officers skilled in HR is required in order to implement the CEL and procedures as specified. Staffing is inadequate. (Activity 1 ANDS HR Cluster). A short-term release masters program, such as that in Islamabad, is an opportunity to address this.

- **HRH Policy and Planning**
- **HRH Production**

Pre-service education: The production of HRH is organized in universities belonging to Ministry of Higher Education in addition to other different institutes belonging to MoPH and other sectors. In the table below, the production capacity of different HRH categories is shown with gaps that need to be filled by this plan.

Table 1: Brief Overview of Current Qualified Health Workers, those in training, estimated numbers at end 2016 and ratio to population – combined public and private sector:

Category	No staff 2011 MoPH & contra-ctees. (A)	Estimate staff MoHE[1] (A) & private (B) (dual counted once) (C)=A+B	Ratio /10KPop (26.92 M)	Estimate students to complete by end 2016 (D)	Estimate No employed by end 2016 (E)=C+D	Estimate ratio/ 10K pop (2016-30.72M)
Doctors	6,162	6,830[2]	2.54	3,029[3] (1/4 f)	9,859	3.21
Nurses: General, Community, Anaesthetic and Auxiliary	5,197	8,690	3.23	3,178[4] (1/3 F)	11,868	3.86
Midwives: hospital community and assistant	2,605	4,000	1.49	2,303[5]	6,303	2.05
Dentists/dental technicians	484 (133/351)	3,000 (500/2,500)	1.11	1019 (408/611) (1/2 f)	4,019	1.31
Pharmacists/pharmacy technicians	1,360	3,050[6] (550/2,500)	1.13	1264 (419/845)(1/2 f)	4,314	1.41
Laboratory/radiography technicians	1,734	5,000	1.86	939 (777/162)(1/3 f)	5,939	1.93

[1] MoHE staff in 3 Kabul Hospitals: Doctors 168, Nurses 190, Pharmacists 15, Pharm Tech 15, Dentist 9, Dental tech 2, X-Ray Tech 11, Lab Tech 16, Admin 49.

[2] Doctor Associations estimate there are 2000 private doctors in Kabul of which most work in the public sector up to 4pm, so there are only about 500 who work exclusively in the private sector.

[3] Despite the MoPH Workforce Plan 2009-2013 recommending less doctors in Kabul, in the last 2 years there has been a 70% increase of medical students in Kabul. Less than 1/5 (616) of the students to graduate in the next 5 years are in regional centres, and only ¼ are female.

[4] Nurse training: 418 private (80% F), 1980 IHS (1/4 female), 325 B.Nurs(3/4 F), 300 Community.

[5] Midwife training: 945 private, 562 IHS, 796 Community.

[6] The Legislation Enforcing Directorate of MoPH estimates that athough there are about 15,000 pharmacies in the country, there are only about 550 qualified pharmacists working (and about 2500 qualified pharmacy assistants). About 90% work in MoPH in non-pharmacy jobs, then work in the private sector after 4pm.

Category	No staff 2011 MoPH & contra-ctees. (A)	Estimate staff MoHE[1] (A) & private (B) (dual counted once) (C)=A+B	Ratio /10KPop (26.92 M)	Estimate students to complete by end 2016 (D)	Estimate No employed by end 2016 (E)=C+D	Estimate ratio/ 10K pop (2016-30.72M)
Other allied health workers: physiotherapists, orthopaedic technicians, psycho-social counsellors, etc.	141	300	0.11	125 (over ½ F)	425	0.14
Public health workers: health inspectors/ Vaccinators	2,715	2,715	1.01	-	2,715	0.88
Health management workers/skilled admin trade workers/trainers	4,644	6,000	2.23	-	6,000	1.95
Volunteer Community Health Workers	20,000	20,000	7.43	-	20,000	6.51
TOTAL QUALIFIED WORKERS	45,042	59,585	22.14	15,614	71,442	23.25

ESTIMATED ratio /10K pop is

From above figures, it is not clear whether the estimated figures of the production capacity by 2016 are the result of existing capacity or after extending it to scale up production during the years of the plan. That does not include figures of public health worker group, health management workers group and volunteers CHW which are surprisingly kept as current figures (2011) without any addition during the years of the plan (2012-16).

The institutes at pre-service production stage still adopt traditional curriculum that need major modernization and reform in addition to ensuring a functioning quality assurance (accreditation) system. Planning for new institutes to be founded in different provinces to increase production and initiate new tracks for new categories of HRH that the plan need to provide the national health system to meet the ambitious coverage, supporting PHC and ensure equitable geographic and category distribution of HRH and health care services.

The plan needs to focus more on scaling up the production to correct the overall ratio of HRH to population. As shown from table 1, the ratio at present is 2.2 per 1000 population and by the end of the plan in 2016 the ratio is estimated to go up to only 2.3. This ratio is still far away from reaching the 2.7 ratio that marks the passing border of overcoming the HRH crisis. In order to reach that, Afghanistan needs to scale up the production and strengthen the retention to increase the estimated (2016) total health workforce population from 71,442 to 82,944. Accordingly, planner should plan to increase institutional production capacity by 11,502. This can be achieved through planning to found new outlets to produce more community workers that can serve in the large number of planned Health Posts, Sub-Centres and Basic Health Centres.

Work is ongoing to ensure courses run by GIHS and MoHE are accredited. However, private institute courses are not accredited. Currently the Ibu ali Sina Balkhi Institute, Afzal Asas Institute and Nangarhar Science Institute run training courses for about 700 students a year in Kabul (nurses, midwives, and dental/laboratory/pharmacy technicians), but their courses have not been assessed according to established standards or accredited – This is required urgently.

Registration of health professionals in the private sector is managed poorly. Work is required to institutionally develop the Legislation Enforcement area of MoPH so private sector registrations can be managed through a computerised database, and remedial action monitored and managed.

The nine Institutes of Health Sciences have been very under-resourced for years. Only five of the nine are functional and have nursing and midwifery curricula that are up-to-date. Their facilities are inadequate, their curricula (unless supported by donors) are out-of-date, and their management and staff skills are low. Activity 5 of ANDS HR Cluster is to re-invigorate the Ghazanfar Institute of Health Sciences in Kabul and the 8 Provincial Institutes, which provide nursing, midwifery, physical therapy, technician pre-service and a number of in-service training courses for health workers, by upgrading the institutional structures, procedures, facilities and infrastructure, and capacity building the staff. A project funded by AFD and run by AKDN is shortly to begin to do some institutional development in GIHS and Badakhshan IHS.

▪ Postgraduate Development

Registration, Licensing, In-service Training and Continuing Professional Development (CPD-CME): In order to improve professional standards of health workers, it was agreed, through the MoPH December 2009 Workforce Plan, to establish transparent mechanisms for the above. This would include establishment of an MoPH/MOHE joint Committee and Professional Councils. Since then the joint committee has been established, but it has no Secretariat.

Also the Midwifery Association has worked with the Nursing and Midwifery Department within MoPH to establish an Afghanistan Midwives and Nurses Council, and AusAID is assisting in working towards establishment of a Medical Council. There is also a Physical Therapy Council. Many others are required, and a Coordinating Council. (Activity 3 ANDS HR Cluster).

Extensions and improvements are required through pre-training, and in-service training of existing staff, as follows:

- There has been a considerable upgrade and increase in community midwifery pre-service training in the last two years but more is required.
- Nursing training is beginning to improve with a degree course established, and a community nursing course, but the numbers being trained are small, and so regional general nurse training through IHSs and private institutions is an ongoing requirement.
- There are considerable needs for curriculum upgrade and in-service training for specialist doctors, nurses, and technicians. In the Nursing and Midwifery MoPH Policy and Strategy there is a proposed plan – From this an in-house system for in-service training needs to be developed.
- Health management and leadership training is required for MoPH central and provincial professionals and administrators. The main gaps for this training identified in the MoPH Needs Assessment and Capacity Building Plan February 2009 were: human resources, administration, hospitals, Institutes of Health Sciences, Provincial Health Offices, as well as independent directorates such as Legislation Enforcement, and Audit. There are similar needs for this in the private sector.

- **Recruitment Policies and Practice**
- **Deployment & Distribution Mechanism**

Remuneration: Remuneration is an issue in attracting and retaining qualified staff in both the private and public sectors. There are considerable inequities of salary between groups working in MoPH : civil servants, those contracted-out working through NGOs on BPHS and EPHS , and the 358 contracted-in as national consultants. Those paid by donors receive considerably more pay and allowances than civil servants, despite pay and grading increases (e.g. doctors working for NGOs get 50% more salary than civil servants, and "super-salaried" consultants often 5 times more).

These anomalies are a major de-motivating factor which encourages the practice of payment of bribes for service provision. It is also hard to attract good applicants to a unit or department that has no "super-salaries", as donors have selected high profile health areas, and the needy support areas are generally ignored. This was discussed in the preamble to the ANDS HR Cluster Activities proposal in August 2010, together with some solutions. Fee-for-service is being considered by Parliament for hospitals but not for health centres – This could address the problem for some staff, but be a huge burden on the poor.

Grading levels do not currently allow for specialisations and higher salaries in say, nutrition, audit, HR, medical engineering, neuro-surgery.

Appraisal and career progression are also not addressed adequately (although the procedures and Civil Employees Law [CEL] is clear) so people are not encouraged to stay working in the public sector.

The Ministry of Finance and Civil Service Commission are keen to address these issues together with MoPH.

Performance Management: It is a priority of the Government to eradicate corruption. The MoPH has planned to reduce corruption by establishing:

(a) A Transparency Working Group to establish standards, monitor processes, investigate system failings and recommend remedial action, and

(b) An independent Health Complaints Office to investigate health worker and patient complaints.

Although the former is established and the latter agreed by the 2009 Consultative MoPH Workforce Planning Committee including MoHE, MoF and CSC, neither have been implemented. Both will assist with HR problems, the latter also in the private sector. Action is required. (Activity 4 ANDS of HR Cluster)

Also the Disputes Resolution Commission required by CSC in all Ministries needs to be established in MoPH and MoHE.

- **Financing of HRH**
- **Key HRH Partners and Stakeholders**

Current and Future National Projections and Gaps: Current plan needs to target figures that ensure overcoming the HRH crisis as indicated by a ratio of total HRH per 1000 population of at least 2.7. The following tables show estimates of projections by 2016 and by 2020 to achieve that ratio. This needs careful costed plans that go beyond the MoPH to include extension of the HRH production capacity at national level through increasing students' enrolment in existing educational institutes and foundation of new institutes in provinces.

How to bridge the supply gaps to meet the plans target of total HW of 82944 to pas the ratio of 2.7 per 1000 population and overcome the HRH crisis by 2020?

HW category	Estimate 2011 staff MoHE (A) & private (B) (dual counted once) (A)	Current cumulative production capacity by 2016 (B)	Expand existing capacity (C)	Establish new capacity (D)	Other sources (E)	Total capacity increase (F)=C+D+E	New Target total number by 2020 (G)=(A+B+F)=14% of (A+B)	New target ratio per 1000 population
Doctors	6,830	3,029 (1/4 f)				1,380	11,239	0.37
Nurses: General,	8,690	3,178 (1/3 F)				1,662	13,530	0.44

Community, Anaesthetic and Auxiliary								
Midwives: hospital community and assistant	4,000	2,303				1,883	8,185	0.27
Dentists/dental technicians	3,000 (500/2,500)	1019 (408/611) (1/2 f)				565	4,584	0.15
Pharmacists/pharmacy technicians	3,050 (550/2,500)	1264 (419/845)(1/2 f)				605	4,919	0.16
Laboratory/radiography technicians	5,000	939 (777/162)(1/3 f)				1032	8,771	0.29
Other allied health workers: physiotherapists, orthopaedic technicians, psycho-social counsellors, etc.	300	125 (over ½ F)				350	775	0.03
Public health workers: health inspectors/ Vaccinators	2,715	-				680	3,395	0.11
Health management workers/skilled administrative or trade workers/trainers	6,000	-				840	6,840	0.22
Volunteer Community Health Workers	20,000	-				4,000	24,000	0.78
TOTAL QUALIFIED WORKERS	59,585	15,614				12,597	84,438	2.75

Extending national production capacity per individual institutional source

Institute (existing & proposed)	Category graduate	Gap till 2016	Current capacity till 2016	Proposed new capacity till 2016	Total planned till 2016	New gap? Notes
Kabul Med Inst.	Doctors					

- **SWOT Analysis (Main strengths, weaknesses, Opportunities and Threats**
- **Main Problems and Challenges**

Main Interventions:

(a) HRH staffing targets

The Targets have been set based on the objectives in the previous section, and build on the expected employment from pre-service training already scheduled and shown in Table 1.

The target ratio of doctors/nurses/midwives combined is 13 per 10,000 by end 2016, which is considered just about feasible if there is a huge focus on training of nurses and midwives, however availability of suitable students could be a problem. It would not be possible to aim for the 23 per 10,000 target which WHO considers the critical threshold.

The target for all skilled health professionals/technicians and qualified support management/technical staff would be 39 per 10,000. This includes doubling the volunteer community health workers so each aid post is staffed (currently only half are). This explains the considerable increase.

THERE SHOULD BE A FEASIBLE TARGET TO REACH TOTAL HRH RATIO OF 2.7 TO OVERCOME THE HRH CRISIS AT LEAST BY 2020. (see tables on projections) . The figures in this table are unrealistic and can not be achieved in 2016. Take an example of increasing dentists and pharmacists from 500 to 2000 as expanding students enrolment or establishing new colleges take at least 4-5 years before graduation and by that time (2016) only one batch will graduate and will never make the 2000 target.

See details in Table 2 below.

Table 2: Targets for staffing ratios, numbers by year, and rural/urban and gender distribution

Category	Current Numbers – all agencies (May 2011)	Target Ratio per 10,000 population	Year Employment Targets				
			2012 (population 27.59M)	2013 (population 28.70M)	2014 (population 29.36M)	2015 (population 30.03M)	2016 (population 30.72M)
Doctors	6,830	3.21					9,242
Nurses	8,690	6.14					17,981
Midwives	4,000	4.00					12,400
Dentists	500	0.65					2,000
Dental technicians	2,500	1.62					4,978
Pharmacists	550	0.65					2,000
Pharmacy technician	2,500	1.56					4,800
Laboratory Technician	4,500	2.05					6,300
Radiography technician	500	0.65					2,000
Physical Therapists	316	0.65					2,000
Orthopaedic Technicians	170	0.33					1,000
Vaccinators	2,579	0.98					3,000
Environmental health workers	136	0.08					250
Psychosocial counsellors	100	0.65					2,000
Health management workers/skilled admin or trade workers/trainers	6,000	2.60					8,000
Volunteer Community Health Workers	20,000	13.02					40,000
TOTALS	59,585	38.84					119,951

These targets are based on WHO ratios, however, workforce planning requires a range of considerations – population projections, utilisation rates, demand rates based on prevalence of diseases, and workload estimations based on local area situations (including travel time and local health priorities). Regarding the latter, the Workload Indicators of Staffing Need (WISN) approach is the ideal, although resource intensive. It is suggested that a simple variation of this approach be developed for local planning by health facility staff and professional health categories, and some funding be provided for such work.

Project	Inputs	Targeted Outputs	Time period	Costs USD and funder if known
Employment of additional qualified staff	Pre-service training first, so these additional staff are qualified	60,366 staff more than current – much more than 2.3% population increase a year	5 years	?????
Local area workforce planning	Training of health facility staff in simplified WISN approach and support for planning	Some simple “bottom-up” provincial forecasting to feed in to Workforce Planning.	5 years	5M

Project	Inputs	Targeted Outputs	Time period	Costs USD and funder if known
	workshops.			

(b) Education, training and skill development of HRH

1. I**n-service training for medical specialists** who are Trainers of Hospital Medical Specialists, following the development of **Updated Curricula** (ANDS HR Cluster Activity 7). 13 medical speciality curricula will be upgraded to international standards, and 383 MoPH trainers and ??? MoHE and private hospital trainers will be trained in the new curricula, over 3 years.

2. **In-service nursing and technician curricula to be upgraded, and training** instituted to accredit participants according to the skills in the new curricula (ANDS HR Cluster Activity 8). This will be implemented through the nine MoPH Institutes of Health Sciences, with on-the-job training in hospitals (? Also in MoHE and private institutions?)

3. **Community Nurses** – There are 300 community nurses to be trained, funded by donors over the next 2 years. The program needs to be extended (as for community midwives) so as to produce 3500 additional in provinces, using the approved two year program, by the end of three years.(Activity 9 ANDS HR Cluster proposed just 400 in 3 years).

4. **General Nurses – Extend Nursing Degree (MoHE) and Registered Nurse Training (MoPH) –** The Nursing degree course needs to be extended to regional centres, and the Institute of Health Sciences nurse training extended, so an additional 3500 nurses (combined from both courses) are deployed in the 5 years.

5. **Community Midwives–** to extend midwifery training by an additional 6000 above the scheduled program, through established provincial midwifery schools, by the end of 5 years. (Activity 10 ANDS HR Cluster proposed 1000 in 3 years – this needs to be extended)

6. **Community Physical Therapists –** To implement community physical therapy training in provinces as designed and approved by Physiotherapy Institute, under auspices of Institutes of Health Sciences, so an additional 800 skilled physical therapists are functioning at the end of 5 years. (Activity 11 ANDS HR Cluster proposed 200 in 3 years, this needs to be extended)

7. **Community Mental Health Workers –** To train 600 psychosocial counsellors in 5 years and implement in-service training for 1000 health workers to reduce high level of mental disorders. (Activity 12 ANDS HR Cluster proposed pre-service training of 60 psychosocial counsellors and in-service training of 1000 health workers in 3 years. The training of psychosocial counsellors needs to be extended to 600).

8. **New University Accredited Degrees for Bio-medical Engineers, Medical Technologists and Environmental Health Specialists –** Develop curricula and train 100 students in each. MoHE (Activity 13 ANDS HR Cluster proposed this for 3 years, but with a preliminary curriculum development year, this project needs to be extended for 4 years so the training is complete and they are employed).

9. **Health Management and Leadership Training for health workers.** In-service training of general managers and administrators in the central and provincial offices of MoPH through the Directorate of Capacity Building in GDHR will be supported by USAID. Hospital

management training will be supported by AusAID. Training of Public Health doctors in management will be collaboratively worked out between APHI and MoHE. Approximately 1600 staff will be trained in management/administrtion. (Activity 14 ANDS HR Cluster for 3 years)

10. **Expansion of Community Health Worker Training**. To train an additional 20,000 over 5 years. (Activity 15 ANDS HR Cluster was to train 10,000 over 3 years – this needs to be extended)

Project	Inputs	Targeted Outputs	Time period	Costs USD and funder if known
1. Medical Specialist curriculum upgrade, in-service training, and accreditation of trainers	26 international specialists to develop curricula and train. International organisations to accredit.	13 curricula updated. 383 MoPH & ?? MoHE and private trained and accredited.	3 years	14.679M for MoPH – add MoHE and private.
2. Curriculum upgrade and in-service training of nurses and technicians	Consultancy to coordinate curriculum development	Curricula in first year and 1267 staff trained in following 2 years – add MoHE and private	3 years – but needs to be ongoing	7M for MoPH for – add MoHE and private
3.Training of Community Nurses	Coordinated through IHS	3500 additional trained in provinces	5 years	59.719M Various through GCMU
4.Training of General Nurses	RGN through GIHS, Nursing degree through MoHE. Bridging courses for existing Diploma Nurses through MoHE.	3500 additional trained in provinces, some through IHS and some MoHE.	5 years	59.719M
4.Training of Community Midwives	Consultancy to plan and coordinate through NGOs. Degree course to be considered by MoHE.	6000 additional with diploma, and maybe some with degree.	5 years	47.25M. Various through GCMU
5.Training of Community physical therapists	As above	800 trained	5 years	14.7M.
6.Training of health workers in mental health	Coordinate through Mental Health Department	1000 health workers trained in-service. 600 psychosocial counsellors – new.	3 years 5 years	1.6M 2.5M
7.Training of Biomedical Engineers, Medical Technologists and Environmental Health Specialists	Through MoHE	Curricula developed and 300 students trained (100 of each)	5 years	10.63M
8. Management training of: (a) central/provincial MoPH general managers/administrators. (b) Hospital managers; (c) Public health doctors.	(a) GDHR with USAID (b) Hospitals with AusAID © APHI and MoHE through collaboration	Roles defined and courses accredited, and 1600 trained in central/provincial administrative areas, hospitals and public health locations.	3 years	6.3M

Project	Inputs	Targeted Outputs	Time period	Costs USD and funder if known
9. Expansion of Community Health Worker Training	Coordinated by MoPH	20,000 trained	5 years	14.70M

(c) HRH institutional development and management

1. Undertake **Institutional Development and Training of the Human Resources General Directorate in GDHR** (HR Cluster Activity 1). This would link with AusAID plans to assist in upgrading the HR database (in collaboration with USAID) and records management system, and the CTAP USAID project which is to train HR Officers in the provinces, as well as in central departments. These activities need to be enhanced and combined with recruitment of competent HR Officers, and establishment and implementation of procedures (in alignment with the CSC laws and procedures) so that operational planning and all procedures (including recruitment, appraisal, etc.) are carried out efficiently and effectively, allowing for decentralised management and computerised records, according to the MoPH Policy.

2. **Improve professional standards of health workers**, through establishing transparent mechanisms for establishing standards, registration, accreditation of curricula, and management of professional misconduct. This would include providing a resourced secretariat for the MoPH/MoHE joint Committee and Professional Councils. Professional Councils would be developed for all health worker categories (some in combination), and coordination of all councils under a national professional council. This all needs to be managed through the MoPH/MOHE Joint Secretariat. (Activity 3 HR Cluster).

3. **Negotiate and implement remuneration packages** with MoPH, MoHE, Private Organisations, Donors, CSC, and MoF which will adequately recompense workers relating to their skill levels, and there is equity across sectors. The agreement would also include allowances, and retirement pensions.(Proposal in MoPH HR Cluster Proposal August 2010). A draft of proposed remuneration levels for specialised staff categories is at Annex B.

4. **Reduce corruption** by effectively implementing two mechanisms; (a) a high level Transparency Working Group in MoPH, which has been established to set standards, monitor processes, investigate system failings and recommend remedial action, and (b) An independent Health Complaints Office to investigate health client and worker complaints, across the public and private sectors. And establishment of the Dispute Resolution Commission as required in Civil Employees Law in MoPH and MoHE.(HR Cluster Activity 4)

5. **Re-invigorate the Ghazanfar Institute of Health Sciences** in Kabul and the ten Provincial Institutes, which provide nursing, midwifery, physical therapy, technician pre-service and a number of in-service training courses for health workers, by upgrading institutional structures, procedures, facilities and infrastructure, and capacity building the staff. (HR Cluster Activity 5)

6. **Institutional development and capacity building at National Hospitals**, and adoption of improved HR standards, so as to achieve improved service delivery. (HR Cluster Activity 6 and now in separate New Policy Proposal of MoPH as part of Hospital Reform).

Project	Inputs	Targeted Outputs	Time period	Costs USD
1. MoPH HR Institutional Development, Training and HR Database upgrade	Computers Trainers HMIS specialist. Employment of skilled HR specialists.	Upgraded database and record system. Qualified and skilled HR Officers centrally and in provinces	3 years	4.725 M. Some through DAFA and CTAP
2. Professional Councils Secretariat	Need one international and two local staff, and associated equipment and infrastructure	Professional Councils set up for all professional groups, and systems for registration and accreditation implemented nationally.	5 years	2.5M (Medical Council planning already funded through DAFA)
3. Remuneration Review and Implementatio n	3-Ministry Task Force (CSC/MoF/MoPH)	An implemented equitable improved pay and grading scale across the health system	1 year for Review – 2 more years for Implementation.	1M for review and ???? for salary increases
4. Anti-Corruption Initiatives	Managing Consultant. 2 local staff. Infrastructure and Secretariat to run.	Functioning MoPH Transparency Working Group. Independent Health Complaints Office operational. Dispute Resolution Commissions implemented.	5 years	3.5m
5. Institutes of Health Sciences	Consultant and contractors	Institutional development achieved, capacity built staff, and improved facilities	3 years	8.925. (Part already funded through AFD (GIHS and one IHS)
6. National Hospitals	Consultant and contractors	8 hospitals have achieved institutional development of HR processes, and capacity building of staff	3 years	Part of a $94.5M proposal for hospital reform (?$8.925M).

(d) HRH research and development

1. **Complete data set (profile) for the private sector** and independent NGOs/INGOs: Currently there has only been a small sample survey of private services in a few provinces. Although there appear to be large numbers in some rural provinces, it is assumed that many are unqualified. A 3-6 months data collection process of collecting data from large organisations and using the Delphi process to get professional judgements of qualified staff by category in provinces is suggested. Later, a profile would need to be developed with the professional associations as they are developed. (This would update further the Afghanistan HRH Profile draft updated July 2011). The Futures Group is working with the Private Hospitals Association, and the MoPH Public/Private Partnership and HMIS on some private sector indicator data collection, but has not yet progressed to planning collection of data on staffing, so this would need to be undertaken collaboratively, but separately, due to the urgent need.

2. There is a need to undertake research and **development of other professional councils for other health worker categories.**

3. **Test incentive and rotation packages** to encourage health workers to work in rural and remote areas.

4. **Conduct study on remuneration/expenses for community health workers,** and the impact on their performance.

Project	Inputs	Targeted Outputs	Time period	Costs USD
1. Develop data set for private health, and independent NGOs.	Part-time consultant. Employ a local researcher for 3-6 months. Then, a local staff member linking with Professional Council development, working with HR Database team in GDHR (linked through MSH).	Afghanistan HRH Profile updated July 2011 - updated again to include all this data, and this 2012-2016 National HRH Workforce Plan updated.	2 years establishment and 3 years data input and maintenance	2.2M (1M for first two years and then 0.4 a year for last 3.)
2. Research into establishment of professional councils for other professions	Consultant	Councils established for all major groups, individually or in combination.	2 years	0.6M
3. Conduct study of health worker accessibility in rural areas and test incentive packages	Consultant	Recommendations accepted and implemented.	1 year	0.3M
4. Examine impact of remuneration of CHWs on their performance	Consultant	Recommendations accepted and implemented	I year	0.3M

4. Strategic Directions

Guiding principles, Strategic Goal, Strategic Aim, Strategic Objectives (SO) and Strategies of each SO).

Guiding principles

Equity

Quality

Accountability

Partnership

Transparency

Satisfaction

Strategic Goal

To overcome the HRH crisis through scaling up HRH production, implementing an effective retention policy, and improving performance through quality assurance of education and continuing development to support the equitable coverage of population.

Strategic Aim

To produce, deploy and retain a well-trained health workforce, possessing the skills needed to deliver affordable and equitable health services to the population of Afghanistan.

Strategic Objective 1 (SO1): Scaling up production

Strategies 1-1, 1-2, 1-3

Strategic Objective 2 (SO2): Implementing effective retention of HRH

Strategies 2-1, 2-2, 2-3

Strategic Objective 3 (SO3): Improving Individual Professional performance

Strategies 3-1, 3-2, 3-3

Strategic Objective 4 (SO4): Strengthening HRH functions at central and peripheral levels

Strategies 4-1, 4-2, 4-3

5. Implementation Plan

Partners and Responsibilities, Action Plan, Assumptions.

This needs detailed costed operational action plan as current plan is not costed as per GHWA criteria; if agreeable we can develop such plan.

6. Monitoring & Evaluation

Monitoring and Evaluation Framework, Indicators, Data Source, Timeline.

SO	Strategy	Activity	Indicator	Data Source	Responsibility	When

7. Financing the plan

The additional costs nominated for the projects in the section above are: Staffing (not yet assessed as dependent on remuneration review and agreement to specialist higher salaries and equitable salary levels), Education/training: $191.55M; Institutional development/management , $29.58M; and Research, $3.4M. The total for the last three is $224.53M.

In the past funding for initiatives has been by short-term project funding from donors. This has been irregular, and many initiatives have been stopping when funding ended. Through ANDS, following the donor conference in 2010, it was agreed by USAID that HR funds to MoPH should go through GDHR. In this way needed initiatives can be coordinated and ongoing. This approach is in its infancy (an on-budget approach) and is a pre-cursor to establishing a SWAp (sector-wide approach), which is being developed in MoPH. The MoPH parts of this Plan will be funded through the development budget, as there will be inadequate funds through operational budget. Currently proposals are being included in the New Policy Proposal for the Ministry.

Funding of MoHE aspects will be xxxx

Private sector aspects

SO	Strategy	Activity	USD Cost	Source 1	Source 2	Total

Total						

8. References

1. HMIS Department, MoPH: Afghanistan Health Indicators, Fact Sheet March 2010, - latest available figures.
2. MoPH/WHO: Health Workforce Observatory, Human Resources for Health, Afghanistan Profile, November 2009, and draft update December 2010.
3. MoPH: Human Resources for Health Policy 2010-2013, Strategy and Plan 2008-2010.
4. MoPH: National Health Workforce Plan 2009-2013, December 2009.
5. HR Cluster, Ministry of Finance, for Kabul Donor Conference, Bankable Program Number Five, Human Resources for Health, July 2010.
6. MoPH: Detailed 16 Project proposals for consideration in next stage of donor conference discussions, Draft 11 August 2010.
7. MoPH: Analysis of Stakeholders in Afghan Human Resources for Health (HRH) and Planning and Development for an Effective National HRH Coordination Forum. Draft December 2010.
8. Shipp P. Workload indicators of staffing need (WISN): a manual for implementation. Geneva, Switzerland: World Health Organisation, 1998.

9. Appendices

A. Proposed HRH Consultative Forum Members

Organisation	Name	Title	Phone	Email
MoPH	Dr Suraya Dalil (Chair)	Acting Minister	020231377/0795 101420	Moph.tdd@gmail.com
	Dr Ihsanullah "Shahir"	Acting Director General (DG) of GDHR	0776126048/079 9329265	Dr.shahir2006@gmail.com
	Dr Ahmad Jan	Acting DG of GDPP	070207826	ahmadjn@hotmail.com
	Dr Noormal	Acting DG of APHI	0700281134	noormalb@yahoo.com
	Dr Kimia Azizi	Director, GIHS.	0788807611	gihs_kabul@yahoo.com
	Dr Husnia Sadat	Head of Health Care Financing	0778324758	drhaseena_sadat@yahoo.com hefd.hsadat@gmail.com
	Dr Sarwar Homayee	HR Consultant, GCMU	0787383559	Sarwar.homayee@yahoo.com
MoHE	Prof. Dr Shirin Aqu "Zarif"	Chancellor of KMU	0700292521	Zarif150@yahoo.com
MoHE	Dr Said Najmuddin	Director of Student Affairs	0700298426	Sn.jalal@hotmail.com
MoHE	Mr A Karim Soroush	Director of the Private Higher Education Institutes	0794953003	Karim_soroush@yahoo.com;karim_soroush@mohe.gov.af
MoF	Dr Waheedullah Popalzai	Health Sector Manager, Directorate-General Budget	0700279767/070 0161191/079935 1754	Waheedullah.popalzai@budgetmof.gov.af Waheed.popal@gmail.com

Organisation	Name	Title	Phone	Email
CSC	Mr Mohammad Essa Rahimi	Legislation and Policy Research Head	0799202165	Er.raheme@gmail.com
USAID	Dr Faiz Mohammad Faiz	Health Team Leader	0799187515/070 0108001	fmohammad@usaid.gov
World Bank	Dr Sayed	Adviser	0700042585	gsayed@worldbank.org
EU	Mr Romin	Task Manager, Health Section	0795226703	romain.boitard@ec.europ a.eu
WHO	Dr Sharif Haqmal	Gender and HR Officer	0799135714	Sharif_haqmal@yahoo.co m
Support to Health Service Provision (SHSP)	Dr Martine Catapano	Team Leader	0799597787	catapanom@yahoo.fr
Techserve (MSH)	Dr Ghulam Rafiqi	Capacity Building Program Manager	0706155628	Grafiqi@msh.org
Private Hospitals Association	Dr Aminullah	Director	0700286484	c/- APHA Coordinator Engineer Bakht Mohd bakht_md@yahoo.com
Public Health Association	Dr Salehi	President	0700040642	salehiahmadshah@yahoo. com
Midwifery Association	Ms Sabera Torkamani	President	0799692754	Ama_president@afghanm idwives.org; sabera7@gmail.com
Nursing Association	Mr Sayed Mohammad Reza Safdari	President	0799048183	ssafdari@jhpiego.net
Integrity Watch Afghanistan	Dr Yama Torabi	Director of Research and Development	0799271624/070 7683787	Yama.torabi@gmail.com yama.torabi@iwaweb.org

B. Terms of Reference: Nursing and Midwifery Health Workforce Planning Sub-Committee of HRH Consultative Forum

Goal: Bridge the future gap of nurses and midwives in the health care system and develop evidence-based gold staffing standards for Afghanistan's Nursing and midwifery workforce.

Background: The current workforce does not match the current or future required model of care. For example, in primary care, which is the foundation of the ideal model of care, WHO states that the minimum number of doctors, nurses and midwives (combined) required per 10,000 population is 23. The Afghanistan public sector has 5.6, which is a quarter of this. These figures emphasize that the allocation of resources does not rise to the required model of care. Afghanistan's current recruitment and retention strategies and its medical education capacity are a potential constraint for future requirements.

Afghanistan's health system is going through an evolution and this is the best time when the country can develop its Human Resource for Health (HRH) based on the globally approved best practices. After transition, MoPH has made considerable success; however, there is a long way to go. A few of the major challenges are as follows, but not limited to them:

- Shortage of female health workers,

- There no concept of skills mix in the hospitals - still no gold standards for staffing in the regional and tertiary care hospital.
- Inadequate positive work environment for nurses and midwives, like long duty hours, unsafe staffing etc.
- Inadequate Career Pathways for Nurses and Midwives.
- Inadequate opportunities for professional development i.e. continuing education and higher education opportunities.
- Inadequate protection from occupational hazards.

The above mentioned challenges lead to job dissatisfaction which leads to absenteeism, lack of interest in work, de-motivation and ultimately leads to withdrawal from job. Afghanistan has a platform namely consultative forum (CF) which is primarily responsible to take all the strategic directions pertaining to health workforce planning; however, the larger forum also needs a sub-committee which can diligently work on the specific issues.

Therefore, the sub-committee has been formed in order to fullfil the following **Scope of Work:**

1. Review HRH priorities for immediate, medium, and long-term of HRD.
2. Conduct situational analysis of nursing and midwifery workforce situation.
3. Assess the workload pressure of the health workers in Essential Package for Health Services (EPHSP).
4. Determine how many health workers are required to cope with actual workload in a given facility
5. Estimate staffing required delivering expected services of a facility based on workload.
6. In collaboration with other multidisciplinary groups, agree on an appropriate and practical methodology for workforce planning to ensure appropriate skill mix.
7. Calculate workload and time required to accomplish tasks of individual staff categories.
8. Compare staffing between health facilities and administrative areas.
9. Establish fair workload distribution among staff.

Deliverables:

1. Gold standards for Nurse-patient ratios
2. Gold Standards for Midwives/client ratios
3. Standard ratios for specific specialties like ICU,CCU, HDUs etc
4. Recommend appropriate skills mix
5. Detailed report on situation analysis

Composition:

1. Representative of AMA
2. Representative of ANA
3. Representative of Hospital Task Force

4. Head of Nursing and Midwifery Department
5. GIHS Representative
6. Representative of HRD
7. Representative of GDCM
8. Head of Hospitals (National)
9. Representative of WHO
10. Representative of RHD
11. Representative from French Medical Institute for Children (FMIC)
12. Representative from Health Services Support Project (HSSP/Jhpiego)
13. Representative from Aga Khan University- Afghanistan Program
14. Others?????

Reporting: The HRH sub-committee will report their progress to the National HRH Consultative Forum.

Chairperson: With the consensus of members, a chair will be appointed **OR** DG – GDHR will chair the meetings.

Meetings: Committee members will decide the frequency of their meetings; however, ideally in the initial phase they should meet on a monthly basis.

C. *Proposed Addendum to NGO Salaries Guidelines*

Introduction

Various MoPH planning documents since late 2009 have recommended that salaries need to be equitable across civil servants, and health workers contracted in or out, for specific job categories, if required staff are to be recruited and retained. These documents are: (a) the MoPH Workforce Plan 2009-2013, (b) the ANDS HR Cluster 16 Activities Proposal from MoPH, and (c) the National Workforce Plan 2012-2016 which is currently being drafted.

An extract from the current document, which is being developed jointly with CSC and MoF, follows:

"Remuneration is an issue in attracting and retaining qualified staff in both the private and public sectors. There are considerable inequities of salary between groups working in MoPH : civil servants, those contracted-out working through NGOs on BPHS and EPHS , and the over 500 contracted-in as national consultants. Those paid by donors receive considerably more pay and allowances than civil servants, despite pay and grading increases (e.g. doctors working for NGOs get 50% more salary than civil servants, and "super-salaried" consultants often 5 times more). These higher salaries are not sustainable.

These anomalies are a major demotivating factor which encourages the practice of payment of bribes for service provision. It is also hard to attract good applicants to a unit or department that has no "super-salaries", as donors have selected high profile health areas, and the needy support areas

are generally ignored. This was discussed in the preamble to the ANDS HR Cluster Activities proposal in August 2010, together with some solutions….

Grading levels do not currently allow for specialisations and higher salaries in say, nutrition, audit, HR, medical engineering, neuro-surgery. ….

The Ministry of Finance and Civil Service Commission are keen to address these issues together with MoPH.

Objective:

To attract and retain qualified staff in both private and public sectors, by establishing agreed remuneration standards which are equitable across the civil service, NGO and private sectors, through advancing the following actions by 2016:

- *The CSC will work towards amending the Civil Employees Law so as to allow higher salary levels for specialist categories of staff.*
- *The CSC and MoF will work towards employing MoPH contracted-out and contracted-in staff in BPHS/EPHS as civil servants, and all long-term local consultants funded by donor projects will be moved into civil service line positions. These staff will all pay pension contributions, and have security of employment. The salary and allowance conditions will be equitable between civil servants and the ex-contractors, which may involve a top-up for civil servants in areas previously not supported by donors, in the medium term by donors."*

Proposed Salary Levels to Recruit and Retain Required Staff by Category

Calculations have been undertaken as part of the BPHS Salary Guideline development process, which has just approved through the Consultative Group on Health and Nutrition (CGHN), and through the Hospital Reform process. The specialist administrative and technical positions have not been assessed adequately in the past.

The following is a table with proposed salary levels and allowances across all sectors (public, private, NGO). The levels are copied from the BPHS salary guidelines recently approved by CGHN, and extended to include other categories with comparative salaries for comparative skill levels.

It is proposed this be used as the basis for amendments to the Civil Employees Law regarding salary levels for specialist positions, and for costing salaries by MoF in the future.

It is essential that these salaries only be paid to those with the specific qualifications that meet agreed national professional and technical standards, and not people currently in the positions who are unqualified in the required speciality.

Many people who would be employed in these categories would head Units or Directorates which already exist in the Organogramme, and be senior staff in those Units, both at central and PHO level,

as well as in BPHS and EPHS. This is essential so each specialist area has two well-qualified staff who can manage the speciality, and train others on-the-job.

Qualified Staff Categories	MoPH Work Areas	Current Salary Maximum	Proposed Salary
General Doctor	BPHS	8,245 - 9700	11,235-12,596
Specialist doctor/general surgeon	BPHS EPHS National Hospitals	21,825 16,000 16,000	28,341 28,341 28,341
High level speciality doctor e.g. Neurosurgeon, Psychiatrist	Regional (EPHS) National Hospitals	16,000 16,000	30,000 60,000
Health Service Administrator	CHC BPHS District Hospital EPHS National Hospitals, Ambulance Service, Central Hospitals Directorate	4,850 9,700 22,400 22,400 11,900 11,900	6,298 12,596 30,000 60,000 30,000 30,000
Health Service Medical Director	EPHS National Hospitals, Dialysis Unit.	22,400 22,400 11,900	30,000 60,000 30,000
Health Service Nursing Director	EPHS National Hospitals, Nursing and Midwifery unit	22,400 22,400 11,900	30,000 30,000 30,000
Anaesthetic Nurse or Intensive Care Nurse (specialities)	BPHS EPHS National Hospitals	7275 7500 7500	9447 9447 9447
General Nurse	EPHS and National Hospitals	7500	8817
Community Nurse	BPHS	5335	6928
Hospital Midwife	EPHS and National Hospitals	7500	8817
Community Midwife	BPHS	6790	8817
Dentist (Stomatolgist)	BPHS and Oral Hygiene Unit	8245	10707
Dental Technician	BPHS and Oral Hygiene Unit	4850	6298
Pharmacist	Pharmacy GD; Hospitals	7275	9447
Pharmacy Technician	Pharmacy GD, Hospitals	5335	6928
Laboratory Technician	BPHS, EPHS and National Hospitals	5353	6928
Radiography Technician	As above	5335	6928
Physical Therapist	As above and Disability and Rehabilitation Unit	5335	6928
Physical Therapy/ Orthopaedic Technician	As above	4365	5668
Psycho-Social Counsellor	BPHS, EPHS and National	7500	8817

Qualified Staff Categories	MoPH Work Areas	Current Salary Maximum	Proposed Salary
	Hospitals		
Psychologist	As above and Mental Health Unit	7500	30,000
Bio-Medical Engineer	Hospitals	7500	30,000
Environmental Health Specialist	Environmental Health Directorate and Community/Hospitals	7500	30,000
Nutritionist	Public Nutrition Unit and Community	7500	30,000
Health Promotion Specialist	Health Promotion Directorate, Nutrition, Community Health, Drug Demand Reduction.	7500	30,000
Medical Technologist	Blood bank, Diagnostic Services, Radiography	7500	30,000
Vaccinator	BPHS	4365	5668
CHW Supervisor	BPHS	4850	6298
Human Resource Specialist	GDHR, GIHS,APHI	11,900	30,000
Economist/Financial Management Specialist	Admin and Finance GD, DHCF, GCMU. Employees Insurance. PHOs, All GDs and Directorates	11,900	30,000
Procurement/stock control/maintenance specialist	Procurement , all GDs, hospitals and PHOs.Central Stock Unit Central Workshops	11,900	30,000
Auditor	Internal Audit Directorate	11,900	30,000
Lawyer/Regulation Specialist	Legislation and Regulation Enforcement Directorate, Food and Drug Authority.	11,900	30,000
Information Management/Records Management Specialist/Librarian	HMIS, HR Database All GDs, PHOs.	11,900	30,000
Engineer/Project Management Specialist	Construction	11,900	30,000
Specialist in Public Health/Epidemiology	Surveillance, Research, Drugs, CDC (AIDS, TB, Malaria), Nomads, Vaccination, Child/ Adolescent Health, Emergency Preparedness.	11,900	30,000
IT Specialist	IT Unit All GDs, Hospitals and PHOs	11,900	30,000
Public Policy and Management Specialist	GD PP and International Relations, and all GDs and PHOs	11,900	30,000

Qualified Staff Categories	MoPH Work Areas	Current Salary Maximum	Proposed Salary
Monitoring and Evaluation Specialist	M&E and all GDs and PHOs.	11,900	30,000