EC-PREP FINAL REPORT

CONTRACTING HEALTH SERVICES INAFGHANISTAN: CAN THE TWIN OBJECTIVES OF EFFICIENCY AND EQUITY REALLY BE ACHIEVED?

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INTRODUCTION

Access to basic services such as health and education are key to improving the lives of poor people (DFID, 2000). Access to adequate and effective health care is central in reducing poverty. The links between improved health and poverty alleviation have been extensively researched (Lopez-Casanovas *et al* 2005). Improved health leads to poverty reduction through higher labour productivity, higher rates of domestic and foreign investment, improved human capital, higher rates of national savings, and changes in demographic dependency ratios (Commission on Macroeconomics and Health 2001, OECD, 2003). This link between health and poverty has special importance in fragile states[1], where health and poverty indicators are particularly poor. Malnutrition and child mortality in fragile states are almost twice that of low income countries (Dollar and Levin 2005). Globally, a third of people living with HIV/AIDS, a third of maternal deaths, half of under five deaths, and over half of disease epidemics, are located in fragile states (Branchflower, 2005).

Interest in the provision of health care in fragile states has increased in light of these statistics, as well as for the following reasons. First, evidence indicates that adequate investment in health systems and services will improve the health of the population which will in turn reduce poverty (Commission on Macroeconomics and Health, 2001; Lopez-Casanovas *et al,* 2005; OECD, 2003). Second, investment in fragile states is critical to meeting the overall Millennium Development Goals (MDGs) (Branchflower, 2005). Third, improved provision of health and other public services may contribute to

[1] Fragile States can be defined as states where the government cannot or will not deliver core functions to the majority of its people, including the poor. These core functions include: territorial control, safety and security, capacity to manage public resources, delivery of basic services, and the ability to protect and support the ways in which the poorest people support themselves. DFID 2005.

the legitimacy of the government through a strengthening of the social contract between a population and its government (Stewart, 2002).

One of the unresolved key problems in resource poor environments is how such a basic package of health services can be delivered to the poor. Using the Afghan case, this study has investigated how mechanisms can be developed to ensure that budget support is transferred into more equitable access to health services.

BACKGROUND

Since the mid 1980s health sector reform has been a central theme shaping global health policy decisions. Within a context of chronic inefficiencies and inequities in the public provision of healthcare in many developing countries, there has been a re-evaluation of the role of the state (Bennett et al in Bennett et al 1997). The state is perceived to be bloated, overextended, and essentially crippled in its ability to respond to health needs due to extensive inefficiencies (Palmer 2000). Consequently, there has been increasing emphasis on ideas within what has been dubbed 'new public management' (NPM) (Walsh 1995). NPM, which injects market-like principles into healthcare provision, has evolved around the notion that the private sector is a more effective provider of health services (Ibid). One response to these problems has been the development of the purchaser-provider split in which the state adopts a stewardship role, focusing on policy formulation and regulation, in favour of direct service delivery, which is left to Non-State Providers (NSPs). Contracts have evolved as one mechanism to govern this split (Palmer 2001).

While contracting has been introduced to reverse public sector inefficiencies, the form that a contract takes may actually reinforce them if not designed carefully. The specifications of a contract create incentives that will shape the provider's behaviour and thus will be a key determinant of their intended impact (Palmer 2001). Different payment mechanisms such as capitation and output-based systems, for example, may create incentives for increased efficiency however none of the methods establish a link between efficiency and quality. Performance-based contracting has evolved as a hybrid payment system which combines performance-based payments with other pricing methods to establish this connection (Eichler 2001). The PPA model is derived from the principal-agent theory of economics and links the payment of providers to pre-determined performance indicators in an effort to increase efficiency and equity of health services. Although not a new concept, performance-based contracting is an innovative approach in the health sector, with a relatively scant evidence base.

These new ideas are reflected in current efforts in the health sector 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 Public Health (MOPH), they are funding Non-State Providers (NSPs) to deliver a Basic Package of Health Services (BPHS) through various

mechanisms such as performance-based contracts and grants, 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 to 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. Linking private provision to national policy objectives, and streamlining donor-NGO-government relationships through improved transparency and coordination are additional potential benefits.

Although the MOPH 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, three provinces have been selected as 'control' areas where the MOPH will directly implement the BPHS, concurrently with the NGO contracts. Named the MOPH Strengthening Mechanism (MOPH-SM), the MOPH will receive funds from the World Bank and, similar to the PPA contracts with NGOs, payment to the MOPH will be linked to performance. Moreover, the MOPH-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) in comparison to a contracting-in model and government provision[2]. 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.

On the other hand the international donor community is struggling with how to engage with fragile states. In order to facilitate poverty alleviation through improved health status and support achievement of the MDGs new strategies are required for engagement in these contexts. Contracting health services to non-state providers represents one option for consideration.

OBJECTIVES

Study Purpose

To describe the development and implementation of Afghanistan's new health policy which focuses on delivery of a BPHS to the rural poor through 2 main strategies: sub-contracting service delivery to NGOs and direct government provision through the MOPH-SM. The study aims to contribute to better informed decision-making around the role of health in poverty reduction strategies.

The research was guided by the following preliminary questions:

1. How does performance-based contracting (e.g. PPAs) function in practice in delivery of a BPHS?

    - How do different donor approaches function?
    - What institutional reforms are necessary within stakeholders?
    - Is it feasible to build government capacity to contract in a post-conflict setting?

2. What factors affect the performance of service providers and in what ways?

    - How do different donor approaches affect implementation?
    - How do stakeholders respond and react? What impact does this have on implementation?
    - What components need to be in place before implementation? of a BPHS in a post-conflict setting (timing issues)?
    - Do NGOs have sufficient capacity to implementation? the entire BPHS?

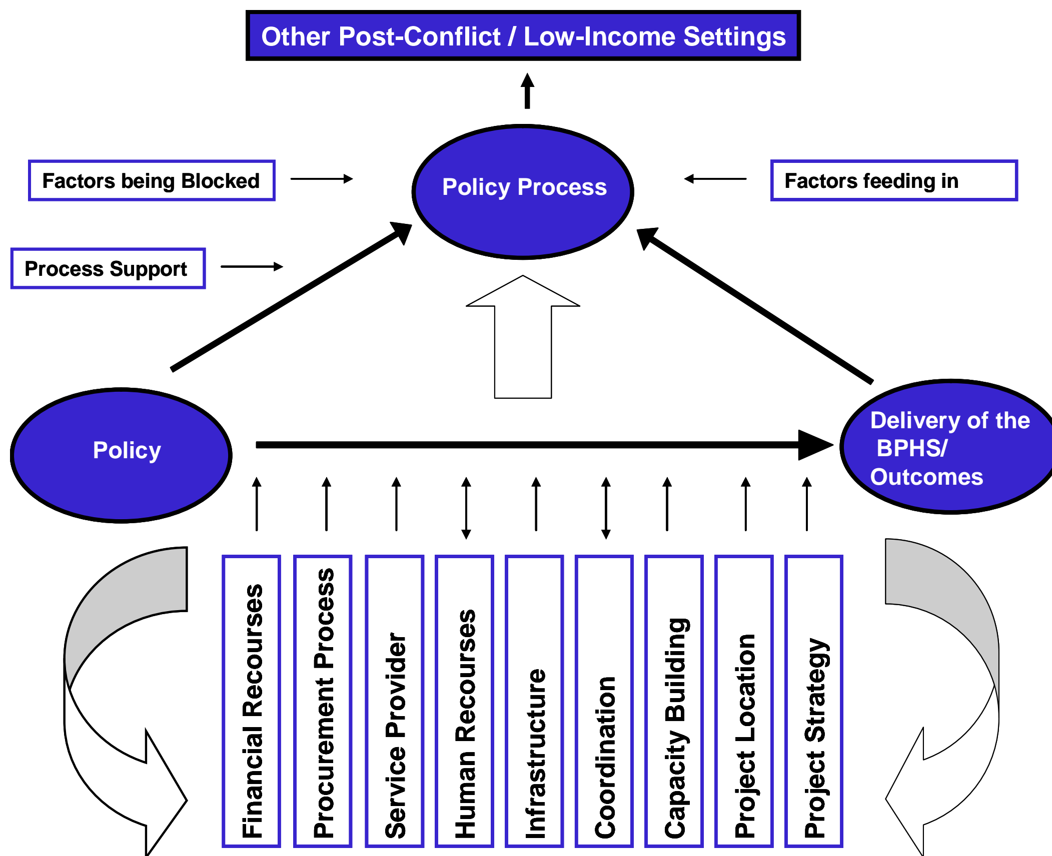
3. How do policy choices affect implementation and influence outcomes at a later stage?

    - How does health policy develop in post-conflict settings and how does this impact on healthcare delivery?
    - What is the potential of the PPA mechanism to support and enhance health policy formulation and coordination of healthcare delivery in post-conflict settings?

METHODS

There has been little research and critical analysis about how PPAs function in practice on such a large scale, as has been set in motion in Afghanistan. However, there are a few experiences which can be drawn on to identify factors impacting on the delivery of health services through contracting. Experiences in contracting for primary health care services in developing countries as well as a review of the theoretical literature surrounding policy analysis, contracting, and the delivery of a basic package, prompted the development of a preliminary conceptual framework (see Figure 1).

Figure 1: Conceptual Framework



The framework illustrates there are a number of factors to consider in the development of policy at the central level in addition to the factors that may influence the intended outcomes of policy implementation at the provincial and district level.

The first stage of the research focused on how Afghanistan's health policy and more specifically, novel health delivery strategy, was developed between 2001 and 2003. In order to capture the complexities involved in the formulation of policy in a post-conflict

environment this component of the study was designed to be broad and descriptive. The description of the lead-up to policy implementation included a pre-existing situation analysis, a description of the major donors and roles of various stakeholders and government policy development. Walt's (1994) policy analysis model which examines context, actors, process and content was used to guide this component of the research.

In the second and main component of the study 6 prospective qualitative case studies examining the implementation of different donor approaches to deliver a BPHS in Afghanistan were conducted. The selection of two cases from each donor camp allowed for comparisons both across and within donor approaches, yielding important lessons learned for future policy initiatives in Afghanistan as well other contexts contemplating contracting. According to Yin's (2003) categorization of case study design, this was a multiple case study. The case study was designed to be both descriptive and explanatory. The unit of analysis were the provinces selected.

Ethical clearance was received from both the LSHTM and Afghanistan's Ethical Review Board. In addition the projects research protocol was shared with representatives of the MOPH, Johns Hopkins University and other technical experts. Comments were received and incorporated to strengthen the protocol and design of the study.

Cases were selected after holding discussions with involved stakeholders and the MOPH. Selection criteria included geographical spread, differences in donor approach, differences in NGO capacity (local vs. international) and province-wide versus cluster-wide approaches. Factors such as security which could affect access to case study sites were also considered.

Data was collected through a series of three site visits conducted at 4-6 month intervals over the life of the project. Primary data collection has consisted of over 200 semi-structured interviews with key informants in each of the study locations at the central and provincial level. Interviewees included the primary BPHS implementing agencies (representatives from the Kabul office as well as the field office), provincial health authorities, UN agencies and other NGOs and organizations working in the health sector. Interviews have also been conducted at the central level with key stakeholders from the MOPH, donor community and UN. All interviewees were selected purposively based on their involvement in delivery of the BPHS in the case study sites. Effort was made to sample interviewees from the central, provincial and actual place of service delivery to ensure that data collected was representative of all stakeholder views and experiences. Written informed consent was obtained from all study participants.

To supplement these interviews and triangulate findings other methods and sources of evidence have been tapped. These include informal consultations with relevant stakeholders, participant observation of key meetings and other events, systematic tracing of documentation related to policy formulation and establishment of an inventory of all contracts and grants awarded to date.

Interviews were audio taped when permitted and detailed notes taken. Interviews were transcribed and coded by theme using NUDIST. Themes from the conceptual framework and others emerging during the course of the research were used to guide the analysis. Separate files have been kept for each field visit to enable analysis of changes that have taken place over time.

Further details on the projects methodology can be found in the research protocol which can be accessed through members of the research team.

RESULTS

Data collected throughout visits to each of the 6 case study sites have produced significant findings which are important in understanding how reconstruction of health systems can be addressed in a coherent and coordinated way, which is acceptable to both the donor community and the recipient government. The results also provide a fresh perspective on mechanisms that could facilitate effective engagement of the international community in fragile states. This report provides insight on some of the most noteworthy results of the study however more in depth analysis will be forthcoming in subsequent reports (see Output section below).

The most significant result produced by the study is that contracting non-state providers to deliver a basic package of health services has been a successful strategy in post-conflict Afghanistan. The placement of PPAs on the policy agenda in late 2001, immediately following the collapse of the Taliban, ignited the policy process. Contracting allowed the donor community to engage early in post-war Afghanistan, avoiding obstacles frequently presented by fragile states including questionable legitimacy and capacity of the existing government. However, while contracting allowed donors to sidestep these concerns it also allowed them to engage closely with the government so as not to bypass them as has frequently happened in other post-conflict contexts. Indeed the MOPH was and has remained actively involved in the contracting of non-state providers through all three donors which has had a significant impact on their capacity to act as steward of the health sector. Although the government had few options available to choose from they were actively involved in weighing the pros and cons of a contracting approach and have remained committed to the decisions taken to refrain from service delivery in favour of a stewardship role.

The establishment of a common framework, extremely effective coordination among all stakeholders and the natural alignment of all three donors within a framework they helped establish has culminated in the award of 53 grants and contracts signed with 27 service providers totalling over $140 million USD. Contracts or grants now exist in all 34 provinces with 77% of the population covered. Although there are some coordination issues to sort through, Afghanistan's health system has been transformed from an irrational distribution of health services, facilities and providers to a more equitable and efficient picture of health care. A baseline national health resource survey in 2002 identified 912 active health facilities, with active defined as some level activity in the clinic. Only a minority of these active facilities actually provided a combination of services included in the BPHS with even fewer having the right complement on staff. The number of properly staffed and equipped facilities has jumped to 1146. Further there are more female health providers operating than ever before and thousands of community health workers have been trained using a national curriculum and currently staff 4,733 health posts. Most importantly all contracted implementing partners are delivering the same package of services. Although there are still some agencies working outside of the BPHS and with private funds the MOPH is aware of where they are working and is slowly but surely tying them into the government framework.

It should be noted that while these findings emphasize the benefits of this type of model for health system reconstruction, they represent short term achievements and therefore the long term implications of such an approach are unknown. Some of the potential pitfalls may relate to governance in terms of the degree of state-building versus state-avoiding behaviour. Indeed there is potential for a negative impact on and alignment with national and local government processes and structures. Drawbacks related specifically to contracting include ineffectiveness of competition, high management costs, weak government capacity to assume a stewardship role and further weakening of any existing government capacity to deliver services. Also, the interaction of longer-term health financing issues and wide-scale contracting is largely unknown. These factors should be further investigated and considered for transfer of this model elsewhere.

Delivery of the BPHS in Afghanistan is an example of the dilemma faced by governments and donors in allocation of resources in a fragile state where health systems are completely collapsed; while there is a political imperative to invest in hospitals the pay off from investments in primary care are much larger and reach more people. Afghanistan represents a case where priorities have been set early and attention has almost entirely focused on primary health care, both in terms of policy decisions and allocation of scarce resources. In an environment where there are a number of issues to address, setting priorities and more importantly, maintaining focus on them, is easier said than done. However Afghanistan represents a case where primary health care was placed on the policy agenda early in discussions and was pushed forward by influential stakeholders. Primary health care and its equitable distribution was made a priority early in the process and has been a key factor in the successes that have been achieved to date.

An important finding that has been consistent over the duration of the project is the misconception of what contracting represents. Many implementing agencies interpreted contracting as a move to privatize health care. Although contracting represents a more business like approach to delivery of health services than has been used in the past, overall health service provision remains a public service in this model, where public money[3] is used to equitably deliver basic health services through what could be described as ‘outsourcing’. It is also clear that some stakeholders are unclear on the concept of a purchaser provider split. Many NGO interviewees have stated that they intend to provide services until such time that the MOPH has the capacity to take on this function itself. The notion that the MOPH should remain as steward of the sector for the longer term has neither been fully recognized nor embraced. More specifically related to the World Bank contracts, adaptation to the more business like PPAs has taken time to sink in. This is in part due to a mismatch between the way most NGO’s finance departments operate, with detailed line item budgets that often require approval for the smallest of changes, and the lump sum contracts where field managers are supposed to manage the projects using the financial flexibility the contracts allow for as one of their tools.

[3] In this case mainly international donor money, substituting for – currently - hardly existing government revenue

A unique occurrence in Afghanistan has been the early alignment of engagement strategies among the three major donors supporting delivery of the BPHS within a framework they helped establish. USAID and the World Bank in particular had similar ideas with regard to utilization of a performance-based approach based on their experiences in other parts of the world. Although alignment may have arisen by chance, the benefits of this natural experiment have been obvious. For example, although the MOPH has been dealing with different donor approaches they are all focused on a similar strategic direction and objectives, which is expansion of the BPHS to the rural poor. This has in part led to positive relations between donors and the MOPH and has created an air of cooperation and compromise. In a number of cases donors have been flexible to adjust international procurement guidelines and rules to reflect the concerns of the MOPH. For example, the World Bank allowed the MOPH to negotiate budgets which is not typically allowable within the quality cost based selection method used by the World Bank.

Interviews with over 200 stakeholders combined with other sources of data collection have allowed the research team to document and observe similarities and differences among donor approaches. Comparison of the different mechanisms can effectively be used to challenge and adapt traditional approaches used by donors to fund improvements in the health sector of fragile states. These changes to donor processes may facilitate more effective engagement with fragile states resulting in the rapid roll out of health services, improvements in health status and thus impact on poverty alleviation.

The World Bank and USAID have been more actively involved the MOPH in all stages of the procurement process which has secured buy-in, facilitated continued involvement of he MOPH in these donor projects and injected much needed capacity into the government regarding procurement of services. The World Bank initiated the establishment of the Grants and Contract Management Unit (GCMU) which has procured, managed and monitored implementing partners financed through the World Bank. In addition they have been actively involved in policy issues. The GCMU has empowered the MOPH to engage in the contracting process and influence decision making processes within donor systems. It has also created a vital link between donors, NGOs and other implementing partners with the rest of the ministry. Identification of a ‘critical mass’ within this unit has allowed for capacity building activities related to contracting and policy to be effectively targeted. Relatively substantial increases in salary for these individuals as well as capacity building opportunities has ensured that turn over is low (only 2 key individuals have left the unit since its inception). As a result funds invested in this unit have had a positive impact. One of the main disadvantages of the GCMU is its perception as a World Bank body. Although this criticism is refuted by members of the GCMU, institutionalization of this type of unit seems important to ensure it is perceived as a neutral entity.

Findings show that provision of technical assistance and establishment of systems to monitor progress are also valuable in supporting implementing partners to achieve maximum impact towards indicators. Interviews revealed that even large international NGOs require assistance in establishing effective health service delivery systems. USAIDs health programme, branded as “Rural Expansion of Afghanistan’s Community-

based Healthcare (REACH)" program and run through their implementing partner Management Sciences for Health (MSH), has applied an interesting model through which to roll out the BPHS quickly while still ensuring performance of NGOs remains high. MSH has a top heavy management structure comprised of different departments providing intensive support to both NGOs and the MOPH. This model has required a higher investment from the beginning but it may be that this investment pays off in the future. The additional human resources and funds MSH has available to them have allowed them to closely monitor REACH NGOs as well as intervene and coach poorly performing NGOs quickly. Ultimately this approach has allowed REACH to focus on the quality of services that NGOs are providing, possibly creating more favourable health outcomes over a shorter period of time. Although this approach is more costly at the outset NGOs operating under this scheme may have more capacity to expand service provision (especially national NGOs) in future rounds of funding and will be able to transfer the benefits of the intensive support they received from REACH to other areas of operation. Criticisms of this approach have focused on the costs required to employ a middleman such as MSH although it should be noted that technical assistance from REACH has been intensive and included input to a number of different areas and initiatives. On the other hand both the World Bank and EC have been criticized for not including enough technical support for implementing partners.

NGO capacity to deliver the entire BPHS on a large scale was a primary concern in early debates regarding implementation mechanisms. Donors feared that rapid expansion in multiple sectors might weaken capacity and were wary of having service providers responsible for entire provinces due to the absence of a safety net should the NGO fail to perform. Amongst the 3 donors only the World Bank immediately engaged NGOs in a more business like approach through establishment of lump sum contracts and PPAs on a province-wide scale. In Afghanistan NGOs have expanded service provision to some of the most remote and insecure parts of the country and have proven flexible to work in a different way without collapse. Although capacity to expand to the remaining areas of the country remains to be seen they have responded well to market forces and performance-based mechanisms to date. In particular NGOs have consistently behaved and responded differently under different donor approaches. It can even be observed that the same NGO operates differently under different schemes.

Findings have highlighted that NGOs operating under the World Bank PPAs and USAID performance-based grants (to a slightly lesser extent) were much more focused on achieving targets outlined in the contracts/grants. As such these NGOs seemed to take more of a proactive approach to solving problems which they perceived would preclude achievement of their targets. Under the World Bank approach in particular NGOs were encouraged to find innovative ways to overcome barriers and had the flexibility to do so. Although the World Bank have given NGOs the freedom to determine how to deliver the BPHS, in contrast to USAID who have enforced much stricter adherence to MOPH policies, both donors have been very proactive in following up and monitoring the activities of their implementing partners. As such they have been able to determine shortcomings and problems early in implementation and provide guidance and support to steer NGOs in the right direction or assist them in coming up with alternative solutions to

problems they face in the field. The EC on the other hand has taken a more gradual approach to introduce performance-based measures and as such agreements have essentially continued to function in a more traditional way. Reporting requirements are much less than USAID or the World Bank and monitoring and evaluation systems for the most part do not exist. While some implementing partners favour the more laid back approach of the EC they seem to have adopted the same laid back attitude with regards to achievement of targets. The absence of some form of a performance-based incentive seems to have had an impact on accountability and the sense of pressure they feel to meet targets. In general performance-based approaches, with an explicit focus on producing results, seem to affect the way NGOs behave and motivate them to find new ways of doing things in order to achieve targets.

ACTIVITIES

During the course of the research a number of dissemination activities have taken place. A preliminary debriefing has been held in Kabul through participation in different coordination forums and regular information sharing with stakeholders. Additional information sessions will be held over the coming months at policy and coordination forums as well as for agencies with a particular interest in the findings. Several requests for presentations have been made from a variety of organizations.

A workshop is scheduled to be held in Brussels with EC representatives in mid February 2006. Presentations will also be made to interested parties in London.

In addition members of the research team have presented elements of the research at a range of academic and policy conferences, presentations and workshops. These include:

- Conference on "Millennium Development Goals in Fragile States", London School of Hygiene and Tropical Medicine, London, June 2005; proceedings available from www.lshtm.ac.uk/hpu/conflict
- Symposium on Health Care in Afghanistan: Working Together for Quality, UK Afghan Health Network in association with the LSHTM, London, November 2005; Report at www. lshtm.ac.uk/hpu/conflict
- DFID Sudan Workshop on Expanding Service Delivery, presentation: "Service delivery in Afghanistan: is the "Afghan Model" relevant for the Sudan?", June 2004'
- DFID Health Resource Centre, Difficult Environments Roundtable, May 2004, followed by case study description "A time-series analysis of health service delivery in Afghanistan" in 'Service delivery in difficult environments; a quick guide through the key issues'. See: http://www.eldis.org/healthsystems/sdde/
- Several presentations during lectures and seminars at the London School of Hygiene and Tropical Medicine
- Presentation for Management Sciences for Health, Kabul
- Presentation for the Deputy Minister of Health, Ministry of Public Health, Kabul.

The initial report published by the research team, 'Health policy in Afghanistan: two years of rapid change', has been actively disseminated to a number of stakeholders both within and outside of Afghanistan including:

- NGOs
- Donors
- UN agencies
- French representative
- Afghanistan
- Afghanistan MOF

Preliminary findings from the research have also been injected into discussions taking place in other post-conflict environments such as during an Interagency Health Evaluation in Liberia, September 2005.

OUTPUTS

As a result of the scope of data collected and delays in conducting case study visits due to issues such as security the major results have not yet been published. However a series of reports detailing findings of the projects major themes are currently being prepared and will be available shortly. In addition journal articles arising from the project are currently under consideration by international journals in addition to work currently being prepared for submission. Preparation of additional articles is anticipated to coincide with findings produced in the report series described above.

Published:

Strong L, Wali A, Sondorp E Health policy in Afghanistan: two years of rapid change. London School of Hygiene and Tropical Medicine: 2005 Available at: www.lshtm.ac.uk/hpu/conflict/files/publications/file_33.pdf

Under consideration:

Palmer N, Strong L, Wali A, Sondorp E 'Contracting health services in fragile states – an approach with a future? The case of Afghanistan'. Submitted to *British Medical Journal*.

In preparation:

Strong L, Wali A, Bornemisza O, Sondorp E 'Improving aid coordination to reach the Millennium Development Goals in fragile states: alignment and harmonization in Afghanistan'

This paper is being prepared for an international journal and will describe the alignment and harmonization agenda and how it has been pursued in Afghanistan. Results triggered in the health sector as well as potential challenges that can be expected in fragile states will be outlined.

Strong L, Wali A, Sondorp E 'Contracting health services in Afghanistan: a summary of the research and case profiles'

This report will summarize the methodology of the research and outline the profiles of each of the provinces included in the study. Each profile will include a description of the BPHS implementers that have been awarded grants and contracts, baseline conditions, achievements to date and descriptions of security, geography and population distribution will be provided to give the reader some idea about constraints faced to deliver the BPHS in Afghanistan. A brief analysis of the amount of coverage that can realistically be expected in these provinces will also be included. This report will provide the context of the overall research and will serve as a referral document for subsequent publications in the series.

Strong L, Wali A, Sondorp E 'Contracting health services in Afghanistan'

This paper will contemplate the issue at the heart of the research project which is the use of a purchaser provider split. More specifically, the contracting of non-state providers to deliver services

with the government taking the role of steward of the sector. A brief outline of the contracting literature will be presented along with findings related to how contracting is being used in Afghanistan, accomplishments, the general acceptability of contracting as an approach to health care delivery in post-conflict settings, and benefits and concerns that are arising under different donor approaches. This paper will set the scene for the following volume in the series which will present findings on implementation issues.

Strong L, Wali A, Sondorp E 'A Contracting health services in Afghanistan: Has implementation been successful?'

Focusing on the actual delivery of a basic package of health services through contracts with non-state providers this paper will describe findings related to issues arising through implementation of policy. Topics related to necessary inputs such as monitoring and evaluation, infrastructure development and capacity building will be explored as well as the mechanics of delivery of the BPHS, associated costs and approaches to community-based health care. Finally a detailed description of the differences in donor approaches expressed by interviewees will be presented.

Strong L, Wali A, Sondorp E Research 'Contracting health services in Afghanistan: A description of cross cutting issues affecting implementation'

A description of findings related to cross cutting themes such as coordination, human resources and gender will be presented in this volume of the report series.

Strong L, Wali A, Sondorp E 'Contracting health services in Afghanistan: Final recommendations and conclusions'.

This final volume of the report series will consider research findings, draw conclusions and make recommendations for Afghanistan and other contexts regarding policy processes in a post-conflict environment and the use of contracting to deliver health services. Recommendations will focus on the benefits of contracting in the Afghan context as well as highlight potential pitfalls to consider for export of this approach to other settings.

Strong L, Wali A, Sondorp E From this series of reports one or more papers will be produced to be submitted to international peer-reviewed journals.

IMPACT

The research carried out under the project has sought to make a significant contribution to the nascent literature on the use of contracting, in particular with regard to post-conflict settings. It has also made meaningful contributions to both the understanding of how contracting can be utilized to rebuild health systems in fragile states and knowledge of the Afghan case. Publications prepared to date have been actively disseminated both within and outside of Afghanistan. Feedback from those who have received the initial publication has been extremely positive and shows signs that the report is having an impact on the way stakeholders are thinking. For example one NGO who has been operating health services outside of the MOPH framework commented that the report has opened their eyes to how the health system is changing and has stimulated them to start thinking about how they can work with the MOPH. After 30 years of working with a government they didn't trust, this organization believed that the new MOPH would be no different. However after reading about the policy framework put into place they are now making plans to start a dialogue with the MOPH. This will allow the MOPH to prevent duplication of services and fund allocation, and help them better understand how to communicate with service providers.

The project has also sought to have an impact upon audiences outside Afghanistan through presentations at various academic events. Findings have been channeled to other post-conflict settings such as Liberia and Sudan, where mechanisms to reconstruct health systems are also needed. It is anticipated that this impact will increase as more of the outputs are published.

Throughout the project there has been significant engagement with policy makers within Afghanistan. A first sign that the project will also raise interest outside Afghanistan and in particular the EC, has been a recent request for the initial publications from the French representative at the European Union.

CONCLUSIONS AND RECOMMENDATIONS

General recommendations:

1. Contracting primary health care services is a novel approach to delivery of health services with a potentially high impact on the way health systems are dealt with in developing countries, but particularly in fragile states. In the case of Afghanistan contracting has allowed the MOPH to place all stakeholders in a common policy framework and successfully expand services to 77% of the country in the first 2.5 years of reconstruction. Contracting has functioned as a tool for early engagement in the health sector and is a model that should be considered for other fragile states and for low income countries in general. Given that health services need to be rapidly expanded in fragile states in order to reach the MDGs by 2015, contracting represents a feasible option and should be placed on policy agendas for discussion. Contracting health services to non-state providers with the MOPH acting as a steward may represent one way to address poverty reduction through improved health status over a shorter period of time in fragile states.

   This research project has been able to document how contracting functions in the short term, and has highlighted the potential benefits of this type of approach in a post conflict setting. More research is required to assess the long term effects of contracting on the health system. This type of model may have undesirable effects on government systems and structures in comparison to more traditional approaches which have focused on strengthening of existing systems. Long term implications may relate to governance in terms of the degree of state-building versus state-avoiding behaviour. Indeed there is potential for a negative impact on and alignment with national and local government processes and structures. Additional drawbacks related specifically to contracting may include: (i) competition and potential benefits of effectiveness and efficiency may become watered down over time or may be absent altogether depending on the mix of non-state providers and their capacity to deliver services, (ii) efficiency gains may be wiped out by management costs required to effectively contract health services, (iii) governments with weak capacity to deliver services may also be weak in a stewardship role, and (iv) governments may lose any capacity for service delivery that exists, which may be particularly problematic where contracting is not seen as a long term solution.

2. Given the achievements made possible in Afghanistan through establishment of a BPHS similar emphasis should be placed on setting priorities in other fragile states with a strong lobby for primary health care in the initial stages of policy discussions and decisions regarding resource allocation. In many developing countries, as was also the case in Afghanistan in the past, most resources go to urban based secondary and tertiary facilities. Afghanistan put clear priority to primary health care, which is

potentially far more cost effective as well as more pro poor. It is an example of the often claimed ‘windows of opportunity’ that may arise in post-conflict settings.

3. Increasing aid effectiveness through improved coordination and relations with recipient governments represent actions that could accelerate progress towards the MDGs in fragile states. The alignment and harmonization agenda that has arisen out of concerns regarding aid effectiveness is gradually being pursued in Afghanistan with good results. The concepts of alignment and harmonization need to be placed on the policy agenda early in the process and pursued enthusiastically so that decisions made and approaches adopted may begin to pave the way towards a more unified system for the government to engage with. Establishment of a common framework within which all stakeholders can work seems to be a crucial component for jumpstarting the process of alignment and harmonization and paving the way to reconstruction of a coherent health system.

4. Given that contracting is a relatively new concept for both governments and actors engaging in the health sector of post-conflict environments an extensive dialogue needs to be established and considerable effort invested to ensure all stakeholders are well informed and understand the implications of such a strategy. Misconceptions of contracting on different levels have emerged in Afghanistan with the most prevalent misconception being that contracting represents privatization. This has resulted in agencies abstaining from engagement with the BPHS, albeit in only a few cases. Nevertheless the effects could be more far reaching in other contexts if the concept is not correctly interpreted. Thus in settings where contracting is being contemplated, the issues need to be clearly outlined, indicating the implications for all stakeholders involved and how roles and responsibilities will change in line with the strategy.

   The donor community should take a proactive role to inform and educate the NGO community of the contracting process which would help reduce misconceptions and keep experienced health NGOs engaged or at least supportive of the process. Unlike Afghanistan most fragile states do not have such a well established national NGO community, therefore international NGOs will play an essential role in the first years of contracting in other fragile states. In this sense it is in the interest of donors to invest efforts to address NGO misconceptions of contracting. Steps should be taken to institutionalize contacting as a possible donor tool and approach in future fragile state reconstruction efforts as has occurred with other tools such as Local Capacities for Peace.

5. NGOs need to be better prepared and more aware of engagement strategies such as contracting in fragile states so they are better able to respond, particularly in a post-conflict, rapidly changing environment. This is especially true in the health sector where contracting is becoming more popular. To ensure that they are not seen as merely contractors of health services - a concern that has been voiced in Afghanistan - an informed community of NGOs will be able to make important contributions to policy discussions in the early stages of transition to a post-conflict state. Indeed

NGOs can add value to policy development; however they need to evolve to be more active in the policy arena rather than only taking a programmatic focus.

Specific contribution to EC-Prep objectives:

We are conscious that policy and valuable experiences from other settings have shaped the way the EC operates which we have not studied and may not be fully aware of. However, in the context of Afghanistan we have recognized a number of key areas that could be improved and/or changed which would allow the EC to better capitalize on their investments in the health sector through a contracting model.

6. The EC can and should introduce performance-based measures earlier than has been the case in Afghanistan. Findings have shown that NGOs have behaved differently under different approaches. Although the EC aimed to gradually introduce performance-based mechanisms, findings have shown that NGOs in general have responded well to market forces and competition has been maintained.

7. If the EC is considering supporting a contracting approach a number of issues should be addressed:

    a. Capacity building for NGOs is required, particularly to foster establishment and performance of national NGOs. This contribution could come directly from the EC or in partnership with another donor more accustomed to technically supporting NGOs. If it is perceived that contracting will be an acceptable way of doing business for central and provincial authorities capacity building for NGOs will be an investment that pays off in the long term.
    b. The establishment of a unit similar to the GCMU is crucial to ensure buy-in, build the institutional capacity of the Ministry of Health as a steward, and most importantly, to ensure governments are not bypassed because of weak capacity. This unit will also allow for targeted capacity building of a 'critical mass' of individuals that will be intimately involved in the management and coordination of contracts. It may evolve, as in Afghanistan, that this critical mass becomes highly involved and influential in wider policy issues.
    c. In order to reap the potential benefits of a performance-based approach which encourages a more results oriented attitude among implementing partners, extensive monitoring and evaluation systems are a prerequisite which the EC needs to have in place.
    d. A more project oriented approach is required for fragile states but carried out as close to the government as possible. This requires strong implementation capacity within local EC offices. If a contracting system is put in place the investment needs to be made to allow the EC to ensure the system is working well and results will be desirable. Although the argument could be made that keeping local offices small keeps costs low the EC will not get the same return on their investment in fragile states. A middleman, such as MSH who was

used by USAID, or a GCMU body, although more costly may produce better results in the long term.

8. Although it is too early to assess, if contracting becomes a more popular mechanism in other fragile states and low income countries in general, the EC needs to reassess their procedures and guidelines. Existing procedures are not the most conducive to this type of approach. Although current systems have been put in place for good reasons adjustments should be considered to allow the EC to adapt to contracting strategies and there are arguments that can be made to adjust these systems to function more effectively and better exploit the benefits of a contracting approach.

   Some examples of how procedures could be adapted include:

   - *Procurement process*

   To promote good governance and engage the MOPH in a more direct way, the EC needs to include MOPH representatives in all phases of the procurement process. The World Bank and USAID included members of the MOPH at both the central and provincial level which has exposed them to the way these donors operate and has given them much needed experience in procurement guidelines. The MOPH has gained a significant amount of expertise through 'learning by doing' and 'on the job training'. Exposure to these donor procedures may allow for a smoother decentralization process. Active involvement in EC processes will also ensure more ownership and buy-in on the part of the MOPH. The study has shown that the MOPH staff is much more engaged with World Bank and USAID projects and is more aware of what is happening in the field due to this involvement.

   Working more closely with ministries of health from the start of the post-conflict period can ensure increased buy-in and involvement in EC projects. This may be particularly important where the government has adopted a stewardship role and is responsible for ensuring provincial authorities understand and work within new government policies and strategies. Furthermore, co-opting provincial health authorities may help to dissipate tensions that arise due to the shift in power that is inevitable at the start of a contracting process.

   - *Evaluation process*

   Involvement of officials from Brussels, while serving a purpose, should not be at the expense of local knowledge. The EC should ensure that there is wide representation from both central and provincial health authorities as well as other local sources of knowledge. This will promote a more transparent process and ensure that proposals are scored on the ability of the bidder to work in a given context, rather than the writing skills of proposal writers who may or may not be familiar with the country but can produce the gold standard documents.

   - *Type and specification of contract/grant utilized*

While grant contracts have their advantages, service contracts may be more appropriate and in line with the nature of contracting. Utilization of lump sum contracts under the World Bank approach for example has offered benefits to both donors and NGOs in Afghanistan. The flexibility created by the lump sum contracts have allowed NGOs to adapt to the new system in Afghanistan. Many NGOs have stated that this flexibility has been crucial in the first three years of implementation, fostering innovation and allowing them to take advantage of windows of opportunity. From the donors perspective services and outputs can be more clearly specified placing implementing partners in a more results oriented framework which may enhance the impact of service delivery. Rigid procurement rules and lengthy and complicated procedures required for budget revisions within current grant systems on the other hand have diminished response time and resulted in long delays in implementation.

The EC's requirement for a 20% financial contribution towards grant contracts awarded is another example of guidelines that do not fit a contracting approach. This requirement seems to go against the nature of contracting. Moreover, NGOs operating under the EC scheme are less results oriented than those operating under other schemes which may highlight that a financial contribution is not a strong enough motivating factor to affect implementation in a desirable way.

9. In general the EC should examine the differences produced under the various donor approaches implemented in Afghanistan. Although the purpose of the research was not to look at which approach was the best, pros and cons of the approaches have been highlighted which the EC can apply to their own set of guidelines and procedures.

FURTHER RESEARCH PRIORITIES

Although contracting has allowed for rapid expansion of health services, actual coverage is difficult to ascertain. Current coverage figures are based on population figures and the submission of budgets to cover a given area of the country. In effect although there may be coverage on paper the reality may be very different. For example, within the 77% of the country that has been covered by contracts or grants insecurity, inaccessibility and lack of human resources have prevented the establishment, staffing and/or monitoring of facilities. Even in areas where these factors are less of a constraint cultural barriers and health seeking behaviour affect access to health services. As a result coverage figures may be quite different from those appearing on paper. Effects on equity and access need to be further explored.

An important point to follow up on would be the link between the re-establishment of services and the re-establishment of the social contract between the people of Afghanistan and the government. Other research has pointed out that re-establishment of the social contract can contribute to state stability and peace.

The long term effects of contracting on reconstruction of health systems needs further attention. Given that decisions made in the early phase of post-conflict reconstruction will have implications for the future and the limited use of contracting on a such a large scale as has been used in Afghanistan, follow up on developments in the medium to long term are essential.

REFERENCES

Bennett S, McPake B and Mills A. 1997. The public/private mix debate in health care. In: Bennett S, McPake B and Mills A (eds.) *Private health providers in developing countries: serving the public interest?* London: Zed Books.

Bhushan I, Keller S and Schwartz B. 2001. *Evaluation Report: Contracting Health Services Pilot Project*. Technical Assistance Report: Asian Development Bank.

Bhushan I, Keller S and Schwartz B. 2002. Achieving the twin objectives of efficiency and equity: contracting health services in Cambodia. *Economics and Research Department Policy Brief Series* No 6: Asian Development Bank. (www.adb.org).

Branchflower A *et al*. 2004. *How important are difficult environments to achieving the MDGs?* Poverty Reduction in Difficult Environments (PRDE) Working Paper 2. London: DFID. http://www.oecd.org/dataoecd/30/63/34041723.pdf

DfID. 2000. *Better health for poor people. Strategies for achieving the international development targets*. London: DfID. http://www.dfid.gov.uk/pubs/files/tsphealth.pdf

DfID. 2005. *Why we need to work more effectively in fragile states*. London: DfID.

Dollar D and V Levin. 2005. 'The Forgotten States: aid volumes and volatility in difficult partnership countries (1992-2002).' Summary paper prepared for DAC Learning and Advisory Process on difficult partnerships.
http://www.oecd.org/dataoecd/32/44/34687926.pdf

Eichler, R. 2001. Constructing and Implementing Capitation Payments as Part of the Performance Based Financing System in the HS-2004 Project. Draft.

Eichler R, Auxilla P, Pollock J. 2001. Performance-Based Payment to Improve the Impact of Health Services: Evidence from Haiti. *World Bank Institute Online Journals*. World Bank: Washington DC.

Global Commission on Macro-economics and Health. 2001. Macroeconomics and health: investing in health for economic development. WHO: Geneva.

Loevinsohn, B. 2002. Practical Issues in Contracting for Primary Health Care Delivery: Lessons From Two Large Projects in Bangladesh. *WBI Online Journals*. World Bank: Washington DC. (www.worldbank.org).

Lopez-Cassasnovas G, Rivera B, Currais L. 2005. *Health and Economic Growth: findings and policy implications.* Cambridge: MIT Press. 385pg. And Commission on Macro-economics and Health. 2001. *Macroeconomics and Health: investing in health for economic development*. Geneva: WHO.

Nieves I, La Forgia GM and Jaume Ribera. Large-scale Government Contracting of NGOs to extend Basic Health Services to Poor Populations in Guatemala. Paper presented at a Conference (The Challenge of Health Sector Reform: Reaching the Poor), Costa Rica, May 2000. Available at: http://www.worldbank.org/lachealth

OECD. 2003. *Poverty and Health in Developing Countries: Key Actions*. Policy Brief OECD. November.

Palmer, N. 2000. The use of private sector contracts for primary health care: theory, evidence, and lessons for low and middle income countries. *Bulletin of the World Health Organisation* 78(6) 821-29.

Palmer, N. 2001. Influences on the Nature and Performance of Contracts for Primary Care: Case Studies from Southern Africa. PhD dissertation. London School of Hygiene and Tropical Medicine: London.

Soeters R and Griffiths F. 2003. Improving government health services through contract management: a case from Cambodia. *Health Policy and Planning* 18(1): 74-83.

Stewart F. 2002. Root causes of violent conflict in developing countries. *BMJ* 324: 342-345.

Walsh, K. 1995. *Public Services and Market Mechanisms. Competition, Contracting and the New Public Management*. Basingstoke: Macmillan.

Walt, G. 1994. *Health Policy: an introduction to process and power*. London: Zed Books.

Yin, C. (2003). *Case study research: design and methods*. USA: Sage.