

Contracting with NGOs in Afghanistan

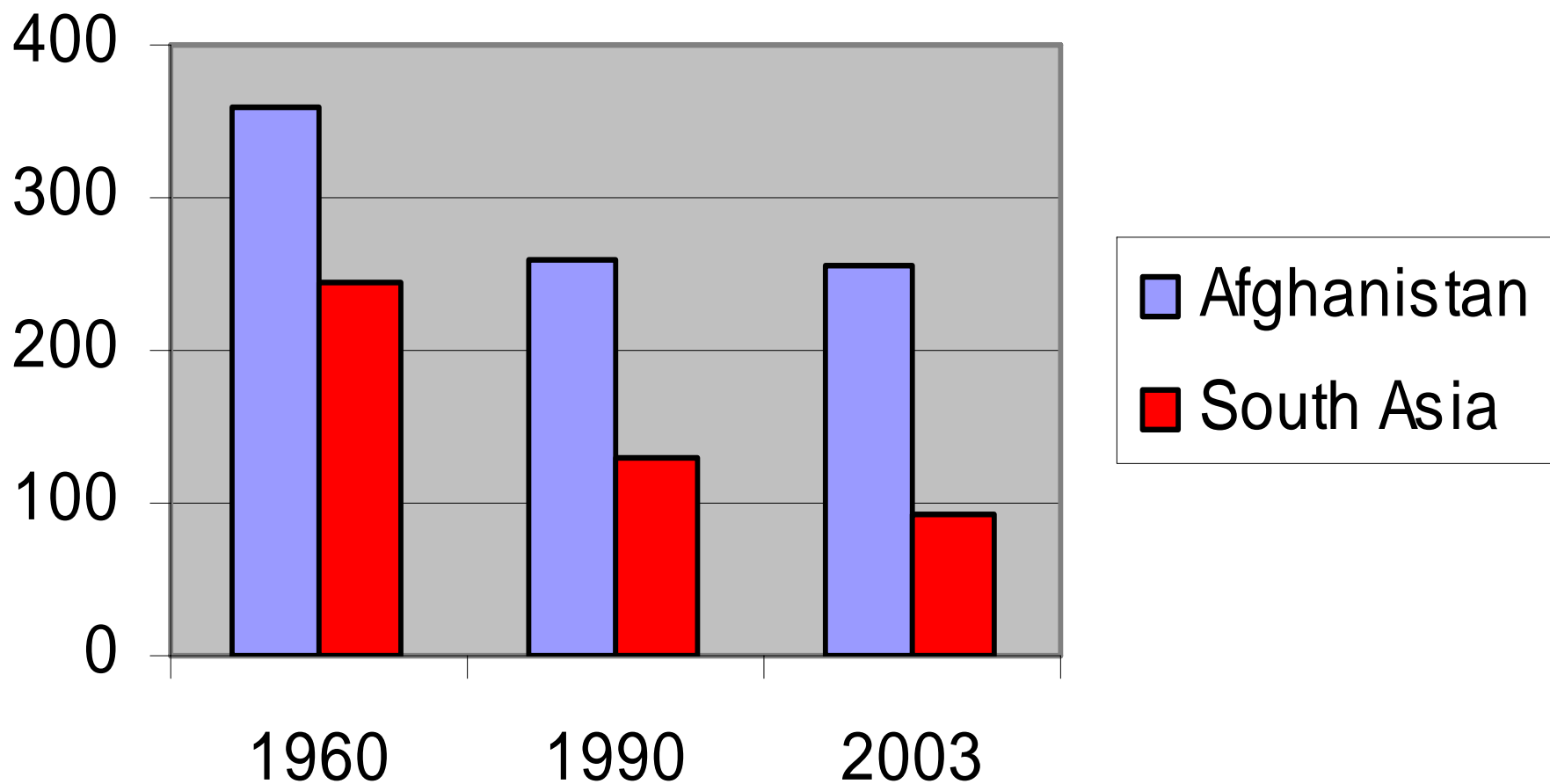
**Initial Results and Implications for
other Post-Conflict Settings**

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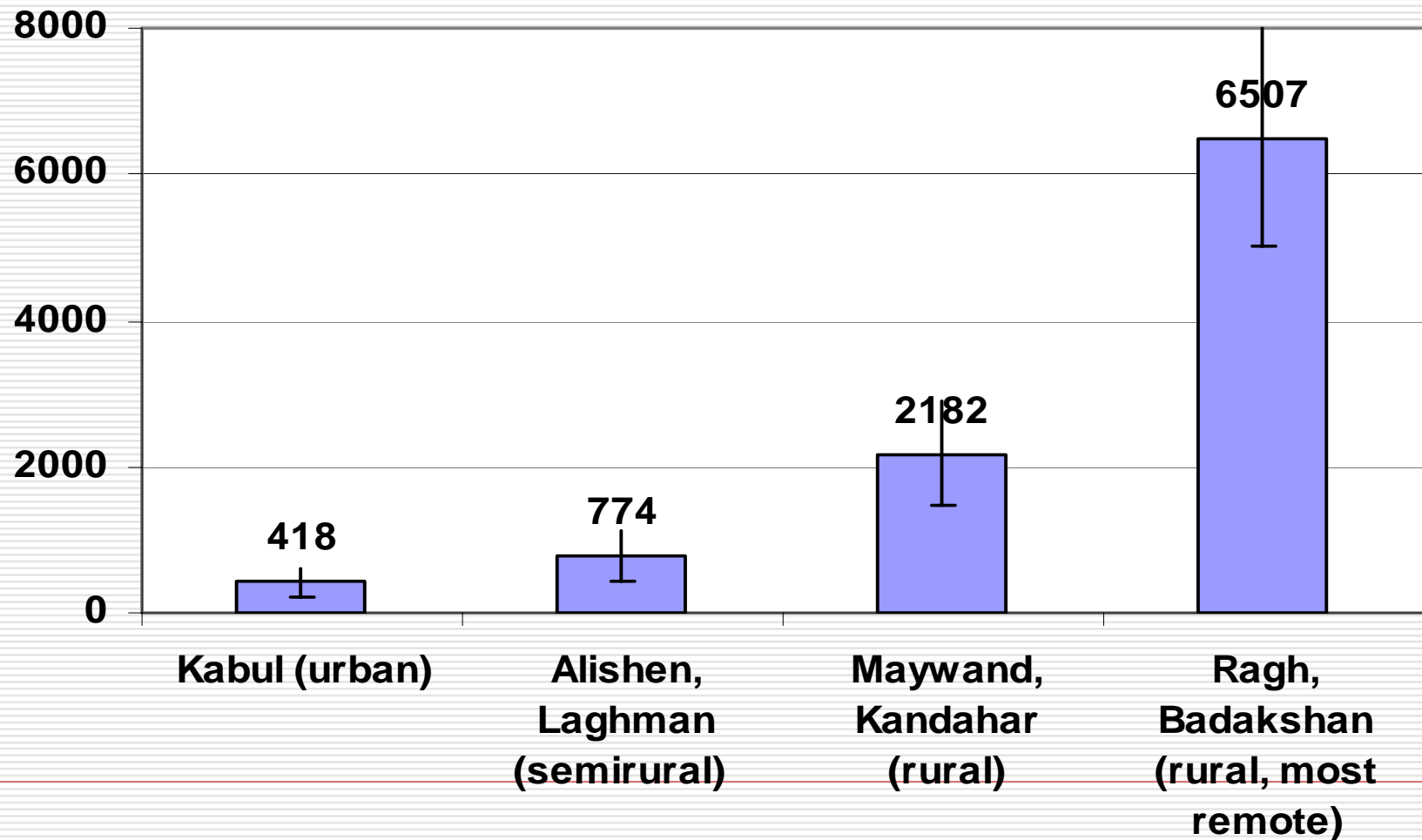
Afghanistan's recent history

- ❑ '79-'89: Russian war
 - ❑ '92: Civil war
 - ❑ '94-2001: Taliban regime
 - ❑ 2001: US, Allied, Northern Alliance unseat Taliban
 - ❑ 2001: Bonn conference
 - ❑ 2003: Health project approved (June)
 - ❑ 2004-2005: New constitution, Presidential elections,
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Afghanistan had high U5MR in 1960 and remains decades behind other countries



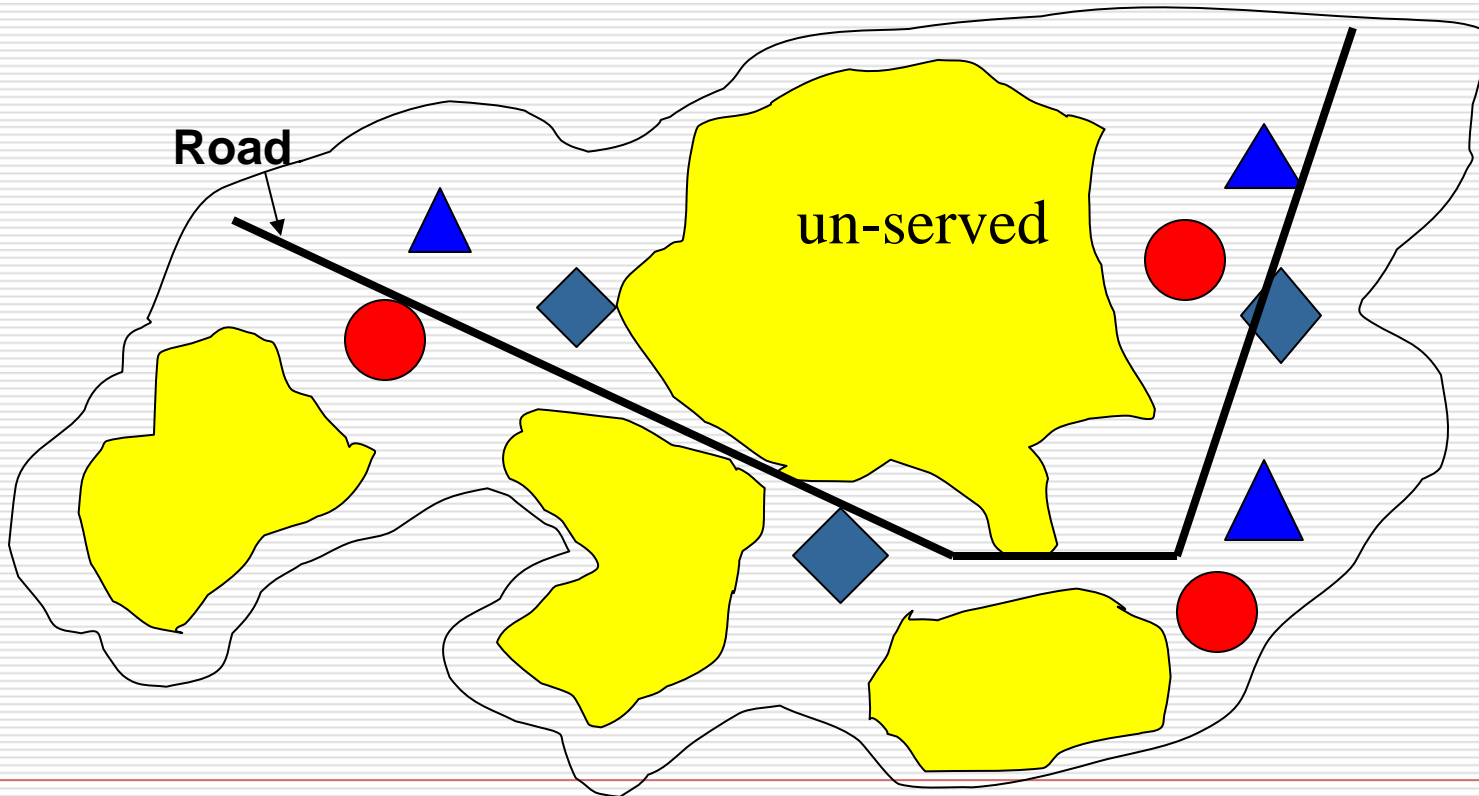
Inequalities are very serious, MMR much worse in rural and remote areas



2002-Reasons to Worry

- ❑ Very poor country
 - ❑ Little physical infrastructure
 - ❑ Health workers afflicted by the “3 wrongs” (i) wrong gender; (ii) wrong skills; (iii) wrong location
 - ❑ >80% of PHC services provided by NGOs
 - ❑ > 65 NGOs but little coordination
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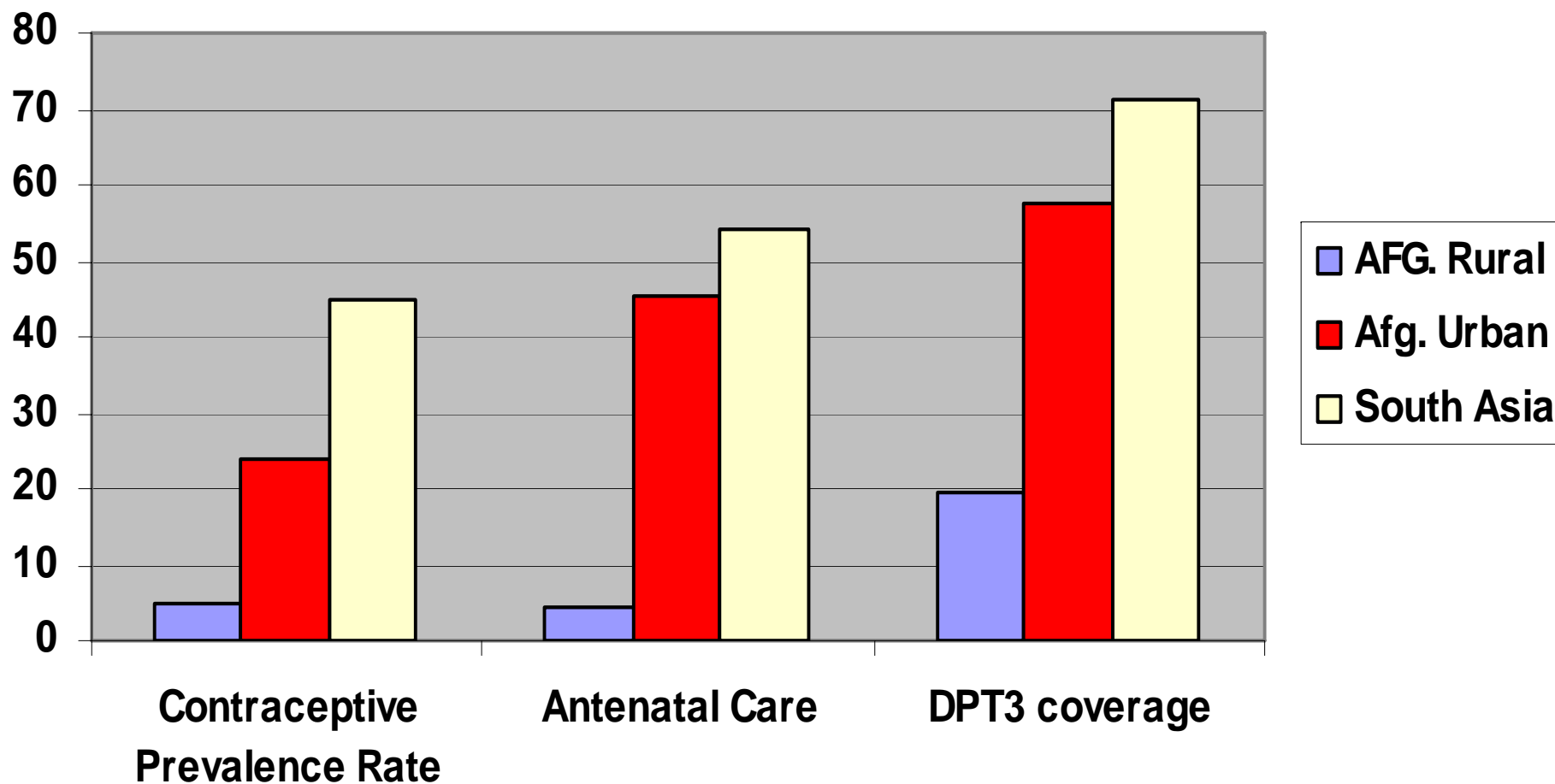
Distribution of NGO Health Centers was Chaotic



Results of the Chaos

- Obvious inefficiencies:
 - Lack of clinics in under-served, remote areas and duplication of effort in some areas
 - Difficult to hold anybody accountable, no clear catchment areas
 - Focus on clinics rather than the community
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Results of the Chaos Indicators from MICS 2003



Approaches to Working with NGOs – WB Financed

- MOPH recognized the advantage of contracting with NGOs – wanted to steward the sector & recognized own limitations
 - MOPH signed performance-based partnership agreements (PPAs) with NGOs
 - Competitively selected NGOs (QCBS)
 - Clear objectives and 10 indicators
 - Performance bonuses worth 10% of contract
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Approaches to Strengthening MOPH – WB Financing

- Established MOPH-Strengthening Mechanism (MOPH-SM)
 - Envelope budget spent through GOA system
 - Slightly higher than NGO budgets
 - Procurement done by agent of GOA
 - Able to pay salaries similar to NGOs
 - Recruited local consultants to work with MOPH Provincial Health Directors
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Changing Design of the Experiment

- Initially 10 provinces were to be randomly allocated to PPAs or MOPH-SM
 - MOPH concerned it was too much so became 7 PPAs, 3 MOPH-SM
 - Concerned about financial management wanted all 10 provinces → PPAs
 - Finally decided to implement MOPH-SM in 3 provinces near Kabul
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Approaches to Working with NGOs - USAID

- USAID \$60M+ program of grants to NGOs in 13 provinces
 - Administered by MSH
 - Modest involvement of MOPH
 - Cost about \$21M to administer
 - Started with small grants where NGOs decided where they would work
 - Evolved to larger grants with pre-determined catchment areas
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Approaches to Working with NGOs and MOPH - EC

- EC gave grants to NGOs
 - administered by EC, modest involvement of MOPH
 - Not performance-based, NGOs contributed 10-20% of costs
 - Whole provinces or clusters of districts
 - No clear indicators, little monitoring
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The Overall “Experimental Design”

- ❑ 8 Provinces with PPAs
 - ❑ 3 Provinces with MOPH-SM
 - ❑ Most of 13 provinces covered by USAID grants, but some gaps
 - ❑ Most of 10 provinces covered by EC grants
 - ❑ Gaps = status quo antes with external and MOPH financing
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Quality of Care - Health Facility Assessment

- ❑ JHU competitively selected and contracted by MOPH as independent evaluator
 - ❑ Worked extensively with stakeholders to develop a health facility assessment
 - ❑ Carried out annually country-wide, every 6 months in WB and EC financed provinces
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Quality of Care - Health Facility Assessment

- ❑ Formulated a “balanced score-card” (BSC) that rated facilities on a scale of 0-100
 - ❑ BSC looked at 27 areas of care including: patient satisfaction; availability of drugs, equipment, & staff; knowledge of providers; quality of patient-provider interaction, patient load
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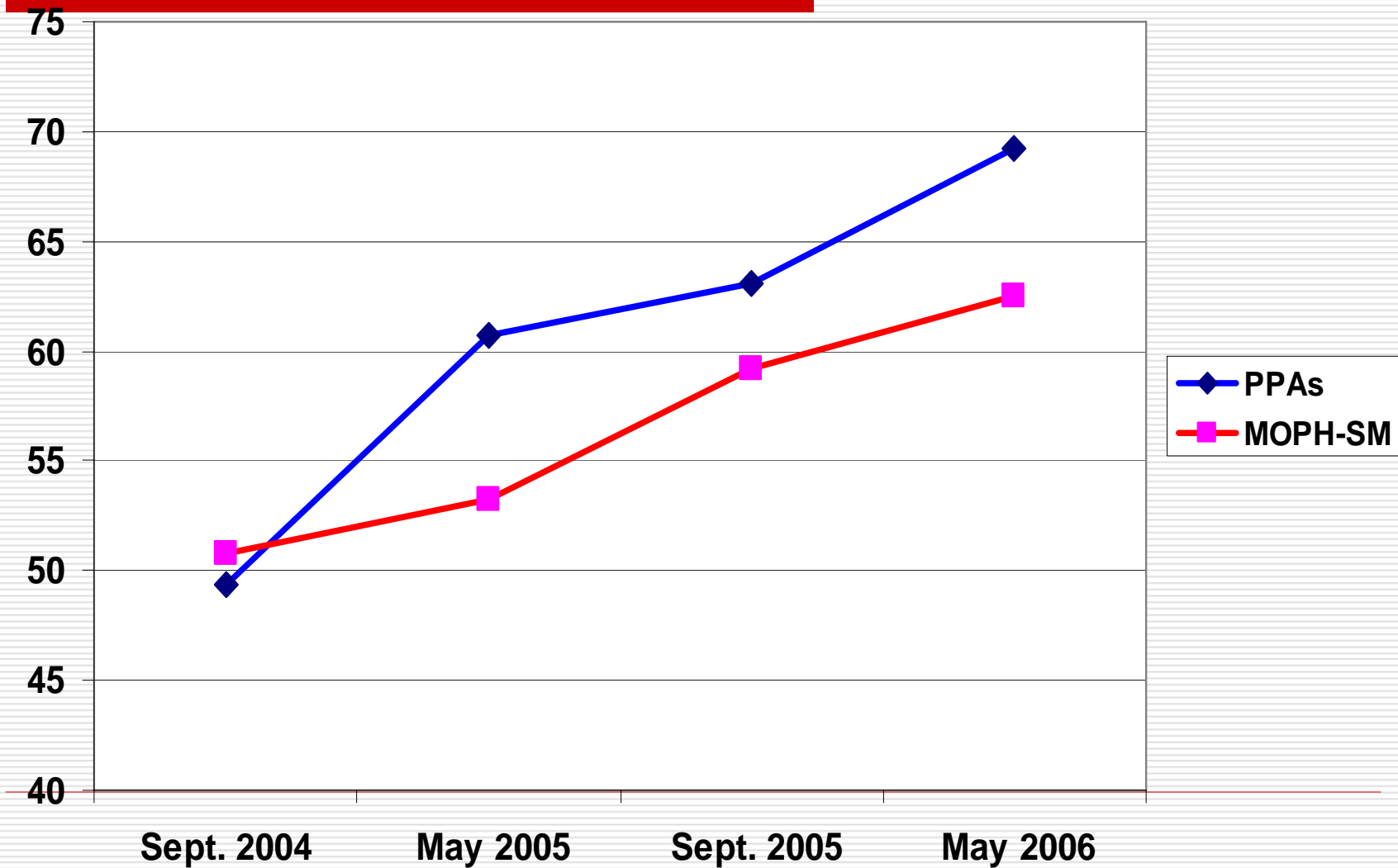
Household Surveys

- ❑ MICS in 2003 provides provincial level estimates of services, ?non-sampling errors, mortality data not credible
 - ❑ Ongoing HHS by JHU will provide results by contracting type comparable to the MICS 2003
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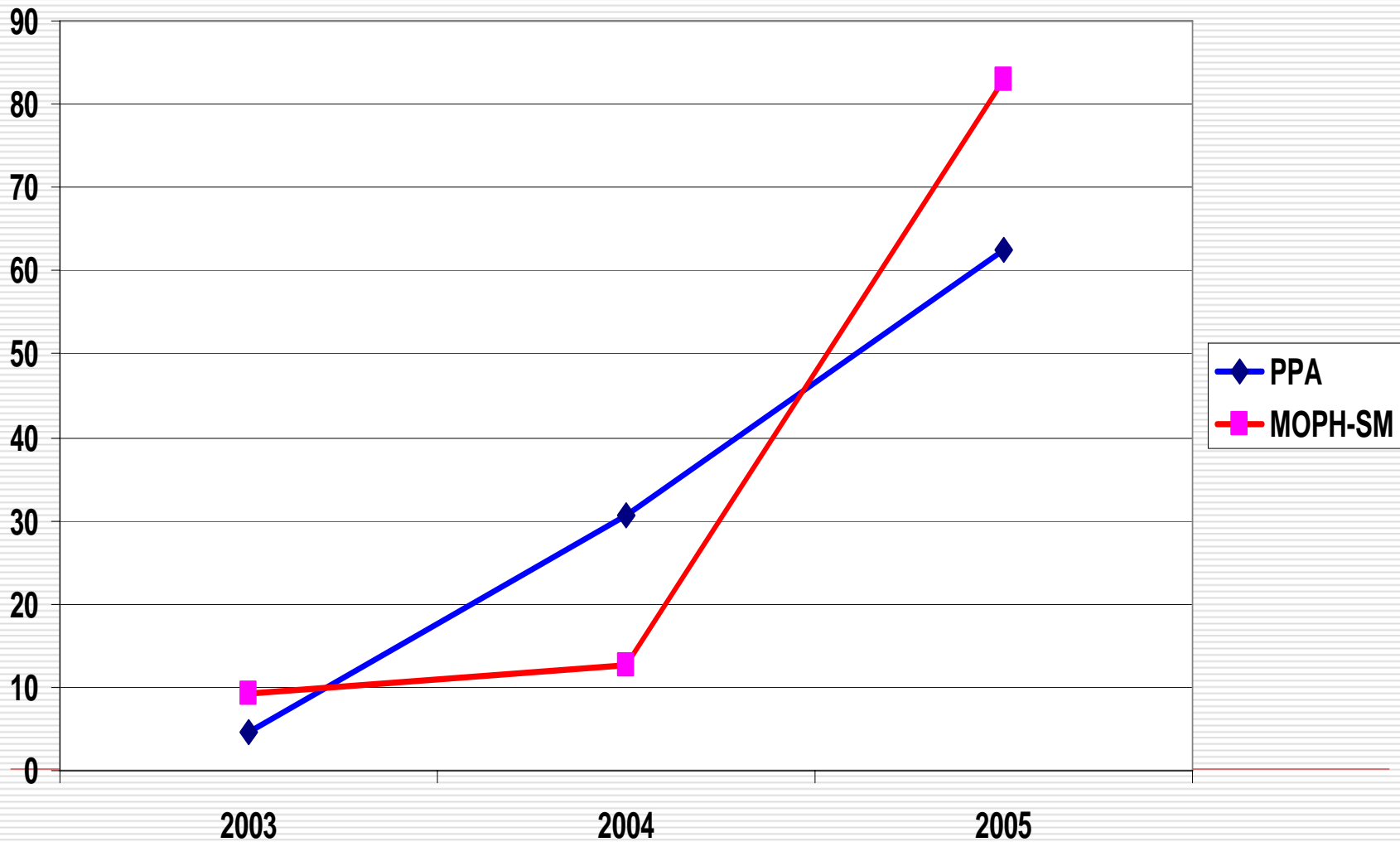
Measuring Performance of the Different Models

- BSC baseline in mid-2004, follow-up every year
 - HHS: MICS 2003, JHU 2006
 - HMIS: Ongoing
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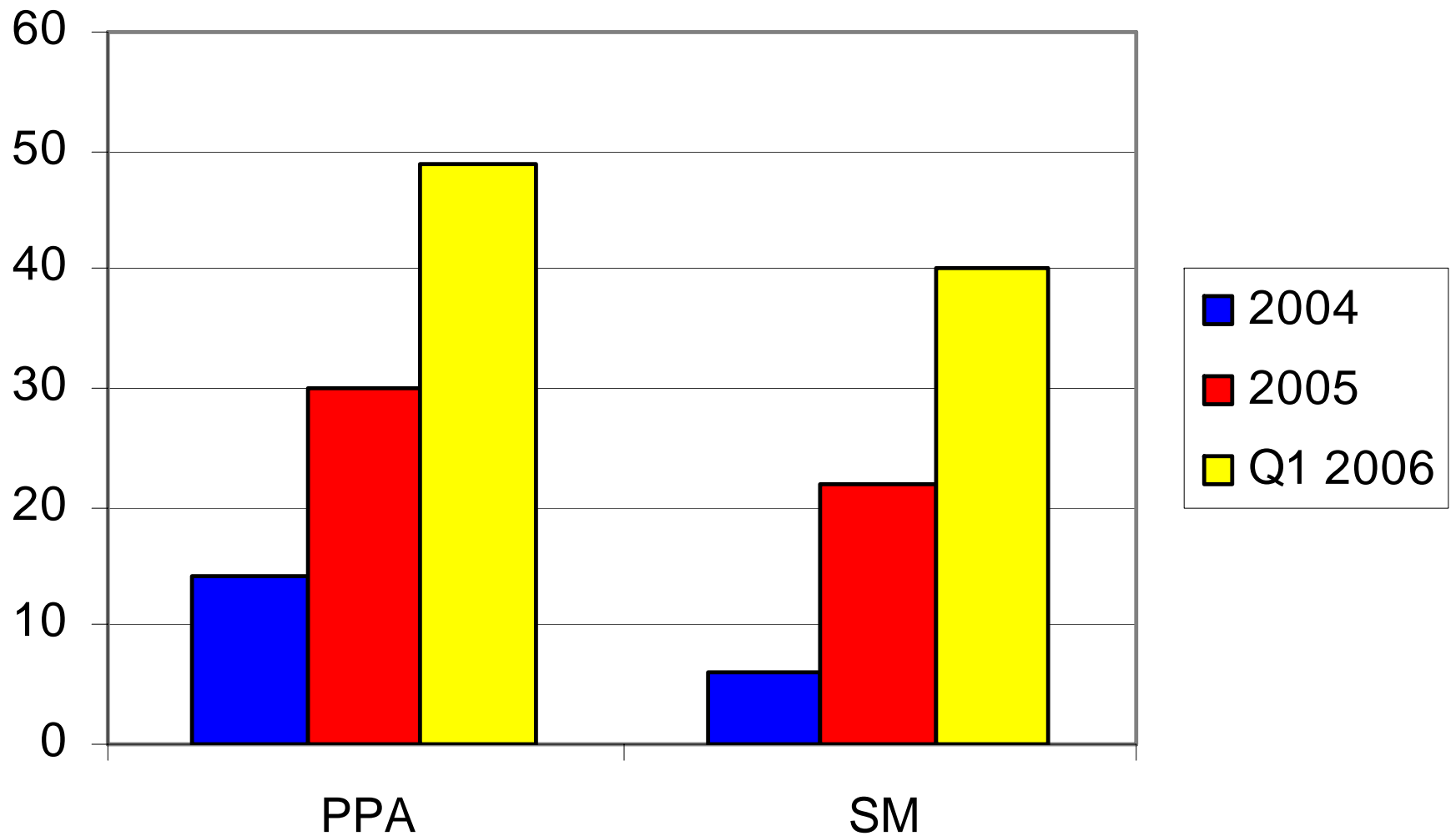
BSC Scores in PPA and MOPH-SM Provinces



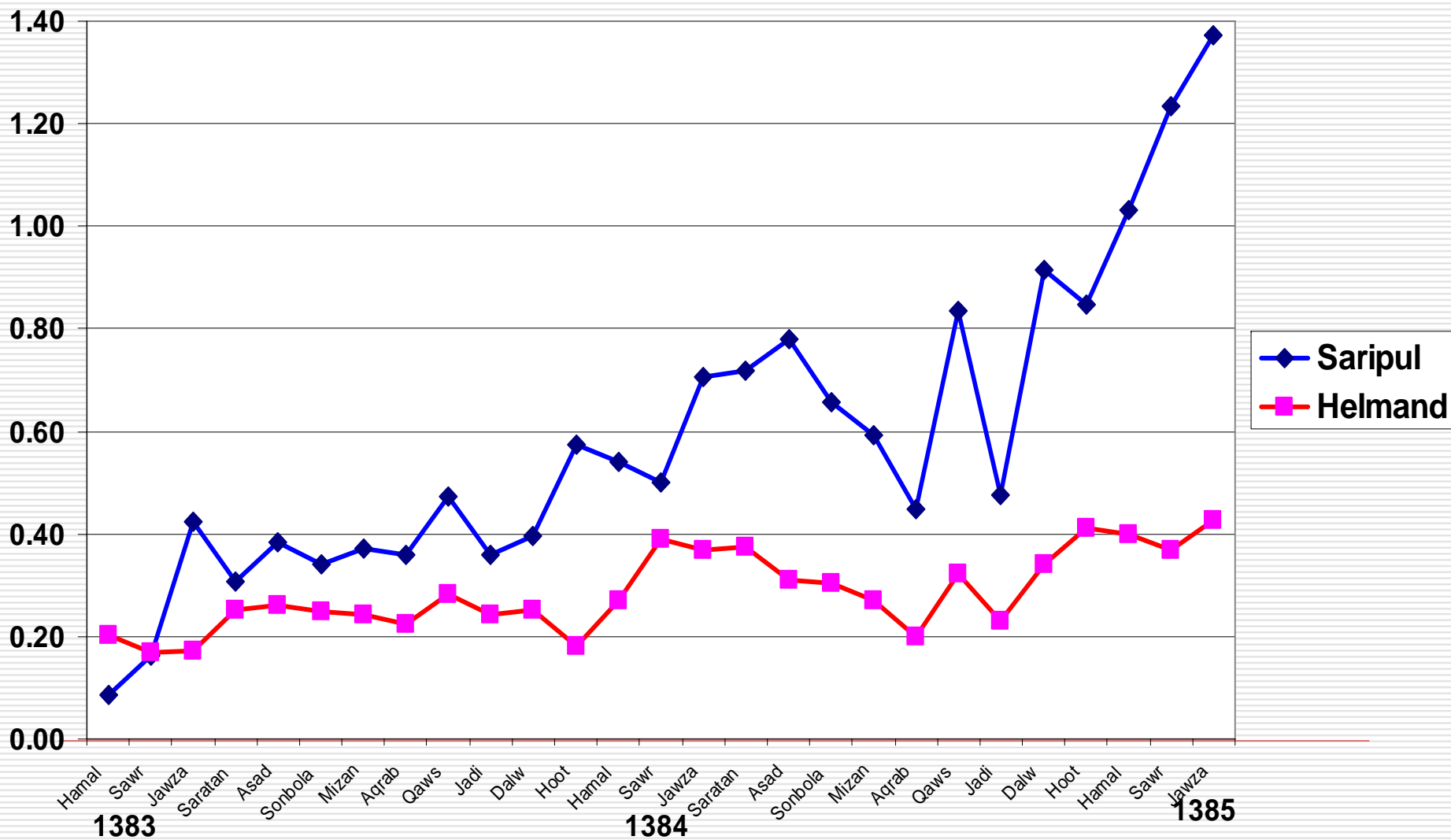
Antenatal Care Coverage – MICS (2003) and HMIS



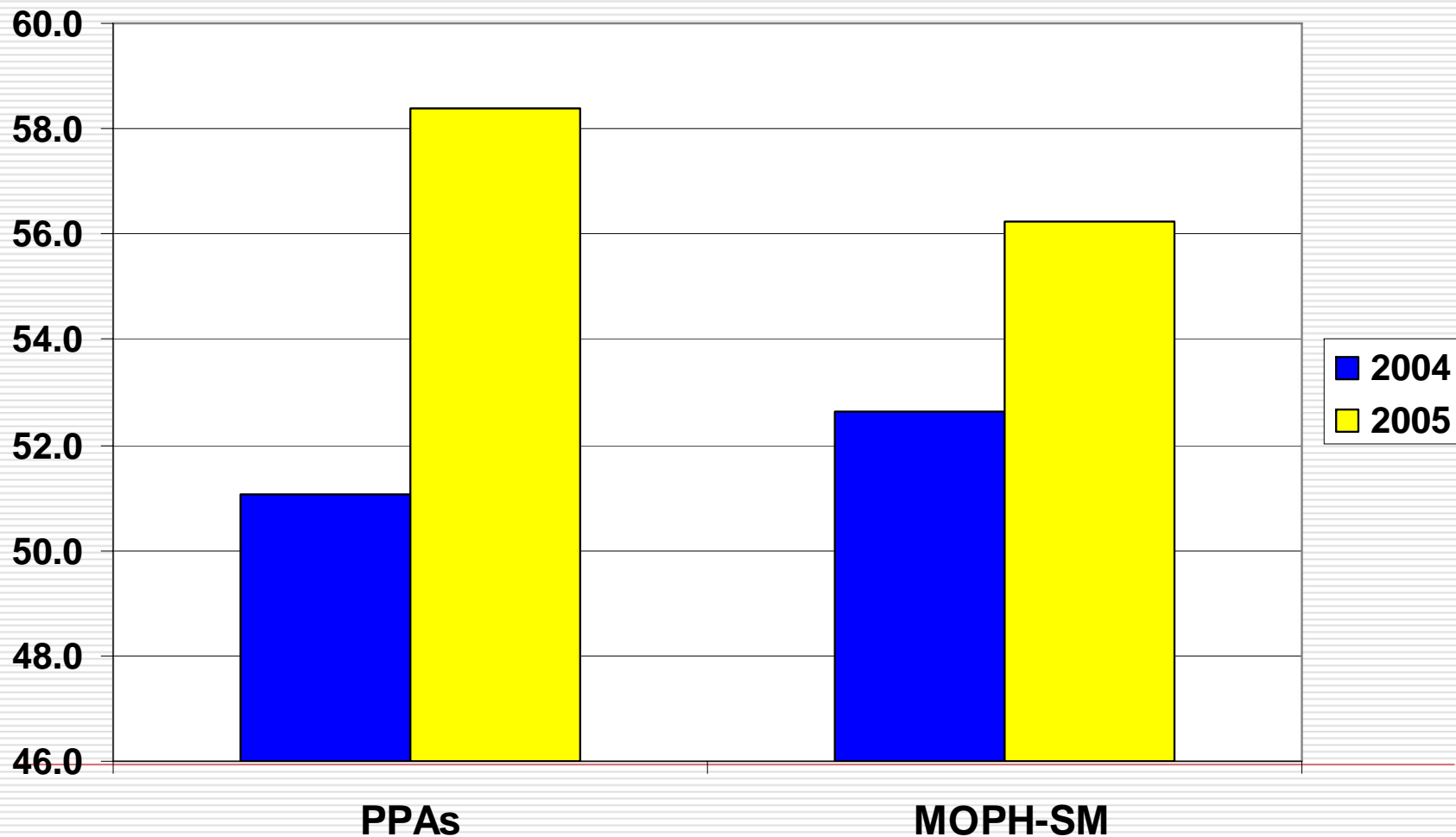
TB Case Detection Rates (%) in PPA & MOPH-SM Provinces



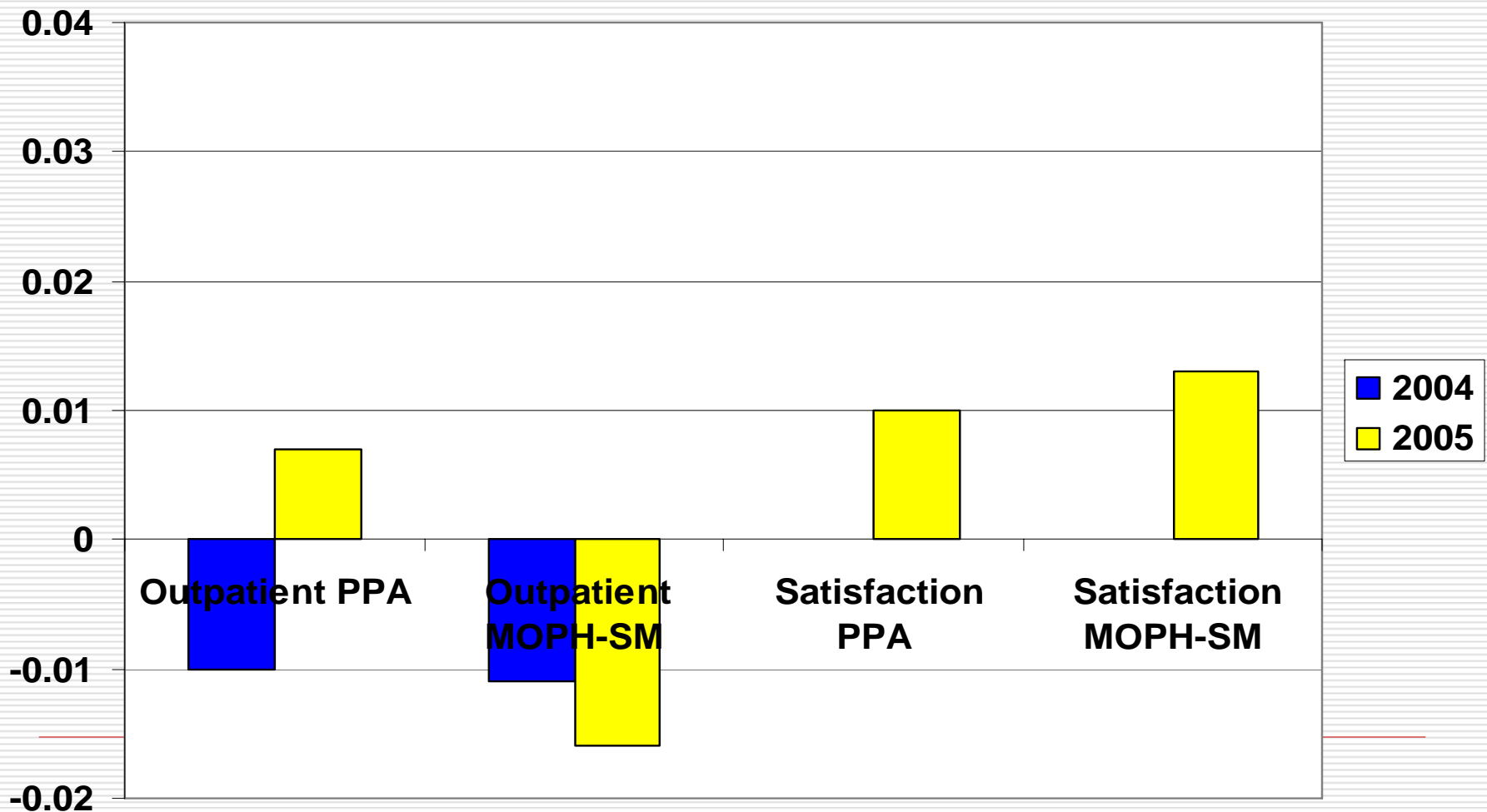
Outpatient Visits Per Capita Per Year in a Secure and Insecure Province



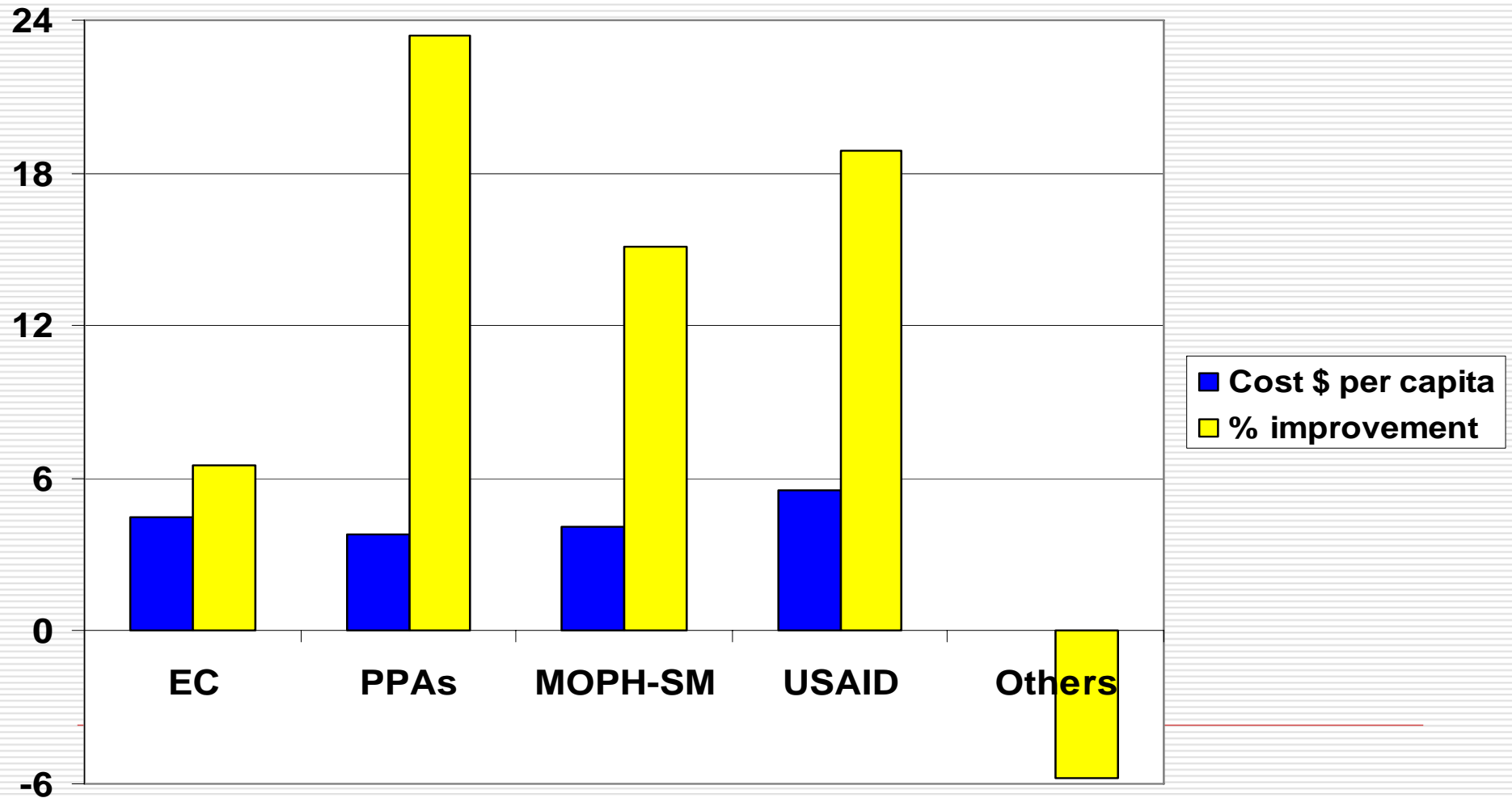
Females as % of new outpatients 2004 and 2005



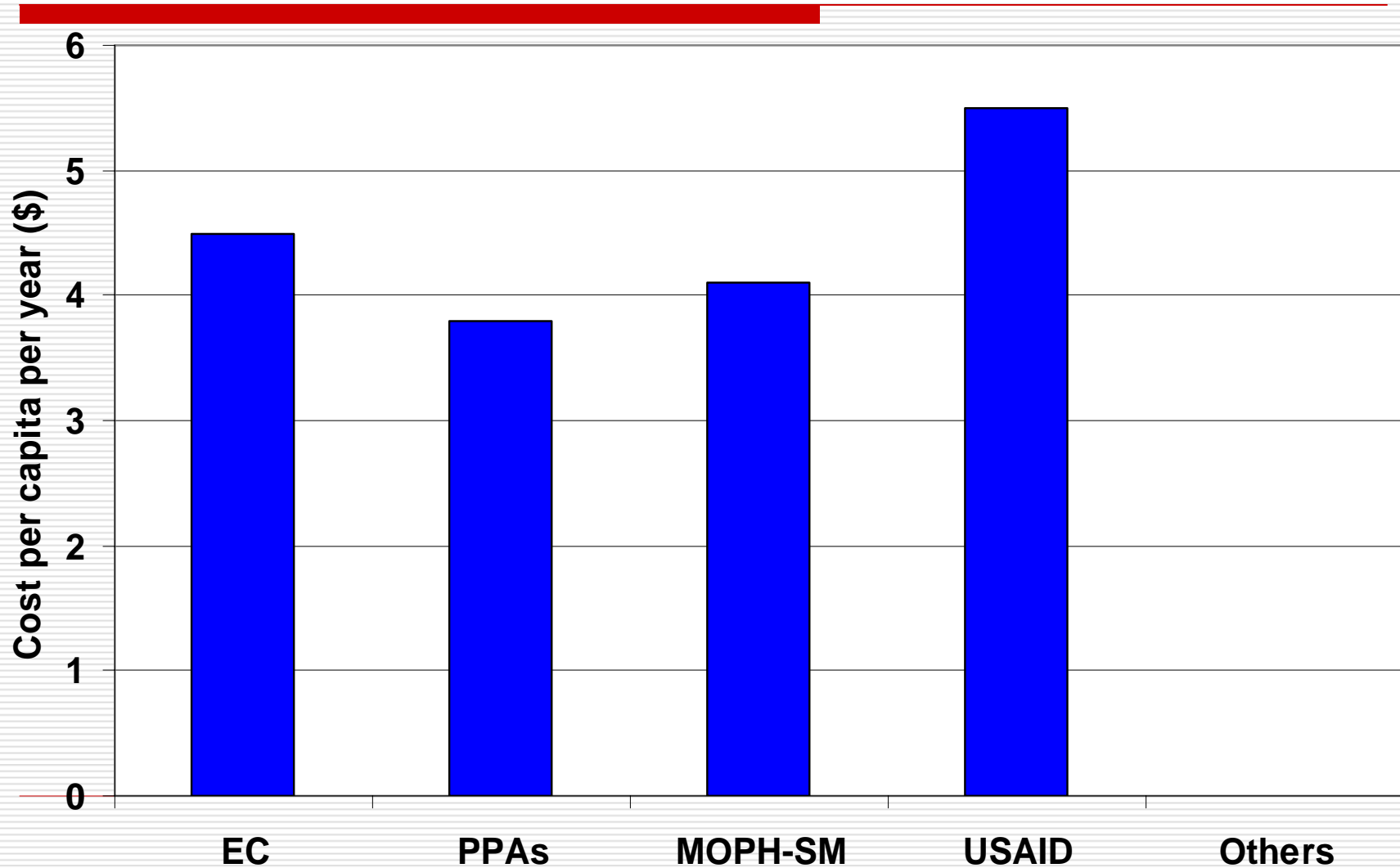
Concentration Indices for Outpatient Visits & Patient Satisfaction



Change in BSC score (%) 2005 – 2004, Cost per capita per year



Cost per capita per year (\$) 2004-2006



Summary of Initial Lessons Learned in Afghanistan

- ❑ On average using NGOs **on contract** leads to large and rapid improvements in health services
 - ❑ Serious progress can be achieved at **reasonable cost**
 - ❑ **Monitoring and evaluation** of performance is possible and of huge importance
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Summary of Initial Lessons Learned

- Just using lots of NGOs alone is not enough:
 - Need to have **contracts** with clear package of services and catchment area
 - Contracts need to have **clear objectives**, need to be carefully monitored
 - Need to do it on a **large scale** = resources
 - Clear **stewardship** role for Government, coordination, strategy, and contracting
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Summary of Initial Lessons Learned

- ❑ MOPH-SM is doing slightly less well than PPAs, less flexibility
 - ❑ There may be an effect of competition among providers
 - ❑ “Others” are the worst off, the status quo antes is not an option
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Sustainability and Replicability of Contracting with NGOs

- Providing PHC costs about \$4 per capita per year in low income countries
 - Community doesn't much care who is delivering services – they want services
 - The biggest threat to using NGOs are:
 - politicians want jobs for supporters
 - control – MOH officials want the power
 - overcoming resistance to a new way of working
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THANK YOU!

