



LINKING RELIEF, REHABILITATION AND DEVELOPMENT PROGRAMME (LRRD) IN AFGHANISTAN

**Performance-based contracting for health service delivery
in post-conflict Afghanistan: Is there still a case for
debate?**

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ACRONYMS

BPHS	Basic Package for Health Services
CHF	Community Health Fund
EC	European Commission
GCMU	Grant and Contract Management Unit
HSR	Health Sector Reform
ICRC	International Red Cross Committee
INGO	International Non Governmental Organization
JDM	Joint Donor Mission
LRRD	Linking Relief Rehabilitation Development
MDGs	Millennium Development Goals
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Non Governmental Organization
PHD	Provincial Health Department
PPA	Performance-based Partnership Agreement
PPP	Purchasing Power Parity
PRR	Priority Reform and Restructuring
\$	American Dollar
UN	United Nations
WFP	World Food Programme

1 Introduction

Afghanistan has recently embarked on health system reconstruction aimed at providing a Basic Package for Health Services (BPHS). The BPHS attempts to deliver effective services to the rural areas and to the most vulnerable and concentrates on defined levels of care, ranging from community health workers to district hospitals (MOH, 2003).

Given the state of the health system inherited from decades of conflict, the country has essentially started from scratch with substantial support from the international community. A key objective was to focus both government and donor efforts on the most important health problems in a coordinated and rational way.

It was the acknowledgment of insufficient government capacity that drove the impetus for change. The Joint Donor Missions (JDM) and the Ministry of Health (MOH) both recognized the significant limitations of the new interim government to provide health services and recommended strengthening relationships with Non Governmental Organizations (NGOs) through Performance-based Partnership Agreements (PPAs). As its central features, the government would contract NGOs to deliver an agreed package of services and the MOH would play a key role in terms of stewardship in order to ensure transparency, accountability and regulation. Through the PPA scheme, the government takes advantage of the presence and capacities of NGOs in an environment where the capacity of the MOH to directly deliver services is extremely limited.

In the recent years we have seen an increasing interest in the issue of contracting for health in low-income countries. The trend is being encouraged because of several factors, including: government and donor concern for health outcomes; interest in improved measurement of results; the move for greater accountability of health care providers to their governments and citizens; the push for stronger accountability of governments to donor agencies; and a recognition that NGOs and the private sector can, in some instances, deliver essential health services more efficiently than the public sector.

Nevertheless limited evidence is available on the success of contracting in post-conflict countries. In Afghanistan, there were strong doubts that the PPA approach would yield the desired results in a country where the population, characterised by ethnic and cultural diversity, is distributed across remote, geographically harsh and insecure areas. Hence the drive to contracting has stimulated much debate and our field experience in the country brought us face to face with the strong emotions that tended to colour, in the early days, heated discussions on such an approach. Limited communication on a poorly understood concept combined with the lack of expertise locally have contributed to a state of affairs where some clung to their respective positions.

Since then, new realities have emerged, shifting the debate on the subject and it seemed important to reflect on the past and current situation. This paper explores the background of contracting and documents how, in a very short time span, donors, MOH and NGOs have created the conditions for BPHS delivery and discusses the potentials and the challenges brought in by contracting in Afghanistan.

This discussion paper is part of a two-year project aimed at lesson learning and sharing within the context of Linking Relief Rehabilitation Development (LRRD). It forms a summary of reports and discussions held with various organisations in Afghanistan between August 2002 and October 2005. The information collected from the field visits has captured a diversity of perspectives through multi-temporal, multi-stakeholder and multi-site visits and a shift from scepticism to a more balanced view of the relative roles of public and private sectors.

2 Performance Based Partnership Agreements as a policy tool: what are they?

2.1 The rationale behind contracting

2.1.1 Inefficiencies of the public health sector

Around the world, governments are under pressure to provide health services effectively, efficiently and equitably. Since the late 1980s, Health Sector Reform (HSR) has been launched on the international health policy agenda as a response to the unsatisfactory performance of the public sector: often inefficient, over staffed, with little incentive to work and lacking accountability.

Table 1: Moving from government-managed health system to new partnerships

Period	Health Policies	Implications	
		Public health services	Private sector
Mid 1970s	Economic problems leading to structural adjustment.	Government health budgets are shrinking; Imbalance in budget allocation: great share spent on staff to the detriment of expenditure on drugs, maintenance or other recurrent expenses; Operate at a low level of technical efficiency; Suffer from deep-rooted inefficiencies; Staff reduction; Low morale; Informal payments from patients seeking public health services are common.	Mushrooming of health service providers without much regulation; Growing of informal care sector with drugs sold on markets; Government health staff engages in private practices.
Late 1980s	Cost sharing schemes introduced as a means to revive under-funded public health services.	Efficiency/equity dilemma or how to reconcile economic efficiency and cost-effectiveness with equity.	NGOs become popular: availability of "free" drugs; qualified staff; flexible working hours.
Mid 1990s	Shift in the government role "from providing health care to financing and stimulating competition between providers" ¹ .	Rethinking of public/private relationships; MOH engages in health-related contracts with private sector; Contract conditions are coherent with the principles of greater access to quality of care; MOH loses its traditional health service provision monopoly; MOH gains monitoring and regulatory powers.	Emphasis is placed on competition as a means to increase efficiency; Private health care providers will bid to deliver a pre-defined health service; Rules between both parties are defined, agreed and respected; Non-government actors loose independence but at the same time they can expand activities and reputation.

Multilateral and bilateral agencies such as the World Bank have often taken the lead with numerous examples of supported HSR initiatives in developing countries. In order to get

¹ World Development Report 1993: Investing in health, World Bank. 1993

health systems to perform better, the HSR agenda attempts to address these issues through different approaches: (i) separating policy and financing functions from service delivery; (ii) decentralising financial responsibility and introducing performance-based incentives for staff and; (iii) encouraging competition in service delivery (McPake and Mills 2000).

The six main components of HSR programmes, as outlined by Cassels (1995), are presented below.

Box 1: Summary of HSR components

- Improving the performance of the civil service
- Decentralisation
- Improving the functioning of national ministries of health
- Broadening health financing options
- Introducing managed competition
- Working with the private sector

Reliance on managed markets is supposed to enhance provider efficiency through competition and the substitution of direct management with contractual relationships. In theory, health care providers make more efficient allocative decisions if they are awarded more managerial freedom. They also work harder if their remunerations are tightly linked to measured outputs. Another efficiency argument is that the contractual relationships between purchasers and providers are a way to promote increased transparency of prices which, in turn, enhances consumer choice.

Efficiency is thus a central policy objective for proponents of HSR who also present equity as a key principle and advocate governments to organise health care systems that enable equal access to anyone. By contrast, opponents to HSR argue that the philosophy of economic liberalisation can only broaden socio-economic inequalities, impose greater burden on the poor and weaken the equity principle.

2.1.2 Towards the Millennium Development Goals

Governments, donors and international agencies are under increasing pressure to show that development assistance budgets are producing measurable results in order to make progress towards the Millennium Development Goals (MDGs). They are thus seeking to increase the effectiveness of the resources by allocating them to programmes that demonstrate progress as measured by performance indicators. Contracting can spotlight such results as funding for health care might be tied to improvements in the coverage of key services, such as immunisation or antenatal care.

2.1.3 Tapping in for additional resources: building public-private partnerships

Health sector reforms have focused on the separation of policy, regulatory and monitoring functions - to remain with the ministries of health - from the delivery of health services to be outsourced to public and private (profit and non-profit) providers. In broad terms the comparative advantages of the private sector would lie in service delivery and in technical efficiency to provide these services. For the government, the main comparative advantages concern ultimate responsibility for the health and well-being of citizens, policy development and regulatory framework and equity issues.

Under this scheme, stewardship, finances and resources generation are disconnected from service provision. Stewardship, defined as "*the careful and responsible management of the well-being of the population*" thus becomes an essential element of the state's role in guiding the health system as a whole (WHO, 2000).

As public-private partnerships are increasingly regarded as fundamental to supporting and improving the development and delivery of health services, many governments are testing mechanisms to engage with the private sector.

A range of different explanations for this boost and interest in increasing and improving co-operation can readily be identified. For a start, the already scarce resources for health care are declining yet further and partnerships with the private sector may raise additional resources. There is also the gradual acknowledgement of the need to develop a systemic approach to health care delivery in order to avoid expensive and useless duplications. Furthermore as such partnerships relieve health ministries of the burden of the direct management of health facilities, they may be attractive and be used to create innovative mechanisms for increasing access to health care and to address inequalities in access resulting from market failures.

In particular contracting out for health service delivery is seen as a strategy to increase efficiency, to improve quality and to strive towards equity. It is defined as a formalised agreement between the public and private sectors to deliver health services in exchange of payment which covers salaries, recurrent costs, drugs and consumable medical supplies. The contracted agent has freedom for service delivery and staffing patterns but is bound by contract to achieve targets.

Contracting in, in its strict meaning, is used to describe a contract between two public sector institutions. In broader terms, it can formalise a relationship between the government and implies that a subdivision of the MOH (such as a hospital, a group of doctors, etc.) is sub-contracted for the provision of goods or services.

2.2 Contracting in use

2.2.1 A variety of arrangements

The definitions of contracting in use suggest that contractual relationships can take various forms: facility autonomy and corporatisation, decentralisation to local authorities and privatisation are often connected to new ideas about the management of the public sector (Walsh, 1995). Examples of applying new public management theory to traditional public sector schemes have also included the use of NGOs to provide health services. The outright transfer of facilities to private actors would constitute the most direct application of the theory but has been far less common (Perrot, 2004). These distinctions depend on the rationale behind contracting and on the nature of the provider.

Formal contracting stipulates the type, quantity, and time period of services provided by the contractor on behalf of government and specifies payment arrangements within an official framework. Informal contracting, based on trust and long term relationships, is a more implicit agreement between the government and the private sector. Rosen (2000) distinguishes between three types of contracting for: (i) ancillary services; (ii) health services and; (iii) management contracting.

2.2.2 Pros and cons

According to classic economic theory, contracting stimulates competition among providers who are forced to adopt innovative technologies and adjust prices to meet the demand and requirements of purchasers. Furthermore contractual relationships induce higher cost awareness among managers and purchasers and enhanced transparency in negotiations, both factors contributing to increased efficiency. More importantly contracting facilitates decentralised managerial responsibility, a shift that can translate in efficiency gains in relation to highly centralised and bureaucratic structures.

Opponents of contracting have raised several arguments summarised in the box below.

Box 2: Restrictions on the potential for contracting

- Health care is subject to a complex set of market imperfections, such as moral hazard² and information asymmetry, which makes difficult to define the object of the contract;
- High transaction costs, including the costs of writing and negotiating the agreements and those incurred in monitoring the contracts and resolving disputes;
- Limited competition among potential contractors: long-term contractual relationships can prevail in disrupted contexts where donor agencies have financed NGO operations through grants. These do not imply open competition, nor are clearly linked to the achievement of specific targets;
- Long-term contracts limit the flexibility for re-allocating resources. For instance, an NGO with a long-term presence in an over-resourced region may find difficult and expensive to move to under-served areas.

These restrictions explain why contracting for health care was at first limited to ancillary services (catering, cleaning, etc), where defining the product is easier. In the late 1990’s, the approach was extended to nutrition services, primary health services and hospital services (Mills, 1998), (Marek *et al*, 1999).

3 Which experience can we draw upon in post-conflict settings?

The experiences of Cambodia and Haiti have been frequently referred to as guides to PPA development in Afghanistan.

Table 2: Circumstances for contracting in Cambodia and Haiti

Country	Rationale behind contracting	Institutional context	Implementation Context
Cambodia	<ul style="list-style-type: none"> • High out of pocket expenditure; • Under-utilisation of health services; • Experimenting with innovative mechanisms to increase efficiency of health services. 	<ul style="list-style-type: none"> • Strong MOH leadership; • Intense capacity building over a period of five to eight years; • Health Coverage Plan launched in 1996 and 71 Operational Districts established; • Operational guidelines completed in 1998; • National Health Financing Charter in 1996-97; • Decentralized management of health services; • Pool of professional management staff at provincial levels; • Large workforce but with inadequate skills. 	<ul style="list-style-type: none"> • Substantial potential with INGOs involved in long term development; • No tradition of national NGOs; • Widespread private practices; • Understanding of demand-related issues; • Access to insecure areas not an issue; • Twelve districts were selected and three approaches devised (Contracting Out; Contracting In; and Control/Comparison); • In 1999: first phase started as a research pilot targeting approximately a population of 1 million; • Second phase: call for proposals in summer 2003.
Haiti	<ul style="list-style-type: none"> • Improve access to high-quality PHC services; • Improve effectiveness of 	<ul style="list-style-type: none"> • Limited MOH leadership; • Health system highly fragmented with NGOs 	<ul style="list-style-type: none"> • In 1999: contracting between USAID/MSH and few NGOs;

² Moral hazard means that people with insurance may take greater risks than they would do without it because they know they are protected.

	NGOs in providing basic health services.	acting as main service providers and operating autonomously.	<ul style="list-style-type: none"> • NGOs are sub-contractors, not grantees; • The institutional capacity of NGOs to succeed in contracting is ensured through strengthening their financial management, strategic planning, human resources management, and drugs management. • Access to insecure areas not an issue.
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3.1 In Cambodia

In Cambodia, the Asian Development Bank's loan project included an operational research component to pilot three alternative approaches to public health service delivery: Contracting In, Contracting Out and Control/Comparison. In all districts, less than 20% of planned health facilities were functional at baseline and health service coverage was extremely poor.

The evaluation showed that contracting had the potential to improve management and supervision and to address the problem of poor health staff attendance. Furthermore the contracting out model, with an average bid price at \$5.04 per capita per year, increased utilisation of facilities and coverage for services such as immunisation and antenatal care and reduced in out-of-pocket costs by 70%. This model proved the most feasible, high performing and cost effective (Keller and Schwartz, 2001). In addition, findings revealed that properly designed and managed user fee schemes made it possible to increase utilisation by the poor and decrease their out-of-pocket expenditure on health care.

Due to local political sensitivities, a phased approach was felt more appropriate as opposed to establishing contractual arrangements for the entire health system in one step. Under contracting out, NGOs had full responsibility for delivery of all health services: they directly employed health staff at district level, procured their own drugs and consumable supplies, and covered all recurrent operating costs.

In the other model, referred as to Contracting-in, all inputs were provided through government channels. Contractors provided only management of health services with health staff remaining MOH civil servants. This model, however, did not prove feasible in practice as the NGO managers were not able to hire, dismiss, transfer or sanction staff. In Pereang district³, experience showed a decrease in total family health expenditure of 40% and a sharp increase in health service utilisation. Innovative concepts were introduced for implementation, including a ban on informal private practices and a performance-based staff incentive structure at the health facility level whereby better work led to higher payments (Soeters and Griffiths, 2003).

The main concerns to be addressed included: limited involvement of the provincial health authorities; poor capacity of district level managers; informal private practices of health workers and sustainability.

3.2 In Haiti

In 1999, USAID introduced performance -based contracting in an effort to improve the effectiveness of some of Haiti's NGOs in providing basic health services, such as immunisation and antenatal care. These NGOs had been operating under a payment system that reimbursed their expenses up to a ceiling.

³ Operational district in Prey Veng province, Cambodia.

The approach to financial incentives included the following principles:

When all targets are met, the performance incentive amounts to 10% of the target budget;

If the NGO is unable to meet individual targets, the incentive is reduced according to a pre-specified formula;

In case of general failure, there is no incentive payment. A penalty is applied (5% of projected operating costs).

Internal evaluations carried out by the implementing agencies have shown improvements in immunisation rates and organisational change (Pollock, 2003). Encouraging results are however limited to NGO projects directly contracted by donor, and government involvement is weak. In addition no detailed cost information is available, sustainability remains an issue and there is no real evidence that performance-based contracting is addressing equity.

3.3 Scope for contracting in Afghanistan

Over the last twenty-five years, the people of Afghanistan have been plagued by health problems related to conflict, displacement, drought and increased poverty. Infant mortality is estimated at 165 per 1,000 live births. Access to health care for women is restricted and the most frequently quoted figure for maternal mortality rate, at 1,600 per 100,000 live births, indicates that the country has one of the highest maternal mortality ratios in the world (UNICEF, 2003). Acute respiratory infections, diarrhoeal diseases, malaria and tuberculosis continue to be the main causes of mortality. In such a context, the nationwide implementation of the BPHS represented a daunting task.

Overall donors shared common objectives in contracting with NGOs to deliver the BPHS and the push for PPA started from the recognition of several factors (cf. Box 3).

Box 3: Main factors for purchasing services from the NGOs

- Need for rapid expansion of services;
- Importance of NGOs in first contact care;
- Recognition by the MOH about the limited public health sector capacity;
- Only mechanism to expand health services and extend government visibility in a relatively short period of time;
- Purchaser-provider split in line with general ideas about 'new public management' and the general policy of setting up a 'lean government';
- Successful experience of contracting in Cambodia and Haiti.

Duplication of investments, rebuilding an old health system that can no longer be afforded, and unregulated expansion of NGOs were also key elements in stimulating the policy process.

However, experience of contracting in transitional contexts such as Afghanistan is seriously lacking. In Cambodia and Haiti, a health system, although largely disrupted by conflict and political turmoil, has been in place for a number of years. Strengthening health services took a significant period of time before mechanisms based on performance could be introduced, and this was initially done on a small scale to test their feasibility. By contrast, establishing a nationwide delivery of health services in Afghanistan through contracts with NGOs represented an unprecedented challenge.

The speed with which the approach has been endorsed is in sharp contrast to the lack of actual experience and empirical evidence for success. This must be seen in a context of a country ruled by regional warlords and powerful local commanders, with limited provincial and district capacity and large pockets of insecurity.

Some would argue that the disrupted health sector has offered no other alternative but to accept contracting and has motivated HSR advocates to push for the adoption of PPA. Nevertheless most observers recognised that, given the health context, pragmatism has been urged in the development of health services.

4 More than twenty years of conflict: how has the health sector evolved in Afghanistan?

Public services were severely affected and weakened by the war. Buildings and equipment were destroyed, looted or damaged. Many of the trained and capable people left the country and those who stayed strove to survive on inadequate salaries. The public health programmes that were active during the war period were donor driven and channelled through NGOs who proved to be able to manage an estimated 80% of health care delivery. The MOH had only a marginal role.

4.1 From 1979 to 2002: NGOs dominated

Historical events have deeply influenced the characteristics of the health sector emerging in present-day Afghanistan.

As a matter of fact, years of conflict from the Soviet invasion to the fall of the *Taliban* have defined the main stakeholders and shaped their political culture. The breakdown of government structures gave many field operators relative freedom, and both international and national NGOs played a crucial role as the main providers of primary and secondary health care. Indisputably NGO projects represented for many Afghans their only access to health care. The table below summarises the political events that have shaped the evolution of humanitarian assistance.

Table 3: From 1979 to 2002: chronology of the political events in Afghanistan

Period		Characteristics
1979 - 1987	The pioneers	It is the period of the “French doctors” and of the “without borders” movement in its purest form: crossing of mountain passes at night, illegal convoys, and essentially medical interventions for the “freedom fighters”; Large operations in the management of refugee camps, which served as a base for the guerrillas.
1988 - 1991	Operation Salaam	Emergence of Afghan NGOs: the lack of field operators inside the country had led the Operation Salaam team to encourage the creation of such NGOs, via Afghans living in camps. During this phase, the network of Afghan NGOs and the culture of “sub-contracting” are born; First large involvement of the UN agencies in rural areas.
1992 - 1995	First civil war following the withdrawal of the Soviet troops	Large relief programmes by ICRC and WFP via NGOs, notably in Kabul; Most UN organisations and donor representatives settled in Islamabad; Most NGOs kept their base in Peshawar, from where they carried out assistance programmes in the camps and “cross-border” operations; NGOs combined development approaches and relief operations, according to the zones, needs, and evolution of local situations.

1996 08/2001	– The <i>Taliban</i> phase	Strong tensions; Temporary eviction of all NGOs based in Kabul in 1998; Provision of assistance limited due to donors' budgetary restrictions; NGOs act as a main interface with the <i>Taliban</i> and the international community.
11 September 2001	American intervention	Rapid evacuation of expatriate teams; NGOs working in the zones controlled by the Northern Alliance continued to strengthen their presence from Tajikistan.
11/2001 04/2002	- The first phase after the conflict	Rush of hundreds of agencies, inter-agency competition, "Flying of agency flags"; With the <i>Loya Jirga</i> and the process of legitimisation of the new government, new questions are being raised regarding the contribution of aid agencies: What kind of post-crisis strategies should they adopt? How should control be devolved to Afghan institutions? With what local human resources? With what kind of relationship between the central government in Kabul and the local power structures in the provinces?

Adapted from: The Quality Project in Afghanistan, Mission report July-August 2002, Groupe URD

The events following the 11 September 2001 have changed the course of history: the number of NGOs has escalated, as has the size of their operations. A complex process of political reconstruction, aiming to gradually build and strengthen central government capacity and legitimacy has been put in place. Confronted by the new situation on the ground, the role of NGOs began to be challenged.

4.2 From 2002 onwards: the shift of paradigm

September 2001 marked a new reality. For the first time in many years, it became possible to build a medium term vision for health system development. The major change agents were the large multilateral and bilateral donors. In particular, the World Bank, USAID and to a lesser extent the EC influenced the planning process and were the main drivers. As an initial step, the MOH initiated a consultative process to design a health policy framework and identify key partners. These efforts received exceptional levels of financial support from the main donors.

The BPHS development involved an intensive programming exercise and has been a critical step in shaping the health policy framework and in creating a framework of cooperation among key donors. A consensus was reached with the MOH who agreed to reduce rapidly the mortality and morbidity through widespread delivery of a basic package and contracting with NGOs.

Suggestions about a less ambitious and phased strategy (e.g. piloting areas and building Provincial Health Departments' (PHD) capacity as starting points) were however tempered by the urgent need to expand health services in the view of the high child and maternal mortality rates prevailing in the country.

Contracting entailed the characteristics as outlined below.

Box 4: Key characteristics for contracting in Afghanistan

- The NGO bids to cover health care delivery as described in the BPHS;
- Contracts are competitively awarded, with bidders submitting a technical and price proposal;
- The NGO takes responsibility for implementing activities as defined in the contract;
- The NGO explicitly agrees to the goals, terms and conditions of the contract;
- The NGO is bound by the contract to achieve health service targets (e.g. to improve antenatal care by 30% points from baseline);
- The MOH administers and monitors contracts;
- Payments are directly tied to results and dependent on the NGO's performance, as measured against a set of defined indicators;
- Financial incentives in the form of a financial bonus can be introduced to encourage innovation.

The geographical distribution of priority provinces has been agreed in the first round of contracts, with a few differences in the models taken (Annexe 1). Through World Bank funding, the MOH is implementing the BPHS in Parwan, Kapisa and Pansjheer provinces.

The potential advantages and disadvantages of the different models, as outlined in several documents (Lesley, Wali and Sondorp, 2005), (World Bank, 2005), are summarized below.

Table 4: Potential advantages and disadvantages from the different models

Donor approach	Advantages	Disadvantages
World Bank	Lump sum gives flexibility; Contract easy to manage; Freedom to adapt services to needs; No need of approval for changes; Contracts directly established and managed by MOH/GCMU; Strong focus on GCMU capacity building.	Province-wide PPA require strong NGO capacity; No safety net if the NGO is kicked out for bad performance; No real lesson-learning process; Danger that meeting the targets takes precedence over quality.
USAID/MSH	Strong focus on NGO capacity-building and quality of care.	Several NGOs can deliver health services in one province without necessarily coordinating: risk of fragmentation; High administrative costs; Scope of services does not always include district hospital.
EC	Phased approach.	Based on Logical Framework and indicators as developed by NGOs; May not provide incentives for improving performance; Less accountability compared to World Bank and USAID; Programmatic change to PPA is foreseen in the near future.

5 Elements of controversy to contracting in Afghanistan

5.1 A debate around several issues

As demonstrated in Cambodia and Haiti, the experience with the private sector suggests contracting arrangements have considerable potential and offer one interesting way to deal with health-related issues. However, characteristics of present-day Afghanistan, including the presence of foreign armed forces, weakened state structures, fragmented civil society and prevailing insecurity, suggest that the situation neither mirrors that of Cambodia nor of Haiti.

Transferring experiences from one country to another, although a valuable exercise, can be misleading and overlooking important aspects of the social, political and economic environment (Palmer and Mills, 2003).

Earlier analysis of contracting in low-income countries has identified four critical aspects that are likely to influence the strategy (Mills, 1998).

Table 5: Factors affecting the success of contracting

Categories	Key aspects	
Private sector	Capacity to supply services.	Sufficient level of development; Government reliable and able to offer an attractive market.
Government	Strong government role; Level of expertise to design, implement and monitor contracts; Sufficient public financing and administrative capacity.	Existing systems (financial management, information collection) and available skills (legal skills, economic analysis); Investments in human resources; Credible monitoring of contractual obligations.
Public provision	Characteristics of public health services and their capacity to change.	Close examination of efficiency.
Context	Aspects of social, economic, political environment; Explicit accountability mechanisms.	Functioning legal system; Banking system; Strong government procedures and good governance.

Adapted from: Mills A, 1998. To contract or not to contract? Issues for low and middle income countries. *Health Policy and Planning* 13 (1): 32-40

In the case of Afghanistan, there were strong arguments against PPAs. In the early days poor communication and local expertise with contracting resulted in an ideological debate, with the strategy viewed by some actors as an imposed privatisation of health services.

Some observers feared that the complex procedures that PPAs entail, combined with the MOH's own weaknesses, limited institutional and NGO capacity, logistic difficulties posed by the country geography, and security issues would hamper programme implementation. Of particular concern has been the MOH capacity to monitor the PPA schemes both at central and provincial levels and the capacity of NGOs to move beyond emergency relief to the implementation of a sophisticated tool. Another important aspect, such as the demand for health care, has received comparatively little attention.

5.2 A blurred concept

At the very beginning, the debate has been dogged by ideological positioning before later moving on to operational questions. Indeed, some actors viewed contracting as an imposed privatisation of health services. While making the approach synonymous of privatisation may narrow vision, contracting needs to be placed in the historical context of health system evolution: the combined effects of the diversification of actors, the separation of roles and the scarcity of public resources have made health systems more complex, with efficiency and equity being challenged.

Gradually the different actors have realised the need to formally establish relationships. Perrot (2004) defines contracting as "a *voluntary alliance between independent partners who accept reciprocal duties and obligations and who each expect to benefit from their relationship*".

If we stick to this definition, privatisation, which entails *stricto sensu* a transfer of ownership of structures to the private sector, would not be equated to contracting. Within a wider meaning, however, privatisation encompasses the implementation of a management model

that draws on the rules of the market, with a purchaser-provider split so as to induce supply-side efficiency through competition. In the Afghan context, the shift from the traditional form of assistance towards a more business-oriented approach, fuelled by the donors' poor communication, added to the lack of objectivity and to the confusion over what is the meaning of public and private. In particular, few NGOs, such as MSF, MDM and ICRC, opted out of the process because the mandate and objective adopted by the donors were perceived to be contradictory to their neutrality and independence mandates.

5.3 The question of MOH capacity at provincial and district levels

In an environment where public health services are either non-existent or questionable, establishing trust can be deemed a challenging exercise. At the beginning, the depressed landscape in terms of institutional capacity and resources at peripheral levels and the mismatch between these and the set of policies developed raised serious questions about the MOH capacity to provide a framework for accountability.

The MOH in Kabul, which initially had a marginal role, has come to have a central position. The flood of donor activity has created a market within the health system, whereby clusters of skills have emerged and a set of departments has moved fast. The Grant and Contract Management Unit (GCMU) under World Bank funding is the most visible example of this change. This was possible because of a handful of capable individuals, who formed the core of GCMU, emerged with recognised authority and took up the leadership. Obviously payments have played a role in the recruitment of skilled managers and have motivated them to support the introduction and strengthening of new instruments. From its privileged point of view the GCMU looks successful, even though considered by some observers as a way to bypass the constraints of public administration and civil service that limits efficiency.

The choice to use NGOs for service provision circumvents one aspect of capacity but there is still a huge need to build additional skills at provincial level to regulate and supervise the contracting process. In a fast-paced decision-making environment, neither provincial health authorities nor health workers had a clear understanding of the new policies and the role they were supposed to play Contracting means also for PHDs that they will loose control and will feel challenged by the NGOs. In many instances, the new strategy for health delivery has created a climate of mistrust and uncertainty among provincial authorities and health workers, which will have yet to be overcome (Evans et al, 2004). In that sense contracting, instead of reasserting the authority of central MOH, may further widen the existing gaps and exacerbate tensions, especially if top-down visits from Kabul are confined to monitoring and implicit sanctioning.

5.4 NGOs at the crossroads

Gilson *et al.* (1994) pointed out the potential strengths and weaknesses of NGOs in contracting for health services (NGOs' strengths and weaknesses).

Table 6: NGOs' strengths and weaknesses

Strengths	Weaknesses
Motivational force Willingness to serve in remote areas Non-bureaucratic and flexible style of operation with a close relationship with communities Ability to experiment and innovate Provision of high quality care at low cost	Vulnerable financial base Reluctance to adopt national policy guidelines Poor information systems Weak management capacities

The NGO contribution to preventing suffering throughout the years and under tough conditions has been remarkable. However, despite significant field knowledge, the lack of public health expertise in many NGOs and the high turnover of expatriate staff have limited

their capacity to contribute to the PPA debate. As a result, their participation in the decision-making process has been limited.

While international and national NGOs were seen as a desirable means of health service delivery, they form a very heterogeneous group with great differences in terms of mandates, technical capacity and agendas. In some cases, their longstanding presence in the country and a good reputation based on the number of health clinics or on political relations have led to considerable overstatement of their capacity.

As the contracting experience was new to most of them, very few were aware of what it meant. Certainly their desire to assist Afghan communities has been the central motivation for entering into the PPA process. In addition NGOs perceived it as a tool which would give them competitive advantage in the crowded terrain of health provision. One might argue further that the funding opportunities brought in by PPA were also a remedy for their survival.

Surprisingly not many questioned their capacity to move beyond small-scale projects to the implementation of an ambitious package of activities. Indeed contracting deviates from the traditional approach where NGOs' main role consisted of supporting a network of health facilities and requires a change in conceptual thinking, management practices and relationships with health authorities. For some this shift from an emergency mode of operations relying on short-term and enthusiastic volunteers to long-term high skilled managers has taken time to be fully understood.

More importantly the NGOs, as frontline providers, put themselves in a position where they must deliver regardless of the all too numerous barriers to effective health service delivery. As events in Afghanistan do not always go as planned, the risk is that any problem faced in implementation may be blamed upon them. Rushed on one side by donors and MOH to show results, NGOs must also deal with high expectations within the community. Similarly the fact that large parts of the country remain insecure makes contract implementation a dangerous endeavour. Over the past years, tragic events targeting humanitarian aid workers remind us that peace in Afghanistan is extremely precarious.

5.5 The demand for health care: a complex pattern

From the beginning policy-makers made the implicit assumption that public health facilities, which offer a standardised package of activities, will respond to people's demand for health care. While there are only snippets of evidence on health care seeking behaviour in Afghanistan, the success of PPAs may be hampered by the presence of a large and unregulated private sector and by uncertainty with regard to actual demand.

Next to NGOs Afghan people have the choice of various health providers who compete in a totally unregulated environment. While the past years have seen an increase in private pharmacies, a wide spectrum of pharmaceuticals, including sophisticated drugs and intravenous infusions, are readily available. An important number of private medical practitioners are government civil servants, working after official health facilities hours. These "extra" activities generate additional income for health workers and are accepted by the MOH.

Evidence is lacking on the magnitude of household out-of-pocket spending in the private sector. Paying closer attention to the range of providers that makes up the health system indicates that individuals wander between practitioners rather than seek care through one avenue or one provider. According to most NGOs working in the medical field, health-seeking behaviour is often inappropriate with widespread self-treatment. Of particular concern is the substantial use made of private pharmacies, both for over the counter drug sales and for medical advice. Modern health care, often equated with polypharmacy and the

administration of drugs, seems poorly understood in terms of what can be offered and how it works.

The fact that a certain proportion of the Afghan population lacks the requisite knowledge to make appropriate choices in the health service market would require increasing the public's awareness of, and trust in, the public services. Over the past years, the multiplicity of stakeholders working in the health sector has added to the confusion of who is who and who is doing what. In addition the population has seldom been consulted on whom they expected to take leadership in the provision of health services or on the kind of health services they wanted.

6 PPA so far and challenges ahead

Even though the do's and don'ts for contracting in Afghanistan have been widely discussed, much of the argument in the preceding sections, both pro and cons, is theoretical and/or anecdotal. As a matter of fact the limited body of evidence on the role of contracting in health-system performance has made policy making very 'opinion-driven'. More recently quantitative and qualitative studies, carried out by the John Hopkins University and the London School of Hygiene and Tropical Medicine, have begun documenting the potential benefits and limits of contracting.

The health system reconstruction, no matter which approach is taken, is by nature a long-term endeavour. It would be over-optimistic to expect quick results in terms of health outcomes but the on-going studies should soon tell whether the BPHS is delivered nationwide, to how many people, under which accountability mechanisms, and for which cost.

6.1 Encouraging results

6.1.1 Increase in health service delivery

The health context in which contracting was introduced was characterised by a poor government capacity to deliver essential services. Perhaps the most visible and positive effect of contracting is that it has boosted the expansion of health services. Implementation of the BPHS has significantly increased the availability of public health services. Currently an estimated 77% of the total population has now access to a minimum package of activities (The Lancet, 2005). Another significant change which has occurred has been an increase in outpatient visits by three fold and in antenatal services from 4.6% to 31%.

6.1.2 The GCMU in the driver's seat

The MOH has been called upon to lead the BPHS implementation and, at the same time, to assume new functions and roles. Considered as one of the most pro-active and open-minded ministries, its first efforts were to enhance the cost-effective purchasing of services through the separation of purchaser and provider functions. Some observers argued that Afghan policy-makers were left with little choice but for senior health officials pragmatism prevailed.

The contracting strategy has been staged by the GCMU which has gained considerable influence in the process within, as well as outside, the MOH, not least in the donor community. Effective capacity to manage and monitor contracts has been set up and seems to function well. Although there may be some truth in the assertion that the MOH is being donor driven, it is also clear that donor involvement has exerted considerable capacity-building, through their role within the GCMU.

Contracting with NGOs has gained momentum as an important means to coordinate and rationalise the delivery of BPHS. The MOH has often been quoted an example in relation to

coordination in the BPHS delivery through its World Bank-funded GCMU. The World Bank has recently proposed that the MOH provides the leadership in the coordination of external resources to the health sector.

6.1.3 *The NGOs: acting fast to adapt to new rules*

The pace of change in health care delivery has been fast. New working patterns have challenged the NGOs who, by and large, responded to the bidding process and entered into contract arrangements with MOH and donors. For most NGOs it meant scaling up with geographical coverage and activities.

Due to the relatively short amount of time that has elapsed since the PPA implementation, an evaluation of NGO performance is limited as yet but there is an indication that some perform better than others. In particular the progress has translated into increased capacity-building for national NGOs under USAID grants.

Nevertheless meeting the targets must be set in the context of geographical and security constraints. Obviously NGOs contracted for the delivery of health services in difficult provinces such as Nimroz, Helmand, Ghor or Uruzgan will have to work under tremendous constraints and may be less successful in achieving the set targets.

6.2 The way forward

6.2.1 *Keeping up the momentum*

The MOH has been extremely open to new ideas and concepts and, with major guidance from donors and international experts, has succeeded to lead contracting and to exercise leadership at central level. However, with the new change of Minister, there are individuals with the view to return to the more traditional provision of health services and it is not clear whether the PPA strategy will continue to be shared and supported at central level over the long term. For instance the expansion of contracting for hospital services appears to be resisted by some senior MOH officials and politicians who see it as an unfavourable cutback in state provision.

Faced with criticisms from some politicians the NGOs and their current role in health service delivery began to be challenged. The available information suggests that there is considerable variation in meeting targets but for the time being interviews with key stakeholders indicate positive and encouraging results, especially among national NGOs.

As for international NGOs relations have undergone difficult phases, especially with PHDs. In some instances high expatriate staff turnover, poor communication with MOH counterparts and difficulties with staff management have made relationships difficult. Indeed international NGOs continue to face recruitment problems and are often unable to attract highly experienced managers and technical advisors who are senior enough to be taken seriously by the different MOH stakeholders. Despite these obstacles some have learned from experience and have changed their approaches in management procedures.

Certain NGOs are thinking about downsizing their operations in order to be able to focus on quality of care, an issue of concern that has been poorly addressed due to time constraints. Overall there is a general feeling that contracting is extremely demanding in terms of time, energy and skills. Adjusting to new challenges such as user fees, community-health fund and new exemption schemes are likely to increase the pressures. Furthermore the fact that large parts of the country remain insecure makes contract implementation a dangerous task as shown in various tragic events targeting to health workers.

The PPA strategy suffers from one crucial weakness that is a total reliance on NGOs for the BPHS delivery. Decreasing the scope of NGO geographic coverage could have potential drawbacks in terms of coverage. Over the long term a possible approach could be the move towards a safer strategy of mixed public and NGO provision.

6.2.2 Policy implications: does the “private for profit” sector matter?

Up to date little empirical work has been done on the volume and extent of services provided by the private for profit sector in Afghanistan but there is clearly an unregulated health care market, with all its problems and benefits. While the heterogeneity of private providers has been noted, many comments on their role appear to carry the implicit assumption that quality of care in this sector is likely to be lower than in the public sector. Nevertheless the limited knowledge about the behaviour and performance of private sector providers fails to enlighten enough on some of the basic issues. For instance the quality offered is a grey area and crucial information to assess the health impact in terms of quality and efficiency is seriously lacking.

The preliminary results of contracting with NGOs underscored the poor quality of care in public health services (MOH *et al.*, 2005a). Attempts to alter methods of working among staff at public health facilities have met with little success. As most health workers are engaged in private practices that can take place during working hours, the accepted proliferation of this dual system is a potential threat to the contracting efforts.

Until now the Government, donors and NGOs hardly caught with this reality but the evidence from the contracting experience in Cambodia calls for a clear separation between public and private interests in order to improve quality and to monitor the prices for health services (Soeters and Griffiths, 2003).

6.2.3 Ensuring access to health care for all

The next challenge for the MOH has come with filling the gaps in BPHS coverage. While public health services are gradually becoming more available to the general population, it remains to be seen whether the patterns of health service utilisation will follow an increased trend, especially with the introduction of user fees.

According to geographical location and socio-economic status, wide disparities of health service utilisation do exist in Afghanistan (MOH *et al.*, 2005b). Current resources for the BPHS are expected to increase the use of primary services but may have little impact on household exposure to financial risk through illness. One possibility is that the government finances subsidised community insurance and an earmarked budget aimed at assisting the poor in their access to health care.

6.2.4 Increasing the overall level of resources

The establishment of contracts between NGOs and MOH, is a major change in the way the health system functions. However, even if the system becomes well-established, one fundamental problem is its sustainability. To date, the need to maintain what has been achieved and to develop different health financing alternatives are key concerns for Afghan decision-makers.

In the light of actual expenditure, the cost for the BPHS delivery has been estimated at about \$3.50 per capita per year. This estimation may look low in relation to MDGs and is not in line with recent studies that have approached this issue. For example cost estimates by Evans *et al.* (2001) suggest that the coverage of basic interventions require around \$80 per person per year in Purchasing-Power-Parity-adjusted dollars (PPP). Using WHO estimates, each \$1 of expenditure in a low-income country is equal to about \$2 to \$3 on a PPP-adjusted basis, which entails an annual spending of around \$33 to \$40 per person. For the least-developed

countries, the report of the Commission on Macroeconomics and Health (2001) has estimated a spending on the order of \$36 per person per year.

Increasing public health spending from 0.8% to 1.5% of GDP as in other low-income countries and introducing a cost recovery system are unlikely to be sufficient to pay for the level of basic and hospital services currently estimated, on an annual basis, at \$140 million. While there is optimism that community health fund (CHF) and user fees will broaden the resources for the health sector, little is known on individual's and household's willingness to pay for health services. In addition, the potential negative effects, in light of widespread poverty, cannot be overlooked. Finding a balance between efficiency and equity will represent a challenge, with careful attention to the capacity of communities to pay for health care and to pro-poor policy and strategies.

7 Conclusions

The unfavourable environment prevailing in Afghanistan required an adaptation of donor and MOH strategies. Apart from diverting assistance from the public sector to non-governmental providers, the options were fairly limited. The contracting approach for BPHS delivery had thus considerable appeal, even though the evidence for success in post-conflict countries is still limited.

Despite the doubts first raised on the potential for contracting in the Afghan context, preliminary findings suggest that PPAs and the dynamism they brought into the BPHS implementation are promising. The MOH is now trying to remove certain bottlenecks, such as efforts to bring contracting closer to remote areas and to PHDs. With appropriate support and regulatory framework, NGOs may be able to maintain accessibility and efficiency in service provision.

The significant advances made by PPA can be seen as major opportunities to bring health policies closer to people's needs but should not result in an overly optimistic and sometimes euphoric view. Simply expanding services may be insufficient for appropriate utilisation and there should be a growing recognition of the need to be more sensitive to the local realities of health care seeking behaviour and private for profit sector.

The PPA tool is still new, and its ultimate impact is as yet unknown. This requires major research efforts to gather relevant data in a systematic manner over time to evaluate the efficiency, quality and equity of the health system. More detailed analysis, based on evidence from internal evaluations and surveys of patients and facilities, are underway.

In the future emerging evidence from quantitative and qualitative studies will be important in order to understand:

- Which model or combinations of models for health care delivery is appropriate;
- What works better in a post-conflict environment of limited resources;
- What is the best mix of health providers;
- How NGOs can be used for service delivery and what is the trade-off with building MOH capacity;
- What mechanisms can be used to ensure a balance between efficiency and equity.

In addition, as the situation has moved fast since the contracting approach was first presented, the review suggests the need to move the agenda a step further into questioning the issue of sustainability. There are efforts to mobilise the local out-of-pocket health resources. These efforts have yet to bear fruits but long-term sustainable development will definitely require continued commitment and lasting international support to the ambitious reform agenda.

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Annexe 1: Different donors approaches

Key features	IDA/WB	USAID/MSH	EC
Project name and duration	Afghanistan AHEAD 29 – 36 months	Rural Expansion of Afghanistan's Community Based Health Care (REACH) 26 – 30 months	Support to Health Service Delivery in Afghanistan 21 – 30 months
Project Design	Influenced by the contracting out model in Cambodia	Influenced by USAID/MSH performance-based payment in Haiti	
Who is the purchaser?	Funding from MOF special bank account->GCMU -> NGOs	Funding from contracting with MSH who then sub-contracts to NGOs	Funding from the EC to NGOs
Who is the provider?	9 grants/7 NGOs and MOH	25 grants/19 NGOs with preference given to national NGOs	7 grants/7 NGOs
Financial scope	Fixed lump sum with 100% budget flexibility Contract with financial bonuses up of up to 10% for meeting predetermined targets	Fixed budget (input-based) Grant	Fixed budget (input-based) Grant
Level of commitments	\$ 1,469,090 – 8,384,143	\$ 342,721 – 5,328,861	\$ 4,341,840 – 1,704, 289
Geographical scope	7 province-wide PPA 1 cluster-wide PPA 3 provinces PPA/MOH-SM	Cluster district approach in 13 provinces and single district	4 province-wide grants 6 clusters in 4 provinces
Scope of services	Entire BPHS	Not mandatory to include district hospital	Entire BPHS and construction of health facilities for some grants
Per capita cost (\$) ⁴	4.30	4.72	3.87
Monitoring/ Evaluation	2003 MICS as a baseline Nationally defined indicators GCMU monitoring visits Mid term review Third party assessments twice a year	NGOs household survey as a baseline USAID standard indicators or/and defined by NGOs and negotiated Quarterly review On site monitoring Posting MSH advisers at provincial level Third party assessments annually	NGOs defined their own indicators Based on logical framework Mid term and annual activity reports Third party assessments twice a year

Adapted from: Lesley, Wali, Sondorp (2005).

⁴ The variations in per capita costs can be explained by the mix of costs in relation to construction, drugs and sub-contracting for training.