

Performance Based Financing of Basic Health Services Delivery in Afghanistan: Challenges and Perspectives

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Afghanistan

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Performance Based Financing of Basic Health Services Delivery in Afghanistan: Challenges and Perspectives

A thesis submitted in partial fulfillment of the requirement for the degree of Master of Public Health

By

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Declaration:

Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

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Signature.....

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LIST OF ABBREVIATIONS

ADB	Asia Development Bank
AHS	Afghan Health Survey
AIDS	Acquired Immune Deficiency Syndrome
AMI	Aid Medical International
ANDS	Afghanistan National Development Strategy
ANHRA	Afghanistan National Health Resource Assessment
BBD	Blood Born Disease
BHC	Basic Health Centre
BPHS	Basic Package of Health Services
BSC	Balanced Scorecard
CHC	Comprehensive Health Centre
CHE	Catastrophic Health Expenditure
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
CSO	Central Statistics Office
CSW	Commercial Sex Worker
DH	District Hospital
DPT	Diphtheria Pertussis and Tetanus
EOI	Expression of Interest
EPI	Expanded Program for Immunization
EU	European Union
GCMU	Grant Contract Management Unit
GDP	Gross Domestic Product
HDI	Human Developing Index
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HNI	Health Net International
HP	Health Post
HPI	Human Poverty Index
IDU	Injecting Drug User
IIHMR	Indian Institute of Health Management Research
IMC	International Medical Corps
IMCI	Integrated Management Childhood Illness
IMR	Infant Mortality Rate
ISAF	International Security Assistance Force
JDM	Joint Donors Mission
JHSPH	Johns Hopkins Bloomberg School of Public Health
JHU	Johns Hopkins University
KFW	Kreditanstalt Fur Wiederaubau
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MoF	Ministry of Finance
MoPH	Ministry of Public Health
MoPH-SM	MoPH-Strengthening Mechanism
MSF	Medicine sans Frontiers

MSH	Management Science for Health
MSM	Men having Sex with Men
NACP	National HIV/AIDS Control Program
NGO	Non Governmental Organization
NHSPA	National Health Services Performance Assessment
NPM	New Public Management
NRVA	National Risk and Vulnerability Assessment
OPV	Oral Polio Vaccine
PBF	Performance Based Financing
PHCC	Provincial Health Coordination Committee
RFP	Request for Proposal
SCA	Swedish Committee for Afghanistan
SHI	Social Health Insurance
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
TFR	Total Fertility Rate
TOR	Terms of Reference
UN	United Nation
UNAIDS	Joint United Nations Program on HIV/AIDS
UNODC	United Nations Office on Drugs & Crime
USAIDS	United State Agency for International Development
VCT	Voluntary Counselling & Testing
WB	World Bank
WHO	World Health Organization

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ABSTRACT

The contracting strategy of the Basic Package of Health Services (BPHS) has begun in Afghanistan since 2003 in response to the poor performance of health system and donors' willingness to channel their support through NGOs.

This thesis describes the concept of contracting of basic health services in developing countries, how it emerged on the policy agenda and its process. It, also, reviews the effectiveness of contracting basic health-care in developing countries and critically evaluates the contracting experiences in Afghanistan using the following criteria: its effectiveness in terms of access, equity, quality and efficiency of health-care. It concludes with some recommendations to decision makers in Afghanistan.

A literature review on contracting of basic health-care in developing countries was done. In addition, the results of 2006 Afghanistan Balanced Scorecard were reviewed.

Significant improvements have been achieved in terms of access to BPHS, quality of care, reduction of inequity in health and reduction of infant and under five children mortality rates. However, it is not possible to conclude that contracting is completely accountable for the health outcome accomplished. Other factors may also have played a role in improving health care: the removal of Taliban government, the removal of restrictions on women employment, the return of health workers, the general improvement of the socio-economic situation and a relative peaceful situation. Contracting started in all 34 provinces at the same time, but without comparing to other possible alternatives.

As conclusion, this thesis gives recommendations for developing a long term strategic partnership between MoPH & NGOs and creation of an enabling environment for the sustainability of health system. A long term partnership will lead to capacity building, maintaining of infrastructure and medical equipments which ensures the sustainability of the health system. In terms of sustainability, it is better to build the capacity of Afghan organisations, especially the Grant and Contract Management Unit of MoPH to gradually take over the work of international donors and NGOs.

Key Words: Contracting, performance based financing, primary health care, developing countries, fragile states, Afghanistan and post conflict countries.

1. INTRODUCTION

The author of this thesis is a medical graduate (MD) with more than 15 years experiences in public health in Afghanistan, Iran and refugee camps in Pakistan working with government, and national & international NGOs.

Afghanistan started contracting the delivery of basic health-care to NGOs since 2003. The objectives of contracting are to improve the performance of health service delivery, to rapidly expand the coverage of basic health-care to rural and under-served areas and to reduce maternal and child mortality and morbidity. The delivery of basic health-care through the contracting strategy was initiated by international donors and especially led by the World Bank.

The following factors influenced the government to opt for contracting to NGOs: (a) The inadequate capacity of the health system; (b) poor health indicators; (c) the availability of external aid; (d) the necessity to rapidly increase the delivery of BPHS; (e) the availability of NGOs (70% of the country's limited public health care services were provided by NGOs); and (f) the result of a pilot project in Cambodia (Palmer N, 2006).

The result of contracting of basic health care in Cambodia demonstrated that contracting improved health care delivery, increased transparency, and reduced overall health cost and out of pocket payment for the poor (Soeters, R 2003).

Since 1978, the Afghanistan health system and health service delivery, due to long periods of war and instability, have deteriorated. The government gradually lost its control over districts and provinces and as a result the health services deliveries in these areas collapsed and the health status of people, especially of women and children, got worse. Following the withdrawal of Soviet troops from Afghanistan and during Taliban regime, in most of districts, Non-Governmental Organizations (NGOs) and private health care providers have been providing basic health services without a clear national health policy, coordination and regulation.

After September 11, 2001, the Taliban government were ousted by coalition troops and a new government was established, which inherited one of the world worst health statistics and an almost collapsed health system. In 2002, in response the Ministry of Public Health (MoPH) and its major donors: United State Agency for International Development (USAID), the European Union (EU) and World Bank (WB), opted to step into reform through initiating the contracting strategy for the delivery of a Basic Package of Health Service (BPHS). Thus, the contracting of BPHS delivery was endorsed and accepted as a National Policy by MoPH.

Since 2003, different national and international NGOs have been implementing this strategy in Afghanistan. It is assumed, that contracting mechanisms by improving efficiency will increase accessibility of people to basic health services, improve quality, reduce out of pocket payment and prevent catastrophic cost, especially to the poor in the underserved and remote area (Strong L, 2005).

During last decade, contracting of basic health-care has been accepted by an increasing number of developing countries as one of the strategies of improving the performance of health system (Liu, 2007).

In this thesis the author would like to do a literature review to illustrate the experiences of developing countries about contracting strategy and critically analyze Afghanistan contracting experience.

2. BACKGROUND INFORMATION ON AFGHANISTAN

2.1. Geographical and demographic situation

Afghanistan is a land-locked and mountainous country, which is located in South-Central Asia, bordering with Pakistan in the south and east, Iran in the west, Turkmenistan, Uzbekistan and Tajikistan in the north, and China in the far northeast, comprising an area of 647,500 square kilometres. It is a crossroads between the east and the west, and has been an ancient focal point of trade and migration. Afghanistan has a continental climate with hot summers and cold winters and with different regions which are located between 150 to 7476 meters above sea level. Administratively, it is divided into 34 provinces and each province has a capital and is further subdivided in districts. The adult literacy rate is estimated at 36% with a large gender gap as it is 51% for males and 21% for females (Wikipedia, 2007).

Afghanistan has different ethnic groups and its population was estimated at 31 millions in 2006 consisting of 13.8% below 5 years, 33.8% between 5-14 years, 50.6% between 15-64 years and 2% above 65 years, and its mean household size is 6.8 (Afghanistan Health Survey, 2006).

2.2. Politics and Governance

Because of its different ethnic groups and its geostrategic location, Afghanistan has been invaded frequently by different powers. Since 30 years, it has been suffering from continuous and brutal civil wars, which started after the invasion of the Soviet Union in 1979. The withdrawal of the Soviet Union troops in 1989 and the ousting of the communist government in 1992 did not bring peace to the country and it even deteriorated. It badly affected the delivery of humanitarian assistance, human rights and especially women's rights. As a result the health status of the population became one of the worst in the world.

After the September 11th 2001 attacks, coalition forces toppled the Taliban government in November 2001. In late 2001, the International Security Assistant Force (ISAF) was established to assist the new government in establishing the writ of law as well as rebuilding infrastructures. In December 2001, after the Bonn Accords, the interim government was established under the leadership of Mr. Hamid Karzai, and a new constitution was developed. A presidential election took place in 2004 and Mr. Hamid Karzai gained the election. A parliamentary election took place in 2005.

In 2005, the United States and Afghanistan signed a strategic partnership agreement committing both nations to a long-term relationship. In the

meantime, billions US dollars have also been granted by the international community for the reconstruction of the country (National Economies Encyclopedia: Afghanistan 2007).

2.3. Socio-economic situation

The socioeconomic indicators are very poor; annual per capita income is about USD200, and 70% of the population is living in extreme poverty, have a poor health status, which put Afghanistan among one of the least developed countries in the world. The total expenditure on health is 6.5% of Gross Domestic Product (GDP) and general government expenditure on health is 7.3% of general government expenditure (WHO, 2007).

Afghanistan human development indicators are very poor. The Human Poverty Index (HPI) is 63.2 one of the worst in the world. The Human Developing Index (HDI) stands at 0.345 which places Afghanistan in 174th position out of 178 countries. Although, reliable data in the area of incomes, purchasing power parity and consumer prices are not yet available. Recent research points out large disparities in income (Afghanistan Human Developing Report, 2007).

2.4. Afghanistan Health System

2.4.1. Health situation

In 2004, Afghanistan had one of the worst health statistics in the world with Maternal Mortality Ratio (MMR) of 1600/100000 live birth, Infant Mortality Rate (IMR) of 165/1000 live birth and under five mortality rate of 257/1000 live birth and total fertility rate (TFR) of 7.4 (World Health Report, 2006). State of the world population estimated the total population of Afghanistan at about 32.3 million, the population growth rate at 3.5%, TFR about 7.1, life expectancy about 47.5years, MMR about 1900/100000 live birth, IMR about 143/1000 live birth, under 5 mortality rate about 234/1000 and HIV prevalence among 15-49 years < 0.1%.

The MoPH in order to improve the health status of people developed an Interim Health Policy and Strategy for 2002-2004 and then a national health policy for 2005-2009 to restore health system (WHO Report 2006).

2.4.2. Health Care Services

Based on the Afghanistan National Health Resources Assessment (ANHRA), which was conducted in 2002, the health system had three main problems: (i) huge inequity in the distribution of available facilities and services among provinces and between districts, (ii) insufficient qualified human resources at both service provision and management levels and (iii) poor drug and equipment availability (ANHRA, 2002).

In response the MoPH has developed several policies and strategies to improve health system efficiency by developing a Basic Package of Health Services (BPHS), training of new health workers, capacity building and contracting basic health-care to NGOs (Strong L, 2005).

2.4.3. Private Sector

Most private health facilities (hospitals, health centers and pharmacies) are located in the big cities providing services, and in certain rural provinces close to the Pakistan border such as Ningarhar. The management and services delivery in the private sector have been managed by physicians and other health workers. The MoPH capacity to monitor and enforce regulation is weak; the quality of services provided by them is questionable. An assessment of laboratory services which was done by HNI in Ningarhar province in 2001 found that only 7 facilities among 30 surveyed met minimum criteria (Afghanistan health sector profile, 2002).

2.4.4. Health Care Financing

International donors, international NGOs and United Nation (UN) agencies contribute a lot to health care financing; it seems the health services are underfunded. Generally, it is difficult to find data on health care financing at household level and on services outside the government and NGOs facilities, but it is estimated that out of pocket spending is relatively high and constitutes more than 70% of overall health expenses (WHO Report, 2006).

Also, there is no insurance system in place and the government doesn't have enough capacity to collect taxes. Therefore, the government faces major challenges regarding how to finance the health care system, how to reduce the out of pocket payment and, especially, how to provide free health care to the population based on constitution requirement which mentions the right for free health care (WHO Report, 2006).

From a normative point of view most health economists would agree that "free health care" is very bad as it ignores market forces, it provides poor quality care and it is unrealistic – as more than 70% of health expenses are out-of-pocket. Furthermore free health care blocks long term sustainability through insurance systems (Soeters R, point of view).

2.4.5. Main Health Problems

Communicable diseases, malnutrition and perinatal conditions are the main causes of morbidity and mortality. Major communicable diseases are tuberculosis, malaria, diarrheal diseases and cutaneous leishmaniasis. Mother and newborn condition and nutrition deficiency disorders, and mental health are among the important health problem (Afghanistan health sector profile, 2002).

2.4.6. NGO Community

The NGOs community has expanded during war and they run around 70% of existing public health facilities. The most important NGOs working inside the country in 2002 are Medicin Sans Frontières (MSF), International Medical Corps (IMC), Aide Medical International (AMI), Health Net International (HNI), and Swedish Committee for Afghanistan (SCA), and other international and national NGOs (Afghanistan health sector profile, 2002).

2.4.7. Donors

Contracting of BPHS is currently supported by five donors: World Bank which supports 11 provinces- 8 provinces by contracting to NGOs and 3 provinces by MoPH under the name of MoPH-Strengthening Mechanism (MoPH-SM). USAID supports 13 provinces through contracting to NGOs. European Commission supports 10 provinces by contracting to NGOs. Some districts are supported through Asian Development Bank (ADB) and Kreditanstalt fur Wiederaufbau (KfW) fund. Donors channel their funds through different contracting schemes. WB funds are managed by MoPH's Grant and Contract Management Unit (GCMU). The ADB and USAIDS outsource their funds to international NGOs, whereas the EC undertakes this process itself (WHO Report 2006).

3. PROBLEM STATEMENT, OBJECTIVES, METHODOLOGY

3.1. Problem statement

Reform of health system, improving efficiency of services delivery and rapidly increasing the coverage of BPHS in the rural area became the core objectives of Afghanistan in 2002 (Waldman R, 2002).

MoPH developed contracting strategy for achieving its objectives mainly because of poor capacity of government to rapidly deliver BPHS to rural area, major donors' willingness, and availability of NGOs as service providers in Afghanistan since two decades (Strong L, 2005).

The goal of BPHS is to provide a standardized package of basic health services in all primary health care facilities. During development of this package the following key elements were taken in consideration:

- to have impact on the major health problems
- to ensure the quality of services
- to be cost-effective
- to improve equity
- to provide a foundation for the new health system in Afghanistan

The BPHS contains seven elements (A BPHS, 2003).

1. maternal and new born health
2. child health and immunization
3. public nutrition
4. communicable diseases treatment and control
5. mental health
6. disability services
7. regular supply of essential drugs

After 5 years of experiences, questions have been raised about the ownership, sustainability, challenges and perspectives of contracting of BPHS in Afghanistan. Therefore, this thesis describes the concept of contracting of basic health-care, how it emerged on the health policy agenda, its effectiveness in developing countries, and critically evaluates contracting experiences in Afghanistan including its justification, process and effectiveness on basic health-care to provide recommendations to policy makers for the development of an appropriate and sustainable health system in Afghanistan in particular and other developing countries in general.

3.2. Objective

3.2.1. Overall Objective

To review literature on the effectiveness of contracting basic health-care in developing countries in order to provide recommendations to policy makers for appropriate service delivery strategy in Afghanistan in particular and other developing countries in general.

3.2.2. Specific Objectives

1. To describe the strategy of contracting basic health-care and its emergence on the policy agenda in developing countries.
2. To review effectiveness of contracting on access, equity, quality, and efficiency of care in developing countries.
3. To critically review contracting experiences in Afghanistan including:
 - Its justification.
 - The process.
 - The effectiveness in terms of access, equity, quality and efficiency.
4. To provide recommendations to policy makers for the development of appropriate and sustainable health system in Afghanistan in particular and other developing countries in general.

3.3. Beneficiaries of Study:

1. The MoPH in Afghanistan
2. The Afghan Public Health Institute
3. The Afghan Health Services
4. NGOs
5. International Development Organizations and Donors in Afghanistan
6. Developing and post conflict countries

3.4. Methodology

This is a descriptive study on contracting of BPHS delivery in Afghanistan. A literature review on contracting of basic health-care in developing countries was conducted. The Afghanistan health sector Balanced Scorecard (BSC) National and Provincial Results in 2006 were reviewed.

Search Strategy

I have done a comprehensive search of literatures and I also reviewed the unpublished materials such as: thesis, reports and presentation to limit the biases within the review. I searched electronic database like: Google, Pub Med, WHO website, World Bank website, KIT library, Course Books & Handouts, and Afghanistan MoPH website & reports. The key inclusion

criteria related to this thesis are contracting of basic health care delivery in developing countries and only English language documents were considered.

Key Words

Contracting, performance based partnership; performance based financing, primary health care, developing countries, fragile states, and post conflict countries.

Limitations

Performance based financing of basic service delivery initiated after significant political and social changes happened in Afghanistan and as a result a lot of health workers came back to the country and also major donors technical and financial supports increased. Any improvement can, therefore, not easily be attributed to contracting. The situation was so desperate that it could only go for the better. This study due to time and resource limitations can not analyze these factors. The study does not review basic procedures for data collection and analysis and uses secondary data which limit the validity and reliability of the study result.

4. CONTRACTING IN DEVELOPING COUNTRIES

4.1. General Information

There are different terms for describing contracting, such as contractual approach, performance based partnership agreement, payment for performance and performance based financing. Contracting basic health service may be used to implement the purchaser-provider split in which government acts as a purchaser and NGOs as providers. However, the government core role is regulation, while purchasing can be better done by an autonomous structure such as insurance companies, fund holder organisations. Alternatively, the MoPH can be the regulator and another government structure the purchaser (Soeters R, 2006).

Generally, the basic rationale for contracting health services delivery to NGOs are: efficiency gains, making use of superior market mechanisms, stimulating the private sector, motivating competition among service providers, providing financial incentives for improved performance and governments' failure in the provision of public services (Liu X, 2004).

Currently, in post conflict countries because of the poor capacity of public providers the contracting is being promoted. It is assumed, that contracting can improve efficiency, equity and reach many of the poorest people and also it is seen as an effective way to expand services quickly but many questions about contracting remained unanswered (Sabri B, 2007).

4.1.1. Definition

Contracting in the health sector is a formal and documented agreement for a contractual relationship between purchasers and providers by which purchasers compensate providers based on their performance for the delivery of a Basic Package of Health Services for a defined target population within a fixed period of time. It is important for a legal contract that the two parties should not belong to the same entities and a contractual relationship should be in place to guide & control the behavior of involved parties (England R, 2000). The purchaser is an organization, government or health insurance company, who buys the services or products from providers through a contracting agreement. The provider is an individual or organization that sells its services or product through the contracting relationship (Rosen J, 2000)

4.1.2. Why did Contracting Emerged on the Policy Agenda

Until the end of the 1970s, in many developing countries, two actors were involved in the delivery of basic health-care: (i) a public health system, which acted as a regulatory, financing and implementing body, was responsible for developing health policy, strategies; financing health care through public fund; endorsing law, norms and regulations; and providing free health care in line with welfare rational and (ii) a private system which was providing health care independently from the public health system with complete autonomy and fragmentation.

During the 1980s, developing countries due to mainly high cost of free health care and poor performance of centralized government introduced reforms to health system. The purposes of these reforms were to address financial crises and enhance the efficiency of services delivery through expansion of active privatisation. Nevertheless, during the above-mentioned two decades, the health system and actors were obviously separated into two sectors: a public health system and a private sector, which usually faced with ideological confrontation. Since 1990s, a marked evolution in health sector reform has been observed mainly due to the diversification of actors, separation of functions, and disappearance of confrontation between public and private sectors and emergence of public-private partnership. On the one hand, different actors- local authorities, insurance organizations, communities, and NGOs- roles and involvement in the delivery of services get increased, and on the other hand, separation of functions- financing, regulation, stewardship and provision- get more specified and marked (Perrot J, 2004).

During the last decade, the developing countries governments' structure and functions in relation to the delivery of public services, mainly due to hierarchical bureaucracy, were found inefficient. Therefore, the policy of contracting as a mechanism for improving the performance of public services delivery emerged, essentially, based on New Public Management theory (NPM). The NPM theory is based on market mechanism and values, which emphasizes that the efficiency of public service delivery will be enhanced by introduction of selective market mechanisms (Mills A, 1998).

There is evidence, that competitive process of contracting based on market incentives and principles improves the efficiency of service delivery and enhances the quality of care which consequently leads to a higher rewards and client's satisfaction. Therefore, the health service providers, public and private, should compete for contracts in order to get public funds (Soeters R, 2007).

4.1.3. Different forms of Contracting

Different forms of contracting mainly depend on different factors such as (Liu X 2004):

- Who are the purchasers: government, donors, NGOs, public insurers or private insurers?
- Who are the providers: public, private, NGOs, religious organizations
- What kinds of services are contracted: clinical, nonclinical, inpatient, outpatient, preventive or curative services?
- Payment mechanism: output-based, outcome-based or performance-based
- Objectives of contracting: to increase efficiency and productivity, to promote access to health care, to improve quality of care, and to improve the performance of health care delivery.

4.1.5. History of Contracting

Primarily, developed countries, specifically, the Organization for Economic Cooperation and Development (OECD) started contracting arrangements, which included transportation, public utilities and sanitation, than, spread to health and education sectors. In developing countries, contracting of health services has started during 1990s under the influence of health reform and health financing ideologies and donors interest (Mills 1998).

4.1.6 Rationales for Contracting

There are two theoretical rationales in favor of contracting: property right theory and public choice theory. Property right theory argues that public sector is inefficient mainly due to lack of feeling of ownership and poor incentive. On the other hand, public choice theory argues that public sector inefficiency is mainly due to acts of politicians and bureaucrats who favor their own interests or powerful groups and who do not favor the public interests. So, both theories suggest, in order to improving efficiency, the delivery of services need to be carried out by a nonpublic or an autonomous body (which can also be public) through a contractual arrangements (Liu X 2004).

Also, there is a perception that the traditional structure of the public sector with its hierarchical bureaucracy is one of the main reasons of public sector inefficiency in service delivery and argues that introduction of various market mechanisms can improve it (Mills A, 1998).

In addition, in order to achieve the health-related Millennium Development Goals (MDGs), governments need to improve the delivery of health services. One way to improve service delivery is contracting to non-state bodies such as NGOs, which offers some opportunities for state to get benefit from greater flexibility, competition, and better morale of private sector (Loevinsohn B, 2005).

4.1.7. Potential Advantages

Several potential advantages of contracting were documented by various authors:

- Contracting can increase access of population to health-care by introducing competition amongst providers, setting up contractual agreement and linking payment to performance.
- Contracting can increase equity by targeting underserved area and those diseases which affect the poor.
- Contracting explains the role, functions and responsibilities of both providers and purchasers and also clarifies their relationships which allow governments to focus more on stewardship and capacity building.
- Contracting, through measuring performance of providers, will improve over all monitoring and evaluation in public health sector.
- Contracting encourages public-private partnerships and should not discriminate either the public, religious or private health providers

Therefore, policy makers and donors like to use contracting as a policy tool for improving efficiency of service delivery and improving access, quality and equity of care (Liu X 2004).

4.1.8. Potential Pitfalls

Contracting of basic health care has three main potential pitfalls:

- High transaction costs: For establishing and maintaining a contract there is a need for a situational analysis, collecting information, preparing proposals, doing monitoring & evaluation, enforcing contract and managing conflict that incur costs, which is called transaction cost.
- Low contractibility of health services: Comparative lack of competition among service providers in health care provision, the asymmetry of information between contractors and contractee and high asset specificity are the main contributing factors for low contractibility of health care services. However, such problems can be avoided by contracting the management of health providers and not the physical building. When the management fails they are replaced, while the building remains the same. This can be done under competitive circumstances even in remote areas where some observers say that there exist natural monopolies.
- Adversarial relationships between purchasers and providers: Better coordination and collaboration among different stakeholders: policy makers, purchasers, providers and consumers are required to improve

the performance of service delivery which is might be undermined by contractual relationship (Liu X, 2004).

In addition, if the providers don't have sufficient autonomy to control their resources and budget, they can not manage the delivery of service effectively. Also, insufficient competition among service providers can be a limitation for a successful contracting, because it limits the purchasers' choice and decreases providers' enticement for better performance. The purchaser capacity regarding managing and monitoring contracts is very vital. It has been seen that without a proper capacity of purchaser for controlling contract, the contract failed to achieve its objectives (England R, 2000).

If a government doesn't have enough capacity to manage the contracting process, the possibility that contract becomes an ineffective or even harmful strategy for service delivery would be increased (Perrot J, 2004).

It is suggested, that the loss of monopsony purchasing power of public for the bulk purchasing and procurement of drugs and equipments may increase the cost of contracting which outweighs the overall benefit of contracting. Finally, it is claimed, that contracting, in already constrained context, may threaten the health equity by selecting low risk patients, focusing on more profitable services, stripping out essential preventive services, competing for limited staff and draining key staff from public facilities (Mills A, 1998).

4.2. Process

Contracting process has seven steps (Rosen J, 2000):

Step 1: Contract's Package

- Services should be clearly defined and specified in terms of quantity, quality, geography and equity.
- Form of contract needs be specified as service contracting or management contracting.
- Some potential pressure should be anticipated and addressed at the beginning: the issue of privatization, equity, duplication, overlap, and transparency in selection process.

Step 2: Contract's Specification

- Outcome of the contract should be clear and be linked to the provider performance: contract's term of references should provide enough and clear information to the providers in terms of specific indicators and targets, baseline data, monitoring and evaluation procedure, performance bonus, and conditions for termination of contract.
- Managerial autonomy: It is crucial that the contract should ensure enough managerial autonomy to the service providers.

- Quality of care: Acceptable quality of care needs to be clearly written in the contract and providers should know about it as: national treatment guidelines, national family planning guidelines and so on.
- Staff training: Service provider staff training and training issues need to be spelled out in the contract, especially, regarding training need assessment, who will conduct the training, who will fund it, and who and how will be assess.
- Quality assurance and supervision system: Quality assurance and supervision system of service providers need to be clear in the contract.
- Sharing of experiences and capacity building: It is good to be mentioned in the contract about sharing the lesson learned by service providers and the need for further improvement through training, technical assistance and operational research.
- Contract size and number: It is important to adjust the size and number of contract based on the capacity of both providers and purchasers.
- Contract duration: The contract duration should to be fixed and it can be determined based on the scope and scale of services and cost of contract renewal. For example, more complex and large scale basic health-care contracts can be more than 4 years and small project with well-defined activities can be at least one year.
- Drugs and supplies: The procedures of procurement and distribution of drugs and supplies should be written in the contract and based on many countries experience this activity is better to be undertaken by the service providers, who may purchase their requirement from competitive distribution centers at national and provincial levels in order to assure their availability and quality at reasonable costs.
- Infrastructures and Equipments: The standards of the infrastructure and equipment should be determined by the regulator. If at the baseline study insufficiencies have been noted, providers can contractually be obliged to upgrade their infrastructure and equipment. However, it is better to give the responsibility of procurement to the service provider.

There should be a quality control system in place to check whether procurement of drugs, medical supply and goods are done based on a competitive and transparent bidding process to ensure quality, economy of scale and harmonization of equipment. Otherwise, provision of different drugs and supplies compromises quality of services and increases cost of contracting because of maintenance of different spare parts and training of health workers.

Step 3: Contract payment strategy

- Payment mechanism would affect providers' behavior and should be identified in the contract. Capitation payment is usual in contracting of basic health-care and has more advantages than fee for services or

global budget (Mills A, 1998). Currently in PBF, payment is done through a contractually agreed subsidy for each output such as a delivery, a child fully immunized, a pit latrine constructed, a HIV patient under ARV, etc.

- Cost recovery: If there is an agreement for cost recovery, it is necessary to clearly describe all the procedures in the contract.
- Performance bonuses are a useful motivation for enhancing performances. The procedure for awarding performance bonuses and the amount of payment should be fixed in the contractual agreement. Performance bonuses are arrangements usually between the management of a health facility and its staff. Therefore, there are usually two levels of contracts: one between the purchaser and the health facility and then between the health facility and their staff members. Unfortunately, in the past this was poorly understood, which creates enormous confusion. This confusion is also seen in Afghanistan, where NGOs directly contract health workers independently from the health facility managers.
- Advance and Performance bond: The amount of payment for advances and performance bond and the procedures need to be determined in the contractual agreement.

Step 4: Selection

- Involvement of potential service providers in the design of contracting: In order to ensure transparency and fair bidding it is important to involve potential service providers in the design of contracting at the early stage.
- Advertisement: Broad advertisement and conducting orientation workshop are important tools to ensure competition and attract prospective service providers.
- Selection process: Three different options are exist for the selection of service providers: a competitive bidding which is based on technicality and cost of proposal, a consulting services approach which is based only on technical proposal and sole source contract which is based on unique experience and skills of a provider. However, in practice in PBF system the already existing health providers from the government, NGO and private sector are requested to develop their business plans. If the business plan is convincing the provider receives a contract.
- Evaluation process: Each proposal should be evaluated and scored based on technicality and price by an evaluation committee. The committee must comprise of independent members including outside experts from NGOs (unconnected to the bidder), and international organization and the committee ought to use clear guidelines and scoring system. This is for NGO contracts, not for health facility contracts.

Step 5: Negotiation

- Completing a draft contract

- A Terms of Reference (TOR) which including all services specification should be clearly developed and attached with the contract.
- Failure to agree: If the negotiation between purchasers and providers failed than the purchaser can open negotiation with the subsequent highest ranked bidder.
- Contract signing: Once both parties agree on contracting it should be signed.
- Notifying stakeholder: An official notification of contract agreement should be distributed to providers and purchasers.

Step 6: Implementation

- Contract management: It is very important to assign or establish a capable unit for managing the contractual agreement.
- Reporting requirement: It should be fixed in the contract: HMIS, financial and human resource reports.
- Prompt payment: The purchaser should ensure on time payment of providers. Delayed payment is a common problem and it is one of the main reasons of contractors' withdrawal or reluctance to bid for proposals.
- Conflicts resolving mechanism: A proper and feasible mechanism for settling conflicts must be included in the contract.

Step 7: Monitoring and evaluation

- Monitoring: Regular and ongoing monitoring of the project is very crucial for ensuring of quality of care, developing better understanding about the field reality and providing feedback. For the sake of proper and fair monitoring, it is suggested that a third party should be involved in the monitoring process. Verification by the purchaser is important such as to verify the registers and to conduct household surveys to prevent falsified data and to measure patient satisfaction.
- Evaluation: Independent performance appraisal of service providers by a third party is essential to the success of contracting. Especially, when the performance of service providers is going to be assessed in terms of quantity, quality and equity, because these issues require household surveys, health facility surveys and qualitative studies for determining beneficiaries satisfaction.
- Effectiveness and Efficiency of Contracting: In order to evaluate the effectiveness and efficiency of contracting, it is better to design an operational research at the beginning to assess contracting in terms of cost and result with some other logical intervention.

4.3. Review of the Evidences for PBF

Since contracting became popular there are 4 reviews were published:

1. Mills and Broomberg carried out the initial literature review on contracting in 1998. Despite limited literature on contracting they found that the result were ambiguous: in Zimbabwe and South Africa

contracting delivered the same or better quality service with at lower cost, while in Ghana and Tanzania, there were no significant difference among contracting and government service providers and they concluded that it is too early to evaluate the effect of contracting strategy (Mills A, 1998).

2. The second literature review on contracting of service delivery conducted by England in 2004. His main objective was to evaluate the effect of contracting strategy on equity in access. He found that there are few evaluations done to assess the effect of contracting on equity in access and he concluded that contracting has some potential for improving access to poor (England R, 2004).

3. The third literature review on contracting of basic health-care was carried out by Benjamin Loevinsohn in 2005 on 10 studies in developing countries. It demonstrated a number of potential benefits of contracting: Firstly, contracting with NGOs can afford services on a large scale, in various situations, and enhance rapidly the delivery of basic health-care and nutrition services and remarkable enhancement can be attained. Secondly, contracting in contrast to government delivery can be more cost-effective. For example, a comparison study of urban primary health care delivery by government (Chittagong City Corporation) and NGOs in Bangladesh revealed that contracting improved quality of care and 10 health indicators better than government with the same cost. Thirdly, coverage of basic health-care can be increased through contracting, even in the underserved and remote area, because NGOs can work in difficult and under-served area willingly. Fourthly, it was found that contracting can greatly improve health services for the marginalized and poor groups if they were targeted and thus reduces the inequities better than government. Fifthly, management of contract is a difficult issue for weak purchaser, but evidences in this study showed that it didn't affect the service delivery improvement by NGO. Lastly, the sustainability of contracting is a real concern because most of the reviewed cases supported by donors and the sustainability of contracting was not evaluated (Loevinsohn B, 2005).

In Cambodia, performance-based financing improved the utilization of basic health care; increased outpatient consultation, antenatal care and institutional delivery; reduced informal payment, improved quality of care reduced out of pocket cost for the poor and increased the level of motivation of staff compare to services run by Cambodian government (Soeters R, 2003).

Contracting of two large-scale community nutrition services in Madagascar & Senegal improved the nutritional status of children considerably, coverage rate improved from 50% to 87% and severe

malnutrition vanished among children age 6-11 months and moderate malnutrition decreased from 28% to 24% among children age between 6-35 months (Marek T, 1999).

4. The last literature review on contracting of basic health-care was carried out by Liu in 2007. He studied 13 cases which the purchasers were government and the providers were national, international NGOs and a private provider and all project supported by donors. The target population of these projects varied, ranging from 30 million populations in the nutrition project in Bangladesh to 54000 populations in the child treatment program in India. They were providing a variety of services including: specific service for treating children common diseases (fever, diarrhoea, ARI and malnutrition) and essential health package. Quality of the studies in terms of the research design, methodology, performance indicators and data were different (Liu X, 2007).

Among 13 cases studied, 12 aimed at improving access to basic health services, 10 of them reported significant improvement of access to health services.

Among 13 cases, 2 studies had direct objectives to improve physical and economic access of the poor to basic health-care and both of them shown significant improvement. One of these projects was, the Urban Primary Health Care, in Bangladesh, which improved equity in access to primary health-care for the urban slums (Mahmud et al. 2002). The second contracting project, which enhanced the utilization of service delivery by the poor and reduced the out of pocket cost, was carried out in Cambodia (Bloom E, 2006). Thus, because of limited study of contracting on equity, it was not concluded that contracting improves equity better than public providers, but it was suggested that contracting has the potentials to improve equity in health-care, if the poor were targeted (Liu X, 2007).

Also, 11 projects were included one or more indicators of quality, either structural, process or health outcome in the projects. Patient satisfaction, patient waiting time and percentage of patient treated according with medical guidelines were incorporated as process quality indicators in 5 projects in different developing countries, which the results were positive. Four out of 13 studies included outcome indicators for measuring the quality of services. Among those, 3 studies related to the nutritional services projects which only two studies, nutritional services in Senegal and rural nutrition program in Bangladesh, showed some improvement in the health status of population of their catchment area. Generally, it was found, that contracting would improve quality of care if indicators for quality measurement well defined or payment of service providers linked to the quality indicators (Liu X, 2007).

In this literature review, only 2 out of 13 projects included efficiency improvement as their clear objectives and the findings suggest that there is little evidence to show the effect of contracting on efficiency. Generally, it was concluded, that it remains unclear whether contracting reduces the overall cost of service delivery or increases the efficiency of health system (Liu X, 2007).

A study on contracting of health services in Cyangugu province of Rwanda reveals that contracting improved utilization of services (increased institutional delivery from 25% to 60% and family planning from 5.4% to 11.6%), increased financial accessibility (decreased out of pocket health expenditure by 62% from USD 9.05 to USD 3.45, and decreased catastrophic cost by 72% from 2.5% in 2003 to 0.7% in 2005) and enhanced health staff motivation (Soeters R, 2006).

However, reviewers argue that the expected objectives of contracting can not be attained in many developing countries because of high overhead cost, lack of competition among service providers, fears of fragmentation of health system and poor stewardship of state (Palmer N, 2006).

As a result, Liu concluded that there are evidences which contracting improved access to services, but the effects on equity, quality, and efficiency and on health system is often unidentified. Nevertheless, contracting remains a controversial strategy for the improvement of health system performance because of insufficient evidence (Liu X, 2007).

4.4. Conceptual Framework for Evaluating Contracting:

A conceptual framework for monitoring and evaluation was developed which describes how to evaluate contracting. It focuses on four types of factors that be considered during evaluation (Liu X, Sep 2004):

1. information on the contracting intervention

- the types of services the contract covers
- the contract's formality
- the contract duration
- the selection of the contractee
- the specification of performance requirements
- contract payment mechanism

2. information about external environment

- characteristics of the overall health sector
- financial and legal setting

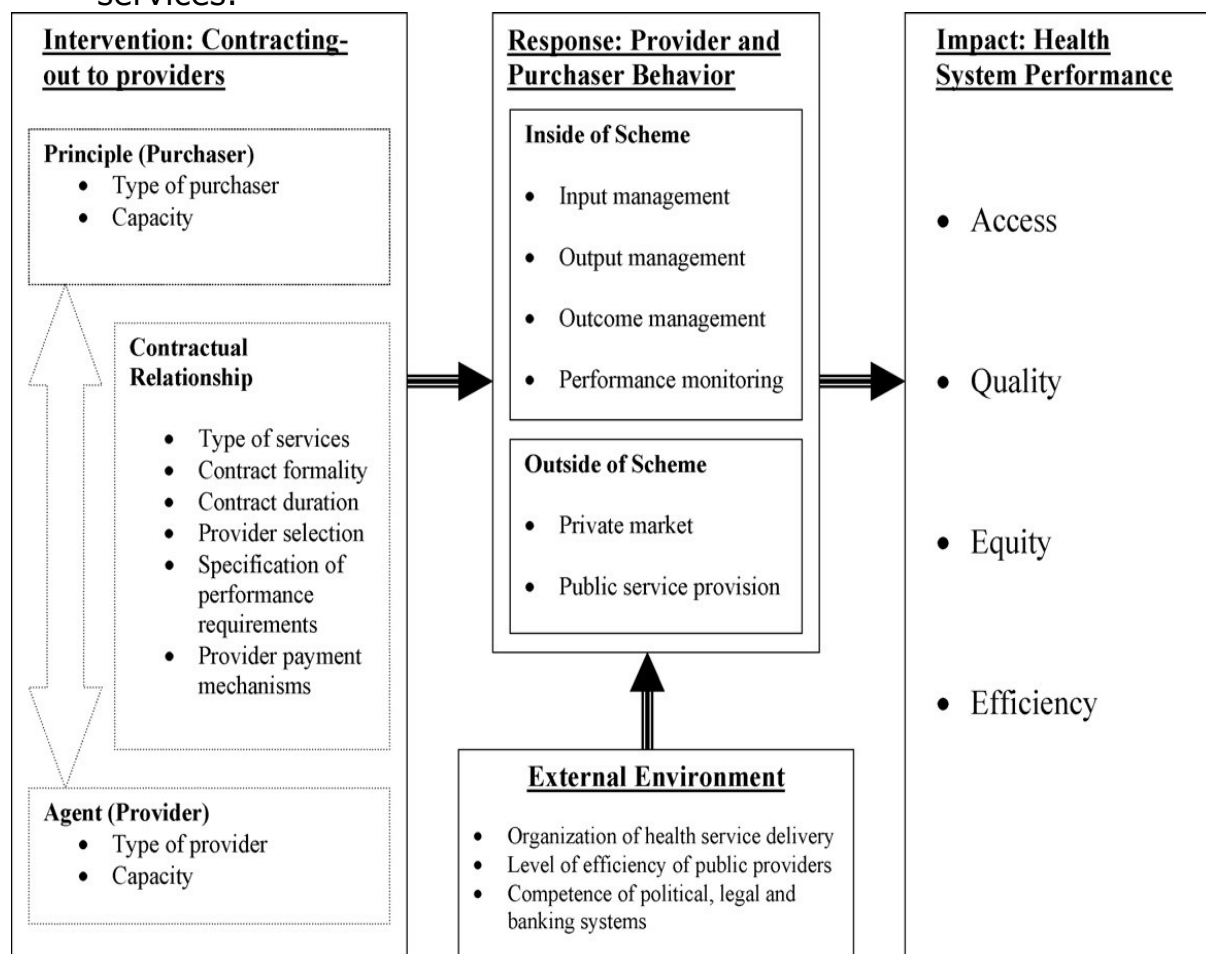
3. the response of providers and purchasers both within and outside the contracting scheme

3.1.1 input management of contractee:

- human resources
- equipment and supplies

- drugs
 - infrastructures
- 3.1.2 output management of contractee:**
- program planning, administration and finance
 - hiring and procurement practices
 - client satisfaction system
- 3.1.3 outcome management of contractee:**
- medical management and quality assurance
 - clinical practice guidelines and standards
- 3.1.4 performance monitoring:**
- 3.1.5 Private market:**
- 3.1.6 Public service provision:**
- 4. Information on the impact of contracting:**
- accesses (physical and financial)
 - quality (structure, process, and outcome)
 - equity
 - efficiency (allocative and technical)

Fig. 1. A conceptual framework for evaluating contracting of health services.



Source: Liu X 2004. Contracting for Primary Health Services: Evidence on Its Effects and a Framework for Evaluation

5. THE AFGHANISTAN EXPERIENCE

5.1. Justification

In 2002, Afghanistan health decision makers, in order to improve access, equity, quality and efficiency of basic health-care, faced with several options for the delivery of BPHS: decentralization, devolution and contracting. The choice of decentralization, which is to give more responsibility to provincial public health offices, was very limited because the overall capacity of provincial health offices to deliver the BPHS was very weak. Also, devolution, which is to transfer legal administrative power to district or provincial political unit, was not possible due to the poor capacity. The only feasible option for MoPH and partners was contracting of BPHS to NGOs.

The main justification which MoPH opted to step for contracting were (Sabri, B 2007):

- Fragmented health system: the existed public health system run by different actors and NGOs and the government didn't have the capacity to deliver BPHS itself.
- Major donors wanted to channel financial support to NGOs through contracting of a BPHS. They did not have trust on the capacity, transparency and accountability of the government.
- The need for rapid expansion of BPHS coverage all over the country, especially to the rural and under served area.

5.2. Process

Since 2003, MoPH has been experiencing contracting of BPHS to NGOs as a clear strategy for enhancement of efficiency of basic health-care delivery. MoPH, after describing its health priorities and developing a BPHS, established a unit under the name of Grant and Contract Management Unit (GCMU) at the central level to manage all the contracting process. The GCMU received enough technical and financial support from major donors, especially the World Bank. Also, there are a number of coordination bodies support MoPH and GCMU on coordination and management of contracting. At the beginning, GCMU was managing contracting process which was supported through WB fund and recently the role of GCMU has expanded to manage other donors' funds.

At the provincial level, there is a NGO project management office that is responsible for the management of service delivery, hiring & firing of staff and procurement of drugs & supply; and a provincial public health office that is responsible for quality assurance, regulation, monitoring & evaluation, stewardship and inter-sectoral activities as shown in table 1. Moreover, there is a Provincial Health Coordination Committee (PHCC) which coordinates health service delivery at the provincial level and

supports implementing NGOs for the smooth delivery of BPHS. The member of PHCC comprises of provincial public health director, implementing NGO project manager, other available NGOs representative, provincial governor representative and UNICEF and WHO provincial representatives.

Table 1: Summary of Provincial & NGO Management Team Functions and Salary

Issue	Provincial Public Health Office	Provincial NGO Office
Functions	<ol style="list-style-type: none"> 1. Coordination 2. Stewardship 3. Quality assurance 4. Monitoring & Evaluation 5. Inter-sectoral activities 	<ol style="list-style-type: none"> 1. Management 2. Hiring & Firing of staff 3. Procurement of drugs & supply 4. Reporting to MoPH provincial & central 5. Providing salary of staff
Monthly Salary	<ol style="list-style-type: none"> 1. Director 500/-USD 2. Deputy 250/-USD 3. Accountant 200/-USD 4. Administrator 200/-USD 5. Technical Officer 240/-USD 	<ol style="list-style-type: none"> 1. Director 1500/-USD 2. Deputy 1000/-USD 3. Accountant 800/-USD 4. Administrator 600/-USD 5. Technical Officers 500/-USD

The level of salary of NGOs management team is threefold higher than public health management team. So, the NGOs could hire more capable staff than MoPH; sometimes the key MoPH staffs were recruited by NGOs. This difference in the level of salary caused some practical problem: more qualified staff left MoPH and the remaining staffs don't have enough capacity to deliver their stewardship functions, which increased friction among NGOs and MoPH at the provincial level.

Contracting gives NGOs total responsibilities in terms of service delivery, hiring and firing of human resources, procurement of drugs and equipment and other budgeting issues. Each contract covers specified types of services which is called BPHS (Sabri B, 2007). The BPHS consists of a comprehensive list of services to be provided at four standard levels of health facilities within the health system: Health post (HP), Basic Health Centre (BHC), Comprehensive Health Centre (CHC) and District Hospital (DH). The services are provided by BPHS are shown through Annexes 2-5.

Three main donors technically and financially support the contracting process in 34 provinces of Afghanistan: WB 11, USAIDS 13 and EC 10 provinces. The WB channels its fund through the Ministry of Finance (MoF) to the MoPH's GCMU. USAID contracted this process previously with Management Sciences for Health (MSH) and currently to WHO. The EC

undertakes the contract process itself through direct communication and negotiation with NGOs.

The process of contracting is different among three major donors and currently MoPH is only responsible to handle the contracts which funded by WB. These differences caused high overhead cost of contracting in Afghanistan which influenced donors to rethink about this issue. Here, I like to explain the process of contracting which is managed by GCMU, because, there is a tendency among other donors to channel their fund through this mechanism. The similarities and differences of the three contracting process are explained in detailed as in Annex1.

Contracting is based on capitation (fixed rate per individual per year) and each contract covers a specified geographical area with estimated population based on Central Statistics Office (CSO) report. In case of under performance the contracts can not be challenged in the court of law because they are not classic contract. The only option for government for non-performance either to terminate or to not extend the contract.

The process of contracting starts after issuing of an Expression of Interest (EOI) by the MoPH and than NGOs are required to apply within a month. The GCMU sends a Request for Proposal (RFP) to shortlisted NGOs, who have one and a half months, to send technical and financial proposals. So far, the bidding process has been carried out smoothly, even though it was a new experience for both MoPH and NGOs. The contracts are based on capitation with monetary bonuses of up to 10% for meeting and exceeding targets. NGOs have considerable flexibility in terms of service provision and recruitment to adjust their budget based on field reality during implementation (Strong L, 2005).

GCMU is responsible for managing all contracting process and must ensure competitive bidding process based on International Development Agency (IDA) procurement guideline. The GCMU staffing consisted of 2 international advisors and some national consultants, who are responsible for all bidding processes, capacity building of related departments and NGOs. The contracts average duration is 26 months and varied between the ranges from 12-36 months and covered all 34 provinces (Palmer N 2006).

In case of any problem encountered, the MoPH is responsible to act as a mediator and there is a rewarding system in place. Involved NGOs in the implementation of BPHS have different size and as well as different level of technical and managerial capacity. Most of them depend on support of donors and UN agencies in terms of vaccines supply & procurement. The government capacity in terms of drug quality control and inspection and regulation is insufficient and there is concern about the quality of drugs procured by some NGOs. Most of NGOs have short-term contracts with MoPH and this affects them to not invest in facilities development and

repairing and maintenance of medical equipments, which has negative implication for sustainability of health system.

The MoPH implements BPHS in three provinces under management contract funded by World Bank which had good result. However, we can not compare them with service contract with NGOs, because all three provinces are located near to Kabul, in Northern area which has better security and socio-economic situation and human resources can easily be recruited (Sabri B 2007).

5.3. Evidence on Effect in Afghanistan:

MoPH has begun performance based partnership strategy to address the public health inefficiency in terms of service delivery of basic health-care, poor quality and equity, poor distribution of resources and uncoordinated efforts of different actors and NGOs involved in the health system. Also it was considered, that contracting can improve the performance of service delivery by using the expertise of national and international NGOs, and establishing a more formal and constructive relationship between NGOs and MoPH. In the meantime, it was assumed, that contracting can ensure equitable distribution of resources and as well as improve decision making of providers for the management of service delivery and provide opportunities for MoPH to build its capacity and stewardship functions. However, there were some concerns in the capacity of MoPH regarding developing, managing and evaluating contracting; ensuring a transparent competitive bidding process, avoiding corruption and dealing with high administrative cost of contracting (Waldman R, 2002). These concerns might be the reasons that EC and USAID kept contracting management for themselves.

In reality, after several years of experience of contracting most of those concerns have not appeared. The capacity of MoPH has been built through establishing a GCMU and transferring of donors' expertise to this unit. Since the starting of contracting strategy, this unit effectively handled the contracting processes and managed the donors' funds. (Consultation on Strategic Contracting in Health System, 2008).

The level of competition for bidding is one of the preconditions for success in contracting. In Afghanistan, based on the study which was done by Natasha Palmer, the level of competition was varied and it was related to the security and the level of remoteness of the provinces. Competition was better in secure and accessible provinces than in non-secure and remote area. As an example, in Badghis province, which is one of the most remote areas, the contracting process was undertaken without competition. Also, renewal of contracting in such a difficult area is a big challenge, especially, how to replace a NGO once who won the contract

and gained expertise on local knowledge and experiences (Palmer N, 2006).

Contracting has the potentials to improve performance of service delivery if the quantity and quality of services are defined clearly. Terms of contracts of NGOs for BPHS deliveries in Afghanistan were different and it depends to the donors. Some donors focused on inputs indicators (number of active clinics, numbers of trained staff), some on process indicators (clinical guidelines) and some on outputs indicators (vaccination coverage, institutional delivery). The contracts are performance based and NGOs with good performance, which is defined as an increase of at least 10% points above baseline indicators, would receive bonuses. Some NGOs already received bonuses amounting to 1% of their contract prices for good performance and only one international NGO contract was terminated for poor performance (Palmer N, 2006).

5.3.1. Access

Based on MoPH reports, the access of population to BPHS is increased. The theoretical coverage based on the population per facility ratios is 85%, but the actual accessibility of population to BPHS, which is more informative, is unidentified. BPHS is delivered by four types of facilities: HP, BHC, CHC and DH. The HP provides a limited range of basic health-care at the community level and run by unpaid Community Health Workers (CHW) and covers 1000-1500 people. The BHC offers BPHS for a population of 15000-30000 people through a medical doctor, a midwife, and two vaccinators. The CHC offers BPHS for a population 30000-60000 and DH covers a population of 100000-300000. The detailed functions of BPH facilities are seen in annex 2-5 (BPHS, 2005).

Human resource recruitment for rural and remote areas was a problem for MoPH. The health staff didn't have any motivation to go to remote areas because of low salary and long and bureaucratic recruitment procedures in government. This problem in some degree was solved by introduction of a new national salary policy for NGO staff and given all authority of hiring and firing of staff to NGOs. Based on this policy, the staffs who work in remote and underserved area receive better salary and hardship allowances. As an example, more than 75% of health facilities had at least one trained female health worker in 2006 comparing to the baseline for this indicator in 2002 which was 25% (Waldam R, 2006). These human resources were recruited from big cities and also a small number of female health workers were recruited from Tajikistan. However, recruitment of proper health workers, especially female, is still a big problem for NGOs in the remote and under-served areas, which will affect the utilization of services by female.

Considering the climatic, geographical and hard terrain and poor roads and transportation in Afghanistan, the population per facility ratio as recommended in the BPHS is a little bit too high to cover all the required population and improve access. Therefore, the MoPH already established some sub-centers to improve actual accessibility of population to BPHS. In addition to physical limitations for improving access of population to BPHS, there are other determinants to be investigated: security, health seeking behavior, financial barriers, private providers, and traditional healers. The security situation in South and South-Eastern regions got worsen which affected the accessibility of people, especially women and children to BPHS (Waldman R, 2006).

Anyway, we can estimate the actual coverage of population to BPHS by measuring service utilization indicators based on WHO recommendations:

1. Coverage of DPT-3 immunization.
2. Coverage of immunization against measles.
3. Average annual number of outpatient contacts per head.
4. Coverage of deliveries attended by skilled birth attendants.
5. Proportion of expected new cases of tuberculosis found and proportion of these cases successfully completing the treatment schedule.

Based on HMIS reports, the number of outpatient visits, antenatal care and TB case detection rates are significantly increased which show a relative improvement in access to BPHS (Waldman R, 2006).

According to Afghanistan Health Survey (AHS) in 2006, BPHS delivery has improved maternal health indicators compare to the estimation from the 2003 Multiple Indicator Cluster Survey (MICS 2003) and the 2005 National Risk and Vulnerability Assessment (NRVA 2005): Contraceptive Prevalence Rate (CPR) increased from 5% to 16%, antenatal care increased from 5% to 32%, use of skilled birth attendants improved from 6% to 19%, and institutional delivery increased from 6% to 15%, during 2003 to 2006, however, these indicators are still low.

During the same period, child health indicators, comparing to the estimation from MICS 2003 and the NRVA 2005, are improved through PBHS delivery, especially, BCG coverage among children 12-23 months increased from 57% to 70%, and oral polio vaccine-3 (OPV3) coverage among children 12-23 months improved from 30% to 70%. The DPT coverage, which measures the access of population to health-care and the effectiveness of routine immunization program in the health care system, was not satisfactory. The DPT1 coverage, which indicates initial contact of population with health care system, was 60%. The DPT2 and DPT3 coverage were 48% and 34% respectively (DPT3 was 20% in 2003). These drops in coverage of DPT3 indicate missed opportunities which existed in the health care. Measles coverage is about 63%. However, because of relative improvement in the delivery of health-care and

indicators related to child health, the infant and under five mortality rates declined from 165 and 257 to 129 and 191 respectively (AHS 2006). Although, this result is under critics of experts, because without a reasonable vital statistics, the household survey can not measure precisely the infant and under-5 mortality rate (Sabri B, 2007).

Access to Directly Observed Therapy, Short-Course (DOTS) has gradually increased from 12% in 2001 to 97% in 2006 and total number of facilities applying DOTS has increased from 36 in 2001, to 803 facilities in 2006. TB case detection has improved from 24% in new sputum smear-positive (ss+) in 2001, to 66% in 2006 and treatment success rate for new ss+ has increased from 84% in 2001 to 90% in 2006 (WHO report, 2008).

Based on AHS in 2006, among people who had sickness or injury in a month before survey, 76% of them sought health-care and 24% of them did not seek any care. Among those didn't seek care, 28% of them perceived that their illness are not severe enough to seek care, 27% said that the facility is faraway to seek health-care and the remaining claimed that they could not afford the cost of treatment. The two main factors affected their care-seeking practices were household wealth status and travel time to the facility. Therefore, household wealth status and travel time to facilities are significant determinants of health care-seeking practice in Afghanistan (AHS 2006).

Another important issue, which contributed to improved accessibility of population to basic health-care, is the role of CHWs. CHWs work in the HP and they have been trained by NGOs based on a standardized national job-description and curriculum. They have significantly improved the accessibility of people to basic-health care and they are the preferred providers for first level of care and for emergency services in the community. Based on MoPH policy, they work as volunteers and not receive any compensation. According to global evidences, lack of appropriate incentives and motivation of CHW in the long term will result in high attrition of volunteers and failure of CHW program which has negative implication for access to basic health-care (Operation Research Study on CHW performance in Afghanistan, 2007).

The findings show that these indicators are still low and there are still some socio-economic and geographical barriers and service deficiencies for the provision of quality basic health-care in Afghanistan which requires further researches. However, the findings show that the indicators for utilization of services are increased more than threefold compare to baseline which indicate significantly improvement of accessibility of population to basic health-care.

5.3.2. Equity

Equity in health is to reduce preventable discrepancy in health and its determinants. The MoPH developed a pro-poor and pro-female policy based on its overall vision in order to reduce huge inequity between urban and rural area and between poor and rich (A BPHS, 2003).

According to Roger England, policy makers can improve equity through using contract as a powerful tool to redistribute resources to those areas with greater needs, and to target poor and under-served area (England R, 2000). He proposed some options to target the poor: providing general subsidy for services in poor area, geographical targeting the poor, establishing social security insurance, and subsidizing specific services related to illness that affect the poor or vulnerable group (England R, 2004). MoPH introduced three indicators: female as a percentage of new outpatients, equity in service utilization and equity in satisfaction with services received, to improve and measure equity dimension of service delivery by contracting. The result of three rounds of performance assessment of NGOs shows that female and poor more than male and non-poor utilized outpatient services as shown in table 2. The outpatient visit concentration index shows that poor slightly more used the services than rich and the patient satisfaction concentration index remained stable (Afghanistan Health Sector Balanced Scorecard, 2006).

Table 2: Scores for indicators reflecting overall vision of MoPH

Indicators	2004	2005	2006	Changes between 2004 and 2006
Female as % of new outpatients	55.2	57.3	57.8	+2.6%
Outpatient-visit concentration index*	50.5	50.6	51.2	+0.7
Patient-satisfaction concentration index**	49.9	49.8	49.9	0

Source: Afghanistan Health Sector Balanced Scorecard, 2006.

*The outpatient-visit concentration index measures the level of equity of utilization of outpatient service and a score of 50 represents equal levels of utilization between the poor and the non-poor and score above 50 indicate higher levels of utilization among poor

**The patient satisfaction concentration index measures whether the poor are more or less satisfied with services compared to the relatively better off and scoring interpretation is as outpatient-visit concentration index.

Factors associated with using health facilities by women are: educational status, age of women, travel time to facilities and household wealth status. For example, among respondents who received antenatal care, 52% of them had some schooling and 31% of them never attended school and 33% of respondents in the best-off quintile delivered in health facilities and 3% of respondents in the poorest quintile delivered in health facilities. Also, 26% of respondents, who are living less than 2 hours from a health facility, used skilled birth attendants and 15% of respondents,

who are living between 2-3 hours far from a health centre, used skilled birth attendants (AHS, 2006).

Household wealth status and travel time to facilities are significant determinants of health care-seeking practice in Afghanistan. For example, based on household survey, 65% of sick household members from the poorest quintile and 88% of sick household members from the wealthiest quintile sought health care for their illness, and 84% of sick household members, who are living within 2 hours travel time to a health facility, sought care and 47% of sick household members, who are living 6 hours or more hours far from a health facility, sought care (AHS, 2006).

The AHS identified that wealth and time of travel are also important determinants for household in choosing service providers. For instance, 51% of people from the poorest quintile used public facilities compare to 38% from the best-off quintile. It revealed that the poor are likely to use public facilities more than non-poor. The time of travel to a public health facility determines the preference of provider for using public or private health-care services. As an example, 26% of households living within 2 hours of a public health facility utilized a public health facilities compare to 18% of households living more than 2 hours faraway from a public health facility. Additionally, it shows that the utilization rate of private services is increasing among those household living more than 2 hours far from a public health facility than household living less than 2 hours. Ultimately, it shows that private health-care utilization rate is growing in Afghanistan, even among poor and remote households (AHS, 2006).

Based on the result of AHS in 2006, the average out of pocket expenses per each treatment outside public health facilities was about 10 USD and 99% of people who sought health care outside their home from private providers spent this amount of money. It includes consultation fee (\$2), drug (\$6), transportation (\$2), lab test (\$2) and food (\$2). At the public health facilities, the median consultation fees for household in the poorest quintile were 0.4 USD and for household in the best-off quintile were 1 USD, which indicates that poor were protected by exemption mechanism. However, several studies show that exemption scheme created serious selection problem and instead it was used more by the better-off quintile than the poorest quintile (World Bank, 1999). In the private clinic the consultation is 2 USD per visit. Households in the poorest quintile spent more money per illness episode compared to people in the wealthiest quintile (10USD vs. 8.40USD). The total median expenditure of using a public health clinic was 3USD, a provincial hospital was 10 USD, and a private doctor/clinic was 12 USD. Although, the total average expenses of using a public health facility is more cheaper than a private provider, a large number of household even in the poorest quintile prefer to go first to a private clinic than to a public health clinic. 12% of households suffer from catastrophic cost, meaning borrowing money, selling household

possession or land, for seeking care. There is no significant association between incurring catastrophic cost and age and sex of the patient, but there is a significant association between travel time and household wealth. The occurrence of catastrophic cost is much higher among households in the poorest quintile and the household living 6 hours far away from a clinic. It revealed, that distance to a health facility and cost of care are the foremost obstacles for households living in the poorest quintile to receiving care (AHS, 2006).

The survey doesn't clarify the different perception about illness among the poor and rich. However, these findings show there is still wide gap between poor and rich in term of accessibility and ability to use the basic health-care which has policy implication. The MoPH should increase the quality and coverage of BPHS to the remaining 15% of the country to cover the most remote areas by establishing more health centres and sub-centres and improving community based health program. Also MoPH should think about the wider determinants of health and find solution for the low literacy rate and education among women and improve the decision making power of them by increasing general awareness about health promotion, prevention and illnesses and diseases.

5.3.3. Quality:

To study the quality of care, we should see quality from both point of view of professional and consumers. Experts define quality as a correct diagnosis and treatment of cases which can be measured through monitoring and quality assurance. Consumers define quality as availability of service, drugs and relevant staff round the clock with respect and immediate attention to them (Soeters R, 2003). Also we can consider quality based on the Donabedian Quality-of-care Framework: the structure, process and outcome of health-care.

The result of three rounds of performance assessment of BPHS delivery shows that the trend of patient satisfaction and patient perception of quality has been improved all over the country by contracting strategy. The key quality indicators, especially convenience of travel to facility, ease of getting prescribed medicines, satisfaction with cost, level of privacy, and level of trust in the skills and abilities of health workers, which are shown in table 3, are improved (Afghanistan Health Sector Balanced Scorecard, 2006).

Table 3: Scores for patient perception of quality in % (N~6000)

Indicators	2004	2005	2006	Changes between 2004 and 2006
Convenience of travel to facility	59.4	58.8	65.3	+5.9
Cleanliness of facility	77.3	76.8	80.2	+2.9

Level of courtesy and respect shown by staff	83.5	87.6	85.5	+2.0
Level of trust in the skills and abilities of health workers	79.3	81.9	82.7	+3.4
Quality of explanations of illness given by health workers	74.6	71.8	74.7	+0.1
Quality of explanations of treatment given by health workers	73.8	71.6	75.6	+1.8
Ease of getting prescribed medicines	75.9	82.7	83.8	+7.9
Satisfaction with cost	72.3	71.1	78.0	+5.8
Level of privacy experienced	79.6	81.5	84.4	+4.9

Source: Afghanistan Health Sector Balanced Scorecard, 2006.

Also, modest improvement in the level of satisfaction of health workers has been seen during 2004-2006 which reflects the overall improvement of quality of basic health-care in Afghanistan. The scores for health workers satisfaction index are shown in table 4.

Table 4: Scores for health workers satisfaction index (N~1500)

	2004	2005	2006	Changes between 2004 and 2006
Working relationships with other facility staff	93.8	92.2	92.8	-1.0
Working relationships with provincial MoPH staff	76.8	74.8	82.6	+5.8
Management of facility by MoPH or an NGO	71.6	70.3	79.2	+7.2
Relationships with local traditional leaders	84.1	81.1	83.5	-0.6
Availability of medicines in the health facility	55.7	61.0	66.8	+11.1
Availability of equipment in the health facility	73.8	71.6	75.6	+1.8
Ease of getting prescribed medicines	53.0	58.6	67.6	+14.7
The physical condition of the health facility building	51.8	47.8	58.0	+6.2
Your ability to provide high quality care	75.6	79.2	82.8	+7.2
Your respect in the community	88.4	91.3	91.2	+2.8
Training opportunities to upgrade your skills and knowledge	50.8	59.1	59.0	+8.2
Your ability to meet the needs of the community	60.5	75.0	78.1	+17.6

Your salary	37.5	42.9	51.8	+14.3
Employment benefits (travel allowance, bonus, etc)	14.9	15.9	23.6	+8.7
Safety and security to live and practice in the community	72.5	79.2	68.3	-4.2
Living accommodation for your family	43.4	52.5	56.0	+12.6
Education for your children	45.0	50.8	54.3	+9.4
Your boss' recognition for your good work	70.0	71.4	72.9	+2.9
Your opportunity for promotion	55.2	56.7	56.5	+1.4
Overall satisfaction with your job	79.6	77.9	81.0	+1.3

Source: (Afghanistan Health Sector Balanced Scorecard, 2006).

The service providers capacity to deliver BPHS is improved which is shown in table 5.

Table 5: Scores of capacity for service provision (N~600)

Indicators	2004	2005	2005	Changes between 2004 and 2006
Equipments functionality index	65.7	67.0	78.7	+13.0
Drug availability index	71.1	83.7	85.7	+14.6
Family planning availability index	61.4	70.0	82.9	+21.5
Laboratory functionality index	18.3	36.3	43.3	+25.0
Staffing index-meeting minimum staff guidelines	39.3	58.0	66.9	+27.6
Provider knowledge score	53.5	69.0	68.7	+15.2
Staff received training in last year	39.0	74.3	68.9	+29.9
HMIS use index	67.7	65.8	74.9	+7.2
Clinical guidelines index	34.8	48.9	61.6	+27.8
Infrastructure index	55.0	44.6	48.7	-6.3
Patient record index	65.6	63.2	69.4	+3.8
Facility having tuberculosis register	15.8	20.6	37.4	+22.6
Patient history and physical examination index	70.6	73.5	82.2	+11.6
Patient counseling index	29.6	35.1	36.6	+7
Proper sharps disposal	62.2	52.0	77.5	+15.3
new outpatient visit per month	22.2	32.3	55.0	+32.8
Time spent with patient	18.6	6.2	7.0	-11.6
BPHS facilities providing antenatal care	62.0	79.3	84.9	+22.0
Delivery care according to BPHS	25.4	22.3	42.3	+16.9

Source: (Afghanistan Health Sector Balanced Scorecard, 2006).

Contracting of BPHS covered a large number of key Sexual Reproductive Health (SRH) services, which could enhance access to SRH care, but the

sexual and gender-based violence services, which are very important in post-conflict context, are left out. In addition, the quality of SRH care in terms of gender based violence can be compromised by contracting to general NGOs. Evidences show that implementing NGOs might not have the specialized knowledge and expertise to provide quality and standard gender sensitive SRH services (Roberts B, 2008).

As a result of Afghanistan Health Sector Balanced Scorecard, the quality of basic health care improved significantly by contracting.

5.3.4. Efficiency:

Efficiency is the ratio of output (service produced) to the input (resources) of any system. Allocative efficiency refers to those interventions that give the greatest value for money and contribute to the improvement of population's health. Based on World Health report 2000, some interventions can decrease the burden of diseases, especially among the poor and at the lower cost relative to the outcome: TB treatment, FP, maternal and newborn health, IMCI, HIV prevention, immunization, STD treatment and malaria control (world Health report, 2000). The BPHS which is contracted to NGOs including all these interventions which suggests better allocative efficiency of service delivery.

Technical efficiency means to achieve the same output with the minimum resources or more output for the same resources.

The annual cost per capita of BPHS in Afghanistan varies from US\$2.06 to UD\$4.83 (Palmer N 2006) which is much lower than the estimated annual cost per capita of World Bank for low income countries which is UD\$15 (World Bank. 1993) and also it is much lower than the estimated cost of Commission for Macroeconomics and Health which is US\$ 36 per person per year (Commission for Macroeconomics and Health estimation. 2001).

The cost of immunization, technical assistance, GCMU, monitoring and evaluation, and overhead cost of donors' country office are not included in the BPHS cost, however, the cost of basic health care seems lower than the estimated cost of World Bank and Commission for Macroeconomics and Health. It is assumed, that NGOs underestimated the cost in order to compete and win the contract, which raised questions about the quality of care provided by NGOs (Sabri B, 2007). On the other hand, if we see the result of three rounds of performance assessment of NGOs, it shows that indicators related to the quality of care have been improved all over the country. The key quality indicators are shown in table 3 (Afghanistan Health Sector Balanced Scorecard, 2006).

The low cost per capita of BPHS delivery by contracting and comparative improvement of the quality of care indicates relative improvement on the technical efficiency of service delivery. Anyway, there is a need for further operational researches to analyze the technical efficiency of BPHS by contracting.

Overhead cost of contracting is a concern of MoPH, which was varied among the different contracting schemes. The GCMU overhead cost was about \$1.5 million over three years to manage contracts worth about \$50 million which is relatively low and the overhead cost of contracts funded by USAID was \$23 million for managing about \$60 million, which is relatively high. The higher overhead cost of USAID funded contracts was due to technical assistance to MoPH and management cost of reimbursement procedures and monitoring (Strong L, 2005). Therefore, MoPH needs to study and analyze the overhead cost of these contracting schemes and develop a unique and reasonable one to reduce the overhead cost.

5.4. Monitoring and Evaluation

The performance of NGOs in delivery of BPHS is regularly being monitored through collecting quarterly progress activities reports of NGOs, Health Management Information System (HMIS) and site visits. MoPH has regularly conducted monitoring visits in each province on a quarterly base. For discussing and solving problems encountered during implementation there is a monthly meeting between implementing NGOs and MoPH at the central level and there is a Provincial Health Coordination Committee (PHCC) to discuss problem at the provincial level. In addition, Monitoring & Evaluation (M&E) has been conducted by Johns Hopkins Bloomberg School of Public Health (JHSPH) and the Indian Institute of Health Management Research (IIHMR) as an independent third party evaluator (Strong L, 2005). A Balanced Scorecard (BSC) was developed by the MoPH, with technical support from third party, JHSPH and IIHMR, to regularly monitor NGOs performance in delivery of BPHS all over the country and provide information and evidences to policymakers for policy and practice. The BSC is a performance improvement tool for monitoring the progress of health service delivery in different provinces and in the entire country, and providing guidance to policymakers for adopting health strategies and managing changes. The data for BSC are taken from the National Health Services Performance Assessment (NHSPA), which includes annual household surveys and annual survey of health facilities, using a stratified random sampling.

The performance of BPHS delivery has been assessed by using BSC three times since 2004 and the result of BSC 2004 has been using as the benchmarks or points of reference for 2005 and 2006 BSCs. The BSC has six domains including 29 indicators as following(Peters D, 2007):

1. patient and community perspectives
 - overall patient satisfaction
 - patient perception of quality index
 - written health committee activities in community

2. staff perspectives
 - health worker satisfaction index
 - salary payments current
3. capacity for service provision (structural inputs)
 - equipment functionality index
 - drug availability index
 - family planning availability index
 - laboratory functionality index
 - staffing index-meeting staff guidelines
 - provider knowledge score
 - staff received training in last year
 - HMIS use index
 - clinical guidelines index
 - infrastructure index
 - patient record index
 - facility having tuberculosis register
4. service provision (technical quality)
 - patient history and physical examination index
 - patient counseling index
 - proper sharps disposal
 - new outpatient visit per month
 - time spent with patient
 - BPHS facilities providing antenatal care
 - delivery care according to BPHS
5. financial system
 - facilities with user fee guidelines
 - facilities with exemption for poor patient
6. overall vision for the health sector
 - female as % of new outpatients
 - outpatient-visit concentration index
 - patient-satisfaction concentration index

BSC compares the trend of performances of NGOs since the beginning of contracting but doesn't compare the contracting delivery of BPHS to different mechanism of delivery because the BPHS delivery was carried out by contracting strategy in all 34 provinces (Peters D, 2007).

6. CONCLUSION

General Conclusion:

The primary goals of health care system is improving health of population, responsiveness to the population expectation and providing financial protection. The role of effective governance is very important to improve health status of population by ensuring access to basic package of health services. One of the important strategies to improve access to basic package of health services is contracting strategy. Contracting is not a panacea for all health system problems, but it can be a useful strategy to improve the performance of service delivery. Contracting is a strategic option for clarifying the functions and relationship between different actors who involved in the health system by a contractual agreement. Evidence indicates that the chances of success in contracting relate to the context in which contracting is executed and the design of the contractual arrangement and interventions. Also, the commitment, stewardship and support of governments are very crucial in relation to the success of contracting.

Based on current literature review, contracting improved access to basic health-care in many developing countries, but the effect of contracting on quality, equity and efficiency are not clearly understood, however, the experts suggest that contracting has the potentials to improve quality, equity and efficiency of health-care.

Effectiveness/impact of Contracting in Afghanistan:

The result of three rounds of performance assessment of NGOs delivering BPHS shows that Afghanistan has achieved significant improvement in the delivery of basic health-care since 2003.

Access: Potential coverage of population to BPHS increased form 5% to 85%, but the actual coverage of population to BPHS based on service utilization indicators still remains low. CPR increased from 5% to 16%, antenatal care increased from 5% to 32%, use of skilled birth attendants improved from 6% to 19%, and institutional delivery increased from 6% to 15%, during 2003 to 2006. During the same period, BCG coverage increased from 57% to 70%, and OPV3 coverage improved from 30% to 70%. The DPT1 coverage was 60%, DPT2 and DPT3 coverage were 48% and 34% respectively (DPT3 was 20% in 2003) and measles coverage is about 63%. Access to DOTS increased from 12% in 2001 to 97% in 2006 and total number of facilities applying DOTS increased from 36 in 2001, to 803 facilities in 2006. TB case detection improved from 24% in new sputum smear-positive (ss+) in 2001, to 66% in 2006 and treatment success rate for new ss+ increased from 84% in 2001 to 90% in 2006.

These findings show that the indicators for utilization of services are increased more than threefold compare to baseline which indicate comparably significant improvement of accessibility of population to basic health-care. However, these indicators are still low which requires further

researches to find the main socio-economic and geographical barriers, service deficiencies for the provision of quality basic health-care and health seeking behavior of the population.

Quality: The key quality indicators: convenience of travel to facility, ease of getting prescribed medicines, satisfaction with cost, level of privacy, level of trust in the skills & abilities of health workers, cleanliness of facility, level of respect, level of health workers satisfaction and availability of medicines & equipments are improved. These findings show significant improvement of the quality of basic health-care in Afghanistan.

Equity: The related indicators for equity are improved by targeting remote and under-served areas and providing services related to illnesses affect the poor or vulnerable groups. It was identified, that female and poor more than male and non-poor utilized outpatient services. Considering that household wealth and travel time to facilities are the important determinants of health seeking in Afghanistan, these issues might affect the health seeking behavior of poor which has policy implication in equity.

Efficiency: The BPHS including all cost-effective interventions which the allocative efficiency of this package is obvious. The low cost per capita of BPHS contracting and comparative improvement of the quality of care indicates relative improvement on the efficiency of service delivery by contracting in Afghanistan.

However, it is not possible to conclude that contracting is completely accountable for the health outcome accomplished. Contracting started just after the new government was established and Afghanistan received a lot of external technical and financial support. Other factors may also have played a role in improving health care: removal of sanctions, which were imposed on the Taliban government, the removal of restrictions on women movement and employment, the return of Afghan refugees including health workers from neighboring countries, the general improvement of the socio-economic situation and a relative peaceful situation. It is also important to point out that contracting in *all* 34 provinces of Afghanistan started without a comparison strategy, except the MoPH-SM strategy, which is not comparable because it was implemented in three provinces near to Kabul, in the North, and has better security.

MoPH needs to consider the following issues:

Coordination: At the moment, there are some mechanisms in place to ensure coordination among MoPH and NGOs. The coordination is well at the central level, but there are some issues, especially at the provincial and district levels to be settled: clarification of roles of NGOs and PHO, incentive structure and capacity building. In each province there is a PHO responsible for the overall health sector. The PHO staffs are civil servants and their salaries are paid by government. In the same province, there is a NGO project management office responsible for the implementation of

BPHS delivery and they are paid by NGOs. The salary level of NGOs project management office is more than threefold higher than MoPH provincial team, which might cause some friction and dissatisfaction among public staff. The MoPH in order to execute its stewardship function should solve this issue.

In some provinces, the technical and management capacity of provincial management team of public and NGOs (national) are weak which could lead to inefficiency of service delivery; therefore, the government with coordination of expert NGOs should develop strategic plan for capacity building of national NGOs and MoPH provincial management team.

Monitoring and Evaluation: M&E is essential part of an appraisal system to pursue whether contracting attains its objectives. Although there is one common framework of M&E (BSC), the USAID and EC practice different indicators and M&E system beside BSC. Currently, the JHU and IIHMR carry M&E under the contract with MoPH funded by World Bank. The cost of this contract was 4 million for three years which is relatively high. The BSC indicators are more process oriented indicators, which can not evaluate the impact of contracting on performance of health service delivery, so it is important to develop some outcome and quality indicators, which can monitor performance. In addition, an impact evaluation is needed to be carried out in the future. At the moment the capacity of M&E department to carry out its functions is insufficient; therefore, it is necessary to build up the capacity of this department to do its functions, which will reduce the overall cost of contracting scheme.

Accreditation: Provision of quality and standardized healthcare is an intricate and challenging process in the developing countries, especially in Afghanistan. One way to facilitate the provision of quality health-care is to develop an accreditation system that could certify the competency, authority and credibility of service providers and NGOs. At the moment, such a mechanism is not in place to certify the service providers' capacity in terms of overall service delivery of BPHS. The capacity of government to ensure a transparent and a quality accreditation process is very crucial. Taking into consideration the current capability, it is very challenging for MoPH in Afghanistan to certify NGOs capacity. Therefore, an autonomous accreditation organization needs to be established to monitor the technical and managerial capacity of NGOs and other service providers including private providers.

Out-of-pocket payment: Out-of-pocket payment is about 65% of the total health expenditure, which is very. This has an undesirable effect on the household health and on equity and access to basic health-care, which requires further research to identify the reasons. In the long term, government should try to find some alternative source of funding: prepayment system, community financing schemes, and limited Social Health Insurance (SHI) or a combination of them to reduce out-of-pocket

payment and especially catastrophic cost. SHI could be linked to accreditation system.

Sustainability: Afghanistan health system has enjoyed significantly from donors' technical and financial support since contracting of BPHS started. Currently, donors contribute huge technical and financial input in the health system, and in the long term the government should think about:

- **Short term versus Long term strategy:** In the short term, contracting strategy of basic health-care was incorporated in the national health policy and it is a legitimate strategy. However, the government needs to think about the long term strategy for building the health system, assuring the confidence of NGOs and gaining the population's trust. The government and NGOs' strategic partnership & collaboration are very important for the improvement of service delivery; therefore, the government should try to develop long term strategy of contracting with NGOs and facilitate enabling environment for them through developing proper legislation. In this way, the NGOs (especially the international) feel themselves as real and strategic partners of MoPH and their commitments improve towards long term vision. Besides service delivery, they would invest more on transferring their experiences and skills to Afghan counterparts, and also to the development of human resources and capacity building, maintaining of facilities infrastructures and medical equipments which will have positive implication for sustainability.

- **Heavy dependence on donors:** Considering the security situation and lack of financial and technical capacity of government, it is difficult to predict the sustainability of contracting without donors' technical and financial assistance. Meanwhile, donors use different contracting schemes and M&E system which increase the overall cost of service delivery of basic health-care in Afghanistan. So, bearing in mind that each of the schemes has its own pros and cons, which need further operational researches to be identified, MoPH needs to develop a unique contracting strategy to reduce the cost and should find some alternative strategy of health financing.

- **Capacity development:** Taking into consideration the unpredictability of technical and financial assistance of donors & NGOs in the long term, and insufficient experiences of MoPH and national NGOs in contracting process, the MoPH & national NGOs have to build their capacity on planning of BPHS based on expected and consistent internal budget, external assistance and donors & NGOs collaboration and coordination. It is also important that MoPH should strengthen its communication and collaboration with donors & NGOs to ensure enough and continuous technical and financial support for the long term period.

- **Overhead Cost:** Contracting always involves costs during all the steps of contract process. During preliminary stage of contracting, the purchaser and providers need to compile a lot of information about the package of services, geographical coverage, cost, and design of contract through different meetings which entail expenses. Also, during

implementation and evaluation contract causes expenditure. Overhead cost of contracting was a concern of MoPH, but it is found unrealistic. The overhead cost varied among different donors' mechanisms. The GCMU overhead cost was about \$1.5 million (3%) over three years to manage contracts worth about \$50 million, which is low, and the overhead cost of contracts funded by USAID was \$23 million (25%) for managing \$60 million over three years, which is higher than MoPH. The higher overhead cost of USAID relates to technical assistance to MoPH & NGOs, reimbursement procedures and M&E. This issue may need further analysis. However, through this study it was found that the overhead cost of contracting through MoPH scheme is very low.

BPHS: BPHS contains a comprehensive package of essential and basic health cares, especially antenatal care, family planning and institutional delivery care, but it doesn't have care to cover the sexual and gender violence aspect of SRH. Considering the post-conflict situation of Afghanistan the level of sexual and gender violence might be high, therefore, this care should be included to the BPHS.

Private providers: In Afghanistan, based on AHS 2006, majority of people seek care from private providers than public providers which increase the out-of-pocket expenditure. Therefore, government should consider incorporating the private providers in the process of bidding and contracting and even involve them in the service delivery by linking their compensation to their performance through an accreditation organization and a SHI.

7. RECOMMENDATIONS

1. **Coverage of BPHS:** Despite increasing the potential coverage of BPHS from 5% to 85%, the service utilization indicators are still low which requires further researches to find the main socio-economic and geographical barriers, service delivery deficiencies, and health seeking behavior of the population.
2. **Policy:** MoPH should develop a long-term policy of performance based partnership to assure technical and financial support of donors and NGOs. A legal framework of contracting must be developed and approved to ensure that the Afghanistan legislation permits contracting practice.
3. **Accreditation:** A national autonomous accreditation organization needs to be established to certify the competency, authority and credibility of service providers including NGOs, private and religious providers.
4. **Coordination:** A strong coordination mechanism needs to be established, especially at provincial level, to ensure better performance of service delivery and transfer of competency and expertise of expert NGOs to provincial management team. The roles & functions of NGOs and PHO staff and their salary levels should be identified and balanced.
5. **Monitoring and Evaluation:** The capacity of M&E department should be developed to carry out its functions. The MoPH needs to develop outcome indicators to evaluate the impact of contracting on health result. The M&E department should conduct operational researches to compare the effectiveness of contracting to other options.
6. **Out-of-pocket payment:** The out-of-pocket cost is high; therefore, MoPH should do researches to find the reasons. In the long term, MoPH should introduce prepayment system, community financing schemes, and limited social insurance or a combination of them.
7. **Sexual Reproductive Health:** Sexual and gender based violence care is recommended to be included in the BPHS.
8. **Sustainability:** Capacity building of MoPH and national NGOs at central and provincial level in terms of planning, monitoring and evaluation and regulation of contracting services is recommended. The current overhead cost of USAID contracting scheme is higher than MoPH. The exact reasons of the difference are not found through this literature review, which require further analysis. However, building of local capacity and integrating the GCMU and other donors grant offices within MoPH structure is necessary for sustainability. MoPH needs to initiate some alternative of health financing to reduce its dependence to donors. Also, MoPH should incorporate private providers in the process of bidding and contracting and even persuading their involvement in the service delivery through contractual arrangement and link them to SHI and accreditation organization.

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ANNEXES

Annex 1: Similarities and Differences in Donors Contracting Process

Characteristics	IDA/World Bank	USAID/MSH	EC
Project name	Afghanistan (AHEAD)	Rural Expansion Afghanistan's Community Based Healthcare (REACH)	Support to Health Service Deliver in Afghanistan
Purchaser	Funding flows from the MoF/MoPH to NGOs	Funding flows directly from MSH to NGOs	Funding flows directly from EC to NGOs
Provider	NGOs	NGOs	NGOs
Type	Fixed lump sum remuneration with 100% budget flexibility. Performance-based contract: NGO performance judge against progress and achievement of measurable indicators. Failure to progress or achieve targets will result in termination of contract. Services contracted by MoPH.	Fixed budget (input-based) USAID contracts to MSH who then subcontracts NGOs. Performance-based grant: payment (including initial advance payment) will be tied to deliverables and achieving outputs. Payment is only made after review and acceptance of deliverables.	Fixed budget (input-based) EC establishes grants directly with NGOs. Grants are used with a priority “ to pave way to new contractual forms between the MoPH and the NGOs for the delivery of the BPHS (Performance-based Partnership Agreement-like contract)”.
Tender process	1.Request for EOIs issued 2. NGOs who submit an EOI are shortlisted 3. RFP issued to shortlisted NGOs 4. Proposal submitted	1. RFA issued (all eligible NGOs can bid) 2. Proposal submitted.	1. International Call for Proposals issued (all NGOs can bid but they must have their headquarters within the EU or in Afghanistan) 2. Proposal submitted
Duration	29-36 months	26-30 months	21-30 months
Size of current contracts/grants	1469090-\$8384143 USD	342721-\$5328861 USD	4341840-1704289 Euros
Payment	16% at signing and 14% every 6 months based on submission of quarterly reports and assessment of performance indicators through supervisory visits and third party assessments	Reimbursement of actual expenditures through submission of quarterly invoices. Payment is tied to achievement of deliverables agreed in grant.	If duration<12 months or <100000 Euros- 80% of budget forwarded. If >12 months or >100000 80% for the first 12 months forwarded. NGOs required providing 10% of the overall cost of the grant from alternative funding sources although exceptions can be made.
Bonuses	1% of contract value every 6 months if an increase of 10 percentage points or more from the highest score in health surveys conducted by third party. 5% of contract value at the end of the contract if an increase of 50 percentage points in the combined score of indicators.	No	No

Evaluation criteria	Quality Cost Based Selection: Proposals are evaluated according to technical and financial criteria. Those proposals with <60 points on technical section are considered unresponsive and sent back. If>60 points then financial proposal is opened. Scores are then tabulated with the following weighting: Technical scores (80%) Financial score (20%)	Scoring system based on evaluation criteria plus a panel discussion system to the highest score does not always win the bid. Budget/cost effectiveness weighted at 10% of overall score. Scores are weighted differently depending on whether the applicant is a national NGO (new vs. experienced) or an INGO. Priority is given to national NGOs with 10P% added to their technical score	Evaluation criteria are divided in sections and subsections which are rated on a scale of 1-5 (1= very poor 5= very good). Evaluation criteria have less of an emphasis on quality of services and monitoring than USAID REACH but more emphasis on budgets and cost-effectiveness. Financial score weighted at 10% Priority given to the highest scores.
Geographical scope	Province-wise	District-wise	Province-wise and District-wise
Scope of services	BPHS delivery	BPHS delivery	BPHS delivery
Monitoring and Evaluation	Third party (JHU/IIHMR) conducts rapid evaluations semi-annually in province-wide projects More comprehensive evaluations of all contracts annually nationwide MoPH also conducts periodic monitoring visits	Quarterly review of deliverables through quarterly reports and spontaneous on-site monitoring. JHU/IIHMR conducts annual evaluation MoPH also conducts periodic monitoring visits	Annual reports required Financial management is considered as a proxy for management capacity. JHU/IIHMR conducts annual evaluation MoPH also conducts periodic monitoring visits
Indicators	Nationally defined core and management indicators Baseline figures came from first round of evaluation done by JHU/IIHMR by using a BSC in 2004	USAID has set standard indicators but the targets can be defined by the NGO and negotiated with the purchaser. Baseline figures are based on household survey conducted by the NGOs in the first quarter of the grant.	NGOs can define their own indicators and use a traditional logical framework, however one of the priorities of the program is to make a start in defining and measuring performance-based indicators related to the BPHS

Source: Strong L, 2005.

Annex 2: Health Post Summary of BPHS services, staffing, facility features and essential drug

Population Catchment Area Served: 1000-1500 people (100-150 families)					
BPHS Core Areas	Interventions, Conditions Treated/Services Provided	Type of Staff Number of staff	Illustrative Facility Features	Illustrative Equipment	Essential Drugs
General	IEC	Female CHW 1	Private home		Analgesic: Acetaminophen
Maternal and Newborn Health	Micronutrient supplementation	Male CHW 1		Scissors	
	Assist normal deliveries, identify danger signs and refer			Forceps	Anthelmintic: Mebendazole
	Identify sick newborns and refer			thermometer	Antibacterial: Co-Trimoxazole
	Counseling on family planning and breastfeeding			Mini-delivery kits	Anti-malarial: Chloroquine
	Distribute condoms and oral contraceptives			ORS measurement jug	Antenatal Supplements: Ferrous Sulphate + Folic acid
Child Health and Immunization	Support outreach immunization and campaigns			tape measure for nutrition assessment	Disinfectants: Chlorhexidine, Gentian violet
	Case management of ARI, diarrhea, fever/malaria; refer complicated cases; ORT			Health education teaching materials	Antacid: Aluminum hydroxide + Magnesium Hydroxide
	Support case management of measles				Support case management of measles Oral Rehydration Solution
	Identify and refer gravely ill child				Oral Contraceptives
Public	Exclusive Breastfeeding support			Condoms	

Nutrition	Multi-micronutrimt and iron. supplementation				Anti-Infective ointment	Tetracycline eye
	Improve sanitation				Vitamins and Minerals: Iodine, Retinol, Multimicronutrient	
	School feeding				Multimicronutrient	
	Community-based malnutrition management				Chlorphenaramin maleate tab. Charcole tablet	
Communica ble Disease	Refer self-reporting TB patients					
	For identified TB patients, encourage compliance with course of treatment regimen based on DOTS strategy					
	Surveillance of cases of interrupted TB treatment; active case-finding					
	Clinical diagnosis of malaria and treatment of uncomplicated cases					
	Insecticide-treated mosquito nets					
Mental Health	Health Education and awareness					
	Case detection (self-reporting) and follow-up of chronic cases					
	Self-help groups for drug addiction					
Disability	Awareness, care-seeking behavior					

	Home visit program for paraplegics (in urban settings) Refer disabled children Refer of war injury to DH					
Regular supply of essential drugs						
General information education and communication						

Source: A BPHS, 2005

Annex 3: Basic Health Center Summary Functions & Staffing

Catchment Area: 15000-30000 people						
BPHS Core Areas	Interventions, Conditions Treated Services Provided	Type & Number of Staff	Number	Illustrative Facility Features	Illustrative Equipment and Supply	Essential Drugs
Maternal and Newborn Health	Antenatal care; refer complicated cases	Nurse male	1	Exam Rooms	Stethoscope	Anesthetics: Oxygen, Lido Gain
	Assist normal deliveries, identify danger signs and refer	Community Midwife	1	Delivery Rooms	Sputum and blood specimen bottles	Analgesics: Acetaminophen, Aspirin and Ibuprofen
	Detection of postpartum anemia, puerperal infection	Community Health supervisor	1	Wound	Vision testing charts	Antidotes: Activated Charcoal
	Identify sick newborns and refer after first aid				Sphygmomanom	Antihistamine: Chlorphenamin maleate
	Promoting exclusive breastfeeding					

	Micronutrient supplementation Counseling on family planning Screening for and treatment of STDs Contraceptive services: DMPA injection distribution of condom and oral contraceptive, IUDs if trained staff available	Vaccinator 2 Physician (male or female) 1 Cleaner 1	dressing area Pharmacy	eter Dispensing counting tray Pediatric and adult scale	Anthelminitics: Mebendazole Antibacterial: Amoxicillin, Cotrimoxazole other antibiotics allowed if physician present
Child Health and Immunization	Delivery of EPI services Case management of ARI, diarrhea, fever/malaria, ORT; refer complicated cases Support case management of measles Identify and refer gravely ill child	Guard 1	Patient registration room Waiting room Medical record area Health education area	Cold Box Refrigerator for vaccination Vaccine carrier and ICE Pack	Anti-TB drugs: Ethambutol, INH, Pyrazinamide, Rifampicin and Streptomycin Antifungal Drugs: Nystatin Anti-amoebic Drugs: Metronidazole Antimalarial: Chloroquine, Fansidar Quinine Sulfonamide: Cotrimoxazole
Public Nutrition	Exclusive Breastfeeding support Growth monitoring Diagnosis & treatment of malnutrition Multimicronutrient and Iron. supplementation School feeding Improvement of Sanitation				
Communicable Diseases and Control	TB case detection using sputum smear (if lab available) Assist normal deliveries, identify danger signs and refer Short Course Chemotherapy including DOTS Surveillance of cases of interrupted TB treatment; active case-finding			Patella hammer Diagnostic set Autoscope Drip Stand Flashlight Minor surgery kit Stretcher Specula Lamp	Scabicide: Lindane Disinfectant: Chlorhexidine Diuretic: Hydrochlorothiazide Antacid: Aluminum Hydroxide + Magnesium Hydroxide

	Preventive therapy for children contacts of TB patients			Suction Midwifery Kit Sterilizer Examining table Scissors Forceps Thermometer Clean delivery kit	Anti-emetics: Metoclopramide Oral Rehydration Salt: ORS Adrenal Hormones: Hydrocortisone Contraceptives: Oral, Condom, IUDs (if trained person available) DMPA injections
Mental Health	Mental health education & awareness			ORS measuring Jug/container	Vaccines: DPT, BCG, Measles, Hepatitis-B, OPV and Tetanus Toxoid
	Case detection			Tape measure for nutrition assessment	Ophthalmic drugs: Tetracycline
	Follow up of psychosis, anxiety disorder depression, epilepsy & psychiatric cases				Anti-asthmatics: Salbutamole and Aminophylline
	Substance abuse: Identification and education				Vitamins and Minerals: Iodine, Retinol and Multi-micronutrients
	Community based rehabilitation				
	Support group for drug addict, psychiatrics patients/families and women				
Disability	Disability awarness/prevetion/education				
	Home visit program for paraplegic patient				
	Refer war injury, traumatic amputation and prosthesis patients to DH				
	Multimicronutrient and Iron. supplementation				
	Refer disable children and physical anomalies				
	Improvement of Sanitation				
Regular Supply of Essential drugs					
General Information, Education and Communication					

Source from: A BPHS for Afghanistan_2005

Annex 4: Comprehensive Health Center Summary Functions & Staffing

Catchment Area: 30000-60000 people							
BPHS Core Areas	Interventions, Conditions Treated Services Provided	Type & Number of Staff	Illustrative Facility Features	Illustrative Equipment and Supply	Essential Drugs		
Maternal and Newborn Health	Antenatal care, treatment of mild pre-eclampsia/eclampsia incomplete miscarriage/abortion	Nurse male 1 Nurse female 1	Exam Rooms	Stethoscope Oxygen gauge and cylinder	Anesthetics: Ketamine Oxygen, Lidocain		
	Assistance with normal deliveries and provision of basic emergency obstetric care	Community Midwife 2	Delivery Rooms	Sputum and blood specimen bottles	Lidocaine+Adrenalin Analgesics: Acetaminophen, Aspirin and Ibuprofen		
	Detection of postpartum anemia, puerperal infection	Community Health supervisor 1	Wound dressing area	Vision testing charts	Antidotes: Activated Charcoal		
	Care for newborns; management of neonatal infection and sepsis	Vaccinator 2		Sphygmomanometer	Antihistamine: Chlorpheniramine maleate		
	Promoting exclusive breastfeeding				Anthelmintics: Mebendazole		
	Micronutrient supplementation	Physician (male) 1	Pharmacy	Dispensing counting tray	Antibacterial: Amoxicillin, Ampicilline, Penicillin, Cotrimoxazole and other antibiotics		
	Counseling on family planning Screening for and treatment of STDs Contraceptive services:DMPA injection distribution of condom and oral contraceptive, IUDs if trained staff available	Physician (female) 1	Patient registration room	Pediatric and adult scale	Anti-TB drugs: Ethambutol, INH, Pyrazinamide, Rifampicin and Streptomycin		
Child Health and Immunization	Delivery of EPI services	Laboratory technician 1		Cold Refrigerator for vaccination			
	Case management of ARI, diarrhea, fever/malaria, ORT; refer complicated cases	Pharmacy technician 1	Waiting room	Vaccine carrier and ICE Pack	Antifungal Drugs: Nystatin Lindane...		
	Support case management of measles	Administrator 1	Medical record area	Scissor, Forceps Thermometer Patella hammer	Anti-amoebic Drugs: Metronidazole		
	Identify and refer gravely ill child	Cleaner 2			Antimalarial: Chloroquine, Fansidar		
Public Nutrition	Exclusive Breastfeeding support						

	Growth monitoring	Guard	2	Health education area	Flashlight	Quinine Sulfonamide: Cotrimoxazole
	Diagnosis & treatment of malnutrition					
	Multimicronutrient and Iron supplementation					
	School feeding					
	Improvement of Sanitation					
Communicable Diseases and Control	TB case detection using sputum smear			Laboratory area	Oxygen gauge and cylinder	Anti-convulsants: Carbamazepin, Diazepam, Magnesium Sulphate, Phenobarbital.
	DOTS-plus in MDR TB			Health Education area	Neonatal resuscitation trolley	Urinary Antiseptics: Nitrofurantion
	Short Course Chemotherapy including DOTS			Holding beds	Hearing screening equipment	Sympathomimetics: Adrenaline, Salbutamol
	Surveillance of cases of interrupted TB treatment; active case-finding			Inpatient beds	Basic EOC kit	Antihypertensive: Methyl dopa, Atenolol and Nifedipine
	Preventive therapy for children contacts of TB patients			Minor surgery room	Sterilization equipment set	Plus all drugs which in included to Basic Health Centers.
	Clinical & microscopic diagnosis of malaria and treatment of complicated cases				Hemoglobin meter	
	Promotion and distribution of insecticide				Hand crank centrifuge	
	VCT for suspected HIV cases				Microscope	
Health Education about HIV/AIDS		Stretcher				
Counseling for HIV/AIDS		Specula				
Mental Health	Mental health education & awareness				Lamp	
	Case detection				Suction	
	Follow up of psychosis, anxiety disorder depression, epilepsy & psychiatric cases				Midwifery kit	

	Substance abuse: Identification and education				
	Community based rehabilitation				
	Support group for drug addict, psychiatric patients/families and women				
Disability	Disability awareness/prevention/education				
	Home visit program for paraplegic patient				
	Refer war injury, traumatic amputation and prosthesis patients to DH				
	Multi-micronutrients and Iron.-supplementation				
	Refer disable children and physical anomalies				
	Inpatient and outpatient physiotherapy Orthopedic diagnosis				
Regular Supply of Essential drugs					
Blood transfusion, Test and screen blood and transfusion					
General Information, Education and Communication					

Source from: A BPHS for Afghanistan_2005

Annex 5: District Hospital (first referral hospital): Functions & Staffing

Catchment Area: 100000-300000 people							
BPHS Core Areas	Interventions, Conditions Treated Services Provided	Type & Number of Staff	Illustrative Facility Features	Illustrative Equipment and Supply	Essential Drugs		
Maternal and Newborn Health	Antenatal care, treatment of mild pre-eclampsia/eclampsia incomplete miscarriage/abortion	Nurse 5 male	Exam Rooms Delivery	Stethoscope Oxygen gauge and cylinder	Anesthetics: Oxygen, Lidocaine+Adrenalin	Ketamine Lidocain	

	Assistance with normal deliveries and provision of comprehensive emergency obstetric care	Nurse female 5	Rooms	Sputum and blood specimen bottles	Analgesics: Acetaminophen, Aspirin and Ibuprofen
	Detection of postpartum anemia, puerperal infection	Midwife 4	Wound dressing area	Vision testing charts	Antidotes: Activated Charcoal
	Care for newborns; management of neonatal infection and sepsis	Administrator 1	Pharmacy	Sphygmomanometer	Antihistamine: Chlorpheniramine maleate
	Promoting exclusive breastfeeding	Vaccinator 2	Patient registration room	Dispensing counting tray	Anthelmintics: Mebendazole
	Micronutrient supplementation	Physician 2 (male)	Waiting room	Pediatric and adult scale	Antibacterial: Amoxicillin, Ampicillin, Penic
	Counseling on family planning	Physician (gyn/obs female) 2	Medical record area	Cold Box Refrigerator for vaccination	
	Screening for and treatment of STDs		Health education area	Vaccine carrier and ICE Pack	
	Contraceptive services: DMPA injection distribution of condom and oral contraceptive, IUDs			Scissor, Forceps The	
	Female & male sterilization				
Child Health and Immunization	Delivery of EPI services	Surgeon 1			
	Case management of ARI, diarrhea, fever/malaria, ORT; refer complicated cases	Laboratory technician 2			
	Support case management of measles	X-ray technician 1			
	Identify and refer gravely ill child	Anesthetist 1			
Public Nutrition	Exclusive Breastfeeding support	Pediatrician 1			
	Growth monitoring				
	Diagnosis & treatment of malnutrition				
	Multimicronutrient and Iron. supplementation				
	Coordinate School feeding				
	Improvement of Sanitation				

Communicable Diseases and Control	TB case detection using sputum smear (if lab available)	Pharmacist	1	Laboratory area	Oxygen gauge and cylinder	Anti-convulsants: Carbamazepin, Magnesium, Phenobarbital.	Diazepam, Sulphate,
	X-ray for smear negative patients	Dentist	1	Health Education area	Neonatal resuscitation trolley	Urinary Nitrofurantion	Antiseptics:
	DOTS-plus in MDR TB	Dental technician	1		Hearing screening equipment		
	Short Course Chemotherapy including DOTS	Support staff (Guard and cleaner) 7		Holding beds Inpatient beds	Basic EOC kit	Sympathomimetics: Adrenaline, Salbutamol	Plus all drugs which in included to Basic and comprehensive clinics
	Surveillance of cases of interrupted TB treatment; active case-finding				Sterilization equipment set	Antihypertensive: Methyl dopa, Atenolol and Nifedipine	
	Preventive therapy for children contacts of TB patients				Minor surgery room	Hemoglobinometer	
	Clinical & microscopic diagnosis of malaria and treatment of complicated cases and insecticide treated mosquito net					Hand crank centrifuge	
	Promotion and distribution of insecticide				Surgery rooms	Microscope	
	VCT for suspected HIV cases					Stretcher	
	Health Education about HIV/AIDS					Specula	
Counseling for HIV/AIDS	Operation theater	Lamp	Suction				
Mental Health		Inpatient treatment of mental health cases			Midwifery kit		
		Mental health education & awareness					
		Case detection					
		Follow up of psychosis, anxiety disorder depression, epilepsy & psychiatric cases					
		Mental retardation: Identification and education to parents and community					
		Substance abuse: Identification and education					
	Community based rehabilitation						

	Support group for drug addict, psychiatric patients/families and women				
Disability	Basic physiotherapy and orthopedic diagnosis				
	Disability awareness/prevention/education				
	Home visit program for paraplegic patient				
	Refer war injury, traumatic amputation and prosthesis patients to DH				
	Multimicronutrient and Iron. supplementation				
	Refer disable children and physical anomalies				
	Inpatient and outpatient physiotherapy Orthopedic diagnosis				
Regular Supply of Essential drugs					
Blood transfusion, Test and screen blood and transfusion					
General Information, Education and Communication					

Source from: A BPHS for Afghanistan_2005