Building a State or Saving Lives? The Processes, Motives and Politics behind the Reconstruction of Afghanistan’s Health System

by

Melody Esther Tulier

A.B. Growth and Structure of Cities
Bryn Mawr College, 2002

Submitted to the Department of Urban Studies & Planning in partial fulfillment of the requirements for the degree of

Master in City Planning
at the Massachusetts Institute of Technology

February 2005

© 2005 Melody Esther Tulier. All rights reserved.

The author hereby grants to MIT permission to reproduce and to distribute publicly paper and electronic copies of this thesis document in whole or in part.

Signature of Author: ________________________________

Department of Urban Studies & Planning
January 14, 2005

Certified by: ________________________________

Diane E. Davis
Professor and Associate Dean
School of Architecture and Urban Planning
Associate Thesis Advisor

Accepted by: ________________________________

Dennis Frenchman
Professor of the Practice of Urban Design
Chair, Master in City Planning Program
THE PROCESSES, POLITICS, AND STRATEGIES FOR THE RECONSTRUCTION OF AFGHANISTAN’S HEALTH SYSTEM

by

Melody Esther Tulier

Submitted to the Department of Urban Studies & Planning on January 14, 2005, in partial fulfillment of the requirements for the degree of Master in City Planning.

ABSTRACT

Startlingly poor health statistics in Afghanistan clearly indicate that, in order to enhance the socio-economic status and overall stability of the state, a complete overhaul of its health care system is imperative. However, providing health is not simply a technical endeavor involving the construction of clinics, the training of doctors, and adequate medical supplies, for instance. In the stage of policy formulation for the reconstruction of Afghanistan’s health system, there was in fact a dynamic, political process.

The specific form of health reconstruction being implemented in Afghanistan was a result of a global consensus regarding the importance of health and general best-practice methods for health reform, external pressure to act quickly, power dynamics, and differing priorities of participating actors. The decisions and the resulting nuances of the plan conceived during this period also have broader implications regarding how and if long-term goals of development for Afghanistan, such as state building, could be reinforced or neglected.

Development aid that overtly includes long-term state building goals seems like a plausible and possibly even more appealing solution than the current plan that concentrates on quick, high-impact health results. However, in a post-conflict state where the weakness of the state primarily characterizes the political context, should state building be a primary goal? Where does state building fit into the world of humanitarian aid and development policy? What do the nuances within the health policy being examined imply for state building efforts in Afghanistan? While there are not any straightforward answers to these questions, it is necessary that planners, health policy makers, and those working in international development are cognizant of the trade-offs of policy decisions, most particularly in post-conflict countries.

Keywords: Afghanistan, health care reform, state building, politics of health policy, post-conflict, reconstruction

Thesis Advisor: Diane E. Davis
Title: Professor and Associate Dean
School of Architecture and Urban Planning Associate
ACKNOWLEDGEMENTS

I would like to thank my family for their unconditional support and love. Also, I am grateful for the opportunity to work in Afghanistan during the summer of 2003. It not only shaped this thesis and altered my focus of study to Afghanistan but also invigorated my passion for working with women and children.
### TABLE OF CONTENTS

**Chapter 1: Introduction** .............................................................................. 1
1.1 Problem to be studied and major research questions
1.2 Significance of the problem and justification for investigation
1.3 Review of the Literature
1.4 Methodology

**Chapter 2: The Context of Afghanistan** ............................................................ 11
2.1 Political and Social History
2.2 Government Goals Leading to Reconstruction
2.3 Prior Health Initiatives in Afghanistan and the Current State of Public Health
2.4 The Present Initiative: The Basic Package of Health Services

**Chapter 3: The Ebbs and Flows of International Health Reform** ...................... 43
3.1 The Global Policy Aid Context
3.2 Donors and Changing Roles
3.3 Policy Transfer of Health Reform: The Seeds for Afghanistan’s Health Care Package

**Chapter 4: Beyond the Global Context: Actors and Motives that Shaped Afghanistan’s Health Reform and Implications** ................................. 60
4.1 The Process of Reform: External Actors
4.2 The Role of the State
4.3 The Logic Behind Geographic and Service Provision Variations
4.4 Conclusions Regarding Potential Implications of Afghanistan’s Health Reconstruction Process
4.1.1 Health Reconstruction and State Building
LIST OF TABLES AND FIGURES

Table 1: Post and In-Conflict Countries as of 2002.............................................6
Table 2: Priorities of the National Development Framework..................................19
Table 3: Ownership and Support of Health Facilities..............................................25
Table 4: Components of Health Sector Reform Programs......................................47
Table 5: Performance of NGOs by Area..............................................................55
Table 6: Geographic and Service Variations by Actor............................................66

Figure 1: Map of Afghanistan Showing Major Ethnic Groups and Areas of Control of Some Key Warlords.................................................................12
Figure 2: Ethnic Groups in Afghanistan...............................................................13
Figure 3: District Population Per Health Facility..................................................24
Figure 4: Afghanistan: Population Density 2002..................................................25
Figure 5: BPHS Implementation Map.................................................................38
Chapter 1: Introduction

The following startling figures have emerged within the development community as the primary rationale for reconstructing Afghanistan’s health system. In Afghanistan, over a quarter of every 1,000 children (257) will not survive to their fifth birthday. An estimated 85,000 Afghan children die each year from diarrheal disease. Approximately 10% of Afghan children are acutely malnourished and 50% are chronically malnourished. Afghanistan has the second highest maternal mortality rate in the world. It is estimated that 45 women die of pregnancy-related causes each day. Only 35% of districts have any maternal and child health services and the country has only 30% of the total birth attendants that it actually needs (Transitional Islamic Government of Afghanistan 2002).

Human resources are vastly inadequate and poorly distributed for a population that is expected to grow from 25 million to 35 million in 10 years. There are roughly 2 physicians for every 10,000 Afghan people and about 35% of all doctors are located in Kabul where only 7% of the population lives. In other words, there is one physician for every 1,700 people in Kabul while there is one physician for every 450,000 people in the rest of the country (Transitional Islamic Government of Afghanistan 2002).

The above commonly cited statistics make it excruciatingly clear that Afghanistan is in dire need of a complete overhaul of its health care system. When attempting to reconstruct the social, political and economic life of Afghanistan after twenty-five years of turmoil, adequate health services is fundamental. However providing health is not simply a technical endeavor involving the construction of clinics, the training of doctors, and adequate medical supplies, for instance. There is in fact a dynamic process of strategizing, negotiating, and implementing an approach for the reconstructing Afghanistan’s health system that is dictated by actors, politics,
and agendas of those both within the country of Afghanistan and globally. These impact the priorities, the kind of policies implemented, and, in the long-term, the overall success and capacity of actors to overcome health needs, build a sustainable health system, and work toward a solid Afghan state.

Machiavelli noted, “There is nothing more difficult to plan, more doubtful of success, nor more dangerous to manage than the creation of a new order of things” (1513 trans. 1950). Who is creating this new order of things for the State of Afghanistan and its health care system? International aid donors undoubtedly play a critical role in shaping the agenda of health care reform, the policy process, and outcome. According to one public health researcher, donors’ contributions account for perhaps 3% of total health expenditure in developing countries, but influence policy and steer the spending of the remaining 97% (Michaud and Murray 1994). In fact, according to Michael Reich, “international agencies have transformed themselves from agents into principals. Rather than serving as the agents of their member-states, international agencies have become independent actors that shape the structures and policies of states” (2002). Given their influence, changing role, and increasing power, how do aid donors decide what kinds of policies, programs, priorities, players and roles of stakeholders are required in a post-conflict country such as Afghanistan in order to reconstruct is health system? This is particularly important because while in the past central governments have taken the lead in providing basic services to their citizens, in a post-conflict country such as Afghanistan, an overall lack of government authority and security by default gives greater importance to external actors.
1.1 Problem to be studied and major research questions

In an effort to establish a sound, sustainable governance structure along with poverty alleviation, USAID, the World Bank, the European Commission, and the Asian Development Bank have joined together to fund a massive re-construction of Afghanistan’s health system. For the first time in history, contracts are being utilized as a tool for the re-establishment of a public health system. As demonstrated in the case of Afghanistan, USAID and the World Bank are requesting proposals from national and international NGOs and consulting firms to provide health care to each province of Afghanistan’s 25 million citizens. After the end of the three-year contract period, it has yet to be decided whether the Ministry of Health, NGOs, international donors, or a combination of these sources will resume responsibility for the health system.

The process for deciding who is awarded the contract is based on the private sector’s fundamental practice of relying on competition. International or local NGOs, or consulting firms in partnership with local NGOs, can submit a proposal. The Ministry of Health, which is staffed with both Afghan nationals and consultants from international multilateral and bilateral aid organizations, judges the proposals on their technical and financial feasibility as well as the experience of the bidding form or NGO in health provision. NGOs are then selected by aid donors and representatives from the Afghanistan Ministry of Health to provide services for three years.

This thesis will not focus on the advantages and disadvantages of rehabilitating Afghanistan’s health system via contracts but instead will focus on the two following questions: 1) Why has health reconstruction in Afghanistan resulted in a performance-based, contract driven process? and 2) Given the correlation between the economically under-development of a state and its propensity to conflict, and the subsequent importance of state-building in post-
conflict countries such as Afghanistan, what are the broader implications of the health reform decisions on long-term goals, such as state-building?

1.2 Significance of the problem and justification for investigation

The importance for planners of this case is three-fold. First, while other developed and developing countries have instituted health care reforms via contracts, the nation-wide scale for rebuilding a country’s public health system that is occurring in Afghanistan has never been attempted through the use of contracts. Planners, who have historically addressed issues of local municipal-level planning, are now being asked to respond to challenges at various scales, including national development schemes. It is thus important to understand how national policies develop and what elements influence the policy and success of large-scale projects.

Second, there is a need for research regarding the provision of services in war-torn and unstable countries, especially when the number of states in conflict are on the rise. Information about how services are provided and the impacts of different approaches are important for the implementation of programs and projects that are successful and sustainable. Projects to alleviate poverty must be formulated in a way to distribute resources equitably, thus decreasing intra-urban and rural-urban social and economic divisions. The increase in conflict and post-conflict countries and the importance of equity in these situations indicates that planners must learn how to think critically about the planning of social services and the way in which they affect the health, wealth, and the security of the population.

Third, donors are more likely to transplant ‘best-practices’ than to think of long-term institution-building with the help of local governments. How should planners mediate between short-term high-impact projects and longer-term goals, such as sustainability and state-building?
Should these long-term goals be considered within social service reconstruction efforts? If not, what are the implications? While this thesis does not seek to answer these questions, working in post-conflict countries requires at least an awareness of the long-term consequences of choices made early on in the reconstruction process.

1.3 Review of the Literature

Currently, there is an abundance of countries that are struggling to stabilize after emerging from conflict and, there are numerous countries experiencing violence and conflict (also called political emergencies in this text) (Table 1). While one can argue over the differences of states and levels of conflict across countries, two points are unambiguous: 1) there are a startling number of post-conflict (which are likely to revert to high conflict) and conflict situations worldwide; and, 2) the majority of post-conflict and complex emergencies are located in less developed countries with extremely limited financial, social and political resources. The international aid system, to be sure, is ill prepared to deal with the nature of these conflicts, as a demise of the state and the ruin of social, economic and political infrastructure creates a very thorny, high-stakes task for external actors with little experience in this new wave of international development.
Table 1: Post and In-Conflict Countries as of 2002

<table>
<thead>
<tr>
<th>Africa (1)</th>
<th>Africa (2)</th>
<th>Europe</th>
<th>America</th>
<th>Middle East</th>
<th>Asia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola+</td>
<td>Mali+</td>
<td>Armenia+</td>
<td>Columbia*</td>
<td>Algeria+/+</td>
<td>Afghanistan+</td>
</tr>
<tr>
<td>Burundi*</td>
<td>Mozambique+</td>
<td>Azerbaijan+</td>
<td>El Salvador+</td>
<td>Lebanon+</td>
<td>Cambodia+</td>
</tr>
<tr>
<td>C.A. Republic+</td>
<td>Namibia+</td>
<td>Bosnia+</td>
<td>Guatemala+</td>
<td>West Bank*</td>
<td>DPR Korea*</td>
</tr>
<tr>
<td>Chad+</td>
<td>Niger+</td>
<td>Croatia+</td>
<td>Haiti*/+</td>
<td>Yemen+</td>
<td>East Timor+</td>
</tr>
<tr>
<td>D.R. Congo+</td>
<td>Rwanda+</td>
<td>Georgia+</td>
<td>Nicaragua+</td>
<td>Iraq+</td>
<td>Indonesia*</td>
</tr>
<tr>
<td>Djibouti+</td>
<td>Sierra Leone+</td>
<td>Former Yugoslav</td>
<td>Peru+</td>
<td>Sri Lanka*</td>
<td>Tajikistan*</td>
</tr>
<tr>
<td>Eritrea+</td>
<td>Somalia*</td>
<td>Republic of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethiopia+</td>
<td>South Africa+</td>
<td>Macedonia and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guinea Bissau+</td>
<td>Sudan*</td>
<td>Kosovo+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liberia*</td>
<td>Uganda+</td>
<td>Former Yugoslav</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Republic +</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Russian Federation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>of Chechnya*</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

+ Countries emerging from conflict (post-conflict) * Countries experiencing violence and conflict

Source: Sondorp and Bornemisza 2002.

More specifically, during the Cold War, political emergencies began as ideologically motivated nationalist and revolutionary struggles, as seen in countries such as Angola, Mozambique, and Nicaragua (Sondorp and Bornemisza 2002). The end of the Cold War in 1990 indicated a change in the nature of these wars, as “conflict was associated with a process of state disintegration, where the quest for power is linked to the economic and political ambitions of armed groups” (Duffield 1994). In light of this shift, the role of first-world states evolved from supporting particular governments in their quest for power via overt and clandestine military interventions, during the Cold War era, to helping to create and restore democratic governments. Collapsed states are now expected to rise again, as soon as possible, with international support. It has been the state – and not some other form of political organization- “that has been promoted as the answer to addressing social and economic upheaval, conflict and war” (Milken and Krause...
New states were envisioned to successfully build legitimate nations, provide wealth, and guarantee security within a few decades (Milken and Krause 2003).

Historically, however, despite the difficulty of the task, developed states have generally had a political purpose or a sense of moral duty in serving and aiding countries undergoing turmoil. In turn, they fulfilled this goal by establishing a framework for the post-war world that could ensure economic development and stability. After World War II, the International Monetary Fund and the International Bank for Reconstruction and Development (currently the World Bank), were established to help Europe rebuild its economic environment. These efforts were theoretically intended to quell instability in Europe and simultaneously ensure and facilitate a future alliance between Europe and the United States. The dual purpose was a result of policymakers’ forethought of a rivalry between American democratic capitalism and Soviet Communism. Moreover, the Marshall Plan of 1947 supported policies in Europe that accelerated the move toward market organization, free trade, and financial stability. In this case aid was an incentive and acted as a cushion to make reform possible (De Long et. al. 1993). Not only was economic stability and growth a major concern, but there was also a sense of urgency, despair and defined role for developed countries:

“The world of suffering people looks to us for leadership. Their thoughts, however, are not concentrated alone on this problem. They have more immediate and terribly pressing concerns where the mouthful of food will come from, where they will find shelter tonight, and where they will find warmth. Along with the great problem of maintaining the peace we must solve the problem of the pittance of food, of clothing and coal and homes. Neither of these problems can be solved alone.”
- George C. Marshall, November 1945
It has been established that there are a high number of complex emergencies and post-conflict areas worldwide. Donor agencies and developed countries have historically had a major role in creating environments that are amenable to reform; their participation has been via monetary support and through their influence of development agendas. There is a critical link between economic opportunities, reconstruction, the return of relative stability, and the growth of a state. Barnett Rubin made reference to this notion when he stated that, “If the international community does not find a way to rebuild Afghanistan, a floodtide of weapons, cash, and contraband will escape that state’s porous boundaries and make the world less secure for all” (1995). A major implication for the process of the reconstruction in general is to (re)build state institutions, which can provide the rule of law and basic services for a war-exhausted society. One way to start this initiative is to focus on public health, which is what is being done in Afghanistan.

The examples of state reconstruction during the 1990s are numerous. However, external intervention has been only partial successful. According to Marina Ottaway, a scholar on democracy and reconstruction, “the patient has been kept alive but not necessarily dismissed from the hospital” (2003). While there has been some debate regarding the content of reform, little has been written regarding the process of reform-defining priorities, how strategies evolved, power struggles amongst agencies, or collaboration (Cassels 1995).

The process of reconstruction and health reform, of course, is even more complicated in an environment in which political and economic crisis, civil war, and a lack of human capacity and resources are present. At the same time, it is these issues themselves that may act as a trigger for promoting health reform. Therefore, the process of resurrecting a country from a conflict situation serves as both a constraint and an opportunity for reform (Macrae et. al. 1995).
To delve into how donor strategies in post conflict countries evolve, how government structures are transformed, and how relations between actors develop, I will focus this thesis on the manner in which the reconstruction of the health sector of Afghanistan evolved and is being implemented, along with the implications of this process for state building and equity.

1.4 Methodology

The aim of this proposed research is two-fold. First, it is to understand the impetus for concentrating on the health sector within the context of reconstruction efforts in Afghanistan. Second, it is to learn what strategies were implemented and what the potential implications are of the particular strategies for long-term goals of increasing equity and building the Afghan state. These goals demand that aid is understood not only as a method for resource allocation but also seen as a dynamic system focused on strategies, agenda setting, politics and power relations.

In an effort to go beyond the literature outlining the rationale of nation-wide health system reform via contracts, I started first with open-ended interviews with USAID and World Bank employees. Through these interviews, I demonstrate why health was a major priority and why health reconstruction has resulted in a performance-based, contract driven process within the context of Afghanistan. These contacts include individuals that have a relationship with MIT’s Department of Urban Studies and Planning and others, whom I met while I was working in Afghanistan during the summer of 2003. While it is important to note that there are more donors associated with Afghanistan’s health reform, including the European Commission and the Asian development Bank, my focus on USAID and the World Bank is reasonable as they have donated the largest sums of money and are more accessible to contact, as research for this thesis is taking place in the United States.
This thesis will not systematically evaluate the advantages or disadvantages of contracts. Health policy is best understood by looking at processes and power (Walt 1994). Insight drawn from these interviews tells a story- a dynamic account of the politics and processes embedded in the reconstruction of Afghanistan health system. Best-practice methods of health reform applied globally, external pressure to act quickly, power dynamics, and differing priorities of participating actors directly shape the form of health reform that is being implemented. The decisions made during this period also have broader implications regarding how and if long-term goals of development, such as state-building, could be reinforced or neglected.

In an effort to illuminate the aforementioned themes, this thesis will begin by providing a political and social context of Afghanistan. It will then discuss past initiatives to resurrect its health care system. Following, the specifics of the current reconstruction effort, entitled the Basic Package of Health Services (BPHS), will be explained. Chapters 3 and 4 will discuss the global trends that directly shaped Afghanistan’s current health policy and how the motives, agendas, and politics between and within stakeholders directed the policy formulation for Afghanistan’s health system. Chapter 4 will also conclude with an analysis of how the reconstruction plan may affect longer-term goals in this fragmented country.
Chapter 2: The Context of Afghanistan

The story of Afghanistan’s political, economic and social past and present is bleak; more than a generation’s worth of overall development was lost due to conflict (World Bank September 9, 2004). Before introducing the Basic Package of Health Services (BPHS) that was adopted by the Ministry of Health, one must understand the context in which it arose. This chapter explains the relevant historical context of Afghanistan, including the government’s goals and its capacity. A detailed account of the health statistics of the country will provide a foundation for understanding the grave landscape that public health policy-makers face.

2.1 Political History and Social Conditions

Geography places Afghanistan in a position to incorporate many cultural and ethnic groups, which bring along with them long histories of tribal, ethnic, and commercial rivalries (O’Connor 1994). Over the past 25 years of conflict, Afghanistan has become highly decentralized with factional leaders operating in distinct geographic areas. These factional leaders (or warlords) within Afghanistan are labeled clearly in Figure 1.1 In addition, numerous ethnic groups, visually represented in Figure 2, further divide the country.

---

1 While Figure 1 includes both warlord strongholds and ethnic groups, the primary purpose of this figure in this context is to demonstrate the number of warlords within Afghanistan and where their power bases are located. Figure 2 gives a more accurate representation of the number and geographic location of ethnic groups in Afghanistan.
Figure 1. Map of Afghanistan Showing Major Ethnic Groups and Areas of Control of Some Key Warlords

Source: Atal 2003.
While multiple factional leaders and ethnic groups undermine the prospects of a consolidated state, Afghanistan once had a strong central governance structure. Afghanistan was formed in the late nineteenth century after the second Anglo-Afghan war left a handful of regional and tribal leaders in control of several regions. Amir Abdul Rahman Kahn received financial assistance from the British Empire to establish a centralized administration. He
imposed this form of government through violence, which eventually led to a revolt. The revolt ended in 1929 when Muhammad Nadir Shah captured the capital and he subsequently worked to strengthen private industry via exports.

Afghanistan later moved toward statism, when the Cold War provided an opportunity to receive foreign assistance from democratic powers such as the United States and Great Britain. Starting in the mid-1950s, foreign aid financed a variety of infrastructure projects along with expanding the army and administration. Urban migration accelerated not only towards Kabul but also to larger provincial capitals. Institutional linkages within education, commerce, and culture were strengthened. Centrally based institutions generally identified with the government and, for the first time, policy-makers in Kabul shifted their concerns from “control of the population to the development of the economy and the fashioning of a sense of a common national culture” (Newell 1981).

In 1978, Marxists were able to take control of the government. However, the rural population revolted, as they were opposed to the Marxist intrusion in religious and social matters (Rubin 1995). According to Newell, “the Marxist coup and the Soviet invasion severed central authority from the painfully built architecture of coercion, co-option, and mutual restraint that had previously held Afghanistan together” (1981). The Soviets finally withdrew their troops in 1988 but those who fought against the Soviets, the Mujahidin, were unable to translate local victories into a national one; the resistance had fragmented political structures (Rubin 1986).

The civil war amongst multiple factions fighting to gain power after communism was defeated continued until the Taliban captured Kabul, eventually controlled the majority of Afghanistan. The Taliban imposed a strict adherence to a form of Sunni Islam that many worldwide have deemed as inhumane. By 1998, the international community condemned the
Taliban’s interpretation of Shari’a law, which condones the repression of women’s rights, civil liberties, and freedom of religion.

After the terrorist attacks on the United States on September 11, 2001, the United States accused Afghanistan of harboring the prime suspect of these attacks, Osama bin Laden. Currently, the United States and its allies are in the process of continuing the fight against terrorism in Afghanistan while they attempt to assist in rebuilding the country in order to bring social, political and economic stability to Afghanistan. These efforts, however, are in jeopardy due to the unstable security situation. While Afghanistan held presidential elections in October of 2004, in which Hamid Karzai was elected to a five-year term, the deterioration of Afghanistan’s security situation is a major impediment to overall progress. For example, 17 aid workers were killed in the first 6 months of 2004, compared to 14 in all 2003. Moreover, in August of 2004, the UN staff union requested the withdrawal of international employees from the country and Médecins Sans Frontières (MSF) also withdrew from the country in July of 2004 following the killing of 5 of its staff. If critical players in development are unable and unwilling to work in Afghanistan, consistent progress toward achieving both short and long term goals for reconstruction are extremely dubious.

While a strong state that can provide security is clearly not the present situation in Afghanistan, as control has been inconsistent these past twenty-five years, Afghanistan’s prior history of a centralized government provides at least a foundation for administrative arrangements. Government is centralized along both administrative and fiscal lines. However, the prevalence of warlords and an informal economy dominated by opium decreased the need for formal government structures for the provision of basic needs. Therefore, there are extremely limited human resource capacities across governmental departments and agencies and a severe
disconnect between the center and subnational level of governance (Manning et.al. 2003). The de jure state exists throughout the territory in the Afghan administrative structures, which have not completely collapsed at the sub-national level. The de facto states in most areas outside of Kabul are controlled by regional warlords and local commanders. Their operations vary from province to province, but their strong power is based on financial and military strength. Politically, the legitimacy and reach of the center remains weak and is largely confined to central government ministries and agencies in Kabul, thus reforms have focused on the central agencies in Kabul. The crisis in Afghanistan is as much an institutional emergency as a humanitarian one (Rubin 2004).

This political instability has also impacted and been influenced by the poor socio-economic conditions and the ethnic divisions within the country.¹ By many measures – average per-capita income life expectancy, other social indicators, or broader indexes like the UN Human Development Index – Afghanistan is one of the poorest countries in the world. In 1996, the country ranked 169th out of 174 countries in the UN Human Development Index, and more recently it was estimated to be second worst in the world after Sierra Leone.

With an estimated population of around 22 million in 2004, Afghanistan has a per capita GDP of close to US$315 (including the opium economy) – one of the lowest in the world. The Afghan economy is dominated by agriculture (32% of estimated total GDP in 2003), mainly cereal crops (27%), and by the opium economy (an estimated 35% of GDP) (The World Bank Economic Report on Afghanistan 2004). The most striking feature of Afghanistan’s economic structure is the dominance of the informal sector, which pervades not only the agricultural and drug industries but also the provision of services such as electricity, for instance. In fact, while it is difficult to estimate the exact proportion of the economy that is informal, a solid estimate is
that some 80-90% of the economic activity occurs in the informal sector in Afghanistan (The World Bank Economic Report on Afghanistan 2004). This reflects a past of failed governance structures, insecurity, lack of law, and a poor formal sector investment climate.

The collapse of the state resulted in an estimated 6 million Afghans leaving the country and one million internally displaced persons (IDPs). Moreover, beyond the destruction of physical capital and public services, the absence of rule of law has resulted in local power-holders taking control in regions and localities. All of these factors have certainly taken a toll on human capital. Similar to pre-conflict levels, the average life expectancy was a little over forty years of age in 2002.

Illiteracy is extremely high, with stark provincial and gender disparities. 57% of men and 86% of women above 15 years of age are illiterate. Illiteracy is particularly high in rural areas. While school enrollment in major cities is as high as 80%, it is only 47% in rural areas. Nationally, the female net enrollment ratio is 40% while that of boys is 67% (The World Bank Economic Report on Afghanistan 2004).

Despite the fact that in the past two years, 2.5 million Afghan refugees have returned and approximately 600,000 IDPs have returned to their place of origin, signs of improving social conditions, there are striking regional disparities. While one must use care before enacting policy based on these preliminary statistics, a World Bank study on the economic conditions of Afghanistan found that compared to the southern region, the per-capita expenditure in the western region is 29% lower, the central region is 16% lower, and the Eastern region is 12% lower. One plausible explanation for these variations is the concentration of opium production in the eastern and southern regions of Afghanistan. In addition, rival warlords, numerous ethnic groups, and a government that is perceived to be, according to Barnett Rubin, ethnically
unrepresentative and unpopular in the Pashtun south also punctuate these economic variations (1999).

Finally, the southern and eastern region of Afghanistan borders a hostile neighbor- Pakistan. On its western side, however, Afghanistan borders Iran, where residents- such as citizens in Heart- enjoy trade possibilities. Allegiances thus are more often shaped by ethnic and regional ties rather than a shared sense of citizenship in the country of Afghanistan. As a matter of fact, the only uniting force within this region that has contributed to this society is their incorporation into a state (Rubin 1995).

2.2 Government Goals Leading to Reconstruction

As explained in the previous sections, the legitimacy of the state is frail but in addition, the government’s administrative capacity to lead the country has been frozen due to chronic conflict and turmoil. In an effort to focus the central government’s capacity on funneling and coordinating aid to the most needy sectors and services, the National Development Framework (NDF) was established. The National Development Framework is country-driven and focuses on long-term reconstruction efforts and aims to guide international donors in this process. The National Development Budget (NDB) translates the priorities of the NDF into specific programs and projects, after consultation with government, provincial authorities, and donors, via consultative groups. Consultative groups are led by a ministry and provide a mechanism through which donors, the UN, and NGOs can engage with each other, coordinate, and set clear objectives for a particular sector.
Table 2 outlines the priorities that NDF has set for the reconstruction of the state. Through these priorities, consultative groups were formed to guide the process of policy strategy, coordination and implementation.

Table 2: Priorities of the National Development Framework

<table>
<thead>
<tr>
<th>Pillar 1 – Humanitarian and Human and Social Capital</th>
<th>Pillar 2 – Physical Reconstruction and Natural Resources</th>
<th>Pillar 3 – Private Sector Development, Governance and Security</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refugee Return</td>
<td>Transport and Communications</td>
<td>Trade and Investment</td>
</tr>
<tr>
<td>Education and Vocational Training</td>
<td>Water and Sanitation</td>
<td>*Governance and Public Administration</td>
</tr>
<tr>
<td>Health and Nutrition</td>
<td>Energy</td>
<td>*Security and Rule of Law</td>
</tr>
<tr>
<td>Livelihoods and Social Protection</td>
<td>Urban Development</td>
<td></td>
</tr>
<tr>
<td>Cultural Heritage, Media and Sports</td>
<td>Natural Resource Management</td>
<td></td>
</tr>
</tbody>
</table>

Afghanistan is a fragmented nation where the central government has yet to gain legitimacy and trust amongst all Afghans. The capacity and control of the central government with respect to provinces in Afghanistan is severely limited. However, the guiding principles for the reconstruction of Afghanistan are clear. It is very clear what needs to be done as there is great need in the country for rehabilitation in all sectors. The key issue now is how to accomplish these goals in light of the limited donor funds, shown in Table 2. Financial aid to Afghanistan, measured per capita, has been far lower than for any other recent nation receiving aid during a period of post-conflict rebuilding. According to an analysis of aid-flows to Afghanistan by the Transitional Government of Afghanistan, aid to the country per capita is far below any other state suffering from a major conflict in recent time (forty-two dollars per capita). Even Rwanda, which is considered a classic example of neglect from the international aid community, received
more than triple the funds per capita than that of Afghanistan (Transitional Government of Afghanistan 2003).

Given the above priorities and the financial constraints, the aid community together with the Government of Afghanistan has chosen health as a focal point for action. The next section will outline the past and present public health efforts and conditions and will follow with an overview of the proposed solution, the Basic Package of Health Services (BPHS).

2.2 **Prior Health Initiatives in Afghanistan and the Current State of Public Health**

"Gul Jan was worried this time. His two-year old son, Ahmad Shah, had never been this sick before; he had a cough that would not quit, a high fever, and a dull, far-away expression so different from his usual happy laugh. Gul Jan’s wife, Bibi Khanom, had already tried everything that was available in the village. She had first given her some old, leftover tablets that she had gotten a year ago for “fever.” When that did not seem to help, she has consulted her cousin, an untrained village midwife who had raised seven children. The cousin’s advice was to stop giving the child “cold” foods especially yogurt or meat. When Ahmad Shah still failed to improve, she asked Gul Jan to take the boy to Mulla Safruddin in order to get a tawiz, or amulet with holy words from the Koran placed inside. But Ahmad continued to get worse, despite the tawiz.

Gul Jan tried to think of what else he could do. Since it was winter, it would be very difficult to take Ahmad Shah to the nearest doctor at the Basic Health Center in Anderab. Anyway, who could be sure that the doctor had not gone to Kabul or maybe the Health Center was “in-between” assigned doctors. There was always the pharmacy in Anderab of course, but how much did the pharmacist know about curing a cough and fever? If the bus could make it though the snow, he would have to pay 80 Afghani (about $2.00) just for round trip transportation. If the bus could not get through, that meant 6 to 7 hours trudging through ice and snow with a sick two-year-old.

Meanwhile, Bibi Khanom was trying to comfort the boy and keep him warm. Even though he was thirsty, she felt it was important not to give him too much to drink, especially any “cold” liquids. The water she did give him, however, came from the nearby jui (irrigation ditch). Since the water flowed continuously, Bibi Khanom knew it was safe to drink.

The situation began to appear desperate to Gul Jan. He was convinced that Ahmad Shah would die unless he received help soon. But what could he do? Finally, Gul Jan made a decision. He would take Ahmad Shah directly to Kabul and find one of the big gleaming new hospitals there. If anyone could help Ahmad shah, a doctor in Kabul should be able to.
Postscript: Ahmad Shah died shortly after reaching Kabul. The doctor said it was pneumonia and that Gul Jan had come too late” (O’Connor 1980).

This moving story illustrates the despair facing many Afghans in the state. It also allows one to see the major obstacles in the health sector that may act as barriers to the progress of reform and reconstruction. Measures of progress in the health sector include the following: 1) services equitably distributed throughout the country; 2) incidence of preventable illnesses; and 3) quality of services.

Equity

Afghans first relied on upon hakims (local healers), dais (traditional midwives), medicine vendors, and shopkeepers for healthcare; once these avenues were exhausted, there was direct aid in patient care through voluntary organizations. Historically, there was a concentrated focus on curative care with a few government-sponsored programs for preventative care that focused on immunizations. Moreover, there was an increased tension between the centralized hospitals of the big cities and the smaller community-centered periphery care clinics. Given existing community reliance on hakims and dais, programs were implemented to utilize this existing and trusted workforce in communities, transforming them into employees and trainees of formally donor funded programs in hard to reach rural areas.

During the war period, beginning in 1978, factional fighting led to increased insecurity and in this way, health services quickly became limited to secure enclaves and cities. According to a USAID official, services were also somewhat limited to those Afghans participating in the wars. It was thus that curative care was at the forefront of the health agenda instead of an
expansion of countrywide public health systems in both curative and preventative care (personal interview with USAID official; July 14, 2004)

Another critical factor that has influenced the provision of equitable services throughout Afghanistan is gender segregation and the restrictions placed on women and girls by local traditions, most significantly over the past two decades. Educated female medical professionals were permitted to practice. Since women and girls were only allowed to be seen by female professionals, this severely limited the medical care available to this segment of population. The inability of many women to travel to clinics due to traditional family norms urging women to stay in the household also created a barrier to equal access.

In addition, health indicators reflect the poor health state of Afghan women. For example, Afghanistan has the second highest maternal mortality rate in the world. It is estimated that 45 women die of pregnancy-related causes each day. Only 35% of districts have any maternal and child health services and the country has only 30% of the birth attendants that it actually needs. Finally, 80% to 90% of women of childbearing age are anemic and women account for 70% of all cases of tuberculosis (Transitional Islamic Government of Afghanistan 2002). This brief synopsis of selected indicators is not intended to provide an overview of health statistics of Afghanistan; however, it clearly demonstrates that women are the most in-need in terms of health services. Furthermore, the statistics indicate that women’s illnesses are preventable, given an effective reconstruction of the health system.

These issues are further aggravated by inequitable availability of health facilities with varied services and staff. On a national level, the population to health service facility ratio is 25,823 to 1, which is better than the proposed target by the Ministry of Health of 30,000 to 1. However, the variation between provinces is significant. For instance, a survey of 912 facilities
showed that in the province of Wardak, there is one facility per 11,800 people but the province of Ghor has one facility per 52,278 people. Nine provinces out of 32 do not meet the standard of 30,000 people to 1 facility. Moreover, there are stark differences even within the provinces. In the province of Ghazni, there is a district that has one facility for 5,727 inhabitants but another district has one facility for 145,300 inhabitants. Nationwide, one-third of all districts do not meet the base standard of one facility for every 30,000 people (Transitional Islamic Government of Afghanistan 2002). For a visual picture of the drastic inequalities, one can refer to Maps 1 and 2. Map 1 provides data regarding the ratio of facilities to inhabitants and Map 2 illustrates the population density of Afghanistan. While one may assume that health facilities are most likely to exist in high-density areas or in turn least likely to exist in low-density areas, this is not necessarily true upon close comparison of the two maps.
Figure 3

District Population Per Health Facility

Source: National Health Resources Assessment, September 2002
MoPH and USAID/AHSEP
November 2002
Figure 4

AFGHANISTAN: POPULATION DENSITY 2002

Released: October 2002

Sources: Population summarized from LANDSCAN 2000 using reduced 'settled area' classifications based on settlements and agricultural land polygons created by AIMS. Landscan is a probability estimate of ambient population computed from population estimates and terrain/mannmade features. Landcover source: FAO 1993 National Landcover of Afghanistan.

Questions regarding this product should be directed to info@aims.org.pk and reference the map title and release date.

The boundaries shown do not imply official endorsement by the United Nations. For standardization purposes AIMS uses the 32 province/329 district boundary model.
Preventable Illness

For every 1,000 young children, just over a quarter of them (257) will not survive to reach their fifth birthday. An estimated 85,000 Afghan children die each year from diarrheal disease. In previous conflict situations, diarrhea has accounted for 25%-40% of all deaths and as much as 80% of deaths among children less than 2 years old. An estimated 10% of children are acutely malnourished and 50% are chronically malnourished (Help the Afghan Children 2003). More than one-third of Afghanistan has no history of routine immunization programs, and immunization coverage rates are estimated to be well below 50% among most children. Measles accounts for up to 35,000 deaths among children each year in Afghanistan. More inaccessible areas such as Hazarajat and Nuristan have been particularly affected. In a recent survey, in the remote Kohistan district of the Faryab province, measles was responsible for 15.7% of all deaths ((Transitional Islamic Government of Afghanistan 2002).

These health statistics, although a small sampling of available data, clearly demonstrate the poor health status of Afghans but it is critical to recognize that most of the health challenges are preventable. A monumental Child Survival Series in The Lancet in July of 2003 essentially tackled the question of why 10 million children worldwide are dying each year from preventable illnesses. Among children living in the 42 countries that comprise 90% of child deaths, a cluster of effective nutrition interventions including breastfeeding, complementary feeding, vitamin A, and zinc supplementation could save about 24 million children each year (25% of total deaths) (Black et. al. 2003). More specifically, interventions against deaths in the neonatal period could prevent 55% of infant deaths, or 18% of all child deaths. Some of the most promising interventions may be delivered at the household level, with limited need for external material inputs; these include promotion of breastfeeding, oral rehydration therapy, education on
complementary feeding, and insecticide-treated materials. These interventions could jointly prevent more than one-third of all deaths (Jones et. al. 2003). The bottom line is that more than 10 million children are dying each year because they have not been reached by known and effective interventions. Children are dying due to the failure to prevent common childhood illnesses, the neglect of health problems in newborn babies, and of lack of measures needed to protect mothers and infants during pregnancy and childbirth (Jones et. al. 2003).

These data imply then that public health efforts should concentrate in relatively inexpensive, high impact initiatives that focus on preventative rather than curative illness, which is the exact aim of the Basic Package of Health Services. Before examining the Basic Package of Health Services, a brief synopsis of the health services that are presently available in Afghanistan is needed.

Current Health Services

In a war-torn country faced with a lack of broad medical expertise, support for health infrastructure and human resource capacity must be incorporated into any plan for developing a contemporary health system. In terms of health infrastructure, state development policies in the past were heavily biased towards the urban setting (World Health Organization 2002). Approximately 50% of the 8,333 hospital beds available in the country are located in Kabul despite the fact that only 22% of all Afghans live in urban areas. The rest of the country has 0.34 beds per 1,000 people, compared to an average of 3 per 1,000 in low-income countries. 20% of all districts have no health facilities at all and only 30-40% of the population have access to some health care (World Health Organization 2002)

2 While this number has increased from 15% in 1979 to 22% in 2004, the division between urban and rural is clear.
Human resources are vastly inadequate for a population that is expected to grow approximately 25 million to 35 million in 10 years. There are roughly two physicians for every 10,000 people and about 35% of all doctors are in Kabul where they serve 7% of the population. In other words, there is one physician for every 1,700 people in Kabul but one physician to every 450,000 people in the rest of the country. Moreover, only 40% of facilities have a female on staff (Transitional Islamic Government of Afghanistan 2002).

Also, the ownership and financial supporters of the health facilities are critical considerations; this information will shed light on the comparative advantages and disadvantages of relying on the Afghan Government or existing NGOs that are already working the health sector to implement future health services for the country. Currently, ownership is roughly divided equally between the government (43%) and NGOs (39%), with a small proportion both NGO and government owned or privately owned. However, only a small proportion (11.2%) of the health facilities owned by the government actually receives financial support from the government. One should note that NGOs were the largest supporters of health facilities according to this survey, by supporting 45% of all facilities (see Table 6).
Table 3: Ownership and Support of Health Facilities

<table>
<thead>
<tr>
<th>Entities</th>
<th>Owned</th>
<th>Supported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government Only</td>
<td>359 (39.4%)</td>
<td>102 (11.2%)</td>
</tr>
<tr>
<td>Gov/NGO</td>
<td>23 (2.5%)</td>
<td>149 (16.3%)</td>
</tr>
<tr>
<td>Gov/NGO/UN</td>
<td>0 (0%)</td>
<td>90 (9.9%)</td>
</tr>
<tr>
<td>Gov/UN</td>
<td>0 (0%)</td>
<td>43 (4.8%)</td>
</tr>
<tr>
<td>NGO Only</td>
<td>394 (43.2%)</td>
<td>410 (45.0%)</td>
</tr>
<tr>
<td>NGO/UN</td>
<td>0 (0%)</td>
<td>60 (5.6%)</td>
</tr>
<tr>
<td>UN Only</td>
<td>14 (1.5%)</td>
<td>23 (2.5%)</td>
</tr>
<tr>
<td>Private</td>
<td>92 (10.1%)</td>
<td>21 (2.3%)</td>
</tr>
<tr>
<td>Community Only</td>
<td>14 (1.7%)</td>
<td>1 (0.1%)</td>
</tr>
<tr>
<td>Other</td>
<td>16 (1.7%)</td>
<td>5 (0.6%)</td>
</tr>
</tbody>
</table>

Source: Transitional Islamic Government of Afghanistan, Ministry of Health December 2002

Given the constraints of a fragmented nation, a limited functioning government, a population in desperate need of aid, and the limited public health resources and capable actors capable of providing health services, what has the Ministry of Afghanistan and the aid community developed as the plan if action to annihilate these detrimental health conditions? A thorough explanation of the Basic Package of Health Services for the country of Afghanistan will follow in the next section.

2.3 The Current Initiative: The Basic Package of Health Service

“Learning by doing” (personal interview with former MOH advisor July 8, 2004). This is the guiding principle of the reconstruction efforts for the public health system. An official at USAID stated in an interview, “Anyone who is familiar with Afghanistan would clearly see that health should be the first priority. It is just a mess there” (personal interview with USAID official July 12, 2004). Several critical issues permeate the discussion of health rehabilitation, and
therefore shape the manner in which it is managed. According to a donor aid memoir that
documented the process of health reconstruction in Afghanistan, a shortage of administrative
talent at the provincial level, uncertain future financing, delays in implementation of planned
efforts, and a difficult security situation are just some of the basic issues (Strong 2004).

There are also questions that the government and donor community grapple with, which
include the following: (1) What is the role of government in the sector? And, does it want to
steer the sector or deliver services? (2) Currently, NGOs are heavily involved in the sector and
either support or provide much of service delivery that is currently taking place. How will the
Government relate to NGOs and what will be the NGOs’ role? (3) How should health workers
be recruited? What kind of accreditation process should be instituted? What kinds of services
should be provided and how will financing occur?

Donor funds are currently available, so how can stakeholders take advantage of this
opportunity and embark on a politically savvy, fast-paced reform that simultaneously builds
capacity at all levels and expands services to the poorest citizens of Afghanistan. This section
outlines what ‘contracting out’ means to stakeholders- NGOs, citizens, the government, and
donors, with regard to the range of and quality of health services offered, and equity.

**Range and Quality of Health Services**

For war torn countries, an added challenge is attaining long-term stability, which in turn
can be reinforced by nation-wide reforms that are sustainable. However, according to one World
Bank Official, the practice is that once one knows a project is working, only then should
sustainability be factored in and considered (personal interview World Bank Official July 28,
2004). In light of the consideration of sustainability as a minor issue, a nation-wide experiment is
being tried in Afghanistan, where PPAs (performance-based partnership agreements) accomplish the following tasks: (1) establish an essential service package and a series of related performance indicators; (2) define the geographical area covered by the PPA; (3) carry out a competitive bidding process among interested NGOs; (4) sign an agreement with the winning NGO based on a fixed price; and (5) carefully monitor the performance of the NGO and access and coordinate payment according to successful service delivery. Its advocates argue that PPAs are shown to quickly and efficiently improve service delivery; this is based on rigorous evaluations that allow the government to effectively manage and coordinate the sector, guarantee that under-served populations receive services, and ensure a mutually beneficial relationship between the government and NGOs (Aide Memoir Joint Donor Mission II 2003).

In essence, the PPA approach dictates that the government establishes a set package of services and performance indicators, defines the geographical area covered by the PPA, carries out a fair competitive bidding process, monitors performance, and ensures timely payments to guarantee consistent service delivery. These measures are in response to the current obstacles to an adequate health system, which -from the government’s perspective- include inadequate health services and numbers of facilities, shortage of essential drugs, medical equipment and supplies, lack of funds to adequately staff existing facilities (particularly in more remote areas), inadequately qualified staff, and lack of community access to functioning health services. The PPA approach ultimately means a shifting role of government from one of provider to one of steward of services. The government must shift from a role in which it commands and controls public services to one in which it applies a sophisticated system of oversight and supervision of other actors in the field.
One of the underlying reasons for contracting is the perception that government provides services that are centralized, inflexible, costly, standardized and supply driven (Tendler and Serrano 1999). Hence, entities that supposedly represent the opposite of these characteristics, the private and non-governmental sector, will naturally fill this role. The idea is that partnerships with the private sector will contribute to cost-effective, demand driven, financially sustainable projects. And, working with the non-profit sector will facilitate reaching out to help the most vulnerable populations, enhancing community participation, and developing innovative strategies (Tendler and Serrano 1999).

NGO and private sector partnerships that are supported by global networks in international aid and implemented by standardized prescriptions to combat the failure of government theoretically simplify the governmental responsibilities and roles. However, in reality the responsibilities of the government are increasing in complexity as they must take on the oversight and management of multiple entities.

Just as the government will be taking on a more complex role of overseeing NGO provision of services, the NGOs must also alter the way they function. According to one informant, “The rule of the game is no longer grants but rather contracts with a whole new set of rules for NGOs. They tell you what to provide, how to provide it, and how much it should cost you.” (official of Care International July 22, 2003) While about 84% of health facilities have some sort of involvement with NGOs, the guidelines and specific services, as outlined below, vary drastically from the united grant process. Some constraints voiced by the NGO community include limited availability of qualified health staff, particularly females, difficulty finding candidates with adequate education to participate in training, difficulty and potential expenses of attracting staff into rural and remote areas, poor quality or non-existence of physical
infrastructure and communications, limited coordination among health stakeholders and non-existent intersectoral coordination, as well as a general lack of baseline data and reliable health information system (Aide Memoir Joint Donor Mission II 2003). This system of employing a basic package for the entire country theoretically would help provide a unified set of services, offer a basic framework for training personnel while also enhancing coordination amongst all actors.

There will be about $276 million available from the participating donors over the next three years or an annual $3.68 per capita. Afghanistan’s health system is fundamentally being reconstructed. The system’s progress has stalled since the 1960s and, to jumpstart its repair the basics must be achieved first. Therefore, the criteria used to inform an intervention in the BPS included strong evidence that would link the approach and its impacts on the high burden of disease, low cost and high cost-effectiveness, and practicality in terms of being easy to implement in Afghanistan.

The Ministry of Health (MOH) identified its priorities early on and formulated a national health strategy that focused on the delivery of a Basic Package of Health Services (BPHS) through a primary health care system. The BPHS contains interventions that are expected to have the greatest impact on the major causes of preventable mortality and morbidity. It includes the following six priority components:

(1) Reproductive Health including maternal health and birth spacing
(2) Communicable diseases
(3) Nutrition
(4) Child health, including immunization
(5) Mental health
(6) Disability.

All but mental health and disability are first tier priority areas. For each of the priorities the BPHS defined the levels of health facilities, the services to be provided at each level, the
health staff requirements for each type of facility, and the drugs and equipment required. Moreover, training for personnel (community health workers, midwives, etc.) is outlined in various documents. Finally, the BPHS outlines a complex set of indicators to analyze impact and outcomes of health efforts. An example of the detailed analysis of all health service activities is below.
### Indicators for the essential package of basic services

The following indicators could be used to assess performance and outcome of basic services.

<table>
<thead>
<tr>
<th>Component</th>
<th>Performance or outcome indicator for 2005</th>
<th>Expected results</th>
<th>Current position</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. REPRODUCTIVE HEALTH</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage of antenatal care: proportion of all pregnant women receiving a minimum of 4 antenatal visits per pregnancy.</td>
<td>50%</td>
<td>unknown</td>
<td></td>
</tr>
<tr>
<td>Maternal Health</td>
<td>Proportion of pregnant women receiving two doses of tetanus toxoid</td>
<td>50%</td>
<td>unknown</td>
</tr>
<tr>
<td>Emergency Obstetric Care</td>
<td>Number and distribution of essential obstetric care</td>
<td>1 comprehensive and 4 basics essential obstetric facilities per 500,000 population</td>
<td></td>
</tr>
<tr>
<td>Proportion of births attended by skilled birth attendant services</td>
<td>20%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Rates of operative delivery as proportion of all births</td>
<td>5-15%</td>
<td>unknown</td>
<td></td>
</tr>
<tr>
<td>Institutional case fatality rates [proportion of women with obstetric complications admitted to a facility who die]</td>
<td>maximum 1%</td>
<td>unknown</td>
<td></td>
</tr>
<tr>
<td>Proportion of all births in an EOC facility</td>
<td>15%</td>
<td>unknown</td>
<td></td>
</tr>
<tr>
<td>Birth spacing</td>
<td>Proportion of health centers offering at least two birth spacing methods</td>
<td>20%</td>
<td>unknown</td>
</tr>
<tr>
<td>Proportion of women in reproductive age group (15-49 years) having knowledge of at least three methods of birth spacing</td>
<td>20%</td>
<td>unknown</td>
<td></td>
</tr>
<tr>
<td>Contraceptive prevalence rate (% of married women 15-49 years currently using a modern or traditional birth spacing methods)</td>
<td>7%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td><strong>2. NUTRITION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Micronutrient deficiencies</td>
<td>Proportion of children 6 to 59 months that have received vitamin A supplement within last 6m.</td>
<td>95%</td>
<td>70%</td>
</tr>
<tr>
<td>Proportion of pregnant women receiving iron folate supplements.</td>
<td>50%</td>
<td>unknown</td>
<td></td>
</tr>
<tr>
<td>Proportion of households consuming adequately iodized salt</td>
<td>20%</td>
<td>unknown</td>
<td></td>
</tr>
<tr>
<td>Breastfeeding Promotion</td>
<td>Proportion of women having knowledge of benefits of breastfeeding and importance of early initiation of breastfeeding</td>
<td>Proportion of women exclusively breastfeeding for 6 months.</td>
<td>unknown</td>
</tr>
<tr>
<td>Child malnutrition</td>
<td>Proportion of children under five years with wasting [weight for height]</td>
<td>2%</td>
<td>unknown</td>
</tr>
</tbody>
</table>
### 3. COMMUNICABLE DISEASES

<table>
<thead>
<tr>
<th>Disease</th>
<th>Measure</th>
<th>To be established</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis</td>
<td>Percentage of the cured and treatment completed cases (Success rate).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of districts using DOTS strategy</td>
<td></td>
</tr>
<tr>
<td>Malaria</td>
<td>Proportion of families using insecticides treated nets (ITNs)</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10%</td>
</tr>
</tbody>
</table>

### 4. CHILD HEALTH

| Disease             | Description                                                                 | 70%               | unknown – one regional estimate – the best - 68%
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Respiratory</td>
<td>Proportion of children &lt;5y with ARI in last 2 weeks taken to an appropriate health provider.</td>
<td></td>
</tr>
<tr>
<td>infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrheal diseases</td>
<td>Proportion of children &lt;5y who had diarrhea in last two weeks who received oral rehydration salt or appropriate household solution.</td>
<td>60%</td>
</tr>
</tbody>
</table>

### 5. IMMUNIZATION

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Coverage</th>
<th>50%</th>
<th>32%</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPT 3 coverage</td>
<td>DPT 3 coverage: children 12-23 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles coverage</td>
<td>Measles coverage: children 12-23 months</td>
<td>65%</td>
<td>37%</td>
</tr>
<tr>
<td>OPV coverage</td>
<td>OPV 3 coverage: children 12-23 months</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
</tr>
</tbody>
</table>

The concept of the Basic Package of Health Services (BPHS), is that “all of the services in the package should be available as an integrated whole, rather than being available piecemeal or as individual services or only through vertical programs” (Ministry of Health, Government of Afghanistan. Basic Package of Health Services 2003) The two main purposes is of the BPHS are (1) to provide a standardized package of basic services that forms the core of service delivery in all primary health care facilities and (2) to promote a redistribution of health services by providing equitable access, particularly to underserved areas.

As many donors have argued, a standardized package and monetary incentives will theoretically help ensure that access to health care will be provided to this fragmented, war torn country. However, health policy is inherently political. As will be seen in Chapter 3, donors have their own ideas and assumptions as to how and what kinds of services should be provided. Should performance-based partnerships be province-wide? Given that research has found that health services are superior in areas supported by war lord activity in comparison to other populated areas, should smaller scale contracts for extraordinarily poor areas in need of concentrated efforts, along with a more challenging health service mandate be made available? Will provincial government structures work directly with the NGOs in order to enhance their own capacity? Donors of course have conflicting viewpoints regarding these questions. As a result, donors have imposed their values and experiences, leading to an approach that divides the country into implementation areas for several variations of the Basic Package of Health Service. This is represented visually in Figure 5.
For instance, the World Bank-funded provinces are offering province-wide contracts to NGOs without consideration of political and context variations, security issues, and ethnic and geographic variations within provinces. The main argument for province-wide contracts is that it is simply easier to distribute funds and requires less bureaucracy. This is an important aspect of the program, as the Afghan government is just now developing its institutional capacity and activities such as the distribution of funding may provide difficulty and slow progress. Additionally, research has shown that a clear definition of roles and a straightforward list of governmental responsibilities increase the success of health sector reforms (Mills 2001). Therefore following this approach may translate into a more successful program.

On the other hand, USAID has divided provinces and granted contracts to various NGOs within one province. These divisions are based on the idea that since Afghanistan is such a fragmented country ethnically and geographically, the best way to ensure access too all is to pay special attention to the pockets of the country that are in most need or that differ from the characteristics of their surrounding areas.

A third variation of the BPHS is one in which the Ministry of Health provides services in three provinces. While this veers from the idea of the government as steward rather than provider of health, it will truly test the ability of the Afghan government to learn quickly, alter its organizational structures, and provide equitable services in these three provinces.

While the original goal of the Basic Package of Health Services was to provide low-cost effective health care, particularly to underserved areas, and to essentially to level the playing field, the implementation schemes of each donor change the way in which services are delivered. The level of interaction between existing local NGOs and provincial
governments also vary with the different approaches; in the long-term, this can affect the success of new projects and also the ability of the local and national government to resume control if the donor community cedes funding after the three year period. In addition, it is important to note that as of July 2004, 40% of provinces have not yet been assigned NGOs to provide health services for the next three years (personal interview World Bank Official July 28, 2004).

With 40% of the provinces still not receiving services and those that do face various forms of implementation schemes, Afghanistan’s health reform has turned into an experiment. Many of the shifts in policy have been more based on intuition, ideology, than on careful evaluation of the evidence. Blueprints of development projects have attempted to alleviate poverty through the developments options that are popular at the moment. In this case, it is performance-based contracts and NGOs are the primary provider of services. However, the design and implementation of these blueprints have overlooked the specific conditions and characteristics of the sector and region.

While one can argue the benefits and disadvantages of initiating a nation-wide reconstruction of a public health system, at this point in the policy process, it is more suitable to answer the question of how these policy options won the favor of the donors. Donors obviously weighed the advantages and disadvantages of the Basic Package of Services and PPAs for Afghanistan. An aid-memoir listed the following points:
Advantages

- Reaches areas that government cannot reach
- Ability to recruit staff in remote areas and correct concentration of staff in urban areas
- May help the political stability by providing more access to health services
- Improves MoPH’s control over NGO activities
- Allows MoPH to learn from NGOs who have experience in many countries
- Proper use of the money and proper way to deliver health services
- *Partnership between MoPH and NGOs will allow things to move faster than MoPH working alone especially in remote areas.*
- Chance for national NGOs to develop their expertise and experience, and their services

Disadvantages

- Potential loss of skilled MoPH staff as a result of higher salaries in PPA areas, affecting the current delivery of health services by MoPH
- Risk that the MoPH will lose the control through lack of capacity to monitor distant provinces
- Risk that focus on contracting will reduce the efforts to build up the MoPH
- Risk that contracting will prevent the MoPH of this legitimate government from taking its place as a service provider after so many years.
- Risk that developments will not be sustainable and will affect continuity of service.
- Risk of political repercussions in the population due to the perceived loss of control by the MoPH — good communication will be needed to explain the changes.


As one can see from the charts above, PPA’s were not a clear choice to all involved. There were clear value-based decisions that were made and the priority was clearly a quick-impact plan that would benefit the most number of people while long-term goals of building the capacity of the state and overall sustainability were overtly neglected. How and why did donors and the Afghan government focus on health and conclude to provide these services via PPAs? Given the poor economic state, social divisions, and political instability
of Afghanistan, why have nation-wide PPA’s for the first time in global history, been chosen as the method for providing health care to twenty-five million people in the second-poorest country in the world? There are two main reasons, one of which involves the international public health environment, and the other revolves around the politics, values, and motives amongst and within stakeholders. These reasons will be discussed in Chapters 3 and 4.
Chapter 3: The Ebbs and Flows of International Health Reform

“We don’t know if it works but we know what’s good for you” (Chitah 2001).

A suitable metaphor for health programs, according to Reich, would be that of “a network, a web of relationships that link organizations and individuals across organizations” thereby capturing the full complexity of a dynamic health system (2002). Given the complexity and dynamic nature of health programs, how has performance-based contracts with non-governmental organizations emerged as the preferred system for Afghanistan? What have been the processes and who are the agents that have molded and directed the flow of international aid increasingly towards this option? The answers, I argue, can be illuminated by looking at the forces of globalization within the health sector and at the impact of donors’ attitudes and approaches on the health sector worldwide. I point to two health reform packages in Haiti and Cambodia that were in fact the foundation for Afghanistan’s health reform. These components influenced which of the global actors played a leadership role in the process and how this shaped the specific reform package that the donors championed. The insight from this exploration provides a foundation for helping to answer the main question of this thesis, which is why has the rehabilitation of Afghanistan’s health system been implemented via a performance-based, contract-driven process?

3.1 The Global Policy Aid Context

International development, which involves transforming societies by identifying the barriers and catalysts for change, functions in an environment of global interconnectedness. Development via the process of international aid is growing in numeric terms and, most
importantly, in influence through the process of globalization. International non-governmental organizations (INGOs) in 1980 channeled $3.5 billion from north to south; by 1999, this figure grew to $15 billion and in 2000, donor countries contributed $53 billion dollars to these efforts (Clark 2001).

Globalization is often perceived as a catalyst for the rising presence and influence of transnational corporations (TNCs) and a means for the internationalization of consumption, production and distribution. Political boundaries are becoming increasingly porous, as even disparate parts of world are growing more and more dependent on one another. But globalization must be conceptualized, particularly in the context of development, as a political economic phenomenon. This phenomenon imposes a framework that is tied simultaneously to large sums of money circling around the world and an agenda imposed or advocated for across borders. The model of the “Washington Consensus” of economic development and the liberalization of markets under structural adjustment and stabilization policies provides an apt example.

How does this relate to health reform and reconstruction in Afghanistan? Globalization impacts the number and type of private actors working in the health sector of Afghanistan, the availability of pharmaceutical drugs, and types and availability of equipment. But, the most critical consequence of globalization for Afghanistan’s health system comes through the money and influence of multi-lateral and bilateral aid donors. Ideas, rules and regulations, conditional loans, and a tendency to transplant ‘best-practice’ models that have been implemented successfully elsewhere, are the essence of the connection between globalization and Afghanistan’s reconstruction efforts. Such influence is common for countries receiving international aid. However, the impact is even more pronounced in post-conflict countries in which a stagnant economy necessitates multilateral
assistance and loans through international agencies that require the revamping of macro-level institutions.

3.2 Donors and Changing Roles

It is recognized that health problems are rooted in social and economic conditions. There are technical answers to the threat to human life, such as increased coverage of immunizations, which seem to be politically neutral and pro-poor. Health reform strategy at one point focused on concrete, tangible results, such as the construction of clinics, or increased immunization coverage. However, it is not solely about producing health outcomes.

Increasingly, health aid is integrated into general development theory. Health reform is intertwined with agendas, motives and politics within donor agencies. The role of donors has shifted from one of being a channel for aid in order to reach development goals of third-world nations to that of controlling how policies are formulated, overall goals and future actions of recipient states.

In this section, I will review how the two primary donor’s of Afghanistan’s health care reform, the World Bank and USAID, conceptualize and prioritize various needs in a given health reform system. The goal of this section is not to link particular donor agencies with specific programs, but rather to understand the options of health reform and the overarching theories and values that drive the policy-making process for each of the donors.

In the 1990s, important achievements of health care in developing countries were attained, such as the movement toward universal childhood immunization, the expansion of oral rehydration therapy, and increasing attention to reproductive health and HIV/AIDS. However, in part due to globalization, which produced greater collaboration amongst all
global health actors, it became increasingly obvious that health systems in developing
countries were of low quality, inefficient, and inequitable (Berman 2000). Therefore,
donors raised the critical question of whether the health gains that resulted in previous
mico-level programs, which focused on concrete outputs such as small clinics, were
sustainable and if increasing funds through these kinds of programs would deliver the
benefits desired.

As a result, the concept of “health sector reform” was introduced and was defined as
“sustained, purposeful and fundamental change” (Berman 2000). According to Berman, it
would not be a “one shot” effort; it emerged from a planned, evidence-based process, and
addressed significant, strategic dimensions of health systems (Berman 2000). As health
actors globally realized the importance of a more coherent, holistic approach to health
reform, the approach to health care reform was revolutionized. What became clear,
however, was the broad spectrum of strategies for health care reform, which spanned from
introducing user charges to expanding a system of national health insurance. There is not a
need for prescriptive models but rather, policymakers need options for addressing key
policy issues (Cassels 1995). The table below provides a basic idea of the numerous options
reformers must analyze before identifying the mix of options that will support the donor’s
idea of what health policy reform implies for the host country.
### Table 4: Components of Health Sector Reform Programs

| Area 1: Improving the performance of civil service | Reducing staff numbers, new pay and grading schemes (including performance related incentives and salary decompression), better job descriptions and appraisal systems, improved financial disbursement and accounting |
| Area 2: Decentralization | Decentralizing responsibility for the management and/or provision of health care to local government or to agencies within the health sector. Establishing self-governing hospitals or autonomous district boards |
| Area 3: Improving the functioning of national ministries of health | Through organizational restructuring, improving human and financial resource management, strengthen policy and planning functions, setting standards for health care provision and developing systems for monitoring performance, defining national disease priorities and cost-effective clinical and public health interventions |
| Area 4: Broadening health financing options | Introduction of user fees, community finance, voucher systems, social insurance schemes, and private insurance |
| Area 5: Introducing managed competition | Promoting competition between providers of clinical care and/or support service |
| Area 6: Working with the private sector | Establishing systems for regulating, contracting with or franchising providers in the private sector including NGOs and for profit organizations |

Source: Cassels 1995

The array of options is extensive however the option chosen is not only dependent on an evaluation of the health needs of the target population, the size and capacity of the state, and level of decentralization for instance, but is a very political process amongst actors. In the end, “the choices made are likely to result from political decisions – even though technical specialists will provide information about the relative merits of different
options and will be responsible for their implementation” (Cassels 1995). Reform decisions are political and are judged through the norms and values of the guiding mission of a donor agency. Since instituting structural adjustment policies, donors became increasingly involved in social sector policy on poverty alleviation and social protection and have developed their own ideas of guiding principles for health reform (Cassels 1995).

Academics have employed key words such as purposeful change, defining priorities, refining policies, and reforming institutions to describe health reform, but how do aid donors—those with hundreds of millions of dollars to act on health reform—conceptualize the health policy process?

The World Bank maintained a distant position toward Afghanistan in the 1980s and 1990s. It only maintained a “Watching Brief”, monitored the country’s progress from Islamabad, Pakistan, and provided some assistance for refugees and studies on food security, landmines, and the economy. Since the fall of the Taliban in 2001, the World Bank is back in Afghanistan. During their absence, it has had an opportunity to develop its own strategies and priorities for thinking about health reform based on current development theory (Gerein 1994).

In 1993, the World Bank published the 1993 World Development Report (WDR), entitled Investing in Health and shed light on the poor access to adequate health care worldwide. This monumental document has essentially changed the terms of discourse in international health development (Reich 1993). The WDR summarized its position as follows: “Priority should go to those health problems that cause a large disease burden and for which cost effective interventions are available” (The World Bank 1993). The World Bank champions a policy in this report that is focused reducing low cost-effective services such as treatment for cancer or heart surgery and advocates for high cost-effective services,
such as medical care for common illnesses in young children such as pneumonia and
diarrhea. The overriding theme of the report is to obtain the most health gain per dollar
spent. This strategy is supported by a series of five articles published in The Lancet, all of
which describe the major public health challenge, “more than 10 million children dying
each year because they have not been reached by known and effective interventions.
Children are dying because of the neglect of common and preventable childhood illnesses,
of health problems in newborn babies, and of the measures needed to protect mothers and
infants during pregnancy and childbirth” (Lee 2003).

To be sure, donors have an integral role in saving lives of millions of children and
adults worldwide. However, the WDR does not outline what kinds of strategies are likely to
work or how to design effective strategies, nor does it clearly discuss the critical link
between politics and health. In essence, the World Bank has followed a single health
paradigm, evaluating the burden of disease and calculating cost-effectiveness of response
methods.

The World Bank’s first loan to the health, nutrition and population sector was in
1970; from that point onward, its presence, leadership, and funds have shaped the direction
of health reform worldwide. At the time of publication if the WDR, the World Bank
projected its funds in the health sector would grow from $350 million in 1992 to about $1
billion in 1995, making it the largest single source of external funding for health (The
World Bank 1993). Today, there are 154 active and 94 completed Bank HNP projects, for a
total cumulative value of $13.5 billion (The World Bank 2002).

USAID, is the international development implementation arm of the United States
government. What does this imply? USAID must abide by and follow United States foreign
policy regarding what kind of funding is given and which countries are eligible for funding.
In fact, USAID has developed a joint strategic plan with the State Department to harmonize foreign policy and development goals. This is exemplified in the inconsistent involvement of USAID in Afghanistan. USAID halted all funding for Afghanistan during the 1990’s when Pakistan, the base for fund operations for Afghanistan, was linked with the development of nuclear arms (personal interview with USAID official July 15, 2004). In this case, politics was the impediment to alleviating poverty and saving lives of the Afghan people.

Development aligned with security purposes raises the question of who is or who should be the primary beneficiary of foreign assistance? Is the purpose of USAID to strengthen and support NGOs that are consistent with US government ideology, such as faith-based organizations, for instance, which is the case with the current administration of George W. Bush? Is the main beneficiary of USAID involvement in foreign countries the United States itself? USAID is used for foreign policy objectives, thereby diverting them from solely development missions. This alters priorities, strategies, and level of commitment and involvement in states.

It is important to keep in mind that USAID’s objectives are attached to US foreign policy. Nevertheless, USAID has a clear set of health objectives that are mostly accomplished by the utilization of contracts with NGOs and the private sector. While the World Bank has advocated for a particular paradigm for health care reform by supporting low-cost, high effectiveness plans, USAID instead has a set of strategic objectives. These strategic objectives include the following: increased use by women and men of voluntary practices that contribute to reduced fertility; increased use of key maternal and child health and nutrition interventions; increased use of improved and effective responses to reduce
HIV transmission; and finally, increased use of effective interventions to reduce the threat of infectious diseases (USAID 1999).

USAID's strategic plan obviously differs in content and presentation from the World Bank's published reports. This does not imply that both agencies would not agree with one another in terms of the importance of respective priorities such as cost-effectiveness or maternal and child nutrition, for example, in health care reform. However, one must note the differences in approaches taken by these donor agencies to advocate for progress in the health sector. While the World Bank supports a theoretical paradigm and has a method for action, USAID policy answers what general goals or objectives should be pursued by developing countries in need of a solid health system.

These two agencies frequently work together. In the next section, I will discuss two case studies—Haiti and Cambodia—in order to illustrate how the strategies of these agencies shaped health reform implementation in these countries. These sector reform strategies in the two countries were the seeds to Afghanistan's health reform, despite the lack of evidence to support the methods employed within them and solely based on donor ideology.

3.3 Policy Transfer of Health Reform: The Seeds for Afghanistan's Health Care Package

It is interesting to note that, while the World Health Organization (WHO) is not a donor, in 1991 it partnered with the Afghanistan government to produce a “Master Plan for Rehabilitation and Reconstruction of the Health System in Afghanistan.” WHO identified itself as the facilitator for this Master Plan, which outlined the health situation in Afghanistan at the time. The Master Plan also proposed programs, budgets, and an overall
goal of a “health system built on self-reliance leading towards the goal of sustainable health programs” (1991). However, WHO is not a major player in the current story of Afghanistan’s health reform. While the focus on preventative health care, the greatest causes of morbidity, mortality, and disability, and on primary care are similar to the major goals of the BPHS, the manner in which WHO proposes that these goals be realized does not include PPAs. PPAs are in fact a relatively new form of improving the state of public health worldwide.

The ability of performance-based contracts (PPAs), such as utilized in Afghanistan, to re-establish a health care system is not yet well documented. As a matter of fact, Afghanistan is the first country to implement PPAs to reconstruct a nationwide health system. Contracting is attractive because it has the potential to accomplish the following: 1) utilize the public sector’s assumed greater flexibility and morale; 2) enhance managerial autonomy from political forces; 3) increase competition to raise effectiveness and efficiency; and, 4) allow governments to focus on ensuring rather than providing health services.

PPAs are trials based on the World Bank’s and USAID’s strategies and priorities in health, which discussed in the previous section. The transition from theory into practice has enabled both donors to play critical roles in forming the health reform packages for Haiti and Cambodia. These experiments are in fact how the strategies of the World Bank and USAID have been translated into real-world prescriptions and action plans. They are the also basis for the policy choices and content of Afghanistan’s reform. In fact, the same person at the World Bank was the main architect for both Afghanistan’s and Cambodia’s health reform. There is an inherent limit in variation, additional input, and critical evaluation that results from this practice, especially in an organizational environment such
as the World Bank where the number of loans given and their perceived successes are rewarded more than the evaluation of lessons learned in a project.

Haiti

Health sector reform is usually part of a larger package of development assistance (loans and aid) in low and middle-income countries such as Haiti. The health sector reform process in Haiti began with the adoption of a new health policy in 1996, within the framework of an economic program that proposed structural reforms including the restructuring of government functions, financial sector reform, the modernization of nine state entities, and a decentralization program. The health policy is based on two basic concepts, which are community health units (CHU), with the hope of decentralizing health services, and the basic package of services (BPS), which is “a basic set of essential integrated interventions, selected from among those that are most effective, to which the State is committed to ensuring access by the majority of the population” (Pollack 2001).

In 1995, USAID launched a ten-year project focusing on increasing the capacity of NGOs to provide basic health services. USAID contracted Management Sciences for Health (MSH), a US-based NGO focusing on health care in developing countries, to manage and disburse funds at 23 NGOs during the first five-year phase and 33 NGOs during the second five-year phase. During the initial period, funding was given to NGOs for their services and in 1997 a survey was taken to review the outcomes. This survey found that NGO performance was uneven; for example, in vaccinations a solidly performing NGO reached 70 percent of the target population whereas the worst performer reached 7 percent. Given these striking inequalities in service, MSH implemented a new pilot study and allocated funds based solely on performance. Performance-based payments allowed
institutions to receive bonuses for achieving performance targets, thereby providing strong incentives to improve management and build capacity and to use resources efficiently. While only three NGOs were included in this pilot study that served about 500,000 people, results were promising; all NGOs increased their performance and outreach. There was a 10 percent increase of children receiving all vaccinations between 12-23 months, and a 20 percent increase of women receiving three or more prenatal visits, which represented a shift from curative to preventative, low cost, high impact medicine (Pollack 2003).

As of September 2003, a total of nine NGOs in Haiti are receiving performance-based contracts and one NGO has had its contract discontinued due to poor performance. As one can see from the table below, while performance has increased within the target areas, as indicated by the percent of the total incentive earned, there continue to be striking variations (Table 5). For instance, NGO 2 enhanced its performance and thereby increased its share of monetary incentives available from 40% to 75% then to 90% for two consistent periods. Their performance was compromised, as indicated by the drop in the amount of incentive earned, to 20% percent. Unfortunately, research regarding the causes of differences in performance and ways the program can be enhanced have not been included in the agenda.
Table 5: Performance of NGOs in Haiti by Area

<table>
<thead>
<tr>
<th>NGO</th>
<th>Population Served total pop 1,194,008</th>
<th>Percent of Incentive Earned (Achievement of All Targets)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>P1</td>
</tr>
<tr>
<td>1</td>
<td>167,374</td>
<td>70</td>
</tr>
<tr>
<td>2</td>
<td>323,513</td>
<td>80</td>
</tr>
<tr>
<td>3</td>
<td>55,983</td>
<td>40</td>
</tr>
<tr>
<td>4</td>
<td>127,706</td>
<td>80</td>
</tr>
<tr>
<td>5</td>
<td>144,905</td>
<td>70</td>
</tr>
<tr>
<td>6</td>
<td>125,207</td>
<td>80</td>
</tr>
<tr>
<td>7</td>
<td>126,700 (discontinued)</td>
<td>10</td>
</tr>
<tr>
<td>8</td>
<td>NA)</td>
<td>48</td>
</tr>
<tr>
<td>9</td>
<td>59,620</td>
<td>78</td>
</tr>
<tr>
<td>10</td>
<td>63,000</td>
<td>48</td>
</tr>
</tbody>
</table>

Source: John Pollack 2003

The sponsoring donor conducted this research, so one should look critically at the methods employed and question what incentives exist for representing the data in a positive light. Even without adequate scrutiny of the complete objectivity of the evaluation, it is clear that performance is not uniform throughout areas. Moreover, with such a diverse set of providers looking to a variety of outcomes in the case of Haiti, as exhibited in Table 5, inequalities between approaches are pronounced and inevitable. Should equity in such a fragmented country be a primary concern for policy makers? As Boyce writes, to concentrate solely on increasing the size of the economic pie, without considering how that pie is divided, is an approach "singularly ill-suited to war-torn societies" (Boyce 2003).
Reasons for this were not given by the donor agency, but it is this type of inconsistency that, if replicated in a fragmented country like Afghanistan, could lead such a country to be even more divided. Haiti’s performance-based system, with its mixed success, does not prove that such a mechanism should be replicated in an even poorer, more fragmented country such as Afghanistan.

Cambodia

Cambodia is conducting a large pilot test to evaluate the effectiveness and efficiency of contracting with NGOs and the private sector for the delivery of primary health care services. Twelve districts with populations ranging from 100,000 to 180,000 were selected for the pilot test and three approaches were developed:

1. **Contracting Out (CO):** Contractors have complete control over service delivery, staff, wages, procuring and distributing drugs and supplies, and organizing health facilities;
2. **Contracting In (CI):** Contractors work within the Ministry of Health (MOH) system and must strengthen and build the capacity of the existing district structure. The contractors cannot hire or fire staff; drugs and supplies are provided by the MOH. The contractor receives $0.25 per capita per year to spend on incentives for staff and operating expenses.
3. **Control:** The management of services remains in the hands of the District Health Management Team (DHMT) and drugs continue to be provided by the MOH. The DHMT receives $0.25 per capita per year to spend on incentives for staff and operating costs. (Fronczak 1999).

A formal contract stipulated the responsibilities of the contractors, and also issued explicit targets for services. For example, immunization coverage was expected to improve by 70% and knowledge of at least three methods of family planning to 70% of the target population. To ensure that contractors would reach the poorest segments of the population, the performance score of contractors included the level of coverage among the poorest 50% of the community, as assessed by the quality of housing. Depending on the contract type,
the MOH would provide the facilities, equipment, training courses, technical guidelines, and drugs and supplies.

After the bidding process, Contracting Out was implemented in 2 districts, Contracting In was implemented in 3 districts, there were four control group districts with additional budget supplements, and 3 districts without any supplements\(^3\). What were the results? After a 2 ½ year trial period, the districts with contracted health service outperformed the control districts. The districts with Contracted Out performed superiorly to the Contracted In districts. Contracted Out districts increased the annual use of public health services to 1.7 contacts per capita, and contracted-in districts increased to 1.2 contacts per capita. Control districts had an annual per capita rate of only 0.8. The increased contact rate in contracted districts is a result of better access to primary health care in village health centers (Bhushan et. al. 2002).

In addition, Contracted Out districts experienced an increase in the use of reproductive health services, where, for example, coverage of antenatal care increased by more than 400 percent, compared to Contracted In and control districts where coverage rose by 233 and 160 percent, respectively. In addition, coverage of child health services also followed a similar pattern. Immunization rates increased in Contracted Out districts by 158 percent, in Contracted In districts by 82 percent, and in control districts by 56 percent (Bhushan et. al. 2002). In sum, contracted districts were more successful than the control districts and the claims of donors, that contracts were more equitable and efficient and were able to expand coverage quickly was supported.

A missing component of the two aforementioned reforms, on which the Afghanistan health system reform was modeled, is that the importance of organizations was not

\(^3\) Each district was chosen randomly for the type of contract that was implemented.
addressed, despite the fact that, “the tool with the largest potential leverage is the design of
the organization, including the systems, the structures and the process by which work gets
done (Nadle and Tuchman 1992). Within a section outlining the weaknesses of the
program, the final evaluation report for the Cambodia Health Service Pilot Project simply
states:

“The use of international NGOs as contractors created a special set of
difficulties for both parties. NGOs are not accustomed to working on contracts; their funding is usually in the form of a grant, and the funder is
generally a donor agency, not the host country government. NGOs
generally relate to the MOH as counterparts or even beneficiaries, but
certainly not as employees. It was very difficult for the contractors to
internalize the change in relationship required . . . The MOH, for its part,
had long been on the receiving end of NGO assistance and found the
sudden role reversal awkward. It was difficult for the MOH to exert a
normal level of management control in dealings with expatriate staff.
(Bhushan et. al. 2002)

Going beyond indicators of health service, what do the stated concerns of the
Cambodia case study imply for the sustainability of reform efforts that transfer this reform
to post-conflict settings such as Afghanistan? Due to the instability of post-conflict states,
should long-term planning be rejected for short-term goals with quick impact and thus the
failure of institution and state-building should not be a priority?

Haiti and Cambodia are relatively new cases and evidence regarding their
effectiveness both in implementing equitable health services across regions, as in the case
of Haiti, and building health institutions, which is a critical component to public health
delivery in general, as seen in Cambodia, is questionable.

This chapter has outlined some of the international ideological reasons for PPAs in
the context of Afghanistan. The logic behind donor’s ideas of what will make a successful
health reform package has guided health reform globally. However, the attempt to restore
Afghanistan’s health system is not solely a process driven by donor ideology and experimentation but there is an additional layer to the story. As the next chapter will explore, Afghanistan had several political influences and internal dynamics amongst aid donors that contributed to the focus on health and the implementation of PPAs for the reconstruction of Afghanistan.
Chapter 4: Beyond the Global Context: Actors and Motives that Shaped Afghanistan’s Health Reform and Implications

Health policy is not solely a product of discussion and research about how to improve and save lives of millions worldwide. Health has become a tool for overall development in the hopes of providing purposeful, fundamental, and strategic change to societies. While, as discussed in Chapter 3, the manner in which health reconstruction is manifested is linked with donor ideology, this is just one aspect of how particular methods of health reform come to the forefront of policy.

In the case of Afghanistan, there is also an additional piece to this story- the role of political will, power dynamics, timing, leadership and motives amongst and between stakeholders. Sections 4.1 and 4.2 will focus on how donors and the MOH of Afghanistan decided upon first immediately focusing on health and then utilizing PPAs as their method for increasing both the quantity and quality of coverage.

In addition, upon close examination of the areas that donors chose to focus on, as seen in Figure 5, one must wonder, why were particular provinces chosen by donor agencies? The logic behind these choices and the possible implications to both health service provision and long-term goals for Afghanistan such as state-building will be discussed in sections 4.3 and 4.4.

4.1 The Process of Reform: External Actors

The aim of the Tokyo International Conference on Reconstruction Assistance to Afghanistan in 2002 was to garner as much financial assistance from the international community as possible. The product of this effort was 5.2 billion dollars pledged to the reconstruction process of Afghanistan. Once these pledges were made, the next step was for
donors to “mark” how their funding was going to be spent. In other words, the key question was what does reconstruction mean to donors and in which sectors did they want to focus their attention? Negotiating power was the first step in focusing on one area of reconstruction and formulating a coherent plan amongst multiple donors.

Negotiating Power

It was at this conference that health reform was first discussed. According to one USAID official, initially USAID was discussing the prospect of reconstructing Afghanistan’s health services with the Ministry of Health (personal interview with USAID official July 12, 2004). However, the World Bank “hijacked” the process and became the leader of all discussion concerning health in the country. This does not imply that the World Bank should not have played a leadership role, as there is a strong need for at least one actor to assume the lead in the policy process in post-conflict countries where there is an absence of strong government (Bornemisza and Sondorp 2002). At the same time, “hijacking” a health sector’s reconstruction process may impede discussion, productive debate, and an objective, careful sifting of the evidence of past efforts. The presence of the World Bank and USAID is not only due to their belief in health as a sector that if reconstructed, would provide the most impact. In addition, political timing and the demands placed by the United States on the development community to produce a strategy that would help further Afghanistan’s development is a critical aspect to the story.

Political Timing

Regardless of who was the leader of the process, one important question to ask, as one informant noted, is why did all donors work together to provide a relatively expedient
solution to a disastrous health situation? For starters, there was intense pressure from the United States government for some kind of action to be taken in Afghanistan. The need for concrete measures was great, not only for the people of Afghanistan but also politically, in order to demonstrate to the world that the United States is taking quick action to rescue Afghanistan from its turmoil. Moreover, the US War on Terrorism made Afghanistan a priority for the United States, as its own security interests were dependent on Afghanistan’s development into a stable, democratic state. States have little experience in transforming in-conflict and post-conflict states into stable democratic states. There is an immediate humanitarian need and also a long-term development agenda. It is exactly these simultaneous forces that contributed to the use of PPAs for the rehabilitation of Afghanistan’s health system.

*Reaching Humanitarian Aid and Development Goals Concurrently*

Timing was not the only factor but also the needs of the particular place in focus played a critical role in deciding how to rehabilitation Afghanistan’s health system. Health statistics are so grim that it is impossible to ignore them. At the same time, a decision had to be made regarding whether to continue humanitarian aid for the health sector. If they chose to continue aid, this would imply quick impact public health efforts aimed at efforts such as nutrition and immunizations.

However, there was also a push by donor countries to produce tangible results with more politically impressive outcomes. According to one World Bank official, Japan proposed to build a 300-bed tuberculosis clinic in Kabul. This is a very specific service, and while it is needed, it is not necessarily the most appropriate approach, as it does not focus on the most basic health problems in Afghanistan. Focusing on basic health problems
would provide simple, essential services to a greater number of people with less expenditure per person.

The question the World Bank was asking, by comparison, was how to get “more bang for your buck”, as one informant stated (personal interview World Bank Official July 28, 2004). One way to get more value out of aid is to develop a more coherent, coordinated development plan for the health sector. But, how can this be accomplished in a country with a weak government and a poor public health system, especially when governments are traditionally responsible for the coordination of these efforts? The solution was PPAs, which were championed as high-impact, relatively rapid, low-cost solutions.

The BPHS is somewhat of an intermediate step between humanitarian aid and long-term development. In other words, as one informant stated, humanitarian aid and development are not on a continuum; they happen concurrently, which makes for difficult planning (personal interview with USAID official July 12, 2004). The BPHS depends on the non-profit sector (a short-to medium term solution that may be likened to humanitarian efforts) and strays from building health institutions equitably throughout Afghanistan (a long-term, capacity building endeavor).

Nevertheless, the BPHS is a strategic plan for saving millions of lives in Afghanistan, even though it does not consider issues long-term issues of sustainability. Why should one think about sustainability, asks one World Bank official, if one does not even know if the reform works? (personal interview World Bank Official July 28, 2004). The fact is that Afghanistan is being used as an experimental ground for health reform. Donors, their agendas, and their respective values shaped the policy. However, the MOH in Afghanistan also affected the policy process.
4.2 The Role of the State

Especially in health reform, the political means and strategies necessary to garner full support amongst all stakeholders have often been neglected. Without doctors, hospitals, small clinics and civil society at large, the opportunities and will from outside interest groups to “hijack” reform efforts increase significantly. Political analysis should occur concurrently with the technical aspects of policymaking (Roberts et. al 2004). What is on the agenda with regard to health reform is a profoundly political process; it is only once the agenda is established, that technical experts are relied upon to provide cost-effective remedies (Reich 2002). The political roots and consequences of the process are overlooked, and it is assumed that a technically sound reform is an implementable reform.

In the case of Afghanistan, donor countries, following their own ideologies of development, have advocated for a system of partnerships for a three year period in an effort to create a sustainable health system in a war torn country. Political timing, leadership, and position of players of the reform have been the critical components that have facilitated the implementation of BPHS via PPAs.

Political timing

Political timing has encouraged increased funds and interest in developing a democratic Afghanistan for the first time in twenty-three years. The US War on Terrorism and Afghanistan’s status with regards to the United States’ own national security interests have provided motivation for the US to help Afghans rebuild their livelihoods and governance and accountability systems. From the viewpoint of Afghanistan, this is an opportunity to be placed on the world agenda and reconstruct their country.
Leadership From Within

While the timing is ripe for health reform, the state has also learned to work with the international donor system in order to garner political support within Afghanistan. The leadership at the Ministry of Health has focused on coalition building with NGOs, donor agencies, and in-country staff to ensure that all participants support the initiative. A Deputy Minister of Health stated at a meeting with government staff and NGOs, “While this is not the best reform, I do not have anything better. I need your unconditional support on this reform system if we are going to do anything for the country of Afghanistan” (personal interview with government official in MOH: March 1, 2004). This kind of leadership encouraged parties to come together and, more importantly, start taking ownership of the reform and accountability. At this point, some staff realized that they were partial owners of this reform and had an integral role in re-establishing a successful health system. This Deputy Minister of Health changed the public perception and ownership status of this reform and at the same time built a supportive coalition.

4.3 The Logic Behind Geographic and Service Provision Variations

Thus far, the impetus for health reform and the utilization of PPAs has been explained, based on both donor agencies and the MOH. Deciding to focus on health and the manner in which health rehabilitation has manifested was a process that involved the overarching ideologies of donors, the politics amongst them, motives, the timing of reform (in terms of both similar reform efforts being conducted worldwide and the timing of global politics), and leadership.
However, to take this analysis a step further, why have the two main donor agencies focused their efforts in particular provinces within Afghanistan (See Figure 5). What is the logic behind these choices? This is critical since, as there are variations regarding the way health rehabilitation is being accomplished, there are possible consequences of these regional variations to long term goals such as state and institution building, for example.

The relationship between the actor working in certain provinces and the geographic location of their work along with the agendas, motives and manner in which health reconstruction efforts are manifested are listed in Table 6.

Table 6: Geographic and Service Variations by Actor

<table>
<thead>
<tr>
<th>Actor</th>
<th>Type of Service Provision and Rationale</th>
<th>Logic for Location</th>
</tr>
</thead>
</table>
| MOH   | • MOH receives funds for the provision of services in 3 small provinces, thereby changing role from facilitator to provider of services  
      • An experiment to test and possibly enhance the capacity of the MOH to provide services  
      • Recently started in September of 2004, but sentiment within MOH is that provision of services for three 3 provinces is overwhelming its capacity | • small cluster of provinces  
      • small cluster situated close to the capital  
      • relatively stable area with better socio-economic conditions than other more rural provinces in Afghanistan |
| USAID | • USAID provides services in small clusters or divides provinces  
      • USAID has hired a private company, Management Sciences for Health, to distribute their contracts. The implementing partner signs a contract with USAID and not the MOH  
      • Focus on areas that were neglected by either government or NGO provision of services, thereby ensuring greater equity | • Concentrated in the south and south-eastern regions of Afghanistan  
      • Focus area for health also overlaps with major security initiatives of the US government.  
      • Services are within close proximity to Peshawar |
The World Bank

- The WB uses provincial-wide contracts
- Rational is that it is less bureaucratic, easier to implement, and more efficient
- The WB distributes funds for the work in their provinces but the implementing partner signs a contract for service with the MOH and not the World Bank

- The WB, upon request, was the last donor agency to pick the provinces they would work in.
- They did not want to be associated with favoring one ethnic group over another, etc.

It is clear that the MOH, USAID and the World Bank have various agendas that have dictated the geographic location of their activities. First, the MOH is partaking in an experiment on whether they have the capacity to provide services to three small provinces. This is a large task to undertake and has been overwhelming the capacity of the MOH and diverting their attention from other tasks within the government. However, it may be a key lesson in this experiment— the government is definitely not capable of handling the provision of services so other options, such as PPAs, may prove to be the most realistic choice.

Second, USAID has opted to provide health services in smaller clusters. The rationale behind this is to help ensure equitable coverage. USAID recognized that small areas may have received adequate funding for health due to their affiliation with a well-known warlord or the health activities of a NGO. Therefore, in order to mitigate these imbalances in coverage, USAID chose to concentrate on smaller areas. Moreover, the majority of these efforts are concentrated in the south and south-eastern portion of the United States, where the US military efforts are based. Finally, USAID has joined with Management Sciences for Health (MSH), who is in control of the actual contracting
process. USAID spends approximately 40% of their funding for health on MSH and 60% of funding for the action provision of services via NGOs.

In comparison, the World Bank has chosen a provincial wide approach to encourage a uniformed system and easier method of provision. Moreover, while the funds are distributed by the World Bank, the NGO providing services signs a contract directly with the MOH.

While all these actors are following the same BPHS, the manner in which they are implementing the services has critical implications to both Afghanistan’s health system and the country’s future as a consolidated state. The two key differences are the cluster-wide versus provincial wide provision of services and the contracting process itself. Dividing provinces into clusters, as USAID does, may allow for NGOs to concentrate their work on neglected areas in greatest need. However, it also may hinder the development of a coherent system of health province-wide, thereby increasing inequalities within the province and further dividing regions. At the same time, if some segments of the population continue to be neglected, as what may occur under the provincial-wide provision of services, could this population eventually pose a threat to the stability of the region, or would it possibly lead to a massive relocation of some groups to where services are being adequately provided? Finally, if the MOH fails at providing health care to the three small clusters they are focusing on, will trust in the value of government decrease within this region? Moreover, have lives been lost because the MOH simply wanted to test their capacity?

Furthermore, the fact that contracts are being signed with the MOH in World Bank provinces versus with USAID in provinces funded by USAID can limit efforts to build the expertise and capacity of the MOH in the long-term. USAID has a tendency to strictly rely
on NGOs as their implementing partner and exclude government in unstable states. This is done to ensure greater accountability of funding; nevertheless, the continued omission of government will not increase their capacity or enhance the trust or reliability of the state’s citizens on their own governance structures.

The cluster versus provincial wide division of health services along with the differences in contracting practices are two examples of how equity and state-building efforts can be potentially fortified or hindered due to the nuances of implementation efforts between stakeholders. The concluding section below will further develop the concern of long-term consequences of Afghanistan’s health reconstruction efforts by discussing the plan’s implications on state-building.

4.4 Conclusions Regarding Potential Implications of Afghanistan’s Health Reconstruction Process

In the 1990s, the concept of health sector reform was defined, as stated in Chapter 3, as “sustained, purposeful and fundamental change that emerged from a planned, evidence-based process, and addressed significant, strategic dimensions of health systems” (Berman 2001). The reconstruction process in Afghanistan, in contrast, has taken the form of a complex experiment. Health reconstruction is not simply a technical matter. The ways in which health rehabilitation has manifested in Afghanistan is rooted in the contextual characteristics and history of the place in country, the forces of globalization that have allowed for policy transfer of health reforms world-wide and the power negotiations, motives, agendas, timing, and leadership between and within major actors.

Simultaneously, these factors were central to the policy formation process for the rehabilitation of Afghanistan’s health system. What do the decisions made during this
process imply for the long-terms goals of Afghanistan? Is the purpose of health reconstruction to save lives? Or, is goal to help build a solid state in a post-conflict country? The implications for equity and state-building as a result of the variations of type and location of donor involvement were discussed in the previous section. This section will discuss more generally how Afghanistan’s health rehabilitation plan can potentially impact broader goals of building a stable state.

4.4.1 Health Reconstruction and State Building

State building is used to describe the goal of building or supporting public institutions through external support. There is a strong link between a weak, economically under-developed state and propensity to conflict, which makes state building important in both post-conflict reconstruction and conflict prevention. For instance, Collier and Hoeffler found that the higher the level of per capita income the lower the risk of conflict (2004). Economic opportunities and options must be revitalized at a micro level, and economic institutions supporting economic foundations must be catalyzed and lead internal efforts toward the rehabilitation of a state. Reconstruction of property and infrastructure is one of the most immediate requirements. This will facilitate return of the displaced to their homes, security, governance and control, transport of food and supplies, and production and commerce to begin rebuilding the economy.

Development aid focused on longer-term state-building goals seems like a plausible and possibly even more appealing solution. However, in a post-conflict state where the weakness of the state primarily characterizes the political context, should state building be the primary goal? Where does state building fit into the world of humanitarian aid and
development policy? Should state building be a priority before immediately saving lives? Can these goals be achieved concurrently?

It is possible that, the post-conflict condition of Afghanistan implies that while the humanitarian need should not be pushed aside, an effort at state building should be incorporated into the plan? Machiavelli once stated, “The ruin of state is caused because they do not modify their institutions to suit the changes of the times” (1513 trans. 1950).

Afghanistan is going through a dramatic change- one that has the potential to transform and reinvent political, social, and economic institutions. However, is this opportunity fully being utilized in order to build responsive institutions? Actors involved were pushing to expedite the process according to their own ideals of a purposeful reform that was based on mediocre evidence of reforms from other third-world countries. Meanwhile they are not committing to a long-term plan and have placed NGOs as the primary providers of health in a piecemeal plan that differs from province to province. These are just a few indications that that a transformation of the public health system that supports the development of institutions is not on the agenda.

Some of the basic components of state building are the assurance of the provision of equitable services, the development of civil society, and the sustainability of development initiatives. These three aspects will be discussed below with regard to the nuances of Afghanistan’s health reconstruction plan.

**Equity**

One of the major components in state building, especially in post-conflict countries, is equity. In post-conflict countries, the major issue is how you divide the pie. Equity is addressed by the implementation of a fixed list of services within the BPHS throughout
provinces. However, will the fact that various agencies leading the provision of services by province create great disparities within regions, thereby further dividing Afghanistan? This is certainly an issue for planners, health policy makers, and those working in international development must consider when formulating a plan. The geographic variations and number of providers, despite having a uniformed BPHS, may increase the likelihood of the provision of inequitable services. This, in the long-term could cause great socio-economic discrepancies within the population in an already fragmented state.

Moreover, time, money, and flexibility are not integrated into the plan, as financial rewards are dependent on reaching numerical goals, such as the number of receiving immunizations. This mechanism is employed to ensure that there is a final product and funds are accountable. However, on the other hand, is it also a disincentive for NGOS to be responsive to their target population and innovate new methods of development? These kinds of decisions may impact the level of responsiveness and level of innovation of NGOs but possibly will impact accountability mechanisms. While there are no easy answers, it is important to be cognizant of the implications nuances within policies may have on the effectiveness of both the short-term goals of improving health and the long-term goals of a stable Afghanistan.

Civil Society

As Afghanistan transitions from conflict to different kinds of challenges, such as governance and service delivery, the growth of civil society organizations could be a vital actor in defeating past injustices and making developing governmental systems accountable
and responsive to its citizens. While globalization has contributed to the growth and rising influence of NGOs worldwide (one component of civil society), this does not necessarily imply that this translates into a strong civic community of NGOs. In fact, NGOs are increasingly called upon to provide tangible services, such as the construction of schools and hospitals. This is in fact case in Afghanistan, where the small number of national NGOs in Afghanistan are increasingly being asked to provide services. These NGOs do provide a regional expertise that very few international NGOs working in the country can compete with. However, they may be possibly moving away from their original missions that could have included broader goals of developing grassroots organizations, building social capital, and developing democratic networks. The plan for rehabilitating Afghanistan’s health system focuses on making NGOs solely assistance agencies in relieving the most visible symptoms of poverty thereby mitigating the value of developing responsive civil society organizations that work toward a strong, democratic state. At the same time, Afghan NGOs providing health services may develop their capacity and expertise in supplying essential services to the Afghan population.

**Sustainability**

During the policy process, a choice for Afghanistan was made- to save lives as quickly as possible. This is a major, if not the main mandate of the reconstruction of a state’s public health system. At the same time, the post-conflict status of Afghanistan makes reconstruction a monumental task- a mission involving the invigoration and reformation of institutions equitably throughout the fragmented nation. While providing

---

4 NGOs are simply one example of how civil society can manifest itself. While this discussion focuses on NGOs, this does not imply NGOs are the only way to build civil society.
health care to 25 million people will most certainly increase the economic and social conditions of the country, the policy does not systematically develop sustainable state institutions in charge of running health services once aid declines.

Is the hesitancy to provide support for long-term capacity building, sustainable health systems, and efforts that would support state-building a reflection of the particular political and economic context? The hesitancy of donor agencies to commit for more than a three-year period and use PPAs for implementation of health services is due to both the health reform trends globally, the particular ideologies of donor agencies, and also the dynamics and motives between and within stakeholders. The ideological assumption of PPAs is that it will help get underway a quick, coherent provision of health care through NGO participation. These NGOs theoretically will either have experience in health care in Afghanistan or will develop it quickly, and will be able to reach remote areas where formal government structures do not exist. Moreover, this approach would bypass the need for developing sustainable health institutions within the country that in the long run would have reinforced the strength of the State of Afghanistan.

Formulating policy is a value-driven, political process. The reconstruction of Afghanistan’s health system is an opportunity for the stability and growth of the country. Its post-conflict state make this task even more difficult, as state-building, humanitarian, and overall development needs are overwhelming the capacity of all stakeholders. Focusing on the rehabilitation of health services instead of also incorporating long-term health policy development in essence shrinks the state. The fact is a downsized state may not produce adequately produce a functioning state, which in the long-term may bring more instability and poverty to an already fragmented country (Reich 2002).
References


Berman, Peter and Thomas Bossert, “A Decade of Health Sector in Developing Countries: What Have We Learned?” in Appraising a Decade of Health Sector Reform in Developing Countries. Washington D.C., March 15, 2000.


Bornemisza, Olga and Dr. Edgbert Sondorp. “Health Policy Formulation in Complex Political Emergencies and Post-Conflict Countries: A Literature Review.” London School of Hygiene and Tropical Medicine, November 7, 2002.


National Geographic. Ethnic Groups in Afghanistan, Figure 2. Source: http://www.nationalgeographic.com/landincrisis/ethnic.html. 2002.


Interviews:

Care International, Interview with official, July 22, 2003, Washington, D.C.

Ministry of Health, Communication with former advisor, July 8, 2004, Washington, D.C.

Ministry of Health, Interview with government official, July 1, 2003, Washington, D.C.

USAID, Interview with official, July 12, 2004, Washington, D.C.

USAID, Interview with official, July 14, 2004, Washington, D.C.

USAID, Interview with official, July 15, 2004, Washington, D.C.