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Afghanistan's Health System Since 2001: Condition Improved, Prognosis Cautiously Optimistic

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OVERVIEW

Five years ago, in the immediate post-conflict period, Afghanistan's health services were in a deplorable state. Based on relatively scant information available at the time, the situation appeared chaotic. Capacity in both public and private sectors was quite limited and the outlook for the future was unclear. The AREU Issues Paper published in July 2002 noted vast differences across the country in access to health services, and drew attention to the severe shortage of health personnel and a "grossly deficient, even absent, infrastructure."¹ Where health services were available at all, the level and quality of delivery varied considerably, and there was no policy framework within which non-governmental organisations (NGOs) could operate. Instead, healthcare was "delivered on a project basis by many distinct, relatively uncoordinated service providers."²

The Issues Paper noted four major constraints to achieving an efficient and effective national health system: lack of managerial and service delivery capacity within the Ministry of Public Health (MoPH); lack of physical infrastructure and qualified personnel; poor distribution of financial and human resources; and, uncoordinated and undirected efforts of the NGOs.

In early 2002, MoPH and the major donors developed a Basic Package of Health Services (BPHS) that would come to form the technical foundation of the Ministry, and provided clear guidelines for infrastructure reconstruction and rehabilitation and for staffing. At the same time, MoPH and its international partners agreed that the BPHS could be managed and expanded more effectively and efficiently if the MoPH contracted with NGOs. Despite the

¹ Waldman R., Hanif H. (2002). The Public Health System in Afghanistan. Kabul: AREU.

² Ibid.

concerns of MoPH and some of the NGOs, the principle of contracting for services was agreed upon.

Five years on, the concerns of the Government, NGOs and some donors appear to have been unfounded, at least in the short-term. MoPH has made considerable progress in making the BPHS accessible to most Afghans. Independent evaluations show improvements in quality of care, the health management information system shows consistent and significant increases in a number of indicators, and the management capacity of MoPH has improved. The concept of contracting for services has worked reasonably well, both with the NGOs and with the three MoPH Strengthening Mechanism (SM) provinces. For the major donors, despite the differences among the contracting schemes (each of which had its own advantages and disadvantages; see overview of donor contracting schemes on pages 14-15), buy-in to the BPHS, to contracting in general,

and to accommodating the needs of the Ministry, reflects a major effort at harmonizing policies.

To date, funding for the health sector has been relatively satisfactory, although Afghanistan will remain highly dependent on foreign assistance for many years to come, and in fact there are already some indications that donor resources may be reduced. Competition among NGOs for contracts and grants has been vigorous and constructive, with a significant percentage of funds going to Afghan NGOs. Three-quarters of the Afghan NGOs that competed for contracts have been formed since 2001, specifically to deliver the BPHS.

Looking to the future, there are a number of challenges facing the Government at central, provincial, and community levels, including full integration of the Grants and Contracts Management Unit (GCMU) and strengthening the technical and managerial competence in other essential departments of

ACRONYMS

BPHS	Basic Package of Health Services	MOU	Memorandum of Understanding
CFP	call for proposals	NGO	non-governmental organisation
CHW	community health worker	NSP	National Solidarity Programme
EC	European Commission	PHD	Provincial Health Department
EPHS	Essential Package of Hospital Services	PHO	Provincial Health Office
FFSDP	Fully Functional Service Delivery Point (FFSDP are standards of quality applied to health facilities)	PPA	Performance-based Partnership Agreement
GCMU	Grants and Contracts Management Unit	PPG	Performance-based Partnership Grant
HHS	Household Survey	PRR	Priority Reform and Restructuring Process
IIHMR	The Indian Institute of Health Management Research	REACH	Rural Expansion of Afghanistan's Community-based Healthcare
INGO	international non-governmental organisation	RFA	request for application
JHU	Johns Hopkins University	RFP	request for proposal
LQAS	Lot Quality Assurance Sampling	SM	Strengthening Mechanism
MICS	Multiple Indicator Cluster Survey	SWAp	Sector-wide Approach
MOF	Ministry of Finance	UNICEF	United Nations Children's Fund
MoPH	Ministry of Public Health	USAID	United States Agency for International Development
MSH	Management Sciences for Health	WHO	World Health Organisation

the Ministry; maintenance of the level of technical assistance; strengthening linkages between central, provincial, and district levels; defining roles and responsibilities of the Provincial Health Offices; and, increasing access and quality, especially in remote areas.

For their part, donors need to be aware of the relationships between vertical programmes, new global partnerships, and the BPHS, and to maintain the level and predictability of funding support, both to keep the system functioning at the now higher levels of the populations' expectations and to enable MoPH to plan with some certainty.

In sum, progress has been made in addressing the four major constraints identified in the AREU 2002 analysis. So far, this progress has been measured only by process indicators, and it is not yet known whether or not it will have resulted in the health status of the Afghan population, something an impact evaluation may show in a year or two.

Although this Briefing Paper reports generally positive findings, there is no room for complacency. In a sense, given the health sector's dismal state in 2001, the relatively easy gains have already been made. Further progress may be impeded by chronic problems such as uneven management, inadequate financial systems, and inconsistent transparency and accountability. Furthermore, a variety of potential problems loom on the horizon, among them ensuring adequate and predictable levels of funding and technical assistance. Finally, with respect to the larger context, additional problems exist because of the unstable security situation, the relative weakness of the government, and the difficult economic situation that for many Afghans has progressed only minimally since 2002.

If the Ministry is able to build on its progress to date, as well as to effectively document impact and communicate results, it can make a strong contribution not just to health, but also to the maintenance of a stable political environment that is an essential requirement for the security, welfare, and improved wellbeing of the Afghan people.

Specific **recommendations** include:

1. MoPH needs to develop a communications strategy to ensure that important policy makers in the Government and the Afghan population are aware of health sector achievements, in part to help ensure ongoing and predictable funding.
2. For their part, donors must strive to ensure ongoing and predictable funding for the health sector.
3. MoPH and its partners should continue to strengthen the management capacity of the Provincial Health Offices to enable them to better discharge their responsibilities for public health management.
4. The Ministry should take the best characteristics of each of the "flavours" of the contracting mechanisms to further improve the overall system of contracting.
5. Within the larger context of discussion of decentralisation/de-concentration and programme budgeting, MoPH, with support from its partners, should identify appropriate decisions which could be better made at provincial or lower levels.

I. Healthcare Service Delivery in Afghanistan since 2001: The Current Context

Five years ago, in the immediate post-conflict period in Afghanistan, health services throughout the country were in a deplorable state. Based on relatively scant information available at the time, mostly from the “gray literature” kept in the files of the United Nations agencies and non-governmental organisations (NGOs), the situation appeared chaotic. The capacity in both public and private sectors was quite limited and the outlook for the future was unclear. At that time, the Afghanistan Research and Evaluation Unit (AREU) published a monograph entitled, *The Public Health System in Afghanistan*, which reported that “the ratio of basic health centres to population ranged from approximately one per 40,000 in the central and eastern regions, to one per 200,000 in the south.” It also drew attention to the severe shortage of health personnel and a “grossly deficient, even absent, infrastructure.”³ For the most part, healthcare was provided by NGOs, many of which had not established relations (formal or informal) with what was then a very fragile transitional government. Where health services were available at all, the level and quality of delivery varied considerably and there was no policy framework within which NGOs could operate. Instead, healthcare was “delivered on a project basis by many distinct, relatively uncoordinated service providers.”⁴

The AREU document listed four major constraints to achieving an efficient and effective national health system:

- lack of managerial and service delivery capacity within the Ministry of Public Health;
- lack of physical infrastructure and qualified personnel;

- poor distribution of financial and human resources; and,
- uncoordinated and undirected efforts of the NGOs.

On the positive side, there was tremendous energy in the health sector. Mass vaccination campaigns against measles and polio were planned and rapidly implemented, with the United Nations Children’s Fund (UNICEF) and the World Health Organisation (WHO) working closely with the very constrained resources of the Ministry of Public Health (MoPH). NGOs continued to provide badly needed services, and took the lead on policies such as salary standards. WHO and MoPH took the lead, working with other partners, to develop a Basic Package of Health Services (BPHS) that would come to form the technical foundation of MoPH. The BPHS also provided clear guidelines for infrastructure reconstruction and rehabilitation and for staffing patterns at different levels of facilities.

In April 2002, a Joint Donor Mission report, drawing on lessons and experiences from other post-conflict settings, particularly Cambodia, suggested that services could be managed and expanded more effectively and efficiently if MoPH commissioned and directed NGOs to implement the provisions of the BPHS.⁵ This contractual arrangement was championed by the World Bank, leading designer and funder of the public-private partnership scheme at that time. Other major donors, the United States Agency for International Development (USAID) and the European Commission (EC) agreed in principle with the suggested contracting approach, but both the Ministry and NGOs viewed this setup with some suspicion.

³ Waldman and Hanif, op. cit.

⁴ Ibid

⁵ The Joint Donor Mission consisted of representatives from eight bilateral and multilateral organisations, tasked with reaching a broad agreement with the Government on a framework for improving and expanding health services.

Ministry officials saw the delivery of health services as a state function, which needed to be fulfilled if the new government was to become legitimate in the eyes of the population. Historically, the state and many citizens distrusted the private sector, which was seen as excessively profit-oriented and insufficiently concerned with delivering effective social services. The war period was seen as a special case, when NGOs had to step into the breach due to the Government's inability to perform its functions.

Many of the NGOs were wary of working with the Government, the World Bank or, to a lesser extent, USAID, the largest of the bilateral donors working in the health sector. In part due to a combination of philosophical reasons and having become accustomed to relative independence during the war years, NGOs felt that their tradition of independence might be compromised and that they would be exposed to unwanted political entanglements. Still, both Government and NGOs acknowledged that they could not fulfill the responsibilities of establishing a health system without the other. Thus, both adopted the proposed public-private design for health service delivery — that is, public sector stewardship of private sector service delivery.

Five years on and the hesitation and concerns of the Government, NGOs and some donors appear to be unfounded, at least in the short-term. To be sure, the potential for medium- and long-term success of Afghanistan's health sector is yet to be realized and many questions remain, including the percentage of the population that actually seeks the health services made available. Still, the Ministry of Public Health has made considerable progress in making the BPHS accessible to most Afghans.⁶ Evaluations conducted by the Johns Hopkins University Bloomberg School of Public Health (JHU) show large improvements in the quality of care from 2004 to 2005 and from 2005 to 2006. In addition, the health

Both the Government and NGOs recognize that they could not fulfill the responsibilities of establishing an effective health system without the other.

management information system shows consistent and significant increases in the number of outpatient visits, antenatal care and TB case detection rates.

One of the factors that facilitated this was the development of a Grants and Contracts Management Unit, which tried to overcome what started out as a weakness in the management capacity of MoPH. With such steps to improve service delivery, international and Afghan NGOs have come to recognize that the Ministry is becoming increasingly competent in managing contracts — a critical function in its role as steward of the health sector. Both MoPH and NGOs have engaged productively with each other and, in partnership with donors, facilitated and managed contracts that have delivered services outlined in the BPHS to an important proportion of the Afghan population. Considering the enormous challenges faced by government agencies in any post-conflict country, not the least Afghanistan, this collaboration has led to the development of a relatively functional health sector.⁷

As for the donors, the World Bank-funded Performance-based Partnership Agreements (PPAs), managed entirely by the GCMU but with close management oversight by the World Bank, has progressed satisfactorily. In fact, the GCMU has recently finalized the second round of contracts, extending the term of most contractors and

⁶ The contracts for most of the "white areas" (areas without contracts for coverage) have been signed and NGOs have begun delivering services. Now more than 85 percent of the population live in districts for which there are clear resources for the BPHS (GCMU, September 2006). However, it is important to note that the proportion of the population living in these areas that has real access to health services is highly variable and much remains to be done in this regard, especially in parts of the country that are less secure.

⁷ Although there are no objective data on which to firmly base this statement, all of those with whom the matter was discussed in Afghanistan agreed that the health sector was performing better than other Ministries responsible for the provision of social services. Also, in relation to the situation in other post-conflict countries at the same post-bellum period, Afghanistan's health sector is characterized by a strong policy framework, clear guidelines for service providers, a formal evaluation plan, and reasonable access.

awarding the next round. NGOs, in general, have expressed their confidence in the GCMU, and their dealings with the management unit have been positive. Discussions aimed at expanding the geographical reach of the BPHS to an even more peripheral level, one beyond that of the Basic Health Centre, are underway.

USAID, for its part, has been supportive of contracting with NGOs from the start. Although it hired an intermediary, Management Sciences for Health (MSH), to manage its funds and contracts for the first term of its agreements, it has recently modified its scheme to allow for much more hands-on public management of its NGO grants (although due in part to USAID regulations, the next phase of financial management will be done by WHO, at least initially). Finally, the EC, which also entered the contracting arena, is modifying its contracting mechanism to give the Ministry a much more important leadership role. The EC plans to continue its previous funding scheme before gradually phasing in performance-based contracts to be managed and monitored by the Ministry.

While all of the major donors agreed on the main principle of contracting out, each took a somewhat different approach based on experience and views of what was feasible and appropriate within institutional guidelines and regulations. The schemes are not directly comparable; each has its advantages and disadvantages.

This Briefing Paper does not intend to compare the contracting schemes or rank them or the NGOs on the basis of merit or performance. An independent in-depth study and analysis of the three different schemes has been conducted recently by the London School of Hygiene and Tropical Medicine, in which two of the authors of this paper participated. A first report⁸ is available and additional publications will be available soon. This paper inevitably draws on the findings of this study and on information obtained from supplementary observations and interviews, as well as from international experience and other available sources.

The purposes of this Briefing Paper are to examine the development of Afghanistan's health system since 2001 and to try to identify and address challenges which may arise in the succeeding cycles of contracting.

Presidential and parliamentary elections have now been held in Afghanistan and a central government, albeit one still struggling for increased stability and legitimacy, is in place. Overall, the funding situation for the health sector is relatively satisfactory at present, although Afghanistan will be highly dependent on foreign assistance for many years to come, and in fact, there are indications that donor resources may be reduced. Any substantial reduction in aid could have a crippling effect on the health sector. In other post-conflict countries, the level of donor funding has been variable and unpredictable and, often, assistance to the health sector is threatened by other perceived priorities. The large sums that helped get the health system in Afghanistan on track are likely to shrink but, fortunately, it is no longer in its infancy and may be able to withstand mild shocks. On the other hand, it is far from being fully developed and there will be many more obstacles to efficient and effective health service delivery to overcome in the coming years.

⁸ Strong, L., Wali, A. and Sondorp, E. *Health Policy in Afghanistan: Two years of rapid change*. www.lshtm.ac.uk/hpu/conflict/files/publications/file_33.pdf.

II. The Government and its Challenges

As Afghanistan's health system develops, careful attention must be given to the management and service delivery aspects at every level of the system — peripheral, provincial and central — by all of the major actors, NGOs, public sector service providers, donors, and managers and policy makers in the Ministry of Public Health. It is unlikely that health system development in Afghanistan will be a smooth process. It will be buffeted by political, economic and social impediments and its ability to move forward rapidly will depend on the extent to which those concerned can anticipate and adapt to the many challenges that will arise. This Briefing Paper tries to identify some of these challenges and attempts to suggest what steps might be necessary to help the sector develop into a respected and consequential arm of the Government.

Looking to the future, there are a number of challenges facing the government at different levels: central, provincial, and community.

Central Level

The Ministry of Public Health has grown considerably stronger since its reformation.⁹ Progress has been facilitated by a number of civil service reforms instituted by the Government of Afghanistan, including the Priority Reform and Restructuring (PRR) Process that is intended to award higher salaries on a competitive basis for certain strategic positions. Among ministries, MoPH has been the most prominent user of this mechanism. It was also an early user of the PRR mechanism, and by the end of 2005, nearly 900 staff across all provincial health directorates had been "PRRd." This was about 70 percent of all PRR positions available throughout the Government. The central level has also benefited significantly, particularly two General Directorates, Policy and Planning and Provincial Health.¹⁰ In addition, the Ministry has greatly benefited by employing a number of Afghan advisors

who are financially and technically supported by the donors.

Liberal use of the PRR mechanism was intended to attract well-qualified candidates to the civil service. The financial incentives may have helped prevent an exodus to UN and NGO health programmes (although this would be difficult to document) — a frequent occurrence in post-conflict countries. In fact, many of the public health physicians employed by the GCMU, as well as other offices within MoPH, have NGO backgrounds, an asset in dealing as closely with NGO partners as they are now called upon to do. Again, this is a departure from the experience of other countries, where civil service and private sector providers have little in common and where their respective organisational cultures frequently preclude close cooperation.

On the other hand, the GCMU, at the start, was viewed with some suspicion. Funded entirely by the World Bank, and formed with the specific intent of overseeing the World Bank-supported Performance-based Partnership Agreements, it was seen by some as a separate entity, rather than as an integral component of the Ministry. Fortunately, this perception is rapidly fading, as other donors have made important technical inputs and as the GCMU now not only manages contracts, but also plays an important role in the formulation of Ministry policies and oversight of its programmes. Still, because of its central role in overseeing the contracting schemes which are the essential strategy for primary health care service delivery, and because it is, arguably, the most visible part of MoPH to the NGOs and donors, the GCMU benefits from considerable external funding, more than most other Ministry departments, and from a higher-level of expatriate technical assistance. None of this is bad. In fact, the strength of the GCMU, with

⁹ As might be expected, its growth has been uneven, with some organisational units, especially those receiving strong donor support, registering the greatest gains.

¹⁰ World Bank. Afghanistan. Managing Public Finances for Development, vol IV: Improving Public Financial Management: Case studies of selected sectors. Report No. 34582-AF, Dec. 22, 2005, p.14.

support from donors and MoPH leadership, has significantly contributed to the progress that the health sector has achieved.

Contracts management is certainly not, nor should it be, the only function, or even the most prominent role of a Ministry of Public Health. Long-term strategic planning based on evidence, increased managerial capacity (including procurement and financial management), oversight of hospital services, technical expertise in priority disease control areas, development and implementation of an operational research agenda and ongoing monitoring and periodic evaluation of the health sector are only a few among many other stewardship functions of a central-level Ministry. For a sustainable and competent health sector to develop, additional assistance will be required in all of these areas.

In other developing countries, donors have a tendency to lower the level of technical assistance as they seek to implement less hands-on, easier-to-manage financial mechanisms, such as sector-wide approaches (SWAs) or “basket” funding. For the most part, Afghanistan’s health sector has benefited from the technical expertise of expatriates. Some of the GCMU Afghan consultants have been put in charge of line departments, and additional

recruitment of line managers, as agreed by MoPH and the World Bank, is ongoing. All these efforts are intended to continue increasing GCMU’s integration, both in perception and practice, by strengthening the technical and managerial competence throughout the essential departments of the Ministry.

Provincial Level

In other post-conflict health systems that have adopted contracting mechanisms to quickly and efficiently expand coverage, lack of attention to the intermediate or provincial level has proved to be a significant obstacle. In Afghanistan, there are two relationships at this level that need monitoring.

First, throughout the Government, not only in the health sector, the central and provincial levels are not always well linked. Even where the relationships are clear on paper, in practice they are quite ambiguous. Moreover, decentralisation (or even de-concentration) is a sensitive political concept in Afghanistan. Despite the years of conflict, which in some ways produced a *de facto* decentralised administration, the desire for a unitary, highly concentrated state persists, and policy makers retain a fear for devolving power and authority to provinces or regions. On the other hand, as one informant put it, “there has to be centralisation before there can be decentralisation” and helping to establish a strong and legitimate central government is a major goal of many of the bilateral donors and the United Nations system.

In health, as mentioned earlier, there has been an attempt to provide financial incentives to provincial-level health teams, especially in the World Bank-supported provinces. This is done both through the PRR mechanism and by awarding bonuses to provincial MoPH staff when performance-based bonuses are awarded to NGOs which score high on the “balanced scorecard.”¹¹ Still, it is the roles and responsibilities of the provincial health authorities that have been called into question by the contracting schemes in which NGOs are commissioned by the central level to provide services. Since the responsibility for health service delivery lies mainly with the private sector, and the

An interesting experiment is taking place in three provinces: Kapisa, Panjshir, and Parwan. The central Ministry of Public Health has contracted the Provincial Health Offices – in the same way NGOs are awarded contracts – to provide service in accordance with the Basic Package of Health Services.

¹¹ The “balanced scorecard” is a system used by a team from Johns Hopkins/Bloomberg School of Public Health, an independent contractor of the Ministry of Public Health, for purposes of evaluating progress toward delivery of the BPHS throughout the provinces.

oversight of the contracts lies with the GCMU at the central level, it is reasonable to wonder about the scope of the Provincial Health Offices' (PHO's) authority.

The second relationship that needs careful attention is the one between PHOs and the NGOs. There have been important attempts to bring the provincial health authorities into the loop of the contracting schemes — in some cases, they sit on the selection panels to review the competitive bids submitted by the NGOs and they participate, to different degrees, in the performance review of NGOs.

According to the London School study, all provincial authorities interviewed thought that the best approach for the future of Afghanistan's health system is public sector service delivery. This is not surprising, given the historical role of the state and the lack of experience with a public sector stewardship role. On the other hand, they recognized the value of contracting at this time, when Ministry capacity is clearly limited. As a potential bridge to the future, an interesting experiment is taking place in three provinces: Kapisa, Panjshir, and Parwan. The central Ministry of Public Health has contracted PHOs — in the same way NGOs are awarded contracts — to provide service in accordance with the BPHS. This MoPH-SM (Strength-ening Mechanism) scheme needs to be followed closely. Although there are more restrictions on the provincial contractors than on the NGOs, in that they have to adhere to government administrative and management guidelines to a much greater extent, PHO performance to date has been reasonable. This is according to World Bank reports backed up by interviews conducted for this study. The SM provinces have, by far, benefited the most from the Ministry's use of the PRR process (about 700 staff in three provinces have been PRRd). This, together with performance bonuses (the SM provinces are part of the World Bank contracting scheme), may provide sufficient incentive to make public contracting for public service delivery a viable long-term option, should NGO participation in the contracting schemes diminish or be phased out. It is important to note, however, that the three provinces selected for the experiment have a comparatively good level of security and accessibility.

More than 82 percent of the population live in districts with resources for the Basic Package Health Services.

SM implementation elsewhere, particularly in remote and insecure provinces, may prove to be a bigger challenge.

In any event, whether or not PHOs return to their pre-war responsibility for service delivery, it is clear that they could benefit from improved management skills and additional technical assistance. This process was begun by Management Sciences for Health under the USAID contracting scheme and there are plans to continue providing this type of assistance. USAID's new Techserve project proposes to do so. The EC started a comprehensive provincial-level capacity building initiative, managed by a team of international and national staff. The World Bank, for its part, has a built-in stipulation in its contracts that NGOs should develop staff capacity in provincial health offices.

All these efforts should have the objective of increasing the confidence and competencies in PHOs. Managing relations between PHOs and central-level officials, and between PHOs and NGOs, is as much the role of the provincial authorities themselves as it is of their partners. Experience in other countries has shown that without the inclusion, in a real and contributory sense, of the intermediate level, further improvements in health system performance will be difficult to achieve.

Community Level

Health system performance also depends as much, if not more, on the access and quality extended to health service consumers. The figure of 82 percent coverage cited earlier is frequently used, but it is acknowledged to be an over-estimation of the population that has real access to, or actually seeks services from health facilities providing the Basic Package of Health Services. In fact, technically this figure means that contracts cover areas of the

The most important focus should never change: reaching the people, not achieving statistical goals.

country in which 82 percent of the population reportedly lives, but services are far more available in cities and in those areas where health workers and the general population feel secure.

The Government has gone out of its way to entice health workers to work in remote areas. For example, the National Salary Policy for NGO staff, initially initiated and drafted by the NGOs, was adopted by MoPH to try to reduce harmful competition for hiring staff. The programme takes into account the need to attract health workers to places where the population has restricted access to social services and provides higher salaries as motivation. Some of those interviewed as part of this analysis reported that this effort was, for the most part, achieving its purpose and that health staff recruitment had become easier because of it. On the other hand, others reported that staffing peripheral facilities — especially with female workers in remote areas — to the levels stipulated in the BPHS was still a problem. For example, some NGOs have had to hire female health workers from abroad and have recruited actively in Tajikistan. Human resources will remain a problem requiring constant attention in the years ahead. On the whole, however, substantial progress has been made. In the World Bank PPA provinces, for example, more than 75 percent of health facilities now report having trained female health workers; in MoPH-SM provinces, the figure is 70 percent. The baseline for this indicator in 2002-2003 was 25 percent.

It has been recommended that the number of health facilities needs to be expanded. Population to facility ratios as suggested in the BPHS are meaningful only if the public can reach the facilities. This is an important point and MoPH is addressing this issue by planning to establish an additional level of facilities, each of which would serve 3,000-7,000

people. Given the nature of Afghanistan's terrain and its poor roads, flexibility in relation to the standard WHO recommendations on facilities for a given population is reasonable.

The World Bank is now encouraging NGOs to apply BPHS guidelines more flexibly and also to explore the option of establishing sub-centres where appropriate. Criteria for these adaptations still need to be worked out since other donors recommend a more rigid interpretation of the BPHS. Still, the most important focus should never change: reaching the people, not achieving statistical goals.

In addition to geographical constraints, it goes without saying that in some areas the security situation may act as a deterrent to seeking health care outside the home. In Zabul Province, for example, only half of the facilities planned have been established and are functional. Similar problems are experienced in Uruzgan, Helmand and Kandahar, where there is a re-emergence of polio cases.

Geographical and security reasons for not seeking care are important, but there are other important obstacles that need to be explored. These include insufficient knowledge of when care outside the home is required, decision-making processes within the household, financial concerns, and/or the availability of other sources of treatment, such as private providers or traditional healers in the marketplace.

Research at the community and household level is very important to determine other reasons why some people do, and others do not, make use of the health services available. All of the contracting schemes have put at least a moderate emphasis on reaching the community (and some have made this a major component of their approach), including the development of community health workers (CHWs). At least one NGO has even taken the initiative of providing financial rewards to CHWs who successfully refer people to health facilities — for example those with symptoms of TB for diagnosis and treatment, or women about to give birth.

Because of the potential importance of community health workers, it is appropriate that policy makers and service providers pay particular attention to them. The public health literature is replete with

discussions regarding quality assurance of service delivery at the community level, and all of the issues surrounding it should be taken into account by the implementing NGOs in Afghanistan. The issue of CHW compensation has been a particularly nagging one, and it takes on additional importance in Afghanistan, since so much of the impact of the health system depends on its ability to increase access and utilization rates. Current MoPH policy does not allow regular payments to CHWs, but some NGOs report that the community workers they have worked with feel that they deserve compensation after training to perform specific medical interventions that go far beyond health education and promotion. Such interventions include prescribing antibiotics for pneumonia, distributing anti-malarials, and using zinc together with ORS to treat diarrhea. Paying this level of “employee” even a small amount could vastly expand the Ministry wage bill in a way that would be unacceptable to donors, but this is nevertheless another important problem that will require attention in the short-term if the Ministry’s objectives are to be achieved.

In some countries, CHWs have been reimbursed by their communities, either in kind or in cash, and the solution to the problem has been left to the local level. This is certainly an option in Afghanistan, but more information needs to be collected about out-of-pocket expenditures for health and capacities and willingness to pay for health care. If it is found that out-of-pocket expenditures on health inhibit the ability to access healthcare, the Constitutional provision calling for free services must be enforced, at least for those services included in the BPHS. Cost should not be a barrier to utilization of health services. The Ministry of Public Health has drafted a national policy on cost sharing and started elaborating guidelines for its implementation. However, since the Afghan Constitution states that health care should be free, the issue has been put on hold, although there is growing understanding that the health sector should move toward increased sustainability and that options for health-care financing should be examined.

High utilization rates of government-supported healthcare services are essential to meet the goal of improving the health status of the population. Given that the standard population health indicators for Afghanistan are among the worst in the world, the widest possible provision of services is clearly important in fulfilling the health sector’s humanitarian mandate. But it should be noted that the delivery of health services in a post-conflict state should have more than traditional humanitarian objectives. Health service delivery in a post-conflict context can also help legitimize a fragile government. This in turn can contribute to long-term political stability — a pre-condition for the fullest possible implementation of health policies and programmes on a national scale.

When considering the leading causes of morbidity and mortality, the medical and public health communities tend to name diseases. Pneumonia, diarrhea, and malaria are, in fact, the leading medical causes of death in Afghanistan, but there are many other factors that contribute to the poor health status of the population. Post-conflict societies require a different approach to public health service delivery because political conditions also have a profound effect on health. It has been shown, for example, that conflict, especially through its indirect consequences, has an important impact on mortality rates.¹² In other words, from a prevention perspective, taking action to prevent the resumption of armed conflict in Afghanistan (and to reduce the level of conflict currently occurring) may be as important, in the long-term, as figuring out

Delivering health services in a post-conflict context involves more than traditional humanitarian objectives; it can help legitimize a fragile government.

¹² For a recent epidemiological analysis of the indirect impact of violence on mortality, see Coghlan, B., Brennan, R., Ngoy, P. et al. Mortality in the Democratic Republic of Congo: A Nationwide Survey. *The Lancet*, vol 367(9504):44-51, 7 January 2006.

how to deliver health services in areas where insecurity contributes to the under-utilization of health services.

It stands to reason that one way for a government to reduce the risk of a country regressing back to widespread conflict is to increase its legitimacy in the eyes of the population. To achieve this, the government needs to show that it is capable of fulfilling one of the key functions of an effective state — providing essential services such as health and education. This is part of what is frequently referred to as the “peace dividend”. A post-conflict health system should also consider adopting the political objective of contributing to long-term peace by helping improve the perception of the fragile government, thereby contributing to its legitimization. In Afghanistan, a central government, respected by the public, can facilitate the promotion of national health programmes — including preventative care — which can have a profound impact on the Afghan population’s well-being.

MoPH should consider putting even more emphasis on health service delivery at the community level, making sure to do the research necessary to obtain information regarding people’s health-seeking behaviour. In addition, it should keep track of indicators of health system performance that measure not only stock-outs of drugs, training of female health workers and other process measures of efficiency, but also ones that measure levels of trust, confidence, and satisfaction with government services. Donors in post-conflict environments, including the major donors to the health sector in Afghanistan, are putting increasing emphasis on state-building. In order to maintain the relatively high level of funding they enjoy in the immediate post-conflict period, all line ministries in fragile states may have to show that they can make substantive contributions to maintaining the political stability that is so important in order for them to achieve their long-term objectives.

It should be added that the Ministry of Public Health has not been as successful as it might be at publicizing its achievements. It seems to be well

There is insufficient knowledge on the health-seeking behaviour of Afghans. Some questions worth exploring:

- *What circumstances compel them to seek healthcare outside the home?*
- *Which are they more inclined to visit first: government facilities, or private providers?*
- *How is healthcare prioritized and decided within a household?*

accepted, at least among members of the donor community who were contacted for this report, that the health sector has been among the best performing reconstruction areas in Afghanistan. MoPH might be well served by developing a communications strategy to let the population know, for example, that far more health services are widely available than at any time in the past. The Presidency should also be made aware that MoPH has contributed to the cause of legitimizing the fledgling Government, and that it deserves more attention and more money. In addition, MoPH might share with other ministries — especially the Ministry of Education which reportedly has performed substantially less well — the benefits derived from contracting with private organisations to deliver health services under its direction and within its policy framework.

Donor support to the health sector in Afghanistan

III. The Donors and their Challenges

has been strong and it has been necessary and beneficial. Looking ahead, a continued strong donor contribution characterized by financial and technical assistance will be required in Afghanistan for a long time to come. It is extremely unlikely that the health system will be able to function adequately without the continued, substantial inputs from the international community.

Delivery of the Basic Package of Health Services has been supported almost from the start by the World Bank, USAID and the EC. Buy-in to the BPHS reflects a major effort at harmonizing donor policies in accordance with the principles for aid effectiveness developed by the Organisation for Economic Cooperation and Development (OECD).¹³

It should be noted that there are differences among the contracting schemes developed by the donors in conjunction with the Ministry of Public Health, and with other partners (see *An Overview of Donor Contracting Schemes* on p.14-15). These reflect, to a large degree, the overall administrative and financing mechanisms to which donor country offices must adhere. Each of the schemes has elements which have been appreciated. For example, most of the NGOs contracted under the World Bank's PPA scheme appreciate the flexibility afforded by up-front, lump-sum payments, as well as mid-term and end-of-contract bonuses based on performance. This arrangement was not possible under the USAID-funded scheme, as USAID is bound by its own rules of accountability, at least for the time being, to enter into contracts based on line-item budgeting and reimbursable expenses. In the same way, as mentioned above, MoPH itself, in its SM contracting scheme, could not afford Provincial Health Offices the same degree of flexibility as the NGOs contracted under the World Bank-funded

scheme — they are bound by the procurement and recruiting rules of the Government. Similarly, NGOs and public health authorities in the USAID-funded provinces expressed strong appreciation of the amount and level of technical assistance they received from USAID's intermediary agency, MSH.

The donors have made a clear effort to accommodate the strengths of each and the desires of the Ministry, and over time, arrangements have become more streamlined. For example, the World Bank has agreed to post-award budget negotiations, while USAID has modified its original scheme to bring it more in line with a performance-based system. The European Commission has also shifted from grants to output-based service contracts for its next round of awards.

The use of these different "flavours" of public management/private service delivery schemes gives the Ministry of Public Health an opportunity to assess their strengths and weaknesses and to try to incorporate the best features of each into its future strategies.¹⁴ While, as expected, there have been glitches with the implementation of each of the contracting schemes, and considerable work remains to be done to improve not only their effectiveness but their efficiency, there is a reasonable degree of consensus that the contracting mechanism was right for Afghanistan during the immediate post-conflict years. Compared to the experience of other countries recovering from conflict, it is not a stretch to say that the public health system in Afghanistan has come a long way quite fast.¹⁵ More important than dwelling on the implementation problems to date is attending to the predictable problems of the future.

¹³ See, for example, OECD-DAC (2004). *Alignment and Harmonization in Fragile States*.

¹⁴ The Ministry of Public Health, to the best of our knowledge, has not yet undertaken a formal evaluation of its contracting schemes. The London School study will clearly lay out the advantages and disadvantages of each, although it is important to stress that on many levels they are not directly comparable and attempting to rank them in any way serves no useful purpose.

¹⁵ In fact, public sector stewardship of private sector service delivery, based on a standard or minimum set of primary health care interventions, has become a model for health sector rehabilitation in post-conflict settings, as seen in the Democratic Republic of Congo, Liberia, and South Sudan.

AN OVERVIEW OF DONOR

* For a list of acronyms, turn to page 2

Donor and Type of Contracting Scheme		Time-frame	Contract/Grant Manager; Flow of Funds	Tendering Process	Evaluation of Proposals
UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID) <ul style="list-style-type: none"> • 2002-05: Performance-based grant • 2006 onwards: adapted to Performance-based Partnership Grants (PPG) • Fixed budget (input-based) • Cost reimbursement payment 		2002-2005	Management Sciences for Health (MSH)/ REACH*; USAID ▶ MSH ▶ NGO	(i) NGOs submit pre-qualification questionnaire (ii) Shortlisted NGOs receive RFA* (iii) Proposals submitted	<ul style="list-style-type: none"> • Formal evaluation and scoring criteria, plus panel discussion • Budget/cost effectiveness worth 10% of total score • Scoring criteria varies between new and experienced Afghan NGOs/INGOs*; 10% extra to Afghan NGOs on technical merit
		Changes for 2006 onwards	Grants and Contracts Management Unit (GCMU); Funds channeled to MoPH* through WHO*	<ul style="list-style-type: none"> • In addition to pre-qualification questionnaire, NGOs also asked to submit EOIs* • GCMU tasked to manage process 	<ul style="list-style-type: none"> • WB Quality Cost-Based Selection system adopted, but with budget negotiations; MoPH tasked to manage evaluation • Scoring attracts consortiums of international and Afghan NGOs • New Afghan NGOs awarded maximum 2 clusters; large Afghan and INGOs, maximum 3 clusters • New evaluation criterion: performance in BPHS* delivery
WORLD BANK (WB)	NGOs <ul style="list-style-type: none"> • Performance-based Partnership Agreement (PPA) • Service delivery contract • Fixed lump sum remuneration with 100% budget flexibility 	2002-2005	GCMU; WB ▶ MOF ▶ MoPH ▶ NGO	(i) NGOs submit EOIs (ii) Shortlisted NGOs receive RFP* (iii) Proposals submitted	<ul style="list-style-type: none"> • Quality Cost-Based Selection: proposals reviewed on technical, financial criteria; those with 60 plus points evaluated financially • Scores are tallied: 80% for technical merit, 20% for financial
		Changes for 2006 onwards	No change	<ul style="list-style-type: none"> • "Good-performing" NGOs awarded contract renewal based on standard per capita cost: 4.50 USD • New contracts face more competitive process: fixed budget selection; ceiling set at per capita cost 	<ul style="list-style-type: none"> • Contract amendments prepared and signed • Quality Cost-Based Selection applied to cluster-wide PPAs with budget fixed at US\$4.50
	MoPH-SM* <ul style="list-style-type: none"> • PPA • Government-provided services with some parts contracted out to NSPs* through MOU* • Fixed lump sum remuneration with 100% budget flexibility 	2002-2005	GCMU; WB ▶ MOF ▶ MoPH	RFP issued to MoPH Proposals submitted	Similar criteria as NGOs but no competition
		Changes for 2006 onwards	No change	Existing SM agreement to be extended	Same as NGOs
EUROPEAN COMMISSION (EC) <ul style="list-style-type: none"> • 2002-05: Grant contract; fixed budget (input-based); cost reimbursement payment; NGOs must contribute 20% of overall budget, reduced to 10% in 2nd and 3rd rounds, with possibility of waiver • 2006 onwards: became service contract (output-based); cost reimbursement based on achieved benchmarks 		2002-2005	EC; EC ▶ NGO	(i) International CFPs* issued: NGOs must be EU- or Afghanistan-based (ii) Proposals submitted	<ul style="list-style-type: none"> • Evaluation criteria for different sections; emphasis on budget/ cost effectiveness • Financial score is worth 30% (10% for budget/cost-effectiveness; 20% for financial, operational capacity); 5% for financial sustainability
		Changes for 2006 onwards	No change	<ul style="list-style-type: none"> • Call for tenders to non-profit agencies based in Afghanistan, EU, or Asian developing countries, operating in Provinces or clusters of districts • Process may be transferred to GCMU 	<ul style="list-style-type: none"> • Evaluation based on criteria under development, with preference for Afghan NGOs or international/Afghan consortium

CONTRACTING SCHEMES

Coverage: Area and Duration	Scope of Services	Performance-based Elements	Monitoring and Evaluation	Indicators
<p><i>Area:</i> 14 provinces; cluster-wide: with clusters of districts recommended but not mandatory</p> <p><i>Duration:</i> 12-36 months</p>	Required minimum service does not ask NGOs to include district hospitals; their inclusion is allowed if NGOs have capacity and experience	Payment can be withheld if deliverables outlined in grant agreement are not met; no monetary bonus	<ul style="list-style-type: none"> Monthly review of deliverables through reports and onsite visits Quality improvement monitoring tool (FFSDP*) implemented in 65% of facilities Baseline, mid-term and end of project HHS* using LQAS* methodology to measure outputs 	<ul style="list-style-type: none"> REACH sets standard indicators but NGO can define and negotiate targets 1st quarter of grant: NGOs provides baseline figures based on household surveys
<p><i>Area:</i> 13 provinces; 3 province-wide PPGs, 18 cluster-wide PPGs (10 provinces) with fixed, pre-defined districts</p> <p><i>Duration:</i> 30 months; may be extended for same period if performance is good</p>	Entire BPHS in all grants plus delivery of the EPHS* in 5 provincial hospitals	No monetary bonus but extension of projects for additional 18 months (project total of 60 months) is contingent on good performance	<ul style="list-style-type: none"> Routine monitoring activities to continue but with less intensity Final household surveys (HHS) data to be used as baseline for new projects/targets to be negotiated with NGOs External body likely to conduct evaluation 	Revised indicators to combine standard USAID and PPA indicators
<p><i>Area:</i> 7 provinces; province-wide: one provider/ consortium per province</p> <p><i>Duration:</i> 26-30 months</p>	Entire BPHS in all contracts	Possible monetary bonus, 10% of contract value; 1% awarded every 6 months for increases of 10 percentage points above baseline (total 5% throughout the project); extra 5% at the end of project for improvements of at least 50 percentage points	<ul style="list-style-type: none"> Nationwide annual HHS and facility-based inspections/interview; and semi-annual facility inspections in all PPA and province-wide projects conducted by third party evaluator (JHU/IIHMR*) Quarterly narrative and financial reports 	Nationally defined core and management indicators; baseline figures extracted from 2003 Multiple Indicator Cluster Survey (MICS)
<p><i>Area:</i> expanded to 6 USAID-funded provinces using cluster-wide PPAs;</p> <p><i>Duration:</i> 18-month extensions on existing contracts; 24 month contracts for new providers</p>	Entire BPHS in all contracts	No change Provincial Health Offices eligible to receive bonus if NGOs qualify	JHU/IIHMR contract extended to continue with the same scheme until 2008	Revision of current indicators based on feasibility of data collection
<p><i>Area:</i> 3 provinces; province-wide</p> <p><i>Duration:</i> 24 months</p>	Entire BPHS in all contracts	Same as NGO	Same as NGO	Same as NGO
<p><i>Area:</i> Plans to expand MoPH-SM to 4 more districts of Kabul;</p> <p><i>Duration:</i> 18-month extension</p>	Entire BPHS in all contracts	No change	Same as NGO	Same as NGO
<p><i>Area:</i> 10 provinces; mix of cluster and province-wide</p> <p><i>Duration:</i> 21 - 30 months</p>	Entire BPHS plus construction of facilities included in some early grants	No performance-based components	<ul style="list-style-type: none"> Annual reports to EC and quarterly technical narrative reports to MoPH (as of late 2004) Third party evaluation conducted in all EC-funded provinces annually, and in 3 province-wide projects semi-annually 	NGOs allowed to define indicators and to use traditional logical framework, although programme was intended to define and measure BPHS-related, performance-based indicators
<p><i>Area:</i> 10 provinces; mix of cluster and province-wide approaches; EC covers all of Ghor Province;</p> <p><i>Duration:</i> 24 months; may be extended for same period if performance is good</p>	Construction to be identified by partners but tendered through MoPH	Reimbursement of expenses upon achievement of benchmarks established at contract start; failure to reach benchmarks could lead to review	Semi-annual reports to MOPH and EC and external evaluation/quality assessment of contracted BPHS projects	Indicators based on national survey, to be made province-specific

Afghanistan will be highly dependent on foreign assistance for many years to come. Any reduction in aid could have a crippling effect on the health sector.

One such problem will be the relationship between vertical programmes, new global partnerships and the delivery of the BPHS. Although one can debate the priority interventions that are included (i.e., the addition of mental health services and disabilities), the BPHS represents a fairly comprehensive, prioritized approach to primary health care, and is organised along the lines of the classical primary health care pyramid: community, ambulatory facility, first-level (district) hospital. However, as is the case in every country, funding now and in the future will be available for vertical programmes from bilateral donors and the new global partnerships (Global Fund for HIV/AIDS, Tuberculosis, and Malaria, and The GAVI Alliance, etc.). Given its still relatively weak capacity to effectively implement nationwide programmes and its ongoing efforts to focus on BPHS-based routine service delivery, MoPH should develop a clear strategy for dealing with donors that insist on specific disease-control initiatives. Some of these donor-prioritized programmes do require urgent attention; for example, focused action on avian influenza, after its detection in Afghanistan, would be warranted, as would be other attempts at outbreak control. It needs to be recognized, however, that in many cases, the adoption of vertical programmes could divert scarce resources and valuable attention from the ability to get on with the job at hand. This may not necessarily occur, but ambitions for Afghanistan's healthcare system at this point must remain focused, and expectations for its ability to take on too many "high priority" tasks at once must be realistic. This is worth reiterating because it is frequently the donors that seek to drive the health

agenda and, in the case of Afghanistan, they must be part of the solution and not the source of additional problems.

Two other related issues that frequently arise during the recovery of post-conflict states are the level and predictability of funding. As the health system of Afghanistan continues to recover there will be a natural tendency to assume that it can continue to expand in depth and in breadth, becoming available to an increasing proportion of the population and offering a broader range of services, including tertiary care in reference and specialized hospitals. This means that substantially more money will be required to keep the system functioning at whatever "higher" level it reaches. Paradoxically, the tendency among donors is to reduce levels of assistance as countries recover. Although donors need to take into account the potential for the health system to progress and to require additional funding, the Government of Afghanistan and the Ministry of Public Health must be able to plan on the basis of predictable and reliable external assistance. The short budget cycles of many of the major donors can lead governments to design and initiate programmes which must later be scaled down, often with bad feelings all around. As mentioned earlier, the local offices of the donors often do not have the autonomy or the independence to adapt their procedures to local conditions. At a minimum, regular, meaningful communication and real collaboration, not just the exchange of information between donors, could go a long way to help the Ministry. In fact, this communication and collaboration back in 2002 was most likely responsible for the progress which was made early on. To a great degree this has continued in Afghanistan, but there is still room for improvement.

IV. The NGOs and their Challenges

Predictability also affects the NGOs in Afghanistan. As discussed in the 2002 AREU report, there was significant hesitation on the part of many of the NGOs regarding the competitive process being instituted at that time. Although their fears have mostly been allayed, competition among NGOs — especially among international ones — for Ministry of Public Health contracts may still wane. Even now, NGOs are more likely to compete for contracts to deliver health services in more secure areas, while competition for more remote, risky provinces is considerably weaker. If conditions in Afghanistan improve, it is also possible that some international NGOs, particularly those whose mandate is oriented more toward emergency relief than development, will decide to leave. This would not be a fatal blow to the evolving health system of Afghanistan; there are efforts by both MoPH and donors to increase the level of competition in order to continue to improve the quality of Afghan NGO proposals and their performance. However, if conditions deteriorate, it is also possible that some NGOs will decide to leave or suspend operations for a different set of reasons.

At the start, one of the primary issues of concern was whether international NGOs, presumably with greater technical resources and more experience writing proposals, would have a competitive advantage in securing contracts. As of May 2006, 27 NGOs — 11 national and 16 international — have participated in the contracting system. Of the more than 50 grants and contracts issued to date, 21 have been awarded to national NGOs, 27 to international NGOs, and four to consortiums consisting of both national and international. Thirty-four percent of total funds have been awarded to national NGOs, (over 50 percent if the consortiums are included), and 49 percent to international. Interestingly, 75 percent of the Afghan NGOs that competed for contracts have been formed since 2001, specifically to deliver the BPHS.¹⁶

More recently, another issue raised by some of the older NGOs is the perceived preferential treatment given to newer, less experienced NGOs, as compared with more established organisations, whether international or Afghan. This “slanted” playing field in the selection of NGOs is an intentional attempt by donors to stimulate the development of newer NGOs with implementing capacity. Since funding is at stake, it is natural that such a policy might engender bad feelings among those NGOs put at a disadvantage in the competitive process. For example, in the latest round of USAID/MoPH contracting (Performance-based Partnership Grants), new NGOs were given a 10 percent advantage in the scoring system. Because of the relatively restricted nature of the technical proposals, which had to be based on the BPHS, and the relatively low level of importance accorded to the financial aspects of the proposals, some of the NGOs felt themselves at a distinctly unfair disadvantage. On the other hand, all parties recognize the desirability

Current investments in developing the technical and managerial capacity of new NGOs will not go to waste.

NGOs are likely to have substantive involvement in the ongoing development of Afghanistan's health sector, one way or another.

¹⁶ London School of Hygiene and Tropical Medicine.

of encouraging new, competent NGOs. Hopefully, the competition for contracts and grants will remain vigorous and constructive, and the award process will remain objective and transparent. These are all qualities to be carefully guarded, and the problems, real or potential, need to be addressed. Any serious erosion of confidence in the system could reduce the interest in participating, and ultimately reduce the level of services available to the population.

There will always be some level of competition and a degree of suspicion, however, between the Government and the NGOs. The contracting schemes try to put each into a position in which it has a comparative advantage. MoPH takes the lead in the role of health sector steward, establishing policy and an operational framework in which that policy can be carried out effectively. NGOs, on the other hand, assume their niche as the health service providers. So far, this division of responsibility seems to be accomplishing its purpose, and the problems that arise, such as the ones discussed above, seem to be more like “growing pains” than a fatal condition.

Finally, it should be mentioned that if many of the NGOs decide to curtail their activities in the future (an unlikely scenario), or should MoPH sour on the idea of private sector service delivery in accordance with its policies (an equally unlikely eventuality in practice at least, if not in sentiment), the future of contracting in Afghanistan may evolve to resemble the MoPH-SM mechanism being implemented in the three provinces close to Kabul: Kapisa, Panjshir, and Parwan. In those areas, the current SM-contracted Provincial Health Offices are sub-contracting with NGOs to provide services that they, the NGOs, are better suited to provide. Such services include discrete, relatively vertical and

disease-specific activities that require close and constant contact with communities, such as tuberculosis control. In time, this kind of arrangement may bring the NGOs into even closer alignment with MoPH vision for the health sector, although it is far too soon to make a recommendation of this nature. In any event, current investments being made in developing the technical and managerial capacity of new NGOs will not go to waste; NGOs are likely to have substantive involvement in the ongoing development of Afghanistan’s health sector, one way or another. That said, there is room to further strengthen both the policy framework established by MoPH and the quality of health service delivery by NGOs.

V. Institutionalizing Monitoring, Evaluation and Documentation

To date, most of the monitoring performed by MoPH and its partners, in conjunction with the delivery of the BPHS, is focused on process indicators. It is beyond the scope of this Briefing Paper to review the data available so far, or even to comment on the content of the monitoring tools and timeframe with which they are being analyzed and reported. There appears to be a number of initiatives toward collecting large quantities of data that the Ministry could benefit from. Among them are: the World Bank/MoPH PPA scheme with its "balanced scorecard" that serves more than just the PPA Provinces; the USAID/MSH/MoPH scheme with its Lot Quality Assurance Sampling (LQAS) at the community level; the Fully Functional Service Delivery Point assessments (FFSDP); and, the development of a Health Management Information System. Over the next few years, MoPH should evaluate these various methods of measuring

progress in the health system with an eye toward developing a single, uniform health information system with a coordinated process of passive surveillance and active data collection in which all NGOs and public sector health establishments would participate.

Despite the large amount of data currently being collected, it is not yet known whether or not all of the resources invested or the activities conducted have resulted in improvements in the health status of the Afghan population; that judgment will require the passage of additional time. Routine data collection techniques that could provide outcome data on a regular basis would contribute substantially to the Ministry's ability to measure its impact. At the time of writing, initiatives focused on this issue were on MoPH's drawing board.

Despite the large amount of data being collected, it is not yet known whether the resources invested, or the initiatives carried out, have improved the health status of the Afghan population.

VI. Conclusion and Recommendations

Progress has been made in addressing all four of the major constraints identified in the AREU analysis of the health sector in 2002. The contracting mechanism that allows the Ministry of Public Health to establish a stewardship role while delegating service delivery to the private sector within a clear and manageable policy framework appears to have worked well for Afghanistan in the immediate post-conflict period. Different mechanisms appear to offer different advantages and disadvantages but, taken as a whole, the MoPH has made substantial progress. This was unanimously expressed by the resource persons interviewed for this paper. So far, this forward motion has been measured only by process indicators. In a year or two, an impact evaluation could show whether or not the measured progress has resulted in better health outcomes for the Afghan population.

Although this paper reports generally positive findings, there is no room for complacency, as there are many significant problems to resolve at this stage of development of Afghanistan's health system. With respect to the health sector itself, a variety of potential problems loom on the horizon, involving all of the players in the MoPH constellation: donors, NGOs, health care consumers and the MoPH itself, at all levels of operation. Adequate levels of funding and reliable, predictable financial allocations will be required for many years to come if progress is to be sustained. Technical assistance is among the most important needs of the MoPH, not only within the GCMU, but also in other important divisions and departments, as well as at the provincial level. Regular assessments of the contracting mechanisms should be carried out, including the innovative MoPH-SM arrangement of public contracting to public entities, with secondary sub-contracting to the private sector as needed. Competition should probably be encouraged and local NGOs should continue to be developed.

In a sense, given the health sector's dismal state in 2001, the relatively easy gains have already been

made: health care delivery at district level, where a moderate degree of access exists, where human resources are relatively available and more or less appropriately skilled, and where reasonably regular supervision can be exercised. Further progress may be impeded by chronic problems such as uneven management, inadequate financial systems, and inconsistent transparency and accountability. With respect to the larger context, additional problems exist because of the unstable security situation, the relative weakness of the overall government, and the difficult economic situation that for many Afghans has progressed only minimally since 2002.

Nevertheless, the overall positive tone adopted in this Briefing Paper is intentional. While the "honeymoon period" during which Afghanistan's population was willing to wait to see whether or not the Government would be able to implement measures that would improve their lives may be just about over, the MoPH, supported by its partners, has made some courageous decisions, adopted forward-looking policies that are innovative and appropriate for the post-conflict setting, and been unusually assertive in insisting that its objective and targets be met. If it is able to build on its progress to date, as well as to effectively document impact and communicate results, it can make a strong contribution not just to health, but also to the maintenance of a stable political environment that is an essential requirement for the security, welfare, and improved well-being of the Afghan people.

Based on the preceding discussion, the following **recommendations** are made:

To the MoPH:

- Develop a communications strategy to ensure that important policy makers in the Government and the Afghan population are aware of the achievements and initiatives in the health sector.

- Engage the President and other influential actors to ensure ongoing and predictable funding for health.
- Take the best “flavours” or the most relevant characteristics from each of the contracting mechanisms to further improve the overall system of contracting for services.
- Encourage research on how people seek services and what types of services they seek; the impact to date of the implementation of contracting and the BPHS; the relationship of security to health-seeking behaviour; and, how community-based health care is actually working.

To the MoPH and its partners:

- Continue to strengthen the public health management capacity of the Provincial Health Offices to enable them to better discharge their responsibilities. This would encourage increased commitment to

public health management (as opposed to direct service delivery) at the middle levels of the administration and reinforce the role of NGOs as partners rather than competitors.

- Maintain technical assistance to further raise the level of capacity and transparency within health institutions.
- Ensure that the GCMU remains well-integrated with the rest of the Ministry, as well as to strengthen other parts of the MoPH which could benefit from additional support.
- Within the larger context of discussions on decentralisation/de-concentration and programme budgeting, identify appropriate decisions which are better made at the provincial level.

To donors:

- Strive to ensure ongoing and predictable funding for the health sector.

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