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

HEALTH SECTOR REVIEW
IN AFGHANISTAN (2001-2006)

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Acronyms

ABD	Asian Development Bank
ACF	Action Contre la Faim
AKDN	Aga Khan Development Network
AHDS	Afghan Health and Development Services
ALNAP	Active Learning Network for Accountability and Performance in Humanitarian Action
AMI	Aide Médicale Internationale
ANHRA	Afghanistan National Health Resource Assessment
ARTF	Afghan Reconstruction Trust Fund
BPHS	Basic Package of Health Services
BHC	Basic Health Centre
BSC	Balanced Score Card
CAF	Care for Afghan Families
CB	Capacity Building
CDC	Centre for Communicable Disease Control
CGHN	Consultative Group for Health and Nutrition
CHC	Comprehensive Health Centre
CHF	Community Health fund
CHW	Community Health Worker
EC	European Commission
EPHS	Essential Package for Hospital Services
EPI	Expanded Programme on Immunisation
DFID	Department for International Development
GCMU	Grants and Contract Management Unit
GDP	Gross Domestic Product
HMTF	Hospital Management Task Force
HIMS	Health Information Management System
HNI	HealthNet International
HP	Health Post
HR	Human Resources
IARCSC	Independent Administrative Reform and Civil Service Commission
ICRC	International Committee of the Red Cross
IHS/IMEI	Intermediate Health Sciences/Intermediate Medical Education Institutes
IPD	In-Patient Department
IPRSP	Interim Poverty Reduction Strategy Paper
JDM	Joint Donor Mission
JICA	Japanese International Cooperation Strategy
LRRD	Linking Relief, Rehabilitation, Development
MDG	Millennium Development Goals
MDM	Médecins du Monde
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
MOF	Ministry of Finances
MOH	Ministry of Health Strengthening Magazine
MSH	Management Sciences for Health
N/A	Not Available
NGO	Non Government Organisation
NSP	Non State Provider
OPD	Out-Patient Department
PHC	Primary Health Care
PHD	Provincial Health Department

PPA	Performance-based Partnership Agreement
PRR	Priority Reform and Restructuring
REACH	Rural Expansion of Afghanistan's Community-based Healthcare
$	American Dollar
SCA	Swedish Committee for Afghanistan
TB	Tuberculosis
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation

Executive Summary

Health Context

Donors and the Ministry of Public Health (MOH) are undertaking ambitious health care reforms. Afghanistan's basic health indicators lagged significantly behind global averages and the urgency of addressing rural needs was underscored by the alarming rates of child and maternal mortality in a context of devastated infrastructure and limited human resources.

The analysis draws on a review of reports from earlier and recent studies, policy documents and surveys as well as from interviews with informants from Ministry of Health (MOH), donors, international and national NGOs and research institutes.

Main achievements

In a fast changing context, achieving health policy developments has meant prioritising the existing but limited resources against overwhelming needs. Following the relief phase, most health sector rehabilitation efforts are now focusing on restoring the systematic delivery of essential health services.

Expanding rural health services, as the most cost-effective strategy to address the inequities between the rural and urban areas, has been the main focus. As a key measure, the health system has evolved towards the purchaser and provider model. The MOH retains control of policy and planning, assuming a stewardship role, but does not actually provide services. Given the importance of NGOs in first contact care, the limited public health sector capacity and the need for rapid expansion of services, contracting or Performance-based Partnership Agreement (PPA) has been the main strategy for the implementation of a basic package of health services. The three major donors, the World Bank, the European Commission and USAID, have adopted a mix of province-wide and cluster approaches. The implementation is sub-contracted to international and national NGOs, which accounts for an estimated 90% of total health service delivery, and to the MOH for three provinces. Three research institutes are involved with monitoring, on-going evaluation and operational research.

Could PPA be a successful strategy in the Afghan context? Meaningful answers to this question can only be provided on a solid evidence-base established over time but the progress in expanding coverage has been swift. Whereas doubts in the past have been raised as to the nationwide applicability of contracting, to date an estimated 77% of the population has access to basic health services. In addition, preliminary results show that out-of-patients visits and antenatal services have increased threefold, from 4.6% to 31% respectively.

Contracting has forced the government to clearly specify outputs, not inputs, that they are willing to allocate public funding for. It also formalised aid coordination through the MOH's Grant and Contracts Management Unit (GCMU). This unit has been a driving force and is a model for an institutional framework for project coordination and coherence among different donors.

The MOH has also undergone progress through the administrative civil reform, which is slowly moving forward. The main objectives are to minimise the number of bureaucratic levels, downsize the number of civil servants and to pay high salaries to new qualified staff and those who remain. The assumption is that domestic revenues will cover the wage bill in 2010 and the operating budget in 2014.

Issues at stake

Maintaining the momentum. To continue with these achievements, expanding coverage to the remaining parts of the country, improving quality of care and implementing different health financing alternatives are the next targets. Although the role of NGOs has been threatened, it is difficult to see how current developments can be maintained without their involvement. For the NGOs under PPA, the decision to continue the provision of services will be based on their effectiveness and efficiency from ongoing evaluation. The future for NGOs outside contracting is uncertain, unless they get involved in specific programmes such as urban health.

Improving the quality of care. Despite the limited evidence on the utilisation of both public and private health services, the latter is widespread and unregulated. For instance many health workers have opened private pharmacies or clinics and are involved in some type of informal private activities. While the quality of care offered is a grey area, this unclear separation made between public and private interests is unlikely to be compatible with the development of a performing health system. Sooner or later, the MOH and other stakeholders will need to consider the relationships and interactions with private providers if quality of care is to be improved and catastrophic outcomes for patients avoided.

Broadening the focus to hospitals. The next challenge to come is to implement the essential package for provincial and regional hospitals which is receiving increasing attention from donors. The driver for including the hospitals as part of the health system is certainly the efforts to meet the Millennium Development Goals (MDGs). There is no definite strategy yet but two approaches will be given priority over the next year: contracting with NGOs in five provincial hospitals with support from USAID and; MOH implementation in five provincial hospitals through Government funding.

The question of hospital reform is a political high risk zone with the health bureaucracy and medical profession opposed to change, especially for downsizing the hospital capacity. Big urban areas, such as Kabul, have a high concentration of inpatient facilities with duplicated functions. In general, hospitals are ineffectively distributed and organised which means that their potential positive impact on health is reduced. The average occupancy rate below 50% in provincial and regional hospitals suggests a lack of connectedness between services and communities; and more evidence is growing on the fact that the poor have difficulties in accessing hospital services. Another concern is uncontrolled growth, as building new infrastructure would imply a significant increase in recurrent expenditure for the future, far exceeding Afghanistan's financial capabilities and threatening sustainability.

Perspectives for financing health care. In the longer term, public funding for health will depend upon growth and expansion of a sound and sustainable fiscal policy against the pressures for new programmes including the ambitious administrative reform. Afghan health policy makers are increasingly interested in finding out whether user fees and community-health fund can contribute in a sustainable way towards adding new sources of revenues in the health system. Even though Afghanistan introduces a cost recovery system, it is by no means sufficient to pay for the level of basic and hospital services estimated, on an annual basis, at $140 million. Clearly the international community has a critical role to play in supporting the MOH to effectively implement health policies over the long term and to build more expertise in understanding household ability and willingness to pay for health care and in health care financing

Access to health care for all. The impact of user fees for the poor, in a context of widespread poverty and ineffective exemption schemes, remains an issue of considerable concern, especially in relation to hospital services. Whereas the issue of exempting the poor is not dealt with explicitly as a central element of the policy programme, the forthcoming

Interim Poverty Reduction Strategy Paper (IPRSP) should provide a stronger commitment so that equity is not ignored politically.

1. INTRODUCTION

The past four years have brought enormous political and socio-economic changes in Afghanistan. The health sector has not been spared the effects of transition and the country has engaged to varying degrees in health system reconstruction. In addition to the marked deterioration of the health of its citizens, the health system in Afghanistan had to respond to a variety of challenges, including the lack of qualified human resources and female staff.

This document aims to present an overview of the health sector, with special attention to the issues considered critical to its reconstruction. Successes, opportunities and constraints are discussed so as to provide a forum for learning lessons within the context of Linking Relief Rehabilitation and Development (LRRD).

This work is part of the two-year LRRD project funded by the European Commission (EC). The project has three main objectives:

- Learning and sharing lessons through iterative multi-sector evaluations;
- Increasing knowledge and experience by carrying out applied research on key issues as identified during the lesson learning process;
- Contributing to the capacity building efforts of relevant ministries and national NGOs.

The health sector review took place in Kabul in October 2005 over a two-week period. For analysis purposes, relevant information was collected through key publications and documents and in-depth interviews with key informants (Annexe 1a and 1b). The latter were carried out with different stakeholders, including senior officials of the MOH, donors, research institutes, and international and national NGOs. Given the speed at which the health sector is evolving, this review is necessarily work in progress.

Some of the initiatives under discussion are being addressed by well-known research institutes. In particular the two-year qualitative research project, carried out by the London School of Hygiene and Tropical Medicine (LSHTM), is monitoring the implementation of the basic package of health services (BPHS) through the contracting approach.

The review is divided into four sections:

- Background information
- Key developments and successes
- The MOH achievements
- Discussion on the issues at stake

2. COUNTRY BACKGROUND

2.1. THE HEALTH SECTOR OVER THE PAST DECADES: A HISTORICAL OVERVIEW

Historical events have had a significant impact on the health sector that is emerging in present-day Afghanistan. Prior to the Soviet invasion, a large hospital sub-sector and services oriented towards disease control programmes, such as malaria, leishmaniasis, tuberculosis and smallpox predominated. Most of the rural areas were left uncovered (Rubin, 2002).

Years of conflict from the Soviet invasion to the fall of the *Taliban* have defined the key actors and shaped their political culture. During the Soviet occupation, the MOH in Kabul incorporated some elements of the Soviet model of health care delivery, such as strengthening the urban hospital network and training clinical practitioners. At the same time, many cross-border operations, financed by external assistance and NGOs, were implemented, relying on a variety of community health workers (CHWs) and volunteers.

After the withdrawal of the Soviets, the ensuing civil war among hostile factions led to the destruction of physical and administrative infrastructure and to the worsening of health statistics. Health care activities became almost totally dependent on NGOs for necessary resources. Under the *Taliban* rulers, the delivery of health care was significantly reduced. Only a few international and national NGOs played a crucial role as the main providers of primary and secondary health facilities and represented for many Afghans their only access to health care.

As highlighted in Box 1, following the *Taliban*'s fall in 2001 the challenges for health policy developments in Afghanistan were considerable.

Box 1: Key features of Afghan health sector, September 2001

Heavy reliance on external assistance
Lack of direction and long history of ad hoc decisions
Fragmentation across country and along vertical lines
Bias towards cities
Health network in poor shape
Distorted workforce
Poor quality of care
Unregulated private providers
Dispersion of power
Multitude of actors with multiple and divergent interests

The first priority had been to rehabilitate Afghanistan's devastated health system. Although basic packages are promising, each post-conflict country has its peculiarities and a quick fix solution to health system reconstruction is easier said than done. According to Hanson *et al* (2003), more robust evidence is required regarding ways of organising, delivering and paying for effective and equitable health services in post-conflict settings.

2.2. MAIN HEALTH PROBLEMS

Data available in the past years suggest that Afghanistan has amongst the worst health indicators in the world. Compared with neighbouring countries, health indicators are three to fivefold higher (Table 1).

Table 1: Key indicators compared to neighbouring countries

Indicators	Afghanistan	Pakistan	Iran	China	Tajikistan
Population (millions)	29.9	152.1	66.9	1,296.5	6.2
GDP per capita (PPA) ($)	800	2,200	7,700	5,600	1,100
% of population living below $1 a day (1992 – 2002)	N/A	13	2	17	10
Life expectancy	43	61	70	71	69
Infant mortality rate (death/1,000 live births)	165	81	33	30	92
Maternal Mortality Ratio (death/100,000 live births) adjusted	1,900	500	76	56	100
Crude death rate/1,000	22	10	5.0	7.0	10
Total Fertility Rate	6.8	5.0	2.3	1.8	3

Source: World Bank, 2005; UNICEF 2005

Until recently available figures, as wild guesses, were to be treated with extreme caution. However, since 2002, a series of surveys have provided more reliable information on key health indicators (Table 2).

Table 2: Some key indicators (national, urban, rural)

Indicators	**National**	**Urban**	**Rural**
Last Delivery of Mother Assisted by untrained Persons (last two years) (%)	86	65	93
Advice/Service not taken from Doctor/Trained TBA during Pregnancy (%)	84	62	92
% of children 12-23 months that have not received DPT 3 immunization	70	52	77
Diarrhoea Prevalence in last than 15 Days (<5 years children) (%)	30	30	30
ARI prevalence last 15 days (<5 years children) (%)	19	19	19
Advice or treatment not sought from hospital/HC during ARI (<5 years children) (%)	72	68	73
Infant mortality rate (per 1,000 live birth)	115	97	121
Under five mortality rate (per 1,000 live birth)	172	142	183
Fertility rate among 15-49 yrs women	6	6	6

Source: UNICEF Multiple Indicator Cluster Survey (MICS) (2003)

The Multiple Indicator Cluster Survey (MICS) highlights the inequalities between urban and rural areas. These differentials are sharper for maternal and child care. For instance in Badakshan province, the under five mortality rate stands at 323 per 1,000 live births, i.e. two times higher than in urban locations. Afghan women are more vulnerable to poor health due to the heavy burden of childbearing and severe constraints in seeking health care.

The adjusted maternal mortality ratio, estimated at 1,900 per 100,000 live births, highlights the burden of illness for women and follows a similar pattern: the more remote the area, the more likely women are to die in delivery. The epidemiological profile is dominated by communicable diseases (diarrhoea, acute respiratory infections among children) and malaria. Tuberculosis (TB) among adults accounts for an estimated 15,000 deaths per year. Cutaneous leishmaniasis, particularly severe in Kabul, is endemic and carries a high burden of social stigma. Available data point to high rates of chronic malnutrition: an estimated 54% of children 6-59 months of age are stunted. Moderate and severe iodine deficiency is also a public health concern.

3. LEARNING FROM SUCCESS

3.1. FROM NOVEMBER 2001 TO DECEMBER 2003: KEY HEALTH POLICY DEVELOPMENTS

Since the all of the *Taliban*, the health sector has undergone a series of major achievements. In their comprehensive report, Strong, Wali and Sondorp (2005) differentiate between three periods: *"(i) the early days; (ii) the MOH in the driver's seat and; (iii) the expansion of the basic health package"* (Table 3).

Table 3: Summary of the major events in the health sector, November 2001 - December 2003

Period	Identified priorities	Key achievements
(i) November 2001- May 2002: • Islamabad conference • First Joint Donor Meeting (JDM) co-chaired by the World Bank and WHO	• Setting the agenda • Policy formulation • National Development Framework	• National Health Policy (WHO) • Interim Health Strategy • BPHS Draft
(ii) June 2002 – March 2003 • Second JDM	• Development of an Interim Health Strategy • Third World Bank pre-appraisal mission in conjunction with DFID and MSH • Developments in health coordination • Developments in assessments and studies • Infrastructure development	• BPHS's final document • Final Interim Health Strategy document, including revised MOH organizational structure • Establishment of the GCMU (March 2003) • Establishment of the Consultative Group for Health and Nutrition (CGHN), six management task forces and twelve general task forces • UNICEF/CDC Maternal Mortality Study • Afghanistan National Health Resources Assessment (ANHRA) • BPHS Costing Study
(iii) April- December 2003 • Third JDM	• Negotiation over approaches to contracting implementation procedures (province versus cluster) • Geographical assignment to donors • Competitive bidding process • Creation of the IARCSC	• National Salary Policy • Recommended Human Resource Development Policy • Reproductive Health Strategy • Starting with contracting • Starting with PRR process

Adapted from: Strong L., Wali A., Sondorp E., Health policy in Afghanistan: two years of rapid change, LSHTM, 2005.

The concept of a basic package to be made universally available to all Afghans was first developed in order to determine which type of services should be delivered and by what mix of vertical and/or horizontal delivery. Indeed the rapidly changing environment required policies to address the most urgent health needs while taking into account the need to rebuild health delivery systems in the longer term. The developments outlined above reflect the recent trend in early post-conflict situations whereby greater emphasis has been placed on establishing a strategic framework and policies for the health sector. This model of health

policy formulation, developed in Kosovo and Timor-Leste, has shown benefits (Shuey *et al.*, 2002), (Tulloch *et al.*, 2003).

3.2. FROM JANUARY 2004 ONWARDS: TRANSLATING POLICIES INTO PRACTICE

3.2.1. The Main BPHS characteristics

The BPHS has several objectives:

- To improve the health care of Afghan people
- To improve equity in geographical and financial access to health services

Box 2: BPHS components

Maternal and newborn health: Antenatal, delivery and postpartum care; family planning; care of the newborn.
Child health and Immunization: EPI (routine/outreach); integrated management of childhood illness; promotion of exclusive breast-feeding for the first 6 months.
Public nutrition: Micronutrient supplementation; treatment of clinical malnutrition.
Communicable diseases: Control of TB and malaria.
Mental health: Community management of mental problems; health facility-based treatment for OPD and IPD.
Disability: Physiotherapy integrated in PHC services. Orthopaedic services expanded to hospitals.
Supply of Essential Drugs.

Source: Transitional Islamic Government of Afghanistan, Ministry of Health., A basic package of health services for Afghanistan. Kabul: Ministry of Health, March 2003/1382

The BPHS consists of four layers:

- A 50-bed first referral hospital or district hospital (100,000-300,000 inhabitants);
- A Comprehensive Health Centre (CHC) (30,000-60,000 population);
- A Basic Health Centre (BHC) (15,000-30,000 population);
- A Health Post (HP) (1,000-1,500 inhabitants).

Although deemed ambitious, the formulation of the package laid out a framework for all stakeholders and forced them to think through the requirements in terms of health facilities, health staff, equipment and supplies, as well as other system issues.

The costing study estimated that BPHS costs would reach a $4.55 per capita per year. Given the fact that the cost of providing the same services varies widely across Afghanistan, establishing a single cost per capita for the whole country has been criticised as running counter to the principle of equity. Nevertheless, despite the limited reliable data, the exercise offered a basis for planning and establishing the financial requirements for contracts and grants.

The basic package is currently under revision and will redefine the CHW status and role in the overall health system. As the evidence on the cost-effectiveness of community mental health activities is still being questioned, there are strong arguments against incorporating them into the BPHS.

3.2.2 Contracting into perspective: recent trends in health service organisation

The second question concerned who should provide health services and the choice of an implementation strategy as contracting. In Afghanistan, poor communication and limited expertise in this mechanism resulted in an ideological debate, with contracting viewed by some actors as an imposed privatisation of health services. While equating this mechanism as synonymous with privatisation is too narrow a vision, contracting needs to be placed in the historical context of health system evolution.

In developing countries, the emergence of contracting as a tool to improve health system performance is reflected in various changes in health service delivery (Table 4).

Table 4: The evolution of health service organisation in developing countries

Period	Organisation	Key features	Implications
1970 – 1980	Public system Private for profit and non for profit system	Central state enacts laws, regulations Central state finances, runs health facilities and delivers free health care Runs in parallel of public health services and operates independently	The two health system operate in parallel with virtually no coordination
1980 – 1990	Public system Private for profit and non for profit system	Financial crisis and health reforms Introduction of user fees The State encourages the expansion of private provision NGO expansion Development of private practices and private clinics	Fragmented health services
1990 – up to date	Public system Private for profit and non for profit system	Decentralisation Separation of roles between health service provision, health financing, regulation and management Introduction of risk pooling mechanisms The number of actors in private sector development increases	Authority is devolved to provincial and district levels. Greater autonomy given to hospitals Increased participation of populations and local authorities

Source: Perrot J., 2004, The role of contracting in improving health system performance. Discussion Paper, No 1, World Health Organisation, Geneva

Looking at this 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.

While a contractual arrangement can take various forms, Perrot (2004) defines it as "a *voluntary alliance between independent partners who accept reciprocal duties and obligations and who each expect to benefit from their relationship".*

If we use to this definition, privatisation which entails *stricto sensu* a transfer of ownership of structures to the private sector cannot be equated to the above definition of contracting. Within a broader outlook, however, privatisation encompasses the implementation of a management model that is based on market regulation. The shift from the traditional form of assistance towards a more business-oriented approach blurred the picture of contracting in Afghanistan and was directly connected to privatisation (MDM, 2004). As a consequence, a few NGOs, such as MSF, MDM and ICRC, opted out of the process because contracting

objectives supported by the donors were perceived as being incompatible with NGO principles of neutrality and independence.

3.2.2. Contracting to kick start expansion of rural health services

Urged with addressing rapidly the direct and indirect effects of war on health and health system, speeding up the policy process was unavoidable. The first JDM identified three alternatives for health services delivery:

- To build the MOH capacity to provide health care;
- To continue with the existing system of activities developed by international NGOs and UN agencies in an ad-hoc way, based on what they perceive as needs;
- To build the MOH strategic capacity and to use the existing NGO network for health service delivery through PPAs.

Under the PPA model, the state continues to set policies and regulate provision, while purchasing health services via contracts with non-state providers (NSPs), such as NGOs. This option was strongly advocated in the view of the following: (i) NGOs operated an estimated 80% of health facilities; (ii) the MOH lacked the capacity to provide a comprehensive scope of services and; (iii) contracting remained the most immediate step for expanding coverage of health services.

The MOH has been extremely open to new ideas and concepts. Some observers argued that they were left with little choice, but for senior health officials pragmatism prevailed at that time. Nonetheless they managed to have their positions taken into account through the direct delivery of health services in three provinces, known to date as the MOH-Strengthening Mechanism (SM).

Basically, the type of contractual relationship adopted in Afghanistan involves the following:

- **Contracting in:** The central MOH contracts with a lower level of Government health facility and there are no major changes in the management structure. Salaries are paid from the government budget via the Afghanistan Reconstruction Trust Fund (ARTF) contribution[1]. Other expenditure is covered using World Bank (WB) funding. The MOH-PPA/SM is currently implemented in three provinces (Kapisa, Pansjeer and Parwan);
- **Contracting out:** Following a competitive bidding process, NGOs are awarded a contract to deliver health services in exchange of payment, which covers salaries, recurrent costs, drugs and consumable medical supplies. The NGO has freedom for service delivery and staffing patterns but is bound by contract to achieve targets.

From the early stages, the WB has been decisive in promoting the PPA approach. On the one hand, the model has been used in Cambodia, where research shows that districts using 'contracts' consistently outperform control districts on a range of indicators including health service coverage, increase in the use of reproductive health services, and immunisation rates. Moreover, these districts provide more than proportionate benefits to the poor (Keller and Schwartz, 2001), (Soeters and Griffiths, 2003). On the other hand, WB proactive individuals were certainly influential in leading the whole process and in shaping the direction of health sector's reconstruction. Surprisingly, the World Health Organisation (WHO) had limited involvement in the process and continues to remain, to date, virtually absent from policy-making discussions.

In the early days the approach has generated heated debates and discussion. Firstly, contracting was an unfamiliar and poorly understood concept for most stakeholders, except

[1] The ARTF, established in 2002, is a coordinated funding mechanism for expenditure related to recurrent costs, investment activities and programmes and salaries for Afghans returning from abroad. The fund is managed by a committee led by the WB.

for maybe the WB, USAID/MSH and a few others. Secondly, there was little comprehensive reporting on contracting or existing evidence of its impact in post-conflict countries. In particular, concerns were voiced on the risk of imported blue prints to the Afghan context which at this time was characterised by weakened state structures, fragmented civil society and prevailing insecurity. Thirdly, the high geographical disparity throughout the country was seen as another constraint to the expansion of services.

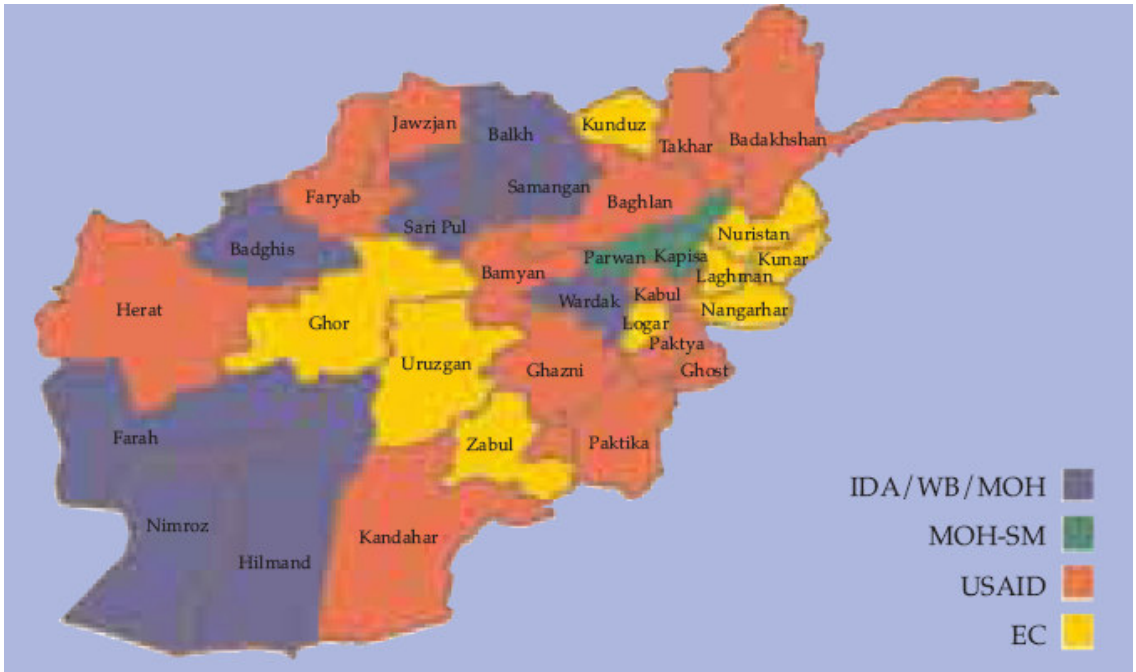
For international NGOs, the lack of communication on PPAs added to the frustration and misunderstandings. As contracting was new to almost all of them, few were aware what it implied to move beyond classic small-scale projects to implementation linked to performance. Undoubtedly, the funding opportunities offered by contracting were attractive to both international and national NGOs.

To date, BPHS implementation is underway and the debate has calmed down. Admittedly remarkable progress in relation to coverage has been accomplished: according to the most recent estimations, 77% of the population has now access to basic health services (The Lancet, 2005). In addition, preliminary results show that the OPD visits and antenatal services have increased threefold, from 4.6% to 31% respectively. One of the key MOH and donor priorities is now to address service delivery backlogs that still persist, a significant challenge given the remoteness of these areas and the ongoing insecurity.

3.2.4 Distribution of funds: a mix of province-wide and cluster approaches

Coordination of external resources has become central for the expansion of the BPHS. The distribution of resources through contracting has certainly helped to address, in a way, the existing fragmentation. Until 2002, the health sector was composed of multiple activities, implemented by central and local health authorities, donors, international agencies and NGOs. Additionally, the proliferation of vertical programmes has compounded the prevailing fragmentation. In order to coordinate the distribution of resources, the WB, USAID, the EC and to a lesser extend ADB, all primarily channelling funding for primary health care provision, agreed to geographical assignments (Figure 1).

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



Source: MOH presentation 2004

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

The geographical distribution of funds has been based on two models: province-wide and cluster of districts. Table 5 outlines the main features of each model.

Table 5: Different donor 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 to GCMU and then to 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 to 10%	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 ($)[2]	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).

3.3. DIFFERENT MODELS FOR CONTRACTING: PROS AND CONS

The potential advantages and disadvantages of the different models, are outlined in several documents (Lesley, Wali and Sondorp, 2005), (World Bank, 2005), and summarised in Table 6.

[2] The variations in per capita costs can be explained by the different costs in relation to construction, drugs and sub-contracting for training.

Table 6: 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 requires strong NGO capacity No safety net if the NGO is dismissed 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	Up to 4 NGOs can deliver health services in one province without necessarily coordinating: risk of fragmentation High administrative costs Scope of services do 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 Focus on the construction of health facilities Less accountability compared to WB and USAID but programmatic change towards PPA is foreseen in the near future

Adapted from: Lesley, Wali, Sondorp (2005)

The capacity-building process through micro-management as emphasised by current USAID-REACH grants seems to be highly valued, with USAID technical assistants supporting national NGOs. The downside effects are relatively high administrative costs, estimated at $23 million over three years as opposed to the $1.5 million cost for the WB grants.

With the EC phased approach, the current grants are not performance-based. Nevertheless, NGOs have now adhered to national indicators and are gradually being included in nationwide monitoring through the GCMU. In the future, the EC approach will evolve to include more elements of the PPA model as adopted by the WB and USAID.

3.4. ROLE OF RESEARCH INSTITUTES IN MONITORING AND EVALUATION

3.4.1. The Johns Hopkins University (JHU)

The Johns Hopkins University (JHU) has been awarded a grant to set up a national evaluation system to monitor and assess the BPHS performance. The three-year, $3.9 million grant from the WB, commenced in April 2004.

The JHU team, in collaboration with researchers from the Indian Institute of Health Management Research (IIHMR) plays the third party role. The evaluation system independently measures the progress of both NGOs and MOH-SM provinces through a balanced scorecard (cf. Section 5.2). They are also involved in the development of a system to finance Afghanistan's healthcare in the future. The health financing pilot project will be tested in eleven provinces under PPA (cf. Section 5.3.4).

3.4.2. The London School of Hygiene and Tropical Medicine

While the JHU is more oriented towards collecting quantitative data, the LSHTM is carrying out a two-year comprehensive qualitative research project. A first report outlining health

policy developments between 2001 and 2003 has been produced (Strong, Wali, Sondorp, 2005). A series of eight case studies will add to the evidence base on contracting in post-conflict contexts. A conference presenting key findings will be held both in Brussels and Kabul in February/March 2006.

4. THE MOH: CONSIDERABLE PROGRESS HAS BEEN MADE

4.1. THE SHIFT FROM PROVIDER TO PURCHASER

From the outset, MOH leadership has embraced the reforms wholeheartedly. Considered as one of the most pro-active and open-minded ministries, it first concentrated its efforts on enhancing the cost-effective purchasing of services through the separation of purchaser and provider functions, employing contracts as the main tool for resource allocation. The rationale for this split was that contracting with NGOs to deliver an agreed-upon package of services would create a new relationship whereby the MOH would be able to focus on management, policy and financing mechanisms. As a result the MOH has been reorganised in order to reflect its new role.

Introducing a purchaser-provider split model is admittedly a major change given the historical tradition of Afghan state provision. It is difficult to assess whether it will continue over the long term or be subject to change. On the one hand the potential problem associated with the split is that, instead of reasserting the authority and legitimacy of central MOH, the MOH is increasingly perceived as a very distant government entity.

The confusion created by this distinct role at provincial and district levels has already been well documented (Evans *et al.,* 2004). Anecdotal evidence suggests that this situation is still prevailing. For instance, the Provincial Health Departments (PHDs) have difficulties in understanding exactly what stewardship means, even though induction courses have been provided. The tension is higher in provinces where the PPA-NGO manages the provincial hospital as a first line referral hospital.

On the other hand, the PPA strategy is not universally shared at central level. Part of the MOH leadership would prefer to build a big public health sector, directly involved in service delivery at all levels. Following Hamid Karzai's election, new MOH senior officials have been appointed, many of whom previously worked for the WHO. MOH departments at the central level have been reorganised recently (Annexe 2). The new structure emerging from this process has indeed grown in size, from two General Directorates and one liaison office to five General Directorates and five departments. The implication for final MOH staffing patterns are not clear yet but with the proliferation of departments that has taken place, high staffing patterns are likely to threaten the sustainability of the MOH wage bill. This is a key concern, especially in Kabul. Based on estimations from the MOH Human Resource (HR) department, 41% of payroll includes staff posted in Kabul[3]. Out of the 1,200 staff working at central MOH, 6,800 are supposedly distributed over the hospitals and public clinics in the city (Personnel communication, 2005).

Moreover, the MOH strategy for 2005-2009 does not clearly mirror the purchaser/provider split. Some statements in the document suggest that the MOH would like to get more directly involved in health service delivery. The main reasons given are as follows:

- Decrease in external funds for contracting with NGOs;
- Return of many hospitals to direct Ministry control;
- Increased expectations in the population for access, quality and range of services;
- Increased private medical services in urban areas.

[3] The MOH workforce is estimated at 19,000, of whom 8,000 are based in Kabul (1,200 at MOH and 6,800 at hospitals and public clinics).

The GCMU, under IDA/WB funding, oversees all donor funds for the Health Sector. Fourteen consultants play a critical role in linking health policies to local needs and contributing to the MOH stewardship. The GCMU manages approximately $66 million, of which $49 million relates to the BPHS delivery with support from the WB office in Kabul and the task manager in Washington. The unit has been able to disburse WB funds fast and most key informants confirm that it is performing well. The possibility of pooling all donor funding for the BPHS through the GCMU is also under discussion.

In the past the GCMU has been perceived as *"a Ministry within the Ministry*" and later, with the new MOH leadership, has been relegated to a secretarial function. While senior MOH officials are in agreement that the unit functions effectively, a major issue is how to shift from a system with highly qualified national consultants to a more institutionalised department.

Three alternatives are being explored:

- To continue with the existing system;
- To continue with the current system but to change the status of the national consultants with a funding linked to the PRR process;
- To mainstream the national consultants through the PRR process.

4.2. THE PRR PROCESS

Reform of the civil service is slowly moving forward. A main pillar is the Priority Reform and Restructuring (PRR) program, which enables government departments to transfer or appoint senior civil servants based on merit. The Independent Administrative Reform and Civil Service Commission (IARCSC) is formally responsible for facilitating this organisational reform linked to performance-based salary supplementation. The main objectives of the reform are to minimise the number of bureaucratic levels, downsize the number of civil servants and pay high salaries to new qualified staff and those who remain to carry out the key tasks. The higher pay scale for a fixed term is meant to attract highly qualified staff from outside government and prevent staff from taking up positions with the UN or NGOs. Because staff in the middle grades feel they are also entitled to higher salaries, the MOH has recently submitted a proposal to the IARCSC in order to extend the PRR process to other levels within the public administration.

Key PRR principles are outlined in Box 3 below.

Box 3: PRR principles

- The Government structures will shift to a lean and responsive public administration;
- The positions are advertised and open to non-civil service persons too;
- It is a merit-based recruitment performed in a transparent way;
- In addition to the current salary (an average $40 per month)., the post holder will be entitled an 'interim additional allowance';
- In case of unsatisfactory performance, the post holder will go back to the original salary and benefits.

In the new Interim Additional Allowance Scale, there are seven levels ranging from 'U-Unchanged-existing salary and allowances' to 'A', a post with a maximum of $245 per month. For exceptional positions, the salary can reach up to $500-600 per month but the current job market for similar positions is estimated at $1,000 per month. Support staff, including drivers, cleaners and cooks are not eligible to PRR and fall under the 'U' category. The initial target for 2004 was 30,000 civil servants. By December 2004, 8,017 positions had been transferred to the PRR scales. To date 1,100 MOH staff have been "PRR'ed" under ARTF resources. The IARCSC is also responsible for the recruitment of PHDs.

National medical staff under contracting are paid directly by NGOs and therefore not included in the PRR process. The three MOH-SM provinces are now under the new MOH salary scale, which includes a rural hardship component. Health facilities have been graded from 'grade 1' (no hardship) to 'grade 4' (extreme hardship). A MOH midwife in a grade 4 BHC will be paid $469/month as opposed to a grade 1 midwife receiving $157/month. Female medical staff, such as nurses, midwives, doctors and gynaecologists, will receive a twofold hardship allowance compared to their male colleagues ($469/month versus $254/month). Whether the process will succeed in streamlining key ministries so that they become more efficient remains to be seen. The process has been criticised for lacking transparency and adding confusion between who is really an MOH employee and who is not. Including large numbers of health staff in "PRR'ed" introduces the issue of sustainability too. The assumption is that domestic revenues will cover the wage bill in 2010 and the operating budget in 2014, but such expectations may be over-optimistic.

4.3. INSTITUTIONAL DEVELOPMENT AND CAPACITY-BUILDING

Institutional Development is one of the top National Health Policy Priorities for 2005-2009 (MOH, 2005).
The main achievements are listed below:

- Eighteen consultants from different MOH departments coached;
- Technical Roundtable sessions;
- Distance learning postgraduate degrees;
- Overseas short courses, workshops and conferences;
- WB Flagship course;
- Participation of the GCMU consultants to PRR;
- Use of the Balanced Score Card (BSC) tool for monitoring and evaluation.

A first capacity building (CB) plan for the MOH Administration was finalised in May 2004. The plan outlines key competencies for the different categories of public health administration staff and includes a costing table. Progress in implementation has been slower than expected due to demanding PRR process and limited technical assistance. To date, the plan, outdated due to the new MOH changes in staffing patterns, is being revised.

One international consultant, under EC funding, has been appointed to capacity build the Provincial Health Liaison Office and the PHDs. Because the latter are still not clear with the stewardship role, an induction course for appointed PRR'ed-PHDs has been planned. In addition contracted NGOs have been entrusted with staff capacity-building but there are mixed results, mainly due to time constraints and in some instances, poor NGO management capacity. One key issue is how the PHDs will be able to apply their new skills in their daily work, especially with limited operational support.

5. ISSUES AT STAKE IN TODAY AFGHAN HEALTH SECTOR

5.1. ENSURING THE CONTINUUM OF CARE

Over the past years, the trend has been to emphasise health facilities in underserved and rural areas where the majority of poor households live. Hospitals in urban centres, well-known for consuming a disproportionate part of the overall resources available, failed to attract the attention they deserved until recently. In particular, concerns have evolved around the uncontrolled growth of public hospitals and the burden placed upon meeting their recurrent costs[4] within the context of severe budget constraints.

Policy-makers have come to realise that it will be difficult for a health system to work without linking basic activities to hospital key functions. In addition, the Millennium Development

[4] Estimated at 30-40% of the capital investment per year.

Goals (MDGs) in relation to infant and maternal mortality are unlikely to be achieved in the absence of a proper referral system.

Another critical issue is that urban centres in Afghanistan, such as Kabul and Mazar-I-Sharif, are affected by increasing poverty, vulnerability, environmental and health risks (Beall and Esser, 2005). The strengthening of urban health system is therefore an important challenge, and a crucial element in the efforts against poverty, underdevelopment and political instability.

5.1.1. What hospital services should be offered?

Improving the hospital system in Afghanistan is a substantial undertaking. The National Hospital Assessment has identified five issues related to the existing hospital system in Afghanistan (2005c):

- Poor distribution of hospitals and hospital beds throughout the country;
- Lack of standards for clinical patient care;
- Lack of hospital management skills for daily running of hospitals;
- Hospital system is fragmented and uncoordinated and hospitals are not part of the health system;
- Financial resources for hospitals and sustainability.

Other assessments indicate that provincial hospitals are inefficient with low utilisation rates, excess beds and too many staff. For instance, Kabul has a totally unregulated and high concentration of inpatients with duplicated functions and recommendations have been made to downsize, consolidate and close down several facilities (Crémieux *et al.*, 2002).

According to Csaszar Goutchkoff *et al*, (2003), hospitals are administrative units rather than managerial units with full accountability. Low wages in the health care sector, coupled with the absence of mechanisms to link remuneration to results, led to the proliferation of informal out-of-pocket payments. In this system where consumers have little say and where quality of care is a major concern, hospitals have a bad reputation.

Based on these findings, the Hospital Management Task Force (HMTF), led by the MOH and USAID-REACH, worked on the content of an Essential Package for Hospital Services (EPHS) within the National Hospital Policy framework, whereby policy makers have agreed upon three layers of hospitals. To date the EPHS has been finalised and recently endorsed by the MOH Executive Board. Its outlines what services should be available (Box 4).

Box 4: Different hospital layers

District hospital
30-75 beds, serving population of 100,000-300,000 in 1-4 districts
Providing basic surgery, medicine, obstetrics and gynaecology, paediatrics, mental health, dentistry, plus support services for nutrition, pharmacy, physiotherapy, laboratory, radiology and blood bank

Provincial hospital
100-200 beds
All the above clinical and support services, plus rehabilitation services and infectious disease control

Regional hospital
200-400 beds
All of the above plus surgery for ENT, urology, neurology, orthopaedics, plastic surgery; and medicine to include cardiovascular, endocrinology, dermatology, lung and chest, oncology, forensic medicine.

Specialty hospital
Primarily located in Kabul and acting as a referral centre for tertiary medical care

Source: MOH, Islamic Republic of Afghanistan, Ministry of Public Health, 2005c, The Essential Package of Hospital Services for Afghanistan, July 2005.

The required human resources have also been defined together with the organisational structure for the hospital (Annexe 3).

The fact that, prior to the war, a plentiful supply of hospitals and hospital beds was regarded as one of main indicators of a good health care system is still reflected in the National Hospital Policy Framework. In the future, Afghanistan, with limited public resources, may be ill-equipped to maintain an expensive structure of four levels of public hospitals services. Indeed the existing hospital hierarchy raises several questions in relation to efficiency and sustainability. Bypassing of BHC and CHC is a common problem which leads to overcrowding of hospitals. Several of those, regardless of their officially recognised level in the referral system, appear to function mainly as first-level district hospitals.

To date the BPHS relationship to other health components, such as provincial and regional hospitals, has not been fully build yet. Towards this end, the WB flagship course, conducted in May 2005, presented contracting as a possible strategy for the EPHS implementation and as a tool for improving the efficiency and quality of hospital services (Annexe 4). However, many MOH senior officials consider that health service delivery at provincial and regional hospitals should come under government responsibility. Given the political and sensitive issues linked to hospital reform, the current picture is still one of severe fragmentation, with several NGOs supporting a variety of services without coordination.

5.1.2. Implementing change: too ambitious?

According to key informants, many difficulties are likely to arise in rationalising the current hospital system. According to Csaszar Goutchkoff *et al* (2003), there are critical weaknesses in the budgetary process and mechanisms between central and provincial levels. In particular, the current cash accounting system practised in hospitals does not record the necessary financial data that are required for a comprehensive financial analysis. Although efforts to improve budget planning, execution and monitoring are ongoing, it will take time before an appropriate budget framework is achieved. In terms of transparency and accountability, this issue is crucial, especially for the credibility and success of any cost recovery scheme.

The bureaucratic organisational structure may hamper reform efforts. People are especially concerned about the challenges and obstacles to implementation that will be left to lower level managers. As elsewhere, the hospital system in Afghanistan is extremely complex, with strong vested interests, principally physicians and local politicians who are likely to oppose changes to old certainties, such as the ownership, scale and role of hospitals.

Another threat is the uncontrolled growth of the number of public hospitals due to pressures from politicians and promises from various countries. Certain organisations have circumvented efforts at donor coordination and made individual approaches to the MOH for hospital construction. This implies significant increases in recurrent expenditure in the future, far exceeding Afghanistan's financial capabilities and threatening sustainability.

EPHS implementation requires substantial new contributions from donors but, for the time being, key donors are not fully prepared to put resources into provincial and regional hospitals. The exception lies with USAID-REACH who, somehow, has managed to introduce contracting with NGOs in five provincial hospitals. On the other hand, the MOH has submitted an ambitious project document for improving the quality of hospital services to the Cabinet and has been awarded a $10 million grant from discretionary Government funds. Five provincial hospitals will be selected as part of the two-year proposal (MOH, 2005b). Although the methodology for implementing the project includes contracting-in certain technical components, it is not clear how this will be achieved.

All hospitals, either on USAID-REACH grant or on MOH funds, will have their staff undergoing the PRR process before implementation. One of the dilemmas is how old staffing patterns will match with the new EPHS skills requirements. The issue of excess personnel and the elimination of "ghost" positions are understandably sensitive, both socially and politically. Despite the obstacles, policy-makers expect interesting changes in the coming two years.

5.1.3. Hospitals: health care for some?

One of the challenges facing hospital reform is to ensure that hospital services are made available to those most in need. To date, the real volume of public and private resources that is benefiting provincial and regional hospitals is unclear. It is therefore difficult to assess which type of activities is really being financed, by whom and whether the vulnerable and poor groups are benefiting. The average occupancy rate of below 50% highlights the need to better understand the determinants of low utilisation, and people's capacity and willingness to pay for hospital costs. The JHU study on health financing found that the wealthier groups were more likely to use district and provincials hospitals as opposed to people in the bottom income quintile (MOH, JHU, IIHMR, 2005b). In addition, anecdotal evidence suggests that the provincial and regional hospitals are beyond the reach of the poor. The widespread practice of informal payments acts as a barrier to the poor.

Within the MOH proposal, although attention has been paid to ensure that all patients have access to adequate hospital care, it can hardly be assumed that the existing exemption system is sufficient to protect the poor. Today protecting the poor at health facilities level does not seem to be a priority and an essential determinant is the degree of political commitment. In this sense the Interim Poverty Reduction Strategy Paper (IPRSP), prepared by the government, is an important document for improving political commitment and developing pro-poor strategies.

5.2. QUALITY OF HEALTH CARE: A CRITICAL ISSUE

The JHU and the IIHMR are supporting the building of a comprehensive monitoring and evaluation system. A baseline National Health Facilities Performance assessment has collected data from a stratified random sampling of all facilities delivering the BPHS[5]. Methodological constraints to the evaluation work have evolved around the sampling restriction: only accessible health facilities were measured. Some of the results need to be interpreted with caution.

The first results have been summarised using the BSC (MOH, JHU, IIHMR, 2005a). There are wide indicator variations across the provinces, suggesting that a combination of factors may impede the BPHS implementation. Not surprisingly provinces such as Ghor, Helmand, Ghost, Nimruz, Paktitka and Uruzgan are lagging behind, partly due to the insecurity that renders parts of the provinces inaccessible.

Overall the results showed encouraging findings but pointed out to some areas of concern as well (Table 7).

[5] Assessments of 600 health facilities, nearly 6,000 patient observations and interviews, 1,600 health workers interviews, 13,000 households interviews and 74 focus groups in communities were included in the final sample.

Table 7: Main findings from the BSC, Round 1, 2004

Domains	Key high scores	Key low scores
Patient and community perspectives	Patient satisfaction	Patient perception of quality *Shura* activities
Staff perspectives		Health staff satisfaction
Capacity for service provision	Availability of drugs and functional equipment Provider knowledge HMIS[6] use index Patient record	Laboratory functionality Facility with TB register Staff training
Technical provision of health services	Antenatal care provision Proper sharp disposal	Average new OPD visit per month Delivery care Time spent with patients
Financial systems	Facilities with user fee guidelines Facilities with exemption for poor patients	
Overall vision	Females as % of new outpatients	

Source: MOH, JHU, IIHMR, 2005a, Afghanistan Health Sector Balanced Scorecard: National and Provincial Results Round (1)

Critics to the BSC have expressed hope for adaptations, as the tool is considered difficult to interpret and to use. Nevertheless, it provides information on the main areas to be improved and makes possible to monitor changes. While health staff dissatisfaction mostly relates to delays in salary payments, contracting has not yet challenged old ways of providing health care. The results show a weak management of common illnesses, poor interaction between providers and patients and insufficient time given to proper diagnosis and treatment. These elements have been identified before as a serious concern (Groupe URD, 2002).

Starting with implementation and scaling up has occupied a great deal of a time. The NGOs themselves admit they had virtually no time left to address the quality of care given the many priorities and pressures brought about by contracting. Some informants pointed out that higher salaries for staff do not necessarily translate into good quality of care but there has been little attempt to link salary supplements to staff performance in terms of quality of care, a notable exception being Health Net International. Based on the Cambodian model, Health Net International is planning a study in order to design an incentive scheme for health workers.

In general, patients do not make informed rational decisions and have low awareness levels. Multiple prescribing and over-prescribing of medication are common practices. This is in part a reaction to demands and pressures from people for antibiotics, injections and intravenous infusions. There are strong indications that this response is hindering concepts of quality of care and opposing health promotion initiatives. In the long term, it can also threaten both quality and sustainability of cost sharing schemes.

The quality of training for midwives is another issue of concern. The MOH has developed a new national curriculum targeting both hospital and community midwives. Out of the nine Intermediate Health Sciences and Intermediate Medical Education Institutes (IHS/IMEI)

[6] Health Management Information System

offering training for hospital midwives and nurses, five are operational and supported by USAID and JICA grants.

The proliferation of community-midwife educational courses and the large amount of centres supported through various agencies raises a few questions. For instance one important standard within the midwifery curriculum is to perform, over the 18-month period, a minimum of 100 deliveries per student. But the large number of students in some training centres, the low caseload in obstetric wards combined with a scarcity of trained trainers is likely to limit the knowledge and skills of community midwives.

In order to address this problem, the HR Development taskforce began an accreditation process for midwifery schools in Afghanistan. The same process in relation to intermediate clinical staff showed wide variations between location and categories of staff. For instance, only 1% of candidates in Kandahar reached the 'registered' level as opposed to 23% in Kabul.

5.3. PUBLIC AND PRIVATE FOR PROFIT SECTOR: WHERE TO DRAW THE LINE?

Although some respondents claimed that the private sector provides about 60% of outpatient contacts in Afghanistan, little is known on its magnitude. As a matter of fact, private providers have continued to function during the conflict and anecdotal evidence suggests that they play a dominant role in the provision of ambulatory care. According to the Afghan Constitution, the government authorises the establishment and expansion of private medical services. As a result, many health workers have opened private pharmacies or clinics and are involved in some type of informal private activities. In particular pharmacy owners appear responsive to people's needs who look at them as a provider in the broader sense and come to the shop expecting advice and guidance. More recently, the rapid growth of private for profit providers in Kabul and certain urban areas, including private clinics, may be an indirect sign of the willingness and ability to pay for services that are perceived of higher quality.

While the private sector is growing fast with all its problems and benefits, the quality offered is, however, a grey area and crucial information to assess the health impact in terms of quality and efficiency is seriously lacking. Obviously NGOs are the main health services providers but there is clearly a health care market, which is very much in a *laissez faire* state. This implies that informal activities also take place during working hours.

Further research is probably needed to understand the dynamics of public and private interactions in health care, but this unclear separation made between public and private interests, while maintaining standards of income, is likely to jeopardise efforts to address the unnecessary diagnostic and therapeutic procedures contributing to an unknown number of preventable morbidity and mortality.

Based on their contracting experience in Cambodia, Soeters and Griffiths (2003) strongly advocate for a transparent separation between public and private practitioners if prices for health services are to be monitored and influenced, catastrophic outcomes for patients prevented and quality improved.

5.4. FACING THE CHALLENGES OF HEALTH CARE FINANCING

To date, capital expenditure and running costs are mostly financed by external assistance. Sustainability for and beyond the major achievements is increasingly becoming an issue that is seriously taken into account by all stakeholders faced with the challenge to meet both BPHS and EHPS specific objectives. For BPHS implementation, which is estimated to cost annually $84 million, uncertainty remains on commitments beyond 2006 and there is a fear that the disbursements committed by some donors may be decreasing.

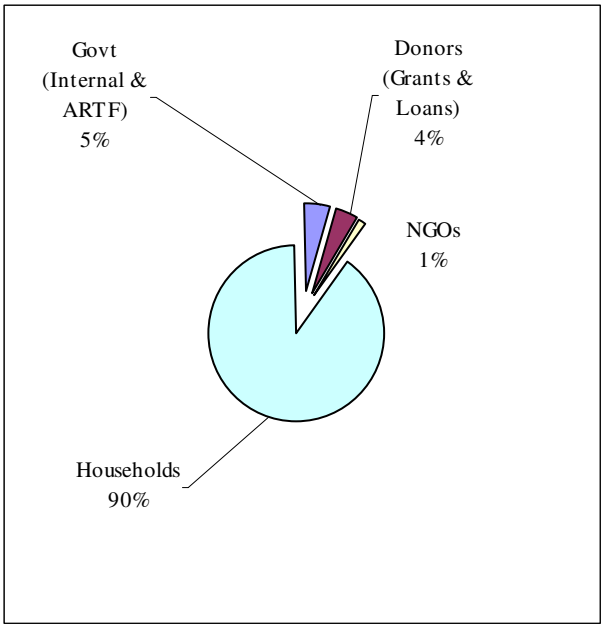
EPHS funding is even more crucial as, until now, insufficient resources have been identified for its annual cost, estimated at $56 million. It will thus be difficult, within the current Afghan context, to sustain a performing health service delivery in the absence of the two other health system functions: financing and resource mobilisation. While fiscal reform is underway in order to increase domestic revenues, sooner or later the government will be faced with the issue of how to generate supplementary resources for the health sector.

One of the options is to introduce a cost-sharing system but ambiguities in the existing Afghan constitution do not leave much room for a national policy[7]. The Supreme Court has recently rejected the draft outlined by the Health Financing Task Force and it is unclear what will be the next step. The impact of such schemes on the poor and disadvantaged in low income countries is well documented. In post-conflict Afghanistan where an estimated 53% of the population is below the poverty line, the design of an adequate cost-sharing system represents a real challenge.

5.4.1. The main sources

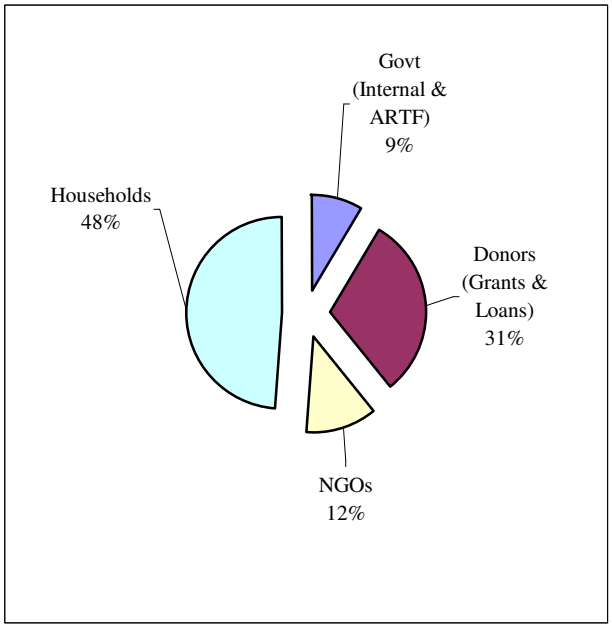
The current sources of health care financing in Afghanistan include national resources mobilised through taxes and local revenues, donors (including multilateral and bilateral aid), NGOs, and out-of-pocket expenditure. The 2001 and 2002 sources, based on WHO estimates, reflect the increase in external assistance (Figure 2 and Figure 3).

Figure 2: Sources of financing for the health sector, 2001



[7] The Constitution states that "preventive health care and curative treatment, together with proper health facilities should be provided free to all citizens of Afghanistan".

Figure 3: Sources of financing for health sector, 2002



Out of pocket payments decreased substantially, a situation that could be partly explained by the access to health care through international aid[8]. However, given the lack of reliable data and National Health Accounts, these figures are only partially reliable.

For 2004/05, the funds disbursed directly by donors to NGOs represented 75% of the total health budget: out of the $314 million spent, $267 million came from external assistance and the remainder from the national budget. But the information about public health expenditure is inconsistent due to the difficulty of disentangling donor, regular and extra-budgetary funds.

5.4.2 Paying for health care: a barrier for the poor?

In order to understand the issues involved with cost sharing, in 2004 the JHU carried out a study that sheds some light on health-seeking behaviours and out-of-pocket expenditure in Afghanistan (MOH, JHU,IIHMR, 2005b). While the study is not a nationally representative household survey[9], the main findings are summarised below.

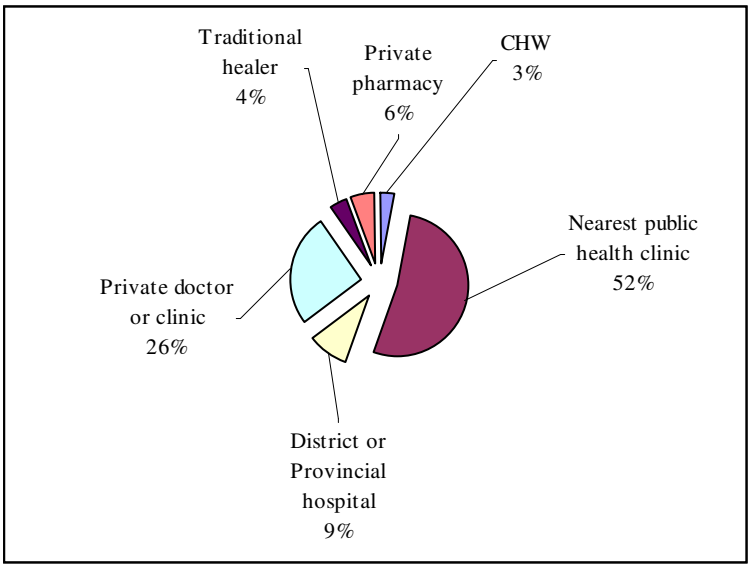
- **<u>Where was health care sought: public health services are used</u>**

Based on the survey results, seeking care in government health facilities is a popular option. The nearest public health clinic was used by a large percentage of the population (Figure 4).

[8] Out of pocket payments include all costs incurred by users, including direct payments, formal cost sharing and informal payments.

[9] Only households within 1.5 hours walking distance from a BPHS health facility were included. In addition the security situation has prevented to cover certain areas.

Figure 4: Health-seeking behaviour in Afghanistan



Source: Ministry of Health., John Hopkins University., Indian Institute of Health Management Research, 2005b, Health seeking behaviour, Health expenditures, and cost sharing practices in Afghanistan: Draft report

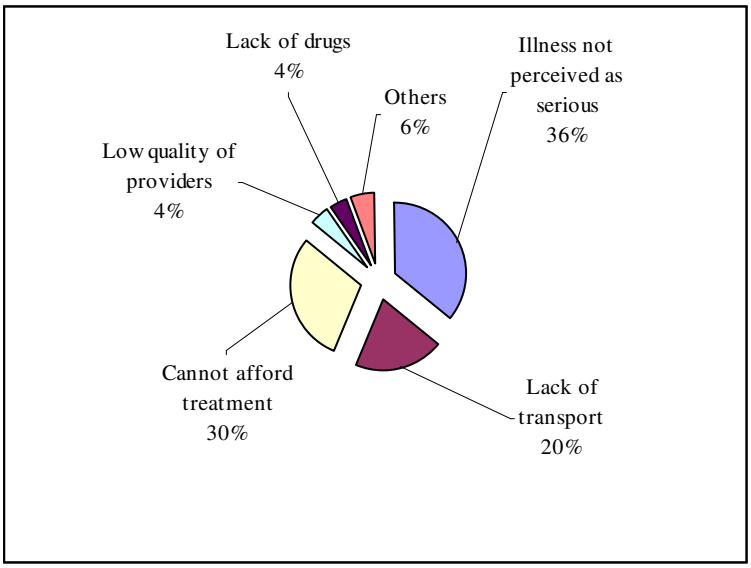
However, these findings may not be fully representative because of the sampling frame limitations. In addition, the fact that CHC and BHC have been grouped under "public health clinic" does not allow for a meaningful comparison in relation to levels of health services.

The use of private doctors and clinics is significant, especially in the wealthiest quintile. It highlights the scale and the importance of the private medical sector in health care provision. Surprisingly, self-treatment, supposedly entrenched in the Afghan society, did not account for a large share of health care expenditure.

- **Why did people choose not to seek health care: affordability can be an obstacle**

The respondents gave a variety of reasons for not seeking health care (Chart 5.4). While 36% did not seek care because they did not perceive their illness as being serious; the cost of treatment affordability was an obstacle for 30% of the respondents.

Figure 5: The main reasons for not seeking health care



Source: Ministry of Health., John Hopkins University., Indian Institute of Health Management Research, 2005b, Health seeking behaviour, Health expenditures, and cost sharing practices in Afghanistan: Draft report

- **How much was paid for care**

Because of the unregulated health care market in Afghanistan, household "out of pocket" expenditure on health is expected to be high and inequitable, with catastrophic costs as a major cause of destitution among the rural poor. Based on these findings, households spent an average $28.5 per capita per year on health care. The breakdown of health expenditure shows that registration fees together with drugs and supplies are the main sources of spending. While a significant amount of money (an average $8) was paid to the CHWs, payments to public health clinics remained low. This finding did not vary significantly between the poorest and wealthiest quintiles.

In Nangahar province, another study, unpublished, found that out-of-pocket expenditure reached $40 per capita per year and represented a significant burden on households (Health Net International, personal communication). This figure is however controversial as many patients in the study area seek health care in Pakistan.

The study yielded limited evidence on the significance of informal payments: less than 2% reported extra payments to public health care providers. This finding is not consistent with anecdotal evidence on the well-known phenomena of charging informal fees, especially at hospitals and in urban centres.

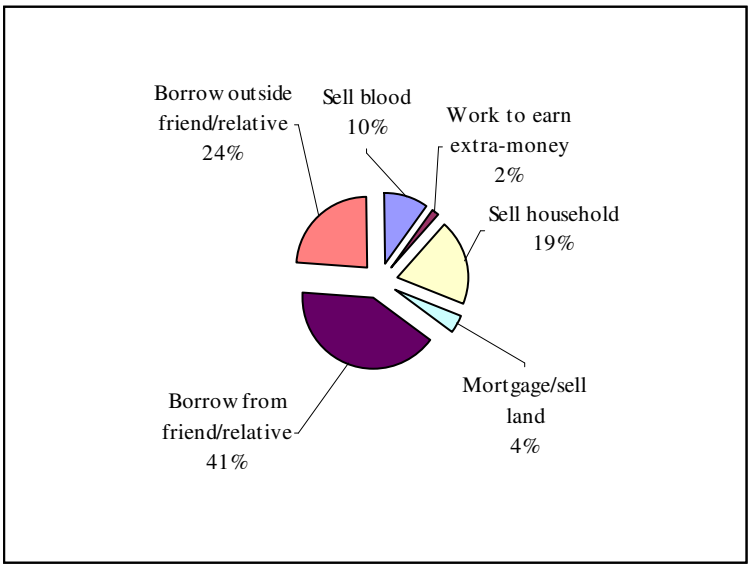
- **Did the poor face barriers: access to hospital care is difficult**

The study provides some evidence that the richest population groups have a better access to district hospital services whereas the poorest quintile face obstacles in accessing hospital care.

The study indicated also that nearly 30% of the respondents experienced financial distress at the time of illness. For these respondents, the most common source of funds was family members and friends but, since these payments have to be repaid, it places an extra burden on the poor. As a matter of fact there is a marked difference between the poor and the non-

poor: 37.8% from the poorest quintile reported financial distress as opposed to the 19.6% in the wealthiest quintile.

Figure 6: Primary sources of funds to cover health care costs among people experiencing financial distress



Source: Ministry of Health., John Hopkins University., Indian Institute of Health Management Research, 2005b, Health seeking behaviour, Health expenditures, and cost sharing practices in Afghanistan: Draft report

Additional information from the NGO cost-sharing assessment stressed that the exemption schemes did not target the real poor and recommended an evaluation of current exemptions mechanisms.

5.4.3 Assessing the current cost sharing scheme: main trends

The current cost sharing system at public health facilities consist of user fees. The type of user fee scheme varies per NGO but overall there is low fee level. The fee structure has not been updated over the past years, probably because finding additional resources to operate health centres was not an acute problem as most health facilities had been supported through external funding.

Fees for treatment at OPD generally amount to 5 Afghanis (approximately to $0.1). Preventive services are free of charge and patients make a symbolic payment for their patient booklet. Drug costs are charged at between 20-40% of their purchasing price, but a distinction is not made between the types of drug, i.e. antibiotics or vitamins for example. The efficiency of the collection system has not been assessed.

Only two NGOs put aside the revenues they collect to replenish their stock of drugs. Typically fees have generated no more than 10% of total recurrent costs. This finding confirms the fact that current user fees were not designed for efficiency purposes. Again it is not possible to determine whether there are any marked differences between the CHC and BHC. The assessment shows that fees are graduated, especially in relation to surgery at district hospital but there is little indication on the cost paid for normal or complicated delivery.

In most places, the exemption system allow services to be provided free of charge to vulnerable groups of people and patients with certain illnesses, including TB. Generally speaking, existing exemptions mechanisms do not work well. Public information is

inadequate and it is not clear to what degree the poor know that they are entitled to exemption.

5.4.2. How can the Government use the results of this analysis to formulate policies?

In general, the current fee system is not aimed at generating income and defraying costs. In order to become an effective tool and to ensure equity, the health financing strategy has been attempted first through a randomised controlled study to determine the results on a small scale. If successful and politically acceptable, these pilot schemes may result in a larger scale implementation.

The study is testing the three following approaches in eleven provinces under PPA with NGOs and MOH: (i) free services; (ii) user's fees and (iii) a Community Health Fund (CHF). The limitations and possible bias of a randomised study is that some of the user fee schemes are tested in poor areas whereas free for services are implemented in wealthier areas.

There is no form of health insurance through central Government yet. The CHF implementation is in its early stages and is expected to be a learning process over a twelve-month period, a timeframe that may be too short to draw definitive conclusions about the costs, benefits and measures for minimising risks associated with health insurance, such as adverse selection[10], moral hazard[11] and cost escalation. Membership covers a basic care benefit package including all services and drugs provided in health centres and district hospital. Enrolling households pay a monthly premium of $6 per family of up to five people. A committee comprised of communities and health representatives will manage the CHF. The reasons for setting a CHF include resource mobilisation for health care and financial protection. It is too soon to tell whether CHF will have a positive effect on resources mobilisation in the piloting areas and a great challenge lies in how insurance could be expanded to benefit the poor. While the $6 pre-payment may appear negligible, this amount is substantial for many Afghan households, suggesting that the scheme could fail to cover the least well-off groups.

As far as fee exemption policies are concerned, experience in Afghanistan and elsewhere shows that targeting the poor is difficult and may even achieve the opposite. The current exemption system is under review and some contractors, in selected areas, have been asked to identify the poor through a questionnaire with detailed socio-economic criteria and to develop a new exemption scheme.

The MOH and the NGOs will learn from actual implementation what works and what does not work. This calls for action-oriented research whereby processes are studied, while implementing. Important relevant questions would include:

- How will user fees affect health care utilisation, particularly among the poor?
- How much are health individuals willing to pay for insurance premiums?
- How will the scheme cope with the problem of moral hazard?
- How to develop the institutional and managerial capacity necessary for administering procedures such as collection and billing?

Another observation worth noting is that informal payments could have a significant impact on the success of user fees or CHF. Very often they reduce the prospects for establishing sound cost recovery systems and further reduce the income base of already vulnerable people.

[10] Adverse selection takes place when people with a high probability of "health loss" predominate in the membership, while those with low probability of loss do not join.

[11] Moral hazard means that people with insurance may take greater risks than they would do without it because they know they are protected, so the insurer may get more claims than it bargained for.

5.4.3. The role of the communities

There is little information regarding people's expectations in terms of types of benefit coverage, type of management preferred, amount of premium willing to pay and mode of premium payment. The CHF is based on the assumption that communities will adhere to the concept and manage the fund. However expectations in the field of CHF should be realistic. Several areas require specific consideration:

- Raising additional revenue is based on the assumption that there is a demand for the services and that the demand is not sensitive to price changes.
- Initiatives such as insurance are a relatively new concept that requires building awareness, recognition and advocacy. Nevertheless, a form of traditional social organisation seems to exist. It establishes a mutual agreement of professional members in order to collaborate with each other whenever any member or their family members are faced with adverse situations.
- Paying for a service, which may or not be taken up, can be misunderstood. Furthermore, the widespread patient fascination with medication is a potential threat to sustainability. There will be a need for a strong focus on increasing people's responsibility.
- For there to be public support, the revenues generated must be used to make quality improvements that are visible to the people.
- An additional implication is that it would seem pertinent to improve community awareness and technical capacities to manage an insurance scheme.

On the one hand, it is important not to idealise the role of community organisations and health committees. Local structures vary in terms of their effectiveness and the extent to which they are representative. In some instances, the role of the s*huras* as authentic representative institutions can be questioned given their lack of representation of poor individuals, vulnerable groups and women (ALNAP, 2003). Existing hierarchy or inequalities may also be reinforced through health committees and the importance of trust in the context of health insurance has been discussed (Schneider, 2004) On the other hand, expecting a committee to manage the CHF by itself may be a bit over-optimistic, as it certainly requires specific expertise which is not fully developed, even within NGOs.

5.5. A STILL FRAGILE OPERATING ENVIRONMENT

In 2002, the lack of specific expertise in many NGOs has limited their capacity to contribute to the policy debate as single organisations but also as a community. As a result, the participation of NGOs in the policy-making process has been limited, a feeling that is still shared to day, especially among non PPA-NGOs. For these NGOs, the future is even more uncertain: most donors are channelling money through the BPHS and with the gradual handover of urban clinics to the MOH, there is little room for manoeuvre, apart from in vertical programmes or urban health care.

So far the MOH has been supportive in adhering to and endorsing the new set of policies. However the fact that contracting does not operate within a legal and recognised framework could make the process vulnerable to changes. Within the government and the MOH, there are individuals who are pushing for a return to a more traditional provision of health services. In particular changes in the Ministry bring their own tensions for the management of external aid as some MOH officials may feel disempowered by the presence of international staff who usurp them of key responsibilities.

Undoubtedly contracting with NGOs is likely to evolve over the long term, but for the time being interviews with key stakeholders indicate positive and encouraging results, especially among national NGOs. As for international NGOs, the government and the media have recently challenged their role.

Tensions have arisen, especially with PHDs at different points of time. In some instances, the high turnover of expatriate staff, poor communication with MOH counterparts and difficulties with staff management have made relationships complicated. 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. Alongside the GCMU as a driving force, NGOs, for the time being, play an important role in promoting the expansion of basic health services.

Adjusting to scaling up and to new challenges such as user fees, CHF and new exemption scheme still have a long way to go. There is a general feeling that contracting is extremely demanding in terms of time, energy and skills. Some NGOs are thinking of reducing the scope of their interventions in order to focus more on the quality process. Furthermore the fact that large parts of the country remain insecure makes contract implementation a dangerous undertaking as shown by the tragic events in October targeting a mobile medical team from Afghan Health Development Services (AHDS). Decreasing the scope of NGO geographic coverage could have potential drawbacks, including the inaccessibility of the BPHS to some populations. Over the long term a possible approach could be to move towards a safer strategy using mixed public and NGO health service provision.

6 CONCLUSION

The first priority has been to demonstrate that the BPHS is being delivered throughout the country. This success has been made possible thanks to considerable financial commitments from donors. Implementation of the BPHS has significantly increased the availability of public health services but access to basic services is highly dependant on geographical situation and security factors.

The available information through the development of contracting is also recent and prevents us from drawing any generalised conclusions. In the future, emerging evidence from quantitative and qualitative studies will be important in order to understand:

- Which model or combination of models for health care delivery is most appropriate?
- What works best in a post-conflict environment where resources are limited?
- What is the best mix of health providers?
- How can NGOs be used for service delivery and what is the trade-off with building MOH capacity?

Over the coming years, the expectations for further health sector development will have to be fulfilled, partly owing to:

- The unstable macroeconomic context;
- The low predictability of external funding over the long term;
- The uncertain future of the provider-purchaser split and of NGOs.

Policy-makers and donors recommend that the Afghan government increases its health expenditure. This recommendation is based on the assumption that the fiscal system can be significantly improved and that taxes will really be used efficiently by the health sector. This is based on the assumption that the population is also willing to pay taxes and has confidence in the state to carry out these tasks.

Even if Afghanistan increases its public health spending from 0.8% to 1.5% of its GDP as in other low-income countries and introduces a cost recovery system, it is likely to be insufficient to pay for the level of basic and hospital services, currently estimated, on an annual basis, at $140 million.

Given the widespread poverty, the potential risks in increasing user contributions cannot be overlooked. And finding a balance between efficiency and equity represents a challenge and specific attention needs to be paid to the capacity of communities to pay for health care and to pro-poor policy and strategies. Effective exemption systems or innovative mechanisms, such as Health Equity Funds, in order to identify the poor and pay on their behalf may be used as alternatives to improve access to hospital services.

Most observers of Afghanistan would agree today that successful health transition goes hand in hand with successful political and economic transition. Given the state of the health system inherited from decades of conflict, the need to maintain what has been achieved and to develop different health financing alternatives are significant challenges for the Afghan Government. Long-term sustainable development will require continued commitment to the ambitious reform agenda and sustained international support. In addition because of the limited expertise in-country, operational research in the area of health financing, including CHF and alternatives to exemption schemes, would be instrumental in obtaining further evidence on what are the most appropriate health financing options in a post-conflict setting.

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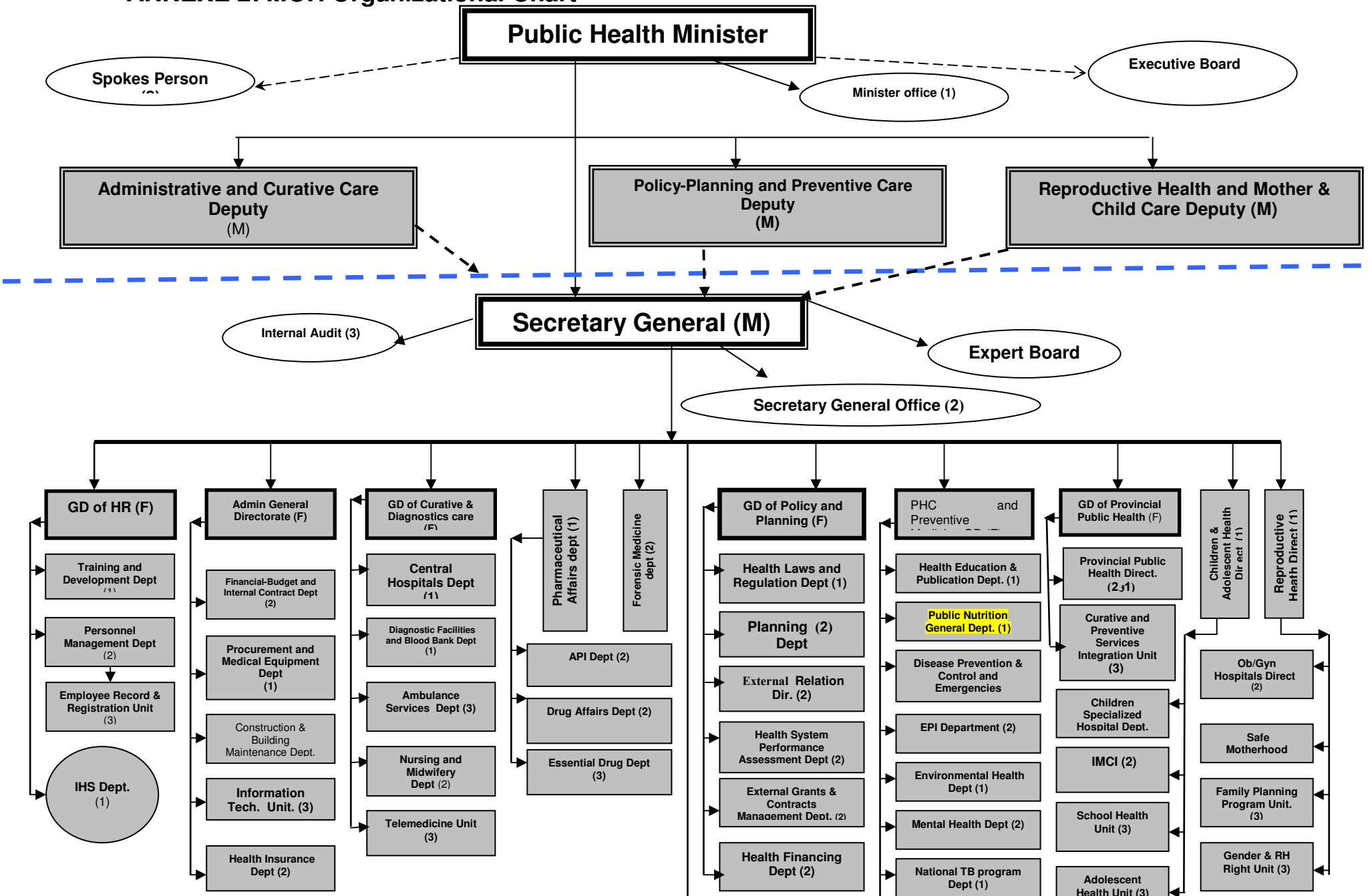
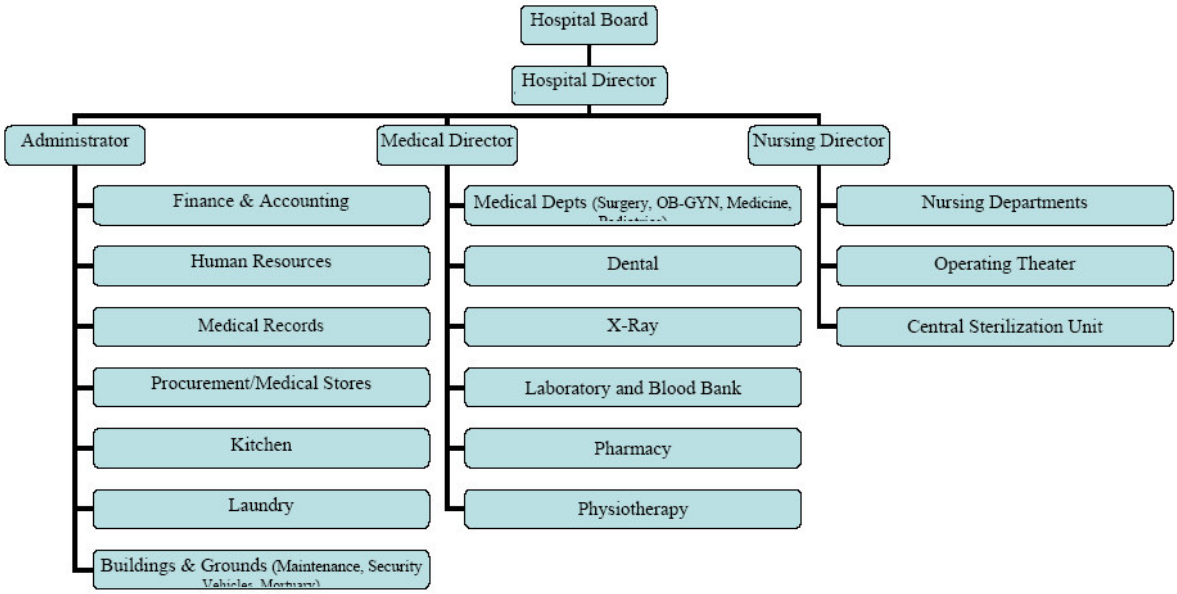
ANNEXE 1b: List of persons met

French Embassy	Emilie Robert, *Chargée de Mission*
Ministry of Health	Dr Ahmad Shah Salehi, Director, International Relations Department & GCMU Consultant Dr Abdul Basir Mansoor, Head of Health Financing, GCMU Dr Sarwar Hemati, Project Implementation Unit, ADB, GCMU Dr Fahim, HIMS Consultant, Project Implementation Unit, ADB, GCMU Dr Noor Mohamed Arzoie, Acting Director & GCMU Consultant, Human Resources Development, Dr Katja Schemionek, EC Technical Assistant to MOH
European Commission	Esmee de Jong, Health and Disability Task Manager Elisabeth Rousset, Deputy head of Section - Operations
World Bank	Jean Mazurelle, Country Manager Dr Kayhan Natiq, Health Sector Manager
USAID/REACH	Dr Pannah, Advisor (email)
JHU	Krishna Dipankar Rao, Programme Manager Dr Sabibullah, National Advisor
LSHTM	Lesley Strong, Researcher Fellow
CICR	Philippa Parker, Hospital Manager
ACF	Thomas Loreaux, Head of Mission
AKDN	DrNaimatullah Akbari, National Programme Officer (phone call)
AMI	Dr Sandrine Robin, Acting Director
CAF	Dr. Bashir Ahmad Hamid, General Director
HNI	MOHammad Zahir Khandan, Office Manager
IBN SINA	Dr. Sidiqullah Shinwarie, Director General
MDM	Camille Perreand, Chargé de projet “Contractualisation”
Terre des Hommes	Dr Noor Khanum, MCH Project Coordinator

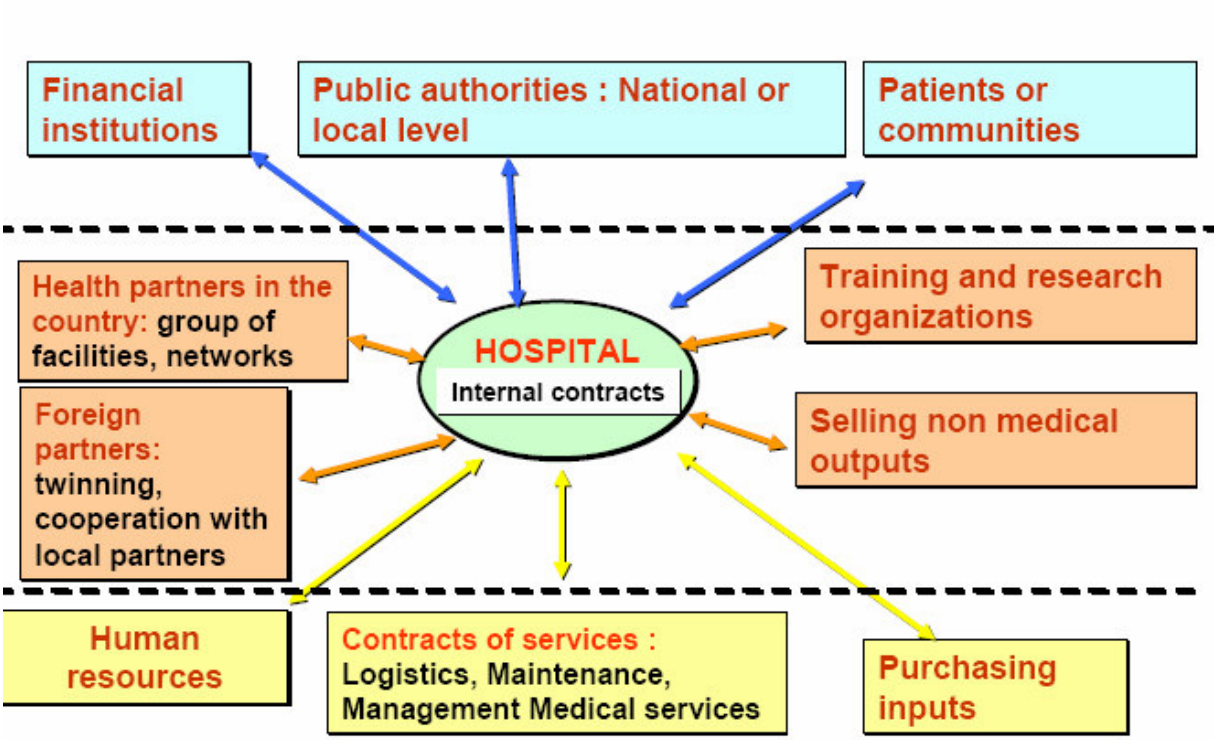
ANNEXE 2: MOH Organizational Chart



ANNEXE 3: Organisational structure for hospitals



ANNEXE 4: Scope of opportunities for contracting at hospital[12]



[12] As presented during the Hospital reform module, WB Flagship course for Afghanistan.