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Title: The Role of Performance-based Partnership Agreement for the Reconstruction of Health Services in Afghanistan

Executive Summary:

Performance-based contracting for health care has been advocated since more than ten years, starting with the World Development Report 1993 - 'Investing in Health…' in achieving more effectiveness and efficiency for public money by private provider competition. Despite the potential benefits of performance-based partnerships agreements (PPA) there is a weak evidence base in the developing countries, especially in post-conflict situations for better results.

In the Islamic State of Afghanistan the World Bank started in 2003 a PPA-scheme for health service rehabilitation in eight underserved rural provinces. Currently 65% of the country have no access to basic health services. In the name of the Ministry of Health NGOs are contracted to deliver a minimum package of health services. The experiment is based on a pilot test in Cambodia. NGOs that reach specific targets are eligible to receive additional payments. Weak government capacity to draft and monitor large-scale contracts is one of the difficulties.

The analysis of the project design demonstrates that it urges the MOH to refrain from actual service delivery in order to regulate the health sector and set policy. Notified are distortions in equity and sustainability due to the scale of coverage on province-base and the selection of provinces and NGOs. Market competition is limited to a number of NGOs with sufficient capacity and previous experience in the field of primary health care. The injection of funds to rebuild the infrastructure is insufficient and the prizing of a minimal package of public health services is below international standards.

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1. Introduction

Ideas around a "New Public Management" have promoted contracts to govern the relation between funders and providers of health services. One example of this purchaser-provider is concept of performance-based partnerships (PPA). For the post-conflict reconstruction of the Afghan Health System has currently become the dominant approach. In a different context of a hostile and early post-conflict environment the PPA-mechanism is still untested. The evidence-base of this approach is still limited.

Due to 23 years of war and civil war major parts of the countries infrastructure collapsed leaving the health system in a state of near-total dysfunction. Standard health indices, child mortality and maternal mortality, are among the worst in the world. After the down-fall of the Taliban government the floor was open for an inflow of international aid, mainly provided by NGOs in a rather uncoordinated way.

In the post-conflict rehabilitation phase for the health sector in Afghanistan the scope has shifted in 2002 to a long-term reconstruction period of health services. Currently 65 % of the people lack access to essential care. The Ministry of Public Health (MOPH) drafted a plan of action to provide a basic package of health services (BPHS) to neglected rural areas. As a major financial tool the World Bank uses performance – based partnerships (PPA) to contract NGO providers on behalf of the MOPH. The approach has been adopted from a pilot study in Cambodia. After competitive bidding the first contracts were signed.

The thesis contains of three main chapters. First a general analysis of post-conflict rehabilitation from medium to long term will be presented followed by an analysis on previous experiences with contracting for health in other settings. The last chapter will deal on the initial implementation of PPA in Afghanistan and one province, Wardak. Key informants were contacted by personal communication. It depends also on some documents and `grey literature' outside the public domain. I have been working in the health sector in the central region for 3 year from January 2000 to February 2003.

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2. Health policy in post-conflict-settings

2.1. Characteristics of a post-conflict scenario

On all continents large areas are troubled by political instability and violent conflicts. In 2004 there are currently around 30 active conflicts, and almost all in less developed countries (www.reliefweb.int). Since the mid-1980ies and 1990ies a number of countries had experiences of peace building, getting the chance to rebuild the infrastructure, including the health system. Rehabilitation in the transition phase will require unique approaches, whereby lessons can be learned from the past experiences.

These long-lasting hostilities are often labelled as "Complex Political Emergencies" to separate them from classical inter-state conflicts with the end of the cold war, and share some common features. The international community plays usually a role in both relief aid and long-term rebuilding. Especially the health sector is prone to these efforts. The challenge for those involved will also be to provide early visible results without compromising national resources for a future sustainable development. Countries like East-Timor and Cambodia resemble many features seen in Afghanistan, which have an impact on the transition phase:

1. Collapsed infrastructure
2. Distorted economy with weak tax base and informal economic system
3. Disturbed social fabric
4. Limited government capacity to establish a policy framework, regulate service and allocate resources
5. Limited absorptive capacity to deal with the massive influx of foreign aid

(Bornemisza & Sondorp 2002)

In countries that have caught a worldwide attention, there is also the promise of a substantial financial support. But the new administration has first to earn the trust of international actors and donors. Both know that a "peace dividend" of effective initial relief effort can result in an on-going stabilisation.

2.2. Impact of conflict on health indicators and health systems

Health indicators and the health system are seriously affected by the impact of complex political emergencies. War-related mortality is among the top ten causes of lost DALYs (disability-adjusted life years) for the Global Burden of Diseases report. Not only is the number of direct deaths attributable to"the man with the gun", also indirect mortality due to the impairment on the health provision system. By this way common preventable and curable diseases and malnutrition causes excess mortality as an indirect effect of fighting. Many other indirect factors affecting health, as increased military expenditure, decreased resources and staff morale are difficult to measure.

Health work force may have been unpaid in the best case or professionally isolated, de-skilled or just not recruited; in the worst case targeted displaced or killed. In Cambodia less than 50 doctors survived the "killing fields" of Pol Pot. In Afghanistan the restrictive gender politics of the past 20 years is responsible for a critical shortage in female health staff, especially nurses and midwives (Waldman & Hanif 2002).

The sudden inflow of huge amounts of international aid and actors in the transition period creates a unique opportunity to improve quality and access to health services. In the absence of clear national authority effective coordination mechanism are important to address waste of resources, duplication and enhancement of long-term effectiveness (Lanjouw et alt. 1999). In the early Afghan crisis inflowing NGOs competed on hiring few skilled staff. Also in "controlling humanitarian aid cowboys" international bodies need to be in place to formulate binding "best practice", like common salary scales for local staff (Fritsche 2001).

A particular problem is often the overabundance of emergency funds in an early phase, which have to be spent quickly, disregarding long-term sustainability. One particular negative effect is the distortion of local salary scales, or the generous oversized rehabilitation of buildings with can later on not be afforded by the health budget. Therefore it is important to have a long-term sectoral planning as early as possible to channel these funds into a sustainable development plan (Waldman 2003).

2.3. Constraints to develop a new health policy

Usually after complex emergencies the health system policy is severely disrupted and fragmented at all levels. Many factors intervene in real decision-making, including politics,

social norms and demands, personal relationships, vested interests, institutional mandates and so on. In less developed countries following key parameter are impaired: limited technical analysis, political instability, bureaucratic management and the influence of international actors. But the whole concept of public policy "*implies the presence of an authoritative and legitimate state with the technical and administrative competence if not to provide services at least to finance and regulate them"* (Lanjouw et al. 1999). The state is new and weak, its authority is not yet proven and its legitimacy to represent the whole nation may well be in question.

Decisions regarding important elements of the policy are often made not in the country's capital, but in Washington, New York, Geneva or Copenhagen. Actual funding opportunities and conditions for receipt by donors influence policy. Delegated technical advisors ensure early that local policymakers take their new health policies in the desired direction (Walt et alt. 1999). No "normal" country would allow NGOs to have a say in the future of health care provision. But NGOs have budgets that dwarf the revenue-raising capacity of the state and provided 80% of the available health care, like in Afghanistan (Waldman & Hanif 2002).

2.3. Policy options regarding health

As mentioned, disruption of the policy making is one of the many costs of war. But the situation also opens up the new opportunity to build up the whole services on a comprehensive, rational basis. Initial resource allocation is followed by health infrastructure in the future and thus shapes already the health system far in the future. Capacity-building and strengthening in the MOH is therefore a crucial focus of attention. It was found more cost-efficient than trying to bypass the problems by providing vertical programs (Walt et alt.1999).

First priority of policy activity in health is to control international input rather than national activity. The challenge is to use this aid in the most efficient manner despite the weakness of information and legitimate concerns about the level of local ownership (Macrae 2002). Finding the best possible way to work with "foreign blueprints" and making decisions about broad policy directions simultaneously with the arrival of the cash to spend. In addition the financial transactions carried out in this period must be transparent. It includes a vision for the future, because in an early stage ill-informed decisions can have an impact on many years to come.

A general framework for the rehabilitation of the health sector during post-conflict situations does not exist. It will very much depend on the local context. Plans should be based on a sound post-conflict needs assessment. The rehabilitation plan focuses on the priority needs of the population. In Cambodia and East-Timor these were identified in strengthening preventive and first-line health services, expansion of the access to rural areas and expanding the human resource capacity (Waldman 2003). The long-term process of regaining stewardship and control over essential public health functions is particularly difficult in low resource settings (WHO 2000).

2.5. Aid coordination mechanisms

Certain aid coordination mechanisms have the power to stimulate and streamline the policy process (Walt et alt. 1999). They include donor coordination units in the MOH, geographical zoning, ear-marked budget support, pooling/basketing of funds, sector investment programmes, Consolidated Appeal Process (CAP) and sector-wide approaches (SWAps). CAPs is used for a coherent fundraising by the UN Office for the Coordination of Humanitarian Affairs (OCHA) in emergency situations. SWAps work on the basis of pooled funds which governments then use according to agreed upon policies and strategies. An obstacle for their use is that nascent post-conflict governments have less robust political and financial systems than more stable countries. Despite this, East Timor recently used a SWAp via multi-donor trust fund. The result "*allowed for coherent sector development, ensuring the sustained financing of core activities and non-duplication of effort"* (Tulloch et alt. 2003).

Another new financial tool to channel assistance fund to governments and NGO-providers are PPAs. PPA can be classified as coordination because they presume the creation of a comprehensive health policy by the MOH (Bornemisza & Sondorp 2002). Performance-based contracting related to a Cambodian pilot model is currently applied in the reconstruction of Afghanistan's health system.

3. The evolution of performance-based contracting

Since the mid1980ies health sector reform has been a central theme shaping global health policy discussions. During the Re-evaluation of the role of the state was found that pure public provision provides no incentives for productivity and quality. The trend to use market mechanisms and competition in the public sector was labelled "New Public Management"(NPM). NPM injects market-like principles also into healthcare provision by modernizing the budget management und service delivery. The state consequently changes his role to 'more steering and less rowing'. It regulates the other actors and acts as a steward serving the public interest (Mills et alt. 2002).

The World Development Report in 1993 introduced these concepts into the development context. It elaborated on strategies, such as competitive contracting, to shift the private sector into the place for service provision (Benett et alt. in Benett et alt. 1997). Financing reform gained prominence in the health agenda through a combination of factors: the neo-liberal social policy, restrictions on healthcare spending enforced through structural adjustment programs, and the waning influence of WHO on shaping the international policy (Green 1997).

Reforms encouraged the split between the function of purchaser and provider, which delegates the role of the state to that of policy formulation and regulation with provision left almost entirely to the private sector. Contracts have been suggested to govern that split (England 2000). The PPA model currently being implemented in Afghanistan is one example of this concept.

These reforms have not been based on a strong foundation of evidence (Mills & Broomberg 1998). They point out that claims of a greater effectiveness and quality in NPM is weak. Decreasing access to healthcare, rising costs and a widening gap between the rich and the poor have been consequences of the economic and political ideologies surrounding NPM. Also a subsequent shift occurred away from the principles of primary health care (Whitehead et alt . 2001). Advocating only a limited service package for the poor, while better-off can purchase in the private sector this sector is not consistent with the Alma Ata declaration (Waitzkin 2003).

3.1. Why contracting for health?

The response to the problem of state failure has been the introduction of market mechanisms, in particular, the development of the purchaser-provider split in which contractual[1] arrangements govern the relationship between the payer and the provider (Palmer 2001). Contracting has grown in at least two distinct areas in the health sector:

(i) public provision, where contracts may be developed within public institutions (i.e. internal contracting) or between the public and private sector (i.e. contracting out), and

(ii) grants systems where agreements are formed between donors and NGOs.

Evidence from both the UK and the US has shown that contracts have tended towards more relational contracting; there is evidence that contracting leads to improved quality for non-clinical services (e.g. hospital cleaning), but extremely weak evidence supporting contracting for clinical services or primary health care, particularly in developing countries (Mills 1998).

In developing countries, grants are commonly used to form agreements between a donor and an NGO to provide services. A grant represents a legal contractual agreement; however it differs from a contract in that the bidding process is not competitive and only not- for-profit entities are eligible for award. There is an emerging trend to contracts and more contract- like grants in response to increasing awareness of poor NGO performance under traditional input-based[2] grants.

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 (Thomas 2003). The payment method, however, has perhaps the most considerable influence over how the provider will behave (see table).

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[1] The definition of contracting used in this paper is borrowed from England's (2000) user-friendly explanation: "…any form of document that provides a quantified specification of the health service outputs expected from given financial inputs within a given time period and to defined quality standards, and that is used to guide and control the behaviour of both the payer of those financial inputs and the provider of the specified service outputs".

[2] Under Input-based grants the provider pays for salaries, supplies and operating costs necessary to provide defined services (e.g. reimbursement of expenditures) (Eichler 2001).

Table 1: Incentives created by selected payment systems*

Payment system	Unit of paid services	Pros	Cons
Input-based (e.g. Fixed budget)	Provider pays for salaries, supplies and operating costs necessary to provide defined services e.g. reimbursement of expenditures in grants	Ensures services continue to function Allow rapid response to crisis situation due to low informational requirements	No incentives for: Increased efficiency Controlling costs Expansion of coverage to underserved areas
Capitation/block contract	Provider is reimbursed a fixed cost/person/time period for a defined package of services (i.e. the outputs are defined)	Focus on paying for services required (i.e. outputs) rather than inputs Incentives to increase efficiency because a surplus can be generated Incentives to improve preventative care to reduce need for hospital care	Incentive to provide fewer services and to healthier consumers (i.e. cream-skimming) because the provider receives payment whether the population utilises services or not
Output-based (e.g. Fee-for-service)	Provider is paid according to a defined number of services to be provided (i.e. measurable outputs)	Incentive to deliver services under contract Incentive to increase efficiency	Incentive to over-provide services under contract (possibly at the neglect of other services)

* These payment methods represent those most frequently cited in the literature but are not an exhaustive list of all possibilities.

Source: Strong 2003

Table 1 demonstrates that the payment system will have a big impact on how services are provided. While capitation and output-based systems may create incentives for increased efficiency, none of the methods establish a link between efficiency and quality. Rather it seems to be a trade-off between one or the other.

3.2. Why performance-based contracting?

Purchasers have begun to combine performance-based payment with other pricing methods to create hybrid payment systems that have the potential to enhance efficiency *and* quality (Eichler et alt. 2001).

Performance-based payment can be been defined as "a system of program funding whereby the payer supports the service provider's program according to that provider's performance (that is, if the provider achieves agreed-on results or health goals for the client population)."

(MSH[3] 2001). Performance-based contracting has become a strategy used by purchasers attempting to target the potential inefficiencies of providers by linking performance to payment. In contrast to traditional input-based funding mechanisms, payment is based on achievement of a predetermined set of indicators (Ibid). Failure to 'perform' or meet the indicators can result in withholding of payment or termination of the contract. Using a 'carrot and stick' approach, an element of risk can be imposed on the provider but with the potential of a financial performance bonus.

The concept of performance-based contracting is a relatively new funding mechanism in the health sector but it is perhaps no surprise that this approach has crept into donor strategies. In a context of increasingly scarce resources and dwindling aid budgets, governments are demanding results to show value for taxpayer monies (Hecht et alt. 2004). The US administration is advocating a switch from the International Development Association's traditional disbursement of funds through loans to grants based on performance, described as "…a gift with strings attached". Figures show that over the past decade there has been a substantial failure rate of WB projects in low-income countries, structural adjustment programs with imposed user fees leading also to a 'medical poverty trap' (Whitehead et alt . 2001).

While there are a number of advantages to contracting, such as increased efficiency and accountability, there are also a number of drawbacks including increased costs and weak government capacity to manage contracts.

3.3. Contracting First Line Health Care

The 2000 World Health Report advocated for increased innovation and operational research in the sense of better performing, more sustainable healthcare. A growing number of low- and middle income countries are experimenting with contracting in the health sector, but most are restricted to for vertical programmes, e.g. malnutrition prevention activities in Madagascar and Senegal (Marek et alt. 1999). Examples are output-based contracts that are simple to monitor, like child health services in Bangla Desh by NGO field workers paid on the knowledge of oral dehydration therapy (World Bank 2004). In sub-Saharan Africa church providers, as private non-for profit entities have contracted their devotional hospitals into the countries national health system by mutual relational contracts. The rational behind was integrating these clinics in the district system, making pre-existing relations more explicit

[3] Management Science for Health

under a “Health for All” policy. Remuneration schemes from public funding agreed payment according to the quality and quantity of services (Verhallen 1998).

Such contracts tend to be co-operative, because they assume that client and contractor have the same (public) interest. Sanctions for failing to deliver are more frequent in short-term contracts. Palmer et alt. (2003) observed commercial companies in South Africa providing standardized primary care at similar low cost than the public system, but more responsive.

3.4. Contracting in Post-conflict settings

The evidence base on contracting schemes initiated by the international community for the delivery of package of primary health care is limited. Cambodia, Haiti and Guatemala[4] are the examples. A primary health care package, expanded to rural areas, maybe comparable between countries. But the design of the contracting approach varies considerably between the contexts. Differences in specific services within the BPHS under contract and definitions of indicators/output prevent direct comparison of results. Methodological drawback to compare all pilots are the limited number of participating districts in Cambodia and no baseline data in Guatemala, as well as the small number of participating NGOs in Haiti (WB2003, see Tables in the Annex).

In all three settings NGOs already provided a large proportion of service previously. In Haiti a survey revealed before the start of the project very uneven levels of performance among the NGOs with immunization rates ranging from 7% to 70% (Eichler et alt. 2001). National health surveys in Cambodia revealed the highest level for under five mortality (124/100.000) in South East Asia (Bhushan et alt. 2001). After the end of the long civil war in Guatemala, the government was obliged to improve the delivery of services to the indigenous population. Infant mortality in the indigene community was 50% higher than in the rest of the country. Local NGOs started a Program for Extended Coverage, prized annually US$ 8 per head for a population of 3.7 Million. Household surveys could be conducted late after implementation leaving no baseline data (Hecht et alt. 2004). Overall gaps in coverage and poor health indicators accompanied the emergence of contracting in these situations.

[4] It must be noted that ‘low-intensity’ conflicts in Haiti and Guatemala had much less destructive character then in the long-lasting warfare in Afghanistan and Cambodia with multilateral interferences.

3.5. Evidence from contracting in practice

Analysing the results on the 3 cases in Haiti, Guatemala and Cambodia show that there is little consistent evidence validating the theoretical merits of health service delivery via contracts on the macro level. This means buying results by NGOs on a geographical basis. The micro level relates to performance management of staff and quality enhancement of an organisation plays an undetermined role (Martinez & Martineau 2001).

The Cambodia project showed an overall better performance of contracting-out (CO) model versus Contracting-in (CI). The same approach performed poorly in Guatemala in comparison to CI. Again it was outperformed by traditional government provision in 3 out of 4 indicators. Evidence supporting contracting is inconclusive, and which form is the most effective one.

The increase in immunization coverage in all contracting models was common. In the close evaluation suggests a´ likely volunteer bias in Haiti among the NGOs and a lack of control areas' (WB 2003).

Only the Cambodia study rigorously compared NGO provision of services to government provision (Loevinsohn 2000). Furthermore the evaluation reported measures of cost-effectiveness and equity in the approaches tested. The overall results in improved effectiveness, efficiency and equity for the contracting-out districts. But the Contracting out-group had also the highest funds per capita by 4.5 US$.

The best performing example overall was a contracting-in district by using increased user fees for a performance-based staff payment on a micro-level (Bhushan et alt 2001). It was assumed that in this particular district private practice was banned, but no report how this could be controlled. The user-fees scheme established increased staff wages by 500% to 800%, half of it from NGO subsidies. For this district utilisation rates for the poorest half of households increased by 16, 9%; out-of pocket expenditures was reduced by 40%. This was achieved by a sophisticated micro-management. Limitations and financial constraints in the CI districts occurred according to tensions accountability in the province level of the MOH (Soeters & Griffiths 2003).

Outside the Asian Development Bank pilot similar results could be obtained from other contracting projects at local level the 'New Deal' in Cambodia with less external funds (Van Damme et alt 2001). A complex participatory management approach using local resources and performance-related payment within the MOH system tended towards a financially sustainable solution in the district health system. This underlines the importance of a micro-management with individual staff performance bonus.

4. Afghanistan- Case study

4.1. Background

Afghanistan has survived more than 20 years (1978 – 2001) of devasting armed conflict. Further social upheaval and major food shortage left the country in the midst of an overwhelming humanitarian crisis. This has also led to massive migration of about 5 million refugees or internally displaced persons (IDP), one third of the population. Violence, destruction and unrest had severe consequences for the government, economy, society and health of the Afghan people. The last military intervention has opened up along-awaited opportunity for change. After the fall of the Taliban finally large-scale emergency relief and development efforts are taking place.

According to United Nations and World Bank estimates the costs of rebuilding the destroyed infrastructure will amount to at least USD 14.5 billion in the next ten years (WB 2003).
The signing of the Bonn Peace agreement on 5th of December 2001 paved the way for an international accepted new government in Afghanistan. Ministries were divided by the different participating factions and ethnic groups, who attended the conference in Bonn. The Afghan Interim Administration (AIA) was established on 22nd on December 2001. Six months later it was transformed into the Islamic Transitional Government of Afghanistan (ITGA) after an emergency convention of the Loya Jirga (Traditional Grand Assembly), under the actual president Muhammad Karzai. But its jurisdiction is still delicate especially outside of Kabul. The Interim governmant has now a two years mandate to govern and prepare the country for democratic elections in 2004

The security in Kabul, where the International Security Assistance Force (ISAF), 4500 foreign troops, arrived at the end of 2001 is still fairly good. It is under the command ship of the NATO, before several Nations like Germany, Turkey and Britain. ISAF is also expanding

its mandate to some provinces outside the capital, like Kunduz and Badachshan on the request of the Interim government.

Some provinces remain unstable with major security incidents including targeting of aid worker. Agencies were forced to suspend to suspend outreach service, because of instability and violence in some regions. In ambushes on aid workers, both local and foreign, have been murdered by anti-coalition forces. Many patients have to travel considerable distance and for days, because the reconstruction of medical services in their living areas has been limited by ongoing conflict. '*The instability to deliver aid means that millions of Afghan civilians are beyond reach of humanitarian assistance, including basic health services.*' (Reilley et alt. 2004). Fortunately these incidents remain isolated and local, but there is no guarantee that the Afghan conflict would not explode again.

4.2. Situation in the health sector

The health system inherited by the new Ministry of Health, whose senior staff came in 2001 from clinical background with no experience in public health, was faced by one of the worst health statistics in the world. Overall, in 2000, the Afghan health profile ranked 173 out 191 nations (WHO 2000). The appalling key indicators on health and nutrition give an incomplete picture of the magnitude of major health problems.

- The life expectancy at birth is 45 for males and 47 for females. The DALE (Disability Adjusted Life Expectancy) for healthy life years is 33 in 2001.
- The infant mortality was estimates 165 per 1000 life births, the child mortality at 257 per 1000 life births. One out of four children dies before reaching the fifth birthday. Three infectious diseases are the main cause: pneumonia, diarrhoea and vaccine-preventable diseases.
- The maternal mortality was recently amounted to 1700 per 100000 life births.[5] Everyday 45 women die of pregnancy-related causes resulting in 16000 maternal deaths annually. Fewer than 15% of deliveries are attended by trained health workers or traditional births attendants (TBA).
- Nutrition surveys measured stunting among half of the children (45-59%) and acute malnutrition up to 10 % (6-12%).

[5] The UNICEF (2002) maternal mortality survey showed maternal mortality ranged from 400 – 6500/100000 live births/year between urban and rural areas, with the latter figure being the highest ever reported globally. The report estimated that 74% of the deaths were preventable.

The overall immunisation rate is around 30%. Only 30% to 40% has access to some health care service and around 75% of females have no access to obstetric care. A large proportion of deaths and illnesses are due to preventable or treatable communicable diseases like measles, pneumonia, tuberculosis, typhoid, malaria, leishmaniosis, meningitis and others. Tuberculosis accounts for 70000 new cases a year with an incidence of 324/ 100000 population(source all data: WHO/EMRO 2002a).

The impact of the conflict and presence of land mines und unexploded ordnance caused physical injury and mental stress. An estimated 30-50% of the people suffer from some level of distress and about 4% of the population have disabilities needing rehabilitation services.

Deficits of the infrastructure

The physical infrastructure shows all signs of a sustained lack of funds, while unregulated private practice has flourished in face of poor and irregular salaries. All resources in the health sector are in a critical limited condition. Health facilities have been destroyed, human resources are scarce and institutions have collapsed. A nationwide project ('Afghan National Health Resources Assessment'= 'ANHRA') gathered information of all 1038 health facilities (Afghanistan MOH 2002).

One third of the facilities showed structural damages, indicating a need for major repair. Many of the existing structures lack basic utilities, like access to safe water source and are insufficiently equipped and staffed to offer basic services. Only half of the district hospitals have a functioning laboratory, what interferes with the management of TB and complicated malaria. Referral rates are low, because an adequate availability of care for the most vulnerable groups, women and children is not guaranteed.

Health staffing is characterized by geographic, functional and, gender misdistribution. There are total of 12,107 public sector health staff working in public facilities. Among these staff are 3950 doctors, bringing the number of physicians to 0.1 per 1000 people on average (compared to 1.1 on average in developing countries, UNDP 2003). Taking into account that currently 8000 medical students will graduate in the coming years, thus the lack of medical doctors is less urgent. But the urban-rural distribution of health staff is very uneven. About 65% of all health professionals are serving in Kabul with 7% of the population.

The gender ratio is biased towards male. There is a dire shortage of female staff. In addition the ministry is under pressure to re-hire staff dismissed under previous regimes, likely to be de-skilled and overstaffing the existing urban facilities (WB 2002 a) This means that policy plans will have to develop incentive for staff willing to work in rural areas. Only 24% (n=695) of the doctors are female. The gender ratio male/female was 3/1, and worse in rural areas. Only 40% of the first line facilities have female staff, extremely important in a largely conservative Muslim country with strong taboos (for adult females to receive care from men).

The pyramid of health workers is very top-heavy, when we exclude short-trained staff from the calculation physician make up 28% of all health workers. The 1:1 ratio of doctors to nurses/midwives reflects a distortion in the workforce structure, where physicians are almost greater in number than support staff. The present composition of health staff does not meet the needs. So training more midwives and female mid-level female health workers is a priority. Besides that, all existing staff, including the doctors, need significant training in skills upgrading and refreshment (WHO 2002a).

There were 41 hospitals nationwide claiming to perform major surgery, but few had all the necessary equipment and anaesthesia to do so. 50% of all 8445 hospital beds are located in hospitals in the capital city.

NGOs, including the UN agencies, play an important role and operate 80 % of all Primary Health Care services and own almost 43% of the PHC facilities. The care provided is of varying quality[6] with a multiplicity of protocols. Hospitals are largely government-managed, but rely heavily on NGO or UN support for supplies. Vertical programmes such as EPI, malaria control and, in limited areas, tuberculosis treatment, are strong. All these elements bring excessive duplication of management and logistic structures.

[6] Some NGOs have built clinics, employed staff, set up their own supervisory structure, training and paying scales and deliver a certain 'package of services'; other simply deliver drugs. A long history of inactive governance meant that many NGOs work independent of national structures.

4.3. The Basic Package of Health Services (BPHS)

The BPHS represents the official health policy of the Transitional Islamic State of Afghanistan[7]. The final version lists in most possible detail a set of comprehensive and mostly evidence-based interventions in each priority field for preventable mortality, attributes them specifically for each standard type of facility.

1. Maternal and newborn health
   - Antenatal care
   - Delivery care
   - Postpartum care
   - Family planning
   - Care of the newborn
2. Child health and immunisation
   - Expanded Programme on Immunisation (EPI) services (routine and outreach)
   - Integrated Management of Childhood Illnesses (IMCI)
3. Public nutrition
   - Micronutrient supplementation
   - Treatment of clinical malnutrition
4. Communicable diseases
   - Control of tuberculosis
   - Control of malaria
5. Mental health[8]
   - Community management of mental health problems
   - Health facility-based treatment of outpatients and inpatients
6. Disability
   - Physiotherapy integrated in the Public Health Care (PHC) services
   - Orthopaedic services expanded to hospital level
7. Supply of essential drugs

source: Afghan. MOH 2003.

The BPHS includes also recommend staffing patterns for each facility type, accepted categories of health workers and essential drugs, skills and equipment at each facility type. The 4 standard types of primary health facilities ranging from outreach activities, to out-patient care at basic health centres, to inpatient services at comprehensive health centres and district hospitals are summarized by features of each type[9]. The most problematic issue is the

[7] While recommended in the initial Joint Donor Mission the aforementioned BPHS developed over time. For example, the essential package initially outlined in the national health policy did not address all priorities specified in the document. A draft was released after a 2-month period and a final copy was released in March 2003, approximately a year later. The final formulation was speeded up by the challenge to present standardized protocols on a national basis to implement health programmes.

[8] Two elements– mental health and disability – are considered as 'second tier' and scheduled for phasing-in later

[9] **Health Post (HP)**: for 1000 to 1500 people with one CHW or TBAat community level

Basic Health Centre (BHC) for 15000 to 30000 people, nursing level

Comprehensive Health Centre (CHC) for 30000 to 60000 people, 2 doctors, beds

District Hospital (First Referral Hospital) for 100000 to 300000 people, special

role of CHWs and TBAs in regard to curative services. A job description for both is undertaken in the BPHS final draft, where limited tasks are outlined, but far from conclusive.

4.4. Strategic choices – Why PPA in Afghanistan?

The new Afghan Interim Administration was not yet fully established when the first conferences and assessment were performed on the future of the country and its health system. The Ministry of Health was still in an embryonic stage when the first consultants arrived. No health minister had a budget to allocate for many years. Most executive personnel has neither training in public health nor experience of national health planning or management. The legacy of the old top-down system means that capacity among lower-level staff to carry out analytical functions is extremely reliant on the arrival of full-time external support.

In the WHO's "Preliminary Assessment of Needs and Opportunities" (WHO 2002) outlined three imperatives for the reconstruction of the Afghanistan health sector:

- to reduce unacceptably high levels of mortality, morbidity and disability in the shortest possible period of time;
- to focus the efforts of all health partners on the most effective interventions,
- to improve the knowledge base to allow development of policy for longer term goals.

For long-term reconstruction projections are carefully determined as 'institutional support at regional level', 'capacity-building by NGOs at sub-regional level' and a vision of a 'network' slowly expanding to rural areas. Annual per capita costs were estimated at 7.4 US$ public expenditure for the next ten years.

Since January 2002 WHO consultants assisted in drafting a National Health Policy (WHO 2002a). The future structure of the public system remained relatively unspecified ('network') defined vague in form of broad statements.

With the arrival of the Joint Donor Mission on Health, Nutrition and Population (JDM)[10] in March-April 2002 it was still unclear how to operationalize the broadly outlined concepts,

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[10] Participants included WB, ADB, EC, DFID, USAID, WHO (Afg/EMRO), UNICEF (Afg/NY),

how to make it work in the real-life Afghan context, taking into account the long-term repercussions of decisions.

Other alternative mechanisms for the coordination of foreign aid have not been taken reasonably and seriously into account in the early phase of discussion, for example:

- A sector-wide approach (SWAp) which has as a pre-requisite the coherent formulation of policy and program by national authorities. But with a strong expert support it could be a possibility to get full authority over service provision on the scale of a national coverage plan.
- NGO provided services by geographical zoning or guided by a donor-coordination unit inside the MOH
- NGO driven services where communities apply for finances together with NGOs which determined more the geographical location than the MOH
- further MOH services could be phasing in, expanded from earmarked budget support, which is already implemented to the salary of civil servants by the Afghan Rapid Trust Fund (ARTF) managed by Ministry of Finance funded from the bilateral donors
- a clear country-specific formulation of aid coordination with a lead donor agency or common basket of funds, for example contracting-in of NGO expert to a geographical defined MOH provision of health services

A 'MOH-strengthening mechanism' (MOH-SM) is still under negotiation. Government provision will be financially supported in the same way like contracting NGOs. Planned is that the MOH delegates provision to provincial health authorities in two provinces (Parwan and Kapisa) has the potential to develop in this direction.

4.5. The World Bank project in Afghanistan

To address the problem of re-building of basic health services in rural areas the World Bank proposed performance-based partnership agreements to the MOPH of Afghanistan during the first Joint Donor Mission. This scheme was transferred from a pilot project of the Asian

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UNFPA. The JDM co-chaired by the World Bank and WHO, represented 70 to 80 % of available funds for the reconstruction of the health sector.

Development Bank in Cambodia to ensure expanded service delivery of selective Primary Health Care interventions.

In principle the Ministry of Health establishes contractual relationship with NGOs to provide the basic package of Health Services (BPHS) within geographical defined areas. NGOs go through a competitive biding process. Contracts were established with one lead provider per province. Payments for services are based on a per-capita basis. Those awarded a contract will have to meet specific national performance targets. This will be measured by regular monitoring through the MOPH and evaluation by a third party. Technical partner of other donors have at least agreed on a ”proposed common approach to PPAs” (aide-memoire to second the joint donor mission, WB 2003) to have a consistent national approach in health.

The financial basis of the contracts is a 60 Million US$ soft loan (“Credit”) from the International Development Association (IDA), managed by the WB, to the Transitional Islamic State of Afghanistan (TISA). Borrower is the Ministry of Health. No monetary contributions from the Afghan Government are foreseen. “The Health Sector Emergency Reconstruction and Development project (P078324)” aims at improved access to health care in underserved rural areas and other perceived objectives to rebuild the public health system.

46.5 Million US$ are spend over 3 years on the geographical PPA contracts, including the MOH provinces, US$ 3.7 Million on rebuilding infrastructure, US$ 6 for capacity building and evaluation by a third party. The WB approved finally project the on 9th July 2003 after ten months negotiations. The first round of bidding started in September and contracts signed; the second round for 6 provinces is still ongoing. Five more contracts have been signed.

4.6. Analysis of PPA contracts

The individual NGO contracts are kept confidential and contain specifications in capacity planning and prizing differs from bid to bid. The description will be based on the ‘Standard for Lump sum remuneration’ and ‘Special conditions’ and ‘Appendices’ specific for the WB Afghanistan PPA project. The prominent features are:

The partners: ‘General conditions of the Contract’ outline the roles of both parties. The contract includes a purchaser-provider split on the services; purchaser is the MOH of Afghanistan, provider the NGO under contract.

Type of Service Main type of service is basic primary care and preventive medicine. The Ministry documented in March 2003 level and content of the "Basic Package of Health Services" into detail. This package is not negotiable. Further emphasis is put on community-based activities and the support of Community Health Workers (CHW). MOPH requires also participation in vertical activities like National Immunisation Days, mass campaigns and the control of epidemic outbreaks.
NGOs will be responsible for the procurement of drugs, supplies and equipment of their facilities; in human resource management for training of mainly female health workers and their certification. They will also ensure the participation of communities in "design, delivery and evaluation of health services".

Purchasing options: Under the Public / Private Partnership with the option for *contracting-out* MOPH provides its facilities, use of vehicles and telecommunication equipment and key report and other data to the NGO. The NGO is responsible for recruitment of skilled health workers and their supervision remains with. The management of the provider concerns the inputs (service type, drugs, and supplies), hiring and firing necessary staff and setting their wages. Key management staff of the NGO is approved by the MOPH. The physical infrastructure of the First Line Health Service, Health centres and Health posts, remain in the property of the MOH. Partially included stay hospitals at the first referral level in regard of emergency obstetric care.

The *duration* of the contract is foreseen for three years.
Target population: Area of responsibility is defined geographically as the "entire population of …province". The second option for cluster-wide approach for adjacent districts with 100.000 to 200.000 inhabitants was cancelled during the "ppa-process". The Grant and Contract Management Unit of MOPH did major adjustments over the geographical areas.

Payment mechanism: The money is remunerated under a block contract, so that the total amount cannot exceed a fixed lump-sum, all risks and over head cost included. The amount of payment will be determined by competitive bidding. It basically reflects the annual cost per capita. An advance estimate was 2.60 $ per head based on an existing NGO service cluster in a well-served eastern region (WB 2003). The financial part of the bid include all costs, such as staff salaries, medications, consumables and costs related to the contractor. The technical

part concludes in suggestions regarding service delivery staffing pattern and is bound to achieve the service targets.

Performance bonus up to 10 % is awarded when a third party scores exceptional improvements on household surveys over the previous one.

Targets are defined by a set of 31 mixed indicators judging whether the BPHS is successful delivered. Besides clinical process indicators on the fields of maternal health, birth spacing, tuberculosis, malaria, micronutrients deficiencies and immunization, process indicators include perceived quality of care, reaching woman and the poor, strengthening the state and capacity building.

Evaluation: A standardized reporting and monitoring system on a quarterly basis is mandatory. Every six month a third party (external evaluator) will perform household and health facility surveys, first to fix a baseline then to follow-up improvements.
This will probably be done by an independent research facility, like the Public Health Institute of a major recognized university.

4.7. Comparison with the health contracting project in Cambodia

With a loan from the Asian Development Bank the Cambodian government started in 1998 an operational research in public/private partnership as a part of the health sector reform. In this experiment eight districts with a population covering 1 million people were divided to different contractual approaches. For the purpose of gaining experience with different reform models, in five districts the district health management was sub-contracted to private health sector operators. Three types of models were applied.

i) **Contracting-out** (CO) of the district management to private providers contractors assume full responsibility for the service and the power to hire and fire staff, set wages, as well as organise and staff health facilities

ii) **Contracting-in** (CI)[11] contractors do solely the district management, but require to work with the MOH system in order to strengthen the district structure. MOH channels provide all inputs (drugs, salaries etc.).

[11] Strictly speaking contracting-in concern the relationship between two public sector operators (England 2000). However the term is used in Cambodia to describe this type of contract between the MOH and a private sector operator, whereby civil service regulation still are in place.

iii) **Comparison/ Control** (CC): continuing existing government policies in a number of reference districts. They received a similar additional budget.

CO districts out-performed CI, which out-performed government provision in terms of increased utilisation rates and coverage. But contracting out produced the highest cost in providing a basic and complementary package of services (US$ 4.50 per capita per year) for the government (Bhushan et alt.2001).

Comparing contracts from the Cambodia with those in Afghanistan some differences can be noted:

- Scale of coverage: Population of responsibility was defined by an "operational district" in Cambodia. Ministry of Health introduce this country-specific entity under the province level to improve infrastructural short-comings of the previous Vietnamese-styled system in 1995 to build a functional two-tier-system with referral hospitals and health centres and address priority health problems (Soeters & Griffiths 2003).The 71 operational districts are not congruent with the administrative division.

  In Afghanistan World bank focuses strongly PPA to the province-wide coverage. This reflects on the issues of the final evaluation of the ADB that emphasized that the district level could have been further extended. Another perceived problem during the implementation phase was created by the non-cooperation of the provincial health teams. To involve them from the beginning might prevent possible leakages (Ibid). Also it works as pre-selection mechanism on the size and capacity of possible bidders.
- Duration: Four years versus three in Afghanistan gives more time to build mutual trust. A long duration reduces monitoring and transaction cost and risk of the contractor for investments. A long duration can act as penalty in case of non-renewal and reduces the risk of the MOH.
- Payment: The amount per capita and year in Cambodia is almost double (4.50 vs. between 2, 50 to 3 US$). In addition Afghanistan has still a policy of "free health care" with no official user fees. So less money is available to satisfy on a decent staff salary, micro-management and reconstruction of facilities in two countries with an almost equal purchasing power.

- Package: Provision of essential drugs in Cambodia forms a major part of regular subsidies to the districts (around 2 US$). The respective "comprehensive package" provides additional tasks, like emergency surgery, chronic illnesses and leprosy.

It seems there have been some lessons learned from the Cambodia experience that have influenced the formulation of the actual ppa-contracts condition. In addition minor adaptations to the context of the country are present. In basic terms the conditions of Ppa in Afghanistan are a "blueprint" of the Cambodia pilot.

The country characteristics are not comparable to Afghanistan. The conflict ended in a transition period 1991 to 1993 more than 10 years ago. Several health sector reforms have provided an operational structure for the centralised public health system. The pilot project was small-scale, involved only 5 out of 91 districts. The challenge in Afghanistan is different - still a 'battle for access' to rebuild a non-existing primary health structure for the neglected rural areas, 65% of the population.

4.7. Constraints to the implementation of PPAs

Selection of the provinces

According to the grants contract with IDA the MoPH had to select a number of under-served provinces for the implementation of the PPA. Further criteria were also fair geographical distribution among the regions and an ethnic balance.

Table 2: the 10 PPA-provinces with population data

Province	Population	Pop/ facility	x 1,5[12]	Implementer
Kapisa	360,000	19000	28500	MOH-SM
Parwan	726,400	16000	24000	MOH-SM
Wardak	413,000	11000	16500	SCA
Farah	338,000	24000	36000	CHA
Badghis	301,000	25000	37500	BRAC
Nimroz	150,000	21000	31500	COOPI
Hilmand	745,000	28000	42000	Ibn Sina
Saripul	457,000	31000	46500	Ibn Sina
Balkh	726,400	20000	30000	BRAC
Samangan	303,700	25000	37500	AMI
Total	**4,520,500**			

Source: ANHRA, GCMU (direct communication)

[12] A correction factor of 1, 5 accounts for the unreliability of data in the ANHRA report. They are biased by responders and recall of the survey. Around 30% are not active or operational for basic health services, including hospitals. The current target is 30.000 people per facility

The provinces are situated in 4 different regions of the country. The provinces surrounding Kabul (Parwan, Kapisa, Wardak) are relatively well-served. The most underserved and also difficult accessible provinces with a facility ratio per population more than 50.000 persons per facility are not included: Nuristan, Ghor, Jawjan. Most of the provinces have mixed ethnic population covering more or less all major ethnic groups: Pasthoon, Tajik, Uzbek, Hazara and other minorities. The first three around the capital were also originally on the tender list divided with 3 to 4 clusters of districts.

Market competition

Analyzing contractual relationships one main criterion on *market competition* was only partially fulfilled by a tendering process among non-for profit providers. NGOs could apply on a Request for Proposal (RFP). The time from the official publication to the deadline was just 12 days(www.dgmarket.com/eproc/np-notice-view 424083). Only those NGOs who were involved in previous discussions had a chance to apply. The bidding documents had to include both technical and financial proposals how they want to perform and prize the delivery of the BPHS. In addition information was asked on qualification to perform services, brochures, other assignment in similar conditions, availability of proper skills among staff etc.

Prizing the contracts

To allocate the winning contracts a Quality Cost Based Selection was performed, the best score from a combined technical and financial proposal. Selection committee consisted of representatives from MOPH/GMCU, the UNICEF and an independent representative of the NGO community (from the coordination body ACBAR[13]). Further criteria included knowledge of the PPA area, quality of the strategic plan for accomplishing the targets and a track record on audited accounts and logistic capacity.

The NGO with the highest score had to negotiate on the costs. The average annual cost per capita for the seven provinces is 3.80 US$ to implant the minimum package.[14] In fact this amount exceeds the original envisaged prizing of 2 to 2.50 US$ by more than 1US$.

Limited choice among NGOs

Among the around hundred international agencies working in the health sector, a consortium of *'around 20 [NGOs] are qualified for contracting'* (WB 2003)in primary health care to compete and have enough expertise and capacity to cover a whole province. The picture of

[13] Afghan Coordination Body for Aid and Relief, is the biggest coordination group among NGOs. Only NGOs can become members. Beginning 2002 more than 100 agencies belonged to ACBAR, among them all the big ones working in the health field (www.pcp.org)

[14] personal communication Head of GCMU

the ‘winners’ is mixed. There are 2 local NGO and 4 international agencies. Because many NGOs have specialised or are working in vertical programs or are more committed to relief aid they might not have participated in the bid. The fact that two NGOs won already contracts in more than one province point to a possible decreased competition. Some NGOs cover already their certain areas with Health Centres (CHA network in Farah province). Local NGOs can be more competitive in future rounds, because they do not the burden of high-salaried ex-patriots and local field experience. Besides BRAC no NGO has experience in contracting.

Transaction cost

The evaluation of the large set of 31 indicators on performance every 6 months by a independent third party, probably an academic institution, also the GMCU itself specifying and monitoring contracts impose substantial additional costs. Until now provincial baseline indicators are not yet established. Baseline data are lacking. To conduct household surveys and health facility assessments in hard-to-reach different sites on a scientific basis requires also control groups for comparison of achievements. A more selective set of indicators to avoid ‘paralysis by analysis’ could serve the purpose of a rigorous evaluation. Targets for the development are often very ambitious (i.e. an utilisation rate of 1,0). Further on cultural barriers exist in Afghanistan to question household directly.

5.8. Example – the Wardak Province

Short Introduction to the province

Wardak province is situated in Eastern Central Region, the eastern edge of the central highlands of Afghanistan (see map Annex). The area consists partly of semi-arid desert, cultivated, irrigated spots along low valleys, and high mountain valleys in the west, extends approximately 100 x 150 km. It is a rural area with small cities in the south. Altitudes are between 1000 and 3000 m above sea level. Most people live whether from agriculture, raising fruits and wheat, or from husbandry.

The province has some ethnical diversity. Pashtoons, the main Afghan tribe lives in the lower lands along the Kabul-Kandahar main road. Tajiks are often farmers in the lower valleys. Hazaras, a mongoloid tribe, live behind mountain passes, up to 3000m scattered, in the high lands. The access is often blocked by snow in the winter. Many roads are in bad condition. A

lot of settlement can only be reached by foot or donkey. Maidan-Shar with 15000 inhabitants is the official administrative centre, but more a market place and can be reached by car from Kabul in less than one hour. The bazaars in the other villages have small scale business and little handicraft.

Situation in the health sector

Living conditions in the south part are better than the average in Afghanistan. Fruits and services are sold along the central trade road and family members find qualified work in Kabul. In the west the conditions are harsher. Existing data from the Health Information System[15] are not reliable. The EPI coverage is probably better than the national average (30%).Leishmania and leprosy are endemic local diseases.

From 38 existing health facilities in the province all were supported or run by NGOs. 5 were inactive and 33 active, which means there was any kind of activity. 5 facilities claimed government ownership by the recent survey (Afghan MOH 2002).

There is a variety of NGO services with different agendas. The 4 district hospitals are owned and run by 4 different NGOs on different care levels. Clear catchment areas of each hospital with referral structure from the Health centre level are not defined and emergency obstetric services not defined. C-Sections can be performed in only two hospitals. For TB-treatment small hostel facilities are built up in two sides. In addition private providers remain the largest part of the health system in the province. The distribution of facilities with their respective 5 km catchment areas(see map Annex) not equitable. The Western districts are underserved, in the South Health Centres are concentrated around certain spots and overlap. For remote districts like Behsud I and II the paucity of qualified staff and equipment is prominent.

Plans of the contracting agency

During the second round in February 2004 of the PPA distribution Swedish Committee was awarded and signed a contract with the MOH for the implementation of the Basic Package in Wardak. According to the agreement around 5 Million US$ will be spent over 3 years to improve the health status. By June 2004 SCA plans support all basic clinics. With operating

[15] The previous Health Information System (HIS) relies on data from Immunisation campaign and a set of 50 genral diagnosis from sentinel sites which are irregularly supplied and often contradicting each other

agencies of hospitals arrangements for coordinating purposes are foreseen. A provincial hospital is not planned.

The initial approach for 4 clusters has been abandoned. For defining a proper referral structure within the coverage plan the Provincial Coordination Committee (PCC) is asked to decide on that together with the Provincial Health Directorate (PHD) – the already established formal coordination mechanism that brings the actors together.

Table 3: Health facilities planed in the districts of Wardak (source: SCA-survey)

District	HP[16]	BHC[17]	CHC[18]	Existing number of clinics	DH[19]	Population According to CSO[20]	Population per facility
Maidan Shahr	6	2	1	4	1	32,100	8025
Jalrez	18	2	1	3		43,400	14467
Hese-Awal e Behsud	21	2	1	3		36,900	12300
Markaz e Behsud	57	4	1	4	1	105,000	26250
Daimirdad	10	2	1	1		22,700	22700
Chak e Wardak	23	2	1	3	1	56,700	18900
Sayed Abad	24	3	1	7	1	78,000	11143
Nerkh	12	1	1	5		38,200	7640
Jaghatoo	9	1	1	3		29,700	9,900
Total	**180**	**19**	**9**	**33**	**4**	**442,700**	**14592**

[16] HP: Health Post
[17] BHC: Basic Health Centre
[18] CHC: Comprehensive Health Centre
[19] DH: District Hospital

Redistribution: The number of facilities of each type per district has been established with the recommendation of the MoPH. New facilities will be set up in the underserved western part of the province; in Syad Abad, Nerkh, and Maidan, half of the existing facilities will get closed. Nevertheless distances will be long in Merkez e Behsud.

Human resources: The lack of skilled health workers is the main constraint to establish all First Line facilities. The teams foreseen in the health facilities will get training in a planned provincial training centre. There is a shortage of female nurses, midwives and 'Advanced Midlevel Health Workers' to deliver MCH services.

Salaries/Performance: According to the MoPH guidelines staff for all first line facilities would exceed the number of 500. But the NGO has certain flexibility in employment. Paid at a living wage, this takes half of the yearly project costs.

Capacity building: The PHD staff will be trained by the contractor to enhance competencies in management field: planning, budgeting, data analysis, monitoring, supervision and evaluation of the health system performance, Unclear is what are the actual competencies if the PHD is not an implementer, besides being a contact person to the MOH, the governor and local authorities.

Financing: SCA plans to introduce a cost-recovery system. According to the practice in its previous facilities it will consist in fee for services and a certain percentage for the price of the drugs.

Community participation: The 180 Health post planned will be staffed with Community Health Workers and Traditional Birth Attendants. Hundreds of them will be deployed, but CHW are volunteers supported by the community.

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[20] Central Statistical Office: the CSO datasets is calculated by extrapolating the data of the last census in 1979, taking into account a presumed 1, 92% population growth. An alternate is population estimations from the NID (National Immunization Days), which are 15% higher.

Vertical Programmes: The contracting agency is responsible for the implementation of TB control activities. For this and other specialized programs SCA will subcontract other partner for the training of health workers and to provide guidance for the purchase of laboratory supply and monitoring.

An intersectoral collaboration is achieved in the province with the agricultural sector. A National Solidarity Project that improves living condition, husbandry and farming in rural areas is implemented by the same agency. Community and official representatives share their views in the Provincial coordination Committee to get a common pace forward.

6. Discussion

This section discusses perceived advantages and disadvantages among the main actors and also if the PPA-Model was adequate to national context in Afghanistan and the provincial context of Wardak.

On pros and contras of performance-based contracting in Afghanistan a lot of arguments have been exchanged between the sides. Many of them like possible efficiency, effectiveness, and equity have to be proven during the implantation. The other important ones are:

Advantages

- geographical access: reaches areas that government cannot reach
- Ability to recruit staff in remote areas and correct concentration of staff in urban areas
- Higher accountability on NGO activities
- Knowledge-transfer from NGOs who have experience in many countries
- Quick impact solution: partnership between MoPH and NGOs will allow things to move faster than MoPH working alone especially in remote areas.
- Chance for national NGOs to develop their expertise and experience

Disadvantages

- Brain drain of skilled MoPH staff as a result of higher salaries in PPA areas
- Risk that the MoPH will lose the control through lack of capacity to monitor distant provinces
- Contracting will reduce the efforts to build up the MoPH capacities
- Risk that contracting will prevent the MoPH of this legitimate government from taking its place as a service provider after so many years.
- Sustainability that will affect continuity of service.
- inequitable allocation of resources
- no local ownership by political repercussions in the population due to the perceived loss of control by the MoPH
- process of nation-building is in question by ‘NGOisation’ of public services

The MOPH also warned about the absence of competition, especially in area where new services are set up, the provider monopoly creates new asymmetries on the long run. Some NGOs are to PPA, because thy guarantee funds for their operations, but realising that additional skills are require managing a complex local health system.

Are PPAs an adequate strategy on the national level in Afghanistan?

There are some important bottlenecks to serve for reconstruction of health services.

1. *Sustainability*: The real sustainability depends on how much the country can support the health sector when external funding ends. Also a bridging mechanism must be put in place when contracts are terminated. The private-for profit sector and low cost-sharing schemes of some NGOs are an indirect sign of the willingness and ability to pay for services perceived as higher quality. Considering extreme poverty among the population, no significant cost-sharing mechanism can be anticipated. The tax-base in the next 10 to 15 years will be too weak to afford any basic health services.

The present level as a starting point of 2-3 US$ per head of external financing seems one of the lowest in the world. Considering the magnitude of the health problems and the costs induced for reconstruction it is vastly inadequate. Rebuilding infrastructure was estimated at a minimum of US$ 7.4 per head for the next ten years (WHO2002). In developing countries for BPHS prizes between US$ 12 (WB 1993) and US$ 34 (Commission on Macroeconomics in WHO 2002). Difficult terrain, the dispersion of a large part of the population and expectations of returning refugees will pose the additional costs. Extreme fragmentisation and inefficiencies induced by it, as well as extra-operational cost for security let the proposed scheme look grossly under funded. On the present level not much health care can be delivered. In the coming years the donor commitment has to increase almost 2-3 folds.

2. Equity: A more equitable distribution of health facilities is questionable. By the selection of 8 out of 32 provinces, only these will receive a sustained injection of funds. For the coverage plan of the whole country remain substantial 'white spots'. A concern on equity is that most of problematic provinces are left out of the PPA-scheme. User-fee schemes threaten the financial access for the poor, even with exemption mechanisms.

The ability to attract qualified staff to remote areas can be improved by decent salaries and other incentives, like housing conditions.

3. *National Health Policy*: Though performance-based agreements are no policy instrument per se, they require the developing an agreed overall strategy between MoH, funding and implementing agencies. The introduction of the PPA-scheme contributed to the formulation of

national standardized guidelines, like the BPHS, and performance indicators for the health status. The pressure of the donors may have speeded up parts of this national policy process, but in the core it should be an independent authentic process. Other policy fields which are not directly concerned are in risk of a dangerous 'laissez-faire'. MOH did not deal with the issues of the regulation of the private sector or the national drug procurement.

The concern is that the 'top-down' approach of PPA's setting performance targets on a central level will not be owned and have the same priorities by the local population. Demand can exceed the supply of the minimum package with additional costs. Communities must have a say in defining where new facilities are placed and local medical problems are addressed. How communities will be adequately integrated in provincial coordination remains unclear.

4. NGOs as implementer of MOH policy: The question is if the government can rely on the long-term on this source, when short-term funding is finalised. The number of agencies with adequate expertise in health system development is limited, selected further by the financial risk to serve a large geographical area, given by the province-based scheme. Alternatives to the province-wide distribution left out potential providers who did not have the capacity for this large scale. There is little guidance for the majority of NGOs who do not want to follow the PPA model, or are interested in other areas such as hospitals. The expertise of those, often active over many years in specialised programs is not tapped and integrated.

Adherence to government policies is not guaranteed by the current contracts that have neo-classical forms with sanctions and bonuses on performance over a relative short period of three years. Their 'flexibility' of NGOs depends largely on a creative and participatory micro-management of human resources. If they improve to long-term constructive relations, depends on the development and if there are common interests, like targeting the poor, and influence health reform policies.

5. Capacity building: The burden of developing and managing large contracts is enormous. MOPH skills are substituted by technical assistance, which is required over a long period. Monitoring and assessment of NGO-performance, requires the regular collection of accurate data. To take over the steering role in the health system needs skills that are the result of a learning process over time. For financial procurement official authorities are effectively by-passed by the donor-led GCMU. The main difference to the Cambodia example is that these

capacities have to be built up first. There MOH Cambodia had already an established management and operational district system in place.
In Afghanistan even provincial baseline data are lacking. Evaluation needs for more operational research not only for data on coverage, quality, and equity, but to compare different ways of implementation of the Basic Package in other small-scale projects. A control group must be clearly defined to compare the 8 PPA-provinces with government and pure NGO provision of health services. A range of fewer, but better selected indicators will rather focus on process-and outcome indicators, like EPI-coverage, than on impact-indicators biased by many regional factors.

Were PPAs adequate on the province level?

For this province in my opinion a 'contracting-in'-like approach is better to strengthen the provincial MoPH in managing the existing network of health facilities. It will be a country-specific contracting model, like the MOH-SM. The Province Department is actually by-passed and without proper competencies. The province is close to the capital and on the whole not underserved. If the NGO cooperates and supports directly with the district management, it will create better conditions for a transitional period until the provincial health authorities are in charge. The credibility of the MOH and public ownership improves, including local resources and creativity.

In Wardak a number of difficulties are foreseeable. The province-wide PPA-approach does not define responsibilities for integrated health systems on two tiers (clusters[21]). The 4 district hospitals are not handed over and continue under own management. Existing health centres will resist to get closed and their staff redeployed to remote underserved areas.
Comprehensive Health Centres are overstaffed (14 persons) and have no function in well-covered area. Deployment of CHW was until now not proven very effective in Afghanistan. Training alone is no substitute for incremental community participation. The selling of some essential drugs can be a risk.

The contractor applies its own cost-recovery scheme, not in line with the ministerial policy, and reduces access for the poor. Whereas it was a common policy among agencies during the conflict to ask for user fees, in the PPA regulations it is only foreseen under a research agenda. The share of governmental clinics is only 5 out of 33 clinics. But the integration of

[21] a pyramid with a district hospital and surrounding health centres

newly established health increase this share constantly and the handing over of existing NGO services centres will that run out of funds. Big challenge is to regulate the substantial number of bazaar doctors (private-for-profit) and develop a community-based outreach care.

7. Conclusion

The role of performance-based partnership contracts in Afghanistan is different from other previous forms of contracting that developed over time. The new role is to use the tool to rebuild a destroyed public health system very soon after a long-lasting destructive conflict together with weak regulating government capacity. Previous examples in post-conflict countries aimed to extend geographical access Primary Health Care (Guatemala, Haiti) or to improve quality of care (Cambodia). There upon the evidence-base for achieving the 'twin objectives of effectiveness and efficiency' is weak and can not justify a large-scale transfer of the contacting-out model.

Covering 10 provinces with approximately 5 Million people this represents the largest 'pilot' project to date. Results are closely watched by the international community in order to learn for other post-war settings. More important is to dissolute information and first experiences of the implementation among the local stakeholders timely and regular to induce a process of collective learning among the local actors. But pre-selection of areas and providers creates also new imbalances and fragmentisation by with winners and losers. The new type of NGO, required for PPAs, needs sufficient skills in health systems development

More attention must be paid on elements that are distorted by the province-wide approach:

- development of integrated local health systems (according to the specific geography)
- a decent salary scale with performance management on the micro level
- involvement of communities in the health structure and financing
- intersectoral cooperation to improve living condition in rural areas

If the 'push-down' of services to a reasonable level will work, depends on creative examples of community-involvement. The country's demographic pattern makes it extremely difficult to provide services to the whole population in an integrated system. How to create the maximal care to all under the conditions of an extremely low population density and missing human resources is still a matter of debate and creative solutions.

Funds foreseen by PPAs to rebuild the dilapidated infrastructure allow no sufficient investment, doubled by transaction cost which account for 10% of the project cost. The prizing of the minimal package with US$ 3 per head is below international standards. No illusions should be created that the current level of funding can ensure a sustainable evolution of the health sector. Additional financial resources are badly needed with long time-frame.

For the future role of the Ministry of Health, whether purchaser or provider, different rates of transition into national ownership are possible. Where there is a sufficient MOH capacity, whether national or regional, the over handing will be earlier than in unserved areas. The fragility in Afghanistan must take the limited government capacity and sovereignty over the regions into account. An exit strategy should be foreseen, when external funding stops. It will depend on positive or negative 'buy-ins' during the PPA-process, if the MOH completely restricts to relational contracts and can rely on a market of local NGOs for service provision.

The health sector is one of the best entry points to begin a process of rebuilding a country after conflict. The expectations on health among the Afghan population are high. The quest for rapid results competes with the slow process of 'nation-building'. Performance-based contracting is oriented on measurable results in target fields, not on the process in the society on the whole. Ensuring health equity in the 'battle for access' to basic health services is also a question of national solidarity in the disrupted social fabric. The health sector can provide space for cooperation between the state and the population. The reason why international donors rush to invest money in public health in Afghanistan is because they count on a peace dividend the background of the recent history. How public health can contribute to the peace process and conflict prevention is an interesting question for further research.

But the impact of medium-term projects on mortality and morbidity is usually incremental and unpredictable. One of the main focuses should be to ensure sustainability of the basic services. Long-term solutions to improve the health parameters will depend on prolonged investment in the health sector and on the ability to put the Ministry of Health in the driver's seat.

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Acronyms

ADB	Asian Development Bank
CI	Contracting in
CO	Contracting out
EC	European Commission
EMRO	WHO Eastern Mediterranean Regional Office
IDA	International Development Association
JDM	Joint Donor Mission
JICA	Japanese International Co-operation Agency
HIS	Health Information System
MoH	Ministry of Health
MoPH	Ministry of Public Health
MSH	Management Sciences for Health
NGO	Non-governmental organisation
NPM	New Public Management
PHD	Provincial Health Department
PPA	Performance-based Partnership Agreements
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
US	United States
USAID	US Agency for International Development
WB	World Bank
WHO	World Health Organisation

Abstract:

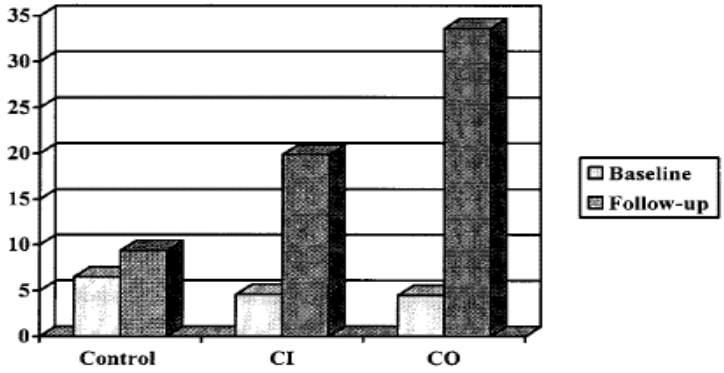
Performance-based contracting for health care has been advocated since more than ten years, starting with the World Development Report 1993 - 'Investing in Health…' in achieving more effectiveness and efficiency for public money by private provider competition. Despite the potential benefits of performance-based partnerships agreements (PPA) there is a weak evidence base in the developing countries, especially in post-conflict situations for better results.

In the Islamic State of Afghanistan the World Bank started in 2003 a PPA-scheme for health service rehabilitation in eight underserved rural provinces. Currently 65% of the country have no access to basic health services. In the name of the Ministry of Health NGOs are contracted to deliver a minimum package of health services. The experiment is based on a pilot test in Cambodia. NGOs that reach specific targets are eligible to receive additional payments. Weak government capacity to draft and monitor large-scale contracts is one of the difficulties.

The analysis of the project design demonstrates that it urges the MOH to refrain from actual service delivery in order to regulate the health sector and set policy. Notified are distortions in equity and sustainability due to the scale of coverage on province-base and the selection of provinces and NGOs. Market competition is limited to a number of NGOs with sufficient capacity and previous experience in the field of primary health care. The injection of funds to rebuild the infrastructure is insufficient and the prizing of a minimal package of public health services is below international standards.

ANNEXES

Cambodia 1: Percent of poor people sick in the last month that used a health facility

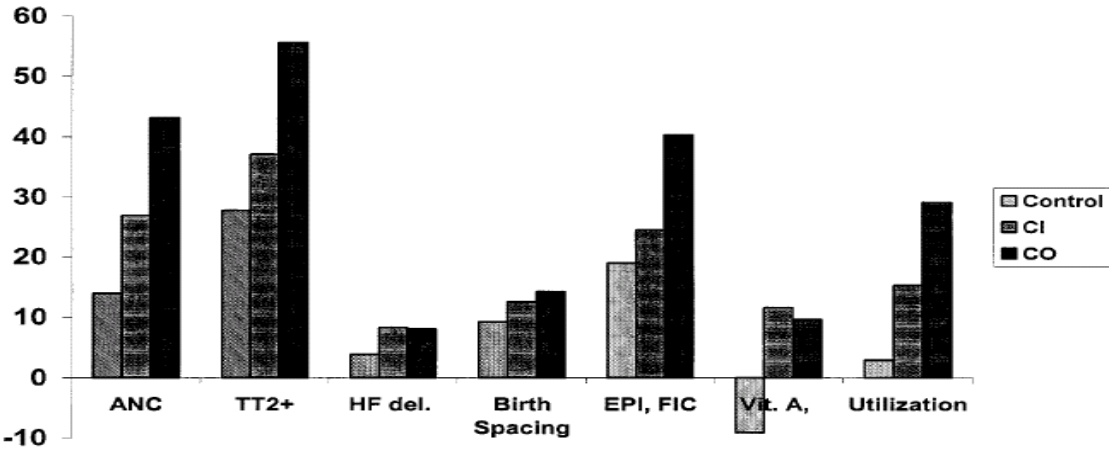


CI = Contracting in
CO = Contracting out

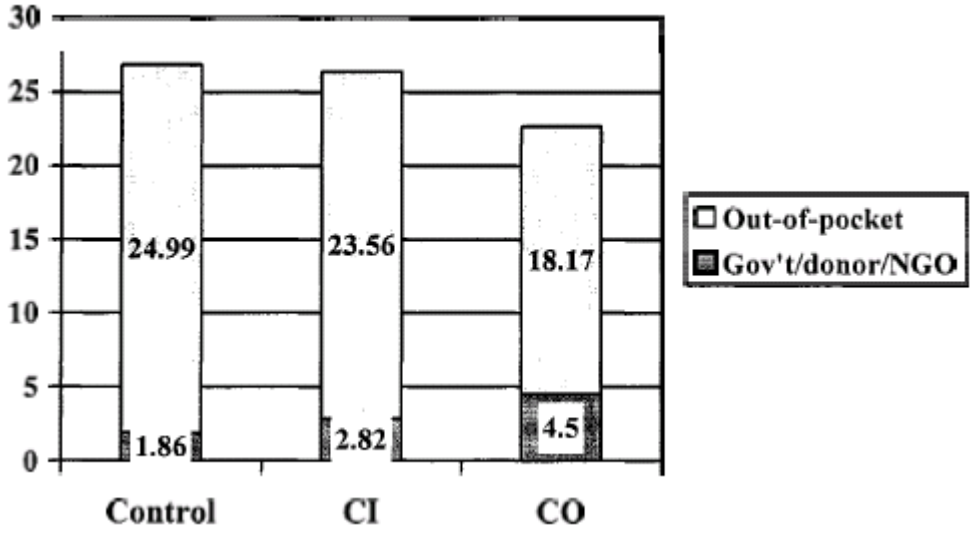
Cambodia 2: Average Change in Health Service Coverage Indicators (percent)

Indicator	Control	Contracted-in	Contracted-out
Antenatal Care	160.1	233.3	401.5
Trained Delivery	26.0	0.0	0.0
Facility Delivery	0.0	225.1	142.0
Antenatal Tetanus Immunization	149.1	148.6	400.0
Family Planning Knowledge – all	307.4	317.4	599.5
Family Planning Knowledge – lower 50% SES	271.0	301.4	559.5
Contraceptive Prevalence Rate	93.4	104.5	122.6
Child Immunization	55.7	81.8	158.1
Vitamin A Capsule Receipt – all	-25.1	18.1	20.9
Vitamin A Capsule Receipt – lower 50% SES	-24.1	29.9	23.9
Percent of Illnesses Treated in Public Health Facility – lower 50% SES	81.7	490.5	1096.0

SES means socioeconomic status.



Cambodia 3: Annual per capita expenditure on Health Care (US$)



Guatemala: Result of different approaches to service delivery

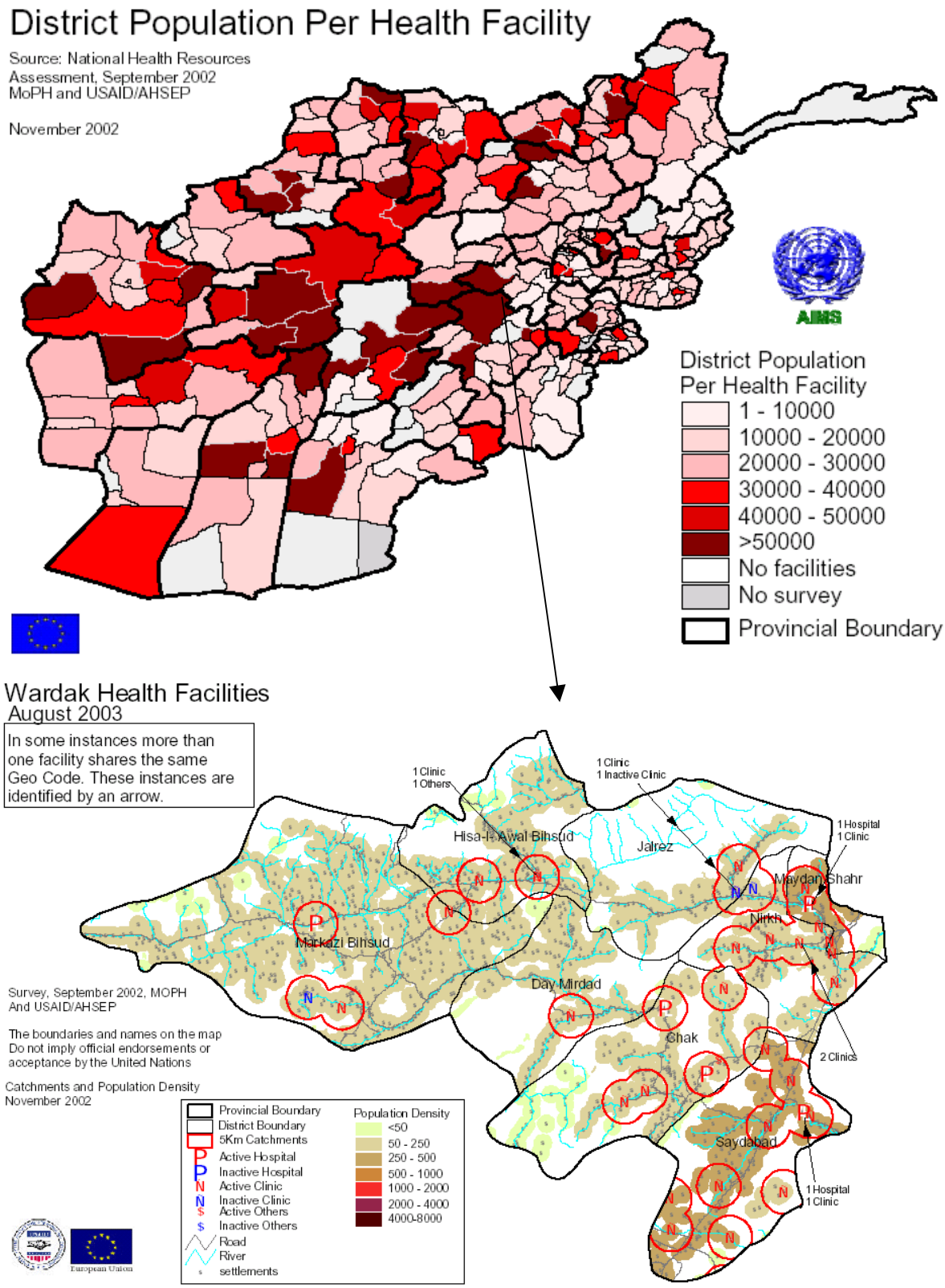
Traditional means governmental
Mixed = contracting in
Direct = contracting out

Parameter	Control Traditional	CI Mixed	CO Direct
% Coverage of prenatal care	75	87	78
% Tetanus toxoid coverage among pregnant women	63	68	57
% coverage among children of DPT3 Immunization	69	80	63
% coverage among children of Measles Immunization	54	61	51
% of children with diarrhea receiving ORT	39	55	36

Haiti: Baseline, Follow-up and target for three Contracting-out NGOs

Parameter	NGO #1			NGO #2			NGO #3		
	baseline	target	followup	baseline	target	followup	baseline	target	followup
Immunization Coverage	40	44	79	49	54	69	35	38	73
Prenatal Care Coverage	32	38	36	49	59	44	18	21	16
Family Planning Discontinuation Rate	32	24	43	43	32	30	26	20	12

Afghanistan and Wardak: Distribution of Health Facilities



Province map of Afghanistan