

**CASE STUDY 1: A TIME-SERIED ANALYSIS OF HEALTH SERVICE DELIVERY  
IN AFGHANISTAN**

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“Well, the question is not if I **would** go or if I would be **allowed** to go [to a health facility] by my husband, but rather where I **could** go. (...)”<sup>1</sup>

## 1 INTRODUCTION

Over the past 25 years, Afghanistan has been through various difficult, but different periods. The intensity of the conflict has varied as has the degree of central control over the country, the interest of the central authorities in social service delivery, the engagement of the international community and the access of the international community to the various parts of the country. The different periods, therefore, show different ‘difficult environments’ and, with the advantage of hindsight, it seems worthwhile to look at these different periods to assess if some currently useful lessons could be drawn and to retrospectively assess if different approaches towards service delivery could have made a difference. With a focus on the health sector this case study will attempt to achieve this analysis. Special attention will be paid to the changes during the current transition period from a largely project based approach to a more system based approach.

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<sup>1</sup> Afghan woman, in Del Valle, 2004

## 2 COUNTRY CONTEXT

*“with a national vision, wise policy choices and coordinated and cogent international support, Afghanistan could become a self-sustaining, moderate Islamic, western friendly state... [Otherwise] Afghanistan at best will become another development failure, lurching from crisis to crisis and at worst a narco-mafia state, with a criminal elite and no respect for rule of law or civil and*

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### Classification of Afghanistan as ‘difficult environment’

Without too much difficulty, Afghanistan can be classified as a difficult environment, and not only now, but over at least the past 30 years. The abolition of the monarchy in 1973 was followed by a series of coups and counter-coups until a communist regime was established in 1978. Only the presence of Soviet troops in the country allowed the communist government to hold onto power until 1992. Thereafter, a very unstable period with Mujahedeen factions fighting each other was followed by a relatively stable period during which the Taliban ruled most of the country, a period that was ended by a military intervention of the international community at the end of 2001. Ever since, Afghanistan has been labelled ‘post-conflict’ and in a transition phase that many hope will lead to a stable, legitimate and democratic state. The quote in the box from a key player in the current government summarises what is at stake.

These 30 years in Afghanistan have seen periods of prolonged, wide-spread fighting as well as heavy, but relatively short bursts of intense fighting in more localised areas, with other parts of the country being relatively unaffected. The area under control of the central government has varied enormously over time and even today extensive areas are only marginally controlled by the central authorities. Throughout this period, the engagement of the international community has shown considerable change over time, ranging from support to the State to support to the ‘rebels’ and deliberate non-engagement. Consequently, the input in service delivery has varied as well, from considerable assistance to the Afghan refugees in neighbouring countries, to ‘solidarity aid’ and humanitarian aid inside the country, to more structured efforts towards rehabilitation during the 90’s and to the current focus on reconstruction.

The table shows a number of key events of the last 25 years.

| Table 1 --- Afghanistan: key events |  |
|-------------------------------------|--|
| • 1978                              | Communist regime established in Kabul  |
| • 1979 - 1989                       | Occupation by Soviet Union; troops leave Afghanistan in 1989   |
| • 1989 - 1992                       | Remaining period of communist regime in Kabul  |
| • 1992 - 1996                       | Coalition Government in Kabul of Mujahedeen groups leads to a rise in inter-factional fighting between the groups. |
| • 1994 - 1996                       | Emergence of Taliban taking control of a large part of the country   |
| • 1996 - 2001                       | Taliban in Kabul from 1996, governing most of the country  |

<sup>2</sup> Ghani A, Afghan Finance Minister, March 2003

- End 2001 International coalition forces and Northern Alliance oust Taliban; establishment of interim authority/government under 'Bonn process'
- 2002 – to date Continued fragile security situation in large part of country; massive return of refugees
- October 2004 First ever presidential elections: President Karzai elected

### Health Indicators and some background to Afghanistan's health system

The estimates in table 2 of some key health indicators available in 2002 show some of the worst health indicators in the world, in particular regarding maternal mortality. A recent UNICEF survey confirmed this average maternal mortality rate for the country, but highlighted huge differences between regions.

**Table 2 --- Afghanistan: health indicators 2002**

|   |   |                             |
|---|---|-----------------------------|
| • Infant Mortality  | - | 165 / 1,000 live births     |
| • Child Mortality   | - | 275 / 1,000 live births     |
| • Maternal Mortality  | - | 1,700 / 100,000 live births |
| • Life expectancy   | - | 47 years for men            |
| • Life expectancy   | - | 42 years for women          |
| • Poor indicators for water & sanitation and education, in particular women |   |                             |

Prior to 1979, Afghanistan's health system was primarily hospital, doctor and city based. Health care for the rural areas was largely restricted to a number of vertically run disease control programmes, including malaria, leishmaniasis and tuberculosis. The Soviet occupation strengthened the urban hospital capacity and medical doctor training in the areas under control. The population in Mujahedeen controlled areas started to receive some medical assistance, mainly through small-scale NGO operations across borders.

When the Soviets left and during the period of inter-Mujahedeen fighting, more areas became gradually accessible to establish a network, or rather patchwork, of NGO run facilities, mainly in the form of health clinics and limited assistance to some rural hospitals.

The Taliban showed little interest in the health sector, apart from enforcing strict gender segregation, which further impeded access to health services for women. However, since security and access in most of the country improved, the NGO facilities further expanded, while support to still existing Ministry of Health clinics also increased.

Thus, since the start of the war in 1979 until the end of the Taliban period, the pre-existing hospital sector gradually dilapidated and was partly destroyed, while rural areas started to receive some more health care in the form of usually quite basic health clinics. The latter provided minimal primary health care services and were mainly run or supported by NGOs. The vertical disease control programmes virtually ceased to function, except for EPI immunisation, and, most notably, the polio eradication efforts.

### Services provided by phase, actor and donor

**The 'communist period'** extended from 1978 to 1992, with Soviet troops backing the regime with an in-country presence from 1979 to 1989. During this period, Islamic 'rebels' called Mujahedeen, grouped under a variety of different commanders, increasingly gained control over extended parts of Afghanistan. In Government controlled areas social services were

expanded with Soviet support and quite some emphasis was given to education and health, for both men and women. The health sector continued to follow the largely hospital based care model, including the required training of substantial numbers of doctors. This has resulted in a legacy of mixed blessings. In terms of health policy development, the country missed out on 'Alma Ata 1979', with its ensuing emphasis on Primary Health Care and organisation of health care at the district level. In the areas under the control of the Mujahedeen, the pre-existing government facilities continued to operate but with increasing difficulty in terms of staffing, equipment, supplies and maintenance. Gradually the NGO community<sup>3</sup> that had sprung up around the millions of Afghan refugees in Pakistan started to extend into Afghanistan. Cross border access was possible, but only on foot, typically involving weeks of travel across mountainous areas. This allowed some small-scale direct service delivery in-country by expatriates walking in, carrying medical supplies in backpacks and on donkeys. Another strategy was to provide training (e.g. community health workers, laboratory technicians) to selected candidates from within Afghanistan in the Pakistani border towns, sending them back after graduation with some supplies and some limited follow up. This period will not be further analysed in the context of this paper. Data is scarce and the overall direct impact will have been limited. But the mode of operation, the contacts established, the expression of solidarity, the evolution of both international and local NGOs, and donor involvement during that period are essential elements to understand what happened in later phases, when more extended service delivery became possible.

**The 'Mujahedeen' period** lasted from 1992 to 1996. During this period the country was 'governed' from Kabul by a coalition of the most important Mujahedeen factions. However, central planning and resource allocation must have been minimal due to the emergence of widespread inter-factional fighting among the Mujahedeen. Most peripheral areas in Afghanistan were under the control of individual Mujahedeen faction leaders. The governance of these warlords in the areas under their control varied from being rather predatory to showing some benevolence to the population, including some attempts to deliver services. Most rural areas remained unstable. Nevertheless, during this period quite large areas became accessible to aid agencies spreading their wings from Peshawar to accessible areas. At that time, in particular after the termination of all USAID funding, the EU was virtually the only major donor, and most NGO activities were funded by the EU, under the DG-1 budget line of 'Aid to Uprooted People' (AUP). The rationale behind this programme was to assist areas to receive (expected) returning refugees; this rationale coupled with physical access from Pakistan, confined the activities mainly to the East of the country. Later on, ECHO established a presence in Afghanistan and assisted emergency and some longer term health activities in other parts of the country. Within a broader framework of assistance, the AUP funded activities as proposed by the NGOs who had managed to establish a presence inside Afghanistan, based on their assessment of needs and their capacity to address those needs. In the health sector, activities ranged from support to over 160 basic clinics in 18 provinces (Swedish Committee of Afghanistan); a model district health service in the province of Nangahar, near Jalalabad (HealthNet International); support to district hospitals in a number of provinces (Aide Medical International); support to clinics scattered over large parts of Afghanistan by an INGO turned into a local NGO (IbnSina), and support to some newer local NGOs in confined geographic areas (AHDS, CHA), to malaria control activities (HealthNet International). At some stage, the EC gave some support to the

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<sup>3</sup> The Soviet invasion and resulting stream of millions of Afghan refugees to Iran and Pakistan gave rise to a large and vocal NGO community to assist and advocate for the Afghans. In addition to pre-existing INGOs, quite a few new INGOs were established, especially around the issue of Afghanistan. Their primary base was Peshawar in Pakistan. The NGOs were supported by substantial flows of money through private fund raising in addition to funds from government donor agencies. Interestingly, and quite uniquely, local NGOs were also established during the war period. Some did so independently, while others were and still are supported by INGOs.

formation of a more overarching Primary Health Care policy, but this was more a model for 'post-conflict' reconstruction than a guide to the EU's own funded activities.

**The Taliban era** started in 1994 when their troops conquered large areas in the South and in 1996 took over control of Kabul. They never managed to take control of the whole country, with an area in the North of varying size still in the hands of what later became known as the 'Northern Alliance'. For most of the country this era heralded a period of increased stability and security. Access was much increased. However, the increasingly repressive policies, particularly towards women, prevented their recognition as a legitimate government by the international community, and no development partner relationship could be established. The Taliban did not show much interest in the social sectors and left them to dilapidate further, while the strict regulation vis-à-vis women further restricted access of women to health services and the employment of female medical staff. The pre-existing assistance pattern more or less continued, with ups and downs, while some attempts were made to at least mitigate some of the worst access problems for women. e.g. through emergency type assistance to some of the hospitals.

**'Post-conflict' period.** By the end of 2001 the Taliban were ousted by a US-led coalition and a new interim authority, (later the interim government) was installed. The Ministry of Health was revived with new leadership in all senior positions. Soon a new health policy was drafted, stating the key policy element of wanting to deliver a basic package of health services to all Afghans. Within a year a health strategy, based on this initial policy, was formulated and put in motion. Key elements were the Basic Package of Health Services (BPHS) for Afghanistan together with a definition of levels of health care with staffing patterns through which delivery could take place; a costing exercise, health facility survey and a standardised national salary policy. It was decided to have the BPHS delivered to as many Afghans as possible by Non-State Providers, i.e. the NGOs who had already been providing 80% of the health services by the end of 2001, possibly supplemented by newly incoming NGOs. This was based on three key considerations. First of all strong recommendations from the World Bank, among others based on a successful pilot in Cambodia. Secondly, the growing realisation by the MoH that they themselves— although traditionally the main provider - would not be able to deliver these services, and definitely not with the speed that was deemed necessary in light of the poor health status and the political need to include all Afghans (including the previously most excluded people in the remote rural areas) so that they would benefit from the renewed unity and peace-dividend. Thirdly, the purchaser-provider split that this new provision mechanism entailed, with the Government (MoH) in the role of setting policy, regulation, procurement and monitoring, was in line with general ideas about 'new public management' and the general policy of setting up a 'lean government'. A later element was to make the contracts between government (or donors acting on behalf of and in coordination with the MoH) and NGOs performance based. To this end the term PPA (Performance-based Partnership Agreement) was coined. Essentially, contract partners receive incentives if they exceed pre-set delivery indicators or are 'punished' (less payment or termination of contract) if these indicators are not met. This kind of widespread contracting out of delivery of health services in resource poor settings is unique. Pilots in other countries show potential benefits, but by and large the evidence base behind this policy is still weak. Key concerns related to this kind of contracting are fears of high transaction costs and insufficient regulation, transparency, monitoring and appropriate follow up action. Paradoxically, the scheme is partly designed to overcome the shortfalls of poor governance, while needing some key elements of good governance (accountability, regulation, enforcement) at the same time as a pre-condition. During 2003, various rounds of 'Call for Proposals' were processed by the three major donors involved in this scheme, the World Bank, USAID and the EC. Contracts with NGOs to deliver the BPHS in a geographically determined area (full province or sub-province level) have now been signed to cover well over 50% of the country. The World Bank implements this scheme very much from within the Ministry, through the newly set up Grants and Contract Management Unit. USAID operates

much more in direct tandem with the NGOs, while the EC takes an intermediate position. The contracts are now in their first phase of implementation. Time will tell if the BPHS will indeed be delivered, to how many people, for what cost, under proper control and accountability mechanisms, with reasonable transaction costs, etc. It is also unknown yet if the scheme, provided it proves to be reasonably successful, will be accepted as a longer term strategy and if sufficient (primarily external) resources will remain available for a long enough period to support it.

**Role of UN agencies.** The previous paragraphs cover the role of the various governments, key donors (Soviet Union, USA, EU) and the NGO community - both the international NGOs and the emerging national NGOs, but the role of the UN deserves a specific mention. The UN has played an important role in Afghanistan throughout the years, having the difficult task of spearheading efforts in international assistance and peace making. Most of the time the UN maintained a presence at Kabul level. In 1998, having realised that after 18 years of international assistance and peace making efforts, there was no common vision as to 'what the UN system is about in Afghanistan', a new approach was tested by the Strategic Framework for Afghanistan. The SFA was designed to promote greater coherence between the assistance and political wings of the UN. A review a few years later concluded that the Framework did not really work, largely due to the major underlying problem that the relationship between aid and politics represents a major unresolved and inadequately analysed issue between donor governments. This was not helpful in guiding the international community during the Taliban period in whether to isolate or engage with the regime. The experiences with the SFA and later work on strategic coordination in post-Taliban Afghanistan are still highly relevant for the current debate on service delivery in difficult environments, but outside the scope of this paper.

Various technical UN agencies also played a role throughout the years. UNHCR provided protection and assistance to the millions of refugees and WFP continued to provide much needed food aid. The health agencies, WHO and UNICEF, also continued to maintain a presence. WHO kept regional offices running in Afghanistan's regional capitals. WHO's role was mainly confined to providing support to communicable disease activities, including work on disease outbreaks and polio eradication. UNICEF's efforts in health focused on immunisation (EPI), with attempts to address the high maternal mortality being less successful. Their continued presence in the regions and at Kabul level throughout most of the war period gave WHO and UNICEF a head start when the chance to work on the reconstruction of Afghanistan arose in the post-Taliban period. UNICEF vigorously took on this role, focussing on filling gaps and contributing to the emerging systematic approach to the reconstruction of the health sector. WHO continued to focus on communicable diseases, but largely refrained from input in the health policy arena. Several observers lamented that WHO did not play a more active role in offering 'neutral', technically sound advice, in particular to support the fledgling Ministry of Health.

### **Analysis of strengths and weaknesses of the approaches employed**

In the previous chapter, four phases in the Afghan conflict were described: the communist period, the Mujahedeen period, the Taliban period and the current, 'post-conflict' period. The communist period will be excluded from this analysis. Aid dynamics were very different during that period, very much linked up with Cold War implications. The period is nevertheless relevant since it gives a historic perspective and explanation to some of the international aid dynamics vis-à-vis Afghanistan that are seen in later periods. In particular, the widespread public response of solidarity with Afghan refugees in the 80's, later transformed into interests to assist inside Afghanistan.

#### *The Mujahedeen period*

The country was formally under a unified government, a coalition of various Mujahedeen groups, but in fact most areas were governed by local leaders with very limited central government control. Although some basic, country wide policies and implementation strategies were maintained, lack of resources and general instability of the central government did not provide a policy environment amenable to upgrading service delivery. The government and local leaders were probably not unwilling, but definitely lacked the capacity. In this environment the EC continued to manage a programme, in health and other sectors, which provided services to a number of areas by contracting NGOs. The rationale of the areas chosen and services provided was practical access concerns and looking at where refugees would return to, if the situation improved (as was expected). Programming was very much NGO driven, based on their capacities, ideas, access and links with communities.

#### *Impact on vulnerable people*

It is difficult to predict the impact on vulnerable people during this period. A broad assumption for the health sector is that undoubtedly quite a few people will have benefited from improved access to health services. But, looking at the nature of the input (mostly a patchwork of very basic clinics, with occasional support to district hospitals and some disease control activities), it is unlikely that this will have had much public health impact. There would possibly have been some impact on child mortality, but less likely on the two other major killers; maternal mortality and tuberculosis. With hindsight, a more overarching health strategy governing the allocation of funds to the NGOs could have been beneficial. The core of such a strategy could have been a focus on the delivery of a minimum package of health services for as many people as could be reached given security, access and the available budgets; a package in line with targets set by the MDGs. Such a strategy, had it existed, could have contributed to improved health in the direction of the MDGs in at least some parts of Afghanistan and could have improved the base on which to build in the post-conflict period.

#### *Impact on sustainable systems development*

In the early days of this period there was an expectation that things would improve. That there would be a legitimate central government (Mujahedeen coalition) again, that refugees would return and that institutions could be rebuilt. A number of activities started to take this longer term perspective into account. The AUP Programme is an example. Here three other examples from within the health sector will be given. One of the largest NGOs active in health (Swedish Committee) operated more than 160 clinics spread over many provinces. With the argument of future sustainability, costs were kept to a minimum. Some have argued that this may have affected quality of care to the extent that the intended immediate health benefits for the population the clinics wanted to serve may not have materialised. The clinics themselves proved not to be very sustainable, as most did not fit with the new health care set up. Another example is the establishment of a district health service along the District Health Management model found in many other countries. The idea was that this project could act as a model that could potentially be replicated elsewhere in Afghanistan should the situation normalise. Although the Taliban era delayed progress towards this goal, the project in the end did act as a model for later health service reforms.

The same NGO (HealthNet International) ran a malaria control programme delivering a number of malaria related services in the Afghan refugee camps and inside Afghanistan. By building local capacity to control malaria there was the hope that this would be a key building block for the re-establishment of a central malaria control unit for the whole of Afghanistan. Now that this has become feasible, the transition from a fully NGO controlled activity into an activity within the framework of the new MoH is taking place. Some hurdles still have to be overcome and it will be useful, in due time, to capture the lessons learned along the way.

#### *The Taliban period*



This period is marked by a government unwilling and lacking the capacity to specifically address health issues and health service delivery. However, the void in the field of service delivery was partly taken up by an increasing number of players from the international community. In addition to the continuation of the mentioned EC programme (Aid to Uprooted People), there was increased UN involvement as well as activities through ECHO. The international community did try to formulate a more overarching strategic framework during this period, but struggled to get its position vis-à-vis the Taliban right. Policies were not consistent and had to respond to ever changing events, until they were taken over by the events post 9/11.

#### *Impact on vulnerable people*

By and large, aid services offered during this period expanded compared to the previous period. However, to an even greater degree than before they were of a 'humanitarian nature', addressing specifically vulnerable people. For the health sector this particularly meant attempts to keep health facilities accessible to women. The unresolved debate on whether to engage and do more versus total disengagement and stopping activities, made it hard to put more thought into longer term planning. However, for health, a more targeted approach as described above for the Mujahedeen period could have been useful.

#### *Impact on sustainable systems development*

The uncertainty as to how to engage during this period made it almost impossible to contribute to any sustainable systems development. On the contrary, NGOs seemed more and more entrenched in their own activities, disconnected from a (non-existent) larger picture. This made it hard for the NGOs to adapt to the sudden major shake up as a result of the removal of the Taliban. Longer term thinking in terms of system building and the role NGOs could play seemed to have almost vanished by then. With hindsight, it would have been good if the (health) NGOs could have retained some of the strategic thinking from the previous period. It would have made them a stronger partner in the ensuing health reconstruction policy process. It was the NGOs after all, who knew what it meant to run health services within the constraints Afghanistan poses.

Two interesting features of relevance to thinking about contributions to systems development during difficult periods should be mentioned here. They appeared during the Mujahedeen period, but were strengthened during the Taliban period. Firstly, there was the emergence of relatively large-scale, capable national NGOs, which is a rare phenomenon during chronic conflicts, in particular in the health sector. Further analysis of why this happened and if this can be promoted elsewhere would be useful. The new post-conflict health policy that aims to contract health services to non-state providers very much benefits from the existence of these NGOs. Secondly, the large health NGO community in Afghanistan proves to have been a home for many who have now taken up key positions in the MoH with a marked contribution to health system development at present.

#### *The 'post-conflict' period*

Chapter 3.4. describes what happened to the health sector in this new period: the establishment of a clear health policy and strategy, the roll out of a Basic Package of Health Services to all Afghans as a first priority and the contracting out of the provision of this package to NGOs.

Currently there is clearly a government that is very willing to provide services to its population. Capacity, though, is still limited. The choice to use NGOs to provide the services circumvents one aspect of capacity. But there is still a huge need to build the capacity at central and provincial level to regulate and supervise the contracting process. In the background human resource capacity building plays an important role, ranging from needed processes like civil service reforms, higher level managerial and public health capacity

building and training of a whole range of health professionals, in particular women. These capacity building activities can be and are being supported by the international community. However, this will take time. And, as some have remarked, the almost exclusive focus on service delivery may not pay sufficient attention to system capacity building. The experiment that is going on in Afghanistan is unique and worthwhile to follow over time, with proper documentation and analysis. The experiment is, however, a response to the specific circumstances of Afghanistan. The induced changes are dramatic, but do not involve the abolition of existing practice as will be the case in most other countries. It remains to be seen if all the practical and inherent difficulties of the chosen model can be overcome. Prerequisites to give the model a chance to develop and show its worth (or not) are of course a sufficiently long period of security and stability in the country, together with a stable policy environment without drastic changes and sufficient resources.

#### *Impact on vulnerable people*

Currently there is a climate conducive for the development and implementation of pro-poor policies. Enormous constraints for the impact of these policies to materialise will still have to be overcome. Some constraints are given and will be hard to influence, like the time it takes to build capacity, Afghanistan's geography, cultural aspects that will influence demand, civil service reform, etc. Other constraints may be more open to influences from outside, in particular the overriding key issue of security and, secondly, the availability of sufficient funds for an adequate length of time.

The current focus on the roll out of the Basic Package and the ensuing system oriented work is by nature a longer term strategy. No quick results in terms of health outcome may be expected. Indeed, some have argued that the exclusive focus on the roll out may hamper relief of more immediate needs in particularly vulnerable populations. This notion may require further analysis to assess if this really is the case, if different choices and allocations can be made, and what the various trade-offs would be.

#### *Impact on sustainable systems development*

The early formulation of a health policy and adherence and support by most stakeholders to this policy, potentially create good impetus to work on longer term institutional development and improved state accountability for pro-poor health service delivery. Time will tell.

#### *Reaction to the fall of the Taliban*

With the arrival of a new Interim Authority of Afghanistan, including a new MoH, there was a sudden void and opportunity to set a new health policy. It was in particular one actor, the World Bank, who came into this void with a clear proposal. Most other actors (new MoH, other donors, NGOs, WHO) did not have alternatives and as such most (one more enthusiastically than others), were happy to collaborate with the Bank. The joining of forces behind this idea meant that things could be put in motion, with sufficient flexibility for key stakeholders to overcome tensions with agencies' procurement procedures and unresolved transparency problems in channelling funds to the government. Key capacity to manage and monitor contracts has been set up in the MoH and seems to function well. The NGOs by and large responded to what some would label 'market forces' and showed willingness to come forward with bids to provide services and to enter into contract arrangements with MoH and donors. For most NGOs who were present in the country this meant massive reorientation from running scattered clinics all over the country to a focus on one or more provinces with the responsibility to run clinics as well as hospitals, to hire and fire staff, to conduct training, to organise supply chains, etc. Here again, time will tell if the NGOs can live up to these new expectations.

### 3 CONCLUSIONS

- Even in relatively unstable areas, with periods of relative calm of unknown prospective duration, and with relatively unwilling or incapable authorities, the delivery of health services with a focus on achieving the MDGs may be enhanced. A minimum willingness of the authorities to 'allow' activities by the international community will be required.
- A prerequisite may be the formulation of an overarching health policy and strategy, which can be disseminated (probably not imposed), among the various stakeholders. WHO could potentially play a role here, but has so far not shown the inclination or the capacity to do this.
- An approach to do more on MDG oriented service delivery during chronic conflict with areas/periods of relative calm would be to lay foundations in a potential 'fruitful' post-conflict period, where things may move relatively fast.
- The experiment in Afghanistan with new ways of service delivery deserves a chance to show its feasibility. Important lessons that may be applicable elsewhere could be learned if properly documented and disseminated.
- Humanitarian aid during chronic conflict is usually provided by NGOs and may have elements of capacity building beyond meeting direct humanitarian needs during periods of relative stability. Predictability that service provision by Non-State providers may continue post-conflict, which is currently usually not the case, may make capacity building programming during periods of relative stability during the conflict more relevant and targeted.
- Service delivery in environments that are as difficult as Afghanistan may be possible, but comes with a cost that can not be borne by a (new) government or the population. If this is not addressed and more explicitly discussed it will probably remain an illusion that service delivery can have much impact on the achievement of MDGs in this kind of environment.
- There is a need to collect more data on outcome of service delivery strategies in difficult environments. Current scarcity of virtually all kind of evaluation data makes policy making very 'opinion-driven'. Evidence is not easily collected in this kind of environment, but this should not be an excuse for not even trying.
- The model used in the post conflict Afghanistan to deliver health services through contracts may have far reaching consequences for human resources in health. The effects are not fully foreseen yet and will need ample attention.
- Finally, further analysis of a number of events in Afghanistan in the past as well as documentation and analysis of current developments may shed more light on the issue of service delivery in difficult environments. Specific issues mentioned in this paper are: the Strategic Framework approach, the Aid to Uprooted People programme, the establishment of well functioning NGOs during conflict, the capacity of the (health) NGO community to address broader health policy issues, the link and trade-off between meeting immediate humanitarian needs and health system development in an early post-conflict environment, the transformation from purely NGO led activity into MoH led activity (the HealthNet malaria case) and the outcome of the current key elements of Afghanistan's health policy – the basic package approach and the contracting of service delivery.

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