BRIEFINGS

The Afghanistan country office and its programs

INVESTING IN HEALTH WORKERS TO SAVE CHILDREN'S LIVES

Bringing care closer to communities in Afghanistan

Save the Children

ABOUT US

Save the Children is an international independent non-governmental, non-profit, organisation founded in 1919. We work in over 120 countries worldwide.

We are the world's leading independent organization for Children.

Our vision is a world in which every child attains the right to survival, protection, development and participation.

Our mission is to inspire breakthroughs in the way the world treats children and to achieve immediate and lasting change in their lives.

Save the Children has worked in Afghanistan since 1976. Our way of working close to people and on their own terms has enabled us to deliver lasting change to hundreds of thousands of children in the country.

THIS PAPER

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1. No health without health workers

Whilst Afghanistan continues to bear a high burden of maternal, newborn and child deaths, there has been significant progress in the reduction of child and maternal mortality in recent years. One in ten Afghan children now die before the age of five, a rate that has halved in the past ten years (1). One in every fifty women in Afghanistan will die from pregnancy related cause in her lifetime. Previous data showed the rate to be one in every eleven women. (2)

Much of this can be credited to improvements in the health system, particularly the introduction and expansion of the Basic Package of Health Services (BPHS), which has brought health care closer to communities. Central to this achievement is an increase in the number and capacity of skilled health workers. It is estimated community health workers (CHWs) treat about 40 percent of all sick children. (3)

"It is estimated that community health workers treat about 40% of all sick children"

Globally, a child is five-times more likely to survive to their fifth birthday if they live in a country with enough midwives, nurses and doctors. (4) Frontline health workers – those health workers based in the community that are the first, and often only, point of contact with the health system for many people – are critical to saving children's lives in Afghanistan. Without adequately supported (5) frontline health workers, no vaccine can be administered, no life-saving treatments given, no family planning services provided and no woman given skilled care dur-

ing pregnancy and childbirth. Without health workers conditions like pneumonia and diarrhoea – which can be treated easily by someone with the right skills, drugs and supplies – become deadly.

There are four main challenges facing Afghanistan's human resources for health: (6)

1. Shortage of skilled health workers
There are too few health workers to meet current and future demands for improving child and maternal survival. In order to deliver basic healthcare to all the World Health Organization (WHO) estimates that at least 23 doctors, nurses and midwives are needed for every 10,000 people. (7) The Afghan public health sector has 4.8. (8) There is also a shortage of health workers with specific skills in reproductive and child health.

2. Gender imbalance
To continue to reduce maternal and infant mortality, Afghanistan needs to increase its skilled female workforce in the sector. Female workers currently make up only 25 percent of the workforce. (9) Nearly a quarter of all health facilities do not have a female health worker. (10)

3. Uneven geographical distribution
A disproportionately large number of health care workers are concentrated in urban areas. There are 4.5 health workers per 10,000 people in rural provinces, compared with 16 per 10,000 in larger, more urban provinces. (11) In addition, conflict and insecurity in many parts of the country provide challenges in recruiting and retaining trained staff. Retention of midwives is a third lower for those working in insecure provinces. (12)

"A shortage of health workers with specific skills in reproductive and child health"

4. Weak retention: remuneration and support
There is a lack of clear data on retention of different cadres of health workers. Data that does exist shows weak rates of retention; the retention rate for community midwifery graduates is less than two-thirds. (13) Appropriate remuneration, supervision, training and support, such as equipment and infrastructure, is critical for attracting and retaining skilled health workers.

This report focuses on the types of frontline health workers that are most critical to child survival. To overcome Afghanistan's health worker challenges and strengthen the health workforce this paper makes the following recommendations to the Government of Afghanistan, supported by international donors and non-governmental organisations:

- Increase the enrolment rates for midwives to train 6300 midwives by 2016 and attain 95 percent skilled birth attendance.
- Increase the number of Community Health Supervisors from one per health facility to two per health facility (one male, one female) to improve capacity for supervision to community health workers, particularly females.
- Develop short to medium term on-site bridging courses for women with less than ten years formal education until the applicant pool has a sufficient number of women from prioritized districts needing midwives and nurses.
- Develop, review and implement comprehensive deployment plans six months prior to midwifery and nursing graduation to ensure the position is available and that security is sufficient at the planned deployment site.
- Improve professional development opportunities including cadre management, career pathways, recruitment, training, and deployment, particularly for skilled birth attendants, as is outlined in the Reproductive Health Strategy 2012-2016. Improve the MoPH HMIS and HRMIS databases to support this.
- Pilot and introduce rotation schemes with the clear aim that professional health workers spend part of their time in rural or remote areas.
- Standardise and improve the quality in-service training by supporting the development and implementation of the new in-service training guidelines managed by Ministry of Public Health Human Resources Department.

"6300 Afghan midwives should be trained by 2016"

Range of health workers: mobile health team doctor, community health worker, head nurse at rural health post, midwife.

II. Political commitment and policies

The overarching Afghanistan National Development Strategy 2008-2013 seeks to address three main challenges related to the health workforce in Afghanistan. These are: low production of trained health workers, misdistribution and low retention and weak remuneration.

Considerable planning for public Human Resources for Health has been undertaken by the Ministry of Public Health in recent years. This includes an approved Human Resources Policy for 2010-2013, the first National Policy for Nursing and Midwifery Services for 2011-2015 and a new strategy to streamline and align in-service training is currently being developed. Other policies, such as the Reproductive Health Policy and Strategy 2011-2016, outline specific requirements for increased numbers and capacity of health workers, particularly at community level, across Afghanistan.

"The new Health Workforce Plan is a significant step forward"

One of three major components of the recent National Priority Plan (NPP): Health for All Afghans, finalised in July 2012, is aimed at increasing human resource capacity to meet rising demand. (14) The development of the recent Afghanistan National Health Workforce Plan 2012-2016 also marks a significant step forward. (15) A National HRH Consultative Forum: a permanent advisory body for the Ministry of Public Health and other relevant Ministries consisting of representatives from Ministries, donors, NGOs and professional organisations, was established, but is not consistently active.

Despite this recognition of the importance of increasing the supply and quality of services provided by health workers in current policy frameworks, policy gaps remain and there is a lack of clear targets and objectives in some areas, such as the number of nurses and midwives. The implementation of the existing policy must be strengthened, for example the new workforce plan 2012-2013 is not finalised, nor a costed implementation plan developed.

Health for all Afghans. A mother waits with her children in a local health post in rural Jawzjan for the midwife to see her.

III. Overcoming the challenges

There are four main challenges facing Afghanistan's human resources for health.

A. Shortage of skilled health workers

The following 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).

Category	**Current number** (16)	**WHO target ratio**	**Current ratio** (17)
Doctors	6628 (18)	3.21 (19)	2.11
Midwives (20)	3000	4.00	0.95
Nurses	5600	6.14	1.78
Community Health Supervisors	1409	N/A	0.44
Vaccinators	2916	0.98	0.92
Community Health Workers	23,907 (21)	13.02	7.54

In addition to these categories of health workers there are dentists, pharmacists and a range of technicians. This table does not include health workers in the for-profit private sector. There is a large private sector in Afghanistan as well, about which relatively little is known. Of total health expenditure, government sources of funding account for six percent; donor sources 18 percent; and private sources (or out of pocket expenditure) 75 percent indicating that a significant number of people may be accessing private health services. (22)

"At least 23 health workers are needed for every 10,000 people - Afghanistan has 4.8"

In order to deliver basic healthcare to all; at least 23 doctors, nurses and midwives are needed for every 10,000 people. (23) The Afghanistan public health sector has 4.8 (24) which is less than a quarter of this, and 7.3 including the private sector and Ministry of Higher Education hospitals. (25) The MoPH Strategic Plan includes an objective to increase the ratio to 10.7 by 2015 but the National Health Workforce Plan includes a more ambitious objective of 13. (26) The GoA must come behind this more ambitious target. This should be analysed further to determine the appropriate mix of cadres, and related policy implications, with operational plans developed for implementation of this commitment.

The Basic Package of Health Services (BPHS) outlines the standardized package of care, which forms the core of service delivery offered in all primary healthcare facilities. The BPHS was amended in 2010, and now covers seven core elements. It is important that the human resource needs for each of these elements is adequately analysed and provided for. For example, Save the Children has recognised imple-

The doctor of a Save the Children mobile health team examines a little boy in a remote village in Uruzgan province.

mentation of the public nutrition component has negatively impacted already heavily-burdened facility staff, particularly at the Basic Health Centre level. The number and categories of additional staff required to effectively deliver all components of the BPHS needs to be clarified, for example in the community management of acute malnutrition (CMAM) guideline which is going to be updated in January 2013.

The current BPHS policy outlines the requirements for health facilities as follows. A Health Post (HP) consists of one female and one male community health worker and serves approximately 100-150 families. The Basic Health Centre (BHC), maintained by the MoPH, is staffed by a nurse, community health supervisor, physician, community midwife and two vaccinators and provides a package of basic services. Comprehensive Health Centres (CHCs), the next level of the system, provide additional services including minor and essential surgery. The District and Provincial Hospitals offer a broader range of more sophisticated medical care. As the BPHS model contracts out delivery of health services to NGOs, NGOs employ nine out of ten health workers in facilities providing frontline services as part of the BPHS. (27)

The MoPH forecasts indicate a further 8.7 percent increase in services is required in the public sector, and 18.6 percent for staffing NGOs in order to meet BPHS requirements. (28) In order to save more children's and mothers' lives, there must be an emphasis on increasing the numbers of adequately trained health workers of the following cadres.

Doctors
The number of doctors is closer to the WHO target than for other cadres. However, it is important that there is equitable distribution of doctors across the country and – since doctors take so long to train – there is a long term investment in training more doctors. Female doctors are particularly crucial for supporting the delivery of MNCH services and to act as a skilled birth attendant as they have proficiency in the skills necessary to manage normal deliveries and diagnose and manage obstetric complications. The referral system, ensuring more complex cases can be passed on to skilled doctors, must also be strengthened.

Midwives
There are 3000 hospital and community midwives in Afghanistan and around one third of births take place in the presence of a skilled birth attendant, a significant improvement in recent years. (29) During pregnancy and childbirth, a midwife or a skilled birth attendant plays a critical role – ensuring women are getting the right nutrition, identifying danger signs and treating complications and providing essential newborn care at the time of birth.

Yet despite progress, there is still a long way to go. All public health facilities in Afghanistan are required to have at least one midwife (30) yet nearly a quarter of current health facilities still do not have a midwife or skilled birth attendant. (31) The MoPH estimates that 3,022 additional midwives are needed by the public sector (to a total of 5,222) with many more needed by the private sector. (32) Yet the Health for All National Priority Program only includes a commitment to train an additional 1000 in the next three years. (33)

"Nearly 25 percent of all health facilities still don't have a midwife or skilled birth attendant"

The GoA must commit to expand targets and increase the enrolment rates to train 6300 midwives by 2016 and attain 95 percent skilled birth attendance. (34) There must be clear agreed objectives and a clear phased training and funding plan for increasing the number of trained midwives. Funding for midwifery training, which sits outside the BPHS, has been ad hoc. Donors must increase financial commitments to continue and expand midwifery training, which currently costs $15,000 per person for the two years of training (35) or $49.5m to achieve the objective of 6300 trained midwives.

Nurses
The MoPH estimates that 692 community health nurses are needed within the BPHS, in addition to general nurses in hospitals, to meet the needs of the health sector. (36) These are in addition to the general nurses required in hospitals. The National Priority Program includes an objective to train 400 community nurses in 25 provinces within three years to supplement current training of 300 nurses. (37) This commitment must be met.

Vaccinators
While 56 percent of children are vaccinated against measles, only 18 percent of children aged 12-23 months have received the full series of eight recommended vaccinations. (38) Lack of access to an appropri-

ately skilled and equipped health worker is one of a number of factors behind low immunization rates and vaccinators play a critical role. In Afghanistan, vaccinators are a separate cadre of health worker, specifically trained to carry out immunization and tackle low immunization rates. However, there may be missed opportunities for the role of this cadre of health worker to be expanded to provide a range of services. In addition, vaccination must be adequately covered in nursing curriculum in order to allow vacant vaccinator positions to be filled by nurses.

Community Health Supervisors

Community Health Supervisors are health facility staff and provide the link between the facility and the communities in the catchment area of the facility. They support and supervise all the CHWs, collect and process all monthly reports from CHWs, meet regularly with shuras (39), and manage all community-based health programs.

The BPHS policy requires each health facility to have one full-time Community Health Supervisor (CHS) to supervise and support all the CHWs in that facility's catchment area. (40) In practice, only about 75 percent of healthy facilities have a CHS. (41) Whilst a health facility might typically support around 20-30 CHWs working out of 10-15 health posts, health facilities can often support many more.

"The MopH is one of the first ministries to establish a gender department and national gender strategy"

The requirement for only one CHS per health facility also results in gender disparities: only around ten percent of CHSs are female resulting in cultural difficulties in the supervision of female CHWs. (42) Two community health supervisors, one male and one female, per health facility could greatly improve the support to and effectiveness of community based health care services. In addition, integrating a CHS Supervisor role into the CBHC approach must be considered.

Community Health Workers

Community health workers are volunteers with limited but targeted training and the initial point of contact for many individuals seeking health care. CHWs provide simple interventions that reduce maternal and child mortality such as treating illnesses like pneumonia or diarrhoea. They have a critical role in encouraging members of their communities to make best use of health facilities and promoting healthy lifestyles, such as handwashing with soap, early and exclusive breastfeeding, immunization, and delivery by a skilled birth attendant.

Community health workers are the backbone of the BPHS system and have had a significant impact on child and maternal mortality. There are currently 23,686 CHWs which see about 70 percent of all family planning clients in Afghanistan and about 40 percent of all sick children. (43) Yet despite the success of the Community-Based Health Care program, many villages still lack CHWs and desperately need them.

The Health for All National Priority Programme includes an objective to train an additional 10,000 CHWs, including 5000 females, to a total of around 32,000 CHWs, over the coming three years. (44) The Ministry of Public Health Strategic Plan 2011-2015 includes a more ambitious objective to bring the total number of practicing CHWs to 40,000 by

2015. (45) In order to move towards the WHO target (46) and ensure a CHW is within reasonable distance of every Afghan community, policy objectives must be aligned behind this commitment and implemented.

B. Gender imbalance

To continue to reduce maternal and infant mortality, Afghanistan needs to increase its skilled female workforce in the sector. Female workers make up only 25 percent of the total health workforce (including unqualified support staff). (47) Other than 97 percent of midwives and 50 percent of community health workers being female, only about 21 percent of vaccinators and university educated groups of doctors, dentists and pharmacists are female. (48) Only around 10 percent of community health supervisors are female. (49)

There has been some progress. The number of health facilities with at least one female skilled birth attendant has increased from 45 percent in 2000 to 77 in 2012. (50) This is due in part to gender sensitive measures in the BPHS in which there are incentives for hiring female health workers, and hiring female staff is a performance indicator. (51)

The MoPH is at the forefront of ministries in establishing a Gender Department and lead the implementation of a National Gender Strategy. (52) This strategy includes an objective to advocate that all administrative policies and procedures of the MoPH are gender equitable, which could have a significant impact on the recruitment of female staff to MoPH.

More could be done to increase the ratio of female to male community health workers. Female CHWs may be more effective in delivering maternal and newborn child health services. Research is required to analyse the comparative effectiveness of male to female CHWs with a view to increasing the target for increasing the number of female CHWs.

There must be an effort to support the recruitment and retention of cadres of skilled female staff for which there is a significant shortage, such as midwifery, community nursing and physicians. Options include granting preferential admission to medical training for women, particularly those committing to work in remote areas or bridging courses for women with less than the required levels of education. These approaches are discussed further in sections C and D.

A female community health worker talks to village women about how to keep childen clean and healthy.

C. Uneven geographical distribution

Rural to urban disparities in the distribution of health workers are significant: in rural areas, some people may still never see a health worker in their lifetime. There are 4.5 health workers per 10,000 people, including private and public sector, in rural provinces, compared with 16 per 10,000 in larger, more urban provinces (Kabul, Mazar, Ningarhar and Herat). (53) Health workers often do not want to work in rural areas, but prefer to move to regional centres where there is better security, food, employment and better health care and education for their children. Retention of midwives at an assigned deployment site is one third lower for those working in an insecure province. (54)

The number of health workers as compared to population only tells part of the story. Much of rural Afghanistan is characterised by difficult terrain, dispersed population and harsh climates. Higher numbers of health workers are required if all families are to be within reasonable reach of health workers. There needs to be sustained effort and incentives in order to counterbalance the social and cultural barriers and security issues that are currently preventing the generation of a local workforce and more staff from being deployed in rural areas, particularly females. (55)

Appropriate remuneration and support to attract and motivate health workers to work in rural and underserved areas is also critical and discussed in the following section.

"In rural areas, some people may never see a health worker in their lifetime"

Selection in deployment

Challenges start with selection. There is difficulty in recruiting adequate numbers of women with sufficient formal education to train for cadres of health workers, such as midwives, particularly from rural or insecure areas where levels of education tend to be lower. Girls' education must continue to be prioritised, particularly in rural and insecure areas, and there needs to be short to medium term bridging courses for women with less than ten years formal education until the applicant pool has a sufficient number of women from prioritized districts.

Expanding the number and intake capacity of training programmes in rurally based accredited training institutes targeting individuals from rural districts could also increase rural deployment. The National Priority Program recognises the need to place emphasis on implementation of programs in educational schools across the country and development of training programs in rural institutes for placement in rural areas. (56) Yet the implementation plan remains unclear how this will be achieved. Rural training institutes could be affiliated with renowned institutions in urban areas in order to share faculty and training resources.

Community Support

Community support is important in encouraging acceptance of health workers appointed to communities for which they are not resident, and ensuring their safety in insecure areas. Community engagement and awareness is critical and must be integrated into deployment plans, for example liaising with community elders and conducting advocacy to-

ward religious leaders. (57) Deployment plans, particularly for midwives, must be reviewed six months prior to graduation to ensure that a midwife position is available and that security is sufficient at the planned deployment site. (58)

Quota and rotation schemes

The government must introduce preferential admission for medical and health worker training to women and people committing to work in remote areas and or alternatively, make postings to more attractive locations, such as Kabul, conditional on first fulfilling a commitment to work in a remote area. A quota scheme for candidates, particularly for women from resource-poor provinces could be introduced, with graduates committing to a 2-4 year service in their community of origin or an underserved area.

"A quota scheme for candidates from resource-poor provinces could be introduced"

A similar approach is used in Bangladesh, where points are awarded for working in remote areas and accumulation of points increases the likelihood of future postings in more attractive locations. (59) The new Workforce Plan identifies the need to further investigate rotation schemes with the clear aim that each professional staff member should spend part of their time in rural/remote areas. (60)

Living and working conditions and infrastructure

Reducing hidden costs and improving living and working conditions in less desirable areas must be considered, including covering transportation costs to/from clinics, the provision of good accommodation and utilities, co-locating health worker spouses and supporting schooling for children.

Professional development and career pathway opportunities

Professional development opportunities for health workers working outside Kabul must be developed and expanded. The Reproductive Health Department, in coordination with Ministry of Public Health/ Human Resource Directorate, the Institute of Health Sciences, the MoHE, and Kabul Medical University, intends to work on the development of a personnel policy for skilled birth attendant cadre management, career pathways, recruitment, training, and deployment according to geographical and national needs. (61) This policy must be developed and implemented.

A community health worker in Uruzgan province. CHWs are the backbone of the public health sector but don't receive pay.

D. Retention: remuneration and support

Data available shows retention rates, particularly in insecure areas, are fairly weak. The overall retention rate of community midwifery graduates is less than two thirds. (62) The level of renumeration and support provided is critical for attracting and retaining skilled health workers as well as influencing the quality of services provided.
More health workers are required yet it is equally important that existing and new health workers are adequately supported. This entails ensuring essential drugs, equipment, training, supervision and mentoring is available, to improve levels of satisfaction, which in turn contributes to retention. The importance of ensuring adequate provision of infrastructure and physical resources, in addition to effective deployment plans is discussed in section C.

Remuneration
There are considerable inequities of salary between groups working in MoPH and those contracted-out working through NGOs on BPHS, for example doctors working for NGOs get 50 percent more salary than civil servants, and donor funded consultants working for the MoPH often five times more. (63) A national salary policy has been formulated to standardize salary and benefits paid to health care workers employed through the BPHS program and to motivate staff to work in rural and under-served areas. (64) The policy should prevent BPHS-implementing agencies paying salaries and related benefits more than

the scale specified, but in practice is difficult to implement and monitor. The policy also only applies to field staff and does not cover NGO management staff.

The policy includes payments of hardship allowances for rural and isolated areas and additional hardship incentives for female service providers. This could help improve retention rates for which insecurity has the biggest negative impact. (65) However, salary baselines remain very low; 215 USD per month for a doctor, 178 USD for a midwife and 138 USD for a nurse. Salary scales must be reconsidered; health workers trained in the public sector are at risk of being attracted by better pay in private sector or management roles.

There has been some successful experience, particularly in Cambodia and Rwanda, in providing incentive payments to health workers based on the number of services they actually provide. (66) There must be careful examination as to the design of results-based or performance-based pay models to assess effectiveness. The Reproductive Health Strategy proposes a sustainable incentive system to ensure skilled health care providers are available for emergency obstetric and newborn care 24 hours a day at all facilities. The incentive system will include performance-based incentives, particularly in rural areas, and may not necessarily include financial incentives. (67) The MOPH is also working with the World Bank on the trial of a results-based financing scheme which will provide a strong basis for understanding the value of results-based payments. (68) It does not, unfortunately, specifically include Community Health Workers - it is up to the health facility staff to decide how to use the CHWs effectively. Results-based financing pilot schemes must be expanded to CHWs.

Although the dropout rate for CHWs is reported as being less than five percent (69) it is not sustainable in the long term to rely on volunteers to deliver crucial health services. This may be particularly relevant as the workload and deliverables expected of CHWs continue to rise. CHWs provide the backbone of the BPHS system, treating about 40 percent of all sick children. (70) All types of health workers, including CHWs, should be paid a living wage, yet it is recognised this would require significant investment because of the sheer number of CHWs. (71) In the case of Afghanistan this might be an ideal that cannot be achieved quickly but steps could be taken in this direction.

"In the long term, it is not sustainable to rely on volunteers to deliver crucial health services"

In the medium term, linking CHW payments to actual performance such as knowledge of handwashing in the community, number of children fully immunised, number of mothers who delivered at health facilities and so on, might be important for increasing CHWs' impact. Piloting and evaluating possible payment schemes is necessary.

Supervision

More must be done to identify and improve the nature and frequency of supervision provided by MoPH and implementing NGO managers to all cadres of front line health workers. (72) The MoPH Strategic Plan 2010-2015 includes objectives to improve performance management such as the development of clear and appropriate job descriptions and

expectations, a fair and transparent performance appraisal system, and support to a results-oriented culture. (73) Increased numbers of capable supervisors will be required.

As is referred to in section A, the numbers of Community Health Supervisors could be increased to support CHWs with an ever increasing work load. The introduction of an additional form of health worker, a Community Health Supervisor Supervisor (CHSS), could be considered. For midwives, training following graduation, particularly supportive supervisio,n has been identified as critical but there are financial and other challenges to implementation. The MoHE should be involved to innovate higher education pathways for midwives to develop a cadre of midwifery leaders, faculty managers, and supervisors. (74)

"High-profile awards for innovation and excellence should be established"

Training and curriculum

Improving the quality of training and building capacity to meet training needs are important components for improved satisfaction and retention. The MoPH Strategy 2011-2015 includes an objective to implement enhanced training programs for various categories of health workers including midwifery and community nursing. (75)

Recent revisions to the CHW curriculum should be commended, but strengthening community-based health care delivery using community health workers will require greater integration of in-service and refresher training for reproductive health issues, as is recognised by the Reproductive Health Strategy. The nursing curriculum must also be updated in the next three years in line with national policy. (76)

The National In-Service Training guideline is currently under development in order to standardise and improve the quality of in-service training across a large number of BPHS implementers. This must receive continued support for development and implementation.

Other incentives

Other incentives and recognition outside remuneration such as high-profile awards for innovation and excellence should also be established. (77) The annual CHW celebration, for example, is one of few opportunities to recognise and celebrate the role of CHWs. One factor for the demotivation of midwives, is that they are not currently being considered as 'civil employees' because of their lower level of secular education; midwives should be considered 'civil employees'. (78)

Data management

In order to better understand and address the causes of poor retention, it would be valuable to bring in improvements in the collection and analysis of data and flow of information related to human resources for health. The MoPH Strategic Plan 2010-2015 identifies some critical interventions that must be implemented, including the amalgamation of HR databases, including payment, personnel and training databases, inclusion of deployment data, and improvements in information on human resource availability, shortages and losses. (79) Better information on deployment, for example, would support strengthening of professional development and career pathways.

IV. Recommendations to the government

Recommendations to the Government of Afghanistan, supported by international donors and non-governmental organisations:

Address the shortage of skilled health workers

- Meet the commitment outlined in the Afghanistan National Health Workforce Plan to increase the ratio of doctors, nurses and midwives for every 10,000 people from 7.3 to 13 by 2016. (80)

- Meet the commitment outlined in the Ministry of Public Health Strategic Plan to bring the total number of practicing community health workers to 40,000 by 2015. (81)

- Increase the enrolment rates for midwives to train 6300 midwives by 2016 and attain 95 percent skilled birth attendance. Expand community midwifery education schools to all provinces. Funding is required to continue the midwifery training, which currently costs $15,000 per person for the two years of training (82) or $49.5m to train an additional 3300 midwives.

- Increase the number of Community Health Supervisors from one per health facility to two (one male, one female) to improve capac-

ity for supervision to CHWs. This requirement must be integrated into Basic Package of Health Services policy and funded. A CHS cost 1600 USD per year. In addition, integrating a CHS Supervisor role into the CBHC approach must also be considered.

- The number and categories of additional staff required to effectively deliver all components of the BPHS needs to be clarified, for example in the community management of acute malnutrition (CMAM) guideline due to be updated in January 2013.

Address the gender imbalance

- Ensure all administrative policies and procedures of the MoPH are gender equitable, with support of MoPH Gender Department.

- Support the recruitment and retention of cadres of skilled female staff for which there is a significant shortage, including community health supervisors.

- Introduce a quota for intake of female medical university students based on provincial and district requirements and bridging courses for women with less than ten years formal education.

- Analyse the comparative effectiveness of male to female community health workers with a view to increasing the percentage of female to male community health workers from 50 percent to 60 percent.

Address the uneven geographical distribution

- Develop short to medium term on-site bridging courses for women with less than ten years formal education until the applicant pool has a sufficient number of women from prioritized districts needing midwives and nurses.

- Expand the number and intake capacity of training programmes in rurally based accredited training institutes targeting individuals from surrounding rural districts.

- Develop and review comprehensive deployment plans six month prior to midwifery and nursing graduation to ensure the position is available and that security is sufficient at the planned deployment site. Plans for community engagement and awareness must be integrated into deployment plans.

- Pilot and introduce rotation schemes with the aim that professional health workers spend part of their time in rural or remote areas. Make postings to more attractive locations conditional on first fulfilling a commitment to work in a remote area.

- Improve living and working conditions in less desirable areas, including ensuring transportation costs to/from clinics are covered, good accommodation and utilities are provided, and opportunities

co-locating health worker spouses and supporting schooling for children are available.

- Improve professional development opportunities including cadre management, career pathways, recruitment, training, and deployment, particularly for skilled birth attendants, as is outlined in the Reproductive Health Strategy 2012-2016.

Address weak retention via improved remuneration and support

- Effectively monitor the implementation of the National Salary Policy 2011 to prevent BPHS-implementing agencies paying salaries and related benefits more than the scale specified.

- Improve the nature and frequency of supervision provided by MoPH and implementing NGO managers to all cadres of front line health workers.

- Improve performance management via the development of clear and appropriate job descriptions and expectations and a fair and transparent performance appraisal system, as outlined in Ministry of Public Health Strategic Plan 2010-2015. (83)

- Improve the MoPH HMIS and HRMIS databases to include pay system, deployment data, attendance data, and training data to support strengthening of professional development and career pathways to better understand and improve retention.

- Continue to invest in, and analyse the results of, sustainable incentive systems or results-based payments to health workers, including and particularly for Community Health Workers, to understand the impact and improve the retention of health workers and quality of health services.

- Enhance midwifery training programs and develop the community nursing curriculum as outlined in the Ministry of Public Health Strategy 2011-2015 and the Reproductive Health Strategy 2012-2016.

- Standardise and improve the quality in-service training by supporting the development and implementation of the new in-service training guidelines managed by Ministry of Public Health Human Resources Department.

- Invest and establish non-remunerative forms of recognition, such as high-profile awards for innovation and excellence, and recognition of midwives as 'civil employees'.

- Strengthen support to the development of institutional bodies and associations such as launching an Afghan Midwifery and Nursing Council as outlined in the Health for All National Priority Program.

Endnotes

(1) Afghanistan Mortality Survey 2010
(2) Comparing Afghanistan National Mortality Survey 2010 (1 in 50 lifetime risk of maternal death) and State of the World's Mothers 2011 (1 in 11 lifetime risk of maternal death), data from WHO. Trends in Maternal Mortality: 1990 to 2008. (Geneva: 2010)
(3) National Priority Program: Health for All Afghans, Ministry of Public Health, July 2012
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(28) National Priority Program: Health for All Afghans, Ministry of Public Health, July 2012
(29) Reproductive Health AMICS Fact Sheet, 2012 (39%) Ministry of Public Health (MoPH) Partnership Contracts for Health 2010 Household Survey (34%)
(30) Basic Package of Health Services Policy, revised 2010
(31) 77% of health facilities have a skilled birth attendant (HMIS database, Ministry of Public Health, November 2012)
(32) National Priority Program: Health for All Afghans, Ministry of Public Health, July 2012
(33) Ibid
(34) State of the World's Midwifery report, 2011
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(36) Ibid
(37) Funded by the Global Fund
(38) Child Health AMICS Fact Sheet, 2012. (Countdown Report 2012 statistics are 62% for measles and 66% for DTP3/HiB3)
(39) Local consultative councils
(40) Basic Package of Health Services Policy, revised 2010
(41) Community-Based Healthcare Policy 2009-2013
(42) Ibid
(43) National Priority Program: Health for All Afghans, Ministry of Public Health, July 2012 p137
(44) Health for All: National Priority Program, July 2012 p137. The need for 10,000 additional CHWs to in order to provide CBHC ser vices to 90% of the population was first laid down in the CBHC policy 2010-2013 but reaching the target of 30,000 CHWs by 2013 will not be achieved.
(45) Ministry of Public Health Strategic Plan 2011-2015
(46) If the 40,000 CHW objective is achieved the ratio will be 12.73. The WHO target ratio is 13.02
(47) HMIS database, Ministry of Public Health, November 2012and Ministry of Public Health Strategic Plan 2011-2015
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(71) For example, providing $20 (Af. 1,000) a month would cost about $6 million a year over what is currently spent on CHWs. Building on Early Gains in Afghanistan's Health, Nutrition and Population Sector: Challenges and Options. The World Bank 2010.
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