Mobilizing NGOs through Coordinated Donor and Ministry Support for Basic Health Care Service Delivery in Afghanistan, 2002–14

**PROJECT DATA**

- **PARTNER ORGANIZATION:** World Bank
- **ORGANIZATION TYPE:** Multilateral
- **DELIVERY CHALLENGES:**
  - Government coordination; stakeholder coordination
- **DEVELOPMENT CHALLENGE:** Health service provision
- **SECTOR:** Health, nutrition, and population
- **COUNTRY:** Afghanistan
- **REGION:** Asia
- **PROJECT DURATION:** 2002–12 (SEHAT project ends in June 2018)
- **PROGRAM TOTAL COST:**
  - HSERDP: US$75 million IDA + US$0.5 million JSDF
  - SHARP: US$79 million IDA + US$46 million ARTF
  - SEHAT: US$100 million IDA + US$537 million ARTF + US$12 million HRITF + US$17 million JSDF (JSDF started during SHARP project and closed during SEHAT project)
- **ORGANIZATION COMMITMENT:** US$254 million (total IDA since 2002)

**CONTACTS**

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**In Brief**

- **Development Problem:** In early 2002, the newly appointed Transitional Government of Afghanistan faced the urgent need to reestablish and strengthen the health service infrastructure, which was shattered when the Taliban government fell in late 2001. All measures of health status, including service coverage, life expectancy, mortality rates, and immunization rates were extremely low.

- **Program Solution:** The government introduced a program of contracting out services to NGOs, funded by international donors. The contracts provided standards for basic health services and mechanisms for monitoring and evaluation.

- **Program Results:** Data appear to show rapid improvement in access to primary and reproductive health services; results may be skewed by the difficulty in collecting data in remote areas. Early use of lump-sum contracts permitted a focus on performance, but the change to least-cost contracts shifted the emphasis to input management. However, since least cost selection method was used only in a few insecure provinces during the SHARP project,
the procurement of NGOs under SEHAT still followed the QCBS method with a results-focused approach and hence might explain the overall positive outcome.

Executive Summary

In 2002, the health care system in Afghanistan was extremely weak. All measures of health status, including service coverage, life expectancy, mortality rates, and immunization rates were extremely low.

The government concluded that contracting out to NGOs was the best means of delivering primary health care services. Most of the primary health services were provided by NGOs in the 1980s and 1990s, so it was easier to use contracting with NGOs as a means to rapidly expand services, while facilitating direct funding by donors to NGOs would not give the Ministry of Public Health (MoPH) the means of building their capacity for delivering these services themselves.

The three major donors to the sector (World Bank, USAID, and EU) support contracting out to mobilize NGOs. The World Bank, through the Health Sector Emergency Reconstruction and Development Project (HSERDP) uses Performance-based Partnership Agreements, which provide for lump-sum, flexible funding. The EU and the USAID, however, use input-based contracts, which are less focused on performance-based assessment.

The MoPH was “in the driver’s seat” in the development of the overall approach, and the Health Sector Emergency Reconstruction and Development Project (HSERDP) in particular. The MoPH develops the Basic Package of Health Services, determining which services were needed in underserved rural areas, prioritizing them, and choosing interventions that were known, based on international experience, to be cost effective. The MoPH also structures the partnerships with NGOs to create and reinforce incentives for performance.

The leadership staff for the approach was carefully chosen. The MoPH establishes the Grants and Contracts Management Unit, staffed with one internationally and several locally recruited Afghan consultants, to determine baseline estimates of the number and distribution of public health facilities and staff, gaps in access, and use of basic health care interventions, lead the development of the Basic Package of Health Services, and manage the contracting process.

Between October 2003 and mid-2004, NGOs begin service delivery in 33 provinces.

The Bank and GCMU agree to the MoPH Strengthening Mechanism, or contracting in, which places some programs under government control. This enables comparison of government and contracted-out service delivery programs.

The government contracts with third parties for annual collection and review of data on health care system performance. The data enable the government to assess the performance of NGOs and to add additional services based on need.

The Afghanistan Health Survey is completed in 2006. The survey shows remarkable improvement in health outcomes, encouraging continued use of contracting-out.

The governmental agencies involved in the health services programs are reorganized. The changes create ambiguity as to the responsibility for oversight of service delivery within the MoPH and tension over the distribution of responsibility for oversight of NGO contracts and performance.

HSERDP closes in 2009. The Bank and the MoPH agree on a follow-up program, Strengthening Health Activities for the Rural Poor (SHARP). SHARP repeats the design of HSERDP emphasizing contracting-out, but changing from a lump-sum to a least-cost payment system.

The Afghanistan Mortality Survey is completed in 2010. The survey data suggested very rapid improvements in the infant mortality, under-5 mortality, and maternal mortality rates, encouraging continuation of the contracting-out approach.

SHARP closes in 2013 with satisfactory results, and System Enhancement for Health Action in Transition (SEHAT) begins. The World Bank, the EU, and the USAID agree to use a single set of contracting-out and monitoring and evaluation procedures for all 31 contracting-out provinces under SEHAT. [Both USAID and EU agreed to channel their resources for BPHS and EPHS delivery via ARTF, which was administered by the Bank].

Introduction

Development Challenge

In early 2002, the newly appointed Transitional Government of Afghanistan faced enormous challenges, including an urgent need to reestablish and strengthen the delivery of health services. Afghanistan’s weak
health infrastructure, never robust, was essentially shattered when the Taliban government fell in late 2001 (see O’Connor 1994). Health conditions were abysmal, particularly for women and children, and, although the Taliban were no longer in charge, it was evident that provision of health care services would remain a challenge in the continuing environment of conflict and insecurity.

Reliable data on health were simply not available, itself a major challenge, but estimates based on models and an early survey of reproductive health data in 2002–03 suggested that Afghans faced some of the toughest health challenges on the globe. Life expectancy was estimated at 44 years for men and 45 years for women, and the maternal mortality ratio was estimated at 1,600 deaths per 100,000 live births, among the highest ever recorded. Only about 5 percent of births were attended by health workers with any form of modern health training. The infant mortality rate and the under-5 mortality rate were estimated at 165 per 1,000 and 250 per 1,000, respectively, very high relative even to neighboring Pakistan (90 per 1,000) and Iran (26 per 1,000) for the same time period. The extent of health care services as measured by full immunization coverage in rural areas was estimated at only about 15 percent. Access to health care services, defined as living within one hour of a health care facility, was limited to less than 10 percent of the population (Newbrander et al. 2014). Private households are the main source of finance for Afghanistan’s health care system, and out-of-pocket expenditures accounted for nearly three-quarters (73.3 percent) of all health spending in 2011–12 (Afghanistan Ministry of Public Health 2013a).

In 2002, coverage of basic preventive, preventive, and curative services was, to the degree it had been documented, very low. For example, routine immunization coverage was estimated to be below 50 percent, access to skilled birth attendance was very low, and few existing health facilities had female staff, crucial for overcoming cultural barriers to women’s use of services (see trends in figure 1).

A health resource assessment carried out by the MoPH and its partners in 2002 found that about 80 percent of existing health care facilities were either operated or supported by NGOs (Afghanistan Ministry of Public Health 2002).

**Delivery Challenges**

As the Transitional Government and its development partners considered the future of the health care sector in Afghanistan, they identified several major problems, especially the need for urgency and speed in developing a response to longstanding gaps in health care service delivery.

Afghanistan’s difficult geography made access to health services challenging for the population in remote rural villages. Health care coverage was especially poor for women, who were further impeded from seeking care because of cultural barriers and a lack of adequate female staff in health care centers (themselves restricted in their mobility due to these prevalent norms). The lack of community midwives in particular led to grave obstacles in the provision of necessary obstetric care, leading to the alarming maternal and infant mortality figures quoted above.

The government and its partners also recognized that there was very little capacity to lead or manage service delivery within the central Ministry of Public Health (MoPH) and even less capacity at the provincial and local levels. In fact, there was no agreed vision of the roles and responsibilities of provincial government and even less clarity on the role of sectoral offices such as health care. Ongoing staffing problems with respect to recruitment, placement, retention, and continuing
education of trained and specialized staff at all levels (including administration and service delivery) made it hard to establish, let alone sustain, public health system infrastructure in remote, rural areas.

In this environment of partial and fragmented service delivery, with most of it managed by NGOs without central coordination or stewardship from the government, the state of health care provision became even more fragile.

The best approach for improving services as soon as possible seemed to be supporting the efforts of existing NGOs to improve and expand their health care service delivery programs. The main delivery challenge the MoPH and its partners now faced was how to mobilize NGOs to improve basic health services, particularly for rural and remote women and children, at scale, while simultaneously developing systems that would enable monitoring and accountability for their performance.

The government and its partners faced three critical delivery challenges:

• The need to build stakeholder support for, and establish leadership to develop and manage the process of, mobilizing and engaging NGOs in expanding their efforts for health care service delivery at a provinceweide level.
• The management of universal, primary, secondary, and district hospital levels of care under the scheme.
• The design of contracting mechanisms and the means of enabling the government to hold NGOs accountable for the delivery of services.

To address these issues, the government launched the HSERDP in 2002.

### Contextual Conditions

In 2002, with a population estimated at about 24.5 million and per capita GDP of US$186, Afghanistan was among the poorest countries in the world. It was in the earliest stages of post-conflict reconstruction and transition with substantial security issues. More than 80 percent of the population lived in rural areas, distributed across a vast and challenging geography, largely in very small remote villages in highly mountainous or high arid plateau regions with few roads and poor transportation and communication links.

### Access to and Coverage of Basic Health Care Services

Access to health care services was poor and coverage of basic preventive, preventive, and curative services was very low. Most of the health care facilities that existed were operated or contracted out to NGOs and these health care facilities were primarily situated in urban and accessible rural areas leaving large parts of the population underserved. In addition, the international NGOs working to support the health sector in 2002–03 were managing relatively small, geographically scattered projects according to their own principles and policies with no policy guidance or oversight from the government. Coordination with central policy makers in Kabul was haphazard and there were no clear policy guidelines or mechanisms through which the MoPH could track what the NGOs were doing, what results they were achieving, at what cost, and the remaining gaps in overall coverage.

### Access to Female Health Service Providers

The low status afforded women has a significant impact on their health and that of their families and creates barriers to the training and placing of women health care providers, a key to providing services to women and children. Women’s lack of mobility and longstanding cultural traditions constrain their ability to travel outside the home without an accompanying male relative. They also constrain the ability of women providers, whether specialists such as ob-gyns or primary care workers such as community midwives, to travel to remote health posts and positions without being accompanied by a father, brother, or mahram (a person with whom the woman is entitled to travel). In this cultural context it is critical that female providers be available to increase access to and use of health services by women and children. In 2002 there were fewer than 500 midwives across the country, and most of these were operating as private providers in urban areas.

By 2014, data show that Afghanistan achieved significant progress in overcoming gaps in the availability of female providers, although, as explored below, the limited supply of women specialists and community midwives is a continuing constraint on the quantity,
quality, and utilization of services. The progress was achieved through the development of a strong community midwife education program, successfully training more than 3,000 community midwives and deploying them throughout 32 of Afghanistan’s 34 provinces.

Looking back over the past 14 years, many observers among the donors, NGOs and in the MoPH cite this development as a core element of Afghanistan’s success in improving access to and use of basic reproductive and health care services. At the same time, they recognize that challenges in recruitment, placement, retention, and continuing education for the community midwives present major risks to further improvement in health care services and outcomes (Speakman et al. 2014).

The health care workforce was also fragmented across skill levels and insufficient in terms of geographic distribution and gender. Few providers remained active in public service, as a result of difficult working conditions, in which salary payments were both inadequate and received on an irregular basis. Although early work on assessing health care resources suggested that as many as 11,000 providers were still in the country (see Afghanistan Ministry of Public Health 2002), there were far too few female providers at all levels, few administrators were working in government positions, and government planning and oversight of provincial-level health administration were inconsistent and did not exist at all at the district level. Those few civil servants remaining in their posts were grossly underpaid. Those health providers that had not left the country were working in private practice, largely in urban areas, or with NGOs. In fact, in 2002 and 2003, it was evident that NGOs were providing 70 to 80 percent of the few health care services that were being provided, although their services were conducted with no policy guidance from the government and were fragmented and unevenly distributed geographically.

**Role of Donors in Health Financing**

Because of its centrality to geopolitical strategy and the effort to counter terrorism and insurgency, Afghanistan receives more external support per capita than any other fragile or post-conflict state. Its capacity to generate revenue is highly constrained, and more than 85 percent of Afghanistan’s health care sector expenditures come from international assistance (Belay 2010). Reliance on international resources will likely continue. Aid has been provided through both on- and off-budget mechanisms, with the World Bank, the European Union (EU), and the U.S. Agency for International Development (USAID) contributing the majority of resources to the sector. As a consequence, Afghanistan’s development partners are integral stakeholders in the setting of health care sector policy.

**Tracing the Implementation Process**

In tracing the implementation process, we first provide a brief overview of the program using a timeline that traces the main inflection points for the project and show how those inflection points affected the choice of delivery response. Subsequent sections explore the implementation of the approach, focusing first on the establishment of contracting mechanisms and their evolution, and second on the establishment and use of monitoring and evaluation systems to manage the performance of the NGOs.

Table 1 outlines the major events and actions in the effort to use contracting-out as the primary means of mobilizing NGOs to provide health care services in Afghanistan. Also refer to annex A for a process-mapping diagram, tracing the implementation process in terms of intermediate steps leading to the end objective of improved health outcomes.

**Early Deliberations on Choice of Approach**

In early April 2002, Ashraf Ghani, the Transitional Government’s acting Minister of Finance (and now the President), representatives of the MoPH, and donors met to discuss how best to respond to the daunting challenges in the health care sector. They identified three major policy options:

- The government could substantially increase the size of the MoPH and make it the primary supplier of services. This approach was dismissed due to capacity constraints for financial management at the national and provincial levels and the possibility that provision of services would be inefficient and prone to risks of corruption.
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Observation</th>
<th>Science of Delivery principle</th>
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<tbody>
<tr>
<td>April–June 2002</td>
<td>Government (Ministry of Finance and MoPH) and principal donors agree to pursue contracting out to NGOs as means of primary service delivery under HSERDP</td>
<td>Inflection point: MoPH would need to develop contracting and accountability mechanisms</td>
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<tr>
<td>June–August 2002</td>
<td>Establishment of GCMU</td>
<td>Use of project preparation funds and international consultant fee schedule accelerated recruitment and enabled hiring of highly qualified staff at rates significantly above civil service scale</td>
<td>Adaptation</td>
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<tr>
<td>Early 2003</td>
<td>Completion of Afghanistan National Health Resources Assessment</td>
<td>Established baseline estimate of number and distribution of public health facilities and staff, gaps in access, use of basic health care interventions; confirmed need to focus on NGOs as sources of service delivery in view of lack of government capacity, especially at provincial and local levels</td>
<td>Evidence-based planning</td>
</tr>
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<td>April 2003</td>
<td>MoPH, principal donors, and other stakeholders agree on standards and priorities for BPHS</td>
<td>BPHS becomes the technical backbone of health policy and strategy and the basis for the content of NGO contracts</td>
<td>Inflection point: Stakeholder collaboration</td>
</tr>
<tr>
<td>June 2003</td>
<td>World Bank and government of Afghanistan approve Health Sector Emergency Reconstruction and Development Project</td>
<td>Health Sector Emergency Reconstruction and Development Project (HSERDP) establishes the basic mechanism for PPAs, including the principle of lump-sum funding</td>
<td>Inflection point: Health Sector Emergency Reconstruction and Development Project (HSERDP) is launched at provincial level</td>
</tr>
<tr>
<td>October–December 2003</td>
<td>GCMU completes PPAs with seven provinces</td>
<td>Both USAID and EU use input-based mechanisms for supporting NGOs, which do not permit use of lump-sum payments and are less focused on performance-based assessments</td>
<td>Scaling up and stakeholder collaboration</td>
</tr>
<tr>
<td>Mid-2004</td>
<td>USAID implements projects, using a technical assistance contractor to support NGO service delivery contracts in 16 provinces; EU starts support to 10 provinces</td>
<td>Enables comparison of government and contracted-out service delivery programs</td>
<td>Inflection point: All three major donors to the sector (World Bank, USAID, and EU) support contracting out to mobilize NGOs. However, EU and USAID’s use of various forms of line item review and monitoring creates three different rules of the game for contracting</td>
</tr>
<tr>
<td>December 2004</td>
<td>Bank and GCMU agree to MoPH Strengthening Mechanism, or contracting in, through additional managerial staff and salaries in three provinces</td>
<td>Enables comparison of government and contracted-out service delivery programs</td>
<td>Inflection point: adaptive response; small-scale pilot programs within Health Sector Emergency Reconstruction and Development Project (HSERDP), learning lessons and going to scale</td>
</tr>
<tr>
<td>2005</td>
<td>MoPH contracts with The Johns Hopkins University and Indian Institute of Health Management Research for third-party monitoring and evaluation</td>
<td>Stakeholder collaboration; organizational change; third-party monitoring and evaluation enables annual collection and review of data on health care system performance</td>
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<tr>
<td>Mid-2005</td>
<td>First revision of BPHS</td>
<td>Using feedback on health conditions, MoPH expands BPHS to include mental health and management of disabilities</td>
<td>Adaptation</td>
</tr>
<tr>
<td>2006</td>
<td>First BSC measures quality and quantity of service delivery; reissued each year through 2012</td>
<td>Important means of assessing performance of NGOs in service delivery and quality</td>
<td>Adaptation and innovation; BSC enables HSERDP to identify and account for poor-performance indicators on a frequent basis</td>
</tr>
</tbody>
</table>
• Encouraging the international and Afghan NGOs who were already providing services to expand their efforts using financial support directly from donors. This might lead to some quick wins on providing services, but would not help the MoPH build its capacity to lead and guide the development of the sector and risked continuation of incomplete, fragmented service coverage.

• The government could work directly with the NGOs, using a performance-based partnership or contracting mechanism. The MoPH would be responsible for defining and managing the agreements between the government and the NGOs on what services should be delivered and where, and could ensure that the multiple international donors eager to help Afghanistan worked from a government-owned and -operated set of principles and procedures.

Reflecting back on these early discussions of strategy in early 2014, Dr. Ahmed Jan, the Acting Minister of Health in 2015 and one of the original leaders of the GCMU in 2003, noted that pursuing the third of these options was clearly the most promising approach. Prior to joining the MOPH to help with the reconstruction of the health sector, and as a leader in a local NGO, Dr. Jan had helped a colleague in the MoPH rehabilitate a dilapidated facility.

Table 1 Mobilizing NGOs to Delivery Basic Package of Health Services: Timeline of Key Events (continued)

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>Mid-2006</td>
<td>Afghanistan Health Survey completed</td>
<td>Shows remarkable improvement in health outcomes, encouraging continued use of contracting-out under HSERDP</td>
<td>Feedback from the 2006 Afghanistan Health Survey reinforces that progress is being made in improving access to services and reinforces decision to contract out</td>
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<tr>
<td>Late 2008–early 2009</td>
<td>Reorganization of MoPH: GCMU reports to Directorate of Procurement and Finance; Health Economics and Financing Department established</td>
<td>HSERDP closes after three extensions of financing and extensions of NGO contracts (for an average of 76 months) and positive evaluations by the World Bank and the government of Afghanistan.</td>
<td>Reorganization created ambiguity as to responsibility for oversight of service delivery within MoPH and tension over distribution of responsibility for oversight of NGO contracts and performance</td>
</tr>
<tr>
<td>June 2009</td>
<td>HSERDP closes</td>
<td>HSERDP closes after three extensions of financing and extensions of NGO contracts (for an average of 76 months) and positive evaluations by the World Bank and the government of Afghanistan.</td>
<td>Adaptation</td>
</tr>
<tr>
<td>2009</td>
<td>Bank and MoPH agree on SHARP</td>
<td>SHARP repeats design of Health Sector Emergency Reconstruction and Development Project (HSERDP) emphasizing contracting-out, but changing from lump-sum to least-cost payment system</td>
<td>Evidence-based planning</td>
</tr>
<tr>
<td>2010</td>
<td>Afghanistan Mortality Survey completed</td>
<td>Information on project performance suggested very rapid improvements in the infant mortality, under-5 mortality, and maternal mortality rates and indicated the need to reform or restructure poorly performing areas</td>
<td>Inflection point: The World Bank, the EU, and USAID agree to use a single set of contracting-out and monitoring and evaluation procedures for all 31 contracting-out provinces under SEHAT</td>
</tr>
<tr>
<td>2013</td>
<td>SHARP closes with satisfactory results, SEHAT starts</td>
<td>Inflection point: The World Bank, the EU, and USAID agree to use a single set of contracting-out and monitoring and evaluation procedures for all 31 contracting-out provinces under SEHAT</td>
<td>Evidence-based planning</td>
</tr>
<tr>
<td>January 2015</td>
<td>MoPH launches the new Way Forward Committee to review service delivery systems</td>
<td>Inflection point: adaptation to provide information on lessons learned</td>
<td>Evidence-based planning</td>
</tr>
</tbody>
</table>

Note: BPHS = Basic Package of Health Services; BSC = Balance Score Card; EU = European Union; GCMU = Grants and Contracts Management Unit; HSERDP = Health Sector Emergency Reconstruction and Development Project; MoPH = Ministry of Public Health; NGO = nongovernmental organization; PPA = Performance-Based Partnership Agreements; SEHAT = System Enhancement for Health Action in Transition; SHARP = Strengthening Health Activities for the Rural Poor; USAID = United States Agency for International Development.
that was needed for high-priority training in a matter of days, much to the surprise of his colleagues, who noted that it would have taken the government months to accomplish the same work. He believed that it would take too long for the government to build the capacity to deliver services directly because they were starting from scratch.

Development of Contracting Mechanisms

Building Stakeholder Support for the Contracting-Out Approach

Stakeholders in the Health Care Sector in Afghanistan

Although other developing countries, notably Cambodia, had experimented with the use of a contracting mechanism to partner with NGOs, Afghanistan was the first country to use the approach on a national scale. Developing the approach in Afghanistan required building support among a wide range of stakeholders, especially in the absence of documented evidence. Beyond leaders in the Ministry of Finance and the MoPH, the donor agencies would need to be convinced that this was the right strategy, and there were concerns among the NGOs themselves with the appropriateness of the approach. Figure 2 and table 2 show some of the key stakeholders whose engagement with Health Sector Emergency Reconstruction and Development Project (HSERDP) would be important to its success.

Mobilization of Stakeholders in Favor of Contracting-Out

Dr. Benjamin Loevinsohn, the World Bank’s Task Team Leader for the health care sector in Afghanistan, had experience in developing Cambodia’s public-private partnership with NGOs, and he played a major role in articulating the basic principles of the contracting-out approach during late 2002 and early 2003. He championed several key points based on his experience in Cambodia.

![Figure 2 Major Stakeholders in Afghanistan: Flow of Resources and Information](image-url)

Source: Author’s elaboration.

Note: ARTF = Afghanistan Reconstruction Trust Fund.
Several leaders of the MoPH attributed much of their early success in addressing these problems to Dr. Loevinsohn’s intensive engagement and, as described by Dr. Jan, his charismatic leadership in articulating the benefits of the contracting-out approach both to those in the MoPH (charged with its development) and to stakeholders among the NGOs and donor representatives concerned with the development of the sector. The major focus of his advocacy, in face of questions about the approach from other donors, particularly the World Health Organization (WHO) and several UN agencies, was on (1) the need for the MoPH to be “in the driver’s seat” in the development of its approach, including determining the priorities for what services would be developed, (2) the need to prioritize provision of services to meet the needs of underserved rural areas using interventions that were known, based on international experience, to

and his understanding of the situation in Afghanistan. Several leaders of the MoPH attributed much of their early success in addressing these problems to Dr. Loevinsohn’s intensive engagement and, as described by Dr. Jan, his charismatic leadership in articulating the benefits of the contracting-out approach both to those in the MoPH (charged with its development) and to stakeholders among the NGOs and donor representatives concerned with the development of the sector. The major focus of his advocacy, in face of questions about the approach from other donors, particularly the World Health Organization (WHO) and several UN agencies, was on (1) the need for the MoPH to be “in the driver’s seat” in the development of its approach, including determining the priorities for what services would be developed, (2) the need to prioritize provision of services to meet the needs of underserved rural areas using interventions that were known, based on international experience, to

Note: BPHS = Basic Package of Health Services; EU = European Union; GCMU = Grants and Contracts Management Unit; HMIS = Health Management Information System; MoPH = Ministry of Public Health; NGO = nongovernmental organization; USAID = United States Agency for International Development.

Table 2 Health Care System Stakeholders in Afghanistan

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Function</th>
<th>Interests/Concerns/Issues</th>
</tr>
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<tbody>
<tr>
<td>Ministry of Finance</td>
<td>Agree on national health sector strategy, channel donor and domestic resources</td>
<td>Endorsed contracting-out as likely to more quickly reconstruct the health care sector</td>
</tr>
<tr>
<td>Ministry of Public Health</td>
<td>Develop and implement national health care policy and strategy</td>
<td></td>
</tr>
<tr>
<td>Grants and Contracts Management Unit</td>
<td>Lead and manage process of contracting with NGOs; provide procurement guidance; from 2003–08, monitored all NGO contracts</td>
<td>Central unit responsible for development and implementation of contracting-out and contracting-in systems; well-resourced and staffed; accountable to donors for implementation and management of all NGO contracts, which make up the vast bulk of expenditure in the health sector.</td>
</tr>
<tr>
<td>Technical Departments</td>
<td>Provide technical guidance</td>
<td>Roles became more prominent later in implementation process, with technical departments taking on various off-budget technical programs</td>
</tr>
<tr>
<td>Monitoring and Evaluation Department</td>
<td>Monitor and evaluate of NGO performance</td>
<td>Allocation of authority among Monitoring and Evaluation Department, Health Management Information System, and Grants and Contracts Management Unit grows more ambiguous through implementation period</td>
</tr>
<tr>
<td>Health Management Information System</td>
<td>Provide data and assist in creating projects that are adaptive and iterative</td>
<td>Responsible for design and collection of routine facility-level health management information systems, funded by off-budget support from USAID</td>
</tr>
</tbody>
</table>

Principal donors

- World Bank: Strategic, technical, and financial assistance
- USAID
- European Union

External monitoring agencies

- Johns Hopkins University and Indian Institute of Health Management Research: Contracted by Grants and Contracts Management Unit to support national monitoring and evaluation through annual health surveys and facility-based Balanced Score Card
  - Provided crucial data and unbiased performance overview

- NGOs: Delivery of BPHS at provincial and district levels through contracts with Ministry of Public Health
  - Concerns about flexibility in contract terms and service delivery, particularly recruitment, retention, and deployment of female health care providers

- Provincial Health Departments: Responsible to provincial governor; in initial stages, not directly involved in selection and oversight of NGO contracts, but later assumed a more central role
  - Relationship to central Ministry of Public Health initially ambiguous

  - Played a key role in the later part of the project after elections in 2008–09, not initially involved in strategy or management of contracting process. Growing engagement and interest/concern with contracting out since elections.

- Citizens and consumers: Beneficiaries and stakeholders; responsible for providing citizen feedback
  - Currently have little voice in determining health policy or strategy
be cost effective, and (3) the need for the mechanics of partnering with NGOs to create and reinforce incentives for performance.

Therefore, the contractual mechanism would need to create incentives to perform among participating NGOs, and the MoPH would need to strengthen its role as a steward of the sector, focusing on policy development, coordination of donor support, and, especially, building its capacity to monitor service delivery and track changes in health outcomes (see annex B for a more detailed overview of the programmatic process).

**Challenges Encountered**

At the start, other key stakeholders, including several government leaders outside the health care sector, wanted to see the MoPH focus on provision of curative services, directing resources to hospitals in urban areas that were in a state of near collapse. Several of the NGOs already operating in Afghanistan were concerned that the contracting-out approach would undermine the development of direct service provision by the government or undermine the independence of NGOs and their ability to innovate or critically comment on the government’s health care services. The Swedish Committee for Afghanistan (SCA) was a service delivery contractor from 2004 through 2014. Dr. Jürgen Homstrom, Executive Director at SCA from 2002 through 2014, recalled in January 2014 that the SCA conceived of its role as that of a “bridging function,” helping fill gaps in service delivery in the short term while the government built up its capacity as the direct provider of services. Other NGOs were concerned that they would not be able to build up their capacity to provide services on a provincewide basis or were skeptical that the MoPH would be able to develop credible mechanisms for defining contractual arrangements or would have difficulty timely paying for contracted services. And, in the early days, several representatives of the donor community suggested that the World Bank generally and Loevinsohn in particular were pushing the approach too strongly, perhaps for ideological reasons, even formally raising their concerns directly with the President of the Bank.

**Overcoming Initial Resistance**

However, the MoPH, with support from its own internal champions and the Ministry of Finance, was strongly convinced of the merits of the approach and pushed consistently for its adoption despite these concerns.

In 2012, Dr. Muhamed Masood, one of the original leaders in the Grants and Contracts Management Unit (GCMU) reflected that the process of arguing for and putting in place the contracting-out approach helped the MoPH establish its role in the “driver’s seat” on the development of the sector, thus avoiding the fragmentation and duplication of effort that has plagued the development of the sector in other fragile and post-conflict states.¹

The Provincial Health Departments, another key stakeholder group, were not significantly engaged in discussions of the merits or mechanics of the contracting-out approach as the program was first being developed. In the early years of the program, the role of provincial governors and their officers in overall governance, including for the health care sector, was not clear (and never had been throughout Afghanistan’s history). However, as the Transitional Government gave way to an elected government in 2008 and more formal approaches to local governance emerged, the views and concerns of Provincial Health Directors and their offices became highly relevant.

**Establishing a Leadership Team**

A key initial step in Afghanistan’s remarkable recovery was the establishment of capacity within the MoPH to develop priorities for service delivery. The team would also be responsible for assuring coherence and coordination of the multiple sources of external assistance for the sector that were becoming available in 2003 and for establishing the mechanisms that would be employed to mobilize and encourage the expansion and monitoring of services by NGOs. The first step was the formation of the GCMU, a small group of six internationally recruited Afghan management and health care specialists, several of whom had spent earlier parts of their careers working on health care delivery for NGOs in Afghanistan. The World Bank provided financial support for the establishment of the GCMU. Consultancy procurement arrangements, using international rates to attract the best talent (although for Afghan staff, it was the local rate of the NGOs and UN agencies working in Afghanistan), were used to recruit and maintain a core leadership team at the GCMU. This enabled rapid startup of preparing the contracting scheme in advance of the Health Sector Emergency Reconstruction

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¹ Masood, Mohamed. Interview by Susan Stout, February 2012. Dr. Masood became the Deputy Minister of Finance in 2012 and the Acting Minister of Finance in 2014.
and Development Project (HSERDP), as well as support programs being developed by the USAID and the EU. Reporting directly to the MoPH’s Directorate for Policy and Planning, and thus with sufficient authority to work across programmatic lines, the GCMU immediately set to work to put the contracting-out approach into place.

Setting Priorities: Basic Package of Health Services

Given the decision to extend services as rapidly as possible through contracting out to NGOs, it was crucial for the government and its partners to agree on the standards and requirements that would guide the development and monitoring of contracts with NGOs. The agreements were called Performance-Based Partnership Agreements (PPAs) to signal that NGOs could hire and fire staff and procure drugs free from government procedures in exchange for documented changes in service delivery outputs and outcomes. The PPAs were structured to encourage the use of 12 output indicators that were derived from the government’s service delivery priorities (see box 1, which includes standards for the Basic Package of Health Services [BPHS]) as the criteria against which NGO performance would be assessed.

The initial effort to formulate the service delivery priorities was driven to a large extent by external technical assistance provided through the WHO, with limited input from the MoPH and with little information about epidemiological conditions, and was considered to lack sufficient prioritization and insufficient specificity to guide the contracting process. Moreover, while the MoPH wanted to prioritize underserved rural areas and the high mortality rates of women and children, other voices sought a more comprehensive list of priorities, including strengthening curative care and addressing the urgent need for hospital-based services. The development of the BPHS was thus a key inflection point in the evolution of the health care sector.

Resolving the tensions took time and would likely not have been possible without the completion of an Afghanistan National Health Resources Assessment (using evidence to encourage stakeholder collaboration), which showed the near absence of health services in rural and remote areas and helped focus priority on this aspect of service provision. The assessment reinforced the need to focus on interventions that (1) had well-established evidence of cost effectiveness for disease in settings such as Afghanistan, (2) could be scaled up and would benefit a large part of the population, (3) identified a set of interventions that could be implemented on a national scale and would assure equity of access and benefits, and (4) would be affordable in the short term and likely sustainable in the long term (Newbrander et al. 2014).

By April 2003, intensive collaboration among key leaders in the GCMU and others within MoPH, with input from external technical advisors and consultants, produced a short, clear document that set seven specific standards (see box 1). These standards constituted the terms of the PPAs, formed the basis for the MoPH’s routine health information system, and constituted the standards used in field monitoring and supervision visits to assess facility-level performance.

Reflecting on their experiences in the sector, Dr. Ahmed Jan and his colleagues stressed how important it was to set out a specific package of health care services for a fragmented and weak health care system. The development of the BPHS (which has since become the acronym for referring to Afghanistan’s overall primary health care effort) was essential to the government’s

<table>
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<th>Box 1 Standards for BPHS</th>
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<tr>
<td>1. Maternal and Newborn Health</td>
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<tr>
<td>• Antenatal care</td>
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<td>• Delivery care</td>
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<tr>
<td>• Postpartum care</td>
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<tr>
<td>2. Child Health and Immunization</td>
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<tr>
<td>• Expanded program on immunization (routine and outreach)</td>
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<td>• Integrated Management of Childhood Illnesses</td>
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<td>3. Public Nutrition</td>
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<tr>
<td>• Micronutrient supplementation</td>
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<tr>
<td>• Treatment of clinical malnutrition</td>
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<tr>
<td>4. Communicable Diseases</td>
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<tr>
<td>• Control of tuberculosis</td>
</tr>
<tr>
<td>• Control of malaria</td>
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<tr>
<td>5. Mental Health</td>
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<tr>
<td>• Community management of mental problems</td>
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<tr>
<td>• Health facility-based treatment of outpatients and inpatients</td>
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<tr>
<td>6. Disability</td>
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<tr>
<td>• Physiotherapy integrated into primary health care services</td>
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<tr>
<td>• Orthopedic services expanded to hospital level</td>
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<tr>
<td>7. Regular Supply of Essential Drugs</td>
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<td>• All essential drugs required for basic services</td>
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ability to clarify its expectations for performance and results. The BPHS ensured that the health care services provided were not subject to the priorities and vision of individual donors. It also prevented the proliferation of program priorities that can occur when each donor works to ensure that its favored program is on the list.

Defining the BPHS mobilized all stakeholders toward the same program priorities. Designing the PPAs based on this set of services further strengthened this focus and consolidated the MoPH and GCMU’s stewardship function.

**Evolution of BPHS**

The BPHS evolved over the next 10 years in response to information on health conditions, experience with the initial package, and the MoPH’s commitment to reviewing the package on a regular basis. The iterative nature of the program enabled it to adapt and improve to deliver better results. For example, the seven standards under the 2003 version of the BPHS were divided into two tiers. Mental health and management of disability were classified as second-tier services, out of concern that the overall packages not be more demanding than could be delivered in highly remote rural areas. By 2005, however, the MoPH, responding to growing evidence of distress caused by the continuing conflict and insecurity, reclassified mental health and management of disability as first-tier services.

Also in 2005, the MoPH extended the concept of a standardized list of services to the hospital sector using an Essential Package of Hospital Services (EPHS), which specified the in-patient clinical and ancillary services and associated staffing, equipment, and drug supply standards for district, provincial, and national hospitals. Together, the BPHS and EPHS continue to serve as the policy framework and technical vision for the development of the sector, and the EPHS was part of the second round of NGO contracting starting in 2009.

**Contracting Mechanisms**

The BPHS was the foundation for the contracts that were used to mobilize NGOs. The World Bank and the GCMU drafted the PPAs. The GCMU determined the technical and financial criteria for selection of proposals, solicited expressions of interest, and shortlisted and ultimately selected the NGOs that would deliver the BPHS in specific geographic areas. Developed in compliance with the World Bank’s procurement guidance for quality cost-based selection, the PPAs provided fixed lump-sum payments with 100 percent budget flexibility for the participating NGOs. Each contract specified a set of 12 output indicators, which were to be used to assess NGO performance and in subsequent rounds of the contracting process. In addition, the Bank and the GCMU established the MoPH’s National Salary Policy, which provided the technical and policy framework for defining NGO contracts, budgets, and work plans.

USAID and the EU, the other two major donors in the sector, also endorsed the contracting-out approach. Their contracts were based on their views on feasibility and on their fiduciary and oversight rules and regulations. Over time, three different forms of contracting-out developed, one for each of the major donors.

Internal regulations prohibited USAID from providing funds directly to government agencies, such as the GCMU. Instead it contracted with Management Sciences for Health, a large consultancy and technical assistance provider with extensive experience in Afghanistan during the war years, which managed the tendering and award of performance-based grants similar to those developed by the World Bank, but using fixed budget reimbursement against specific line items. The EU was also unable at the start to channel funds directly to the GCMU, but supported direct grants to NGOs using fixed budget reimbursement payments. Review and oversight of grants were carried out by internationally recruited technical assistance providers working with the GCMU. Also, the three donors relied on different tools for monitoring and evaluation, which are discussed in greater detail below. Annex C summarizes the three mechanisms for contracting with NGOs.

Overall, by 2005, contracts or grants to NGOs for service delivery were in place for 31 of Afghanistan’s 34 provinces. Although there were significant differences in the forms of the contracts and grants for each of the major donors, all were designed to provide standards of service consistent with the BPHS (Waldman et al. 2006).
establishment and operation of systems that would enable the MoPH and the donors to monitor and evaluate performance in service delivery. Over time, the MoPH collected and analyzed data through the development of four major tools.

**Routine Health Information Systems**

Starting in 2003, with technical and financial assistance from USAID and other donors, the MoPH worked to increase the availability of routine health information. Routine health information systems provide health care service output data, data on the availability of drugs and supplies, and staffing patterns from health facilities at all levels, whether supported by NGOs under contract or in government-managed facilities (Afghanistan Ministry of Public Health 2012). Data on activity and output was sent to the MoPH’s Monitoring and Evaluation (M&E) and Health Management Information System (HMIS) Departments for monitoring and evaluation, which are responsible for collation and analysis. HMIS produced a variety of reports, including annual Provincial Profiles that mapped the geographic distribution of facilities.

Dr. Ashraf Mashkoor, who has led the HMIS since 2004, notes that the system is currently receiving reports from over 90 percent of facilities. He also identifies several lessons from Afghanistan’s experience. The strengths of the system were that they were grounded in standards and service expectations—the definitions of the BPHS and the EPHS—and were developed by a task force that included representatives from NGOs and the donor community. However, as various off-budget donor projects have been established within the MoPH, he has found that individual technical departments have added their own indicators and requirements to the HMIS tools and reporting formats, resulting in difficulty in “keeping the system simple,” which he believes was key to its success.

The HMIS also established accessible databases to enable collation and analysis by multiple users. Data analysis can be further improved by active engagement of technical specialists with service providers and frontline workers. Enabling service providers to access data collected at the facility level may provide better local service delivery.

**Independent Third-Party Monitoring and Evaluation**

A second and complementary step was the regular and robust measurement of health status, service delivery, and health outcomes. Early in 2004, the MoPH approved a contract (financed with funds from the first World Bank project) with Johns Hopkins University and the Indian Institute of Health Management Research to design and implement systems for independent third-party monitoring and evaluation of the performance of the health care system on a national basis. The systems used population-based household surveys of health status, the first delivered in 2006, as well as the design and implementation of a Balanced Score Card (BSC) used to assess performance in the delivery of the BPHS (and later, EPHS) packages at the provincial level.

The BSC was a compilation of data collected from the National Health Services Performance Assessment, which was conducted annually between 2004 and 2008 and on a rolling basis. The BSC provided robust measures of six areas of health care service delivery, including patient and provider satisfaction, and its reports encourage cross-province benchmarking of service delivery performance. The most recent report on BSC findings was released in 2012. (The survey covers an average of 700 randomly selected facilities at all levels, observations of about 6,500 patient-provider interactions, and interviews of an average of 6,000 consumers and 6,000 health care workers every year.) The BSC was an innovative monitoring tool designed in the course of the program that enabled successful information tracking and comparative donor impact analysis and, more important, encouraged evidence-based decision making, crucial in a setting with so many stakeholders.

**Monitoring NGO Service Delivery at the Field Level**

Third, the GCMU (and later the M&E, HMIS, and Technical Departments of the MoPH) conducted regular field monitoring visits at the provincial level. The GCMU had a clear monitoring plan in line with the BPHS and EPHS policies, and their reports were comprehensive, well structured, and detailed. Monitoring reports were completed adequately and were available upon request. There was also a systematic follow-up of their monitoring activities; for example, half of the facilities visited were revisited in the next monitoring mission to see if there had been any improvement.

The GCMU’s monitoring efforts were duplicated, however, when the Technical Departments and HMIS of the MoPH also carried outfield monitoring visits, which contributed to tension among them.
Population-Based Surveys

The planners of the performance-based contracting approach recognized that regular household surveys would be key to independent verification of trends in health outcomes and a complement to systems for tracking service delivery quantity and quality. To address this, a third-party evaluator designed and implemented the Afghanistan Health Survey in 2006. Although the 2006 survey showed gains in access to and use of health care services, it was, due to sample size issues, unable to estimate maternal mortality ratios.

The MoPH works closely with other surveys, particularly the National Vulnerability and Risk Assessment Survey, to track changes in health status and use of health care services and has collaborated with donors to conduct several major surveys of particular issues. In 2009, for example, the MoPH and the USAID collaborated on a survey of private-sector health providers and levels of use of health care services (ref Alsi et al. 2009) and in 2010 collaborated on the nationwide Afghanistan Mortality Survey.

Furthermore, the Afghanistan Mortality Survey, was completed in 2010 with USAID support and implemented in collaboration with the Central Statistics Office and the MoPH with a particular focus on estimating current levels of infant, under-5, and maternal mortality rates as well as on use of services. The findings confirmed evidence from the BSC that access to and use of basic services were improving and, encouragingly, suggested a 25 percent decline in infant and under-5 mortality between 2002 and 2006. It also provided encouraging outcome data on maternal health and under-5, infant, maternal, and adult mortality. For instance, the 2010 survey estimated a maternal mortality ratio of 367/100,000 in 2010, a remarkable, and in some analysts’ opinion, unrealistic level of improvement that may reflect the significant problems in getting accurate data, particularly in the most insecure southern provinces. The third-party monitors were also expected to conduct two additional household surveys in 2008 and 2010. These surveys were not implemented, however, and instead the monitors designed and implemented a survey to evaluate an experimental demonstration of results-based financing of providers, which the World Bank and the MoPH expected would further improve performance.

In light of the lack of a working civil and vital registration system and adequate demographic surveillance, conducting and collecting the data recorded through these surveys is remarkable reflection of the commitment on the part of all the stakeholders to ensure robust data collection to inform policy decisions and track performance.

MoPH Strengthening Mechanism

The flexibility of the program enabled various collaborative approaches to delivery of a common package of services. As the World Bank supported the development of the contracting-out model, growing interest and demand for support for provincial health departments led the Bank and the MoPH to develop a contracting-in approach to BPHS implementation in the three provinces immediately surrounding Kabul. The MoPH initially hoped to contract out for services among clusters within these densely populated provinces, but ultimately found that approach not workable. Instead the MoPH implemented a contracting-in model in these provinces, called the MoPH Strengthening Mechanism (MoPH/SM). Support from the Bank’s health projects (Health Sector Emergency Reconstruction and Development Project (HSERDP) and later SHARP and SEHAT) enabled the three provinces to contract in consultant managers into their provincial health offices. Funds were channeled from the Bank to the MoPH and then directly to the additional advisors and staff (including provincial managers), who were responsible for staffing and management of services using the BPHS standards. The provinces submitted quarterly reports for funds based on completion of activities in their agreements with the MoPH, where a contracted-in provincial manager facilitated interaction with the GCMU as well as with the MoPH’s Technical Departments.

Decisions on recruiting and placing health providers and procurement of essential drugs in these provinces are generally governed by Afghanistan’s standing staffing and procurement guidelines, which often result in implementation delays. An advantage of the MoPH/SM approach, however, was that it gave decision makers in government and in the donor community the ability to compare the two means of recruiting staff and procuring drugs. The MoPH/SM has continued throughout the three major projects through which Bank channeled its support to the sector flows.
Reorganization of the MoPH and the Role of the GCMU in 2008–09

In response to advice from the Civil Service Commission and internal concerns that the GCMU had become a “Ministry within the Ministry” through its control of the service delivery contracts and interactions with the major donors, two major organizational changes were made in 2008 and early 2009 to strengthen the MoPH’s stewardship role. First, the GCMU was reorganized as one of several departments reporting to the MoPH’s Directorate of Procurement and Finance. Second, the MoPH formed a new Health Economics and Finance Directorate (HEFD), which would report to the Deputy Director for Policy and Planning, to address several key policy and resource allocation issues (including the sustainability and relative cost efficiency of the three major contracting-out schemes) and to develop policy options to address the high levels of out-of-pocket expenditures in the sector.

The HEFD was formed to take on many of the strategic policy development tasks originally assigned to the GCMU. Many of the individuals who were involved in the development of the contracting scheme saw two negative consequences to this change. First, after being demoted from a directorate to a department, the GCMU, which previously had responsibility for the large majority of development of and recurrent expenditures in the sector, focused its attention primarily on the procurement and fiduciary elements of the contracting-out process. Second, the GCMU now reported to the Directorate of Procurement and Finance, whose staff were part of the normal civil service, as opposed to most GCMU staff, who were paid by donors as international consultants.

As a consequence tensions arose as to how to best organize the monitoring and evaluation of NGO contracts, as responsibilities among the GCMU, the HEFD, an HMIS department, and a new Monitoring and Evaluation Department (subsequently merged with HMIS) were not clearly delineated. Thus, the GCMU’s authority was reduced compared to that of other technical departments in the MoPH, which were growing stronger due to off-budget projects funded by the USAID and other donors, such as the Global Alliance for Vaccines and Immunization and the Global Fund. In effect, the GCMU lost authority while it faced increased pressure from internal auditors and others, including the Attorney General’s office, which did not support the lump-sum, flexible, performance-based approach to contracting that had enabled the original rapid improvement in the provision of services. Today, the GCMU is not a decision-making body, but works as the procedural guardian and facilitator of the procurement process. It organizes panel reviews, files and manages all legal documents related to the contracts, and monitors the delivery of the procured services. By 2010, with a significant increase in oversight from the Attorney General and from the MoPH’s internal audit department, the GCMU had become significantly more risk-averse, and, according to NGOs, still tends to micromanage existing contracts through line by line review rather than by evaluating the delivery of outputs and outcomes as originally intended.

Transitions in NGO Contracting Mechanisms

The World Bank, the USAID, and the EU focused their assistance to Afghanistan’s health care sector through financing NGO provision of the BPHS, and in selected provinces EPHS, with starting dates varying by donor and contract lengths between 21 and 36 months. The World Bank’s initial project, the HSERDP was extended and received additional financing twice, in 2006 (US$30m) and 2008 (US$20m). The original contracts with NGOs were extended, and the project came to a successful close in 2009. The major donors were pleased with the results that were achieved through the contracting approach, and as the projects they supported were completed, several changes were introduced in the contracting mechanisms.

The Bank and the MoPH prepared a follow-up project, Strengthening Health Activities for the Rural Poor (SHARP), which replicated the design and implementation arrangements of the first project. SHARP, however, changed the Bank’s procurement procedures from quality cost-based selection to least-cost terms. The change created headaches for the GCMU, which had to develop new procedures for tendering and evaluating NGO proposals. In addition, the transition to least-cost contracting seemed to weaken the GCMU’s initially resolute focus on monitoring and evaluation of performance and service delivery. This, in conjunction with the
reorganization of the GCMU discussed above, was perceived by NGOs as contributing to a loss of their flexibility and their capacity to innovate within given budget constraints. Moreover, the focus on least-cost procurement came, in their view, at the cost of focus on the quality of the BPHS and EPHS services. The change in the procurement regime contributed to significant delays in signing contracts for the NGOs recruited through SHARP. Five of the eight provincial contracts were not approved until the end of 2009, and the three remaining contracts were not approved until the third quarter of 2010. The delays weakened the NGOs’ ability to motivate and retain health personnel (World Bank 2014a), and they undercut the GCMU’s capacity to focus on supervision and support of contracts as it worked to meet the shifting fiduciary requirements of the three donors. The GCMU also faced increasing pressure from internal government auditors who questioned the value of lump-sum, performance-based contracts, but was able to overcome these problems and adapt to the new needs. Moreover, as the EU and USAID extended their support to provincial NGO contracts using similar but not identical procurement and financial management rules, the GCMU grew in size and complexity over time. As noted by a USAID officer in 2015, it is now more appropriate to think of “three different GCMUs” in one unit, with each trying to be responsive to external and donor requirements and balancing these with Afghanistan’s more traditional rules.

Despite these difficulties, the MoPH and the major donors maintained their commitment to the contracting-out approach and have actively worked to align the three different contracting mechanisms. A large part of that success can be attributed to the flexible stewardship of the GCMU. In anticipation of the closing of the SHARP project in late 2013, the MoPH, the GCMU, and all three donors worked to ensure that a second follow-up project, System Enhancement for Health Action in Transition (SEHAT), coordinated the support from the EU, the USAID, and the World Bank using a single, harmonized mechanism. This was a major step toward reducing transaction costs and represented, for both the EU and the USAID, a major shift toward encouraging the use of GCMU’s own system for managing the contracting process and bringing previously off-budget external support into the government’s budget management arrangements. In addition, SEHAT more explicitly makes payments on the basis of performance. (SEHAT will also continue a pilot program of results-based financing, begun during the last two years of SHARP, which gives health workers incentives for improved levels of performance, a program that could be the subject of a second case study.) The 10 provinces previously supported by the EU and the 11 previously supported by the Bank are now being supported through this unified approach, and the process of bringing the 13 provinces previously supported through off-budget support from the USAID under the unified approach is currently underway.

Use of Performance Information Going Forward

Using the monitoring and evaluation tools and systems, the MoPH developed a robust system for collecting data on health care service delivery as well as the ability to track trends in outcomes, a remarkable achievement especially when compared to other countries at similar income levels with far less fragile environments. The contracting process under SEHAT will follow the World Bank contracting process used in the past.

There are also ongoing efforts to encourage greater use of BSC and HMIS findings at the service delivery level. For the last two years, for instance, the MoPH has conducted annual BPHS-EPHS coordination meetings, where provincial officials and NGOs review the findings from these sources; these meetings constitute an important step toward encouraging benchmarking and learning across provinces and NGOs. There is strong interest among the NGOs in building on these early efforts and working toward a more robust approach to sharing lessons and issues across implementing partners.

The HEFD also makes intensive use of performance information, most recently in conducting comparative analyses of costs and efficiency between contracting-out and contracting-in approaches for strengthening the MOPH. The remaining problems of collating and organizing the various streams of monitoring information that are being collected might be addressed by the development of a central data warehousing capability. HEFD also points out that key information systems focus exclusively on data about and from providers; the patient satisfaction elements of the BSC and the systematic work to regularly gather and review feedback from health care consumers—the demand side—need to be developed.
Current Stakeholder Perspectives and Concerns

- Government officials in the MoPH: Although the MoPH and the principal donors to the sector continue their support of contracting-out, recent interviews in Kabul suggest that there are continuing debates on the merits of the model. The proponents of the contracting-in approach argue that service provision should be left entirely to the government, while defenders of the contracting-out approach argue that the NGOs are better equipped to assume the service delivery role and have more experience. Some MoPH officials indicate that this discussion has affected the cooperation and coordination between different directorates at the MoPH. There are also concerns that NGO service providers may have become complacent with current levels of effort, and that government has become unduly dependent on NGOs for service delivery.

- Provincial Health Departments: Interviews with a sample of heads of Provincial Health Departments also reflect some frustration with the contracting-out approach. They recognize that because NGOs have the flexibility to hire and fire staff and procure essential drugs locally, they are able to provide good services. Although the representatives of the Provincial Health Departments are largely supportive of the work, they express frustration with the tension between their accountability to local political leaders, which can be intense, and their limited and ambiguous responsibilities for the selection and oversight of the NGOs providing services within their provinces. Significant differences in pay between Provincial Health Officers, who are paid on the government’s civil service pay scale, and the managers and senior providers of NGOs are also a source of discontent. Officials at the MoPH in Kabul as well as among the major donors recognize the need to strengthen the capacity and engagement of the Provincial Health Departments and Provincial Health Officers going forward, explaining that they were not sufficiently engaged (since they essentially did not yet exist) when the approach was initially designed.

- NGOs: In general, NGOs support the contracting-out approach, finding the mechanism to be fair and managed professionally from Kabul, and are understandably proud of the improvements in service delivery that they have contributed. However, they have encountered substantial difficulties in identifying, recruiting, and placing sufficient numbers of female health providers, particularly specialists such as ob-gyns, where supply is simply insufficient to meet demand. Although they use their flexible contracting models to creatively hire resources from neighboring countries, procedural complications, such as visa issues, can add months to the time before a recruit is placed.

They are also frustrated that analysis of NGO proposals for service delivery contracts do not take into account past performance data, especially for the initial NGOs that overcame some challenging initial conditions. Under the current performance management mechanism there is also a great deal of micromanagement of individual line items by officials in the MoPH, and the transaction costs of working with the MoPH have dramatically increased. In addition, the tight focus on delivery according to the standards set out in the BPHS may work against the NGOs’ ability and interest in experimentation and seeking new ways of meeting the challenges of delivery in remote and rural areas.

Moreover, the absence of sectorwide pharmaceutical reform makes it difficult for NGOs to meet the international quality standards specified by donors and the specifications of the BPHS and EPHS.

Other program delivery challenges include (1) weak census data leading to poor service provision and dilution in the quality of service, (2) irregularity of performance review through monitoring tools such as BSCs, (3) not enough encouragement given to cross-provincial learning, and (4) multiplicity of information systems due to competing priorities among donor and MoPH monitoring and evaluation units.

Several NGOs also note that, particularly in recent years, they face increasing levels of pressure for expansion of service delivery facilities, particularly at the hospital level. This pressure emanated particularly from Provincial Health Officers and Departments, themselves pressured by local politicians who would value expansion of services and facilities well beyond the boundaries articulated in the BPHS and EPHS standards.

- Members of Parliament can be a source of significant pressure and interference in the contracting-out approach and in specific elements of program implementation (particularly recruitment and placing of staff). But their intervention is likely a reflection of an effort to represent the interests of citizens, which include a demand for higher quality services. Members of Parliament are also seen as champions of the contracting-out mechanism, largely supporting NGO collaboration.
Some Steps Going Forward

- Better integration of the Provincial Health Departments: Officials in Kabul and among the principal donor agencies are acutely aware of the need to clarify and strengthen Provincial Health Department and Provincial Health Officer roles and work. SEHAT allocates additional financial resources to address these issues in the context of still-evolving views on overall governance arrangements at the provincial level. Joint efforts with Provincial Health Departments and NGO managers and representatives of technical departments and GCMU for monitoring NGO facilities and performance using the National Monitoring Checklist are further steps for collaboration going forward.
- Better coordination is needed among NGOs and MoPH to reinforce common contracting mechanisms and a common management information system for data collection and performance review.
- Continuation of the annual BPHS-EPHS coordination meetings to facilitate the exchange of good practice information among provinces and donors.

Lessons Learned

Contracting for Services Can Have Positive Effects on Policy, Management, and Delivery

1. The MoPH gradually built up its capacity to manage the sector. Initially, setting up contractual services with NGOs allowed the MoPH to focus on defining the country’s health sector policy and strategy, guiding donor support to the sector, and developing mechanisms to fund a set of basic health services in all locations. At the core of this process was the GCMU, a small team of competitively recruited, internationally qualified Afghan staff who put in place service delivery contracts within 10 months of donors’ funding decision.
2. The MoPH set explicit priorities and standards in basic health care service delivery. To encourage NGOs to compete for service delivery contracts, and to ensure that all NGOs were working toward common goals, the MoPH developed clear guidance and standards for the BPHS. The MoPH was then able to use this process to review and revise these standards in response to changes in priorities and demand.
3. Key donors were encouraged to support a common vision of institutional development. The government’s decision to contract out encouraged all donors to use similar procedures and to focus on enabling NGOs to provide services at the provincial level, rather than pursuing separate, parallel visions of how to build sector capacity.
4. Stakeholders focused on performance rather than on the provision of inputs. As long as contracts were managed in a flexible way (that is, as lump-sum contracts with an agreed per capita allocation) the focus of both NGOs and government was on tracking service delivery performance and adjusting operational programs as experience showed what was and wasn’t working. However, as support to the approach transitioned through different phases of donor support, and as provincial health departments and Parliamentarians become more directly engaged with health sector issues, the willingness of the MoPH to focus primarily on performance rather than input management declined.
5. NGOs were able to use their flexibility to improve service delivery. Because they were not subject to existing government rules for recruiting and placing staff and procuring drugs and equipment, NGOs were able to quickly staff service delivery units in their areas and reduce the incidence of drug shortages. The recruitment, training, and placement of community midwives addressed the gap in access to adequately trained female providers and dramatically improved maternal and infant mortality rates. However, the program was not always successful in keeping them in place in highly insecure parts of the country.
6. Robust monitoring and evaluation mechanisms were developed. To hold NGOs accountable for the successful delivery of the BPHS to the local community, the MoPH hired Johns Hopkins University and the Indian Institute of Health Management Research to develop and implement a sophisticated monitoring service through facility-based surveys, regular household-based health surveys, and a health management information system.

Contracting for Services Can Be Vulnerable to Changes in the Environment

1. Because of a lack of capacity in more remote areas, NGO contracting was developed and managed by the central MoPH. Over time, however, the Provincial
Health Departments started demanding a role in input and oversight.

2. The MoPH’s focus gradually shifted from supporting improved performance to line by line budget management and negotiation over NGO expenditures.

3. Notwithstanding the rapid improvement in access to primary and reproductive health services, much was left out. Although the BPHS was amended to include additional basic services, such as mental health and disability management services, the concentration of service delivery resources on primary care left unaddressed major gaps and needs for improved hospital and tertiary level care outside Kabul.

**Ongoing Delivery Challenges**

1. Resurgence of conflict and insecurity constrain overall results. An increase in insecurity at all levels makes it difficult for NGOs to reliably support and supervise their service delivery staff, for MoPH to regularly visit and support provincial officials, and for donors to understand the realities of service delivery on the ground.

2. Gender norms hinder access to critical health services. Although community midwives are accepted and valued once placed in a community, their ability to provide services is constrained by the social norms prohibiting women (midwives and patients) from traveling without a male companion. This factor, combined with the remoteness of many locations, the huge gaps in communication and transportation, and the limited resources of district and provincial hospitals, makes it almost impossible to effectively manage emergency delivery services and to reduce the existing high levels of maternal mortality.

3. Donors’ diverse rules in contracting services from NGOs. Although the three major donors (the World Bank, the EU, and the USAID) agreed to the contracting-out approach, each used a different mechanism to manage the process, which led to the development of three sets of contract management staff in the MoPH and no common vision of which contracting process should be institutionalized over the long run. The EU and USAID required large amounts of international technical assistance, which in effect undercut the MoPH’s ability to build capacity. This has been addressed to some extent, however, by the creation of a single contracting mechanism for all NGOs under SEHAT.

4. It is easier to collect performance information than to use it. Although the system set up by the third-party monitors provided a robust set of metrics to enable comparison of provincial performance, the MoPH has been less successful in using these metrics for service improvement or for soliciting, reviewing, and oversight of new and existing contracts. Policies and procedures for monitoring performance are fragmented at the central level, and are not standardized across the provinces or technical units of the MoPH. In addition, the flow of performance information was delayed by contractual adjustments between the two World Bank projects.

5. Increased stakeholder oversight makes program delivery more difficult. Stakeholder conflicts and a lack of consensus among the various departments of the MoPH, provinces, and members of Parliament have led to increased and inconsistent oversight. The current director of the GCMU, Dr. Hemati, notes that the number of oversight bodies that audit their efforts, including the line by line oversight of NGO contracts, has steadily increased over the last three years. He notes that there are instances in which members of Parliament have tried to interfere with the procurement process, with contract specifications, with the selection of NGOs, and with the location of health facilities. Throughout the MoPH, many mid-level civil servants complain that political interference by members of Parliament and provincial political leaders affects their work.

6. Need to improve engagement of Provincial Health Departments. The representatives of the Provincial Health Departments are largely supportive of the NGO contracting system. They also, however, express frustration with the tension created by their accountability to local political leaders, which can be intense, and their limited and ambiguous responsibilities for the selection and oversight of the NGOs providing services within their provinces. Significant differences in pay between Provincial Health Officers, who are paid on the government’s civil service pay scale, and the managers and senior providers of NGOs are also a source of discontent. Increased collaboration between these departments under SEHAT addresses this issue.
7. NGO program delivery and implementation challenges.

- **Difficulties in hiring and recruiting female service providers.** External hires face delays because of procedural and administrative requirements, and local hires are unavailable or inadequately trained or both. Lack of government policy on health workforce development contributes to continuing shortages in the supply of female service providers, particularly specialists who can address yawning gaps in the availability and quality of obstetric and reproductive health services.

- **Failure to use performance data from previous contracts.** Implementation experience is not used in the selection and contracting of new NGO contracts. Too much weight is given to the preparation of glossy project proposals and identification of key personnel, leading to competition to hire externally, which damages carefully cultivated local stakeholder relationships.

- **Discontinuation of lump-sum contracting.** Lump-sum contracting provided NGOs with flexibility in programming and the ability to focus on performance. Current contracts, based on least-cost pricing, have caused a great deal of micromanagement of individual line items by officials in the MoPH, dramatically increasing transaction costs. Tight budgeting and contracting is unsuitable for rural and remote areas where flexibility to try new approaches enables providers to find methods that work.

- **Inability to invest in facilities and lack of pharmaceutical policy.** The original Health Sector Emergency Reconstruction and Development Project (HSERDP) project design, repeated in SHARP and SEHAT, deliberately excluded expenditures on facility construction as part of NGO proposals, based on experience in a variety of country contexts showing the investments in facilities can easily displace focus on staffing and service delivery. The projects thus enabled only small-scale investments in facility rehabilitation. The NGOs’ inability to invest in larger scale construction and civil works, in the view of some NGOs, makes it difficult for clinics to meet BPHS and EPHS facility and equipment standards. Similarly, the lack of a sectorwide pharmaceutical policy makes it difficult for NGOs to maintain international drug quality standards.

- **Lack of prompt availability of performance sector data.** BSC findings are disseminated annually, which is too infrequent. Weak census data restrict proper estimation of province capacity and need, leading to reduced service quality and inadequate service provision.

- **Multiple monitoring systems.** The GCMU, HMIS, and M&E all monitor and evaluate the NGOs. The GCMU reorganization has further compounded this issue. Many NGOs believe that the GCMU had a better monitoring and evaluation mechanism and prefer to follow that method over those of the HMIS and M&E.

- **Pressure to respond to local needs.** NGOs are under increasing pressure to respond to local needs, particularly from Provincial Health Officers and Provincial Health Departments, who are pressured by local politicians.

**How the Case Study Informs the Science of Delivery**

The MoPH’s decision to use a contracting-out approach to extend basic health care services to underserved areas expanded access to and use of several key primary care interventions. Afghanistan is the first country to do this on a national scale. Given the conditions at the start of this effort, the documented declines in infant, under-5, and maternal mortality and the improved (though perhaps plateauing) access to and use of these interventions justify learning from Afghanistan’s experience with this approach. Several elements of this experience serve as lessons for the science of delivery.

**Strong Government Ownership and Leadership**

The government’s early decision to fully commit to contracting-out and to the MoPH’s stewardship and coordination role, rather than attempting to build a public service delivery infrastructure from scratch, showed realism, courage, and a deep commitment to meeting the health service needs of the rural population as quickly as possible. The commitment is particularly remarkable given that many in the donor community questioned whether this was appropriate or whether it would be possible to implement. The government’s early commitment to establishing and providing high levels of compensation to a team to spearhead the effort and its resisting the temptation
to take a more traditional approach prevented significant delays to improvements on the ground. In addition, by expressing its ownership and desire to “be in the driver’s seat” and by insisting on taking charge of defining and developing performance metrics for the BPHS and later the EPHS, Afghanistan was able to effectively insist that the multiple donors in the system align their efforts in accordance with the government’s position.

It is evident, however, that the government’s ownership and leadership was heavily concentrated in the MoPH in Kabul, leaving Provincial Health Directors and Provincial Health Officers disengaged from the contracting process. This led to frustration and jealousy toward the NGOs and missed opportunities to strengthen stewardship at the provincial level. The appropriate role of decentralized administration in Afghanistan remains unclear, but the consequences of the centralized approach, in terms of the frustration of provincial officers and their resentment of the NGOs’ much higher pay scales (heavily boosted by donor input), risk reducing rather than enhancing cooperation between government and NGOs at this level.

**Resilience of Input Management**

The government and principal donors’ early commitment to the creation and reinforcement of incentives that encourage results is particularly remarkable and is reflected in the level of investment in the measurement of performance documented in this case. It appears, however, that over time both donors and the government have had challenges in maintaining their focus on results. Afghanistan’s commitment to measure and use information on performance is laudable, but the responsibility for monitoring service delivery within the MoPH will need to be clarified to ensure added value from this investment. Afghanistan must educate all stakeholders, particularly members of Parliament and Provincial Health Directors, on how to use results to create performance incentives for both government and nongovernment service providers at the local level, as it builds on its considerable accomplishments in the health care sector.

**Adaptive, Flexible, and Iterative Solutions**

The Health Sector Emergency Reconstruction and Development Project (HSERDP) and follow-on projects used flexible and iterative approaches to the improvement of health care delivery and enabled flexible program design that enabled innovation and adaptation.

- The initial contracting-out approach using lump-sum payment contracts has been commended by many of the original NGO service providers for providing the flexibility to innovate and experiment in rural areas in the early stages, which enabled quick provision and access to care.
- The GCMU was headed by highly qualified Afghan and international technical experts and designed to function like a directorate within the MoPH, which enabled it to provide leadership and direction to the program. It was autonomous yet within the government’s purview.
- The seven standards under the 2003 version of the BPHS were divided into two tiers. Mental health and management of disability were classified as second-tier services, out of concern that the overall packages not be more demanding than could be delivered in highly remote rural areas. By 2005, however, the MoPH, responding to growing evidence of distress caused by continuing conflict and insecurity, reclassified mental health and management of disability as first-tier services.
- The designs of the performance-based monitoring and evaluation tools are innovative and resourceful, especially given the resource constraints. The BSC has been a source of performance and delivery information about providers in each province, allowing for benchmarking and cross-province comparison.
- The MoPH now conducts annual BPHS and EPHS coordination meetings where provincial officials and NGOs review BSC and HMIS findings. These meetings address the need to include Province Health Departments in this process and the need for NGOs to exchange good practices across provinces.
- The lessons learned from the Health Sector Emergency Reconstruction and Development Project (HSERDP) have been successfully incorporated into SEHAT, again showing program adaptability. All the donor groups have agreed to the lump-sum payment model for contracting-out and have agreed to use one system of monitoring and evaluation and performance tracking. Addressing the need for more stakeholder involvement, MoPH has more actively involved the Provincial Health Departments in the creation and implementation of a national monitoring checklist.
Annex A  Process-Mapping Diagram

Challenge:
Postconflict setting in Afghanistan after the fallout of the Taliban government in 2001 and a need for reestablishing and strengthening the delivery of health care services due to despairingly poor health indicators such as infant mortality rate, under 5 mortality rate 165/1000 and 250/1000.

Theory of Change:
Creation of an independent unit that would function under the authority of the MoPH but have sufficient autonomy to manage and oversee NGO performance separately and hire competitively.

End Outcome:
Afghanistan Mortality Survey completed, suggests very rapid improvements in infant mortality rate, under 5 mortality, maternal mortality.

World Bank and MoPH agree on SEHAT project, same basic design as initial project, but change in procurement approach: EU and USAID agree to use same contracting modality as World Bank, same contracting and Monitoring and Evaluation arrangements to cover all 31 contracting output provinces under the SEHAT umbrella.

Theory of Change:
Setting up contracts and mechanisms for delivery was one part of the two pronged approach to ensure service provision. The establishment and operation of systems which would enable MoPH and the donors to monitor and evaluate performance in service delivery was crucial to ensure efficient and effective service delivery.

Intermediate Outcome:
Establishment of checks and monitoring mechanisms to ensure that accountability of performance is maintained, building systems to track performance.

Strategy for Implementation:
First Annual report of Balanced Scorecard measures of service delivery quality and quantity issued. Key instrument for assessing performance of NGO in service delivery and quality with strategic innovation in the nature of the instrument.

Strategy for Implementation:
MoPH initiates contract with Johns Hopkins/IIHM for Third-Party Monitoring and Evaluation.

Strategy for Implementation:
Development of the HMIS platform. Responsible for design and collection of routine facility level health management information system, supported through off-budget support from USAID but later used as the common monitoring and evaluation platform for all NGOs.

Intermediate Outcome:
Stakeholders agree on standards and priorities for BPHS and the EPHS.

Strategy for Implementation:
Evolution of BPHS as information on the health conditions and discussions of experience with the initial package developed. Inclusion of mental health services in the initial package after reviewing the need for the service, being an example.

Strategy for Implementation:
MoPH initiates contract with Johns Hopkins/IIHM for Third-Party Monitoring and Evaluation.

Strategy for Implementation:
In 2005, the MoPH decided to extend the concept of a standardized list of services to the hospital sector, and developed and disseminated an EPHS, which specified the inpatient clinical and ancillary services and associated staffing, equipment and drug supply standards for district, provincial and national hospitals.

Intermediate Outcome:
Formation of NGO accountability mechanisms by establishment of terms of performance partnership agreements.

Strategy for Implementation:
Establishment of GCMU, which completes PPAs with seven provinces.

Strategy for Implementation:
USAID and EU decision to support contracting out means, effort to mobilize NGOs would be implemented by all three major donors to the sector. However, EU and USAID are not able to use lump sum PPAs, and instead use various forms of line item review and monitoring— which creates three different rules of the game for contracting.

Intermediate Outcome:
World Bank and MoPH (GCMU) agree to MoPH Strengthening Mechanism, or contracting-in—which creates three different rules of the game for contracting.

Strategy for Implementation:
MoPH, principle donors, and other stakeholders agree on standards and priorities for BPHS and EPHS.

End Outcome:
Survey completed, suggests very rapid improvements in infant mortality rate, under 5 mortality rate 165/1000 and 250/1000.

Intermediate Outcome:
Establishment of checks and monitoring mechanisms to ensure that accountability of performance is maintained, building systems to track performance.

Strategy for Implementation:
Evolution of BPHS as information on the health conditions and discussions of experience with the initial package developed. Inclusion of mental health services in the initial package after reviewing the need for the service, being an example.

Strategy for Implementation:
In 2005, the MoPH decided to extend the concept of a standardized list of services to the hospital sector, and developed and disseminated an EPHS, which specified the inpatient clinical and ancillary services and associated staffing, equipment and drug supply standards for district, provincial and national hospitals.

Theory of Change:
Creation of an independent unit that would function under the authority of the MoPH but have sufficient autonomy to manage and oversee NGO performance separately and hire competitively.

End Outcome:
Afghanistan Mortality Survey completed, suggests very rapid improvements in infant mortality rate, under 5 mortality, maternal mortality.

World Bank and MoPH agree on SEHAT project, same basic design as initial project, but change in procurement approach: EU and USAID agree to use same contracting modality as World Bank, same contracting and Monitoring and Evaluation arrangements to cover all 31 contracting output provinces under the SEHAT umbrella.
Annex B  Public Health Service Delivery Chain in Afghanistan


Note: CDC = Community Development Council; MoPH = Ministry of Public Health; NGO = nongovernmental organization;
## Annex C  Three Mechanisms for Contracting with NGOs in Afghanistan

<table>
<thead>
<tr>
<th>Donor</th>
<th>Time frame</th>
<th>Contracting mechanism</th>
<th>Flow of funds</th>
<th>Coverage areas</th>
<th>Performance-based elements</th>
<th>Monitoring and evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Bank</td>
<td></td>
<td>PPAs under HSERDP; Service Delivery Contract; fixed lump-sum remuneration with 100 percent budget flexibility</td>
<td>World Bank to Ministry of Finance to MoPH to NGOs; GCMU manages contracting process</td>
<td>Seven provinces; one NGO or consortium per province</td>
<td>Monetary bonus equal to 10 percent of contract value, 1 percent awarded every six months for increases of 10 percentage points above baseline; additional 5 percent at end of project for increase of at least 50 percentage points; quarterly narrative and financial reports</td>
<td>Nationwide annual facility-based inspections and interviews for construction of Balance Score Card; household health surveys by third-party monitoring and evaluation team; in later years, HMIS reports, and field monitoring</td>
</tr>
<tr>
<td>NGOs</td>
<td>2002–05</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2006–09</td>
<td>No change</td>
<td>No change</td>
<td>No change</td>
<td>No change until approval of SEHAT project (2013)</td>
<td>No change</td>
</tr>
<tr>
<td></td>
<td>2009–13</td>
<td>Procurement changed from quality cost-based selection to least-cost selection</td>
<td>No change</td>
<td>No change</td>
<td>No change</td>
<td>No change</td>
</tr>
<tr>
<td>MoPH/Strengthening Mechanism</td>
<td>2002–05</td>
<td>PPA Government provided services through Memorandum of Understanding with province; fixed lump-sum remuneration with 100 percent budget flexibility</td>
<td>World Bank to Ministry of Finance to MoPH</td>
<td>No change</td>
<td>Same as for NGO contracts; HMIS reports</td>
<td></td>
</tr>
<tr>
<td>USAID</td>
<td>2002–05</td>
<td>Performance-based grants under HSERDP; fixed-budget, input-based cost reimbursement</td>
<td>USAID to Management Sciences for Health to NGO</td>
<td>14 provinces; clusterwide coverage</td>
<td>Payment can be withheld if deliverables in grant agreement not met; no monetary bonus</td>
<td>Monthly review of deliverables by Management Sciences for Health and MoPH; baseline, mid-term, and end of project provincial-level home health surveys using LQAS methods</td>
</tr>
<tr>
<td></td>
<td>2006–13</td>
<td>No change</td>
<td>Funds channeled to MoPH through WHO</td>
<td>13 provinces</td>
<td>No monetary bonus but extension of project from 30 to 48 months contingent on good performance</td>
<td>Routine monitoring of activities, but less frequency, final home health survey to be used to negotiate new projects with NGOs</td>
</tr>
<tr>
<td>European Union</td>
<td>2002–05</td>
<td>Performance-based grant under HSERDP; fixed budget, input-based cost reimbursement</td>
<td>European Union to NGO</td>
<td>10 provinces</td>
<td>None</td>
<td>Annual reports to the European Union and quarterly technical narrative to MoPH; NGOs allowed to define indicators, although program was intended to measure BPHS-related indicators</td>
</tr>
<tr>
<td></td>
<td>No change</td>
<td>No change</td>
<td></td>
<td>No change</td>
<td>None</td>
<td>Annual and later semiannual narrative reports to MoPH</td>
</tr>
</tbody>
</table>

Source: Based on Waldman, Strong, and Wali 2006.

Note: BPHS = Basic Package of Health Services; GCMU = Grants and Contracts Management Unit; HMIS = Health Management Information System; HSERDP = Health Sector Emergency Reconstruction and Development Project; LQAS = Lot Quality Assurance Sampling; MoPH = Ministry of Public Health; NGO = nongovernmental organization; PPAs = Performance-Based Partnership Agreements; SEHAT = System Enhancement for Health Action in Transition USAID = United States Agency for International Development; WHO = World Health Organization.
Bibliography


