Factors Affecting Contracting-out for Primary Health Care in Fragile and Conflict-Affected Countries: Afghanistan and South Sudan

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Dedication

I will like to dedicate this work to my family in Yemen.

Acknowledgement

I acknowledge the support of my thesis supervisor in going through this research process. I also acknowledge the support of my academic advisor and the entire staff of the Royal Tropical Institute.

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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
BHC	Basic Health Centre
BPHS	Basic Package of Health Services
BPHNS	Basic Package of Health and Nutrition Services
BSC	Balanced Scorecard
CHC	Comprehensive Health Centre
CHE	Catastrophic Health Expenditure
CHW	Community Health Worker
CHV	Community Health Volunteer
CHD	County health department
DH	District Hospital
DPT	Diphtheria Pertussis and Tetanus
EPI	Expanded Program for Immunization
EU	European Union
EPHS	Essential Package of Hospital Services The
FBO	Faith-Based Organizations
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
HPF	Health Pooled Fund
HPI	Human Poverty Index
ICRC	International Committee of the Red Cross
IMC	International Medical Corps
IMCI	Integrated Management Childhood Illness
IMR	Infant Mortality Rate
KIT	The Royal Tropical Institute
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
MoF	Ministry of Finance
MoPH	Ministry of Public Health
MoPH-SM	MoPH-Strengthening Mechanism
NGO	Non-Governmental Organization
SBA	Skilled Birth Attendant
UNICEF	The United Nations Children's Fund

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Abstract

Background: Contracting Out for primary health services to NGOs, has been applied in fragile and conflict-affected countries including Afghanistan and South Sudan. Both countries have experienced a long period of war, that lead to having a weak health system with worst indicators ever recorded, Afghanistan had 1600 per 100,000 live births and South Sudan had maternal 2054 per 100,000 live births mortality. Contracting Out is a method designed to expand health services coverage, with better quality and reduced inequity in such conditions. Literature has highlighted different factors that can affect contracting out, these factors will be analysed by comparing two FCAS.

Methods: A literature review on contracting out on Afghanistan and South Sudan was done, by reviewing papers, reports and grey literature related to the topic. The framework proposed by Liu et al. for studying key factors and their interaction of the contracting mechanism was used for the results and discussion.

Results: MoPH leadership was the factors was the cause of success in Afghanistan, but a cause of weakness in South Sudan. But other factors like political interference, hard geography and insecurity in some areas caused low performance in both countries. The capacity of the providers to deliver services, in terms of input and output management, like human resources and pharmaceutical management were the most common effective intervention in both countries. The role of local NGOs in Afghanistan lead to improvement of performance and its sustainable, this was missing in South Sudan. Monitoring and evaluation methods had a big role in contracting out a specialty in Afghanistan, with the positive effect of performance-based payment in both countries.

Conclusion: The two countries have shown the contracting out experience implemented in FCAS context, with a set of factors that affected the experience. During designing of contracting out, decision-makers should consider these factors, as different countries have different political and socioeconomic context, that can determine the success of contracting out. Another aspect to keep in mind is the sustainability of contracting out with recommended research to find more sustainable ways to rebuild FCAS

Introduction

During my experience working for an NGO providing lifesaving relief services in Yemen, and where I worked in a highly fragile and conflict-ridden context, I understood first-hand the role NGO's play. My interest in exploring process and factors contributing to the success and failure of relief services in such settings was piqued. It was important for me to understand the different and often interchangeable dynamics, and roles and responsibilities each of the NGO's, Government, and private sector. This was the key to gauging the level of effectiveness and success, the sustainability of the response.

CHAPTER ONE

1. Background

1.1. Afghanistan

1..1.1 Geographic and demographic characteristics

Afghanistan is a land-locked country, at South-Central Asia, covering an area of 647,500 square kilometres mostly mountainous and rugged. Its surrounded by Turkmenistan, Uzbekistan and Tajikistan in the north, Pakistan in the south and east, Iran in the west, and China in the far northeast. The land is variable with mountains, valleys, deserts and forests. Administratively it is divided into eight development regions, 34 provinces and each province is further subdivided into districts. Afghanistan total population is estimated to be about 32.2 million, 51% of them are male, and 49 % are females. Approximately 46% of the population is under 15 years of age, and 74% of all Afghans live in rural areas. Seventy-six per cent of the population lives in rural and 24% in urban areas.

1.1.2 Political and Socioeconomic situation

Afghanistan has faced war and conflict for three decades, in the 70s and 80s was the soviet union war, the 90s was the civil war with Taliban and ended by US invasion removing Taliban government and establishment of a new government in 2002. The new presidential republic government with international efforts helped to relatively stable the country's political situation. New strategies and policies for reconstruction in different sectors, were developed under the new constitution (Afghanistan, 2005).

Afghanistan is one of the poorest countries, at the Human Development Index (HDI) it is positioning at 168 out of 189 countries in the world (Indices, 2018). The economy has been affected by the different political events, the GDP has improved since 2001 to US$ 641 in 2012, then dropped to US$ 502 per capita in 2019. Afghanistan depends mainly on Agriculture, constituting one-third of the country's economy. The religion of Afghanistan is Islam and about 99% of the population is Muslim. About twenty-one, ethnic groups are living in Afghanistan. The two official languages are Dari and Pashto(Bank, no date).

1.1.3 Health system and health status

Afghanistan health status has improved since 2002 after it had one of the worst health indicators in the world. Maternal Mortality Ratio (MMR) improved from 1600/100000 live birth in 2002 to 638/100000 live birth in 2017, skilled birthed attendance rose from 11% in 2003 to 58.8% in 2018, and ANC rose from 16% 2003 to 65.2% 2018(Ministry of Public Health, 2018). The MoPH developed an Interim Health Policy and Strategy for 2002-2004, then a national health policy for 2005-2009 to restore health system and a basic package of health services to restore the health system in the country (WHO Report 2006). The capacity of the government to finance the health in Afghanistan is limited, depended mainly on the out of pocket with 73.6% and The external donors represent 20.8% of the total spending (MoPH, 2013a)(Global Health Expenditure Database, 2017).

1.2 South Sudan

1.2.1 Geographic and demographic characteristics

The Republic of South Sudan, the world's newest nation located in East African region, it is also a lock-down land surrounded by Sudan in the north, the Central Africa Republic and the Democratic Republic of Congo in the west and south-west, Uganda in the South, Ethiopia, and Kenya in East and South-East respectively. It covers a total area of 644,329 sq. km and a population of 8.26 million people and a population density of 13/sq.km. The total population is about 8.26 Million with, the population is very young with 51% under the age of 18 years and 83% of the population is rural (Profile, Poverty, 2016).

1.2.2 Political and Socioeconomic situation

South-Sudan experienced two long civil wars (1955-1972 and 1983-2005), which makes it the longest civil war in Africa, ending up with the Comprehensive Peace Agreement (CPA) in 2005. South-Sudan gained independence in 2011 as the newest country in the world, (Downie, 2012). The percentage of poverty 66 % in 2015. South Sudan depends mainly on oil production in addition to agriculture(Profile, Poverty, 2016). There are about 60 ethnic groups with about 75 languages, of which about 11 are related. The main religion is Christianity, there are also Muslims and indigenous African religion (Profile, Poverty, 2016).

1.2.3 Health system and health status

South Sudan has one of the worst indicators, maternal mortality is about 2054 per 100,000 live births, and less than five mortality is 105 deaths per 1,000 live births (UNICEF, 2015). South Sudan implements a Basic Package of Health Services (BPHS) for all citizens, often contracted to nonstate providers (Howard et al. 2014). The MOPH in South Sudan has decentralized health services into four levels: central, state, county and community (Ministry of Health, 2015). Regarding the domestic revenues the main sources of revenue for financing health care in South Sudan is domestic taxes such (as income tax and VAT), and Oil revenue, social health insurance participation, private health insurance and out of pocket payments(Bank, 2009).

1.3 Contracting

Contracting for health services is defined as a formal documented agreement between two parties that belong to legally separate entities, the purchaser and the provider, in which the purchaser will compensate the provider to deliver set health services for a targeted population. The agreement between the two parties is regulated by legal contractual relationship in which the quantity and quality of the services are defined, at an agreed-on price for a specified period (England, 2000)(OECD, 2011).

CHAPTER TWO

2.1 Problem statement and justification

Countries that have experienced a long period of war face enormous challenges for rebuilding. According to the United Nations Development Program, about 35 countries have become post-conflict since 1989, 59% of these are low and middle-income countries. In post-conflict countries, most of the basic sectors are not functioning as health and education, distorted economy, human capital flight, and destroyed infrastructure (UNDP, 2008). Post-conflict counties come under the term 'fragile', referring them as Fragile and Conflict-Affected States (FCAS), which are defined as "States that lack abilities to perform basic functions, such as meeting the needs of the own population"(Taylor, 2014)(OECD, 2010). Health outcomes are the worst in FCS, not only because of direct disabilities resulting from war, but also due disturbed health system, for example, damaged health service infrastructure, reduced availability health staff and lack of drug supply (Martineau et al., 2017)Haar and Rubenstein, 2012)(Newbrander, 2007). As a result of that, infectious disease spread increase and reducing the access to health, about half of under-five death occur in FCAS in addition to more than third of the maternal mortality (Newbrander, 2007) (Kruk et al., 2010).

In post-conflict period, reducing morbidity and mortality is a priority for both newly formed governments and donors, with weak legitimacy and limited capacity to provide health services of these governments, external donors take action and support these disturbing health systems, but these donor efforts are usually fragmented and uncoordinated (Newbrander, 2007). In response to that, contracting out of primary health care services has been promoted in FCAS, as a way to rapidly expand health services and helps to rebuild the health system (OECD, 2011). Contracting out can be seen as contractual agreements in which health services are provided by the private sector on behalf of the governments, (Liu et al., 2004). In FCAS, contracting out was introduced in Cambodia 1999 to 2003, the government contracted with NGOs to provide district health services, and it was shown that health services provided through contracting out was delivered efficiently and equitably (Bhushan et al., 2002). This encouraged donors to promote contracting out in other FCS, including Afghanistan, DRC, Liberia, Haiti and South Sudan(Bertone et al., 2019)(Loevinsohn and Harding, 2005).

Contracting out in Afghanistan has received much attention, and has been analysed from various angles (Salehi et al., 2018)(Alonge et al., 2015)(Natasha Palmer, Lesley Strong, 2005)(Arur et al., 2010). After the war ended in 2001, Afghanistan had one of the worst health indicators, the maternal mortality rate was one the highest in the world (1600/100,000 live births) and the under-five mortality rate was one of the worst in the region (257/1000 live births)(Waldman and Newbrander, 2014). The new government of Afghanistan established the Basic Package of Health Services BPHS as a way to prioritize the most urgent health problem and as the first step for the health sector, Following that, donors led by the World bank introduced contracting out to deliver the BPHS (Newbrander et al., 2014). Evidence suggests a relative improvement in the health system performance indicators after the implementation contracting out in Afghanistan, for example, skilled birthed attendance increased from 11% in 2003 to 58.8% in 2018, ANC increased from 16% 2003 to 65.2% 2018 and childhood vaccination coverage rates doubled (Akseer et al., 2016)(Ministry of Public Health, 2018). Despite the apparent success of contracting out in Afghanistan, other FCAS counties has faced challenges and constraints towards contracting out for health services, such case apply to south Sudan(Morgan, 2005).

Apart from the literature on contracting out in Afghanistan, little attention has been paid to contracting out in other FCAS as South Sudan. Few of these studies focused in the money aspect of donors, or the barriers of NGOs implementing reproductive, maternal and child health, but did not explore the external and internal factor for contracting out process(Banke-Thomas *et al.*, 2019)(Salehi *et al.*, 2018). The lack of documentation from other settings means little is known about the variation in contracting mechanisms, including their advantages and drawbacks, Besides, the gap in comparing contracting out FCAS context. This study will address this gap in the literature.

2.2 Objectives:

2.2.1 Overall objective:

To analyse the contracting out the process of basic health services in a fragile and post-conflict country, to provide recommendations for policymakers for a better service delivery strategy in post-conflict countries.

2.2.2Specific objectives

1- To describe the features of the contracting-out interventions, including the characteristics of the contractor, the provider, and the contractual relationship, affecting contracting out of basic health services in fragile and conflict-affected countries in Afghanistan and South Sudan
2- To describe the external environment that affects the contracting-out in fragile and conflict-affected countries Afghanistan and South Sudan
3- To analyse the response of the provider in management input, output and outcome, public and private provision.
4- To provide recommendations to policymakers for appropriate service delivery structure in fragile and post-conflict countries.

CHAPTER THREE

3. 1 Methodology and Literature Search

This study is a literature review. I did a literature search through PubMed database, Google Scholar and Vrije University library. I looked fir peer-reviewed papers, reports and grey literature related to the topic. Several other sources from MOPH research centres, UN agencies, organizations, donors, and relevant actors, were considered for review and analyses, to reach the main objectives of this paper. The search was conducted using keywords in various combinations. The search result was narrowed by selecting relevant topics. After this abstract was read through and those with good quality and relevance to the topic were selected and later, I went through the entire paper extracting data using a data collection. table. Papers in English were used and paper from 2000 to recent. In some cases, I was relevant papers despite published earlier to 2000.

Keywords: contracting out, performance-based contracting, purchaser, provider, NGOs, Afghanistan, South Sudan

3.2 Framework

The evaluation used of Afghanistan's and South Sudan contracting out a mechanism for BPHS is the conceptual framework proposed by Liu et al. as a comprehensive guide for designing the study, analysing the results. The framework approach is through interactions among the many factors that can improve health care delivery, and affect the performance of contracting in terms of the impact through quality, equity, efficiency, access. (Liu, Hotchkiss and Bose, 2007) The framework is formed of different parts and factors, with the interaction between them as the following.

- **The intervention**: it describes the components of the contract, with contractual relation, to help understand the full structure
- **External environmental factors**, are factors surrounding the contracting out and has a role of in the success or failure of contracting-out
- **The response**: it describes the process of the contract and the intermediate results, which can help with analysing the changes that can affect the overall impact, it includes input, output, outcome management, in addition to the public and private sector
- **The impact**: the effectiveness of contracting in terms of quality, equity, efficiency, access

  This study included the intervention, the response and the external environment with the exclusion of the impact because it is not within the scope of the objective.

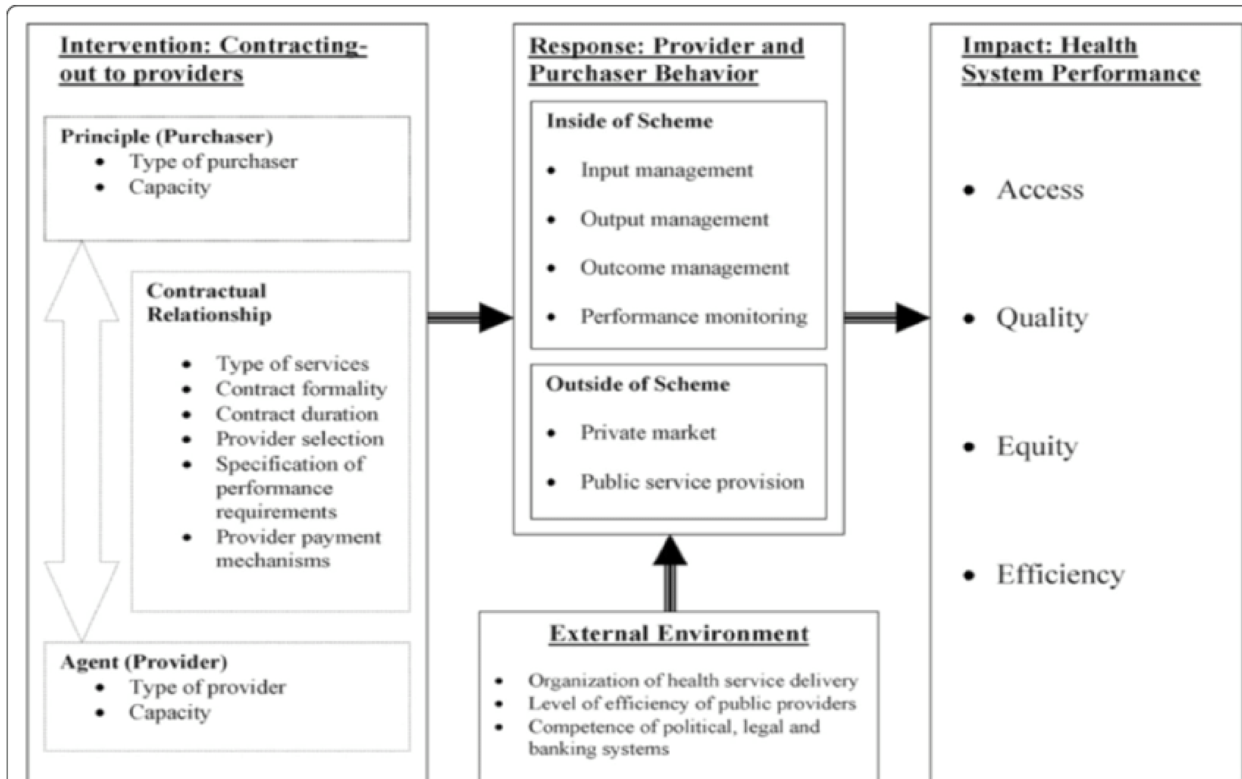

Figure 1. Liu et al. Framework on contracting out

Limitation

Most of the literature found were limited to donors reports, which does not describe the main components of the contracts, with few studies and reports in South Sudan, especially on the contracting out under HPF and World Bank. Also, limited NGOs reports describing their intervention in both countries.

CHAPTER FOUR

4. Study findings/results

4.1 The Principle/Purchasers

4.1.1 Type of Purchaser

This represents the entity or institution paying for the services rendered by the contractor. The purchaser provides majorly the function of financing and oversight in the contracting process with the expectation of health system performance improvement (Liu, Hotchkiss and Bose, 2007)**.** The purchaser is different in both countries. In Afghanistan, the central government in the MOPH represents the purchaser, while its represented by the donor in south Sudan (Salehi *et al.*, 2018)(Bol, 2019). The government of Afghanistan is a considered a 'lean government', which is an efficient system for implementation of services, with limiting the role of MoPH with setting policy, regulation, procurement and monitoring, on the other hand splitting the purchaser-provider, which facilitate for the idea of contracting out for the health services (Sondorp, 2004).

The financial fund is provided by a partnership of external donors agencies called the Afghanistan Reconstruction Trust Fund (ARTF). ARFT was established in 2002, administered by the World Bank currently it a partnership of 34 donors and the Afghan government, supporting contracting out a project called Sehatmandi this fund helped to strengthen the efforts of the external aid to be under one platform. In addition to the financial support, ARTF assesses the government to manage the national budget, with better allocation, in line with the country systems, policies and priorities which helps the government to improve its stewardship. (SIGAR, 2014)(WHO, 2013).

In South Sudan is a bit different, the purchasers are the external donors represented by lead agencies or fund managers rather than the government, due to the limited technical and financial capacity of the government. On the other hand, the government role is in the form of supervision and monitoring through the Steering Committee. Steering Committee is a coordination structure established by HPF and chaired by the MoH with the participation of ministry of finance, and human resource development, it was established to help coordinate, guide and monitor the development of the project, and to strengthen the stewardship of the ministry of health (Bol, 2019).

Two main donors are supporting the health services in South Sudan through contracting out, The Health Pooled Fund (HPF) and the World bank. HPF is a partnership led by British Government's Department for International Development (DFID) and supported by the Government of Canada, the Swedish International Development and Cooperation Agency (SIDA) and United States Agency for International Development (USAID), and the Global Vaccine Alliance (GAVI). It is managed by a Crown Agents which is considered as a fund manager responsible for managing the fund, subcontracting with NGOs to provide basic health services, carrying out monitoring and evaluation, in addition to, providing technical assistance with the MOPH Steering Committee. HPF supports services in eight counties of South Sudan and 21 geographically distinct Lots. (HPF South Sudan HPF Phase 3 - HPF South Sudan),(DevTracker Project GB-GOV-1-300427,)(Integrity, 2018).

The other main donor is the world bank fund, through the South Sudan Provision of Essential Health Services Project, a three-year project worth 105 million $, and managed by ICRC and UNICEF. World bank project has two approaches for contracting in south Sudan, contracting-in with County health departments CHD in select counties and contracting-out with NGOs, both are subcontracted through UNICEF and ICRC. (World Bank, 2019). One of the challenges reported for the donors in South Sudan is a lack of communication which caused a delay in the implementation of contracting out (Morgan, 2005).

4.1.2 Capacity of purchaser

The capacity of the purchaser to handle contracting out depends on its managerial capacity which refers to, performance monitoring of the provider, payment mechanism for providers and procurement procedure. The other aspect of capacity is financial capacity in terms of management and sustainability of the financial resources and timely payment to providers. (Liu, Hotchkiss and Bose, 2007). In Afghanistan, the capacity of the MOPH to manage contracts has improved over time and with the support of external donors especially the World Bank.

At the start of contracting-out in 2002, government and donors established Grants and service Contract Management Unit (GCMU) at the central level in the MOPH, to manage the process of contracting-out, coordinate the donors' funds and work closely with NGOs for implementing the health services. The GCMU consisted of several local Afghani consultants that have experience in health care delivery for NGOs in Afghanistan, and one international expert for technical support(Initiative, 2015) GCMU was the starting step to strengthen MOPH stewardship on the health sector, prevents the fragmentation of the donors' assistance and helped fasten the process of rebuilding the health services in the country (Afghanistan MOPH, 2019). During its development, the transaction cost of about $ 4 million donors was spent within three years for management and monitoring of the project (Natasha Palmer, Lesley Strong, 2005). In addition to the GCMU, another department has been added to strengthen the MOPH capacity to manage contracts summarized in Table 1.

Team name	Tasks
Grants and Service Contract Management Unit (GCMU)	Manage the process of contracting-out, coordinate the donors' funds and work closely with NGOs for implementing the health services
Performance Management Office (PMO)	Oversee the performance of NGOs according to a specific set of targets and indicators
Technical departments (TDs)	Provides technical inputs and feedbacks through reviewing the reports and filed visits on the performance of the NGOs, in addition to their guiding role through in job training to the NGOs
General Directorate of Policy and Planning (GDPP)	Receive from the PMO the Quarterly Reports, and Semi-Annual Review Reports and provide feedback to the PMO on systems and policy issues
Provincial Public Health Directorates (PPHDs)	Responsible for the performance of the NGOs that operate in the province
Emergency Preparedness and Response Unit (EPRU)	Coordinate efforts to address any health emergency through the Senior Performance Management Specialists with relevant NGOs

Table 1. Teams in the MOPH responsible for contracting out

The current ARTF, Sehatmendi started in 2018 and will last for three years is worth 600 million $, the fund has increased compared to its previous project which was worth 400 million $(World Bank, 2018). Although Afghanistan depends on external aid, ARTF has played an important role to improve the Public Financial Management in Afghanistan through capacity building, oversight and monitoring. In addition to that, Afghanistan has improved in budget management by using modern budget tools and automated payments, also establishing a legal, institutional and operational framework for PFM (PEFA, 2018).

South Sudan efforts to rebuild its health system was weak, and it was still challenging for the government and the donors during the transition period to strengthen the role of the government due to severe lack of the capacity for administrative and financial management including weak accounting systems, lack of basic public finance management (PFM), low credibility, late payments and insufficient planning, in addition to, no experienced or skilled staff at the central MOPH or county level (Bank, 2017)(MOH, 2011)(Giorgio Cometto, 2010). Despite these weaknesses, the Public Finance Management Assessment showed some improvement for budget planning, the introduction of an electronic payroll system and establishment of both internal and external audit system (Accountability and Pefa, 2012).

HPF is currently in its phase 3 project, with a budget of about USD 200 million, an evaluation report has calculated the spend per capita for the phase 1 and 2 which was $8.5 per capita for services. (Integrity, 2018) . HPF was planning to strengthen public financial management (PFM), however, due to the political situation, which led to distrust between donors and the central government, PFM improvement was not applied except for supporting CHDs to access government financial transfers. World

bank project budget is about 105 million$ an annual per capita spending for health estimated at US$4.93 and its managed through ICRC and UNICEF (World Bank, 2019). (Integrity, 2018)

4.2 Agent/Provider

4.2.1 Type of provider

Providers are the agents or party who provide the health services listed in the contracts. The provider can be private(for-profit or nonprofit) or public (Liu, Hotchkiss and Bose, 2007). Both in Afghanistan and South Sudan, the providers are national and international NGOs, non-profit private agents, on the other hand, some few areas are contracting into the public sector to the Provincial Health Offices (PHOs) in Afghanistan under the name Ministry of Public Health Strengthening Mechanism (MOPH-SM) and the County Health Departments in South Sudan (Bol, 2019). On both countries, Local NGOs were encouraged to apply for the bidding, especially the faith-based organizations (FBOs) and community-based organizations (CBOs) in South Sudan.

In Afghanistan, currently, the MOPH is contracting with 20 NGOs, covering 31 of the 34 provinces in the country, and the remaining 3 provinces are under MOPH-SM. Most of the contracted NGOs are local, out of the 20 NGOs, 14 of them are local and 6 international, compared to 2002, 10 local and 17 international NGOs (Natasha Palmer, Lesley Strong, 2005). This makes local NGOs covers 74% of the health services in Afghanistan under Sehatimandi project. Most of NGOs covers one provinces each, but some cover more than one, for example, Assistance for Health, Education and Development (AHEAD) provide health services in 3 provinces, Nooristan, Samangan and Takhar (World Bank, 2018)(Afghanistan MOPH, 2019).

In South Sudan, both funds are contracting with NGOs mostly international NGOs. Under the HPF in south Sudan, crown agent subcontracted with the following NGOs, Cordaid, CUAMM, HealthLink, World Vision, AMREF, HealthNet TPO, GOAL, CCM Italia, SSUHA, Malaria Consortium, and IRC, From the 11 NGOs, there is one national and 10 international.

4.2.2 Capacity of the provider

The provider capacity to provide services will depend on their public-private status, experience, motivation, management and monitoring capabilities to deliver the services. (Liu, Hotchkiss and Bose, 2007). In Afghanistan and South Sudan, NGOs have been providing basic health services for a long time during the conflict with the absence of formal government structures, this caused the development of the public-private partnership, which facilitated the introduction for the contracting out(Sondorp, 2004)(Giorgio Cometto, 2010). Therefore NGOs tend to have the more technical, financial and managerial capacity, which gained the trust of donors and been selected as the health services provider and to receive larger contracts (Bol, 2019).

Although reports have shown that National NGOs in South Sudan has a better communicating capacity with communities, easy to reach people especially during

an emergency time, they spend low the transition cost and fill the gaps where international NGOs can't work, for example in high-security areas. (Tanner and Moro, 2016)(Ali et al., 2018)(HPF3 SOUTH SUDAN Crown Agents). But their logistical, financial, human resources and coordination capacity is still weak, with low cluster participation (Tanner and Moro, 2016). Under the contracting process, the county health authorities at county level support NGOs to implement BPHNS, but in some counties, the NGOs are working without authority support due to extremely limited capacity of the county health offices(SHAHINIAN, 2019)

4.3 Characteristics of the contractual relationship

4.3.1 Type of services

According to the framework, the type of health services provided in the contracts is important because the characteristics of the services either by the level (primary, secondary, and tertiary)or functions (preventive versus curative), can make it less or more suited to be contracted out. And to evaluate how better services are contractible it refers to some services, services with defined quantity, services associated with outcomes, services with a standardized protocol and technical complexity of services (Liu, Hotchkiss and Bose, 2007)**.**

Both in Afghanistan and South Sudan, a basic package of health services was developed to set priorities for the government, donor fund and to guide the health sector implementation for service delivery(William Newbrander, 2011)(Ministry of Health, 2008). In Afghanistan, the services in the contracts are the Basis Package Health Services (BPHS) that covers 7 interventions, and the Essential Package of Hospital Services (EPHS), in South Sudan is under the name Basic Package of Health and Nutrition Services (BPHNS) that covers 6 interventions, both lists of services. Both lists of services focus on prevention, treatment, and promotion of healthy behaviour, which focus on maternal and child diseases (MoPH, 2009)(Ministry of Health, 2008). Priority setting in Afghanistan was based by criteria that included equity, effectiveness, scaling up, and sustainability of an intervention (Newbrander, Waldman and Shepherd-Banigan, 2011), that was missing in South Sudan and the list did not reflect the reality of the health sector in terms of funding, shortage of health shortage and infrastructure (SHAHINIAN, 2019). This made donors like the HPF to develop a modified list that can implemented by NGOs, generally includes: maternal and reproductive care, child health, common diseases and public health risks, and high priority non-communicable diseases(SHAHINIAN, 2019). The BPHS in Afghanistan cost $4.30 to $5.12, in South Sudan the BPHNS cost about US$4.93(William Newbrander, 2011)(World Bank, 2019).

On the other hand, BPHNS in south Sudan is not linked with clear targets or indicators, with few protocols to refer to as ANC guidelines. (MoPH, 2009). In addition to the list of services, both packages refer to managerial activities, human resources, drugs and equipment at each level of care. The Afghan BPHS also contains a job description of health worker duties at each level of care, which is lacking in South Sudan BPHNS. (Ministry of Health and SUDAN, 2010)(MoPH, 2009)(SHAHINIAN, 2019).

4.3.2 Contract formality

Contracts between the purchaser and the providers can be formed within legal contractual relationship that can include different specific components as the types, quantity, and quality of contracted services in relation to provider behaviour in performing the agreed services through monitoring specific agreed targets and payment conditions. (Liu, Hotchkiss and Bose, 2007)**.** Performance-based contracting is the main form of contracting in Afghanistan and South Sudan, in which the performance is defined in a formal legal agreement between two parties with setting a defined price for the desired outputs and includes rewards for performance that meets the standard defined in the contract and penalties for poor performance(Loevinsohn, 2008).

4.3.3 Contract duration

This is the period from the agreement between the purchaser and the provider in which the contract is effective and it is usually between a year and five years. This period is usually influenced by several other factors including the nature of the contract, trust between the parties and availability of providers (Liu, Hotchkiss and Bose, 2007). Contracts duration in both countries ranged from 36-18 months, an average of 26 months. Extension of the contract can depend on the annual performance of the providers (Salehi *et al.*, 2018)(World Bank, 2019).

4.3.4 Provider selection

When it comes to providers selection, it depends on the providers that meet the requirements stated at the proposal request, to be able to participate for the bidding process and to be selected as the provider agency. Some of these requirements that can deliver contracted services, developing a plan for inputs in human and physical resources, and experience in working with the public sector (Liu, Hotchkiss and Bose, 2007). Referring to the requests for proposals of the purchasers in both countries, the requirements include qualifications, the experience of the provider, financial bid letter and others (*Afghanistan Sehatmandi*, no date)(HPF, 2016). In Afghanistan, 70% are selected quality-cost based selection, and 30% based cost (Blaakman, 2020).

4.3.5 Specification of performance requirements

Contracting out is designed to improve the quality of health care through setting targets for the provider to achieve to measure its performance, these targets should be clear with identified specification (Liu, Hotchkiss and Bose, 2007)**.** In both countries**,** most targets required are in terms of access including the availability of the services, measures of the number of services provided, and population coverage of the services (Afganistan MOPH, 2019)(World Bank, 2019). Afghanistan in addition to adds targets regarding the quality of services, as skills of health workers with during counselling of patients and infection prevention control practices (KIT, 2018). The following are the set of indicators used in Afghanistan current contracting out the project:

- Pay for Performance (P4P) indicators (inputs): The first set of indicators are related to set of services, that are used to measure the performance of NGOs and for which the NGOs will be paid.
  1. Antenatal Visits (all visits)
  2. Postnatal visits (all visits)
  3. Institutional deliveries excluding C-Section
  4. Family Planning-Couple Years of Protection (CYP)
  5. Penta-3 for children under one year 6. TT2+ for women of reproductive age
  7. Number of sputum smear (+) TB cases treated
  8. Growth monitoring of under 2-year children and IYCF counselling for pregnant and lactating women (GMP/IYCF)
  9. Under-five children morbidities (HMIS-MIAR-A1-morbidities)
  10. Caesarean Section (CS)
  11. Major Surgeries excluding C-Section

- Minimum Standards of Services: number of minimum standards detailed in Table 2. Any deficiency in achieving the minimum standards as per the TPM verification is going to trigger MOPH's step in rights with disciplinary actions which will not necessarily result in financial penalty immediately
- Quality of Care Indicators (output): The performance management system adopts two approaches to measure the quality of care provided by the SPs: the Balanced Scorecard (BSC) and the Quality of Care indicators. Former serves as an overall performance measurement of SP activities and the latter is used by the TDs for their supportive supervision in the field. The Balanced Scorecard (BSC): The current BSC includes a number of indicators associated with quality of care.

In South Sudan, the world bank project performance indicators are
(a) Number of people who have received essential health, nutrition, and population (HNP) services
a. A number of people who have received essential health, nutrition, and population (HNP) services - Female
b. Number of children immunized;
c. Number of women and children who have received basic nutrition services;
d. Number of deliveries attended by skilled health personnel;
(b) Number of curative consultations provided for under 5 children;
(c) Number of health facilities with essential medicines available;
(d) Number of health facilities providing at least 75 per cent of the essential package of health services;
(e) The proportion of disease outbreaks detected and responded to within 72 hours of confirmation. (World Bank, 2019)

4.3.6 Payment mechanisms

Payment mechanism in contracting can include the method that the purchaser will apt the provider, also includes the payment done by the providers (Liu, Hotchkiss and Bose, 2007)**.** In both countries payment in contracting out is by lump-sum payment on the base performance-based payment. According to the World Bank, lump-sum contracts are �much when providers receive an agreed-on amount of funds regularly that is not reimbursement for specific expenditures they have incurred. It is flexible for managing the project, with no purchaser

permission on changes within the budget lines, and less monitoring on the purchaser(Loevinsohn, 2008).

Other payment mechanisms used on previous contracting out projects under other donors are cost-reimbursable payment mechanism which is based on reported outputs, this payment mechanism is preferred by the MOPH because it allows for closer supervision by the MOPH. On the other hand, NGOs prefers the lump-sum payment mechanism because it allows for more flexibility for planning activities, reporting and monitoring(Salehi *et al.*, 2018). NGOs can adjust their payment according to insecurity and geographical inaccessibility of the provinces (Engineer *et al.*, 2016)

4.4 External environment

Success or failure of contracting-out projects can depend largely to varies external environmental factors surrounding the contracting-out intervention, these factors include the political, financial, legal conditions, socioeconomic, and security situation. (Liu, Hotchkiss, and Bose, 2007). Both countries have faced security changes through long destructive wars. Although post-conflict peace is achieved in both countries, armed groups violence remain active in some areas, that can target the health facilities, health workers, and citizens (Ameli and Newbrander, 2008)(Checchi *et al.*, 2018). Also, it was has shown that insecurity affects the availability of female health workers in Afghanistan's quality of services of the health facilities (Ameli and Newbrander, 2008).

Political situation can interfere largely with the contracting out, because it determines the commitment level of governments to improve service provision, with the risk of losing their authority on the health sector. It also determines the level of trust of the donor on the government and the capacity of the NGOs (OECD, 2010). In both countries, political interference through political leaders can affect with the implementation of the health services for their political or personal preference, as changing areas to deliver services, expansion of services beyond the BPHS/EPHS, interfering with the hiring and firing process of health workers or dealing with specific companies for logistical support (Salehi *et al.*, 2018)(Integrity, 2018)(Initiative, 2015).

The economic situation can affect the contracting out, especially that both countries considered poor, in Afghanistan 54.5% of the population live below the poverty line, and its much worse in South Sudan in which almost 80% of the life below poverty line(*About South Sudan | UNDP in South Sudan*, no date)(*Afghanistan: Poverty | Asian Development Bank*, no date). Although services under the contracting out are free of charge, in both countries, the poverty status of health worker and the hight corruption, can make them charge for the services or work in the private sector instead (Cockcroft *et al.*, 2011).

To process with contracting out there should be laws and regulations in place to control the process, and that determines that legal system of the country. Examples of these, are law and regulations for procurement laws, contract laws, enforcement laws, laws and regulations regarding standards as product quality, and laws relating to business organizations and NGOs (OECD, 2010).

In general, both countries are characterized by the weak legal system, at the corruption perception index, both countries are at the top 10 corrupted countries worldwide, South Sudan ranks as the 2nd, on the other hand, Afghanistan ranks as the 8th (*Corruption Perceptions Index - Transparency.org*, no date). But on the other hand, Afghanistan contracts are regulated through several laws public procurement regulations, national medicine law and contract laws in addition to, UNCITRAL Model Law on Procurement of Goods, Construction and Services that was developed by The United Nations Commission on International Trade Law (UNCITRAL) (Guides, 2019)(OECD, 2010)(Republic *et al.*, 2011). In South Sudan, they have general pubic laws, but it is not clear how they are used for contracting(Procurement, 2005).

Other external factor affecting health services, is sociocultural factors, for example in Afghanistan, it is unacceptable for a woman to be in contact with men outside the family, and this affects the recruitment of female health works, which affects the access of the Afghani women to the health services (Salehi *et al.*, 2018). South-Sudan face different cultural factors too, it has about 60 different ethnic groups, which make it a challenge to understand the health-seeking behaviour, to design better health services (Initiative, 2012). Geographical factors also affect health services, both countries are characterized by hard to reach geographical areas, like mountains, rivers or bad weather like rainy or winter seasons that can affect the delivery of health services, in terms of the distribution of medications and supplies, recruitment and retention of health works (Salehi *et al.*, 2018)(Bol, 2019).

4.5The response

The effectiveness of contracting depends on how providers and purchasers operate both within and outside the contracting-out intervention. This is considered the response to the intervention, and they do that by provider management of the interventions in terms of the input, output and outcome, also the monitoring of the interventions are a type of response within the contracting. Outside the contracting can occur within the private market and the public service provision(Liu, Hotchkiss and Bose, 2007)

4.5.1 Input management

Since identifying and selecting inputs for health services is one the most important steps for service delivery, it is an essential part of the contracting out scheme to reach the required performance. These inputs include human resources, equipment, drugs, supplies, and infrastructure(Liu, Hotchkiss and Bose, 2007). In Afghanistan, despite the increase of education and production of health workers, there is still a shortage of qualified health workers employed in the public health sector across the country, with ratio of 7.26 doctors, nurses, and midwives per 10,000 population, which is below minimum ratio stated by WHO which 23 health care professionals per 10 000. Additionally, only 1.9 doctors for 10 000 people with a rate as high as 7.2 in urban areas, and as low as 0.6 in rural areas. In 2011, the MOPH estimated that about 18,000 health worker are employed with NGOs through contracting-out mechanisms, which represents 40% of the health workers in the public sector (MoPH, 2011).

In South Sudan, the shortage is more severe with about 1.9 doctors, nurses, and midwives per 10,000 population, unequal distribution across the country and it is estimated that most of the health workers are under the contract with NGOs (Ministry of Health, 2015). Due to the shortage of health workers, in some health facilities, there

were untrained and unqualified health workers, like home health promoters (HHPs), community health volunteer and health workers with no formal training. (Integrity, 2018), (Bol, 2019). Out of all the health workers shortages in both countries, female medical staff are the least available, especially in rural areas, for example, In Afghanistan, 28% of the workforce are female workers including community health volunteers(MoPH, 2011).

In terms of medications, the list included in the contracts are the "Regular Supply of Essential Drugs" which is as part of BPHS/EPHS of Afghanistan, and 'Essential Medicine List' which part of the BPHNS in south Sudan (KIT, 2015)(MoPH, 2009). In Afghanistan, It is estimated that an average of 20% of the donors budget is spent on medicines with 4 USD per capita per year compared to South Sudan under the HPF which is account to 2.34 USD per capita per year which includes 68 items of medications (Harper and Strote, 2011)(Integrity, 2018). Infrastructure is another input that affects the effective provision of services. In both countries, the construction of new health centres or rehabilitation of the exciting infrastructure is not mentioned in NGOs proposals. On the other hand, there are some regulations and procurement policies of donors that do not approve for construction. In case of no available health facility in an area, some NGOs will usually rent local houses or other buildings and use them as health facilities(Salehi *et al.*, 2018)(Integrity, 2018).

4.5.2 Output management

To turn the inputs to the required outputs of health project, there are several steps for the provider to go through, from Program planning, hiring for human resources to financing to procurement practices to achieve the performance required, (Liu, Hotchkiss and Bose, 2007). In Afghanistan, NGOs involved in the contracting out have the authority to manage human resources using the national salary policy for NGOs staff and national recruitment guidelines. NGOs are in charge of recruitment for new positions, fill vacancies and planning coverage for staff vacations(Salehi *et al.*, 2018). However, in South Sudan, the NGOs have limited authority for recruitment and selection of health staff, with pressure by the MOPH and the CHD on the NGOs to hire specific individuals (Integrity, 2018)(SHAHINIAN, 2019). The salary level for health workers employed by NGOs in Afghanistan is fivefold more than the salary paid to the civil servant to work for the same health facilities, a similar gap is also seen it south Sudan, with some efforts by NGOs and MOPH to harmonize the salary rate (Salary Policy Working Group, 2005).

Since both countries are suffering from a shortage of female health workers, availability of female health workers in the health facilities, especially in rural areas, is one of the important outputs of the contracting-out project (Newbrander *et al.*, 2014)(Integrity, 2018).In Afghanistan, NGOs and the MOPH tried to solve this problem, by several solutions, for example, adding hardship payments, offering special vacation opportunities, hiring the female's doctor husband in the same health facility and hiring from neighbouring countries, like Tajikistan. These efforts result in increasing the availability of female health workers from 45% in 2000 to 92% in 2017. (Salehi *et al.*, 2018)(Benderly, 2010). On the other hand, since south Sudan suffers more of the availability of educated females, recruitment of female health workers has been a challenge, as a result, training of more female community health workers with task shifting has been the solution on of the solutions(Integrity, 2018).

In both countries, training and capacity building is focused on community-based program training, in Afghanistan, contracting out has established community midwifery education and community health nursing education programs in addition to community health volunteer programs(Safi *et al.*, 2018). in South Sudan, community training was

focused on ICCM Integrated Community Case Management program training (Integrity, 2018)(Safi *et al.*, 2018). In South Sudan, there was a continuous delay in training due to the security situation(Integrity, 2018).

Medications purchasing mechanism can differ with different donor preference mechanism either international or national procurement. Currently, in Afghanistan, medicines are purchased from local pharmaceutical companies that are certified by the MoPH, this mechanism is preferred by the health workers than the international procurement mechanism because reports on stock out are less, and the supply is faster and on regular basis (Salehi et al., 2018). In South Sudan, not clear how procurement is processed. Reports show that there are frequent stock-outs of medications in the health facilities, due to low budget allocated to drugs by donors, weak forecasting drug consumption, pilferage difficult to transport due to bad roads and weather. (Integrity, 2018) (Jones, Howard and Legido-Quigley, 2015)(Belaid *et al.*, 2020). A practice that has been reported in South Sudan, is the redistribution of medications by the CHDs between the health centres according to the need, rather than to distribute according to the distribution plan prepared by the NGOs (Integrity, 2018)

4.5.3 Outcome management

Outcome management is the approach that ensures that health services are reaching its best quality with the given inputs, activities planned and expectations of the contracts, it includes quality assurance activities, client satisfaction and clinical practice guidelines and standards (Liu, Hotchkiss and Bose, 2007). Afghanistan has developed its outcome management using the Balanced Scorecard (BSC), with clear task described later, while in South Sudan outcome management is still limited to Household Satisfaction survey (Integrity, 2018). The Balanced Scorecard Report by the Third part monitoring team, has 6 domains or indicators, each of the six domains contains several indicators (KIT, 2018). Some of the aspects that are measured are cleanness, waiting time, cost of the visit, behaviour amount of time health workers spend with patients, the way health workers explain the patient's illness, and the way health workers explain treatments(KIT, 2018). In South Sudan, the client satisfaction system is not clear, each NGO has its mechanism, with no standard tool(Integrity, 2018) Client and Community

1. Human Resources
2. Physical Capacity
3. Quality of Service Provision
4. Management Systems
5. Overall Mission

The overall median score has increased from 55 per cent in 2011 to 63 per cent in 2017, in 2018 there was then a decrease to 59 per cent in 2018. This decrease was mainly in two indicators 'Salary Payment Current', and 'Provider Knowledge Score', on the other hand, two indicators have increased compared to last years spent with client' and 'new outpatient visit concentration'(KIT, 2018).

Making sure that the clinical diagnosis and guidelines are available for the health workers are followed is one of the outputs management for quality assurance. In Afghanistan, other than the BPHS implementation guidelines, there is the National Standard Treatment Guidelines for the Primary Level that serves as the treatment guide for health workers implementing the BPHS(MOPH, 2013). In South Sudan, the clinical guidelines are limited to separated vertical programs as IMCI, Malaria, ANC and PNC(Berendes *et al.*, 2014).

Quality assurance is another activity that can be done by NGOs, that can make sure that the activities are according to standards. This is applied in Afghanistan through the

Data Quality Assurance Plan (DQAP), which is required by being submitted by NGOs to MOPH within one month of contract signing which reflects the internal verification systems of the NGOs (Afganistan MOPH, 2019).

4..5.4 Performance monitoring

One of the most important components in performance-based contracting is monitoring the performance to make sure that the provider reached to the target required and held accountable in the project objectives. The result of the monitoring, performance will be measured and payment will be performed. There are different dimensions that the framework assess the monitoring process, its comprehensiveness, its frequency during the project, and by whom it is conducted to ensure neutrality(Liu, Hotchkiss and Bose, 2007).

In general in both countries, monitoring is conducted through field visits, quarterly and monthly meetings to review reports and progress against the agreed on targets in the contracts, conducted by the MOPH and the NGOs routine, verification of health management information system HMIS, household surveys, and supervisory checklists(World Bank, 2019)(World Bank, 2018). The main performance monitoring in Afghanistan is Balanced Scorecard (BSC) developed by the MOPH, conducted by an independent third party monitor (TPM) agency, which has been assigned to KIT Royal Tropical Institute since 2015(KIT, 2018). (KIT, 2018). The MOPH oversees the TPM team activities and reports and makes sure its independence for the neutrality of the results. The TPM has the following responsibilities,(World Bank, 2018)

1. Balanced Scorecard (BSC), which is an annual health facility surveys in all 34 provinces
2. Monthly verification of health management information system (HMIS) indicators
3. Assess the effectiveness of the innovations introduced under the project
4. A nationwide household survey in collaboration with the Central Statistics Organization (CSO)
5. Drug Quality Assessment

Balanced Scorecard (BSC) defined as ‛ management system to convert mission, vision and overall strategy of organizations or systems into a plan that links strategies to measurable targets and actions. It is made up of domains and indicators derived from the strategic vision of organizations or systems aimed at measuring their performance ’ (KIT, 2018)(Kaplan and Norton, 1992). BSC is a tool used by Afghanistan MOPH to measure the performance of providers in each province, it contained 6 domains and 23 indicators and benchmarks, is based on National Health Services Performance Assessment (NHSPA) and it has scored from 0 to 100. BSC has been the cornerstone of the government monitoring and evaluation system and other stakeholders (KIT, 2018). BSC was used in the high-income countries, until 2010 it was introduced by WHO to be used as a monitoring and evaluation tool in low and middle-income countries(WHO, 2010). Although BSC has shown success in measuring performance it has not been able to measure the contracting out process and measure the provider capacity to deliver BPHS (Peters *et al.*, 2007). Other than the BSC, that was mentioned above, HMIS is another tool for collecting and verifying data reported by the health workers, and since these data are prone to mistakes, TPM review and verify it monthly. Health workers get feedback, after verification and analysis of these data, on a monthly and quarterly basis, for correction and improving their performance(Salehi *et al.*, 2018). In South Sudan, there are third party monitoring agencies, and that mostly evaluate key interviews and household surveys (Bol, 2019).

4.5.5 Private market

Private market in both countries consists of, a for-profit private sector that includes private hospitals, clinics, pharmacies, private health practitioners and not-for-profit organizations in the form of national and international NGOs, in addition to faith-based organizations (FBOs) in South Sudan(Bol, 2019)(Natasha Palmer, Lesley Strong, 2005). Through the contracting out, there has been an increase in competition among the NGOs, which lead to an increase in the number of local NGOs with improving the quality of implementation of health service delivery (Salehi *et al.*, 2018). In South Sudan, international NGOs are still prioritized over the local NGOs, and competition is still weak(Tanner and Moro, 2016).

Although the for-profit private sector was not involved directly in the contracting out projects in both countries, it was still affected. For example, In Afghanistan, the for-profit private sector provides mainly secondary and tertiary health services, due to the coverage of primary health care by NGOs through contracting-out (Salehi et al., 2018). South Sudanese for-profit private sector is weaker and mostly in urban areas (Waldman, 2006). In both conditions, for-profit private sector try to benefit from NGOs contracted out public health facilities, it has been reported that medications provided by NGOs in both countries are leaking and being sold in the private sector (Integrity, 2018)(Paterson and Karimi, 2005). Additionally, some public health providers sell these medications in the health facility, for example, In Afghanistan, a study showed that about 77% of patient had to pay unofficial payments for medications inside or outside the health facility, although services in health services under the contracting out project are free of charge(Cockcroft *et al.*, 2011). Furthermore, since public health providers in Afghanistan take part in the private sector after or during working hours, they refer cases to their private clinic (Amare *et al.*, 2009)(Johnson *et al.*, 2017).

Another finding by the same study showed that, although almost all (93%) of patient sampled seek help from NGOs contracted-out public health facilities, they would prefer to go to private health facilities if they can afford the cost, because of the better quality of services, availability of medications, and qualified health workers(Cockcroft *et al.*, 2011). In another study in Afghanistan, it showed that patients are slightly more stratified with private clinics/hospitals mean of 64.5% than public health facilities with mean of MoPH clinics were scored slightly lower 57%(Ministry of Public Health, 2018). At In South Sudan, 36% preferred private clinics for quick better quality services and medications, on the other hand, 47% will choose a government for free services and drugs, in this study the public NGOs contracted out health facilities that were not indicated(Basaza *et al.*, 2017).

4.5.6 Public service provision

There has been an improvement of public health provision through the contracting out with NGOs to deliver BPHS/EPHS in Afghanistan and BPHNS in South Sudan, but there has been less attention to service delivery in public secondary and tertiary hospitals in both countries. In Afghanistan, there are a total of 134 hospitals, 26 in Kabul, 18 of them are referral hospitals(WHO, 2019). Management of these hospitals is centralized, with limited autonomy given to the hospitals, these hospitals characterized by poor human resources financial and procurement capacity management. Centralized human resources management leads to delay in the recruitment process in addition to the availability of unqualified and unbalanced health staff between clinical, administrative, and support staff. Also, there is a weak allocation of budget, procurement process, and inefficient spending(Health, 2012)(MoPH, 2013). Contracting in, that has not been focused on in the results, is a way to increase the capacity of public provision through contracting with province or county health office, in Afghanistan is called the MoPH-SM

and is usually implemented in secure areas to facilities the implantation(Afganistan MOPH, 2019)(Bol, 2019).

CHAPTER FIVE

5.Discussion, Conclusion, and Recommendations

5.1 Discussion

Here we will discuss the factors by comparing the experience of both countries, although they have different contractual arrangements, discussion of the factors in FCS context can give more insight into contracting out. These factors are specific for evaluating contracting out and they considered key elements used frequently for analyzing contracting of health services(Liu, Hotchkiss, and Bose, 2007). Contracting out is a recent method and it's going through the developing and learning process, especially by applying it in different countries, before we are deciding on it the effectiveness. Contracting out has different components, that can be complex especially with the interaction of these components and other external and internal factors. Generally, the capacities of the purchase and the provider with the external environment surrounding contracting out, are the important determinants for the success of contracting out.

Through our study, the capacities of both purchasers and providers, in addition to, the purchaser-provider relationship is the cornerstone of contracting out unless such capacities and relationships are strengthened, contracting out cannot be effective. Technical qualified public health local consultants and specialists in Afghanistan MOPH, in addition to the effective capacity building of the health workforce at the MOPH, lead to strengthening the leadership role of government for the contracting out. In addition to organizational capacity in the form of different teams with a delegation of tasks. That was also shown in contracting out experience in Liberia, with effective capacity building efforts by donors with the new leadership of the MOHSW(Petit et al., 2013)

Moreover, involving different parties in the process can put risks on the effectiveness of contracting out(OECD, 2010). In South Sudan, the stakeholder's involvements are multiple, different donors, fund managers, and NGOs with the weak leadership of the government lead to miscommunication, fragmentation, low coordination, and no clear roles of the purchasers and the provider. On the other hand, the purchaser-provider relationship within contracting out, is not clear is it built on real trust, or it is affected by the negotiation power and the authority of the purchaser(WHO, 2004). This should be considered as some unclear interests of different parties can affect the contracting out.

Donors' support has been the main financial source for contracting out health services, in both countries, in addition to technical assistance and monitoring services, which is applied to most contracting-out programs in developing countries that are supported by donors (Liu et al., 2004). This raises concerns about the sustainability, which has been a topic of debate, some argue that contracting-out programs lead to dependency on donor aid, especially with poor infrastructure and human resources (Natasha Palmer, Lesley Strong, 2005)(Siddiqi, Masud and Sabri, 2006). On the other hand, some argue that contracting-out helps the government strengthen its legitimacy through the leading role in managing and monitoring contracts and create local NGO markets (OECD, 2010).

This debate applies in our study, In Afghanistan, although contracting-out has improved the management capacity of the MOPH, planning, and setting policies through capacity building in addition to increasing local NGOs, Afghanistan still relies on external aid for the past 20 years, especially with weak domestic financial resources, high out of pocket and. Furthermore, there are no exit strategies, or gradual transition plans to public service mentioned in the contracting out projects in both countries.

Liu argues that services that are more contractable are the single, specific, with a standard protocol to follow, technically simple, more associated with outcomes(Liu, Hotchkiss and Bose, 2007). But a more comprehensive list on large scale has proved that they can be contractable, in addition to Afghanistan and South Sudan, other countries have contracted a package of services as Bangladesh, the Democratic Republic of Congo, and Pakistan (Loevinsohn, 2008). Liu also suggests that contracting out can increase efficiency,(Liu *et al.*, 2004) despite the limited studies regarding efficiency, the results of the cost of the services are close to other studies, with an average of $3 to $6 per person per year(Loevinsohn, 2008). Transition cost in our study, studies show that high transition cost for managing and maintaining the contracts can affect the efficiency of contracting out(Liu *et al.*, 2004).

The findings on how the external environment affects the contracting out, are in line with others' findings. Studies suggest that social, political, and economic factors can influence the contracting out programs(Mills, 1998)(Li, 2012). For example, in a fragile context when the government is weak politically and economically, its legal, banking, and security systems can't be guaranteed, making contracting difficult(Li, 2012). In both countries, political interference was common, studies have shown that this interference can be explained by the fear of the public sector to loss of authority and control on the health services by shifting the provisioning role to the private sector instead (Loevinsohn, 2008).

Remote areas in both countries were the most affected areas for health services under contracting out, mostly due to insecurity such as attacks and violence that can affect the health workers and the citizens, in addition to a limited number of health workers that can work in such difficult conditions. Newbrander highlighted that security is a key determinant of a successful contracting-out program (Newbrander, Waldman, and Shepherd-Banigan, 2011). Additionally, through our findings socioeconomic situation a role in contracting out, studies have emphasized on targeting equity and cultural considerations in contracting out design(Liu *et al.*, 2004).

Monitoring and evaluation are one of the key elements of contracting, because it helps to assess the performance of the provider, and linking their performance to the payment. Without monitoring, providers are not accountable for their work and can focus on making sure that the fund is available rather than focusing on improving efficiency or quality services (Eichler, Auxila, and Pollock, 2001). It was obvious that design the monitoring and evaluation system was more advanced in Afghanistan than South Sudan, with a different set of indicators, different departments in the MOPH for verification, and the clear tasks for the third party agency which was weak in South Sudan. BCS was the most useful tool for monitoring and evaluation for MOPH, NGOs, and other stakeholders, and it has helped to strengthen the stewardship of the MOPH. Other than Afghanistan, BSC has been a valuable monitoring and evaluation tool in Bangladesh and Zambia as a (Mutale *et al.*, 2013).

Furthermore, studies have shown than most contracting our projects monitors mainly coverage and utilization of the services(Liu *et al.*, 2004). HMIS was another tool used

but studies showed that it's challenging verify data and use it for performance, and it needs a high level of accuracy to make sure it reflects the real numbers, for example in Pakistan there were discrepancies between the data in the HMIS and the survey data done for coverage of immunization(Loevinsohn, 2008). And a study from Costa Rica has shown that the data collected, it's not helpful to the purchaser it assesses the contract performance (Abramson, 2001).

An important factor that makes the monitoring process successful is how indicators are chosen and what do they measure. Studies show that some aspects that should be considered in design the indicators for successful measuring performance are by considering the coverage of the services, quality, and equity, in addition to ensuring the participation of the communities for better public satisfaction(Liu *et al.*, 2004)(Loevinsohn, 2008). The indicators used for both contracting out in both countries were mainly focused on accessibility and coverage of the services, with a focus on quality in Afghanistan case. However, other aspects of health services as equity and efficiency are not common in both countries, although by increasing access to free services can improve to reach poor or marginalized populations, no specific indicators were measuring targeted poor or underserved populations. These findings are similar to Liu findings, in which most of the contracting out projects focus on access, rather than quality, equity, and efficiency (Liu *et al.*, 2004)

In terms of inputs, the management of human resources is considered the most important input to manage. (Newbrander *et al.*, 2014)(Peter M. Hansen, David H. Peters and Lakhwinder P. Singh, 2011)(Arur *et al.*, 2010). The most challenging issue was the shortage of female health workers, but through the results, Afghanistan had succeeded with them to attract more females to work in health facilities. The cost spent on the pharmaceuticals Is another input that can affect the contracting out. As mentioned above the budget spend on medications is between 4-8 $ per capita which is lower than the international drug need which estimates $13 to $25 per capita is required to finance a basic package of 201 essential medicines in LMICs(Das and Horton, 2017), however, this can be explained by the efficiency approach of the contracting out, and limited budget of the donors.

5.2 Conclusion

In the recent years, fragile and conflicted affected states have been a public health concern, because of the lack capacity of these states to respond to their people's basic needs, with limited available resources and destroyed health systems. Contracting out has been a solution when the public sector is limited to deliver health services. This study has shown different factors that affect the contracting out process in Afghanistan and South Sudan.

The role of government stewardship role shows crucial importance in the contracting out process, with the commitment to the process, availability of local qualified consultants, and collaboration with donors. The government role was very weak which

did not allow it to be the purchaser in contract, compared to other countries, where the government is usually the purchaser. However, these governments depend largely on the financial aid of donors, which is not sustainable and does not motivate the government to improve the domestic financial expenditure. The government-NGOs relationship is also important in contracting out, as it can facilities the contracting out process, in addition to increasing the stimulating the competition, which has helped to raise local NGOs, with better quality and cost-effective interventions.

Monitoring and evaluation system is the base of performance-based financing which is the type of contract applied in both countries. It can be approached by different tools, different indicators, that commonly measure access, with few targeting quality and equity. The evaluation process, started with the design, choosing the third party, ending to using the data collected for payment of the providers, and by policymakers on how to further improve the contracting out.

The external environment surrounding the contracting can which is a common environment in FCS can affect the performance of contracts, security, political, and sociocultural mainly affected the human resources management speciality availability of health workers. Weak legal system affected some procurement aspect and its role for the hight out of pocket and with uncontrolled the private sector. Furthermore, geography affected the output management and the payment of the providers.

Cost of the contracting out process can influence the effectiveness of contracting out, other than the performance-based payment which designed to make contracting out more efficient, there are transaction costs and other hidden costs, which can make the process less cost-effective. Also, cost of the inputs needed for the contracting out can play a role for the efficiency and the effective, as the salaries of health worker, they are almost fivefold than the civil servant, it can be not efficient, not sustainable and can risk for tension between health worker, but it can solve a big problem of the shortage of health providers. So analyzing the cost with the benefits of the intervention can improve the designs pf the intervention.

5.3 Recommendations

1. Governance: strengthen the role government by improving the capacities in MOPH, especially in weaker government as South Sudan is key to contracting out. Although other external factors can affect the stewardship role in such settings and limited literature on how to establish these capacity buildings, recruiting the qualified local staff with additional capacity building on contracting can be a suggested recommendation.

2. Need assessment and stakeholder analysis: each country has its own needs, list of morbidities and mortalities, and external factors that should be considered before starting contracting out, and can help with design better contracts. Also, stakeholder analysis can map the actor's interests which can help contract out.

3. Coordination: strong coordination mechanism should be developed, mainly by the government, but also by donors through a stronger role of clusters and meetings that needs to be established.

4. Donor partnership: to strengthen the humanitarian efforts on a large scale,

partnerships and consortium between donors should be recommended in design for financing contracting out.

5. Monitoring and Evaluation: M&E system should be strengthened, development of better tools for evaluation and research designs. In addition to evaluation of providers' management performance, to help in the proper selection of providers with better quality and efficiency. Moreover, develop indicators more relevant and comprehensive that can include measure access, quality, equity, and efficiency.

6. Local/national NGOs: encouraging local NGOs to participate in contracting out, by strengthening their managerial, financial capacities, building skills, and knowledge. Also advocacy for directing the funds to Local/national NGOs as a way of sustainability.

7. Sustainability: capacity building of MOPH at central and province or county level in terms of planning, monitoring, and managing of contracting services is recommended. More research is recommended for the best way for capacity building for contracting out. To reduce governments' dependence on donors, it needs to strengthen its domestic resources or find alternatives for health financing. The involvement of private providers in contracting can be another suggestion with more research on how this can be done in FCS.

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Annexe I Research Table

Objectives	Issues	Methods	Source of Data
1. To describe the features of the contracting-out interventions, in Afghanistan and South Sudan	including the characteristics of the contractor, the provider, and the contractual relationship, affecting contracting out of basic health services in fragile and conflict-affected countries	Literature review	PubMed VU Library Google Scholar
2. To describe the external environment that affects the contracting-out in fragile and conflict-affected countries Afghanistan and South Sudan	Governance		
3. To analyze the response of the provider in management.	input, output and outcome management		
4. To provide recommendations to policymakers for appropriate service delivery structure in fragile and post-conflict countries.	To generate recommendations for improved contracting out interventions		