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Expanding health service delivery and developing institutional capacity: Getting the balance right in Afghanistan

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As in other post-conflict and fragile states, the Afghan Government is managing tensions between demand for rapid (re)expansion of social services and achievement of health targets, and for improved governance and public administration reforms.

Since the end of the conflict in 2001 the Ministry of Public Health, working with development partners and non-state providers, has made significant progress in improving basic health care delivery. It has also made progress in some areas of institutional development, but others have been neglected. This might place current achievements at risk and affect the sustainability of health system performance. All stakeholders acknowledge the importance of strengthening governance functions, and the government is taking forward an ambitious reform agenda. However, there has been limited consensus on which approaches to take, and the key institutional and organisational challenges are not being fully or systematically addressed.

This paper calls for a well coordinated and long term commitment from international and national partners to strengthen the Ministry of Public Health across its core functions. It endorses recent proposals for the implementation of a coherent, long term and balanced approach to developing the Ministry, and to maintain and strengthen its stewardship of the health sector as envisioned in the Afghanistan National Development Strategy.

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1. Introduction: the role of institutional development in fragile states

There is broad agreement that state building is crucial in fragile states, and that it needs to be supported through institutional capacity development. Institutional development is about acquiring the ability to perform good governance, which in turn sustains the robust systems needed for better services.

Government capacity to perform core governance and system functions contributes to increased credibility and stability, as well as to service delivery than can be sustained over time.[1] Governing the health sector involves assessing the health situation and the system's performance, developing appropriate evidence based policies and plans, monitoring and managing the overall performance of state and non-state providers and overseeing the regulatory framework. Government leadership is necessary for oversight of financing, management, the health workforce, infrastructure and medical supplies, information systems, and fulfilling stewardship functions.

'Good governance' is characterised as transparent, participatory and equitable; it promotes the rule of law and aims to improve the efficiency and accountability of the public sector. Achieving good governance requires a strategy for institutional and organisational development which takes into account several factors. Internal factors include lines of reporting and responsibilities, 'drivers of change', power and decision-making processes, and how these relate to laws, policies, cultures and norms.[2,3] External factors include the social, political and economic context, the overall commitment for reform and levels of aid dependency.

This is a very ambitious agenda, which the principle of 'good enough governance' attempts to reduce to more realistic terms. This principle can help deliver visible results in the short term, while strengthening capacity for the longer term. 'Good enough governance' recognises that *minimal* conditions of governance are necessary to allow political and economic development and to protect people from harm. In practice this can mean building the momentum of change through incremental steps – rather than addressing all critical issues at once (such as engaging in fully fledged public administration reform). It can also mean applying what works best in the particular context, rather than what would be best in an ideal situation. Steps taken by the Afghanistan's Ministry of Public Health (MoPH) to overcome initial challenges – described in this paper – can be seen as an example of 'good enough governance'.

The paper explores Afghanistan's progress and challenges in key areas of institutional development: human resource development and management, planning and budgeting, the management and administration system, and delegation of authority to provincial health teams. It is based on data and information gathered during a two-year project in 2004-06 to provide technical assistance to the MoPH for developing capacity for institutional reform (carried out through HLSP and funded by the European Commission as part of a larger project to support the Public Administration Reform programme in Afghanistan). The paper also draws on information on the current situation provided by national MoPH consultants.

[1] Eldon J et al (2008) Health systems reconstruction: can it contribute to state-building? HLSP Institute for the Health and Fragile States Network.
[2] Second Quality Conference for Public Administrations in the EU (2002) The Common Assessment Framework: Improving an organisation through self-assessment.
[3] DFID (2003) Promoting institutional and organizational development. A source book of tools and techniques.

2. The experience of the Afghanistan Ministry of Public Health

Since the end of the civil war in Afghanistan in 2001, the Ministry of Public Health has achieved impressive progress in rapidly expanding basic health services throughout the country[4,5] through the adoption of a contracting out model. In the absence of a functioning public administration, the approach to contracting with non-state providers is widely viewed as an effective response (see Annex on page 9 for a more detailed description of the approach). The approach has been managed and implemented successfully, and the Ministry has gained credibility and legitimacy among the international community (this is also true, although perhaps to a lesser extent, for the Afghan population for whom the implementing NGO is often more visible than the MoPH as contractor).

The creation of a Grants and Contracts Management Unit (GCMU) within the MoPH to manage and oversee contracts has been critical to the success of this strategy. Substantial funding and technical assistance to the GCMU have built capacities for effective contract management and monitoring of service delivery, and have enabled the MoPH to demonstrate leadership and guidance to a variety of non-public health care providers. The creation of a Basic Package of Health Services (BPHS) also enabled the Ministry to perform its governance role as designer and regulator of a system for unified service delivery.

As demand grows for the rapid expansion of other services, the contracting out model has potential for replication in other sectors. However the literature on this approach, while often stressing the need for robust government stewardship, rarely addresses issues regarding the capacity required to deliver it effectively.

Institutional development was one of the top priorities in the country's first health policy (2005-2009), and was also reiterated in the 2008-2013 health strategy.[6] However, a capacity building approach (similar to that adopted for the GCMU) has not been introduced across the whole Ministry. The objectives of building core skills for effective and efficient health management and administration have been only partially followed through; strategies for strengthening the Ministry's governance functions and its role as regulator of the sector have not been fully articulated. Efforts have been uneven: some divisions have been supported by national consultants and international assistance and have developed rapidly, but others have not. But other issues have also affected the process of institutional development:

- the lack of clear vision for reform and long term commitment (both from government and external partners);
- the government's mixed willingness to fully engage in these processes and limited ability to execute key functions; and,
- difficulties in defining the tangible or measurable short term results that donors may call for.

Despite donor awareness and policy commitments, there is limited consensus on the best way to approach these issues.

The highly politicised context – with international pressure to produce quick results – makes governance reforms particularly challenging. Furthermore, MoPH reforms do not take place in isolation from the national governance agenda. This involves drawing on national legislation for procurement and regulation on internal control mechanisms; devising anti-corruption measures that are in line with the national framework for countering corruption; improving the budgeting process in accordance with the requirements set by the government through the Ministry of Finance. Equally important is addressing other factors that hinder reform processes, such as the restricted budgetary authority of provincial health directors, the lack of a specific operational budget for various departments, lengthy administrative and procurement procedures and the absence of guidelines.

In the next section, the paper describes in more detail progress and challenges in key areas of institutional development.

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[4] Afghanistan, Ministry of Public Health (2006) Afghanistan Health Survey 2006, Estimates of priority health indicators.
[5] Peters D et al (2007) A balanced scorecard for health services in Afghanistan. WHO Bulletin 85(2):85–160.
[6] Afghanistan, Ministry of Public Health. National Health Policy 2005-2009; National Health Strategy 2005-2009; Health and Nutrition Sector Strategy 2008-2013.

3. Progress and challenges in developing institutional capacity in the health sector

The political and policy context

The external environment has had, and continues to have, important influence on the MoPH's capacity. The country is emerging much weakened from decades of armed conflict. With support from the international community, the new government initiated a multisector process of reconstruction after the fall of the Taliban in late 2001. This included engaging with partners on a longer term national development framework and a public administration reform process.[7]

A five-year Afghanistan National Development Strategy *(*ANDS) was approved by the President in April 2008.[8] The strategy draws on targets and strategies set out in Afghanistan's Millennium Development Goals report,[9] and builds on other transitional frameworks,[10] and the 2006 Interim ANDS.

There has also been an overarching Public Administration Reform (PAR) programme which aims to regenerate the disrupted Afghan public administration. This is seen as critical for achieving the poverty reduction targets and managing external funding. One of the principal components of the PAR has been the Priority Reform and Restructuring (PRR) process for the civil service, aiming to recruit appropriately qualified staff for service delivery and administrative functions through a transparent, competitive and merit-based selection procedure.

The PAR has been criticised for being slow and ineffective, and for focusing attention on higher remuneration levels rather than on bringing in fundamental structural changes.[11] However the MoPH has been seen as relatively successful in the reform process despite the substantial challenges it continues to face.

Increasing political instability and insecurity have spread from the Southern and South Eastern Provinces to other areas, including the capital Kabul, posing serious threats to reconstruction as well as to peace and stability. Health facilities have been targeted by militants and threatened health personnel are leaving their jobs. Despite efforts by the MoPH to offer better salaries and benefit packages, it is increasingly difficult to attract staff (especially women) to remote areas. The MoPH is under political pressure from both government and parliament to establish additional and visible health facilities in politically important urban areas, and to maintain staff in employment. This increases the inefficiency of administrative procedures and the inequitable distribution of resources and health services in a country where the most vulnerable live in rural and remote areas.

Afghanistan remains heavily aid dependent and much of its aid is fragmented. The government has reportedly increased its share of the overall budget, but has expressed concerns about high levels of external funding that are under donor control and not aligned to national plans.[12] For example, external funds are being used for the construction of a large number of health facilities, which is not necessarily in line with government plans. The government struggles to convince donors to provide (or at least report) funds to the Treasury and to support agreed priorities.

Priority setting

Vision and leadership are essential for the Ministry to play an effective stewardship role – from formulating policy, strategy and setting standards to regulation and monitoring. The MoPH demonstrated strong leadership in its early recognition that urgent action was needed to reduce unacceptably high levels of morbidity and mortality, especially among women and children. The Interim Health Strategy in 2003 was followed by the National Health Policy 2005-2009, the National Health Strategy and recently by

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[7] Schemionek K (2007) Technical assistance to 'Support the Health Sector' in the framework of the EC project AF/AIDCO/2005/0523. End of mission report, October 2004-November 2006.
[8] Afghanistan (2008) Afghanistan National Development Strategy.
[9] Afghanistan (2005) Millennium Development Goals, Country Report 2005.
[10] Examples are the National Development Framework (2002), the Securing Afghanistan's Future report (2004), the Public Investment Programme (2004).
[11] Lister, S (2006) Public administration reform in Afghanistan: realities and possibilities. Afghan Research and Evaluation Unit (AREU).
[12] Nixon H (2007) Aiding the state? International assistance and the statebuilding paradox in Afghanistan. AREU.

the Health and Nutrition Sector Strategy 2008-2013. The mission statement in the 2005-2009 health policy document states that the MoPH 'is committed to ensuring the accelerated implementation of quality health care for all the people of Afghanistan, through targeting resources especially to women and children and to under-served areas of the country, and through working effectively with communities and other development partners.'[13] A number of other supportive policies and strategies were also formulated at an early stage, such as the National Salary Policy, the Human Resource Development Policy and the Reproductive Health Policy and Strategy.

The first National Health Policy states that the MoPH 'is committed, as a top priority, to organising and managing the national health system to respond effectively to change resulting in increased efficiency, effectiveness, quality and accountability at all levels'. 'Reducing mortality and morbidity' and 'institutional development' are given equal importance as the two complementary and overarching strategic objectives. This means that, while putting into action the Basic Package of Health Services and a similar package for hospitals services (the Essential Package for Hospital Services) is the key strategy to implement health services, similar emphasis is also given to institutional development, including planning and monitoring, human resources reform and development, strengthening provincial level management and coordination, and developing health care financing and national health accounts.

Institutional development remains a priority. Following proposals by the Ministry of Finance for programme budgeting reform, the strategies in the National Health Policy and National Health Strategy have been assigned to eight core programmes in the latest Health and Nutrition Sector Strategy. Programmes for institutional development are of equal standing to those for health care services provision.[14]

However, while strategies and plans for health services provision are well developed and targets are clearly defined and widely understood, there is much less clarity on the institutional development strategy. Clearly defined indicators and targets are not included in the strategy documents. Where they exist, they are often simplistic and limited to 'number of staff trained' or 'number of staff having undergone the Priority Reform and Restructuring process'. Efforts are too often limited to enrolling personnel in training courses that do not respond to actual needs and have limited benefit. This reflects the complexity of undertaking institutional development, the challenge of identifying meaningful short term results and the limited experience among the stakeholders on how to go about it.

Coordination mechanisms

Strong and effective arrangements for the coordination of the health sector have been central to expanding basic health services. A Consultative Group for Health and Nutrition (CGHN) was set up at an early stage as demanded by the interim government. It includes key stakeholders to advise line ministries on effective allocation of funds and has evolved into a 'large' CGHN involving other ministries, and a 'working' CGHN for overseeing national issues, coordinated by the MoPH. A Technical Advisory Group assembles high level MoPH decision-makers and technical experts from different agencies, providing specific expertise to the Executive Board of the MoPH. A number of technical task forces address specific technical issues and report to the Technical Advisory Group.

However, approaches to set an agenda for institutional development of the MoPH as a whole and to take it forward have not been successfully followed through in the various coordination mechanisms; areas that are critical to good governance have not been tackled. This indicates weak priority setting, limited coordination between departments within the Ministry and lack of coherence between activities and programmes formulated and implemented in different departments (and at senior management levels). Urgent issues such as examining and addressing the causes of health service under-utilisation or exploring options for financing the sector are not addressed with sufficient emphasis.

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[13] See also the Health and Nutrition Sector Strategy 2008-2013: 'The mission of the Ministry of Public Health (MoPH) is to improve the health and nutritional status of the people of Afghanistan in an equitable and sustainable manner through quality health care services provision and the promotion of a healthy environment and living conditions along with living healthy life styles'.

[14] Afghanistan, Ministry of Public Health (2008) Health and Nutrition Sector Strategy (2008-2013).

Human resource management and development

There is wide agreement that the main challenge to the Afghan health system is ensuring the availability of a suitably qualified, appropriately skilled and motivated workforce that is evenly distributed throughout the country to deliver both the Basic Package of Health Services and Essential Package for Hospital Services, and those central ministry services and other specialised programmes (e.g. environmental health and pharmacy services) that serve to manage the health sector and to 'govern' the health system. However, more than 20 years of war and disruption have severely affected health worker training. Training facilities are in decay or destroyed; emergency and ad hoc training of varying categories of health workers takes place to meet immediate needs, with differing curricula and teaching methodologies.

Between 2002 and 2005 the MoPH's Directorate of Human Resources has partnered with the Independent Administrative Reform and Civil Service Commission (IARCSC) to implement the Priority Reform and Restructuring process, with the aim to restore administrative capacities in key departments of essential ministries.[15] From an early stage the MoPH developed an organisational structure consistent with recommendations made in the National Development Framework and a Human Resources Policy.

The Human Resources Policy sets out a number of critical programmes such as: i) encouraging development of professional councils with responsibility for health worker standard setting and registration, curricula and training institute accreditation; ii) testing and certification of existing health personnel without adequate training; iii) increased training of nurses and midwives. A national health workforce plan is currently under development.

Staff in both administrative and health care roles in 34 Provincial Public Health Directorates, nine provincial hospitals implementing the Essential Package for Hospital Services, eleven hospitals in the capital and some of the relevant General Directorates at central level have undergone the Priority Reform and Restructuring process. These efforts were rewarded by the IARCSC, which in 2005 recognised the MoPH as an outstanding example of leadership in implementing a model for human resources management which could be used by other ministries.

MoPH strategies envision employing the workforce through two mechanisms: around 11,500 staff are, and will continue to be, employed by NGO grantees to provide health services through the contracting mechanism; the MoPH will directly employ over 14,500 staff. But there are challenges ahead.

Substantial external support has ceased and financial and technical resources are insufficient to provide training and to develop and implement clinical capacity building plans and curricula. Several factors – some inherent within the MoPH, others related to the broader political environment – may jeopardise what has been achieved unless corrective measures are taken. In a traditional environment that is used to patronage-based appointments, merit-based appointment procedures are not always respected, resulting in the re-appointment of 80% of previous staff. The Public Administration Reform process is widely perceived as a way to achieve better remuneration.[16] In addition, high-level posts are often exposed to political and traditional pressures and candidates who fail in the recruitment process are hired in a different position. Other issues include a slow pay and grading process; a remuneration level that is lower for public sector employees than for equivalent staff working for non-state providers; the overall lack of managerial capacities; and the high failure rate of nurses and midwives in the testing and certification process.

Often senior staff do not have the necessary skills and experience to implement planned reforms, especially in crucial positions relating to financial management, procurement, human resources, audit, regulation and monitoring. Key decision-makers are often absorbed by day-to-day management or by the agendas of important partners, which do not necessarily contribute to the overall sector goals. A survey among managerial staff in the central and provincial MoPH reported perceived needs for developing skills in management related areas, English language communication, computer skills as well as better knowledge in key public health issues, health information management, and monitoring and evaluation.[17]

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[15] Lister, cit.
[16] Ibid.
[17] Afghanistan, Ministry of Public Health (2006) Capacity building and learning needs assessment. General Directorate of Human Resources with Johns Hopkins University and the Indian Institute of Health Management Research.

The government's recurrent budget, including salaries, is still largely dependent on external funding and will remain so for the medium term. However, donors tend to prioritise direct programme funding for morbidity and mortality reduction over strengthening public health managerial and administrative systems. The confidence of development partners in the government's approach to human resource issues is therefore critical.

The MoPH and its partners have tried to overcome these obstacles by hiring national consultants for strengthening public health capacities. They were initially based in the Contracting Unit but later were assigned to executive positions or as consultants supporting important central directorates. What at first glance looks like a parallel system that undermines the reform efforts is in fact the result of intense discussions among the Ministry's leadership on how to overcome the shortage of skilled personnel and the need for lengthy training for existing staff, while responding to pressure from the government and the public to fulfill public administration functions. Although it helps filling key gaps, this system of consultancy contracts is not sustainable if there is no concurrent support to public sector structures.

However, these attempts by the MoPH to overcome initial challenges (in the absence of results from broader reforms) can be acknowledged as an example of 'good enough governance' as the MoPH has demonstrated leadership in finding appropriate strategies to perform effective public health management.

Building capacity at provincial level

The Provincial Health Teams have a health system governance role at the peripheral level. All have undergone the Priority Reform and Restructuring process, resulting in the appointment of eight technical officers in each team. But in practice it is difficult for the teams to carry out governance functions. For example health planning processes for service provision are often carried out by the NGOs implementing donor funded service contracts. Where implementing NGO staff supervise as well as deliver services as part of their contractual arrangements, the provincial teams' role becomes redundant. Moreover, provincial staff often has less capacity than central level staff. The absence of a clear vision for the roles and responsibilities of government at provincial level is also hampering efforts.

Programmes funded by USAID and the European Commission are working to build the capacities of provincial teams. Sub-national consultations have taken place as part of the ANDS process and increased attention has been given to the challenges of decentralising health system management in an environment where budget oversight is minimal and non-state health care providers set agendas. This situation contributes to loss of provincial government ownership of the arrangements to deliver basic health services, and is likely to hamper efforts to sustain progress, or to strengthen the provincial teams' stewardship role.

Planning, budgeting and management

The reform process should not ignore the critical need for building sustainable systems – as opposed to creating additional 'boosted' units that are not integrated in the traditional institutional structure. But so far administration and management functions have received little attention.

The General Directorate for Administration and Management includes: i) financial budget and internal contract department; ii) logistics and procurement; iii) construction and maintenance; and iv) health insurance. These units have not undergone the Priority Reform and Restructuring process and the Directorate is overstaffed. Personnel are not appropriately qualified and often lack essential skills. Salaries are low (but would increase through the PRR payment structure), and there is no incentive and appraisal system. Staff tend to be randomly included in capacity development activities.

Administrative procedures follow established traditional practices where financial and administrative authority is executed by very few, and internal control mechanisms are not always clear. Clarity is lacking on procurement procedures currently in use and on the status of applying national legislative frameworks such as the new national procurement law. Appropriate equipment and physical infrastructure are not in place. In addition, the Directorate is physically separated from the main building and rarely included in rehabilitation work, and is not included in the Ministry's overall planning and budgeting process which is taking place in individual units and department.

Bolstering capacities in areas that are key to administrative and managerial reforms but at a first glance appear difficult to strengthen (such as those under this Directorate but also others such as health laws

and regulations, located under the Policy and Planning Directorate) would help establish an overall ministry planning and budgeting process, which could then be translated into work plans with a system for monitoring performance.

4. Conclusions: creating a momentum for change

The Afghan Government is committed to the principles of good governance, as reiterated by the President in the Afghanistan National Development Strategy. However, the government is under pressure, caught between international expectations to engage fully in the national development process, increasing local political resistance to its reform efforts, and the weaknesses of the public administration system.

The concept of 'good governance' – for example, ensuring oversight, transparency, accountability and legitimacy – has been introduced relatively recently at sector level in Afghanistan. Given the current environment, the principle of 'good enough governance' could help the Afghan government deliver visible results for the short term as well as strengthen its capacity to provide social services.[18] 'Good enough governance' focuses on improving key government functions but also takes into account institutional realities such as the lack of qualified staff and growing corruption. The local context might require specific approaches, for example in dealing with the fact that merit-based recruitment is out of line with accepted ways of working.

The MoPH leadership has articulated its commitment to engage in this area, recognising the need for enhancing capacity for those internal functions that are responsible for good governance, including central and peripheral managerial and administrative structures. There is, for example, a policy commitment to establish a 'Transparency Working Group' which would set transparency and integrity standards with representation from relevant directorates working under the leadership of Deputy Minister for Administration.

As in other post-conflict and fragile states, successful reform of public management and administration functions is difficult and not attainable within a short time frame. MoPH leaders and major stakeholders agree that efforts for developing institutional capacity must be better articulated and streamlined. However they have not yet proposed how the Ministry should look as an institution at all levels and what role in governing the health sector it should play in forthcoming years, particularly given its important responsibility in the continuing public-private partnership for service provision.

Although a policy and strategic framework is in place for some aspects of governance and systems reform, and some progress has been made, so far efforts to address institutional capacity development have been somewhat ad hoc and have not led to tangible results. The principal components of the health system, including policy formulation, arrangements for service delivery, and governance and administrative reforms at central and provincial levels, have been developed at varying speed and degree of investment. The MoPH is leading a number of critical processes for contributing to stability and social development, but sustaining the pace of change is proving challenging.

The MoPH needs a well coordinated and long term commitment from international and national partners that seeks to strengthen the Ministry across its core functions. At the request of the MoPH, the European Commission is continuing to fund support for institutional capacity development and has brought international experts to key areas such as administration and management, health care financing and policy development. With appropriate external support, the Ministry has a unique opportunity to demonstrate how building capacity for good governance, including strengthening management and administration functions, can contribute to sustainable improvements in health service outputs and outcomes in public and non-state sectors. This will ensure balance between making rapid gains in basic services and longer term and sustainable improvements in institutional capacity to build a strong health system, further improve services and ensure government ownership. The prize will be better health for the people of Afghanistan, and, through the so-called 'peace dividend', greater legitimacy for the Government.

[18] DFID (2005) Why we need to work more effectively in fragile states.

Annex: Delivering basic health services – a success story

Contracting out to non-state providers

After the end of the civil war Afghanistan had very poor indicators for maternal and child health. In the absence of a functioning public administration, and following the first joint donor mission in early 2002, a decision was taken to develop a package of health services and adopt a strategy of contracting out basic health services to non-state providers. In 2003 the MoPH developed a Basic Package of Health Services (BPHS), which defines a set of cost-effective interventions with particular focus on women and children, to be provided at primary health care facilities and district hospitals. This has taken place through contracting out service delivery to non-governmental organisations (NGOs) and elements of contracting in for three provinces where the MoPH is implementing BPHS services. The BPHS is delivered at four types of facilities: Health Posts, staffed with one female and one male Community Health Worker, Basic Health Centers, Comprehensive Health Centers, and District Hospitals. The BPHS is complemented by an Essential Package of Hospital Services.

Most of the delivery of the BPHS has been contracted out to NGOs which were already operating in much of the country – and now managing over 80% of facilities, mainly financed by international development partners.[19] The estimated cost of delivering the BPHS is about US$4 per person per year; this excludes contracting and management costs as well as vertical programmes such as immunization and TB control.[20] Significant progress has been made in bringing services to the people in most need. Infant mortality is estimated to have decreased to 129 per thousand life births and under-five mortality to 191 per thousand life births as compared to 165 and 257 in 2000 respectively. Pregnant women receiving prenatal care at least during one visit increased from 8.0% to 32.4% and deliveries attended by a skilled health worker from 9.0% to 18.9% respectively.[21]

Contracting management arrangements

The three major donors in the Afghan health sector (the World Bank, USAID and the EC) jointly fund the contracting out mechanism but have been using different arrangements for financing it. In 2003 the World Bank decentralised the procurement and financial management to the MoPH. USAID has also signed an agreement with the Government to decentralise service procurement and financial management to the MoPH in mid 2009, while the EC has maintained a centralised approach. The donors also provide technical assistance to the MoPH and non-state health care providers (national and international NGOs) to oversee, manage and fulfil these contracts and to develop a common framework for monitoring and evaluation of service delivery in regard to contractual performance and, in the longer term, to establish quality standards. The longer term strategy envisions standardised arrangements that will hold the MoPH fully responsible for managing and overseeing contracts with NGOs.

The MoPH, supported by these donors, set up a Grants and Contracts Management Unit (GCMU) to manage (technically and financially) the performance based contracts, and, in the case of the World Bank's support, the MoPH has been in the driving seat for contracting services. Although there were initial concerns about the capacity of the MoPH, reviews have shown that the ministry's GCMU has taken its contract monitoring responsibilities seriously and has become increasingly proficient in managing contracts.[22]

Monitoring performance

To monitor implementation, a 'Balanced Scorecard' (BSC) has been developed, with 29 indicators organised into six domains: patients and community; staff; capacity for service provision; service provision; financial systems; and overall vision. Data has been collected every year from 2004-07 in a random sample of more than 600 health facilities, 1700 health workers and 5800 patient-provider interactions. The routine Health Management Information System that collects quarterly information from

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[19] Strong L, Sondorp E, Wali A (2005) Health policy in Afghanistan: two years of rapid change.
[20] Loevinsohn B, Harding A (2005) Buying results, contracting for health service delivery in developing countries. Lancet 366 (9486): 676–681.
[21] Afghanistan, Ministry of Public Health. Health Survey Report 2006.
[22] Waldman R, Strong L, Wali A (2006). Afghanistan's health system since 2001: condition improved, prognosis cautiously optimistic. Afghanistan Research and Evaluation Unit. Briefing Paper Series.

facility levels made substantial progress and by late 2005 data on selected process indicators was available from 80% PHC facilities.

Responding to the results from the 2004 BSC, the MoPH identified eight priority areas in need of improvement, based on two main factors: the unsatisfactory level of performance for each indicator and its importance to the MoPH's strategy to improve people's health. These priority areas include: establishment of functional village health councils; drug availability; laboratory functionality; provider knowledge; health worker training; availability of clinical guidelines; monitoring of TB treatment; and provision of delivery care for pregnant women.

Analysis of the 2006 data shows that, from a low base in 2004, BPHS providers made improvements on five of the priority indicators, but drug availability and provider knowledge stagnated at 2005 levels and health worker training decreased in 2006 after large gains were achieved in 2005.[23] The authors of the analysis note that: 'the absolute level of performance in many areas – including provision of delivery care, laboratory capacity and monitoring of TB treatment – remains inadequate, and further improvements are required on a priority basis'. They also note that a further challenge lies in incorporating the Scorecard approach into the supervision process. Concerns about the BSC relate to the use of provincial public health offices staff in some provinces for data collection purpose which may bias the result. Many officials do not know the concept and use of BSC and the extensive gap between data collection and report minimises the important role of a timely report in decision making process.[24]

[23] Hansen P et al (2008) Measuring and managing progress in the establishment of basic health services: the Afghanistan Health Sector Balanced Scorecard. International Journal of Health Planning and Management, 32 (2): 101–117.
[24] Natiq K (2008) Institutional analysis of the health sector in Afghanistan.

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