Working with NGOs in Post-Conflict Settings

Some Lessons from Afghanistan and their Implications Elsewhere

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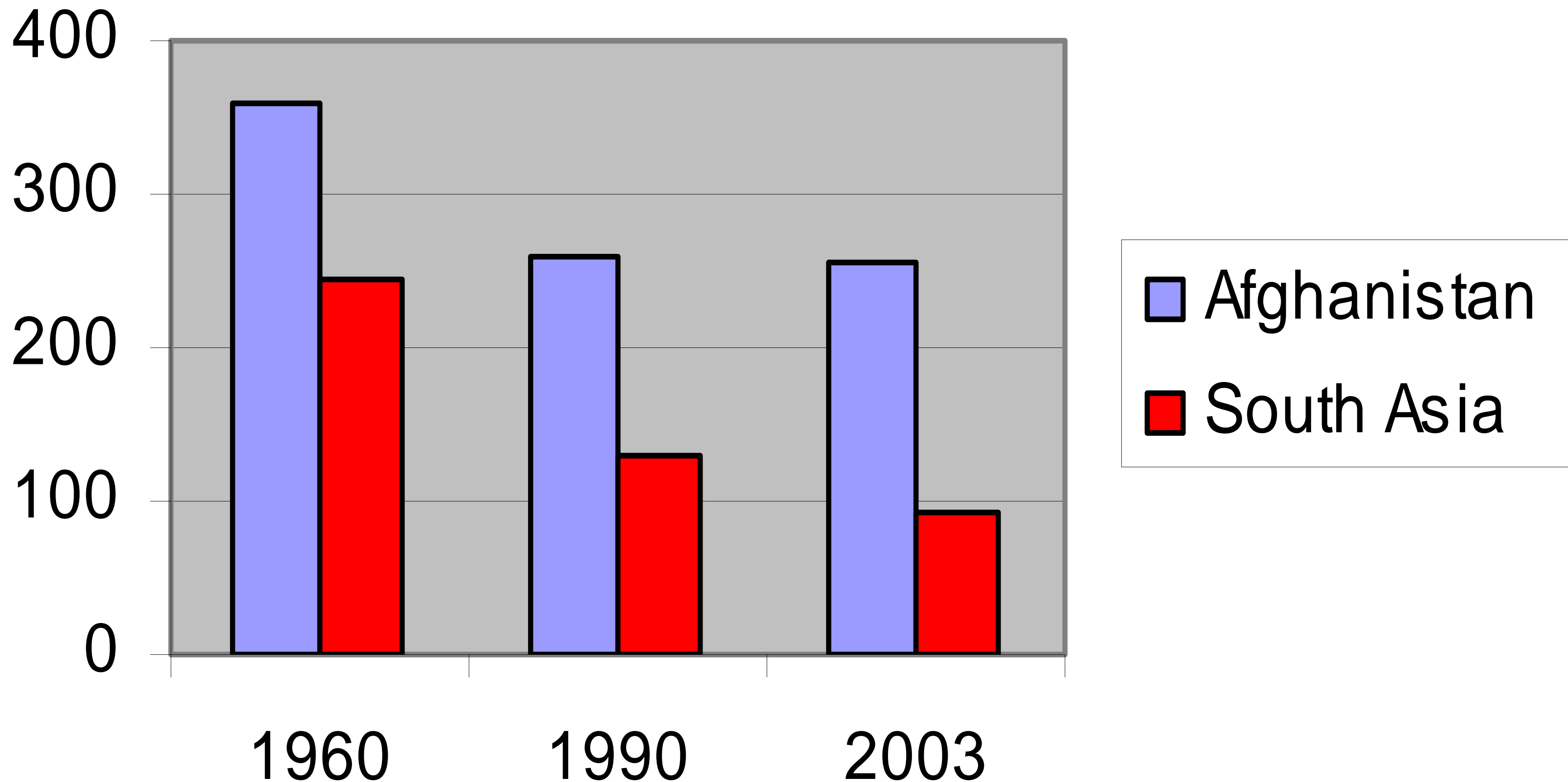
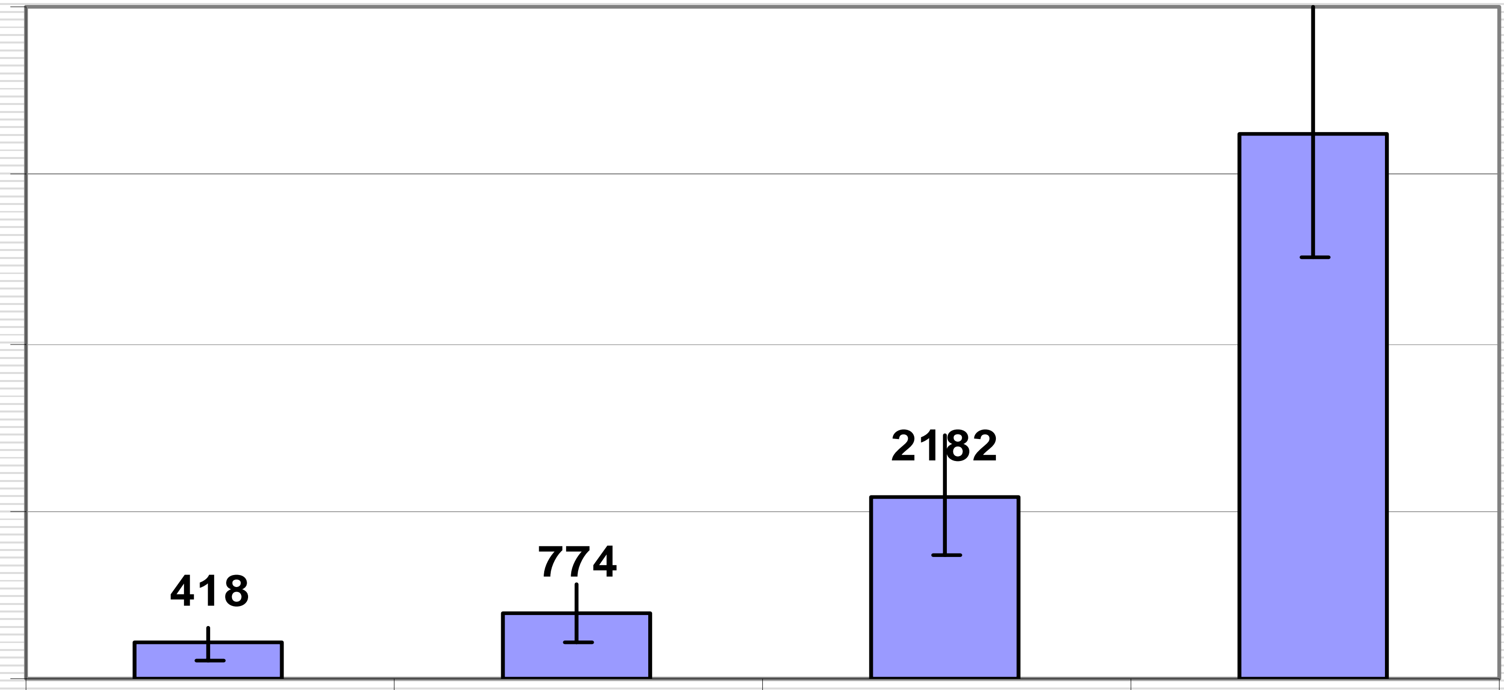
Outline

- Afghanistan background
- Afghanistan experience of working with NGOs
- Summary of Lessons Learned and Implications

Afghanistan had high U5MR in 1960 and remains decades behind other countries



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



2002-Reasons to Worry

- Very poor country
- Little physical infrastructure
- Health workers afflicted by the "3 wrongs"
  - wrong gender
  - wrong skills
  - wrong location
- Little coordination of NGO activities

Distribution of NGO Health Centers was Chaotic

Results of the Chaos

- Obvious inefficiencies:
  - Lack of clinics in under-served, remote areas
  - Difficult to hold anybody accountable, no clear catchment areas
  - Focus on clinics rather than the community

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Approaches to Working with NGOs and MOPH - WB

- MOPH recognized the advantage of contracting with NGOs – wanted to steward the sector & recognized own limitations
- MOPH signed performance-based partnership agreements (PPAs) with NGOs
  - Initially covered 8 whole provinces
  - Clear objectives and 10 indicators
  - Performance bonuses worth 10% of contract

Appro25 $ to Working with NGOs and MOPH - WB

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Approaches to Working with NGOs and MOPH - WB

- Established MOPH-Strengthening Mechanism (MOPH-SM) in 3 provinces near Kabul
  - Envelope budget spent through GOA system
  - Procurement done by agent of GOA
  - Able to pay similar salaries through "PRR" process
  - Recruited local consultants to work with MOPH Provincial Health Directors

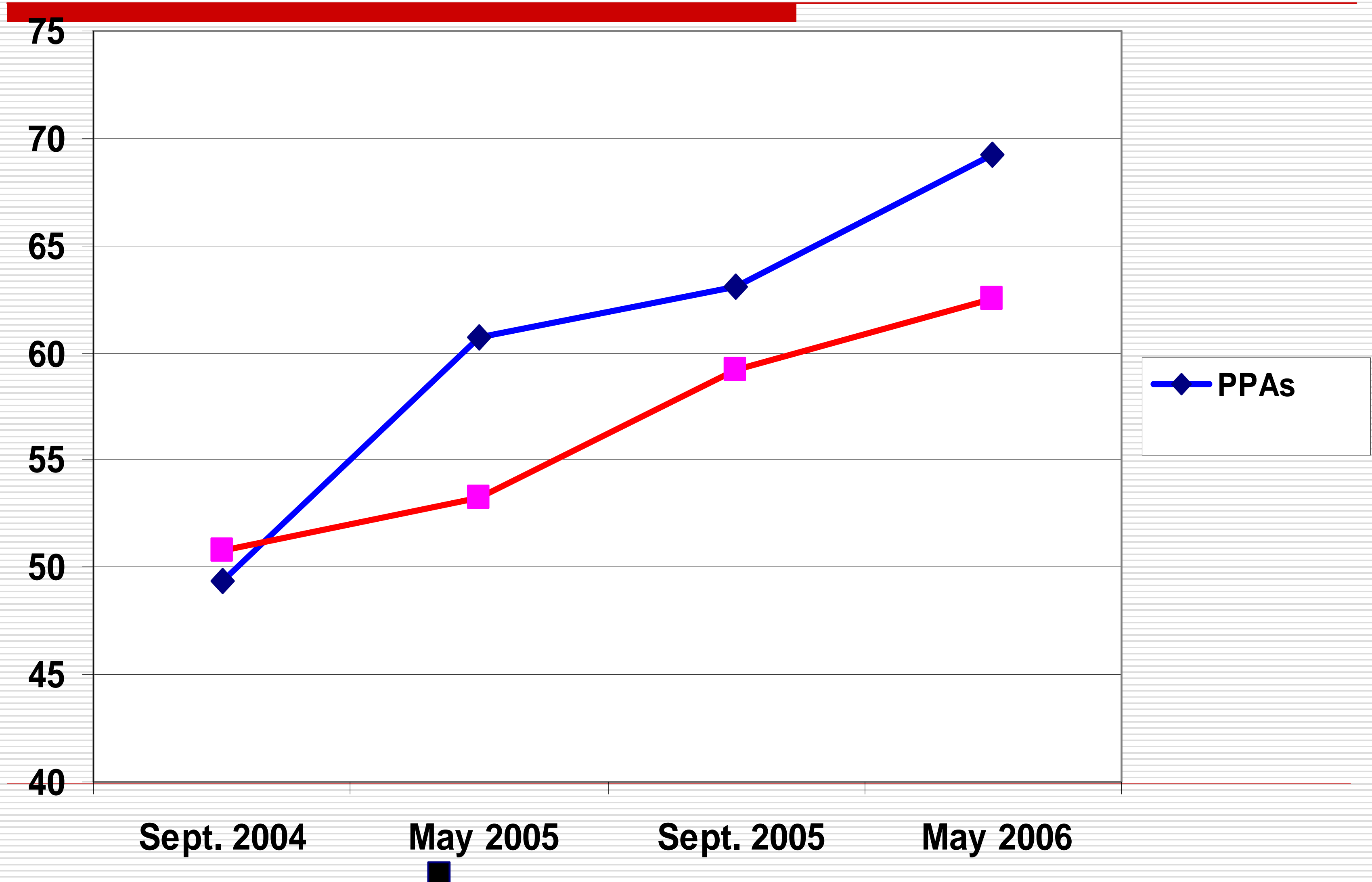
DIGRESSION: Quality of Care - Health Facility Assessment

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

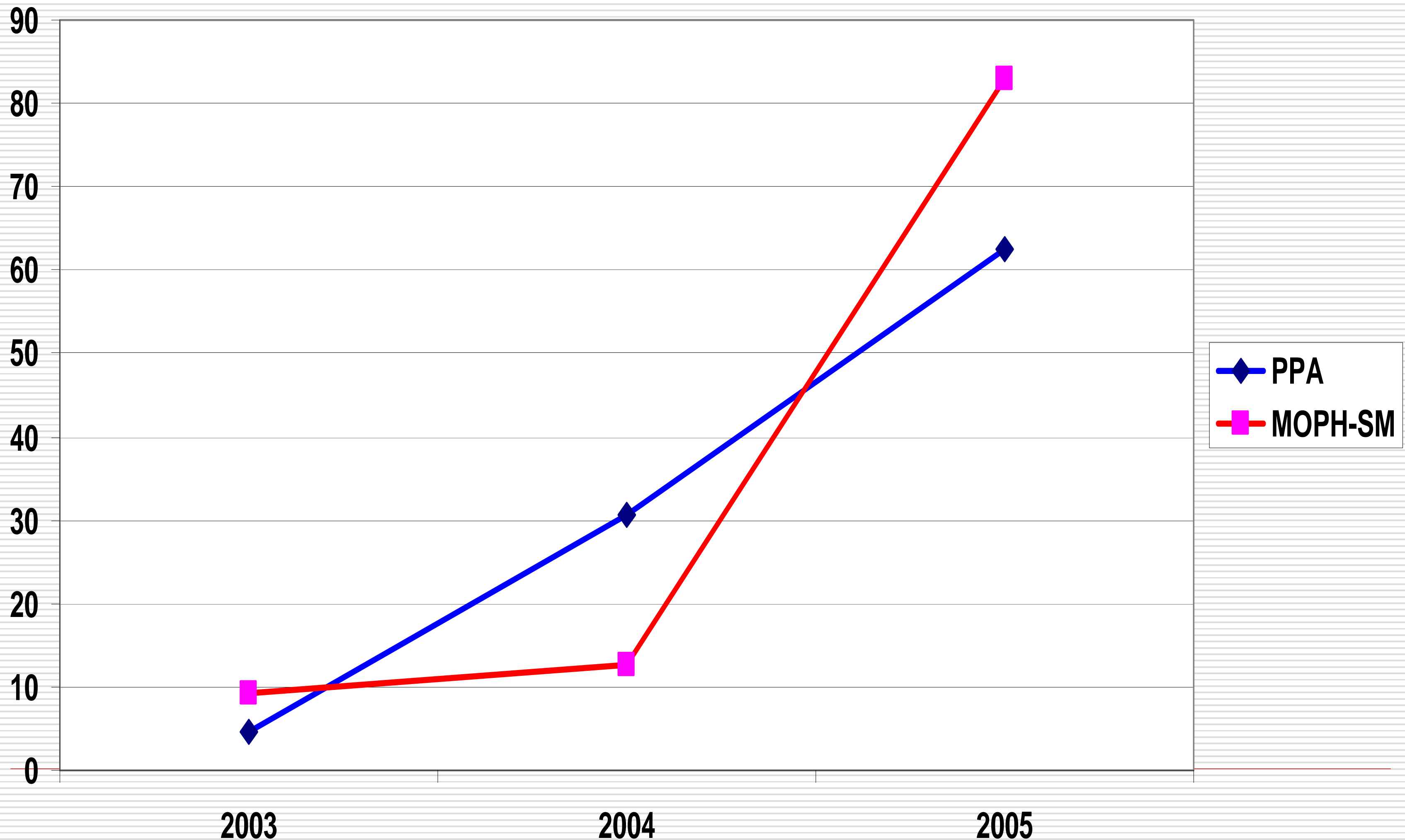
Quality of Care - Health Facility Assessment

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

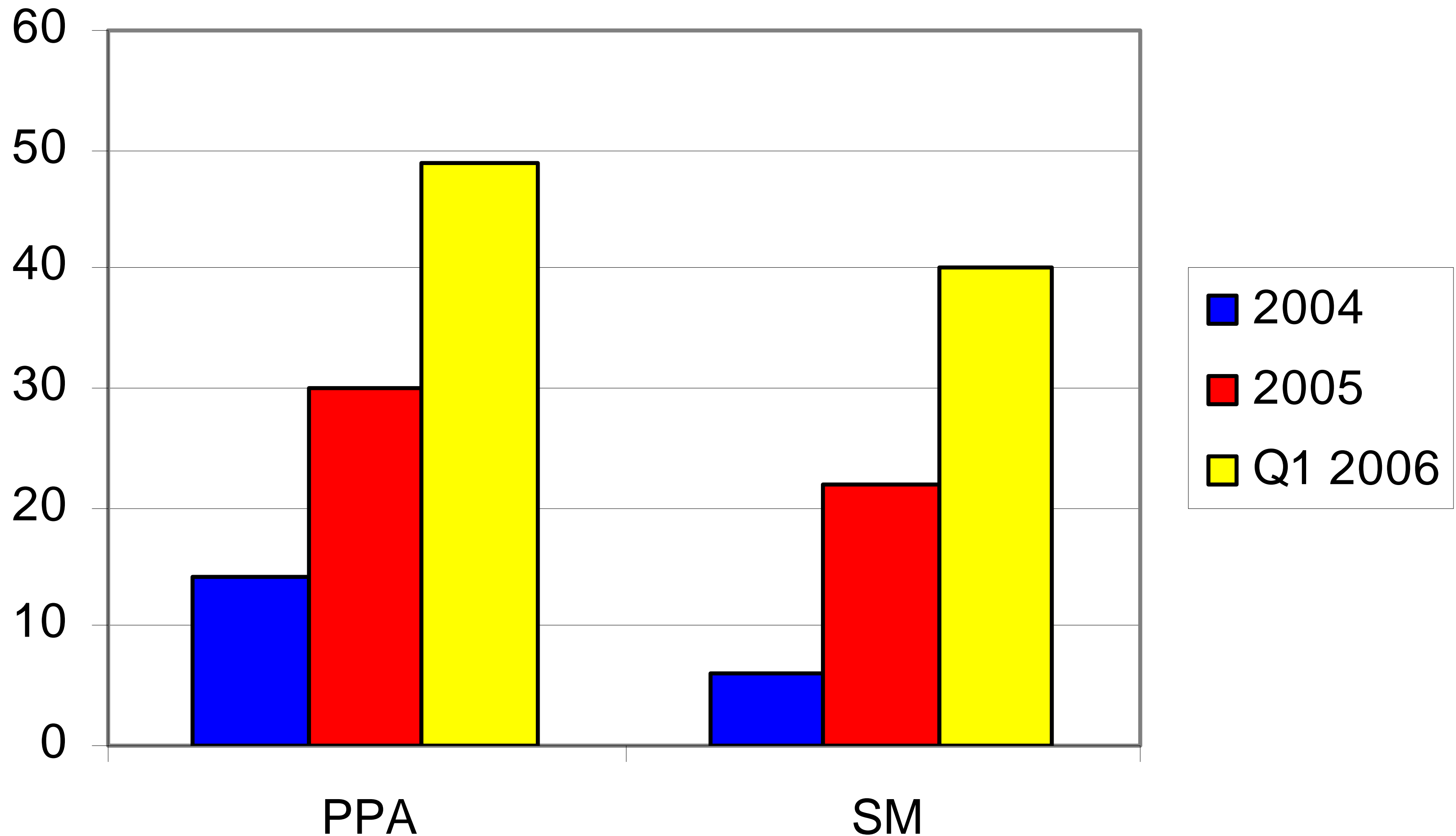
BSC Scores in PPA and MOPH-SM Provinces



Antenatal Care Coverage – MICS (2003) and HMIS



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



Reasons for Success

- Number of health centers increased 66% & 41% in PPA/MOPH-SM provinces
- % of facilities with trained female staff increased from 24.8% nationwide in 2002 to 85% in PPA areas & 72% in MOPH-SM
- Friendly competition, focus on results
- MOPH-SM guided by very talented manager

Approaches to Working with NGOs and MOPH - USAID

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

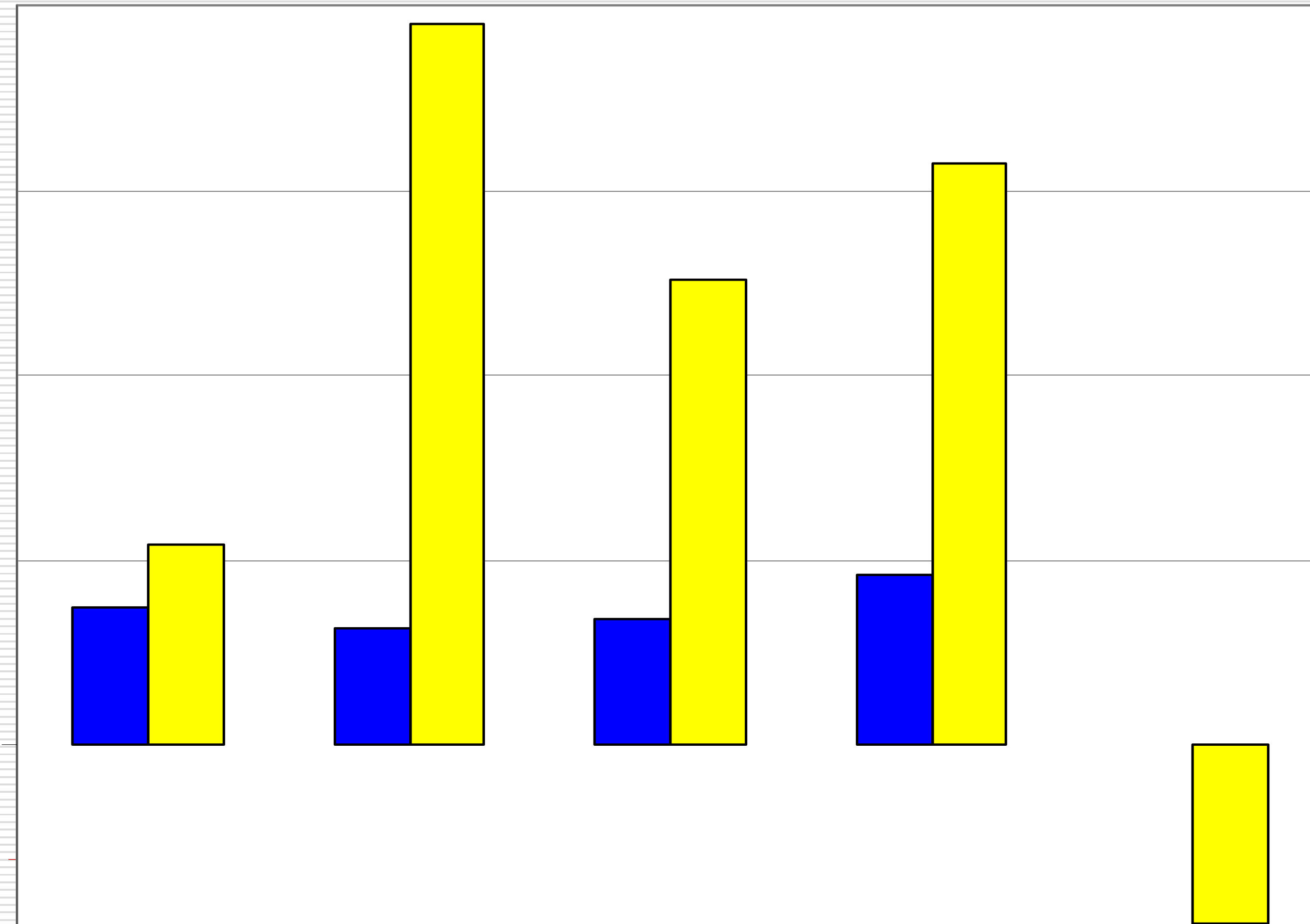
Approaches to Working with NGOs and MOPH - EC

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

Similarities in Approaches

- All based on the MOPH's Basic Package of Health Services (BPHS)
  - A series of preventive and curative services including vaccination, maternal care, TB
- National salary policy put cap on health worker wages to avoid wage inflation
- MOPH had bilateral donors choose provinces to coordinate and ensure accountability – used WB financing for rest

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



How have the different approaches evolved?

- EC in process of coursing funds through MOPH, MOPH responsible for monitoring
- USAID coursing funds through intermediary (WHO) to MOPH
  - larger catchment areas
  - more competitive, more contract than grant
  - now called performance-based partnership grants (PPGs)
- WB financing "holes" in BPHS coverage
- BPHS now covers 90% of country

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Sustainability and Replicability of Contracting with NGOs

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

Possible Lessons for USAID in Fragile States

- Do more, and more systematic, contracting with NGOs
- Continuous and sustained financing
- Focus on outputs and outcomes, not inputs à lump sum contracts rather than re-imbursement
- Each NGO contract should be large (significant economies of scale)
- Consider performance-based bonuses

Possible Lessons for USAID

- Geographic division of responsibilities is helpful and avoids confusion
- Follow the government's lead and course money through government
- Reduce dependence on external TA, hire local talent to work in the MOH
- Decentralize procurement to NGOs