HEALTH SECTOR REVIEW: UNDERSTANDING BETTER
THE SCALE AND NATURE OF SUCCESSES AND
CHALLENGES IN POST-CONFLICT AFGHANISTAN

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

The Health Context:

Donors and the Ministry of Public Health (MOH) undertook 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 a devastated country 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.

The 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 have moved to restore 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 NGO 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 subcontracted 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.

Can PPA be a successful strategy in the Afghan context? Meaningful answer to this question will be made on evidence-based over time but the progress in expanding coverage has been fast to come. 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 the out-of-patients visits and antenatal services have increased by three fold and 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 formalized 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.
The issues at stake:

Maintaining the momentum: To continue with the achievements, expanding coverage to the remaining parts of the country, improving quality of care, and implementing different health financing alternatives will be next targets. Although the role of NGOs has been threatened, it is difficult to see how the current developments can be maintained without their involvement. For the NGOs under PPA, 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. Soon 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 Millenium 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. Overall hospitals are ineffectively distributed and organised which means that their potentially 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 the uncontrolled growth as building new infrastructures would suppose a significant increase in recurrent expenditures 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, by no means it will be 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 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 Interim Poverty Reduction Strategy Paper (IPRSP) to come 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, health system in Afghanistan had to respond to a variety of challenges, including the lack of qualified human resources and female staff.

The scope of this document is 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 2-year LRRD project funded by the European Commission (EC). The project has three main objectives:

- Learning and sharing lessons through iterative multi-sectoral 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 2-week period. In order to elaborate the analysis, relevant information was collected through key publications and documents and in-depths interviews with key informants (Annex 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 fast moving situation confronting the health sector, this review is necessarily work in progress.

Some of the initiatives under discussion are being addressed by well-known research institutes. In particular the 2-year qualitative research project, carried out by the London School of Hygiene and Tropical Medicine (LSHTM), is following 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: AN HISTORICAL OVERVIEW

Historical events have deeply influenced the characteristics of the health sector 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 to 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 infrastructures and to the worsening of health statistics. Health care activities became almost totally dependent on NGOs for the resources they needed. 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 2.1, following the Taliban’s fall in 2001 the challenges for health policy developments in Afghanistan were considerable.

Box 2.1. 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 particularities and a quick fix solution to health system reconstruction is easier said than practiced. According to Hanson et al (2003), more robust evidence is required regarding ways to organize, deliver and pay 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. If comparing with neighboring countries, health indicators are three to fivefold higher (Table 2.1).

Table 2.1. Key indicators compared to neighbouring countries

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Afghanistan</th>
<th>Pakistan</th>
<th>Iran</th>
<th>China</th>
<th>Tajikistan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (millions)</td>
<td>29.9</td>
<td>152.1</td>
<td>66.9</td>
<td>1.296.5</td>
<td>6.2</td>
</tr>
<tr>
<td>GDP per capita (PPA)</td>
<td>$800</td>
<td>$2,200</td>
<td>$7,700</td>
<td>$5,600</td>
<td>$1,100</td>
</tr>
<tr>
<td>% of population living below $1 a day (1992 – 2002)</td>
<td>N/A</td>
<td>13</td>
<td>2</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>Life expectancy</td>
<td>43</td>
<td>61</td>
<td>70</td>
<td>71</td>
<td>69</td>
</tr>
<tr>
<td>Infant mortality rate (death/1,000 live births)</td>
<td>165</td>
<td>81</td>
<td>33</td>
<td>30</td>
<td>92</td>
</tr>
<tr>
<td>Maternal Mortality Ratio (death/100,000 live births) adjusted</td>
<td>1,900</td>
<td>500</td>
<td>76</td>
<td>56</td>
<td>100</td>
</tr>
<tr>
<td>Crude death rate/1,000</td>
<td>22</td>
<td>10</td>
<td>5.0</td>
<td>7.0</td>
<td>10</td>
</tr>
<tr>
<td>Total Fertility Rate</td>
<td>6.8</td>
<td>5.0</td>
<td>2.3</td>
<td>1.8</td>
<td>3</td>
</tr>
</tbody>
</table>


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 2.2).

Table 2.2. Some key indicators (national, urban, rural)

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


The MICS points out the inequities between urban and rural areas. These differentials are sharper for maternal and child care. For instance in Badarkshan province, the under five mortality rate stands at 323 per 1,000 live births, or two times higher than in urban locations. Afghan women are more vulnerable to ill-health due to 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 (diarrhea, 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 Taliban’s fall, 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 3.1).

<table>
<thead>
<tr>
<th>Period</th>
<th>Identified priorities</th>
<th>Key achievements</th>
</tr>
</thead>
</table>
| (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 |

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 much more emphasis has been put 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 3.1 The BPHS components

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


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 requirements in terms of health facilities, health staff, equipment and supplies as well as other system issues.

The costing study estimated the BPHS cost to reach a $4.55 per capita per year. Given the fact that the cost of providing the same services would vary widely across Afghanistan, establishing a single cost per capita for the whole country has been questioned for 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 expertise with this mechanism resulted in an ideological debate, with contracting viewed by some actors as an imposed privatisation of health services. While making the mechanism synonymous of privatisation may narrow 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 reflecting different changes health service delivery (Table 3.2).

Table 3.2. The evolution of health service organisation in developing countries

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


When 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 realized 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 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 as defined above. Within a wider meaning, however, privatisation encompasses the implementation of a management model that draws on the rules of the market. 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, few NGOs, such as MSF, MDM and ICRC, opted out of the process because the mandate and objectives supported by the donors were perceived to be incompatible with their neutrality and independence mandates.

3.2.3 CONTRACTING AS A KICK START TO EXPAND 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) the 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. Other expenditures are covered using World Bank (WB) funding. The MOH-PPA/SM is currently implemented in three provinces (Kapisa, Pansjeer and Parwan);

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1 The ARTF, established in 2002, is a coordinated funding mechanism for expenditures related to recurrent costs, investment activities and programs and salaries for Afghans returning from abroad. The fund is managed by a committee led by the WB.
• **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 stage 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 immunization 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 the policy-making discussions.

In the early days the approach has generated heated debates and discussions. First, contracting was an unfamiliar and poorly understood concept to most stakeholders, except may be for the WB, USAID/MSH and a few others. Second, there was little comprehensive account of 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 characterized by weakened state structures, fragmented civil society and prevailing insecurity. Third, the geographical disparities of the country were seen as other constraints to the expansion of services.

Among international NGOs the lack of communication surrounding PPAs added to the frustrations and misunderstandings. As contracting was new to most of them, not many were aware of what it meant to move beyond classical small-scale projects to implementation linked to performance. Undoubtedly, the funding opportunities brought in by contracting played an attractive role for both international and national NGOs.

To date the BPHS implementation is under way 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 by three fold and from 4.6% to 31% respectively. One of the key MOH and donor’s priorities is now to address the service delivery backlogs that still persist, a high challenge given the remoteness of these areas and the ongoing insecurity.

**3.2.4 THE DISTRIBUTION OF FUNDS: A MIX OF PROVINCE-WIDE AND CLUSTER APPROACHES**

Coordination of external resources has become central to expand the BPHS. The distribution of resources through contracting has certainly help to address, in a way, the existing fragmentation. Until 2002 the health sector picture was the result of multiple actions, 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 (Map 1).
The geographical repartition of funds has been based on two models: province-wide and cluster of districts. The Table 3.3 outlines the main features for each model.

Table 3.3. The different donors approaches

<table>
<thead>
<tr>
<th>Key features</th>
<th>IDA/WB</th>
<th>USAID/MSH</th>
<th>EC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project name and duration</td>
<td>Afghanistan AHEAD</td>
<td>Rural Expansion of Afghanistan’s Community Based Health Care (REACH)</td>
<td>Support to Health Service Delivery in Afghanistan</td>
</tr>
<tr>
<td></td>
<td>29 – 36 months</td>
<td>26 – 30 months</td>
<td>21 – 30 months</td>
</tr>
<tr>
<td>Project Design</td>
<td>Influenced by the contracting out model in Cambodia</td>
<td>Influenced by USAID/MSH performance-based payment in Haiti</td>
<td></td>
</tr>
<tr>
<td>Who is the purchaser?</td>
<td>Funding from MOF special bank account to GCMU and then to NGOs</td>
<td>Funding from contracting with MSH who then sub-contracts to NGOs</td>
<td>Funding from the EC to NGOs</td>
</tr>
<tr>
<td>Who is the provider?</td>
<td>9 grants/7 NGOs and MOH</td>
<td>25 grants/19 NGOs with preference given to national NGOs</td>
<td>7 grants/7 NGOs</td>
</tr>
<tr>
<td>Financial scope</td>
<td>Fixed lump sum with 100% budget flexibility Contract with financial bonuses up to 10%</td>
<td>Fixed budget (input-based) Grant</td>
<td>Fixed budget (input-based) Grant</td>
</tr>
<tr>
<td>Level of commitments</td>
<td>$ 1,469,090 – 8,384,143</td>
<td>$ 342,721 – 5,328,861</td>
<td>$ 4,341,840 – 1,704,289</td>
</tr>
<tr>
<td>Geographical scope</td>
<td>7 province-wide PPA 1 cluster-wide PPA 3 provinces PPA/MOH-SM</td>
<td>Cluster district approach in 13 provinces and single district</td>
<td>4 province-wide grants 6 clusters in 4 provinces</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Scope of services</td>
<td>Entire BPHS</td>
<td>Not mandatory to include district hospital</td>
<td>Entire BPHS and construction of health facilities for some grants</td>
</tr>
<tr>
<td>Per capita cost (S$)^2</td>
<td>4.30</td>
<td>4.72</td>
<td>3.87</td>
</tr>
<tr>
<td>Monitoring/ Evaluation</td>
<td>2003 MICS as a baseline Nationally defined indicators GCMU monitoring visits Mid term review Third party assessments twice a year</td>
<td>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</td>
<td>NGOs defined their own indicators Based on logical framework Mid term and annual activity reports Third party assessments twice a year</td>
</tr>
</tbody>
</table>

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

### 3.3 THE 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 summarized in Table 3.4.

<table>
<thead>
<tr>
<th>Donor approach</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| 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).

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^2 The variations in per capita costs can be explained by the different costs in relation to construction, drugs and sub-contracting for training.
The capacity-building process through micro-management as emphasized by current USAID-REACH grants seems to be highly valued with USAID technical assistants nurturing 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, the NGOs have now adhered to national indicators and are gradually being included in the 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 THE 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, started 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 is independently measuring the progress of both NGOs and MOH-SM provinces through a balanced scorecard (See Section 5.2). They are also involved in the development of a system to finance Afghanistan's health care in the future. The health financing pilot project will be tested in 11 provinces under PPA (See 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 2-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-based on contracting in post-conflict contexts. A conference presenting key findings will be held both in Brussels and Kabul in February or March 2006.

4. THE MOH: CONSIDERABLE PROGRESS HAS BEEN POSSIBLE

4.1 THE SHIFT FROM PROVIDER TO PURCHASER

From the very beginning, the MOH leadership has embraced the reform wholeheartedly. Considered as one of the most pro-active and open-minded ministries, first were efforts to enhance 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 reorganized so as to reflect its new role.

Introducing a purchaser-provider split model is admittedly a major change given the historical tradition of the 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, it reinforces the feeling of the MOH being perceived as a very distant Government entity.

13
The confusion this distinct role created at provincial and district levels has already been pointed out (Evans et al., 2004). Anecdotal evidence suggests that this situation is still prevailing. For instance, the Provincial Health Departments (PHDs) have difficulties to understand what stewardship means, even though induction courses have been provided. The tensions are more important 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’s officials, many of whom from previous WHO positions, have been appointed. The MOH departments at the central level have been recently reorganized (Annex 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 implications on the 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. 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.

The GCMU, under IDA/WB funding, has an oversight role on 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 admit 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 admit 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.

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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).
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 organizational 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 to 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 some well-qualified staff from outside government and to 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 4.1 below.

**Box 4.1. The 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. Up to date 1,100 MOH staff have been PRR’ed under ARTF resources. The IARCSC is also responsible for the recruitment of PHDs.

The 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 two-fold 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 criticized 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 brings in the issue of sustainability too. The assumption is that domestic revenue 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 has been finalized in May 2004. The plan outlines key competencies for the different categories of public health administration staff and includes a costing. Progress in implementation has been lower 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 a 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 emphasize health facilities in underserved and rural areas where the majority of poor households live. The hospitals in urban centres, well-known for consuming a disproportionate part of the overall resources available, did not attract the attention but 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 realize that it will be difficult for a health system to work without linking basic activities to hospital key functions. In addition, the Millennium Development 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.

\(^4\) Estimated at 30-40% of the capital investment per year.
5.1.1 **What hospital services to 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):

- Misdistribution 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 utilization, 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, to consolidate and close 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 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 image and low 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 5.1).

Box 5.1. The different hospital layers.

<table>
<thead>
<tr>
<th><strong>District hospital:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>30-75 beds, serving population of 100,000-300,000 in 1-4 districts</td>
</tr>
<tr>
<td>Providing basic surgery, medicine, obstetrics and gynaecology, paediatrics, mental health, dentistry, plus support services for nutrition, pharmacy, physiotherapy, laboratory, radiology and blood bank</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Provincial hospital:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>100-200 beds</td>
</tr>
<tr>
<td>All the above clinical and support services, plus rehabilitation services and infectious disease control</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Regional hospital:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>200-400 beds</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Specialty hospital:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primarily located in Kabul and acting as a referral centre for tertiary medical care</td>
</tr>
</tbody>
</table>

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

The fact that, prior to the war, a plentiful supply of hospitals and hospital beds was regarded as a main measure 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.

Up 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 be the responsibility of the Government. Given the political and sensitive issues linked to hospital reform, the current picture is still one of heavy 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 be found in rationalizing the current hospital system. According to Csaszar Gochtchoff 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 practiced in the hospitals is unable to record financial data that are needed for a comprehensive financial analysis. Although efforts to improve budget planning, execution and monitoring are ongoing, time will be required to achieve an appropriate budget framework. In terms of transparency and accountability, this issue appears crucial, especially for the credibility and the success of any cost recovery scheme.

The bureaucratic organizational structure could prevent from effectively responding to the reform. Concerns relate to the challenges and obstacles to implementation that will be left to lower level managers. As elsewhere, 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 in the number of public hospitals due to the pressures from politicians and the 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 expenditures in the future, far exceeding Afghanistan's financial capabilities and threatening sustainability.

The EPHS implementation requires substantial new contributions from the 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 side, 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 from discretionary Government funds. Five provincial hospitals to be selected will be part of the 2-year proposal (MOH, 2005b). Although the methodology for implementing the project includes contracting-in certain technical components, it is not clear how it 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, 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 hospital reform challenges is then to ensure that hospital services are made available to the most in need. To date the real volume of public and private resources going into the provincial and regional hospitals is unclear. It is therefore difficult to assess which type of activities is really financed, by whom and whether they are benefiting the vulnerable and poor groups. The average occupancy rate below 50% highlights the need to better understand the determinants of low utilization, and the ability to and willingness to pay in relation to 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 going beyond the poor, with significant informal payments which act 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, will be sufficient to protect the poor. To-day the conviction to protect the poor at health facilities level seems rather weak and an essential determinant is the extend of political commitment. In that sense the Interim Poverty Reduction Strategy Paper (IPRSP), prepared by the Government, should be an important document to amount for a level of political commitment and for developing pro poor strategies.

5.2 THE 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 BPHS5. Methodological constraints to the evaluative work have evolved around the sampling restriction: only those accessible health facilities were measured. Some of the results are thus 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, Ghazni, Nimruz, Paktitka and Urugzan are lagging behind, partly due to the insecurity that renders parts of the provinces inaccessible.

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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.
Overall the results showed encouraging findings but pointed out to some areas of concern as well (Table 5.1).

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

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 paying salaries, contracting has not yet challenged old ways of providing health care. The results show a weak management of common illnesses, poor interactions between providers and patients and insufficient time given to proper diagnosis and treatment. These elements have been previously identified 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 within the many priorities and pressures brought it by contracting. Some informants pointed out that higher salary 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, the NGO 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 levels of awareness. 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 related to the training of 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) offering training for hospital midwives and nurses, five are operational and supported by USAID and JICA grants.

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\(^6\) Health Management Information System
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 the problem, the HR Development taskforce began an accreditation process for midwifery schools in Afghanistan. The same process in relation to intermediate clinical staff showed huge 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 IS 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 authorizes 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 the 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 jeopardize 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 expenditures and running costs are mostly financed by external assistance. Sustainability for and beyond the major achievements is increasingly becoming an issue seriously taken into account by all stakeholders faced with the challenge to meet both BPHS and EHPS specific objectives. For the 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.
The 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 revenue, the Government will be soon or later be faced with the issue of how to generate supplemental 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. 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

Currently the sources for health care financing in Afghanistan include national resources mobilized through taxes and local revenues, donors (including multilateral and bilateral aid), NGOs, and out of pocket expenditures. The 2001 and 2002 sources, based on WHO estimates, reflect the increase in external assistance (Chart 5.1 and Chart 5.2).

Chart 5.1. Sources of financing for the health sector, 2001

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Govt (Internal &amp; ARTF)</td>
<td>5%</td>
</tr>
<tr>
<td>Donors (Grants &amp; Loans)</td>
<td>4%</td>
</tr>
<tr>
<td>NGOs</td>
<td>1%</td>
</tr>
<tr>
<td>Households</td>
<td>90%</td>
</tr>
</tbody>
</table>

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.”
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 can be considered as partial.

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 remaining from the national budget. But the information about public health expenditures 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, the JHU carried out, in 2004, a study that sheds some light on health-seeking behaviours and out-of-pocket expenditures in Afghanistan (MOH, JHU, IIHMR, 2005b). While the study is not a nationally representative household survey\(^9\), the main findings are summarized below.

- **Where was health care sought: public health services are used**

Based on the survey results, seeking care in government health facilities is popular. The nearest public health clinic was used by a large percentage of the population (Chart 5.3).

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\(^8\) 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.
However, this finding may not fully be 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 expenditures.

- **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 thirty six per cent did not seek care because they did not perceived their illness as serious; the cost of treatment affordability was an obstacle for 30% of the respondents.
Chart 5.4. The main reasons for not seeking health care

- **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 the findings, households spent an average $28.5 per capita per year on health care. The breakdown of health expenditures 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, the payments to the public health clinics remained low. This finding did not differ significantly between the poorest and the wealthiest quintiles.

In Nangahar province, another study, unpublished, found that out-of-pocket expenditure amounted $40 per capita per year and imposed a significant burden on households (Health Net International, personal communication). This figure is however controversial as many patients in the study area are seeking 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 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 commonly source of funds to pay was family members and friends but, since these payments have to be repaid, it could place 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.
Chart 5.5. The primary sources of funds to pay for health care among people experiencing financial distress


Additional information from the NGO cost-sharing assessment stressed that the exemptions 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 by 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 amounts 5 Afghanis, which equals approximately to $0.1. The preventive services are free of charge and patients make a symbolic payment for their patient booklet. The drug costs are charged at between 20 to 40% of their purchasing price, but there is no difference between the drugs, whether antibiotics or vitamins. The efficiency of the collection system has not been assessed.

Only two NGOs were retaining the revenue they collect to replenish their stock of drugs. Typically fees have generated no more than 10% of total recurrent costs. This finding confirms that the current user fees had not been designed for an efficiency purpose. 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.
5.4.4 How can the government use the results of this analysis to formulate policies?

The current fee system has not been aimed, with few exceptions, 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 stage and is expected to be a learning process throughout a 12-month period, a timeframe that may be too short to draw definitive conclusions about the costs, benefits and measures for minimizing 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 persons. A committee comprised of communities and health representatives will manage the CHF. The reasons for setting a CHF include resource mobilization for health care and financial protection. Whether CHF will have a positive effect on resources mobilization in the piloting areas is too soon to tell and a great challenge lies in how insurance could be expanded so that it reaches the poor. While the $6 pre-payment may appear negligible, this amount is substantial for many Afghan people, 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 doesn’t. This calls for action-oriented research whereby processes are studied, while implementing. Important relevant questions would include:

- How will user fees affect health care utilization, particularly among the poor?
- How much are health individuals willing to pay for insurance premiums?
- How will cope the scheme with the problem of moral hazard?
- How will develop the institutional and managerial capacity necessary to administer 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 system and further reduce the income base of already vulnerable people.

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\(^{10}\) 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.
5.4.5 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 would demand 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 organization 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 enhancements that are visible to the people.
- An additional implication is that it would seem pertinent to improve community sensitisation, and technical capacities to manage an insurance scheme.

On the one hand, it is important not to idealize the roles of community organizations and health committees. Local structures varies in terms of their effectiveness and the extend to which they are representative. In some instances, the role of the shuras 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, awaiting for a committee to manage the CHF by itself may sound 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 those, the future is even more blurred: most donors are channelling money through the BPHS and with the gradual handover of urban clinics to the MOH, there is little space available, unless targeting 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 with the view to return back to the 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 a large 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, high expatriate staff turn over, 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. Next to the GCMUs as a driving force, the NGOs, for the time being, have 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 represents 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 to reduce the scale of their intervention 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 in the tragic October events targeting to a mobile medical team from Afghan Health Development Services (AHDS). Decreasing the scope of NGO geographic coverage could have potential drawbacks with the BPHS remaining inaccessible 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. Success has been possible because donors have made considerable financial commitment. 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 hardly allows drawing generalised conclusions. 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.

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 must increase its health expenditures. Such recommendation is based on the assumption that the fiscal system can be significantly improved and that the taxes will really be used efficiently by the health sector. Presumably, the population is also willing to pay those taxes and have the confidence in the State to carry out the tasks.

Even though 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, potential downside risks in increasing user contribution cannot be overlooked. And finding a balance between efficiency and equity will represent a challenge, with careful attention 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, to identify the poor and pay on their behalf may be used as alternatives to improve access to hospital services.

Most observers of Afghanistan today would agree 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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**ANNEX 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  
Dr Naimatullah 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. Sidiquallah Shinwarie, Director General

MDM  
Camille Perreand, Chargé de projet “Contractualisation”

Terre des Hommes  
Dr Noor Khanum, MCH Project Coordinator
ANNEX 2. MOH Organizational Chart
ANNEX 3. Organizational structure for hospitals
ANNEX 4. Scope of opportunities for contracting at hospital\textsuperscript{12}

\textbf{Financial institutions} \hspace{1cm} \textbf{Public authorities: National or local level} \hspace{1cm} \textbf{Patients or communities}

\textbf{Health partners in the country: group of facilities, networks}

\textbf{Foreign partners: twinning, cooperation with local partners}

\textbf{HOSPITAL Internal contracts}

\textbf{Training and research organizations}

\textbf{Selling non medical outputs}

\textbf{Human resources}

\textbf{Contracts of services: Logistics, Maintenance, Management Medical services}

\textbf{Purchasing inputs}

\textsuperscript{12} As presented during the Hospital reform module, WB Flagship course for Afghanistan.