

Towards sustainable delivery of health services in Afghanistan: options for the future

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Abstract Disruption caused by decades of war and civil strife in Afghanistan has led many international and national nongovernmental organizations (NGOs) to assume responsibility for the delivery of health services through contracts with donor agencies. Recently the Afghan Government has pursued the policy of contracting for a basic package of health services (BPHS) supported by funds from three major donors – the World Bank, the United States Agency for International Development (USAID) and the European Commission. With the gradual strengthening of the public health ministry, options for the future include pursuing the contracting option or increasing public provision of health services.

Should contracting with NGOs be pursued, a clear strategy is required that includes developing accreditation instruments, better contracting mechanisms and a system for monitoring and evaluating the entire process. Should the government opt for an increasing role, problems to be solved include securing the transition to public provision, obtaining guarantees that appropriate financing will be provided and reconfiguration of the public health delivery system. Large-scale contracting with the private for-profit sector cannot be recommended at this stage, although this option could be explored via subcontracting by larger NGOs or small-scale trial contracts initiated by the public health ministry. Irrespective of the option chosen, an important challenge remaining is the recalcitrant problem of high out-of-pocket payments.

Sustainable delivery of health services in Afghanistan can only be achieved with a clear national strategy in which all stakeholders have roles to play in the financing, regulation and delivery of services.

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Introduction

Decades of war and civil strife have adversely affected the delivery of health services to the population of Afghanistan. Until recently, the network of public service delivery had been disrupted by prolonged war and the lack of a central government. In response, many international and national nongovernmental organizations (NGOs) had assumed responsibility for the provision of essential primary health-care services via direct contracts with donor agencies.

After the end of the Taliban regime and during the evolution towards the election of a new parliament and government in 2002, health-care services continued to be provided mainly by NGOs. The network of public facilities was weak, and most qualified health

professionals either left the country or left the public sector to look for better opportunities with NGOs. The limited national budget did not allow the ministry of public health to retain necessary staff or to provide medicines and other supplies required to offer basic services. Given its limited capacity in terms of human resources and the highly bureaucratic system, the new Afghan administration opted to pursue the delivery of health-care services through NGO contracting initiatives. External donors were equally influential in adopting this approach.

Since the public health sector was, and has remained, severely underfunded (the public health ministry's annual budget allows about US\$ 1 per capita), it was unable to appropriately finance

public health facilities. In addition, the experience of contracting in countries such as Cambodia¹ led major funding agencies, including the World Bank, the United States Agency for International Development (USAID) and the European Commission, to channel financial support to NGOs through contracting for a basic package of health services (BPHS).²

As in other countries such as Rwanda³ and Timor-Leste,⁴ the strategy has been to provide basic health services via contracting with national or international NGOs. However, after some years of contracting and in view of the gradual strengthening of the public health ministry at central and peripheral levels, alternatives are emerging – pursuing the contracting option or following the

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policy of increasing public provision of health services. This paper discusses these and other options in order to develop a sustainable health-care delivery system for Afghanistan.

Contracting for basic health services

Policy and process

Since 2002, the Afghan Ministry of Public Health has had an explicit policy on partnership with NGOs through contractual arrangements for the delivery of the BPHS.^{2,5} As the ministry had inherited limited managerial capabilities in handling contracting activities, donor agencies invested in capacity-building through the establishment of an “elite” unit for management of grants and contracts. This unit, funded by the World Bank, has acquired experience in independently managing most aspects of the contracting process and has recently been expanded to manage funds channelled by donors other than the World Bank.

Contracting relies on capitation, payments made directly to health-care providers for each individual enrolled with that provider, by various national and international NGOs for a list of services based on the BPHS. Currently the three major donors listed above support contracting for the BPHS. The World Bank covers eight provinces and six clusters (a cluster being a specified area within a province assigned to the NGO for delivery of services) through contracting with NGOs, as well as three provinces and one cluster through the Ministry of Public Health Strengthening Mechanism. USAID covers 13 provinces, of which seven are also covered by the World Bank. The European Commission covers 10 provinces (Fig. 1). The World Bank has a flexible incentive-led performance-based partnership agreement⁶ and channels its funds through the finance ministry to the public health ministry's grants and contracts management unit, which is responsible for awarding and managing contracts to competing NGOs. USAID, which follows a cluster approach, previously contracted the process to an international NGO and now contracts through WHO. In contrast, the European Commission undertakes this work itself, contracting directly with NGOs.

Contracting is based on lease contracts and NGOs are expected to achieve

certain targets and to cover a given population with a package of basic health services, excluding those provided free of charge by agencies such as WHO, the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA). The criteria developed to select NGOs have been based on their previous knowledge of Afghanistan, experience in primary health-care programmes and capacity for service delivery. These are not classic contracts but “relational contracts”.⁷ In the case of Afghanistan, the obligations of the providers have been defined in general terms – these contracts cannot be easily challenged in the court of law in case of non-performance, and the only provision available to the purchaser is non-renewal of the contract.

NGOs participating in the process of bidding for these contracts are of different sizes, and have different levels of experience and managerial/financial skills. The managerial skills of most are limited, and many rely on donor help to procure medicines and on UNICEF to supply vaccines. Some NGOs also benefit from donations from charities. Concerns have been voiced about the quality of medicines provided in view of institutional weaknesses related to regulation and inspection.

NGOs using the facilities of the public health ministry are free to recruit staff from inside or outside the country. Some NGOs contract with staff previously employed by the public health ministry and pay them salaries that are fivefold those paid by the ministry to work for the same health facilities they served as public-sector employees. The salaries paid to staff working for NGOs are based on a national salary policy set up by the public health ministry in 2005.

Patients have access to health-care services for nominal user charges. The responsibility to deliver preventive and promotive services lies with the NGOs as part of the BPHS. The public health ministry retains responsibility for programme planning and monitoring, while UN agencies provide substantial material support and technical assistance to these priority programmes.

Analysis of some contracts between NGOs and funding agencies shows that the terms of reference for coverage are relatively vague and do not identify quantifiable indicators for access and use. The most important quantifiable

element for assessing facility use is the target of one consultation per capita per year, which is low in view of the population structure and the need for several contacts for preventive and promotive services. In a previous study, it was estimated that at least 2.7 consultations per person per year should take place over the entire population.⁸

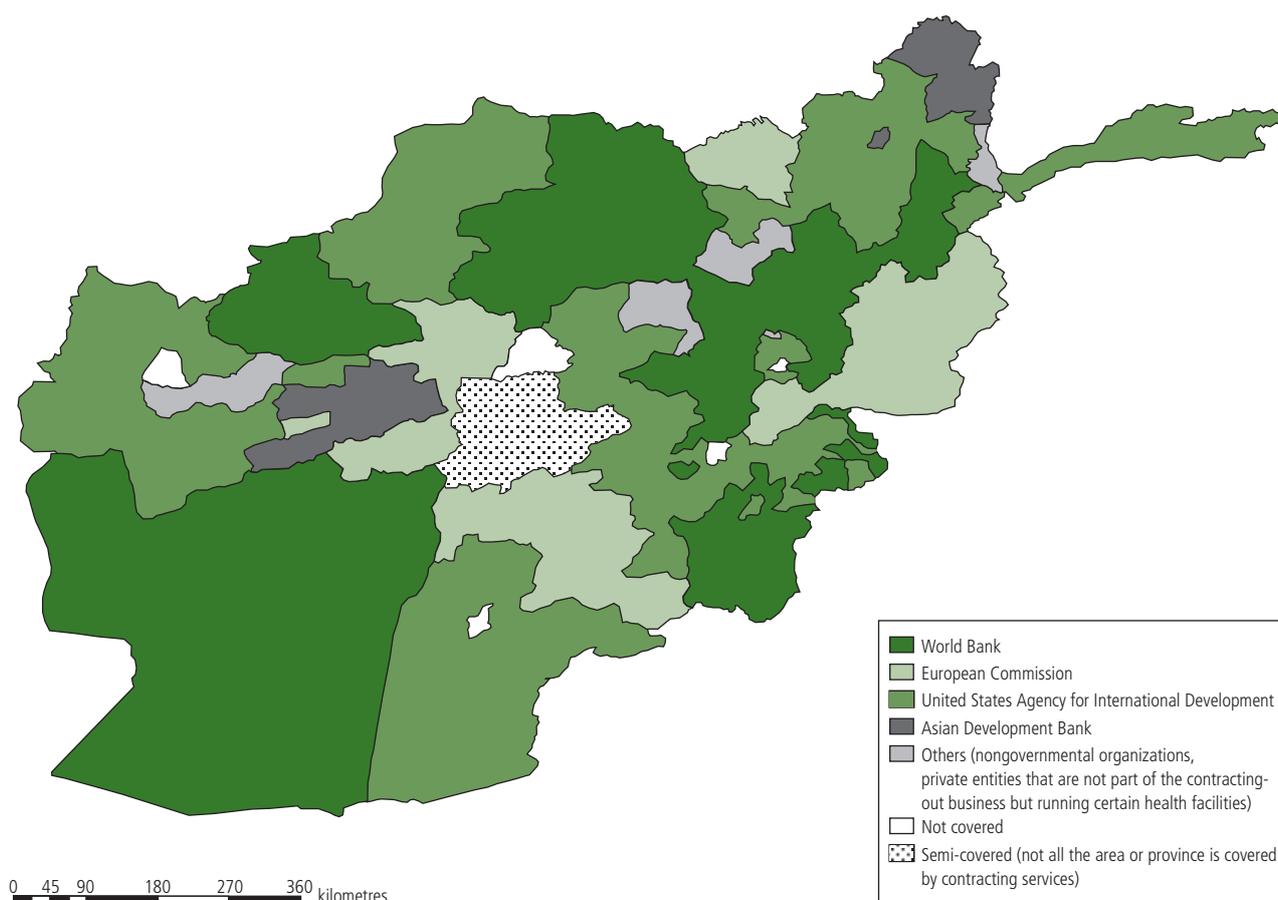
Three provinces financed by the World Bank are implementing the BPHS through the Ministry of Public Health Strengthening Mechanism, in which management is contracted under the same conditions and targets that are set for NGOs. Recruitment of staff is carried out as part of the government's priority reform and reconstruction policy, which seeks to retain qualified and motivated health professionals and to provide them with competitive salaries.

Financing and cost of health services

The health-care system of Afghanistan is clearly underfunded, as shown by the WHO national health account estimates⁹ and international agency studies.^{10,11} The estimated total expenditure on health in Afghanistan was US\$ 11 per capita in 2004; of this, almost 65% was incurred “out-of-pocket” – paid at the point of service by the individual or household (Table 1). The public health system is financed mainly by contributions from donors. These funds are channelled for contracting to national and international NGOs, to the ministry's strengthening mechanism, and to support the ministry's regular budget.

A team from Management Sciences for Health has estimated the cost of the BPHS based on a limited sample size of NGOs and facilities working for USAID.¹² The reference cost used to negotiate the delivery of BPHS with contracted NGOs was US\$ 4.5 for 2002. The cost varied among the different donors, ranging from US\$ 3.8 to US\$ 5.1 (Table 2, available at: <http://www.who.int/bulletin/volumes/85/9/06-036939/en/index.html>). Based on these figures, funding is allocated on a per-capita basis to NGOs that are obliged to implement the BPHS. In awarding new contracts, these figures have not so far been adjusted for inflation, which is estimated to be 10% per year.¹² Claims have been made that a basic package of services could be provided for between US\$ 3 and US\$ 6 per capita per year in low-income countries.¹³ However, in

Fig. 1. Geographical coverage by agencies funding delivery of the basic package of health services in Afghanistan



Source: Grants and Contract Management Unit of the Ministry of Public Health, Afghanistan, 1 September 2006.

the light of estimates of the cost of an essential package of health services at US\$ 12 by the World Bank in 1993¹⁴ and at US\$ 34 by the WHO Commission on Macroeconomics and Health in 2001,¹⁵ concerns have been raised as to whether an essential package of services of adequate quality can be provided for US\$ 4.5 per capita per year in Afghanistan, and about what impact such a package will have on health outcomes.¹⁶

Monitoring and evaluation

Several assessments of population coverage of basic health services have been made since contracting started. Population coverage of basic health services has increased from 9% in 2002 to 82% in 2006;¹⁷ however, the actual extent of the service coverage remains unclear. Although 90% of the Afghan population is theoretically covered by the BPHS, anecdotal evidence suggests that the quality of services provided is poor, with long waiting times, absence of laboratory services, shortage of drugs, and even disrespect for patients. Patients

in several provinces are compelled to visit private facilities or are encouraged by health facility staff to visit clinics after working hours. This is perhaps the most important reason for the high out-of-pocket spending on health care in Afghanistan.

To evaluate the performance of service providers, a balanced scorecard system is being implemented by a team from the Johns Hopkins University Bloomberg School of Public Health and the Indian Institute of Health Management and Research, working under contract with the World Bank.^{18,19} Two rounds of assessment have been completed since 2004. The exercise is aimed at monitoring and evaluating the delivery of basic health-care services in the 34 provinces covered by national and international NGOs and through internal contracts with the provincial tiers within the public health ministry (via the strengthening mechanism).

Despite the focus on availability of services rather than on access and quality, assessment has provided some

elements of comparison between the three major donors which support contracting. The facilities run under the ministry's strengthening mechanism and NGOs contracted under World Bank and USAID schemes appear to perform better than NGOs contracted by the European Commission (Table 2). Despite having a good track record in other countries, NGOs contracted by the European Commission perform poorly in Afghanistan due to cumbersome administrative procedures that inhibit performance-based financing of cash disbursement to health providers, as described in Cambodia and Rwanda.^{1,3} There is, however, limited information available concerning the indicators and processes used in the models of contracting pursued by the three donors.

The fact that facilities run by the government via the health ministry's strengthening mechanism are performing relatively well in terms of service delivery of essential primary health-care services has important policy implications. This makes a case for revitalization

Table 1. Trends in financing of health care in Afghanistan, 1998–2004

| Health financing indicators | Year | | | |
|--|-------|-------|------|------|
| | 1998 | 2000 | 2002 | 2004 |
| Total expenditure on health as a percentage of gross domestic product | 3.1 | 2.8 | 6.7 | 6.0 |
| General government expenditure on health as a percentage of general government expenditure | 1.6 | 1.6 | 7.4 | 6.9 |
| Total expenditure on health per capita at exchange rate (US\$) | 4 | 3 | 11 | 11 |
| General government expenditure on health per capita at exchange rate (US\$) | < 0.5 | < 0.5 | 4 | 4 |
| General government expenditure on health as a percentage of total expenditure on health | 1.5 | 1.5 | 41.1 | 35.3 |
| Private expenditure on health as a percentage of total expenditure on health | 98.5 | 98.5 | 58.9 | 64.7 |
| Net out-of-pocket spending on health as a percentage of private expenditure on health | 98.4 | 98.0 | 75.9 | 76.2 |
| Externally funded expenditure on health as a percentage of total expenditure on health | 2.8 | 3.2 | 46.8 | 43.1 |

Source: WHO Geneva 2006.⁹

of the public-sector network of broadly distributed and decentralized health facilities in the medium to long term, to cover all provinces and promote equity in the provision of essential services. The improvement in performance of these facilities can be attributed to the well-remunerated and motivated workforce and the availability of medicines and supplies. It is, however, important to bear in mind that their proximity to Kabul, better security, closer technical supervision and regular monitoring have also contributed to these facilities' satisfactory performance.

Monitoring and evaluation systems should be internalized within the public health ministry as part of its governance function and tools should be better refined to capture use, access and quality of health services at the various levels. Technical and financial resources in the monitoring and evaluation unit of the public health ministry currently depend entirely on support from Johns Hopkins University Bloomberg School of Public Health, the Indian Institute of Health Management and Research and the World Bank. Unless the public health ministry finds an appropriate solution for the institutionalization of this unit, its future will remain uncertain.

There had been no national surveys to monitor trends in health status indicators since the policy of contracting-out was adopted in 2002, until the Afghanistan household survey conducted in 2006 by the Johns Hopkins Bloomberg School of Public Health and the Indian Institute of Health Management

Research. In 2000, the maternal mortality ratio was estimated to be 1600 per 100 000 live births, while mortality rates for children aged less than five years and for infants were estimated at 257 and 165 per 1000 live births respectively.²⁰ Preliminary results of the Afghanistan household survey have shown the under-five child and infant mortality rates to be 191 and 129 respectively.²¹ In the absence of a reasonable vital statistics programme, nationally representative household surveys are critical for monitoring improvements in health outcomes and to indirectly point to the effect of contracting-out health services on childhood and maternal mortality.

Outstanding issues in contracting

The involvement of NGOs responsible for delivery of basic health-care services has created distortions within the Afghan health-care system that have important implications in the short to medium term. The government thus needs to develop flanking policies to address some issues.

Long-term vision and sustainability

During the war, many NGOs, particularly international, contributed to shaping national policies on priority health problems such as malaria and mental health. However, NGOs currently have short-term contracts and lack long-term vision in health-care delivery. They have few incentives to invest in facility development or in the maintenance and

repair of biomedical equipment. This has negative implications for sustainability. Many international NGOs could leave the country if the political, social and economic context became less favourable, leaving large populations without access to health services. Building the population's trust in and the credibility of health services over longer time periods is as important as shorter-term results.²²

Public sector performance versus donor-supported NGOs

The public sector is in a weak position to compete with the donor-supported NGOs for scarce resources. If this situation is not reversed through increased public spending, the whole system for delivery of essential health-care services could eventually be privatized, further increasing out-of-pocket spending and inequities in access to health care. Such an evolution will be encouraged by the health system's weak governance function.

Coordinating NGOs and health directorates

The NGOs' health service delivery function in districts does not seem well-coordinated with provincial health directorates. This could lead to duplication, inefficiency and neglect of programmes for health promotion and disease prevention. If the provincial management capacity is not strengthened, it will be difficult to target the input of NGOs towards overall improvements in health.

Standardization

There is no standardized national system for ensuring quality during BPHS delivery. Some donors are interested in the implementation process and use special monitoring tools to ensure at least a minimal service quality. Others focus only on outcomes and have a limited interest in service quality. Standardization is essential to build a solid foundation for an effective health system that values quality of services rather than simply purchasing the services offered in the BPHS.

Building the capacity of local NGOs

Almost half of contracting NGOs are national organizations, most of the international NGOs also have subcontracts with local NGOs. The government would like the local NGOs to replace the international NGOs as soon as they are capable of doing so. Currently, there are no guidelines or mechanisms to encourage international NGOs to build the capacity of local NGOs. In the absence of such guidelines, some elite NGOs will continue to dominate health delivery in Afghanistan and “crowd out” others.

Options for the future

Important and strategic decisions are being contemplated for the Afghan health-care system, taking into consideration population expectations, political commitment and prospects for health-care financing.

The use of contracting as a quick fix to provide basic health services was an appropriate option in the short term in the absence of other viable alternatives. Several commentators have questioned whether such an approach is sustainable in the medium to long term.²³ The public health ministry has since gained in credibility and has been strengthened at the central and provincial levels. Strategic decisions must be made about the ministry’s responsibilities – whether to contract for essential health services, to opt for an increasing role in direct provision, or to combine the two options.

If the public health ministry is to enhance its role in the direct provision of services, important issues have to be resolved. First, how will the transition from an NGO-run system to a system dominated by public provision be secured, and what guarantees provision of appropriate financing through

public sources? The transition should be phased in view of the inadequate public workforce, the limited financial capabilities of the public health ministry and cumbersome administrative procedures. It is important that the transfer of competence should be part of the new terms of reference of contracted NGOs and should be negotiated with them. Useful experience has recently been gained in Timor-Leste where, after periods of prolonged conflict, an interim health authority led by nationals permitted the donors to shift funding from NGOs to the newly established health ministry, phasing out NGOs and building local capacity to manage the new district health system. Early evidence shows that use of health services continued to grow during and after implementation.⁴

The second important question is how the new public health delivery system will be reconfigured and whether amendments are needed, particularly with respect to separation of financing, regulation and delivery functions, autonomy of public institutions, contracting and the establishment of results-based management in the public system. What is clear is that reverting to “business as usual” based on the situation before the war in Afghanistan will no longer work. Monopolist government-oriented systems have a poor reputation worldwide and are rarely advocated. They tend to be inefficient and do not recognize or respect the importance of the non-state sector as a partner in the achievement of public health goals. A key determinant would be for the public health ministry to delineate its role as the main steward of the health system and review the rules of health system governance.

If the public health ministry opts to continue the national policy of relying on contracting with NGOs to deliver basic health-care services, and assuming that a shift towards privatization is not envisaged, a clear strategy is needed to manage and regulate the contracting process. Upstream, the public health ministry should develop and strengthen its accreditation instruments, and should design norms and standards for service delivery, better contracting mechanisms and indicators to monitor and evaluate the process of contracting. In this respect, efforts should be made to internalize and sustain the newly acquired competencies in developing, managing and monitoring contracting within the public health ministry. It is difficult to see how the

unit for the management of grants and contracts in its current form would be able to sustain its activities once World Bank support is withdrawn. Indeed, a cautious approach has been proposed following experience in contracting for health services in the WHO Eastern Mediterranean Region²⁴ and by other authors.⁵ National policy should also spell out the future role of the private sector in delivering health services. The approach should be balanced in terms of strategies that facilitate as well as regulate the private sector to maximize its contribution; this has been called the “carrot and stick” approach.²⁵

The contractual relationships between the public health ministry and NGOs should feature working partnerships maintained on a regular basis, institutionalize the relational contracts with an in-built system of performance-based incentives and ultimately ensure that NGOs see their role as a mission or public duty.

In relation to management and implementation, the public health ministry should develop the necessary regulatory capacity and strengthen supervisory skills at the provincial and facility levels, and should strengthen NGOs’ technical capabilities through training and continuing professional development. The public health ministry should also develop appropriate instruments for monitoring and evaluation as part of the routine information system at various levels.

It is tempting to consider contracting for health services from the private for-profit sector in Afghanistan. The private sector has expanded rapidly in recent years, provides basic health services to a substantial portion of the population and is the main reason behind high out-of-pocket payments that provide up to 65% of the total health budget. On the other hand, the private sector is concentrated in urban areas, is not well organized, is largely unregulated, and provides poor-quality care. Thus it is difficult to recommend large-scale contracting with the private sector. However, a watchful approach could encourage large NGOs to subcontract to the private-for-profit sector to deliver BPHS, and the public health ministry could pursue small-scale contracts with selected private-sector agencies and learn from the evidence that accumulates. This approach should be phased and scaled up only if results are promising.

Another important challenge for the Afghan Government is the recalcitrant problem of high out-of-pocket payments. Patients are being charged fees for services at private health facilities, as well as a user fee at public health facilities, both of which promote inequity in health. In the long term, some form of prepayment system that ranges from increased government allocation and expenditure on health, community financing schemes, limited social health insurance programmes or a combination of these could be helpful. Discontinuing user fees charged at public facilities is neither possible nor realistic at this stage, so the most feasible short-term option is to strictly monitor user fees, retain the funds generated to support salaries and non-salary activities locally, and improve the quality and range of services offered. This option may prevent patients from paying large amounts of money at private health facilities and allow the gov-

ernment to reallocate resources towards preventive and promotive programmes. The major caveat to this option is that it will not protect the poor.

Conclusions

NGOs have contributed to improving access to basic health-care services in Afghanistan. Yet the public health ministry is at a crossroads, having to decide whether to pursue the contracting policy or to increase its role. Given the influence of international donors in the country, it is as much a political as an evidence-based choice. Unless the public health ministry takes a considered decision, further delay will allow contracting to become embedded as the long-term strategy to deliver health services in Afghanistan.

Since contracting-out for basic health services is likely to remain the main mode of service delivery in the

medium term, there is a need to revisit the content of contracts by clarifying the terms of reference and defining measurable outputs while revisiting the cost of the basic benefit package.

In the long term, the public health ministry should evolve strategies to secure greater indigenous resources for the financing of the health sector, develop more balanced human resources and revive the dilapidated health infrastructure. It should also strengthen its governance function at the central and provincial levels, with particular emphasis on standard setting, regulation, contracting and strategic planning and management. These elements are critical, irrespective of whether the public health ministry continues with the policy of contracting or opts for direct provision of essential health services. ■

Competing interests: None declared.

Résumé

Choix d'une option pour assurer durablement des prestations de santé en Afghanistan

La désorganisation provoquée par des décennies de conflits armés et de guerre civile en Afghanistan a conduit de nombreuses organisations non gouvernementales (ONG) internationales et nationales à assumer la délivrance de prestations de santé par le biais de contrats avec les agences donatrices. Récemment, le gouvernement afghan a prolongé cette politique contractuelle par un ensemble de prestations de santé de base, bénéficiant du soutien financier des trois principaux donateurs : la Banque mondiale, l'AID des Etats-Unis d'Amérique (USAID) et la Commission européenne. A mesure que le ministère de la santé publique se renforce, on peut envisager de poursuivre l'option contractuelle ou de développer la prestation de services de santé par le secteur public.

Si l'on continue de passer des contrats avec des ONG, il faudra disposer d'une stratégie claire, prévoyant la mise au point d'instruments d'accréditation, de meilleurs mécanismes contractuels et d'un système de suivi et d'évaluation du processus

dans son ensemble. Si les pouvoirs publics optent pour un accroissement de leur rôle, il faudra assurer la transition vers une délivrance par le secteur public des prestations, obtenir des garanties quant à la disponibilité de fonds suffisants et reconfigurer de manière appropriée le système public de prestations de santé. Nous ne recommandons pas à ce stade de passer de grands contrats à visées lucratives avec le secteur privé, bien qu'il soit possible d'envisager cette option en sous-traitant auprès d'ONG plus importantes ou en passant de petits contrats pilote à l'initiative du ministère de la santé. Quelle que soit l'option choisie, il reste à résoudre le problème épineux du paiement des prestations par l'utilisateur.

La délivrance durable de prestations de santé n'est possible en Afghanistan que si l'on définit une stratégie claire dans laquelle toutes les parties prenantes ont un rôle à jouer dans le financement, la réglementation et la délivrance des prestations.

Resumen

Hacia una prestación sostenible de los servicios de salud en el Afganistán: opciones para el futuro

Las perturbaciones causadas por décadas de guerra y contiendas civiles en el Afganistán han llevado a muchas organizaciones no gubernamentales (ONG) internacionales y nacionales a asumir la responsabilidad de proveer los servicios de salud mediante la concertación de contratos con organismos donantes. Recientemente el Gobierno del Afganistán ha aplicado la política de contratar un paquete básico de servicios de salud con el respaldo de los fondos facilitados por tres importantes donantes, a saber, el Banco Mundial, la Agencia de los Estados Unidos para el Desarrollo Internacional y la Comisión Europea. Con el gradual fortalecimiento del Ministerio de Salud Pública, las opciones con miras al futuro son el mantenimiento de la política

de subcontratación o la ampliación de la prestación pública de servicios de salud. Si se opta por los contratos con ONG, se requiere una estrategia clara que abarque el desarrollo de instrumentos de acreditación, mejores mecanismos de contratación y un sistema de seguimiento y evaluación de todo el proceso. Si el gobierno decide desempeñar un papel más importante, habrá que resolver problemas como la necesidad de asegurar la transición a la prestación pública de servicios, la obtención de garantías de que se contará con la suficiente financiación y la reconfiguración del sistema de prestación de servicios de salud pública. La subcontratación a gran escala con el sector privado con fines de lucro no es una opción recomendable en esta etapa, aunque se

podría explorar esa posibilidad subcontratando servicios a grandes ONG u organizando ensayos a escala reducida desde el Ministerio de Salud Pública. Con independencia de la opción elegida, un problema arduo que se resiste es la elevada cuantía de los pagos directos. Para que la prestación de servicios de salud en el Afganistán

sea sostenible, habrá que adoptar una estrategia nacional clara en la que todos los interesados directos tengan funciones que desempeñar en materia de financiación, reglamentación y prestación de servicios.

ملخص

نحو ضمان استمرار إيتاء الخدمات الصحية في أفغانستان: خيارات للمستقبل

القيام بدور أكبر، فسوف يتعين عليها حل مشكلات مثل تأمين عملية التحول إلى تقديم الخدمات عن طريق القطاع العام، والحصول على ضمانات بتوفير التمويل المناسب، وإعادة تشكيل نظام تقديم خدمات الصحة العمومية. ولا يمكن التوصية في هذه المرحلة بالتعاقد الواسع النطاق مع القطاع الخاص المستهدف للربح، برغم أن هذا الخيار يمكن استكشافه عن طريق التعاقد من الباطن من قِبَل المنظمات غير الحكومية الأكبر حجماً، أو عن طريق العقود التجريبية المحدودة النطاق من قِبَل وزارة الصحة العمومية. وبغض النظر عن الخيار المفضل، لا يزال الإنفاق النقدي المباشر والباhez يمثل مشكلة مستعصية وتحدياً هاماً.

ولن تتحقق استدامة تقديم الخدمات الصحية في أفغانستان ما لم توجد استراتيجية وطنية واضحة تؤدي فيها جميع الأطراف المعنية دوراً في تمويل الخدمات وتنظيمها وتقديمها.

أدى الانهيار الذي خلفته الحروب والصراعات الأهلية، التي امتدت عقوداً في أفغانستان، إلى اضطلاع العديد من المنظمات غير الحكومية الوطنية بمسؤولية تقديم الخدمات الصحية عن طريق التعاقد مع الوكالات المانحة. وقد تبنت الحكومة الأفغانية مؤخراً سياسة التعاقد على تقديم مجموعة من الخدمات الصحية الأساسية بدعم مالي من ثلاث جهات مانحة رئيسية، هي البنك الدولي والوكالة الأمريكية للتنمية الدولية والمفوضية الأوروبية. ومع التقوية التدريجية لدعائم وزارة الصحة العمومية، تُطرح عدة خيارات للمستقبل، تشمل تبني خيار التعاقد أو زيارة تقديم الخدمات الصحية من خلال القطاع العام.

إذا وقع الاختيار على التعاقد مع المنظمات غير الحكومية، فسوف يستلزم الأمر استراتيجية واضحة تشمل إعداد أدوات الاعتماد، وتحسين آليات التعاقد، ونظماً لرصد وتقييم العملية برمتها. أما إذا اختارت الحكومة

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Table 2. Comparison of contractual arrangements and approaches adopted by the three major donors funding basic health services in Afghanistan

| | Ministry of Public Health/World Bank | | USAID | European Commission |
|---|--|---|---|--|
| | Contracting out | Ministry of Public Health Strengthening Mechanism | Contracting out | Contracting out |
| Overall approach | Outsourcing to national and international NGOs | Internal contracts with provincial health directorate of the public health ministry | Outsourcing to national and international NGOs | Outsourcing to national and international NGOs |
| Population covered (million) | 3.6 | 1.1 | 6.7 | 4.0 |
| Provinces and clusters covered | 8 provinces and 7 clusters | 3 provinces and 1 cluster | 13 | 10 |
| Provincial/cluster approach | Mainly province-wide | Mainly province-wide | Cluster approach (covers limited areas in province) | Mainly province-wide |
| Performance incentives | Yes | Yes | No | No |
| Contracting channel | Through the Grants and Contracts Management Unit in the public health ministry | Through the Grants and Contracts Management Unit in the public health ministry | Subcontracted through Management Sciences for Health. Currently, funds are channelled through WHO | Directly contracted with NGOs by the European Commission |
| No. of grant contracts | 15 | 1 | 30 | 13 |
| Contracting focus | Output-based lump-sum service delivery contract | Output-based lump-sum service delivery contract | Input-based grant with robust focus on results | Input-based grant with ideas to phase in elements of performance |
| Grant funds allocated (US\$) | | 47.0 million | 55.0 million | 32.0 million |
| Annual per-capita cost (US\$) | 3.78 | 4.10 | 4.28 | 5.12 |
| Monitoring system | Third-party evaluation by JHUSPH/IIHMR through balance scorecard, nation-wide baseline and follow-up surveys | | Third party evaluation, also developed own tools LQAS, (FFSDP) | By third party, through an external evaluation team |
| Balanced scorecard performance ^a | | | | |
| Year 2004 | 52.3 | 53.7 | 53.4 | 54.2 |
| Year 2005 | 64.4 | 61.8 | 63.6 | 57.7 |

FFSDP, fully functional service delivery point assessment; JHUSPH/IIHMR; John Hopkins University Bloomberg School of Public Health and Indian Institute of Health Management and Research; LQAS, lot quality assurance sampling assessment; NGO, nongovernmental organization; USAID, United States Agency for International Development.

^a Source: Afghanistan Health Sector Balanced Scorecard Assessment, Ministry of Public Health, JHUSPH and IIHMR scored performance of all donor contracts.