Health Policy in Afghanistan: two years of rapid change

A review of the process from 2001 to 2003

LONDON SCHOOL OF HYGIENE & TROPICAL MEDICINE

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About the London School of Hygiene and Tropical Medicine...

The London School of Hygiene and Tropical Medicine (LSHTM) is a renowned research and teaching institute in public health, based in London, UK. Its aim is to contribute to the improvement of health worldwide through the pursuit of excellence in research, postgraduate teaching and advanced training in national and international public health and tropical medicine. The Department of Public Health & Policy is one of three Departments within LSHTM. The main thrust of the Department's work is to link public health, policy and practice through research and analysis. This is undertaken by the largest multidisciplinary group in Europe focused on public health, with epidemiologists, statisticians and mathematicians, economists and policy analysts working together with anthropologists, sociologists, historians, psychologists and geographers. Within this Department sits the Conflict and Health Programme, which conducts a range of research and teaching activities related to conflict induced changes to population health and health systems as well as to the reconstruction of the health sector during the post-conflict phase. One of its projects is to look at the roll-out of the Basic Package of Health Services in Afghanistan. More information on other activities can be found on www.lshtm.ac.uk/hpu/conflict.

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Acronyms

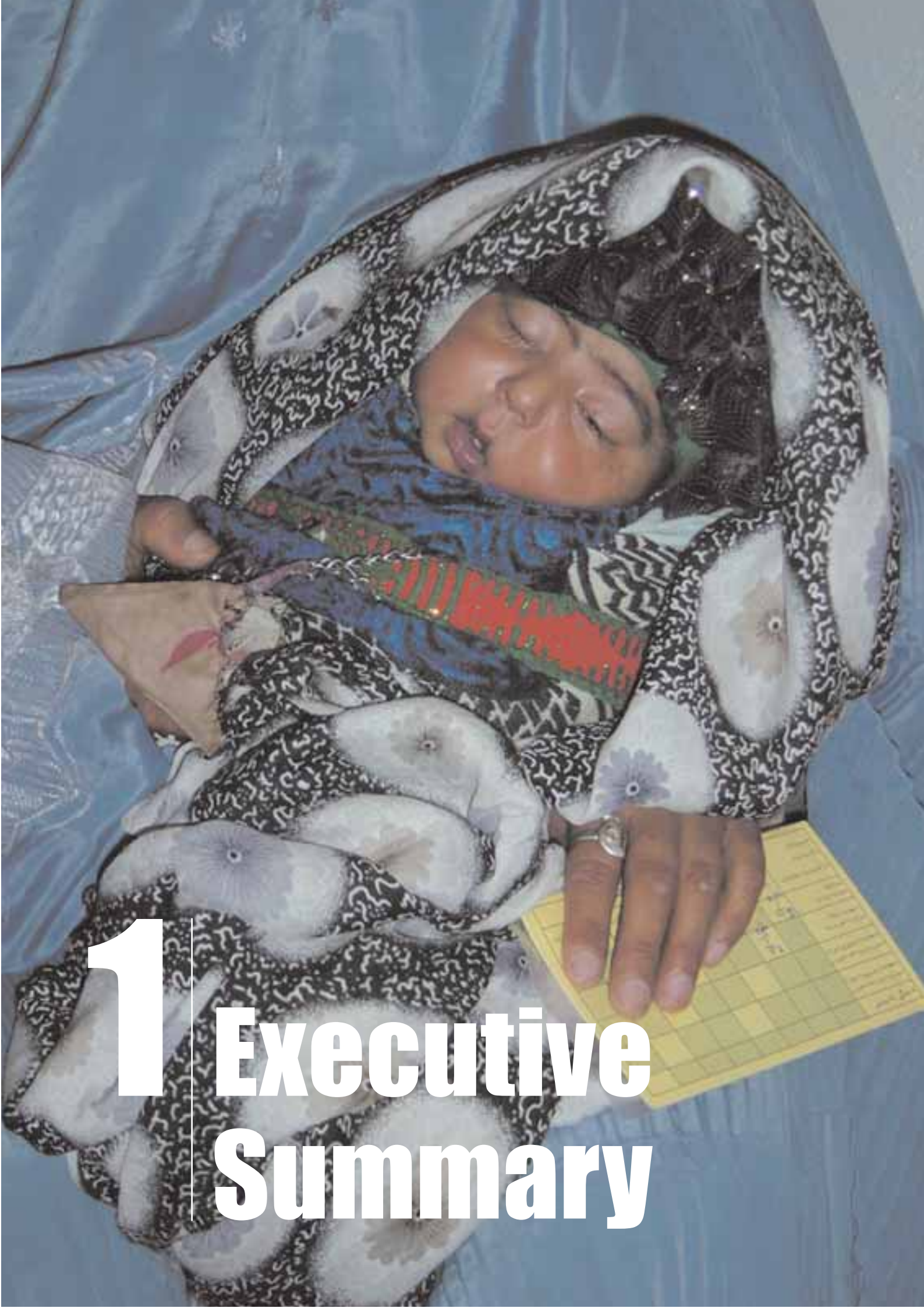
ADB	Asian Development Bank
AHSEP	Afghanistan Health Services Expansion Project
AIA	Afghanistan Interim Authority
ANHRA	Afghanistan National Health Resource Assessment
BPHS	Basic Package of Health Services
CDC	Centre for Communicable Disease Control
CGHN	Consultative Group for Health and Nutrition
CHW	Community Health Worker
CI	Contracting In
CO	Contracting Out
CSC	Civil Service Commission
DFID	Department for International Development
EC	European Commission
EOI	Expression of Interest
EPI	Expanded Programme on Immunization
FC	French Cooperation
GCMU	Grants and Contract Management Unit
GTZ	German Agency for International Development
HCTF	Health Coordination Task Force
IARCSC	Independent Administrative Reform And Civil Service Commission
ICRC	International Committee of the Red Cross
IDB	Islamic Development Bank
JDM	Joint Donor Mission
JHU	Johns Hopkins University
JICA	Japanese International Cooperation Agency
KfW	German Bank for Reconstruction
KOICA	Korea International Co-operation Agency
LBG	Louis Berger Group
MSF	Medecins Sans Frontieres
MSH	Management Sciences for Health
MOF	Ministry of Finance
MOH	Ministry of Health
MOH-SM	Ministry of Health Strengthening Mechanism
NDF	National Development Framework
NGO	Non-government Organisation
NORAD	Norwegian Agency for Development Cooperation
NPM	New Public Management
NSP	Non-State Provider
NTCC	National Technical Coordination Committee
OPM	Oxford Policy Management
PACBWG	Public Administration Capacity Building Working Group
PHCC	Provincial Health Coordination Committee
PIU	Project Information Unit
PPA	Performance-based Partnership Agreement
PRR	Priority Reform and Restructuring
REACH	Rural Expansion of Afghanistan's Community-based Healthcare

RFA	Request for Application
RFP	Request for Proposal
SIDA	Swedish International Development Agency
TA	Technical Assistance
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WB	World Bank
WCGHN	Working Consultative Group for Health and Nutrition
WDR	World Development Report
WHO	World Health Organisation

Timeline of key events in the health sector

Nov. 27-29 2001:	Islamabad Conference on Preparation for Reconstruction
Dec. 8 2001 – Jan. 10 2002:	Preliminary Needs Assessment for Recovery and Reconstruction: WB, ADB, UNDP
Jan. – Mar. 2002:	First draft of the National Health Policy released for circulation
Mar, 2002:	National Health Planning Workshop
Mar. 19 – Apr. 2 2002:	First Joint Donor Mission on Health, Nutrition and Population sector: WB, ADB, EC, DFID, USAID, WHO (Afghanistan/EMRO), UNICEF (Afghanistan/New York), UNFPA
April 2002:	First draft of the National Development Framework released for circulation
May 2002:	First draft of basic service package produced, WHO Final draft of National Health Policy released
Jul. 17 2002:	Costing of Basic Package of Health Services, MSH
Jul. 13 – 17 2002:	Second Joint Donor Mission: WB, ADB, EC, USAID, GTZ, KfW, JICA, WHO (Afghanistan), UNICEF (Afghanistan/New York), UNFPA, MSH
July 22 – 25 2002:	JDM seminar on government-NGO collaboration and Performance-based Partnership Agreements
July 2002:	Establishment of Consultative Group sectoral coordination mechanism, called the Consultative Group for Health and Nutrition in the health sector
Nov. 2002:	Afghanistan National Health Resource Assessment Preliminary Results, MSH
Dec. 2002:	European Commission, Support to Health Services Delivery in Afghanistan, Guidelines for Application to Call for Proposals 2002 for an Informal Consultation
Jan. 2003:	MOH provincial planning workshops start

Jan. – Feb. 2003:	WB pre-appraisal mission
Jan. – May 2003:	Ongoing debate and discussion between MOH, WB, USAID, EC and the French regarding implementation mechanisms for the BPHS
Feb. 2003:	World Bank presentation on Performance-based Partnership Agreements for NGOs
Mar. 2003:	Final draft of the Basic Package of Health Services released
Mar. 2003:	Establishment of the Grants and Contract Management Unit (GCMU) in the MOH
Apr. 21 -23 2003:	Third Joint Donor Mission
Apr. 2003:	Transitional Islamic State of Afghanistan, Health Sector Emergency Reconstruction and Development Project, Provincial and Cluster level Performance-based Partnership Agreements, Request for Expression of Interest
May 2003:	European Commission, Support to Health Services Delivery in Afghanistan, Guidelines for Application to Call for Proposals 2002 for an Informal Consultation (second round)
May 16 2003:	USAID Rural Expansion of Afghanistan's Community-based health Care (REACH) program awarded to Management Sciences for Health (MSH)
Jun. 2003:	Request for Application , USAID Rural Expansion of Afghanistan's Community-based Health Care (REACH) Grants Program
Jul. – Dec. 2003:	Second round of EC grants awarded (7 grants in total)
Aug. 2003:	National Salary Policy finalized and released
Oct. – Nov. 2003:	First round of REACH grants awarded (16 grants in total)
Nov. 2003:	First round of WB/MOH contracts awarded (3 contracts in total). In the second round of bidding another 5 contracts were signed



1 Executive Summary

Health sector reform has flourished since 1980s in response to increasing recognition of public sector inefficiencies in the delivery of health care. Consequently there has been an emphasis on ideas surrounding New Public Management, which injects market-like principles into healthcare provision through concepts such as competition and contracting. While there has been an upsurge in interest in the use of contracting in the health sector, and performance-based contracting in particular, evidence of theoretical benefits such as increased efficiency and equity, are limited, inconsistent and largely outside of the public domain.

Despite a weak evidence-base these new ideas are reflected in current health policy developments in post-conflict Afghanistan. In order to address the alarming health trends produced by the last twenty years of war, three major donors (EC, USAID, and World Bank) are investing considerable sums of money to rehabilitate Afghanistan's devastated health system. Together with the Ministry of Health, they are funding Non-State Providers (NSPs) to deliver a Basic Package of Health Services (BPHS) through various mechanisms including Performance-based Partnership Agreements (PPAs), within the framework of government health policy. This approach is premised on the notion that delivery of a BPHS to a majority of Afghans will address the major burden of disease and mortality through a set of cost-effective interventions at a cost that can be sustained. Furthermore, performance-based approaches are based on the argument that

delivery of this package by non-governmental agencies, within a government-led (regulated and monitored) framework, will not only lead to higher efficiency of the delivery of the package, but also to better uptake by the poor (improved equity), in comparison to direct government provision.

Although the MOH has made the choice to restrict itself, mainly in relation to implementation of the BPHS, to a stewardship role, subcontracting health service delivery to NGOs, the MOH will also directly implement the BPHS through a MOH Strengthening Mechanism (MOH-SM) in a selection of provinces. The MOH-SM will receive funds from the WB and, similar to the PPA contracts with NGOs, payment to the MOH will be linked to performance. Moreover, the MOH-SM provinces will undergo the same third party evaluations as NGOs, which will allow for comparison between public and private provision of the BPHS.

The promotion of the PPA approach by the World Bank is primarily based on experiences of an Asian Development Bank pilot study in Cambodia, where contracting out health services to NGOs resulted in improved health care delivery, increased transparency, reduced costs for the poor and for health costs overall (*Bhushan et al 2001; Bhushan et al 2002*). However, available evidence from this experience as well as from other post-conflict and low-income countries (*see Bhushan et al 2001; Soeters and Griffiths 2003; Nieves et al 2000; Loevinsohn 2002; Eichler et al 2001*) is still scarce and largely outside the public domain. Scaling up, sustainability, effects on health staff, definition of appropriate performance indicators, and possible high transaction costs are some of the expressed concerns (*Palmer 2001*). Moreover, given that there is little evidence to support large scale contracting in low-income settings implementation of such a mechanism in a post-conflict context, which faces a myriad of additional challenges, could be called into question. Thus, there is an urgent need to study this contracting mechanism in much more detail and in various settings.

This report is the first of a series that will be produced at regular intervals throughout a qualitative research project conducted by the London School of Hygiene and Tropical Medicine that will follow health policy developments and the implementation of the BPHS in Afghanistan between January 2004 and December 2005. The purpose of this initial paper is to outline policy developments in the reconstruction of Afghanistan's health system between 2001 and 2003 which will establish the contextual basis for the remainder of the research. In addition to this description of events between 2001 and 2003, a brief overview of the current health system and successes to date will be presented together with an update on more recent developments. The paper is based on a review of published and unpublished documentation from Afghanistan's health sector and uses a policy analysis approach.

The paper describes health policy developments in a fast moving, post-conflict environment, characterised by a large number of international stakeholders, all of which have different agendas, mandates and ideas of the best way to reconstruct a health system. Despite this multitude of actors and views, the process of developing health policy and implementation strategies has been quick and by mid 2004, only a year and a half after the articulation of the BPHS, the MOH together with its partners have expanded coverage of BPHS proposals to reach approximately 59% of the population. Despite this progress signs of donor fatigue hint at problems of further expansion and sustainability, and insecurity is hampering NGO efforts to get down to the business of implementation. Furthermore, although the MOH is now clearly in the driver's seat, side effects of

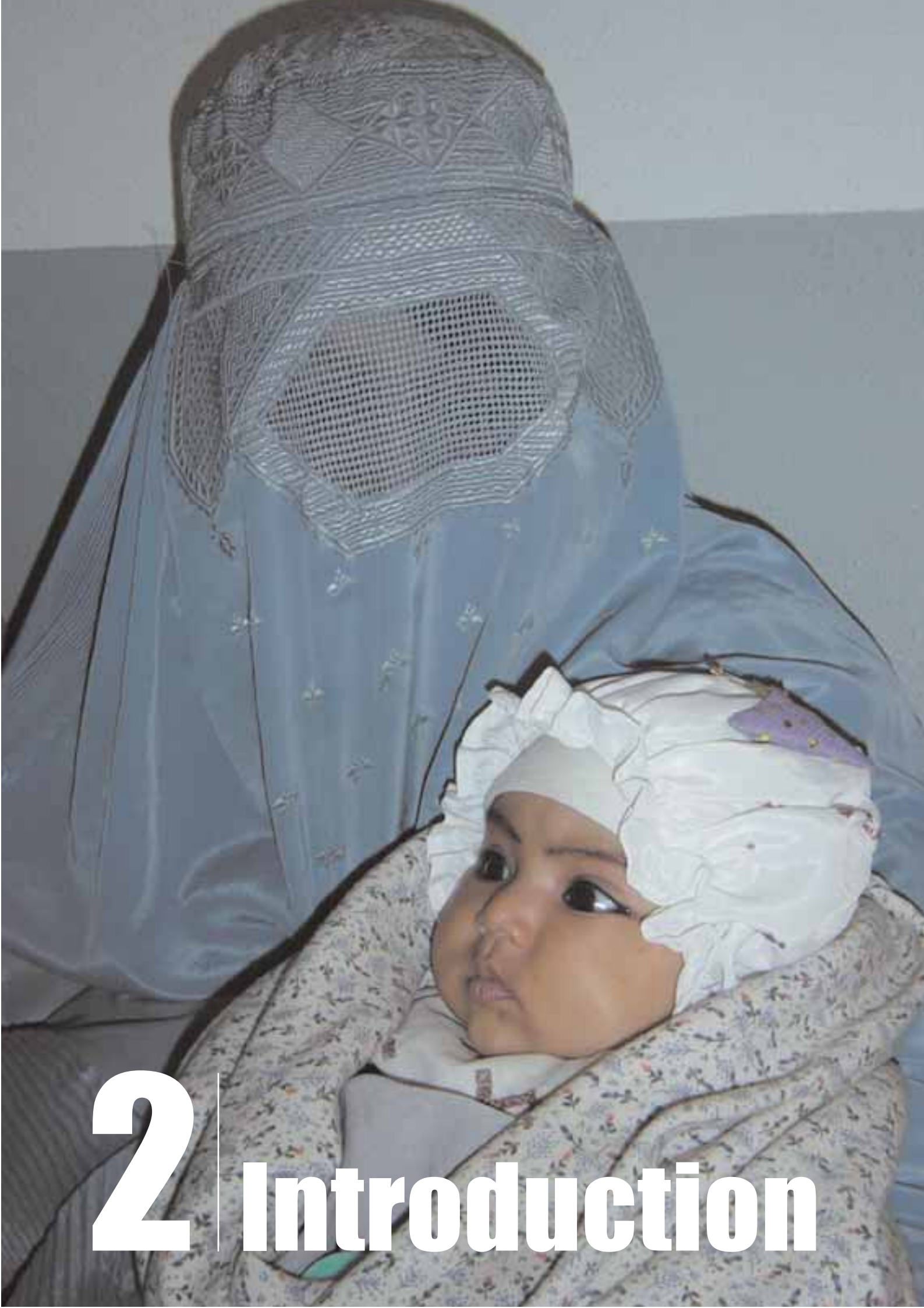
donor driven policy in the early stages of the post-conflict environment may become more apparent with time.

The paper concludes by identifying a number of issues for further research, some of which will be the subject of further study under this project. Such research is required to provide the basis for more empirically-based policy making in the areas of contracting and the use of a basic package of health services in post-conflict and low-income settings.

This paper has been written from an external perspective and may under emphasize internal MOH dynamics as a result. It is important to note that the opinions expressed in this paper are those of interviewees and key informants, not the authors.

The authors would like to acknowledge the many people who took time out of their busy schedules to give comments on earlier drafts. While the authors have tried to present an accurate picture of events, any errors in interpretation are the responsibility of the authors and do not reflect on the interviewees who have participated in the study to date.

Any comments on the report are welcome and can be sent to *lesley.strong@lshtm.ac.uk* or *egbert.sondorp@lshtm.ac.uk.*

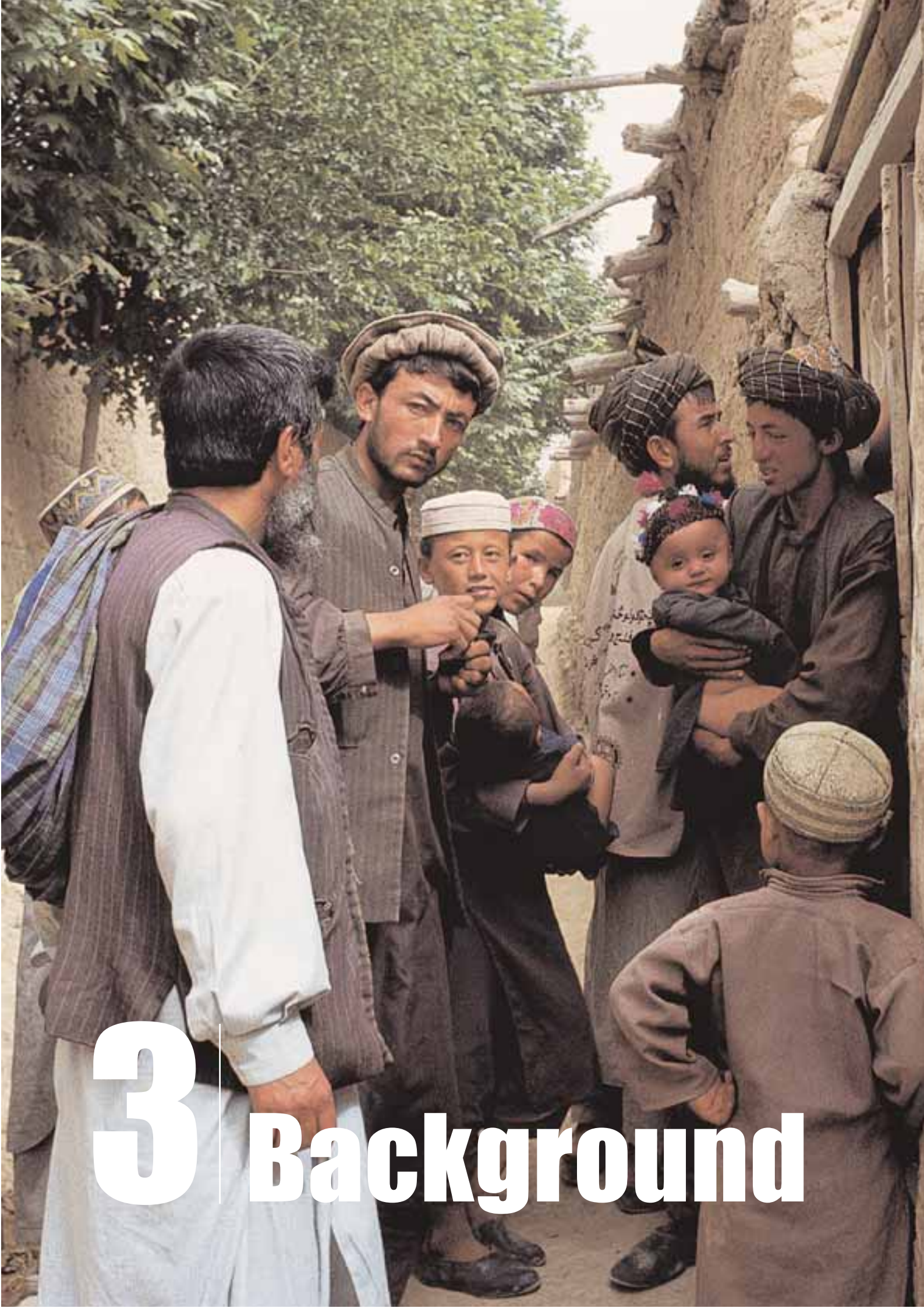


2 Introduction

In an attempt to curb some of the worst health statistics in the world three major donors (EC, USAID, and World Bank) are investing considerable sums of money in Afghanistan's health system. Together with the Ministry of Health, they are funding Non-State Providers (NSPs) to deliver a Basic Package of Health Services (BPHS) through various mechanisms including Performance-based Partnership Agreements (PPAs), within the framework of government health policy. Although donors have adopted different implementation mechanisms, the MOH, through the WB, has established PPAs with NSPs, which ties payment to performance measured against predetermined indicators. A pilot project in Cambodia showed that this model may achieve the objective of increasing efficiency as it lowered total cost, while at the same time increasing equitable access as well as lowering out of pocket payments by the poor.

Evidence from other post-conflict and low-income settings however, is limited, inconsistent and largely outside of the public domain. To contribute to research efforts towards documenting the experiences of this novel health delivery mechanism in Afghanistan, the London School of Hygiene and Tropical Medicine has been awarded a grant to conduct a research project entitled "Contracting health services in Afghanistan: Can the twin objectives of efficiency and equity really be achieved?", funded by the European Commission's Poverty Reduction Effectiveness Program (EC-PREP). The study consists of 3 parts: (i) description of the context, policy and actors in Afghanistan (ii) field-based study of the implementation phase through the establishment of 6 prospective case studies, and (iii) evaluation of the initial 2 years of implementation. The study will document experiences and contribute an objective perspective to the evidence-base on the utility of contracting out a basic package of services in a post-conflict and low-income settings.

This paper has been produced as phase one of the study with the objective to provide a commentary of the development of Afghanistan's new health policy between 2001 and 2003 and an update on the current state of affairs with regard to the roll out of the BPHS. The report will establish the contextual basis for the remainder of the research and serve as a point of referral in the ongoing development of Afghanistan's health system. The paper is based on a review of published and unpublished documentation from Afghanistan's health sector, supplemented by preliminary interviews held with key stakeholders to triangulate findings and gain further insight into early policy developments.



3 Background

3.1. Afghanistan's Turbulent Past

Since the dawn of history, the landlocked territory of Afghanistan has been the crossroads for Asia and a buffer zone for warring civilisations. Countless armies and conquerors have made their way through the region dating as far back as 329 BC, bringing with them different religions, languages, and cultures. Afghanistan today is a product of these influences with the population comprising an interesting mix of ethnicities and languages.

The arrival of the soviet army in 1979 was just the beginning of what was to be over 20 years of devastating war and instability. Afghanistan however, had been at the center of international rivalry before. In the 19th century, Afghanistan's kings had to hold off two new expanding empires: Britain's Indian empire to the east and Russia's ever growing control over much of Central Asia to the north. What emerged in the years that followed has been called 'the Great Game', with Britain and Russia using Afghanistan as a buffer state to keep each other at a safe distance as they fought for domination over Central Asia (*Rashid 2001*).

Following the overthrow of President Sardar Mohammad Daud in 1978 by Marxist sympathisers, the Soviet army rolled into Afghanistan in 1979. Despite large amounts of financial support ($5 billion USD / year) to subdue the anti-Soviet Mujahedin troops who were strongly backed by Western and Islamic countries (a total of over $10 billion USD between 1980 – 1992), the Soviet army withdrew in 1989 unvictorious. During the course of their occupation (1979–1988), some 1.5 million Afghans lost their lives. The Mujahedin endured and overthrew the communist government in 1992, making them heroes in the eyes of their fellow Afghans. Instead of peace, however, the struggle for power between Mujahedin factions resulted in "…the Mujahedin forfeit[ing] the title of heroes and assume[ing] the mantle of criminals when they took Kabul in 1992 and turned their guns on each other and the surrounding civilians" (*Gannon 2004*).

The Taliban emerged in late 1994 with Afghanistan on the brink of collapse. The country was divided up by warlords, all of whom "…had fought, switched sides and fought again in a bewildering array of alliances, betrayal and bloodshed" (*Rashid 2001 p.21*). The Taliban regime quickly gained control of Afghanistan, with forces in control of over 90% of the country by 1998. In the four-year fight for Kabul another 50,000 Afghans were killed, most of whom were civilians, with countless more maimed (*Gannon 2004*). Despite the regime's control over most of the country, their repressive policies, particularly regarding women, prevented their recognition as a legitimate government by the international community.

The Taliban fell in November 2001 after the US-led coalition forces launched an attack on the country in response to the September 11th attacks. Since then Afghanistan has been labelled as post-conflict and aid has poured in to assist in rebuilding various sectors of the country that have been eroded over years of war and political turmoil.

3.2 A Historical Perspective on Health

Although Afghanistan remained free of war throughout the 1960s and 1970s, health statistics occupied no higher a ranking amongst other countries in the region or even amongst developing countries as a whole, as they do today. Child mortality was 30% higher than the average of the least devel-

oped countries in 1960 (360 per 1,000 live births) and 61% higher than the average for developing countries (*MOH 2004*). Health care, largely provided by the government, was largely absent in rural areas with the exception of a collection of vertical disease control programs such as tuberculosis, malaria and leishmaniasis. In urban areas, the health system was dominated by hospitals and large numbers of doctors, a trend which still resonates today. Despite this curative-focused, inequitable picture of health care, the government did attempt to introduce a district health system, incorporating the principles of primary health care. However, with only 1-4% of the national budget devoted to health between 1952–1972 (*Pavignani and Colombo 2002*), facilities remained ill equipped and understaffed and thus, under utilised.

Starting from this already weak foundation the public health system continuously deteriorated in the years of war that followed. The health administration, already highly centralised, became even more detached from the provincial and district levels, which were increasingly under the control of local Mujahedin commanders (*MOH 2004*). NGOs emerged in the mid-1980s, congregating in Pakistan to provide health care for the millions of Afghan refugees, and later on establishing small cross-border operations. With the signing of the Geneva Accords in 1988 and the injection of donor funds, NGO activities flourished resulting in an increase in the number of health facilities, especially in rural areas. However, lack of a strong centralised government, coherent national framework, and the outbreak of civil war, resulted in fragmented service provision reflecting the mandates of donors and their implementing partners.

This trend continued with the emergence of the Taliban in 1994. With no health professionals amongst them, religious leaders were placed in charge of health sector. NGOs became the primary providers of health services, managing over 80% of facilities by the fall of the Taliban. Despite the Taliban's restrictions on education for girls and strict gender segregation rules NGOs played a key role in facilitating the return to work for female medical staff who were completely forbidden to do so for a period of time. Also a key factor was that females could only use the services of female health providers. As a result doctors, nurses, vaccinators and even health educators were permitted to work in the clinics. Although access to health care continued to be frustrated by a lack of roads and transportation infrastructure, insufficient numbers of facilities, personnel and socio-cultural factors some opportunities were created to improve the situation faced by Afghanistan's women. The Taliban's restrictions on education for females however, prevented the development of female health providers from higher education systems which has created one of the main constraints that the new government faces in increasing access to health care for women.

3.3 Present Day Afghanistan

Following the fall of the Taliban in November 2001, Afghanistan woke up to find an interim authority in place, newly appointed through the Bonn Agreement in December 2001, later to become the Transitional Islamic Government elected by the Loya Jirga in June 2002. The MOH, whose staff had been whittled away through several years of conflict, emerged with a relatively new team of leaders, many of whom came from UN agencies and NGOs with valuable exposure to the realities of the field. This group of health professionals collectively inherited a health system that had been producing some of the worst

Box 1: Health Status (as of June 2004)

Under 5 mortality 257/1000 live births
Infant mortality 165/1000 live births
Maternal mortality 1600/100,000 live births
Acute malnutrition 6-12%
Chronic malnutrition 50%
Iron Deficiency Anaemia 71% in pregnant women
TB 70,000 new cases/year
Annual incidence for TB 225/100,000
Life expectancy 42.6

(CDC/UNICEF/MOH 2002, MOH 2004, UNICEF MICS 2003)

health statistics in the world for nearly half a century. Indeed, the newly appointed MOH faced a formidable task in establishing a framework for an efficient and equitable health system.

3.3.1 Current health status (June 2004)

Afghanistan emerged from over 2 decades of war with some of the worst health statistics in the world. Various agency produced reports and studies such as the 1997 and 2000 Multiple Indicator Cluster Survey (MICS) conducted by UNICEF revealed staggering rates of infant and child mortality, ranking fourth highest in the world. While the overall rate of acute malnutrition is considered relatively low, factors such as micronutrient deficiencies, sustained food insecurity and poor caring practices have combined to produce a 50% chronic malnutrition rate (moderate and severe stunting) (*MOH 2004*). Infectious disease contributes heavily to the burden of disease with diarrhoea, acute respiratory infections and vaccine preventable illnesses accounting for an estimated 60% of deaths among children. Tuberculosis, which leads to an estimated 15,000 deaths a year among adults, disproportionately affects females with women accounting for approximately 70% of detected cases (*MOH 2004*).

The health of Afghanistan's women and girls has suffered tremendously due to a combination of factors including lack of female health staff, gender segregation and restrictions placed on the female population by local traditions. In Afghanistan's first ever national maternal mortality survey, a UNICEF/CDC/MOH study estimated maternal mortality at 1,600/100,000 (*UNICEF CDC MOH 2002*). This

Table 1: Health trends in the region

Location	Chil d Mortality Rate		Infant Mortality Rate		Life Expectancy		Fertility Rate	
	1960	2002	1960	2002	1970	2002	1960	2002
Afghanistan	360	257	215	165	38	43	7.7	6.8
The Region								
Bangladesh	248	77	149	51	44	61	6.8	3.5
Bhutan	300	94	175	74	42	63	5.9	5.1
India	242	93	146	67	49	64	5.9	3.1
Maldives	300	77	180	58	50	67	7.0	5.4
Nepal	315	91	212	66	42	60	5.9	4.3
Pakistan	227	107	139	83	48	61	6.3	5.1
Sri Lanka	133	19	83	17	64	73	5.7	2.0

UNICEF 2004

figure varies dramatically throughout the country (400 to 6,500/100,000), and with some 50 women a day dying in childbirth, Afghanistan has the second highest maternal mortality in the world.

3.3.2 Current health system (June 2004)

The health status of the Afghan population points to the failings of a health system that has been battered and bruised over several years of war. As can be seen in table 1 Afghanistan's health indicators still lag significantly behind other countries in the region.

In response to a lack of information regarding the current status of the health system, the Afghanistan National Health Resources Assessment (ANHRA) was carried out in June – September 2002[1]. The ANHRA confirmed substantial inequities in the distribution of health facilities and services both between and within provinces throughout the country. Although the national ratio of BPHS health facilities[2] to population is 25,823 to 1, well above the MOHs short term goal of 30,000 to 1, variation between districts in Ghazni, for example, ranges from 1:5,725 to 1:145,300. The sheer lack of health facilities in many areas of the country precludes access to essential services, even if people could afford to, if females were permitted to, or if families recognised the need to. A woman quoted in an article on reproductive health in Afghanistan explains "Well, the question is not if I **would** go or if I would be **allowed** to go [to a health facility] by my husband, but rather where I **could** go. (…) We would certainly use those services if they were accessible and proven to be reliable" (*del Valle 2004*).

Box 2: Health System (as of June 2004)

Infrastructure

Avg. pop. per BPHS facility (clinic to district hospital) 1: 25,823

Range 1:11,800 (Wardak) to 1:52,278 (Ghor)

Existing BPHS facilities 926 (42% of actual requirement)

Damaged health facilities 292

NGO ownership/support 80%

Services

Bed patient ratio 0.4/1000

BPHS facilities offering delivery services with approp. equipment and female staff 18%

Hospitals with complete equipment to perform c-sections 10%

Immunisation (DPT3) coverage 30%

Antenatal care (at least one visit) 16.1%

Human Resources

Avg. doctor per pop. 0.4/1000

Range 3.1 (Balkh) to 0.01 (Uruzgan and Pakitka)

Male/female ratio 3:1

Range 2:1 (Hirat) to 43:1 (Nuristan)

BPHS facilities with no female health provider 40%

(UNICEF MICS 2003, MOH 2004, MSH/MOH 2004)

Perhaps one of the biggest challenges facing the health sector is human resources. Doctors make up a quarter of the health providers in the country with an average ratio of 0.4 docs per 1,000 population, well below the average of 1.1 for all developing countries (*WB 2001*). The majority of these physicians are

1 Although the results of the ANHRA are widely quoted in documentation, the reliability of the results has been called into question by some stakeholders. While the ANHRA results constituted the only comprehensive data on health facilities and human resources at the time it was conducted, it has been suggested that the results can not be used for planning purposes. Consequently, the statistics quoted above should be viewed with caution. A more detailed description of the ANHRA can be found in section 4.2.5.

2 BPHS health facilities include district hospitals and all health facilities below (comprehensive health center, basic health center and health post)

located in Kabul and other city centers resulting in enormous distortion in the distribution of health professionals. Moreover, only 24% of the overall number of doctors in the country and 21% of nurses are female (*MOH/MSH 2002*).

Only 21% of BPHS facilities have a midwife and some 40% of facilities have no female health provider at all, which, given the restrictions placed on women, creates a serious barrier for them to access health services (*Ibid*). Given the lack of female health providers coupled with a lack of facilities having the appropriate equipment to offer delivery services, it is not surprising that just 10% of deliveries are attended by skilled personnel. It has been suggested that this figure is overestimated and skilled attendance is thought to be even lower.

Routine immunisation (DPT3) is offered in only 58% of BPHS facilities, perhaps contributing to an alarming routine coverage rate of just 30% (*MOH 2004*). Moreover the ANHRA shows that some 70% of existing primary care clinics are unable to provide even basic mother and child services.

3.3.3 Successes to date (June 2004)

Despite these abysmal health conditions and the state of the health system there have been rapid strides forward in the health sector since November 2001 that can give hope to the Afghan people that the MOH and its partners are taking the improvement of health seriously. The most important achievements include:

- The choice of the MOH to refrain from implementation, mainly in relation to the BPHS, instead taking on a stewardship role and subcontracting health service delivery to NGOs
- The early development of numerous policies and strategies to guide health system development and investment including a national health policy (02/2002), the BPHS (finalised 03/2003 but used for guidance since mid 2002), the Interim Health Strategy (02/2003), National Salary Policy (08/2003), Recommended Human Resource Development Policy (08/2003), and Reproductive Health Strategy (06/2003) (*MOH 2004*). These have been developed with the contribution and participation of all stakeholders which has increased ownership and thus commitment to uphold national policy
- Successful coordination amongst donors facilitated by the adoption of a common approach for health service delivery and the geographical division of the country by donor to prevent duplication of service provision. Coordination is enhanced through active participation in the Consultative Group process, a coordination mechanism introduced to all ministries by the Ministry of Finance
- Successful coordination between NGOs and the MOH as illustrated by the replacement of the national health NGO coordination platform with coordination mechanisms such as the National Technical Coordination Committee (NTCC)
- Several studies have been conducted to inform planning and direct resource allocation, such as the costing of the BPHS, the Afghanistan National Health Resource Assessment (ANHRA), the National Hospital Assessment, the Maternal Mortality survey, a nutrition survey, and a large baseline drug indicator study
- As of July 2004 44 contracts awarded to 32 NGOs and the MOH in 30 provinces and 243 districts, covering 70% of districts and 59% of the population, using a third party evaluator who will conduct annual nationwide health facility assessments (semi-annual in 13 provinces in which services will be delivered province wide through one service

provider), and analysis of the performance indicators using the MICS database (baseline and after two years)

- Graduation of the first group of certified community midwives in April 2004 and the development of a new midwifery training curriculum
- Mass polio vaccination campaigns have reduced the number of cases in the country to 4 in 2004 and measles campaigns have reached more than 90% of children between 6 months and 12 years
- Establishment of the Grants and Contract Management Unit (GCMU) within the MOH whose main task is to coordinate and manage the PPA contracts and coordinate donor inputs in the health sector[3]
- Start of the Priority Reform and Restructuring (PRR) of the MOH civil service; proposals for the Provincial Health Department (including Provincial Health Offices) and the Policy and Planning General Directorate have been approved with the remaining Directorates expected to follow suit in 2005

3.4 Challenges for the Health Sector

In order to achieve an efficient and equitable health system that is sustainable in the long term, there are a number of challenges facing the MOH. Several factors preclude access to health services for which there are no quick fixes. A shortage of skilled staff, particularly females, may be one of the biggest constraints to scaling up health service delivery. Although contracts have been awarded to NGOs for training of midwives and women have also been enrolled in community midwife training schemes, a training period of at least 18 months

means that service providers will find it difficult to adequately staff health facilities with female health professionals for the present. Existing capacity to train the numbers required is scarce and furthermore, even after training has been completed, attracting females to rural areas will remain a challenge, particularly if current insecurity persists. Presently, even with the offer of exceptionally high salaries, NGOs are experiencing extreme difficulties in recruiting female staff to rural areas. Given that a reduction in the millennium development goal for maternal mortality of three quarters is a priority for the MOH, these human resource constraints will pose a formidable challenge in achieving this goal.

Recruitment of skilled male staff, while not as drastic as for females, will also present difficulties. While the ratio of physicians to population in Kabul is 1:1,765, the number in the rest of Afghanistan is 1:14,432 (*MOH 2004*). Lack of schools, housing and other social infrastructure

3 Although the GCMU was established primarily to manage the WB contracts, their role has expanded to include development and implementation of various other policies. See section 4.4.1 for more details.

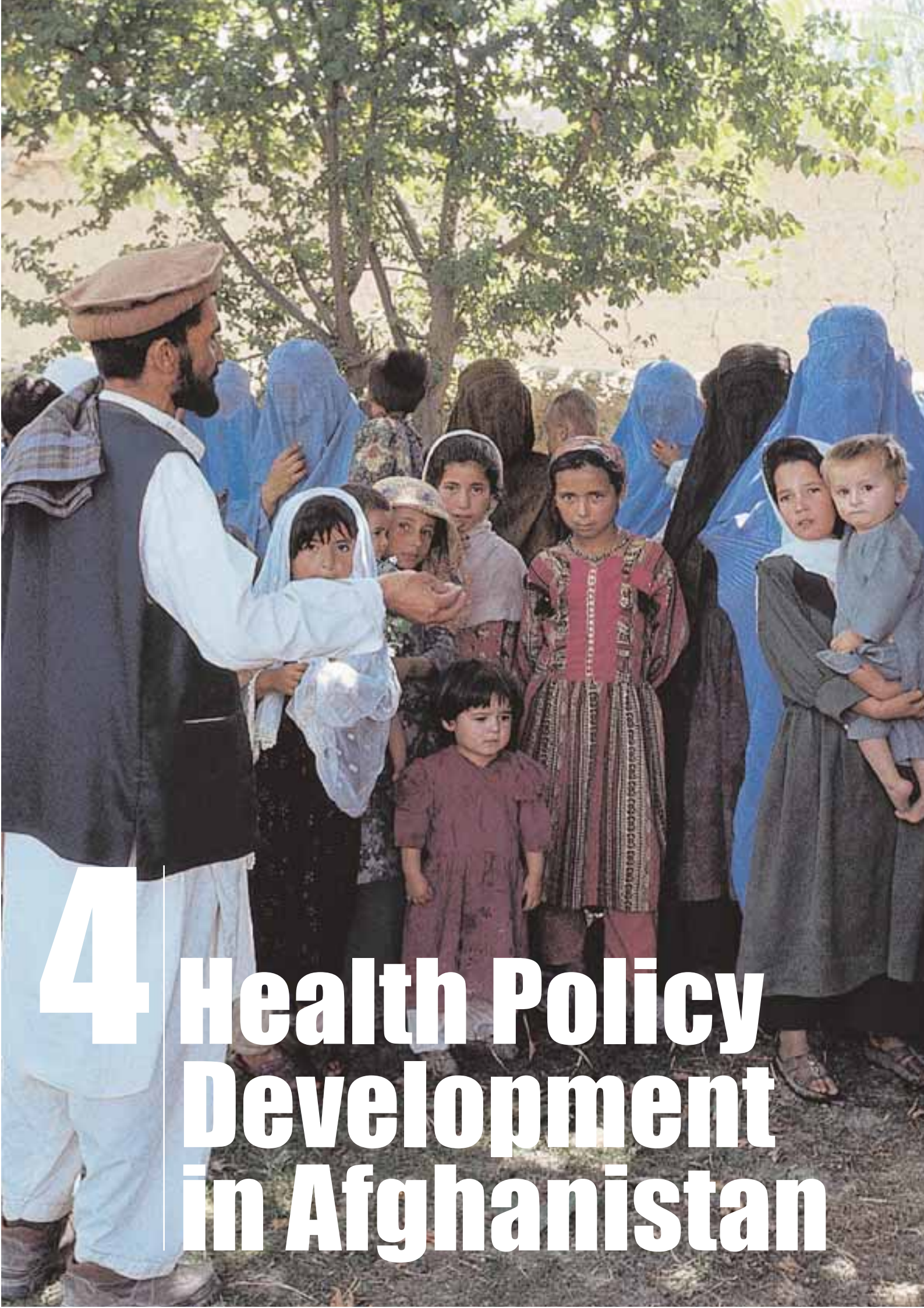
such as potable water, mean that male health professionals are just as likely to remain in urban centers. Furthermore, even if staff can be drawn to rural areas the adverse effects of the Taliban regime on medical education mean that the quality of medical skills may also be questionable (*Ibid*).

Other significant challenges in the health sector include lack of infrastructure, weak managerial capacity particularly at the provincial level, slow roll out of systems to the provinces and lack of security throughout the country (*Ibid*). The difficult socio-political circumstances that NGOs will face in delivering the BPHS in rural, underserved areas are further constrained by low population density in many areas, problematic geographical access and marked seasonal variations in access.

Another important long term challenge will be finding additional funds for the health sector. As of July 2004 only 59% of the population have been 'covered' by the minimum health facility to population ratio through contracts and grants in the initial phase of Afghanistan's transition to post-conflict. In addition to this lack of funds for even basic services, lack of an early policy regarding secondary and tertiary hospitals has had a significant impact on monies allocated for the hospital sector. While it is commendable that the majority of scarce resources have been allocated to the BPHS rather than sunk in expensive hospital costs, this lack of attention to the hospital sector has created disappointed expectations and dissatisfaction amongst the urban and semi-urban populations of Afghanistan. This carries some political risk in addition to being a potential health issue for these populations[4].

A review of the literature on the constraints to scaling up health interventions has shown that developing countries experience constraints on five different levels: (i) community and household level, (ii) health service delivery level, (iii) health sector and strategic management level, (iv) public policies cutting across sectors, and (v) environmental characteristics (*Hansen et al 2001*). For countries emerging from conflict, these constraints may be heightened. Lack of skilled human resources, weak government capacity and lack of infrastructure have been frequently cited as major constraints in other post-conflict settings such as Cambodia and East Timor. Indeed, 'year zero' in Cambodia was characterised by a depleted work force and a lack of sound structural buildings for static health facilities, with continuing insecurity precluding access to rural populations (*Bhushan et al 2001*). Describing the rehabilitation of the health sector in Cambodia eight years after the cessation of conflict, authors of an evaluation report comment: "The magnitude of this task is hard to convey to anyone who has not firsthand seen what a "year zero" society is like, and the progress which has been made in less than a decade is enormous. Nonetheless, it is still very much a society and country in the making, lagging far behind the rest of the region in its socio-economic indicators and human resource capital" (*Ibid*). This description illustrates that the challenges facing Afghanistan in re-building the health system are many in the years to come.

4 The ongoing development of the Essential Package of Hospital Services (EPHS) has gone some way to address the issues of hospitals beyond first level referral facilities. However, with continuing gaps in funding for the BPHS, the MOH may find it difficult to identify further sources of funding for the EPHS.



4 Health Policy Development in Afghanistan

Increasing attention has been devoted to the role of health systems and the significance of policy-making in achieving effective health systems (*Hanney et al 2003*). Indeed it is widely recognised that unwise policies contribute extensively to the underperformance of health systems in many countries (*Ibid*). In post-conflict contexts policy choices made can have profound and long-lasting consequences. In this regard, attempting to understand the processes involved in the formulation of policy can help to shed light on the forces that shape the health sector and can highlight constraints to decision-making and future implementation (*Pavignani 2003*). It has been shown elsewhere that early formulation of a national policy framework is crucial in post-conflict settings with improved health outcomes suggested as one product of better health policy formulation (*Bornemisza and Sondorp 2001*). A major challenge, however, is how to initiate and maintain policy momentum while maintaining a considered and rationale approach to decision making that is contextually appropriate and addresses the demands of the health sector. Given the impact that policy can have on the ability of health systems to perform effectively, and the unique opportunity in post-conflict settings to develop and overhaul ineffective policy from the past and revitalise health systems, it is useful to describe and document the ways in which health policy is developed.

This section describes the development of Afghanistan's health strategy from 2001 to 2003 and details the processes through which policies were developed, the contribution of various stakeholders, and where the MOH is at today with the roll out of the BPHS. The section is divided into 3 parts coinciding with three Joint Donor Missions that took place, as it was during these times that policy options were placed on the agenda, debated, and concrete steps were taken to ensure that discussion was transformed into action. During each of the missions there was an element of 'taking stock' of events and processes. Moreover, these time periods coincided with the phenomenon of planning and resource allocation.

4.1 The Early Days (November 2001 – May 2002)

The first key event following the fall of the Taliban was the Islamabad Conference on Preparation for Reconstruction that was held in Islamabad on November 27th – 29th, 2001 by the ADB, WB, and UNDP. Plans were made at the conference to carry out a series of needs assessments to determine the external assistance required for the reconstruction of Afghanistan in the short to medium term, and to identify priorities for a ministerial meeting to be held in Tokyo in January 2002. The priorities identified during the conference included institutional support, repairing structures and delivery of an essential package of primary health care services. This was the first point that delivering a basic package was articulated as a strategy to improve health.

The assessments were carried out by the ADB, WB and UNDP between December 2001 and January 2002, primarily from Islamabad and Peshawar, and results were presented at the ministerial meeting. It was estimated that $12.2 billion would be required to address immediate reconstruction needs over the first five years (*WB/ADB/UNDP 2002*). An important output of the meeting was the designation of agencies to lead assessment missions in each of the major sectors in order to collect more detailed information. It was agreed that under the leadership of the Afghan Interim Administration (AIA), the WB and WHO would head the mission for the health and nutrition sector with members from ADB, DFID, EU, UNICEF,

UNFPA and USAID. Although the mission report states that meetings were held with NGOs, they were not included as members on the mission despite supporting over 80% of heath facilities in the country.

4.1.1 Agenda setting and policy formulation

After the signing of the Bonn Agreement on December 5th, 2001, the newly revamped MOH got right down to business. With the support of WHO an initial National Health Policy was agreed in February 2002, in order to outline strategies for priorities in the health sector. The policy was explicit in stating that 'the national health sector will be organised and streamlined to deliver an essential package of health services to the entire population' (*MOH 2002*). While this represented a step in the right direction, the policy was confined to technical details and the ideals of a health system to aspire to but provided no direction on the nuts and bolts of critical policy issues such as the role of the MOH, health care financing, and the approach to service delivery (*Pavignani and Colombo 2002*). A qualitative policy study conducted in 2002 (*Bower*) reveals that although there was an attempt to involve different stakeholders in the process, the document lacked critical analysis due to the failure to present different approaches, weak capacity in the MOH and lack of policy vs. programmatic knowledge amongst NGOs, and poor coordination within the international community. Nonetheless, a policy statement has rarely been produced faster in a post-conflict environment and while some argue it was too fast, it got policy momentum rolling.

The first Joint Donor Mission (JDM) was conducted in March – April 2002, co-chaired by WHO and the WB[5]. The JDM took charge of raising some of the policy issues not addressed in the national health policy and proposed strong recommendations for the MOH to consider. The JDM, as mentioned above, was part of a request from the newly established AIA that came out of the January Tokyo meetings to, among other things, delineate a framework for assistance for the following 2.5 years, and more importantly, to define a government-led mechanism for coordination (*WB 2002a*). Using the policy goals outlined in the National Health Policy as a springboard, the aide memoire put forth 3 concrete policy options to operationalise the health system:

1) Expansion of the MOH to become a provider of services
2) Continuation of the current system of funding NGOs with limited guidance from the MOH
3) Establishment of Performance-based Partnership Agreements between the MOH and NGOs which would allow the MOH to utilise existing NGO capacity to deliver services while still maintaining control over the strategic direction of the health sector

Given the post-conflict context and the estimation that some 80% of health facilities were being operated by NGOs (*WHO database in WB 2002a*), the aide memoire made strong recommendations that the government refrain from service provision in favour of a stewardship role focusing on policy development and regulation. In line with this concept, option three was suggested as the best way forward. Through PPAs, the government would establish contractual agreements with NGOs to deliver health services within geographically defined areas. NGOs would go through a com-

5 Other participants included the ADB, DFID, EU, UNICEF, UNFPA and USAID

petitive bidding process and payment for services, on a per-capita basis, would be based on achievement towards pre-determined national indicators with performance measured through regular monitoring by the MOH and independent evaluations (*WB 2003b*).

The proposed PPA strategy was premised on positive findings from a pilot project in Cambodia which tested the performance of 2 different contracting models against government provision (*Bhushan et al 2001; Bhushan et al 2002*). Afghanistan's transition to post-conflict coincided with the completion of the pilot evaluation in November 2001 that concluded "Government contracting of the provision of health services to non-government entities is: feasible, cost-effective, high performing, [and] equitable" (*Bhushan et al 2001*). Conclusions reached and recommendations made in the evaluation were used as one of the primary justifications for the promotion of the PPAs. As part of the JDM the MOH were given a presentation of the findings of the evaluation.

The aide memoire tackled hard issues evaded in the national health policy and became an important document in the policy arena due to the practical nature of its content. Essentially, it became the backbone of the national health policy, and some argue, served to steer policy development in such a way that would facilitate health service delivery through PPAs (*Bower 2002; Daly 2003*).

It was in these early stages of the post-conflict environment, through the JDM mechanism, that the WB began to assume a primary role in shaping health policy. Although the JDM was co-chaired by WHO and the WB, the proactive presence of the WB made it an influential player in the policy arena. While WHO was selected as the focal point for policy formulation and planning, the WB arrived in country with concrete ideas about how to move forward with the reconstruction of Afghanistan's health sector. According to views from key informants, the charisma of very proactive staff enhanced the WB's influence. The JDMs were successful in initiating policy debate and served as a mechanism for effective coordination and communication between donors and the MOH. Bower *(2001)* points out

that, "…JDM experts … followed up their advice closely, regularly and in managerial detail, albeit often at a distance". Although WHO created some early opportunities for policy debate, recommendations and advice provided by various policy experts brought in on short term consultancies was not acted upon or followed up when these experts left. As such WHO's role contracted to focus more on technical assistance in programmatic areas such as EPI (*Ibid*).

The WB's influence gained momentum even after the JDM as they continued to remain engaged with the MOH via audio-conference calls from Washington regarding developments and next steps forward. The conference calls filled a gap in coordination and were an effective mechanism with efficiently chaired meetings and people phoning in regularly to receive updated information that wasn't available through other channels. Although WHO could (and should) have stepped into this coordination role, internal politics and underutilisation of policy expertise brought in from outside hampered their performance with regard to coordination and policy functions.

Also playing an active role in the policy arena were USAID/MSH, French Cooperation, UNICEF, UNFPA, JICA and the EC to a more limited extent. While USAID was fiercely opposed to some of the ideas that would evolve from the PPA concept they brought in a number of technical experts on topics such as health reform and health financing at an early stage who participated in various meetings, workshops, task forces, and working groups. This technical capacity was brought in through an early contract established with MSH in February 2002 to operate the Afghanistan Health Services Expansion Project (AHSEP) program. This injection of technical expertise provided much needed process support and assisted the MOH in moving policy forward in an informed way. While the EC was also a key player in policy discussions, their participation was more reactive than proactive; they did not bring alternative options to the policy agenda and were slow to bring in technical assistance. On the other hand, the EC did continue to provide considerable financial support to NGOs, who were some of the very few that were involved in the policy process, albeit to a limited extent.

Although not interested in directly funding the BPHS due to the abundance of funds from other larger sources, the French Cooperation (FC) was also playing an active role in the policy debate. While the FC did not oppose the concept of the PPAs entirely, they urged the government to carefully consider the promotion of PPAs on a large scale (as was proposed by the WB) due to lack of evidence to support the expansion of the PPA mechanism from a pilot level.

UNICEF also played an important role in terms of support to the policy process. Presence of an action-oriented individual contributed technical expertise in more programmatic areas such as maternal and child health, nutrition and EPI. In addition they actively participated in policy discussions and an international advisor was seconded to the GCMU in early 2003 to provide support. UNICEF is also contributing substantial funding support in areas such as EPI, safe motherhood, salt iodization, water and sanitation and education.

Although most health NGOs were interviewed by members of the JDM, and it was information obtained through these interviews that fed into the policy debate, they remained largely unaware of the PPA proposal that was made at this point in the process (*Bower 2001, Waldman and Hanif 2002*). During research for the AREU report 'The Public Health System in Afghanistan: Current Issues' (*Waldman and Hanif 2002*), NGOs requested a meeting in order

for the research team to present the key features of the PPAs. The report notes that key concerns at this stage revolved around their capacity to provide the entire range of services from health post to district hospital on a provincial level. There was also apprehension regarding reactions of provincial health authorities and their involvement in the design process of this kind of delivery strategy. Although there were a few NGOs included as focal points of programmatic areas such as TB (Medair), malaria and leishmaniasis (HNI) and national level emergencies (ICRC), and some were included in smaller advisory groups, a distinct lack of NGO involvement in the policy debate in these early stages has been noted (*Ibid*). It has been suggested that NGO involvement in the health sector pre 2001 was largely programmatic and they came into the post-conflict period with the same focus, which left them ill-prepared for discussions on policy issues. Nonetheless there were a few active participants from a limited number of NGOs who did raise their voice in the meetings they were invited to and took the initiative to get involved in the process beyond programmatic issues. However, observers have commented that contributions were individual rather than organisational, and it was these individuals that were chosen (by the MOH and not the NGO community) to represent NGOs in formal meetings.

4.1.2 National development framework

A first draft of the National Development Framework (NDF) was produced in April 2002, which reflected results of the preliminary needs assessments carried out for the Tokyo ministerial meeting in January. The goal of the NDF was to identify national strategies, priorities and policy directions in order to guide assistance from development partners to a series of programs and projects (*MOH 2002a*). The NDFs strategy identified three pillars (see table 2). Health and nutrition, one of 12 Public Investment Programs (PIP) to be funded by recurrent and development budgets, was slotted under pillar I with malnutrition and essential obstetric care identified as priorities requiring urgent attention.

Within health and nutrition, six priority needs were identified: (i) decrease infant and child morbidity and mortality (ii) decrease maternal mortality; (iii) combat malnutrition; (iv) decrease incidence of communicable disease; (v) improved equitable distribution of quality health services, and (vi) enhanced capacity of MOH to implement effective and efficient

Table 2: Three pillars of the National Development Framework

Humanitarian, human & social capital	Physical reconstruction & natural resources	Private sector development, governance & security
Refugee return	Transport and communications	Trade & investment
Education and vocational training	Water and sanitation	Governance & public administration
Health and nutrition	Energy & natural resource management	Security and rule of law
Livelihoods & social protection	Urban development	
Cultural heritage, media & sport		

health services. For 2002-3 (Afghan year 1381) the PIP was $173M. By 2003-4 (Afghan year 1382) it was estimated a total of $320.52M was required to fund all 46 programs under health and nutrition. Delivery of the BPHS was to account for $90M of this total (28% of the PIP), with projects aimed at improving the quality of hospital services accounting for 14% and enhanced capacity of the MOH at 17%. Despite this shift in focus away from curative, hospital based care towards basic preventative health care, there was a 61% gap in funds to implement priority programs (*MOH 2003*).

Funding support for the NDF was identified to come from domestic resources, the international community and the Afghanistan Reconstruction Trust Fund (ARTF). The ARTF was established in April 2002 in order to create a coordinated funding mechanism to finance priority expenditures for Afghanistan's reconstruction. Three categories of expenditure were identified as eligible through the fund: (i) recurrent costs including salaries and non-project technical assistance; (ii) investment activities and programs, and (iii) salaries for returning Afghans who were living abroad. The fund is administered by the WB with a management committee consisting of ADB, UNDP, IDB and the WB. While the ARTF represents an attempt to give the government more control over the allocation of funds to development priorities, Bower (*2001*) points out that funds were slow to come in with donors reluctant to fund recurrent costs and provide un-earmarked funds preventing channelling of money to their own priorities. Indeed, by May 2002, only 90M out of 400M requested by the government had been committed (*BIC 2004*). With domestic sources of revenue estimated to contribute $80M to the government budget a gap of $230M for the recurrent budget still existed.

Box 3: Basic Package of Health Services

Maternal and newborn health
Antenatal care, delivery care, postpartum care, family planning, care of the newborn

Child health and immunisation
Immunisation (EPI), Integrated Management of Childhood Illnesses (IMCI)

Public nutrition
Micronutrient supplementation, treatment of clinical malnutrition

Communicable diseases
Control of tuberculosis, control of malaria

Mental Health

Disability

Supply of essential drugs

MOH 2003

4.1.3 Formulation of the Basic Package of Health Services

In the weeks that followed the JDM, discussion surrounding contracting and the PPAs captured center stage in the policy debate. Dialogue concerning a basic package only started with the realisation that in order to contract health services the services had first to be identified. In this respect the concept of a basic package appeared closely related to the contracting strategy. Indeed, even in the second draft of the BPHS, it is stated "One of the first steps to achieve [contracts with NGOs under the recommended PPAs] … is to define a basic service package, which can later be used to draft the contracts and establish the progress indicators" (*WHO/MOH 2002*).

Having sparked interest amongst MOH officials with the PPA approach, the WB continued to push forward with a strict timeline for fulfilling the 'next steps' recommendations in the process. It wasn't until pressure was applied from the WB in Washington that an advisory committee was appointed by the Health

Coordination Task Force[6] (HCTF) to work on producing the package. The committee consisted of the MOH, WHO, UNICEF, UNFPA, and MSH. As the focal point for policy formulation and planning and the secretariat for the coordination task force, WHO took the lead in producing the package. With limited input from the MOH or the task force, little assistance from the advisory committee, and no examples to work from, a draft of the Basic Package of Health Services (BPHS) was essentially formulated by one WHO consultant who was armed with very limited information about the country (*X. Modol, personal communication, May 26, 2004*). Expertise was sought from various UN agencies and NGOs on all aspects of the package, to add to available existing information. As there was no literature regarding the cost-effectiveness of the components specific to Afghanistan (mental health and disability) local expertise was relied on exclusively.

Just two weeks after being commissioned, the first draft of the BPHS was presented to the HCTF for comments, again with little input received. Due to mounting pressure from the WB and other key actors, discussion on the contents of the BPHS and important aspects such as the role of community health workers[7] was largely limited, with the MOH anxious to have it endorsed. Rather than certain stakeholders being excluded from the process, limited input was more a consequence of hectic schedules and the time constraints of producing a document (*Ibid*). Another contributing factor was the lack of understanding of the implications of a basic package approach. While some tried to inject words of caution into discussion regarding the limitations of adopting such an approach, these were mostly drowned out by the perceived necessity to keep on track. Some of the main constraints highlighted included: (i) the weaknesses inherent in producing such a policy with limited consultation and local evidence[8], (ii) the BPHS is demanding in terms of its requirements for human resource development, which will be problematic in Afghanistan, (iii) the demographic pattern of the country translates into heavy reliance on community health workers and outreach which are less dependable and more costly than routine services from health facilities, and (iv) limited capacity of all stakeholders to commission, coordinate and monitor service provision (*WHO/MOH 2002*). The authors specifically emphasised that "…although each one of the components listed in the basic package proposed can be regarded as modest, providing the whole range of services has proven too big a challenge for most developing countries" (*Ibid*).

The final document was issued in March 2003 and outlined the contents of the BPHS (see Box 3) including four service levels through facilities (health post, basic health center, comprehensive health center, and district hospital), each with its own recommended staffing pattern and defined catchment area. Although mental health and disability were included in

6 The mandate of the Health Coordination Task Force was to among other things, serve as a forum for discussion of policy issues to be communicated to the MOH leadership. Membership composed representatives from the MOH, UN agencies, NGOs, ICRC, and donors. This task force was later defined as the Consultative Group for Health and Nutrition, which is now currently under amendment again (*Pavignani and Colombo 2002*).

7 Experience with a similar cadre of health workers in the 1995 national health plan revealed difficulties with supervision, monitoring and supply which resulted in CHWs setting up as village doctors in some areas. Fears of similar results prompted suggestions to create a working group to explore the role of CHWs in the BPHS. Stakeholders involved, however, neglected to devote time to the issue.

8 Just 7 months into the roll out of the BPHS, a review process of the contents of the BPHS began due to concerns raised by implementing NGOs.

the BPHS, they were excluded in the initial rounds of funding. While deemed important problems specific to Afghanistan, these two components have been relegated to second tier services.

One of the consequences of defining a package of health services, and an important policy development within the formulation of the contents of the package, was the redesign and reclassification of the Afghan health system. Previously, the taxonomy of health facilities was inconsistent and ill-defined, with an array of different names floating around to describe the same facility. Causing confusion about the type of services signified by different names, staffing patterns and the function of different facilities in the referral chain, the health system's current nomenclature reflects an attempt to alleviate this problem and standardise services by facility level.

It is interesting to note that while this restructuring of the system represents a significant policy development, little 'air time' was given to the issue. Indeed, the implications of such a change are far reaching with all PPAs, performance-based grants and building programs based on this model. These changes also impact on the future sustainability of the system. The consequences of this restructuring will only become evident in years following the initial contract periods. While the new structure is not unreasonable and is based on experiences from the reconstruction process in Mozambique, it has been the replacement of the old confusing terminology rather than evidence that it is the right structure that has facilitated its easy acceptance.

4.2 MOH in the Driver's Seat (June 2002 – March 2003)

This period of time in the process of identifying Afghanistan's health delivery strategy was characterised by hot debate, conflict, confusion, and camp building. Opinion regarding the PPA proposal for Afghanistan's health system was divided along both NGO and donor camps. Donor and MOH concern regarding the PPA approach revolved around the implementation capacity of NGOs to deliver the BPHS on a provincial scale, as proposed by the WB. Disagreements reached a climax following the release of a WB aide-memoire which donors felt did not reflect decisions and compromises made at a series of meetings during a WB mission in early 2003.

Also under discussion was the possibility of direct provision of the BPHS in a limited number of provinces through a MOH Strengthening Mechanism (MOH-SM) using IDA/WB monies.

Despite conflict and disagreement this phase was ended by a clear choice on the way forward both at the end of the second JDM and the WB mission in April 2003. The MOH was effectively in the 'driver's seat' from this moment onwards, pushing consistently for the implementation of the BPHS and subcontracting service delivery to NGOs. Moreover, this period of time is significant, as it heralded the end of the discussion phase and work was started on implementation modalities.

4.2.1 Pushing the agenda forward: the second Joint Donor Mission (July 2002)

The objectives of the second JDM were to follow up on issues and next steps that had been raised during the first visit, continue policy dialogue regarding the mechanism by which the MOH would work with NGOs, and to assess the costs to deliver services outlined in the

BPHS and the resources available with which to finance it (*WB 2002b*). Despite the fact that the government had still not made a decision pertaining to their role in health, the PPAs remained the sole strategy on the agenda.

Participation in this JDM had expanded to include GTZ, KfW, JICA, and the French Cooperation. While GTZ and KfW did not have an active presence in the health sector during the first JDM, there were other actors who were present and had been providing funds for health activities for several years that were not included (e.g. SIDA). Although some of these donors, such as SIDA and NORAD were progressively phasing out of the health sector due to the perceived abundance of funds available, other donors such as KOICA were interested in contributing to areas in health other than the BPHS. This was primarily due to funding availability and a desire to program funds on their own terms, based on past experiences, at their own pace (*interview data*).

Despite scepticism generated by the presentation of evidence on the use of PPAs and other performance-based payment systems in Cambodia and Haiti, a number of important decisions had been taken by the end of the second JDM that would drive the policy process onward. Even though some stakeholders were uncertain of the WB's agenda it was generally agreed that the PPAs represented an interesting option for healthcare delivery. Given the lack of evidence of its efficacy in practice however, it was expressed that implementation on a pilot basis would be more advisable in the initial stages of the roll out of the BPHS. Perceived as a show of support the MOH endorsed contracting-out in unserved areas and contracting-in in underserved areas.

In addition, a list of guidelines was developed to facilitate a unified approach to management of PPAs for the MOH and a common approach (i.e. the World Bank approach) for donors to follow. Some of the key points included that provinces or clusters of districts would be the geographical area covered by a PPA[9], donors would adhere to common terms of reference based on the BPHS, and that agreements should be established for at least 2–3 years (*WB 2002b*). However, while all donors have more or less based their contracts/grants on the BPHS, implementation mechanisms evolved to be quite variable and only the WB has adopted the term PPA for its project areas (see section 3.3.2).

4.2.2 Development of an interim health strategy

Although a policy direction had been outlined, the next challenge for the MOH was how to translate the policy into a strategy for the health sector. Supported by a series of visits conducted by a DFID funded institutional development consultant the MOH began working on an interim health strategy in August 2002 in order to clearly define priorities for health service delivery and strengthening of the health system[10]. The process was helped along through a series of seminars held by the consultant, which introduced international experiences in health systems development and reform and facilitated brainstorming sessions on priority steps for strategic development of the health sector (*Simmonds 2002*). In addition to these seminars, daily sessions were held in a

9 Although the initial proposal from the WB was for NGOs to cover entire provinces, negotiations took place over a 10-month period with the final agreement allowing for both provincial and cluster-based coverage. A cluster constitutes a group of districts that form a logical entity in terms of geography, access, referral patterns etc (*EC 2003*)

10 DFID funded 5 short term consultancies between August 2002 and March 2003 addressing key areas such as policy, strategy and institutional development, health financing, budgeting and financial management, and human resource development (*Simmonds 2003*).

second visit in November 2002 on topics such as the role, values and purpose of the MOH, setting priorities and development of options, and the value of thinking strategically while dealing with the everyday (*Sondorp et al 2004*). This practical approach to capacity building not only supported the development of an interim health strategy, but provided guidance on day-to-day issues that the MOH was dealing with. Faced with demands and expectations from an ever growing international community, the seminars provided an opportunity for MOH staff to discuss their positions on key issues, and receive advice on matters that were becoming part of their daily routine such as how to chair a meeting effectively.

By December 2002 a draft of the interim health strategy had been formulated and a series of position papers had been developed that described the MOH's position on various issues such as capacity building, coordination, and construction of health facilities. By February 2003 the final interim health strategy was agreed and circulated. In line with the NDF which identified health and nutrition as a priority, the interim policy outlined 12 strategies for delivery of health care including capacity building of institutional and management functions within the MOH. The strategy includes a revised organisational structure for the MOH and outlines a series of indictors and outputs to achieve priorities. A commitment to the provision of the BPHS for the next 3–7 years was also included in the strategy.

4.2.3 3rd World Bank pre-appraisal mission

In January – February 2003, a pre-appraisal mission was conducted by the WB (also attended by MSH and DFID) to assess and finalise the design of the PPA project components, and come to an agreement with other development partners on their involvement and coordination mechanisms (*WB 2003a*). During the mission the following agreements were arrived at:

- 10 provinces would be designated to the PPA model; 7 contracted out to NGOs and 3 in which the MOH would deliver services itself using WB/IDA monies through a MOH Strengthening Mechanism (MOH-SM), which would provide technical expertise and advice on proposal development, management systems, etc. It was envisaged that the MOH-SM would operate as traditional government provision and serve as a control group to compare against the contracting out of service delivery to NGOs, similar to the pilot design in Cambodia;
- In order to ensure efficient use of resources and prevent duplication of efforts a lead donor was proposed for each province;
- The establishment of a Grants and Contract Management Unit[11] to coordinate donor assistance coming into the health sector and serve as a focal point for the PPAs;
- The mandate to finalise work on a national salary policy.

The aide memoire presented another checklist of 'things to do' in the coming months that stakeholders felt the MOH did not have the capacity to do alone, and would take a substantial amount of time, over and above other pressing matters that they had to deal with. Donors felt that they were being pushed into providing support for preparations for the WB's project who wasn't around to chip in.

11 The objectives of the GCMU are: (i) expansion of the BPHS through NGOs and the private sector, (ii) strengthen the stewardship role of the MoH, (iii) integrate NGO and donor efforts in the reconstruction of the health system, (iv) develop MoH capacity to work with NGOs and the private sector to encourage use of domestic resources in future partnerships (*Draft terms of reference in Daly 2003*).

They also felt the time schedules given to complete tasks were simply unrealistic given that the PPAs were neither the only thing the MOH, nor other donors had to devote attention to.

In this early part of 2003 debate over implementation mechanisms continued and tension was exacerbated amongst donors with the release of the aide memoire. Some of the reactions and concerns of key stakeholders are outlined below to illustrate the array of opinions and some of the blockages preventing consensus.

Donor/UN reactions and concerns

Although eventually donors were able come to an agreement on how to program their funds in a coordinated way there was a period of heated debate where irritations began to brew amongst stakeholders. Below some of these 'irritations' are highlighted to illustrate some of the issues that can derail the process of strategy development. Rather than pointing fingers, this section should be read from a lessons learned perspective.

The four main donors in health are USAID, WB, EC and UNICEF. While the WB was responsible for introducing the PPA concept, there was general consensus among the main donors regarding the overall principles necessary for implementation of the mechanism, which consisted of subcontracting NGOs for service provision, with the Afghan government acting as a regulator and policy-maker. There was considerable controversy, however, regarding implementation strategies.

The main points of contention have revolved around the following technical issues:

1) Evidence-based policy: given the lack of evidence and field experience with the PPAs, implementation on such a large scale poses an ethical and moral dilemma.

2) Scale of coverage: based on the Cambodia evaluation the WB advocated strongly for province-wide PPAs in at least 10 provinces, with one NGO responsible for delivery of the BPHS. Other donors were more favourable of a cluster approach with only a limited number of province-wide PPAs as a pilot. Concerns were that with only 1 NGO providing the entire BPHS in a province there would be no safety net if the approach failed. Moreover, the number of NGOs with the capacity to implement at a province-wide scale was felt to be limited, especially given that many of the lead NGOs working in the health sector were also working in other sectors such as education, and receiving substantial injections of funding to expand these services at the same time.

3) NGO and government capacity: the capacity of NGOs to provide the scope of services in the BPHS in the context of Afghanistan is not certain, and many have argued, is not possible without a more phased approach. Government capacity at all levels is understandably weak and PPAs would occupy most of their time, preventing capacity building in other areas.

Disagreements came to a boiling point with the release of the pre-appraisal aide memoire. The report triggered the exchange of very frank letters between the WB and donors who had participated in various meetings throughout the mission. Donors claimed *"it (the aide memoire) does not reflect … discussion with the MoH and donors nor the points of view expressed and apparent compromises made by the various health sector partners, including the WB, during the appraisal mission"* (*USAID et al 2003*). This perception that all views were not taken into account created friction and slowed down policy decisions even longer.

While the debate amongst the donors listed above had continued ardently since mid 2002, other donors had chosen to opt out of participation in JDMs as well as the PPA scheme. Some felt they didn't have enough funds to get involved and have instead invested in other areas in the health sector such as hospital construction. Others were of the opinion that while the PPAs represented a viable option, they were more comfortable with programming their funds based on their own past experiences. An additional complication was the MOFs request for donors to choose three sectors for support, which limited them in spreading their resources and caused smaller donors to opt out altogether. In contrast, while the French Cooperation steered away from supporting the BPHS financially, they remained fully engaged in the policy process, contributing an additional perspective which, due to lack of involvement from other donors, was in short supply.

Another issue that donors were debating was the funding of district hospitals. Despite the inclusion of district hospitals in the BPHS, both the WB and USAID were seriously contemplating not funding this component. The WB eventually agreed to include them after it was estimated that a 50 bed hospital would cost approximately $150,000 per year. USAID stood by their decision at this point in time but have since taken a more relaxed attitude, funding a limited number of district hospitals.

MOH reactions and concerns

There was general consensus among the international community that the MOH was extremely open to suggestions and criticism throughout the policy process, and were open to taking risks and trying new things in determining the best way to deliver health services in Afghanistan. While the MOH was primarily concerned with the proposed scale of the PPAs it seems they acted within the confines of 'bounded rationality' (*Walt 1994*), having limited information and making decisions based on options which offered a better solution to the way services were being delivered.

A position paper released at approximately the same time as the pre-appraisal mission reinforces the notion that the MOH was in favour of a more considered approach in delivery of the BPHS: "At this point in time we think a mix of … the 3 options is the way to move forward. There is no one right way to deliver services in our country. We need to be flexible, be prepared to do things differently from the past, if the health of our people, especially mothers and children is to improve" (*MOH 2003a*). Although there were discussions regarding direct government provision through the MOH-SM the balance of these policy options tipped in favour of contracting NGOs for service provision. According to key informants, there was, and continues to be considerable speculation over the degree of choice that the MOH has had in making these decisions. The literature continually points out that involvement of international organisations is more likely to lead to coercive adoption of policy (*Dolowitz and Marsh 2000; Stone 2001*), and with the energetic approach used to promote to the merits of the

PPA approach, many actors feel that some degree of pressure has influenced policy.

NGO reactions and concerns

Most NGOs had serious concerns about the PPA proposal put forth by the WB. As news spread that PPAs were on the menu and would be the only policy served for discussion, shock waves were sent through the NGO community. PPAs represented a shift from traditional forms of humanitarian assistance to a more business-oriented approach geared towards privatisation which didn't sit well with some. Indeed, NGOs feared losing their traditional identity to be seen as merely 'contractors'. While some fiercely opposed the PPA approach, most NGOs were somewhere in the middle, confused and unsure of what position or strategy to adopt. Despite presentations on the PPA concept made during the second JDM many NGOs seemed to remain unclear on the specifics and implications of such an approach. Some organisations made the rounds in an effort to join forces and raise concerns, however they didn't manage to rally amongst themselves to present a common opinion. While papers and letters were written regarding perceived flaws of the approach (*for example see Ridde and Bonhour 2002; Daly 2003*) they didn't have much success in raising any high profile question marks pertaining to their concerns before decisions were taken.

Some organisations who had been receiving funds from donors other than USAID, WB or the EC were slow in responding to the PPAs. Confident that their current support for health activities would continue they didn't pay much attention to the ensuing debate and remained somewhat indifferent. However, as funding for the BPHS became available, donors who had been supporting health projects on a smaller scale made plans to phase out of health and into other sectors such as education. This transition caught organisations off guard and triggered a rush to develop proposals for subsequent rounds of funding.

While the majority of NGOs (and international organisations), albeit reluctantly, eventually decided to participate in the bidding process, some opted out of the process from the beginning as a result of clashes with organisational principles and mandates. MSF, for example, while officially supporting the PPA initiative have chosen not to participate due to their position on neutrality and independence. Moreover, their emergency mandate prevents them from engaging in development related activities such as provision of a basic package. Also strictly upholding the core humanitarian principles, ICRC has chosen not to engage. Apart from these agencies however, on the whole, relatively few have opted out of the process completely.

4.2.4 Developments in health coordination

In April 2002 WHO was installed as lead in the health sector, with responsibility for policy and planning and overall sector coordination. However in the same month a new approach introducing 'programme secretariats' and 'programme groups' emerged, endorsed through the NDF. WHO was again announced as head of the Program Secretariat[12] in June 2002 with the responsibility for overall coordination in the health and nutrition sector.

In order to improve the effectiveness and efficiency of aid coordination, the MOF announced that sectoral coordination mechanisms called Consultative Groups were to be established for each of the 12 national programs in the NDF. In line with this wider government move the MOH created the Consultative Group for Health and Nutrition (CGHN),

12 The Program Secretariat was to be responsible for overall coordination in the health and nutrition sector.

replacing the Program Secretariat which to date had failed to function effectively. While the Program Secretariat was criticised for having too many expatriates involved and not enough Afghan leadership, the MOF stressed that Afghan ownership of the CG process would be key for development and change. The CGHN is held once a month and chaired by the MOH, with USAID and the EC serving as joint focal points. The meeting includes representatives from other ministries as well as the donor, UN and a few select NGOs[13]. A smaller version of the CGHN was also formed (WCGHN) which serves as a venue to discuss technical and policy issues. The meeting is chaired by the Technical Deputy Minister and include members from select NGOs, donors, and the UN[14].

In addition to the CGHN, six management task forces and twelve general taskforces have been created to allow for focused technical input on specific topics with the aim to provide recommendations or develop intervention strategies. Membership of task forces includes technical experts and donor, UN, NGO, and MOH representatives based on involvement in the topic. There are also several working groups that are in operation such as the capacity building working group.

One of the main sources of problems in the Cambodia pilot was that provincial health departments did not have a stake in the success of the intervention districts. To avoid this problem in Afghanistan, coordination mechanisms have been established at the provincial level in the form of a Provincial Health Coordination Committee (PHCC)[15]. The PHCC has been created with the objective "…to coordinate the activities of all stakeholders in achieving MOH priorities, particularly the expanded delivery of the basic package of health services (BPHS)" (*MOH 2003c*). However the role that the PHCC and the Provincial Health Office would play in the different flavours of contracting adopted by donors was suggested to be unclear among stakeholders. For example, the function of the PHCC would be much different in a WB province with one provider compared to a USAID province where there may be as many as 5 providers. Although this mechanism may go some way towards building relationships between provincial authorities and NGOs, some donors have suggested that the lack of inclusion of provincial hospitals and Provincial Health Directors (PHD) into the BPHS has led to a lack of buy-in to the process in some provinces. Indeed the current lack of a decentralised system may create the potential for conflict given that many PHDs are political rather than technical appointees who are largely concerned with controlling resources. Whether this situation will improve over time as PHDs become more familiar with policies and the NGOs operating in their provinces will be key to the success of BPHS projects.

13 The CGHN is not officially an NGO coordination mechanism. The few NGOs that do participate have been invited by the MOH and do not necessarily represent the NGO community as a whole.

14 In order to improve input of technical expertise a Technical Advisory Group will be established. A group of permanent and floating members will be appointed to advise on 4 main priorities in the health sector: (1) decrease in infant mortality rate, under five morbidity and mortality, malnutrition, and communicable diseases, (2) decrease in maternal mortality rate, (3) improve equitable distribution of quality health services, and (4) enhanced capacity of MOH to implement effective and efficient health services (*MOH 2004b*).

15 PHCC: Provincial Health Coordination Committee. The terms of reference for the PHCCs include: (i) Information sharing, (ii) coordinate regular reporting system for HMIS, (iii) draft annual provincial workplan, (iv) coordinate expansion of services, (v) identify sites for new health facilities, (vi) assign catchment areas, (vii) review and approve proposals (viii) participate in emergency response and special activities, (viiii) mediate among stakeholders, and (x) coordinate with MoH and governor. Membership will include the PHD as chair, the provincial health deputy director, provincial HMIS focal person, and a representative from EPI management. No more than 7 other members may be chosen from: other relevant line ministries, NGOs providing services, 1 representative from the private sector and international agencies with an office in the province or region (*MOH 2003a*).

4.2.5 The influence of assessments and studies on the policy process

Several studies took place during 2002 and 2003 to establish a base of information which could inform planning and resource allocation. Those which have had a significant impact on the health policy process specifically are described below.

UNICEF/CDC Maternal Mortality Study

Although it was widely recognised that the maternal mortality ratio in Afghanistan was extremely high, accurate figures were not available. In Afghanistan's first ever national study on maternal mortality, a staggering MMR of 1,600 per 100,000 live births (95% CI 1,100 – 2,000) was revealed, one of the highest in the world. Even more disturbing was the discovery of an MMR gauged at 6,500 maternal deaths per 100,000 live births (95% CI 5,000 – 8,000) in Badakhshan province, the highest MMR ever reported globally. While the MOH recognised maternal mortality was responsible for a high proportion of preventable deaths, these staggering figures ensured that conquering maternal mortality was included as a top priority in Afghanistan's health strategy. One of the main aims of the strategy is to reach the Millennium Development Goal for maternal mortality which is a reduction by three quarters by 2015.

Afghanistan National Health Resource Assessment

At a provincial planning workshop in March 2002 it became apparent that there was extremely limited up to date information on the status of health resources available in the country to address pressing health needs. In order to facilitate rational planning and direct the equitable allocation of resources the Afghanistan National Health Resource Assessment was conducted by MSH and HANDS in April – September 2002 funded by USAID, EC,

UNFPA, and JICA. The objectives of the assessment were to (i) conduct an inventory of existing resources and their distribution, (ii) establish an up to date database of information to facilitate rational planning, and (iii) establish the basis for development of data sets for human resources and health service infrastructure that could be routinely updated (*MOH/MSH 2002*).

Main findings showed that there was extreme inequity in the distribution of health facilities, an acute shortage of services dealing with pregnancy and delivery and a need to ensure availability of community-based health workers due to poor accessibility health facilities, particularly in rural areas.

The ANHRA has played an important role in the expansion of the BPHS. First, it underscored the shortage of female health workers and the need to initiate training for midwives as quickly as possible. Second, data collected on the distribution of facilities was used to de-

termine whether provinces were underserved and therefore a priority for the expansion of the BPHS. This assisted the MOH and donors to gauge where resources should be directed as a priority. Particularly for donors such as USAID, who focus on districts as geographical units rather than whole provinces, the data allowed them to determine which districts should be covered before others. The data collected in the ANHRA was also used to facilitate health facility planning during several provincial planning workshops held with PHDs from across the country in Kabul. The workshops represented the first time that all provincial stakeholders were brought together in a systematic way and provided an effective means to disseminate information and policies developed at the central level (*MOH 2004*). Some feel, however, that distorted estimates of the quantity, quality and location of existing facilities have led to inaccurate planning. For example, large discrepancies have been reported between the number of ANHRA reported health facilities and those found in situational analyses conducted by NGOs (differences as large as 50%).

Although initial data analysis was flawed it was corrected and a final version of the assessment was circulated in April 2003. While the assessment document admits that the information was not 100% accurate, it was stated that it represented the most comprehensive data available for planning. Despite requests to maintain the database, updating it with new information as it became available, with the exception of areas where USAID is working, this has not been done due the perceived inaccuracy of the data. So, while the ANHRA has served a purpose, its usefulness has waned.

Costing of the BPHS

Conducted in March 2003, this study has the aim to cost the recently developed BPHS in order to be *"used by MOH and donors for grants and contracts with NGOs to extend health service to the relevant areas and provide a benchmark for operation of government health services"* (*MSH 2003*). To determine the costing, data was collected from 6 NGOs over a total of 10 facilities at Basic Health Centre or Comprehensive Health Centre level, which were sampled from across 9 provinces. Hospital costs were based on one estimate of a 50 bed hospital.

Results showed that the BPHS could be provided for a total of $4.55 per capita per year. Since the costing, the figure of $4.55 has been used substantially, cited in several documents and used by most donors as a benchmark in determining appropriate financial requirements for grants/contracts. It has been particularly useful in that all donors, and NGOs in the preparation of proposals, have been working off the same figure. However, considering the information constraints in conducting this exercise it would seem that $4.55 can only be a very vague indication of what costs might be, which is clearly acknowledged by the authors themselves: *"the data required for this study did not exist…the quality of data that did exist was questionable"* (*Ibid*). Other weaknesses in the study are the small sample size, the data used was based on 2001 and 2002 when a lot of changes were occurring and lack of clarity on how to do economic costing of CHWs and TBAs. Despite these weaknesses and the timeframe over which the study was conducted, the study is a valiant attempt to produce an initial benchmark for planning.

While some argue that $4.55 is too low to include quality services up to the district hospital level and despite the weaknesses in the study, initial analysis of winning proposals show that per capita costs are hovering around this figure (see section 3.3). It will be important however, to examine whether NGOs have cut corners in an attempt to be competitive and within reason of the $4.55 benchmark. This is

particularly true for rural provinces where the logistics of access alone constitute significant costs. The trade off between lower costs and quality of care is also another issue which should remain on the radar of policy-makers.

4.2.6 Infrastructure development

Providing the bulk of funds for reconstruction of health facilities, the USAID REFS program officially started in September 2003. The planning process and site assessment however, started at the beginning of 2003. At a provincial planning workshop held in early 2003 one of the priorities was to establish priority areas for facility construction. Given that there was no funding envelope attached to this planning process, what emerged was a construction 'wish list' with gross overestimations of health facility requests. Nonetheless, this process was used to assist in identifying priority sites for construction of health facilities, based on the availability of funding from USAID. The Louis Berger Group (LBG), a U.S-based construction firm, was contracted by USAID to manage the reconstruction process. Over 300 health facilities were planned for construction by September 2004.

While the REFS program was established at approximately the same time as the WB and USAIDs first tenders for delivery of the BPHS were issued, the EC announced their first round of funding in late 2002 with awards granted in mid 2003. With the REFS program not yet foreseen there was much more emphasis on infrastructure development within the first tender round[16]. In contrast, construction under USAID REACH and the WB PPAs was an unallowable cost. This is one difference that exists between the project activities conducted under each of the three major donors.

4.3 Expanding Coverage of the BPHS (April – December 2003)

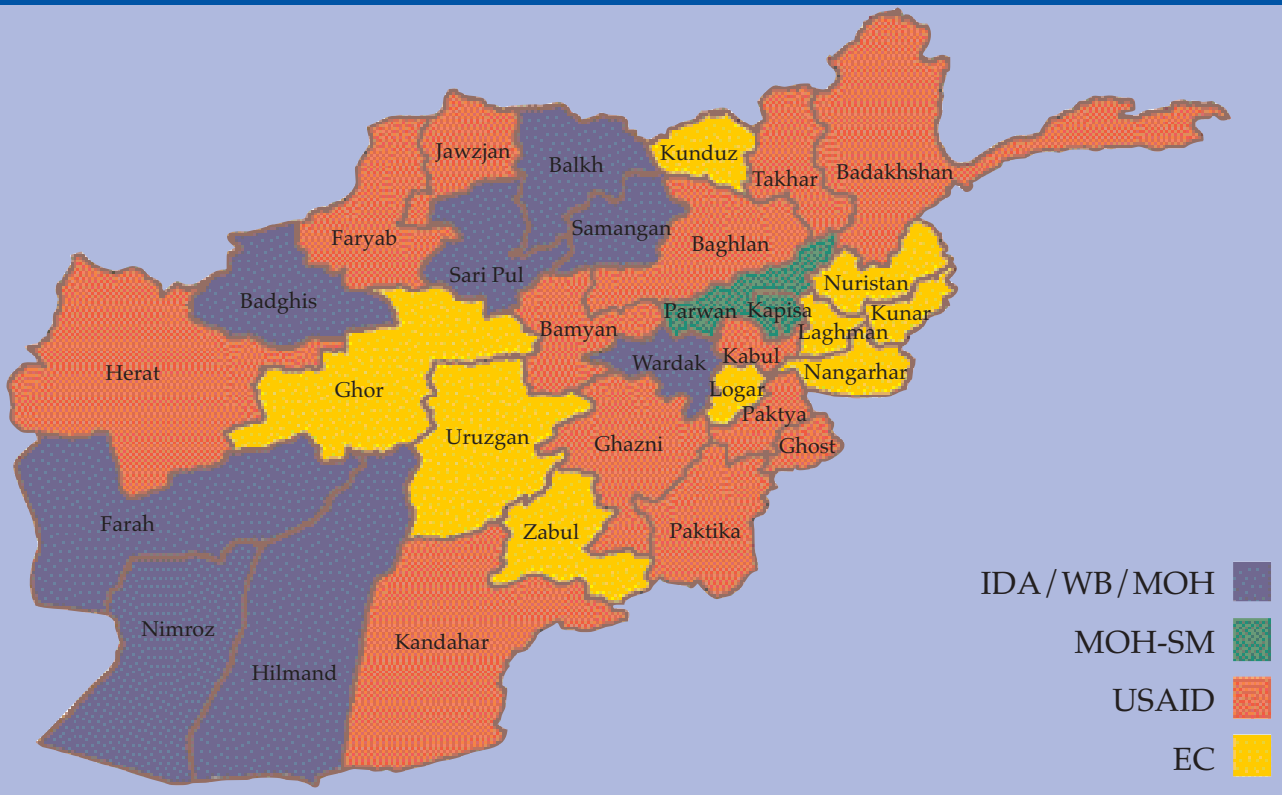
Debate, discussion and negotiation over approaches to implementation had taken place over a period of 10 months by this point in time. Given that the tendering process was supposed to begin by June, specifically for the MOH/WB PPAs, consensus had to be reached and decisions taken. Although the MOH was more favourable of a cluster approach and continually expressed concern over the scale of the PPAs, they formally agreed to NGO provision throughout the country and a mix of the cluster and province-wide approaches in May 2003.

The concept of a lead donor in each province evolved from this process whereby specific donors would be responsible for specific provinces, creating fewer coordination problems with having multiple donors in one area. In line with this idea the country was split up and provinces assigned to each donor (see Map 1). While the EC and USAID finally agreed to province-wide and cluster-wide projects, their agreement was conditional on being able to select the provinces in which their projects would be implemented. Essentially the EC and USAID chose the provinces they wanted and the WB was left with the rest of the country.

A third JDM was held from April 21–23 chaired by the MOH. A two day workshop was held in Kabul with a variety of stakeholders from the UN, NGOs, donor agencies, and different levels of the MOH. Numerous issues were presented and discussed amongst small working groups including implementation of the BPHS at the provincial level, integration of vertical programs, and piloting of health financing mechanisms. The MOH also presented

16 Construction was only included in grants awarded in the first round and has been removed from subsequent rounds of funding

Map 1: BPHS funding status by donor as of July 2004



Source: MOH presentation 2004
*The ADB funds the BPHS in 4 district in Ghor and 5 districts in Badakhshan, KfW funds half of Badghis province, and USAID funds 1 district in Ghor.

developments in the new interim health strategy including the restructuring of the MOH, capacity building, strengthening of provincial health departments, human resource development strategies, and future directions for health sector reform (e.g. civil service reform, health financing options, health facility construction).

4.3.1 Procurement

The WB issued requests for Expressions of Interest in April 2003 and NGOs were given a month to respond. A Request for Proposal was then issued to shortlisted NGOs between May and August 2003 who had 45 days to submit technical and financial proposals. USAID issued a Request for Applications on June 10th, 2003 with a closing date of July 24th, 2003. The EC's first Call for Proposals (CFP) came in December 2002, before the finalisation of the BPHS. Their second CFP was issued on May 15th, 2003 with the same closing date as USAID. The bidding process went smoothly, although there was some indecisiveness caused by high costs for provinces that were initially tendered out as clusters under the WB PPA model (see box 4). High overhead costs with more than one NGO in a province caused the MOH to rethink their strategy and it was decided to eliminate the cluster approach and expand all contracts to province-wide coverage under one NGO[17].

The competitive bidding process has been a new experience for many NGOs. As one con-

17 Due to some coordination problems in Badghis province both KfW and the WB have NGOs under contract providing the BPHS. However the province has been split into 2 clusters with each NGO covering half of the province.

Box 4: Higher costs with the cluster approach?

In the final agreement over the geographical unit that each WB PPA would cover the MOH decided to opt for a mix of the cluster and province-wide approaches; 4 provinces would be province-wide and 3 would be based on the cluster approach. However, after receiving bids for 2 of the cluster provinces the MOH felt that the overhead costs involved with having more than one NGO in a province were too high and not an efficient use of resources. NGOs were asked to bid again, but this time for the entire province. After receiving bids for the second time, the MOH decided they should have some experience with implementation and wanted to experiment with other contracting models, so they designated the provinces as those that would fall under the MOH-SM. USAID and the EC have gone on to establish several cluster grants in their responsible areas. Per capita costs in the clusters range from $1.75 - $48 USD* whereas in provinces they range from $2.95 – $6.25 USD. An important issue to examine in upcoming performance assessments will be whether lower cost has an impact on the quality of services, and whether NGO capacity is sufficient to provide the BPHS at a provincial level. Moreover, the different mix of costs in NGO budgets (e.g. construction, capacity building, etc.) should also be considered.

*It should be noted that drugs are provided in kind

sultant states the process differs in that "…before, NGOs submitted a proposal and then started talking, now they have to get it right the first time around or they get eliminated". This change in procedures coupled with the speed in which the tendering process was initiated put pressure on NGOs to produce proposals for entire provinces within 1–2 months time. Furthermore, it put pressure on them to design strategies for implementing an entire district health system, including management of hospitals which many had little to no experience doing. Some organisations thought ahead and brought in experienced consultants to write proposals three months in advance. Others, who were either unsure of whether they would bid or simply didn't have the resources to hire expensive consultants, had to struggle through with the capacity they had in country. According to one evaluator of the bids "The market was favourable for NGOs so nobody really lost out, but the proposals funded weren't great". Indeed, it is evident that some NGOs have not fully understood the idea of the MOHs new role as a policy-maker versus service provider. Describing a strategy to service delivery, one proposal submitted for northern Afghanistan explained that "this is seen a gap filler until the MOH can take over fully".

Although many NGO's initial response to the PPAs was negative there are few that haven't participated in the bidding, primarily due to two main reasons. While still not necessarily agreeing with the PPA approach, many feel it will be impossible to change things or have an impact on policy if they opt out of the process. They feel that being involved in implementation will enable them to remain engaged, and allow them to raise flags and concerns from the field which might not otherwise be heard. The second reason arises out of the simple need to stay afloat. Given that all funding for primary health care is being channelled through WB/MOH, USAID and the EC health NGOs with little access to private sources of funding have little choice in the matter. However, in general, this all or nothing approach has excluded few organisations and has served to establish coordinated service delivery within a clearly defined national policy framework.

An interesting point to note is that despite the marked differences in donor approaches, many NGOs are viewing all 3 as one and the

same. NGOs contemplating their role in this new initiative feel that if they reject the WB or USAID model, it would be hypocritical to accept an EC grant as all donors are working towards the same objective, which these NGOs consider to be privatisation.

4.3.2 Implementation mechanisms

Despite the plea for a unified approach in the implementation of the PPA mechanisms, the three major donors have each adopted somewhat divergent modifications on the World Bank's 'Proposed Common Approach to PPAs' outlined in the aide memoire from the second JDM. The main features of each of the main donors are described below. For a broader picture of similarities and differences see annex 1.

World Bank: The perceived success of the contracting-out model in the Cambodia pilot is reflected heavily in the World Bank's design for Afghanistan. The competitive tendering process involves 3 main steps: (i) issuance of a request for expression of interests (EOI) from prospective bidders (both for-profit and not-for-profit agencies), (ii) request for proposals from 3–6 shortlisted bidders and, (iii) bid evaluation involving a two envelope system where a technical and financial proposal are submitted separately. Much the same as Cambodia, the contracts are performance-based with financial bonuses of up to 10% for meeting and exceeding predetermined targets[18]. Contracts are based on lump sum remuneration which gives considerable flexibility to NGOs to adjust the budget as necessary to accommodate changing situations during implementation. Moreover the lump sum contracts represent a much lighter burden in terms of management as NGOs are free to provide services as they see fit and spend funds according to how they feel will best benefit the project, without having to get approval for changes.

One of the major differences in the WB approach is that funding is channelled through the MOF, albeit under tight controls, and it is the MOH that establishes contracts with NGOs. The GCMU is the focal point for all negotiations and contract management, including the tendering, evaluation and implementation process. In contrast USAID and EC establish agreements directly with NGOs and channel funds through them rather than the government.

USAID: Successful experiences with their implementing partner, MSH, in the performance-based payment pilot in Haiti led USAID to adopt a similar approach in Afghanistan. The REACH program brings in elements of performance-based payment based on submission of deliverables on a monthly basis, but uses a grant as opposed to a contract and does not offer financial incentives for good performance. Payment mechanisms are based on cost-reimbursement which is another significant difference from the WB approach. Moreover, the geographical area covered by REACH program is clusters of districts and in some cases single districts. As a result some provinces have up to 4 NGOs delivering the BPHS in different clusters of districts. Moreover, although the process was competitive it differed from the WB process in that competition was not over a pre-defined geographical area; instead NGOs could determine the geographical units they wanted to bid on e.g. one district, a cluster of districts, etc.

18 A bonus of 1% of the contract value will be paid every six months in the case of exceptional performance, defined as a 10 percentage point or more improvement from the previous highest score on a health facility assessment carried out by a third party using a standard quantitative checklist. 5% of the contract value will be paid at the end of the contract based on exceptional performance, defined as 50 percentage point increase in the combined score on the indicators listed in the terms of reference as measured by household and health facility surveys (*WB 1997*).

Unlike the WB, performance indicators are proposed by the applicant and negotiated upon award based on capacity to implement the BPHS. Preference is given to national NGOs or international NGOs partnering with national agencies. Although a similar evaluation process is carried out as in the WB model with scores allocated for both technical and financial aspects of the proposal, the scores are only used as a tool and NGOs with the highest score do not necessarily win the grants. In order to ensure decisions were as informed as possible, discussions were held amongst evaluation panel members after the scoring process. Panel members included representatives from USAID, MSH technical staff and the MOH (both central and provincial authorities). Taking into account information from the scoring process and discussions, a vote was then taken to determine the winning bid.

The scope of services is also different as REACH does not require NGOs to support district hospitals, which are included in the BPHS. Instead, it is stated that "One of the main purposes of the grants program is to help in developing an integrated, comprehensive community-based delivery system that at a minimum includes Health Posts, Basic Health Centers and Comprehensive Health Centers in the initial phase" (*USAID/MOH 2003*). Considerable effort is invested in capacity building activities for all NGO partners, however a specific emphasis is placed on national NGOs in order to improve their ability to prepare and manage grants according to international standards and regulations.

It is interesting to note that the REACH program has evolved to include more elements of the PPA model than the previous AHSEP, where proposals were submitted rather than solicited through a competitive process and grants were only commissioned for 6–8 months duration (*USAID/MSH 2002*). Funding however, remains channelled through USAIDs implementing partner MSH rather than through the MOF which represents another significant difference to the WB strategy.

EC: A more phased approach has been adopted in order to "pave the way to new contractual forms between the Ministry of Health and the NGOs for the delivery of the BPHS (*Performance-based Partnership-like Agreements*)" (EC 2002 italics added). In this sense the current EC grants are not performance-based. One of the expected outcomes of the project is to begin to define measurable performance-based indicators for delivery of the BPHS. In the initial grants, NGOs have submitted logical frameworks and defined their own indicators. In subsequent projects it is envisioned that national indicators will be adhered to. In line with this phased approach some EC projects are only 21 months in duration in comparison to 36 under the WB contracts and construction of health facilities is a focal activity[19].

While the WB and USAID remain at opposite sides of the spectrum in terms of the geographical unit of coverage, the EC has opted for a more considered approach adopting a mix of both the province-wide and cluster-wide projects. Although the EC has a much more relaxed approach to monitoring and evaluation than the WB or USAID, their projects will be included in the JHU/IIHMR nationwide assessments. Results from these assessments will constitute the only monitoring data that the EC will receive apart from midterm and annual activity reports and spontaneous monitoring visits.

19 Infrastructure is a large component of many of the EC's initial grants (awarded in early 2003) as USAID's REFS program had not yet materialised.

4.4 A Brief Overview of the Current State of Affairs

4.4.1 Delivery of the BPHS: Contracts and Grants

The GCMU has functioned very effectively since its establishment in March 2003. Comprised of 2 international advisors[20], 5 local consultants and 8 local consultants working both in the GCMU and other parts of the MOH, they have discussed and finalised bidding documents with all donors and carried out complex procurement procedures including the tendering, evaluation and negotiation of numerous contracts in a very transparent manner. The GCMU initially consisted of only 4 national consultants, however it was agreed that more staff were required in order to strengthen other MOH departments that weren't progressing as quickly as the GCMU such as monitoring and evaluation and health care financing, which were deemed important in the successful functioning of the contracting process and the final outcomes. Although this was a valiant attempt to build capacity amongst those staff that weren't as experienced as the national consultants, MOH representatives admit that policy development and procedures surrounding contracting happened so quickly that there wasn't time to include these departments in the process.

The function of the GCMU has not been confined to dealing with contracts and the unit has become very involved in other sector policy initiatives. Dubbed 'the ministry within the ministry' the GCMU has been a driving force behind many policy initiatives, such as the PRR process. Relationships between the GCMU (both national and international staff) and other components of the ministry have been remarkably horizontal with trust established

through previous work ties. These strong relationships have facilitated the GCMUs involvement in policy related issues. Although the national MOH consultants are funded through WB monies, who some argue handle things from a WB perspective, the GCMU has served as an effective way to bring service delivery closer to the government. Indeed, with a national consultant heading the GCMU it is Afghan staff that are dealing with day to day issues and have been actively involved in the contracting process. Moreover, GCMU members stress that they represent the MOH and deal with all donors from this perspective.

20 An international advisor was first seconded through UNICEF. Since then, one international advisor has been recruited using WB monies and a second has been placed in the GCMU through the EC. The EC advisor is located in the GCMU for strategic reasons with support to the GCMU being part of a wider working framework.

Table 3: Contract/Grant Summary for Expansion of the BPHS as of July 2004

Donor	Total no. provinces	Total no. districts	No. contracts/ grants awarded	Total funds awarded ($)	Total pop'n served	Average pop'n coverage in responsible areas (%)	Total pop'n covered by contracts/ grants (%)*	Duration of contract/ grant (months)	Per capita costs ($)
USAID									
Round 1 (06/03)	9	60	16	37,410,957	2,927,700	33	14	30	5.11
Round 2 (11/03)	5	33	9	15,472,800	1,870,757	40	9	26	3.82
SUB-TOTAL	**14**	**93**	**25 grants (19 NGOs)**	**52,883,757**	**4,798,457**	**40**	**23**	**28**	**4.72**
ID/WB									
Round 1 (05/03)	8	73	8	37,017,073	3,585,000	100	17	33	3.78
	3	17	1 contract with MOH under MOH-SM	10,635,941	1,104,300	100	5	24	4.82
SUB-TOTAL	**11**	**90**	**9 grants (7 NGOs and MOH)**	**47,653,014**	**4,689,300**	**100**	**22**	**28**	**4.30**
EC									
Round 1 (12/02)	4	27	4	11,552,359	1,718,300	100	8	21	3.84
Round 2 (05/03)	4	22	3	10,116,163	913,300	43	4	30	4.43
SUB-TOTAL	**8**	**49**	**7 grants (7 NGOs)**	**21,668,522**	**2,631,600**	**68**	**13**	**26**	**3.87**
ADB									
Round 1 (04/04)	3**	11	3	2,868,006	294,500	24	1	12	4.83
SUB-TOTAL	**3**	**11**	**3 grants (3 NGOs)**	**2,868,006**	**294,500**	**24**	**1**	**12**	**4.83**
TOTAL	**33**	**243**	**44 (30 NGOs)**	**125,073,299**	**12,413,857**	**58**	**59**	**27**	**4.55**

* The total population was extracted from the MOH's 'BPHS Project Update Information by Districts' spreadsheet as of March 22, 2004

** These provinces are also funded by USAID

The roll out of the BPHS is well underway throughout the country with 43 contracts operating in 33 out of 34 provinces (see table 3).

The rapid expansion of the BPHS has resulted in 59% coverage of the BPHS countrywide. An attempt will be made in autumn of 2004 to fill some of these gaps through a third round of funding from both USAID (approximately 10M USD) and the EC (13M Euros). Both will fill the gaps in their cluster-wide provinces, and the EC has included Nuristan which remains the only uncovered province in the country and Ghor province, which currently has funding from USAID and the ADB.

Per capita costs vary amongst the different donor approaches. This is due to a number of factors including the mix of costs included in budgets. For example, construction costs have been included in the EC and ADB projects but not in USAID and WB projects. In addition the cost of medicine has not been included in USAID per capita costs as they are provided in kind. At any rate per capita costs through USAID REACH will not actually be known until the end of the grant period as project budgets are revised every 6 months and any unspent funds can be taken back and used for subsequent rounds of funding. The MOH-SM per capita costs are higher than the other MOH/WB projects as they will provide some services, but will employ a mix of contracting-out and contracting-in for certain parts of the project such as CHW and midwifery training, based on the Cambodia experience. Finally, USAID, ADB, and some EC per capita costs reflect a cluster-wide approach, in which economies of scale cannot be exploited.

Another issue that the MOH is raising is the costs of contracting incurred through the different donor approaches. While the GCMU claims to cost only $1.5 million over three years to manage 11 contracts worth $47,653,014, overhead costs for the REACH program may be as high as $23 million to manage 25 contracts worth $58,419,407. However, it should be noted that the costs of the REACH program include several individuals providing much needed TA to the ministry. Moreover, it has been suggested that although the USAID approach to contracting is more costly due to management intensive cost reimbursement procedures and monitoring, these mechanisms may be what the MOH need to adopt in the future to keep a closer eye how NGOs are spending funds and the details of implementation.

The profile of the NGOs contracted to deliver the BPHS varies significantly across the 3 donors. While the formation of consortiums between national and international organisations was emphasised in all three donor tender documents, only 4 of the current contracts/ grants are operating under this means (2 under EC and 1 each under USAID and WB). This seems to be as a result of the constraints involved in forming a consortium over the short time period between the issuance of a call for bids and the deadline for submission of a proposal, and due to the implications of partnering with agencies under a performance-based model where the lead NGO will assume a financial risk.

Looking at the involvement of national NGOs in the delivery of the BPHS, 48% of REACH grants have been awarded to Afghan NGOs, 43% under the WB, and 29% under the EC (as part of a consortium with international agencies). Only REACH however, is working with new national NGOs on a large scale, with 67% of the total number of Afghan NGOs awarded grants being new. For the most part the EC and WB agreements have been established with 3 of the most well known and reputable national NGOs in health, with the exception of one consortium including a new national NGO under the WB scheme. In total, national NGOs have been awarded 43% of available donor funds. In addition 2 of the more well established national NGOs have been awarded a total of $37.5 million, representing almost 30% of total funds awarded to date[21].

The MOH-SM was formally agreed upon in December 2003 and the GCMU has been working full time on submitting proposals for approval by the WB. Several site visits have been conducted over the last 3 – 4 months in order to discuss the project with provincial health directors and identify sites for health facilities. Currently, all sites have been identified, all proposals have recently been approved and most key staff positions have been recruited.

The ADB established a full time presence in the MOH in October 2003 with the establishment of a Project Implementation Unit (PIU) in the MOH. The PIU has a similar function of the GCMU to manage the tendering, evaluation, award and monitoring of the contracts. Although the majority of their assistance is concentrated in the agriculture and transportation sectors, they are programming $3 million USD for expansion of the BPHS for 4 districts in Badahkshan and Ghor provinces. A RFP was issued in April 2004 and proposals were awarded in August 2004.

The MOH is taking the performance of NGOs seriously and have been proactive in conducting site monitoring visits in all 8 PPA provinces. Warning letters have already been

21 These calculations include funds disbursed through the ECs third round of funding.

issued to two NGO who have failed to fill key positions in the field, ensure adequate supply of drugs and initiate CHW training programs among other things. The MOH intends to conduct monitoring visits each quarter to keep a close eye on progression, in addition to monthly meetings with PPA NGOs. Monthly meetings have taken place for all PPA NGOs since June in order to allow discussion of problems encountered during implementation thus far. USAID/REACH also recently conducted a similar review forum. The four most common problems for NGOs operating under REACH included cost recovery, clarity on the role of CHWs and the health posts, EPI, and BPHS staffing patterns.

The MOH is currently strategising to determine the best way to finance further expansion of the BPHS to achieve 100% coverage. The MOH will use leftover project resources from the AHEAD program and, if necessary, tap into a programmatic structural adjustment credit of $20 million USD provided by the WB. However the gap is filled, it is evident that the MOH is fully committed to ensuring the BPHS reaches as many as possible in line with the priorities of the interim health strategy.

Monitoring and evaluation will be conducted by Johns Hopkins University (JHU) and the Indian Institute of Health Management Research (IIHMR) who have been contracted to function as an independent third party evaluator. Annual health facility assessments will be conducted in addition to semi-annual rapid surveys in areas where province-wide contracts exist. The first annual survey got underway in July and results are scheduled to be ready by early 2005. Part of the third party's terms of reference includes building the capacity of the MOH to conduct similar monitoring activities in the future.

4.4.2 Security

Increasing insecurity in many parts of the country and upcoming presidential elections have added to the challenges NGOs are facing in implementation of the BPHS. Previously confined to the south-eastern parts of the country, security has also become problematic in formerly stable areas in the west. The death of 5 MSF workers in Badghis province in June 2004 has placed a new emphasis on the safety of relief workers in these areas. Other NGOs working in this area have considered withdrawing their services due to continuing insecurity and have requested the MOH to take action to reduce their risks. Gaps in coverage with the departure of MSF[22] has already placed stress on the MOH to find funds. With 45% of the country still uncovered, the MOH cannot afford the departure of more NGOs.

4.4.3 Policy developments

Priority Reform and Restructuring

The Bonn agreement provided for the establishment of the Independent Administration Reform and Civil Service Commission (IARCSC), which was created in July 2003. Through the IARCSC, ministries can apply for Priority Reform and Restructuring (PRR) status which allows for performance-based salary supplementation for key MOH, based on recruitment of staff with relevant qualifications. As the MOH felt that a key threat to effective public sector services was poor morale and motivation caused by low staff salaries (*Simmonds 2003*), the decision was made to apply for PRR status. Proposals for the PRR of Provincial

22 All branches of MSF withdrew from Afghanistan after the incident in Badghis province. This was in part due to the perceived lack of action taken by the government to address the crime. It is believed that those responsible for the killings are publicly known and walking free in the communities of Badghis.

Health Departments and the Policy and Planning General Directorate were submitted to the IARCSC and approved by the cabinet in late 2003 and early 2004. There are plans for two additional General Directorates in the central Ministry under similar reforms this year (*MOH 2004*).

Although the proposals have been approved there has been significant delay in implementation due to high workloads at the IARCSC. In order to assist in the implementation of the PRR process for the MOH, DFID announced a tender for TA that would assist in getting the process up and running. However, after the MOH had begun the recruitment process of national consultants DFID suddenly withdrew their support with the funding redirected to narcotics programs. As the PRR process had already started this placed the MOH in a difficult position. Fortunately the WB agreed to provide 8 months worth of salaries for staff which has filled the void temporarily. The WBs assistance has been timely as the MOH-SM provinces need to recruit staff as soon as possible. Several discussions have taken place with the IARCSC to try and fast track the process in these provinces. The MOH has already announced the positions for the MOH-SM, so recruitment will have to be pushed through by the IARCSC relatively soon.

While the PRR salary scales were approved by the MOF the capital and running costs were not approved and the MOH was told that these costs should be included in the recurrent budget of the ministry. However funds allocated to the recurrent budget were already accounted for at this point in time which has left the MOH without the funds to provide PHOs with the tools they need to fulfil their job descriptions, e.g. computers, buildings for offices, vehicles,

etc. This lack of equipment and running costs may dampen any effects that more attractive salaries have on motivation and morale.

Capacity building

It is increasingly recognized that injecting money, for example through budget support, will be insufficient to improve health systems without considerable support to other factors such as human resources and management and service delivery capacity (*Mills 2002*). As such, there has been considerable effort invested in developing a capacity building plan for the central and provincial MOH. In January 2004 the MOH Public Administration Capacity Building Working Group (PACBWG) was formed in order to develop a capacity building plan for the central and provincial MOH. Drafts of the plan were circulated in April–May 2004. Although the PACBWG was comprised of all major stakeholders it has been suggested that donor coordination has been poorest in this area.

OPM, funded by the ADB, is also providing technical assistance in two main areas; general public administration and management including personnel and financial management and procurement and strengthening of the department of construction in terms of organizational arrangements, development of construction standards and a plan for upgrading health facilities (*OPM 2003*).

One component of the capacity building plan for the public health administration core staff that has already started is a technical roundtable discussion group which aims to provide an opportunity for discussion of relevant technical information about health systems and to keep the MOH up to date of health system developments from around the world and the literature. The roundtable will be facilitated by various technical experts visiting Afghanistan on a different topic every two weeks. Discussion leaders circulate an article relevant to their topic one week before the roundtable and facilitate discussion of the contents, raising key questions about findings and how they relate to Afghanistan (*MOH 2004a*). This initiative represents an innovative way to take advantage of expertise coming in and out of the country and to expose MOH core staff to important health systems issues.

In addition to training capacity has also been bought in through national consultants, staff seconded from international agencies such as WHO and UNICEF and the placement of permanent international TA in various departments of the ministry.

5 Concluding Remarks and Issues for Further Research

Policy in Afghanistan's health sector was developed relatively quickly and with few blockages between 2001 – 2003. While there is scepticism surrounding the amount of choice the government had in selection of policy options, they have been firmly established in the driver's seat since mid to late 2002. The MOHs main priority continues to be expansion of the BPHS through subcontracting NGOs and resources are consistently being allocated to achieve their objective of 100% coverage; it is a lack of funds rather than strong political commitment by the MOH that is frustrating attempts to reach this goal.

Although there was no consensus reached within the donor community on the best way to provide the BPHS, there was agreement on the overall principles of reform, namely the delivery of a BPHS through contracts/grants with NGOs with the MOH refraining from service delivery in favour of a stewardship role. Whether the MOH views these reforms as a long term strategy will only be revealed with time. If the MOH's enthusiasm regarding the MOH-SM is any indication however, a more balanced approach of public provision and a mix of contracting-in and contracting-out NSPs may be on future policy agendas.

While policy development in Afghanistan occurred with few obstacles, the published literature on the achievement of the theoretical advantages of a basic package approach and contracting is very limited (*for example see Tarimo 1997, Ensor et al 2002, Palmer 2000*). Given this lack of evidence and the international diffusion of health sector reform ideas regardless, there are many important questions to answer. The progression of Afghanistan's health sector reform presents an opportunity to document the development of health policy in a post-conflict environment and the emergence of a novel method of service delivery. Moreover, an opportunity arises in which private provision can be compared to that of public provision through the MOH-SM, which is a source of ongoing debate in the contracting literature (*for example see Brugha and Zwi 2000 and Mills 1997*). The following questions can help to add to the evidence base:

What is the potential of the PPA mechanism to support and enhance health policy formulation and coordination of healthcare delivery in post-conflict settings?

Although not technically a coordination mechanism PPAs can be seen as an innovative way to facilitate development of a coherent national framework with which to guide investment and reconstruction efforts (*Bornemisza and Sondorp 2002*). For example PPAs necessitate policy formulation regarding definition of services and targeted regions of operation, which can stimulate dialogue and the establishment of priorities for the health sector. Do PPAs represent an effective mechanism with which to coordinate the multitude of actors and interests in post-conflict settings? In low-income settings? Can health policy formulation be enhanced as a result?

What are the implications of a BPHS approach in Afghanistan?

Given that many other countries have attempted to provide a BPHS and failed due to resource constraints, and given emerging signs of donor fatigue in Afghanistan, will a BPHS approach be sustainable? Can an essential package of services be provided of adequate quality for $4.55 per capita per year? What impact will Afghanistan's BPHS have on health outcomes?

Is it possible to deliver a basic package of health services through contracts with private providers?

The approaches taken by donors to implement the basic package of health services in

Afghanistan are varied. The PPA mechanism used by the MOH/WB is much more flexible than the other approaches, particularly in terms of budget flexibility. The geographical area of coverage is also different with the MOH/WB funding single NGOs to provide the entire BPHS in one province versus USAID who funds multiple NGOs. What is the most effective and efficient approach to contract service delivery? Does one method have advantages over the others? Is quality being sacrificed to achieve efficiency gains (i.e. by funding province-wide vs. cluster-wide projects)? Can delivery of a BPHS through contracts with private providers be accomplished in a cost-effective and transparent way? What factors may impact on the delivery of a BPHS through contracts with private providers?

How do key stakeholders respond and react to PPAs and other donor approaches?

PPAs represent a new funding mechanism which have significant differences from more traditional forms of funding through introduction of concepts such as competition and performance-based payment. These differences may necessitate changes in all key stakeholders including donors, NGOs, multilateral agencies, and the MOH. What changes are required to facilitate the successful implementation of this approach and are stakeholders willing to adjust their mandates and/or institutional arrangements? Do performance-based approaches influence the way in which providers deliver services? If so, in what ways?

How can government capacity to contract (at various levels) be established in a post conflict setting?

It has been documented elsewhere that contracting requires government to learn an array of new skills compared to those required for public provision. Post-conflict environments are typically fast moving and characterised by a large number of international actors. Is it feasible to build this kind of capacity in a post-conflict setting which is typically fast moving and characterised by large numbers of international actors, which demand a large amount of the government's time and effort? Will government have enough time to learn these new skills in this type of setting? What is the most effective way to cultivate these skills?

Should NSPs be favoured for service provision above government?

Mills (*1998*) points out that it is not clear that the private sector is more efficient provider of services than the public sector and contracting may potentially represent a higher cost to the government than direct provision (*Mills 1997*). It has also been noted that the same determination is required to increase capacity to contract as is required to reverse public sector inefficiencies, for which contracting has been prescribed to eliminate (*Ibid*). Based on these premises, researchers claim that government provision should not be ruled out (*Mills 1998*). However, supporters of health sector reform state that public choice and property rights theory create inherent management deficiencies in the public sector (*Mills 1997; Mills and Broomberg 1998; Palmer 2000; Walsh 1995*). Indeed, findings from the Cambodia pilot showed that contracting out service delivery to private providers performed better than government and marginally better than a contracting-in model (*Bhushan et al 2001*). However, an inconsistent evidence base requires more research on the merits and disadvantages of contracting health services with NSPs. Should government be bypassed for service delivery in post-conflict and low-income settings in favour of private providers? Do NGOs have more capacity to deliver services than government?

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Annex 1: Similarities and Differences in Donor Procurement[23]

Characteristics	IDA/World Bank	USAID/MSH	EC
Project name	Afghanistan (AHEAD)	Rural Expansion of Afghanistan's Community-Based Healthcare (REACH)	Support to Health Service Delivery in Afghanistan
Purchaser	Funding flows from the MoF/MoH to NGOs	Funding flows directly from MSH to NGOs	Funding flows from the EC directly to NGOs
Provider	NGOs	NGOs	NGOs
Type	Fixed lump sum remuneration with 100% budget flexibility Performance-based contract: NGO performance judged against progress and achievement of measurable indicators. Failure to progress or achieve targets will result in termination of contract. Services are contracted out by the MOH	Fixed budget (input-based) USAID contracts out to MSH who then subcontracts NGOs Performance-based grant: payment (including initial advance payment) will be tied to deliverables and achieving outputs. Payment is only made after review and acceptance of deliverables	Fixed budget (input-based) EC establishes grants directly with NGOs Grants are used with a priority *"to pave way to new contractual forms between the Ministry of Health (MoH) and the NGOs for the delivery of the BPHS (Performance-based Partnership Agreement-like contracts)"*.
Tender process	(i) Request for EOIs issued (ii) NGOs who submit an EOI are shortlisted (iii) RFP issued to shortlisted NGOs Proposals submitted	(i) RFA issued (all eligible NGOs can bid)[24] (ii) Proposals submitted	(i) International Call for Proposals issued (all NGOs can bid but they must have their headquarters within the EU or in Afghanistan) (ii) Proposals submitted
Duration	29 – 36 months	26 - 30 months	21 - 30 months
Size of current contracts/ grants	$1,469,090 – $8,384,143 USD	$342,721 – $5,328,861 USD	4,341,840 – 1,704,289 Euros
Payment	16% at signing and 14% every 6 months based on submission of quarterly reports and assessment of performance indicators through supervisory visits and third party assessments	Reimbursement of actual expenditures through submission of quarterly invoices. Payment is tied to achievement of deliverables agreed in grant	If duration <12 mths or <100,000 Euros - 80% of budget forwarded If >12 mths or >100,000 80% for the first 12 mths forwarded NGOs required to provide 10% of the overall cost of the grant from alternative funding sources although exceptions can be made
Bonuses	(i) 1% of contract value every 6 mths if an increase of 10 percentage points or more from the highest score in health surveys conducted by 3rd party. (ii) 5% of contract value at the end of the contract if an increase of 50 percentage points in the combined score of indicators	NO	NO
Evaluation criteria	Quality Cost Based Selection: Proposals are evaluated according to technical and financial criteria. Those proposals with <60 points on the technical	Scoring system based on evaluation criteria plus a panel discussion system so the highest score does not always win the bid.	Evaluation criteria are divided in sections and subsections which are rated on a scale of 1-5 (1 = very poor 5 = very good). Evaluation criteria have less of

23 Information is current as of August 2004

24 In the most recent Request for Proposals NGOs must first pass an initial screening before they are eligible to submit a proposal. This mechanism has been put in place to eliminate the submission of proposals from NGOs who are ineligible

Annex: Similarities and Differences in Donor Procurement

Characteristics	IDA/World Bank	USAID/MSH	EC
	section are considered unresponsive and sent back. If >60 points then financial proposal is opened. Scores are then tabulated with the following weighting: Technical scores (80%) Financial scores (20%)	Budget/cost effectiveness weighted at 10% of overall score Scores are weighted differently depending on whether the applicant is a national NGO (new vs. experienced) or an INGO. Priority is given to national NGOs with 10% added to their technical score	an emphasis on quality of services and monitoring than USAID REACH but more emphasis on budgets and cost-effectiveness Financial score weighted at 10% *Priority* given to the highest scores
Geographical scope	3 approaches: >7 province-wide PPAs >1 cluster-wide PPA >3 provinces designated as MOH strengthening mechanism (MOH-SM)	13 provinces (+ 1 district of an EC province) are being funded although most are not fully covered[25] Both single districts and clusters of districts are funded, however priority areas are defined as underserved areas rather than by district or cluster	4 province-wide grants 6 clusters in 4 provinces[26]
Scope of services	Entire BPHS in all contracts	The minimum required service levels do not require NGOs to include district hospitals but they can include them if they have the capacity and experience	Entire BPHS plus construction of facilities is included in some early grants
Monitoring and Evaluation	Third party (JHU/IIHMR) will conduct rapid evaluations semi-annually in province-wide projects and more comprehensive evaluations annually nationwide MOH will also conduct periodic monitoring visits to PPA sites	Quarterly review of deliverables through quarterly reports and spontaneous on-site monitoring JHU/IIHMR will include USAID provinces in annual nationwide performance assessments	Annual reports required Financial management is considered as a proxy for management capacity JHU/IIHMR will include all EC provinces in annual nationwide performance assessments and province-wide areas in semi-annual rapid surveys
Indicators	Nationally defined core and management indicators Baseline figures will be extracted from a MICS conducted in 2003	USAID has set standard indicators but the targets can be defined by the NGO and negotiated with the purchaser Baseline figures are based on household surveys conducted by the NGOs in the first quarter of the grant	NGOs can define their own indicators and use a traditional logical framework, however one of the priorities of the program is to make a start in defining and measuring performance-based indicators related to the BPHS

Sources: WB Request for Proposals (2003), USAID Request for Application (2003), EC Call for Proposals (2002)

25 Average coverage is 39% as of July 2004 with a range of 12 – 100%

26 Average coverage in 4 cluster-wide provinces is 42%. Including province-wide project average coverage totals 73%

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