8

Afghanistan: Paying NGOs for Performance in a Postconflict Setting

Egbert Sondorp, Natasha Palmer, Lesley Strong, and Abdul Wali

Highlights

Large-scale contracting of nongovernmental organizations can deliver essential services to the population, even in a postconflict setting with weak service delivery capacity.

Government stewardship of the health sector can be enhanced with services delivered by contracted nongovernmental organizations.

Results suggest that nongovernmental organizations that are paid based partly on results perform better than those that are paid for expenditures on inputs, although this evidence is far from conclusive.

In 2002 donors and the nascent Afghan Ministry of Public Health decided to contract nongovernmental organizations (NGOs) to provide access to a defined package of essential health services. The three major donors active in the health sector—the European Commission (EC), the U.S. Agency for International Development (USAID), and the World Bank—varied in their approaches to payment, technical assistance, and accountability, which presented a wonderful opportunity to compare the effectiveness of alternative approaches. The World Bank incorporated performance bonuses in addition to a reliable fixed payment

and allowed recipients to use funds in ways they deemed to be most effective. Other donors reimbursed for documented expenditures on inputs, without an explicit performance-related financial incentive, and imposed rigidities on the use of funds. Each approach required NGOs to report and account differently for performance, and each donor provided access to different forms of technical assistance. This case, therefore, offers an opportunity to contrast the effectiveness of payment for performance with input-based payment in a postconflict setting and to explore implementation issues.

We describe the different contractual approaches and explore the limited evidence on their effectiveness. The available evidence suggests that those providers being paid with a pay-for-performance element in their contract perform better in some areas than NGO providers being paid with other mechanisms. The methods used to assess performance show some weaknesses, however, as do the measures of performance themselves, making it difficult to draw conclusions about the effectiveness of payment for performance in this complex picture. For example, location-specific factors such as security, geography, and baseline conditions at each facility may partly or fully explain observed differences in performance.

Background

Afghanistan has had some of the worst health statistics in the world for almost half a century. Even in the 1960s and 1970s, the health of Afghan women and children was far behind that of others in the region, and health services were largely absent in rural areas (Strong, Wali, and Sondorp 2005). This situation worsened as a result of years of conflict. The United Nations Children Fund's multiple indicator cluster surveys for 1997 and 2000 placed Afghanistan as having the fourth highest rates of child and infant mortality in the world. One child in four dies before he or she is five years old (Fleck 2004). The country's recent national survey of maternal mortality estimated maternal mortality at 1,600 per 100,000, on average, but the range varies between 400 and 6,500 per 100,000 across regions (Bartlett and others 2005), the second highest rate in the world. Inadequate human resources in the health sector present another extreme challenge: Afghanistan has only one doctor per 2,500 people and a severe shortage of trained midwives; only one in five nurses is female (Ministry of Public Health, Management Sciences for Health 2002).

Following the fall of the Taliban regime in 2001, donors began to review possible approaches to building up Afghanistan's barely functioning health system.

Table 8-1. *Contracts Awarded in Afghanistan, by Donors since 2003*

Donor	*Number of grants or contracts*	*Number of provinces*	*Population*	*Coverage (percent)*	*Annual costs per capita (U.S. dollars)*[a]
USAID	30	14	6,711,526	33	4.82[b]
European Commission	13	40	4,031,000	20	5.22
World Bank MoPH-SM	8	8	3,585,000	18	3.80
World Bank-PPA	1	3	1,105,247	5	4.82
Asian Development Bank	3	3	294,500	1	4.83
Totals	55	34	15,727,273	77	4.68

Source: Authors.
a. Bid prices.
b. USAID bid excludes drug costs.

The first joint donor review mission in 2002 highlighted the possibility of contracting NGOs to provide health services under the stewardship of the Ministry of Public Health. This would fit both the policy intention to create a lean government and the reality on the ground, where the majority of health services (estimated at 80 percent) were being provided by a number of well-established NGOs. The notion of using output-based incentives was also introduced, and the proposed contracts were referred to as performance-based partnership agreements. NGOs would compete to win contracts to provide a basic package of health services to people living in a geographically defined area. The Ministry of Public Health officially endorsed the approach, and the first contracts and grants were signed in 2003. All major donors in the health sector subscribed to this approach, but from the start some differences among donors were visible, primarily motivated by institutional arrangements internal to each agency (Strong, Wali, and Sondorp 2006a).

In collaboration with the Ministry of Public Health, between 2003 and 2005, the European Commission, the World Bank, and USAID entered into contracts with NGOs worth more than $155 million to provide the basic package of health services in regions covering 77 percent of the population. Between 2003 and late 2005, fifty-five contracts were awarded in a series of bidding rounds. Some details on these contracts are given in table 8-1. The Asian Development Bank (ADB) funded several contracts, also shown, but these were small in comparison to those of the other donors, and there are no plans to finance more. We do not include

discussion of ADB contracts because they are of marginal importance in future plans for contracts in Afghanistan.

Donor Approaches

Although the basic package of health services and contracts with NGOs for its delivery are common to all approaches, the nature of the contract used to govern the relationship differs among the donors. This variation is reflected in the use of quite different terminology, ranging from the European Commission calling them grants to the World Bank calling them performance-based partnership agreements. We refer to them generally as contracts (see table 8-2 for more detail on the various mechanisms).

The World Bank

World Bank funds service delivery through two types of contracts: those with NGOs to provide the basic package of health services to an entire province and those with the Ministry of Public Health to deliver services in three provinces through the so-called strengthening mechanism (MoPH-SM). The World Bank is the only donor to incorporate performance-based incentives as defined in this volume. Performance-based partnership agreements offer the prospect of winning a bonus worth 10 percent (amounting to more than $800,000 in some cases) of the contract value as an incentive to reach or exceed specified targets. This is achievable in stages, with 1 percent of the contract value payable for at least a 10 percent increase from the baseline for specified indicators. The final 5 percent bonus is paid at the end of the contract. By 2007 interim performance bonuses had been awarded to three NGOs, and more NGOs are expected to receive the bonus. In addition, the Ministry of Public Health is expected to earn a bonus for performance in the three provinces where the contracts are funded through the strengthening mechanism.

These contracts allow relative flexibility in how funds are spent, but they are still subject to the National Salary Policy and the tight specifications of the basic package of health services, which details services, staffing patterns, and ratios of facility to population. World Bank managers emphasized that this type of contract decentralizes authority to field managers and encourages innovation, because providers are motivated to reach performance targets by the autonomy and associated flexibility to use funds effectively and efficiently as well as by the opportunity to earn performance bonuses. The World Bank approach does not provide formal technical assistance, but its monitoring missions do offer frequent feedback.

Table 8-2. *Summary of Features of Approaches in Afghanistan*

Features and time period	*USAID*	*World Bank/Ministry of Public Health*		*European Commission*
		NGOs	*Ministry of Public Health strengthening mechanism*	
Type				
2002–05	Term used by donor: performance-based grant. Cost reimbursement against budget line items, with limited flexibility between items	Term used by donor: performance-based partnership agreement. Fixed lump-sum remuneration with 100 percent budget flexibility, with possibility of earning up to 10 percent of contract price in bonus	Term used by donor: performance-based partnership agreement. Set up as specific project within Ministry of Public Health, but will use regular government procedures; certain elements subcontracted to NGOs. Fixed lump-sum remuneration with 100 percent budget flexibility; possibility of earning up to 10 percent of contract price in bonus	Term used by donor: grant contract; cost reimbursed against line-item expenditure. NGOs required to contribute 20 percent of the overall budget (but mostly waived)
Plans for 2006 onward	To be called performance-based partnership grants; same budget and payment mechanisms	Same	Same	Cost reimbursement, but based on more detailed reporting of outputs

(continued)

Table 8-2. *Summary of Features of Approaches in Afghanistan (continued)*

Features and time period	*USAID*	*World Bank/Ministry of Public Health*		*European Commission*
		NGOs	*Ministry of Public Health strengthening mechanism*	
Geographic scope of coverage				
2002–05	Fourteen provinces; cluster-wide coverage: clusters of districts are recommended, but NGOs can propose their own clusters or even one district for funding. Other parts of the province may not be covered by a contract	Eight provinces; province-wide coverage: one basic package of health services provider in one province. They may work in partnership with other NGOs	Three provinces; province-wide coverage	Ten provinces; mix of cluster and province-wide approaches
Plans for 2006 onward	Thirteen provinces; three province-wide performance-based partnership grants; eighteen cluster-wide performance-based partnership grants (nine provinces): districts are predefined and cannot be altered	Province-wide coverage in eight provinces; the World Bank will expand coverage in several uncovered clusters in other provinces in early 2006	Province-wide coverage in three provinces; plans to expand the strengthening mechanism to four uncovered districts of Kabul	Mix of cluster and province-wide approaches in ten provinces; European Commission responsible for all of Ghor province
Duration				
2002–05	Twelve to thirty-six months	Twenty-six to thirty-six months	Twenty-four months	Twenty-one to thirty months
Plans for 2006 onward	Thirty months, with the possibility to extend for the same time period if performance is good for a total of five years	Eighteen-month extensions on existing contracts and twenty-four-month contracts for new providers	Eighteen-month extension	All areas will come up for tendering again during 2007

Performance-based elements				
2002–05	Performance-based grant: payment can be withheld if deliverables outlined in the contract are not met, but there is no monetary bonus	Performance-based partnership agreement: monetary bonus of 10 percent of the contract value over the life of the project. 1 percent awarded every six months for increases of 10 percentage points above baseline (for a total of 5 percent over the project) plus an additional 5 percent at the end of the project for improvements of at least 50 percentage points.	Same as NGO: monetary bonus of 10 percent of the contract value over the life of the project. 1 percent awarded every six months for increases of 10 percentage points above baseline (for a total of 5 percent over the project) plus an additional 5 percent at the end of the project for improvements of at least 50 percentage points	No performance-based components to date
Plans for 2006 onward	Performance-based partnership grant; there is still no monetary bonus, but extension of projects for an additional 2.5 years (for a project total of five years) is contingent on performance in line with expectations	Provincial health officers will be eligible to receive a bonus if NGOs qualify for a bonus	Same	Plans to instate "service contracts," where reimbursement of expenses is contingent on achievement of outputs. However, last-minute decision to revert back to "grant contracts"

(continued)

Table 8-2. *Summary of Features of Approaches in Afghanistan (continued)*

Features and time period	*USAID*	*World Bank/Ministry of Public Health*		*European Commission*
		NGOs	*Ministry of Public Health strengthening mechanism*	
Reporting, monitoring, and evaluation				
2002–05	Monthly review of deliverables through reports and spontaneous on-site monitoring and evaluation. The fully functional service delivery point quality improvement monitoring tool has been implemented in 65 percent of REACH facilities; baseline, midterm, and end of project household survey using Lot Quality Assurance Sampling methodology to measure outputs	Nationwide annual household surveys and facility-based inspections or interviews and semiannual facility inspections in all performance-based partnership agreements and province-wide projects conducted by third-party evaluator (Johns Hopkins University, IIHMR); submission of quarterly narrative and financial reports; ad hoc missions of World Bank and Ministry of Public Health	Same	Submission of annual reports to the European Commission and quarterly submission of technical narrative reports to the Ministry of Public Health as of late 2004
Plans for 2006 onward	Routine monitoring activities will remain more or less the same, although not at the same magnitude. Data from the final Household Health Surveys will be used as the baseline for new projects,	Johns Hopkins University–IIHMR contract has been extended to continue with the same scheme until 2008	Same	Semiannual reports to the Ministry of Public Health and the EC and external evaluation and quality assessment of the contracted basic package of health services projects

	and targets will be negotiated with NGOs. Evaluation will most likely be conducted by an external body			
Indicators				
2002–05	USAID has set standard indicators, but the targets can be defined by the NGO and negotiated with the purchaser. Baseline figures are based on household surveys conducted by the NGOs in the first quarter of the grant	Nationally defined core and management indicators. Baseline figures will be extracted from a multiple indicator cluster survey conducted in 2003	Same	NGOs can define their own indicators and use a traditional logical framework. However, one of the priorities of the program is to start defining and measuring performance-based indicators related to the basic package of health services
Plans for 2006 onward	Indicators will be revised to include a mixture of previous USAID standard indicators and PPA indicators. Targets are still set by the NGO and negotiated with the purchaser	Indicators will be revised based on feasibility of data collection on current indicators	Same	Indicators will be based on national indicators, to be made province-specific

Source: Strong, Wali, and Sondorp (2006a).

The World Bank is the only donor that channels funds through the Afghan Ministry of Finance; the Ministry of Public Health is responsible for paying contractors. The Ministry of Public Health also carried out the procurement process, subject to approval by the World Bank. A Ministry of Public Health unit is responsible for collecting quarterly health data for ongoing monitoring. To complement this, independent monitoring and evaluation are contracted to a third party made up of Johns Hopkins University and the Indian Institute of Health Management Research.

USAID

USAID's Rural Expansion of Afghanistan's Community-based Healthcare (REACH) project has awarded contracts to NGOs to deliver the basic package of health services with the Management Sciences for Health as the implementing agency. REACH awards two types of contracts: those to NGOs to deliver services in single districts or clusters of districts and those to implementing partners and the Ministry of Public Health to deliver technical assistance. Unlike the World Bank, REACH permits multiple providers in a province. REACH has an explicit focus on capacity building, so attention has been paid to establishing new and improving the management systems of existing national NGOs.

Management Sciences for Health representatives in Afghanistan felt that in the first phase of funding NGOs were not prepared to operate successfully under pay for performance and wanted to see how well NGOs could function without incentives. Because they believed that introducing monetary incentives would create opportunities for fraud, they thought that efforts should focus on improving the technical capacity of NGOs to deliver the basic package of health services.

Under the REACH project, therefore, NGOs establish targets for improvement for a standardized set of indicators—a mix of input, process, and output indicators—developed by Management Sciences for Health. Performance is measured against these indicators, but there is no performance-based bonus. Payment can be withheld if deliverables (monthly reports) are not submitted or if monitoring visits reveal problems. Contracts can also be terminated for failure to perform. This has happened once.

Although Management Sciences for Health ran the procurement process in the initial round, the Ministry of Public Health was involved in all stages, including development of tender documents and evaluation of bids. Both central- and provincial-level representatives of the ministry were included in the evaluation. Although monitoring activities and grant management were responsibilities of Management Sciences for Health in the initial round of grants (between 2002 and

mid-2006), USAID handed over these tasks to the Ministry of Public Health in the second round. Institutional procurement rules continue to prevent USAID from channeling funds through the government. The World Health Organization will manage payments for the second round of contracts.

European Commission

The European Commission was the first donor to contract NGOs to deliver health services in early 2003, before the final version of the basic package of health services was approved. Contracts awarded to date do not contain any performance-based features, and the EC approach most closely resembles traditional grant funding. A competitive process was put in place to award contracts, but NGOs are reimbursed for expenditures on inputs. NGOs define their own indicators based on a logical framework. To date, the EC monitoring systems require the submission of annual narrative progress reports. The Ministry of Public Health has been involved in a review of tender documents and evaluation of proposals, although to a more limited extent than with other models. However, it is envisaged that all procurement responsibilities will be handed over to the Ministry of Public Health in future rounds of funding.

Table 8-3 illustrates the forms that contracting has taken in Afghanistan and details some of the main differences among them. It also highlights some of the changes that donors have made to upcoming rounds of funding in response to greater familiarity with the Afghan context and developments in the health sector. In general, the models have become more similar over time, and newly adopted features have streamlined donor approaches. The World Bank, however, is the only donor with plans to continue incorporating financial bonuses.

Monitoring and Evaluating Systems

For pay for performance to work, performance has to be measured and validated. The value of monitoring and evaluating services delivered has received attention in Afghanistan, and support is being provided by several sources. A new national Health Management Information System (HMIS) has been put in place by the Ministry of Public Health together with USAID's REACH project, and training has been conducted on a national scale to establish systems at the provincial level.

The HMIS represents the national monitoring system that all providers are required to report on, but donors have established additional mechanisms to monitor performance. Some of these are specific to donor activities, and some cover all facilities.

Table 8-3. *Reporting, Monitoring, and Evaluation in Afghanistan, by Donor Program*

USAID	*World Bank, Ministry of Public Health*	*European Commission*
Submission of detailed quarterly reports Quarterly monitoring visits (one visit per facility per quarter) Implementation of fully functional service delivery point Household surveys conducted at baseline, midterm, and end of project by NGOs Semiannual roundtable meetings Semiannual face-to-face meetings	Submission of quarterly technical and HMIS reports Third-party performance assessment conducted annually nationwide and semiannually in performance-based partnership agreements, Ministry of Public Health strengthening mechanism, and three European Commission projects Ad hoc monitoring missions conducted by the Ministry of Public Health and the World Bank Monthly performance-based partnership agreements coordination meetings and some face-to-face meetings Wide circulation of aide-mémoires documenting mission findings to all stakeholders	Submission of annual technical and financial reports Submission of quarterly technical and HMIS reports to the Ministry of Public Health Ad hoc monitoring visits from European Commission head office in Brussels

Source: Authors.

The World Bank is funding a large external evaluation program conducted by Johns Hopkins University and the Indian Institute of Health Management Research (IIHMR). This includes four annual assessments of the performance of national health facilities in all thirty-four provinces and three semiannual assessments in eleven provinces covered by World Bank contracts (eight provinces with NGO contracts plus the three MoPH-SM provinces) as well as three provinces covered by EC grants.

Based on the annual assessments, scores on a balanced scorecard are calculated at the provincial level. Details of the components are shown in table 8-4. The

Table 8-4. *Components of the Balanced Scorecard*

Domain	*Component*	*Detail*
Patients and community	Patient satisfaction	Patients were asked to rank whether they were satisfied with their visit
	Patient perceptions of quality	Patients were asked to score a range of quality-related items such as courtesy of staff, cleanliness, and availability and cost of drugs. This is a composite index of nine items
	Written community health committee activities	Percent of facilities with a written record of activities
Staff	Health worker satisfaction index	Staff were asked to rank fourteen measures of their own satisfaction such as working relationship with other staff, availability of equipment, and salary. This is a composite index of these fourteen items
	Salary payments current	Whether staff have received their salary within the past month
Capacity for service provision	Equipment functionality index	Presence of key equipment, such as weighing scales for children, thermometer, and sterilizer
	Drug availability index	Presence of five key drugs (Paracetemol, Amoxicillin, Tetracycline eye ointment, ORS packets, and iron tablets)
	Family planning availability index	Presence of family planning supplies
	Lab functionality index	Eleven items to measure the functionality of the facility's laboratory
	Staffing index	Whether the facility had the requisite staff as prescribed by the basic package of health services
	Provider knowledge score	Level of knowledge of providers relevant to their cadre
	Staff received training in last year	Percentage of staff who attended post service training in the last year
	HMIS use index	Availability and upkeep of HMIS
	Clinical guidelines index	Availability of various clinical guidelines

(continued)

Table 8-4. *Components of the Balanced Scorecard (continued)*

Domain	*Component*	*Detail*
	Infrastructure index	Appropriate number and condition of rooms
	Patient record index	Maintenance of appropriate patient records
	Facilities having tuberculosis register	Availability of tuberculosis registers
Service provision	Patient-provider care index	Time spent to check a patient
	Proper disposal of sharp objects	Checks for proper disposal of sharp objects
	Average new outpatient visits per month	Number of new patients
	Provision of antenatal care services	Availability of antenatal care services
	Delivery of care according to the basic package of health services	Availability of delivery services
Financial systems	Facilities with user fee guidelines	Availability of user fee guidelines
	Facilities with exemptions	Facilities with exemption mechanisms for poor people
Overall vision	Females as a percent of new outpatients	Females as a percent of new outpatients
	Outpatient visit concentration index	Proportion of poor versus rich using health services
	Patient satisfaction concentration index	Satisfaction of poor versus rich with health services

Source: Ministry of Public Health, Johns Hopkins University, and IIHMR (2004).

scorecard is based on a random sample of health facilities in a province and measures the extent to which their activities are aligned with those prescribed by the basic package of health services. This mechanism is the only independent monitoring and evaluation mechanism in place that documents performance in all provinces, making it a valuable investment for the Ministry of Public Health.

Other monitoring mechanisms include the submission of quarterly narrative, financial, and HMIS reports to the Ministry of Public Health and ad hoc monitoring missions to the field (a World Bank midterm review in mid-2005 and quarterly visits under REACH contracts, for example). USAID introduced the fully functional service delivery point (FFSDP) monitoring tool as a way for NGOs to monitor the level of quality in facilities. It consists of internal and external exercises to monitor improvements in a number of indicators related to quality of care. Many of the indicators are similar to those included in the balanced scorecard.

Table 8-5. *Proportion of Facilities to Population in Afghanistan, 2002–05*

Indicator	*Number*
Number of provinces	34
Number of health facilities	
Baseline	606
Current	1,050
Population	20,569,020
Ratio of health facilities to population	
Baseline	1:33,993
Current	1:19,560

Source: Authors.

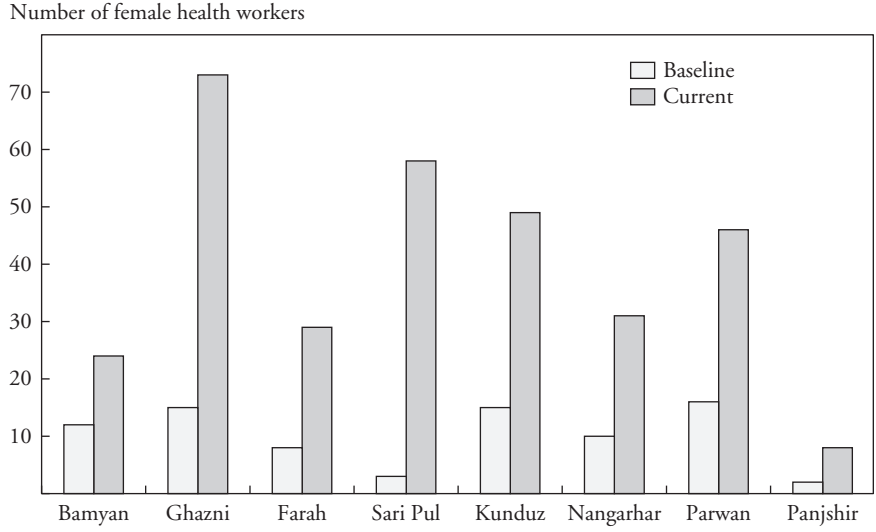
The FFSDP tool aims to encourage NGOs to monitor their own performance. To date, the FFSDP tool has been implemented in 65 percent of REACH facilities, and there are plans to pilot it in four provinces with World Bank and EC contracts, with the possibility of expanding it to the entire country.

Under USAID's REACH project, NGOs are responsible for conducting their own baseline, midterm, and end-of-project household surveys using the lot quality assurance sampling methodology. The surveys collect baseline and subsequent information on ten key health indicators focused on maternal health, reproductive health, and child health. Data have been collected by staff employed by NGOs such as community health workers. Questions have been raised over the reliability of the results given that the NGOs are directly responsible for data collection. REACH has provided close supervision and engaged NGOs in joint analysis to reduce the possibility of falsifying results.

Contracting NGOs

Overall, contracting NGOs has helped to expand service delivery rapidly. Between early 2003 and mid-2006, availability of the basic package of health services has expanded to all thirty-four provinces, nominally covering 82 percent of the population, with only sixteen districts and the centers of some major cities still uncovered. In addition, the proportion of facilities to population has increased from one facility for every 34,000 people to one for every 20,000 people (see table 8-5), and inequities among provinces have been reduced. At baseline, the availability of health facilities ranged from one for every 12,027–92,578 people. By 2005, this gap had been reduced to a range of one facility for every 12,027–26,968 people (Ministry of Public Health 2005). Significant progress has also been made in recruiting and placing female staff in facilities, specifically, a

Figure 8-1. *Change in the Number of Female Clinical Health Workers in Afghanistan, by Province*



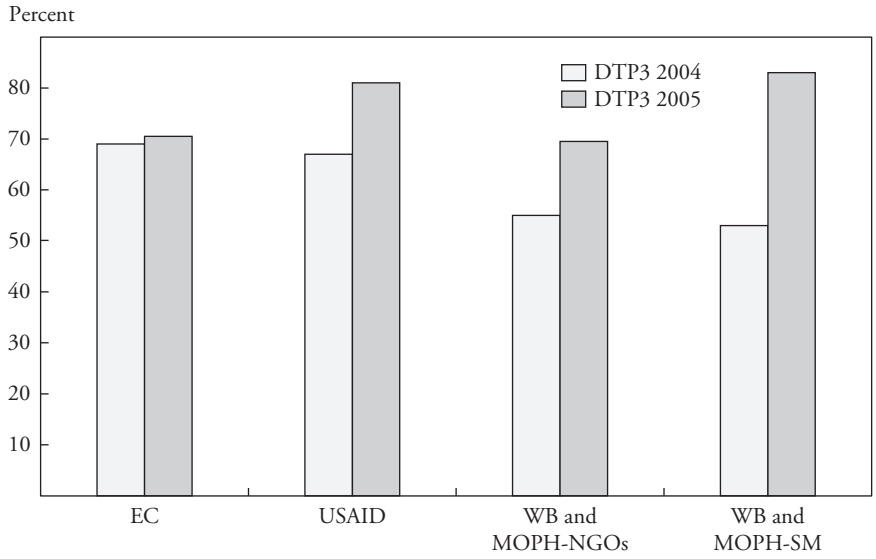
Source: Strong, Wali, and Sondorp (2006b).

300 percent increase within the eight case study locations examined by Strong, Wali, and Sondorp (2005; see figure 8-1).

Promising progress toward reaching health service delivery targets such as immunization coverage (DPT3) and skilled delivery has also been made (see figure 8-2). For example, analysis of HMIS data shows that the number of women delivering in health facilities more than doubled between 2004 and 2005 (see figure 8-3).[1] The proportion of women receiving a first antenatal care visit at least doubled in all approaches (see figure 8-4). Findings from the third-party evaluation show that the number of facilities providing antenatal care in the three MoPH-SM provinces increased from an average of 45 percent to 75 percent between the first annual round of facility-based inspections in 2004 and the first semiannual round in 2005.

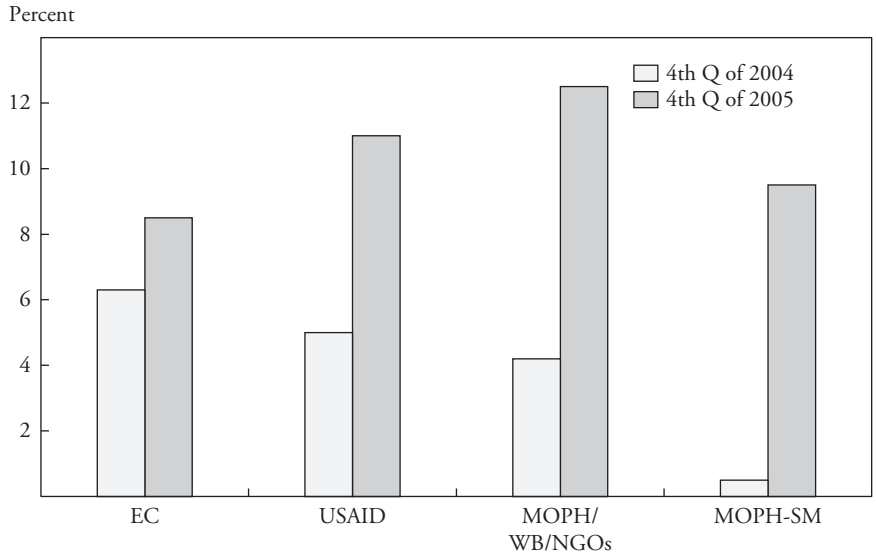
1. Because pockets of data in the HMIS database were missing, all data were corrected for underreporting. Data were analyzed by quarter. If data for one month of the quarter were missing, then the mean of the remaining months in the quarter was calculated. The HMIS database was more incomplete for some donor areas than for others, which necessitated these corrections to allow for valid comparisons of performance across approaches.

Figure 8-2. *DPT3 Coverage in Afghanistan, 2004 and 2005*



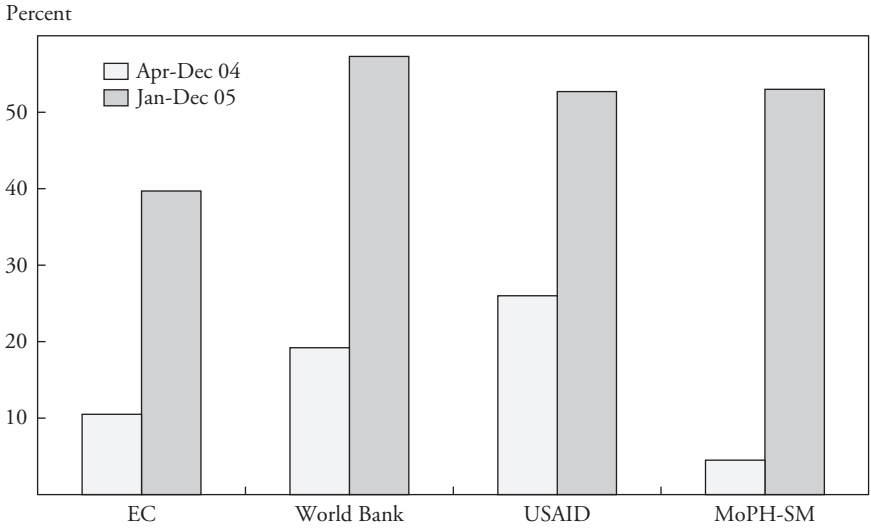
Source: Strong, Wali, and Sondorp (2006a).

Figure 8-3. *Proportion of Deliveries Attended by Skilled Birth Attendants in Afghanistan, Corrected for Underreporting, 2004 and 2005*



Source: Strong, Wali, and Sondorp (2006a).

Figure 8-4. *Proportion of Pregnant Women Receiving First Antenatal Care Visit in Afghanistan, 2004 and 2005*



Source: Strong, Wali, and Sondorp (2006a).

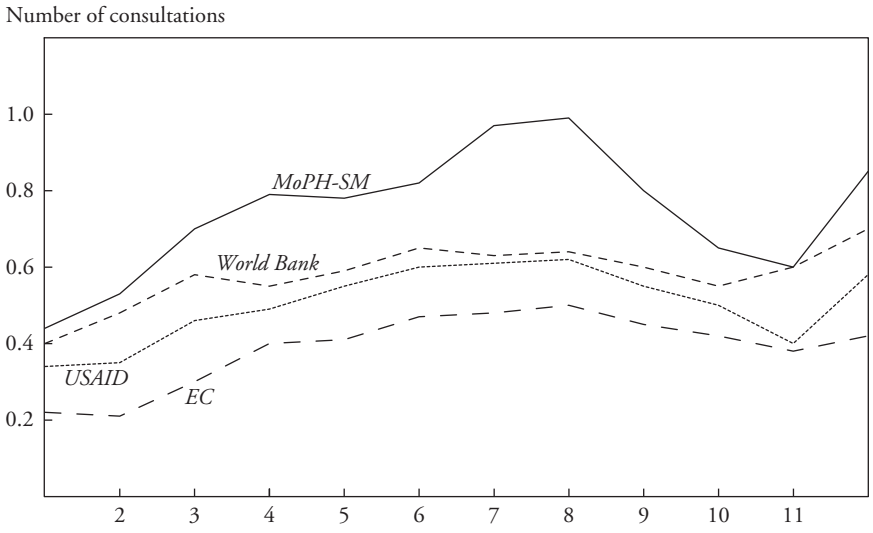
Performance-Based Payment

Contracting NGOs has clearly increased the availability and use of the basic package of health services by the Afghan population. It is less clear whether the different donor approaches, and in particular performance-based payment by the World Bank, have influenced the effectiveness of NGOs.

Data

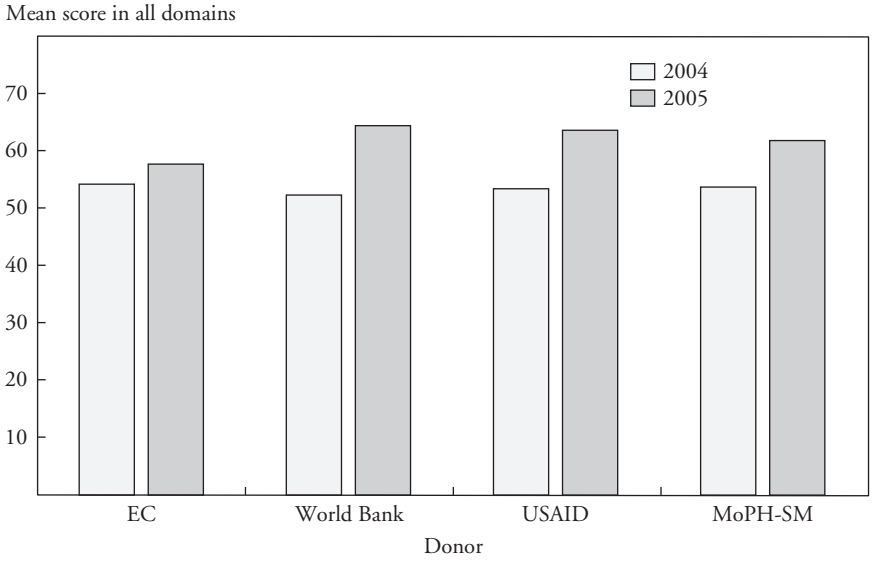
HMIS data show that the number of consultations per person per year has increased steadily over time (see figure 8-5). All donor approaches show the same general trend over 2005, but the MoPH-SM model appears to have outperformed the others. There has been wide interest in the potential for comparing the effectiveness of the different approaches taken by donors using the balanced scorecard data. Figure 8-6 illustrates the mean performance by contracting group according to the balanced scorecard in 2004 and 2005. The net gain in each group was 3.5 (European Commission), 12.2 (World Bank), 10.1 (REACH), and 8.1 (MoPH-SM). World Bank–NGO provinces score the highest, followed by those of USAID, the MoPH-SM, and the European Commission. Bonuses are paid in

Figure 8-5. *Number of Consultations per Person per Year in Afghanistan, Corrected for Underreporting*



Source: Strong, Wali, and Sondorp (2006a).

Figure 8-6. *Comparative Performance in Afghanistan, by Contracting Group, 2004 and 2005*



Source: Strong, Wali, and Sondorp (2006a).

the World Bank scheme according to percentage change over time rather than absolute score. The pay-for-performance mechanism appears to be outperforming the other models, but the differences are relatively small.

Results

The balanced scorecard and the HMIS suggest different patterns of achievement for different groups of NGOs. Both sources of information should be interpreted with care. Various factors may influence performance as reflected in the balanced scorecard, and concluding that variations are attributable to pay for performance alone is not possible. Equally, data from the HMIS may not be accurate enough to reflect differences among providers. There are several drawbacks to comparing performance on the basis of an assessment such as the balanced scorecard.

First, the data exclusively reflect services provided at functional facilities. This introduces a bias for provinces that have only a handful of functional facilities in more accessible areas. A province with extremely low and unequal coverage may receive a good score if the few facilities that exist are doing well. For instance, in Zabul and Uruzgan, only four facilities were included in the initial 2004 assessment, yet the provinces were ranked first and fourth of thirty-four (Ministry of Public Health, Johns Hopkins University, and IIHMR 2006), despite the fact that many residents of these provinces had limited, if any, access.

Second, the balanced scorecard was designed primarily to measure performance in province-wide projects funded by the World Bank. As such, interpretation in USAID and some EC provinces is more difficult because one NGO does not necessarily cover an entire province.

Third, balanced scorecard results were not meant to be compared directly across donor approaches. Given that the data do not report the relative starting points in each of the areas or provinces and are not weighted for security and geographic considerations, a 5 percent increase in a difficult setting may be a greater achievement than a 15 percent increase in an easier setting.

Last, the balanced scorecard cannot reflect improvements in access or health outcomes for the broader community.[2] Although these assessments provide some information on access, the information is limited to populations living within the immediate catchment area of functional facilities sampled.

2. To address this problem, the Ministry of Public Health, with World Bank funding, is commissioning the same third party to conduct a small national sample household survey to measure a collection of health coverage indicators. Data from this are not yet available.

Similarly, the apparently good performance of the MoPH-SM must be reviewed critically as an example of further contextual confounding factors:

—The three provinces within the MoPH-SM are near Kabul and enjoy good security, creating more favorable circumstances for attracting trained and experienced health staff. For example, several female health providers are transported daily from Kabul to the health facilities in the province where they work (Strong, Wali, and Sondorp 2006a).

—Most facilities were already well established and being run by reputable NGOs when the MoPH-SM took over the provinces.

—The MoPH-SM team has the authority to hire and fire provincial health staff, including the provincial health director, which allows them to create the best circumstances possible for successful implementation.

—The MoPH-SM subcontracts a range of services. In one province, for example, the provincial hospital and several clinics are managed by an NGO. Several components of the basic package of health services, such as community health worker and midwifery training, have also been contracted to NGOs.

Finally, it is clear that the monitoring and evaluation tools being used by different stakeholders produce different results. For example, data on skilled attendance at deliveries for USAID areas vary depending on the source used. HMIS data show that skilled deliveries at the end of 2005 were 11.18 percent of all deliveries, on average (Ministry of Public Health 2005 in Strong, Wali, and Sondorp 2005). USAID's end-of-project household survey shows 22.9 percent for the first two rounds of grants (Ministry of Public Health, Management Sciences for Health 2006). Finally, the balanced scorecard data show that delivery care according to the basic package of health services was 32.5 percent in 2005 (Ministry of Public Health, Johns Hopkins University, and IIHMR 2006). Clearly all these data have confidence intervals that are wider than many of the differences reported for the performance of different models.

The health module of the National Resource Vulnerability Assessment, scheduled to begin in 2007 and designed to produce information on coverage indicators such as immunization at the district level, should prove useful. In addition, the Afghan household survey to be conducted by the Johns Hopkins University and IIHMR may provide complementary information. Accurately measuring performance under different contractual approaches will be a long-term process. Currently, using balanced scorecard data to compare performance between providers and donor models to draw conclusions on their effectiveness may not be appropriate.

However, based on the limited information available at the time of writing, NGOs paid through contracts that incorporate performance-based payments appear to do relatively well. Factors other than the opportunity to earn performance bonuses may be driving this apparent better performance. Another possible contributor to performance is the autonomy and flexibility to use funds in ways that NGO management deems most effective. Input-based reimbursement approaches, by contrast, require accounting for spending on inputs according to a predetermined budget and may limit flexibility to change the mix of inputs. The emphasis by the Ministry of Public Health and donors on monitoring results may also be driving better performance. The perceptions of the different stakeholders shed some light on the various factors that play a role.

Stakeholder Perceptions

Qualitative interviews in the study by Strong, Wali, and Sondorp (2005) explored the perceptions, experiences, and attitudes of donors, the Ministry of Public Health, and NGOs to the idea of using performance bonuses. NGOs were asked about their perceptions regarding performance-based approaches and whether they had spurred changes in the way they operated.

Although some providers felt that pay for performance was too early to introduce in the Afghan context, others felt that a more explicit focus on results was having a good impact on their performance by encouraging NGOs to work harder. A number of NGOs, for example, cited that difficulties related to obtaining needed inputs—such as drugs and supplies, health professionals, training, and equipment—limited their ability to achieve the desired outcomes. Additionally, it was thought that although the overall idea of pay for performance was good, the timing was not right.

The focus on performance has encouraged NGOs to become more decentralized and to improve their monitoring capacity. Some felt that the new emphasis on performance motivated useful management and organizational changes that strengthened their capacity. Changes in structure included the addition of HMIS officers and provincial monitors to allow for closer tracking of progress toward targets. In general, NGOs felt that their organizations had become more decentralized and that this had had a positive impact on performance.

Many interviewees operating under the World Bank model commented that mission findings were extremely useful and that feedback had had a positive influence on their performance. According to one NGO manager, the number of

patient consultations increased four times after receiving guidance from a World Bank mission.

USAID-funded NGOs implementing the FFSDP tool also described significant improvements in performance. Interviews with REACH NGOs revealed that the FFSDP tool allowed them to improve the quality of services. It was also suggested that unannounced quarterly monitoring visits to facilities put greater emphasis on performance.

Interviews showed that the most favored aspect of the World Bank approach was the lump-sum contract. The financial flexibility this permitted created more freedom for implementation and responding to changes at the field level. The prospect of obtaining a financial bonus seemed secondary to the lump-sum contract, which represented a new way of doing business for most NGOs involved. Some of the larger NGOs remarked that easy access to funding from other external sources meant that there was no pressure to obtain the 10 percent bonus provided through the scheme.

Another NGO commented that any decisions on how the bonus funds would be used would be determined by their main office and that they were sure that field staff would receive no direct benefit, meaning that the bonus was not really a source of motivation. They felt that if they knew they would receive some personal benefit, then it might serve as an incentive. These views, however, were obtained before bonuses were awarded. Anecdotal evidence collected after the study showed that field staff benefited from performance bonuses, which may help to change the perceptions of this approach.

NGOs that received bonuses showed considerable pride in the outcome. Funds usually were spent on small luxuries for clinics, such as heaters for the staff, and for staff bonuses. It is unclear, however, whether it was the money, the sense of being rewarded for good performance, or both that pleased staff.

Some NGOs cited fear of failure as a more prominent motivator than the performance bonus. Interviews with NGOs operating under the World Bank and REACH schemes revealed that they also felt under pressure to perform. When asked about penalties for poor performance, most World Bank and USAID NGOs said that their contracts would be terminated and their reputations tarnished. By the later stages of fieldwork, all NGOs were aware that national monitoring mechanisms were in place and understood that their performance would be compared with that of other NGOs across the country.

REACH representatives felt that the design and specifications of the grant could improve performance without financial bonuses and have a sustained impact on the organizations and their employees as well. For example, REACH

grant requirements include submission of HMIS reports and recruitment of female community health workers. As a result, 98 percent of REACH-supported facilities are submitting HMIS reports and 53 percent of community health workers are female. Workshops on a number of different topics, such as training for illiterate women, have helped REACH grantees to satisfy grant requirements. Another also saw monitoring as a key part of the process of improving performance, without the need for financial incentives. It was claimed that the REACH approach has helped to increase transparency and reduce fraud in the NGOs.

A potential drawback of the pay-for-performance approach has been identified as the tendency to become overly focused on targets. Some stakeholders expressed concern that strong incentives to improve in certain areas of service delivery would weaken the focus on overall quality of care. This was raised by one NGO where the overarching concern was that the new payment arrangements were pushed through very quickly and that this might have an impact on how lasting some of these positive changes would be.

Financial freedom opens the door for NGOs to accumulate funds not spent on project activities. This was of some concern in various parts of the Ministry of Public Health. Under a lump-sum contract, budgets of the winning bid cannot be negotiated, and if organizations spend less than what was budgeted to reach performance targets, they can, in theory, keep the surplus. Although the World Bank has made a few exceptions for budget negotiations, the ministry is still concerned about how the NGO can accrue profit but not allocate any financial benefit for the purchaser. These fears have been quelled to some extent by clauses in World Bank contracts to the effect that any surplus funds must be used for continuing project activities.

Conclusions

We have briefly described the various contractual approaches being used in Afghanistan and considered whether there is evidence on the effects of performance-based payment. What evidence does exist supports the idea that payment for performance has encouraged stronger performance among NGO service providers. It would appear that both World Bank and Ministry of Health provinces are performing very well and better than those providers not receiving a pay-for-performance incentive. However, we have also identified a number of alternative explanations for why this may be the case. These reasons are related both to the way in which performance has been measured

(measurement bias) and underlying differences in the provinces in each group (selection bias).

Additional issues related to the implementation of pay for performance in a fragile, postconflict setting should be raised. The first is a question of the degree to which some NGOs are able to respond to the types of incentives presented by a pay-for-performance approach. The pay-for-performance approach is predicated on an idea that, given proper incentives, providers can improve their performance. For some NGOs in Afghanistan, the external constraints in which they operate may mean that this is not the case. It may lead NGOs to fail to bid for the most difficult areas for service delivery.

To better understand the potential impact of pay for performance in Afghanistan, it is also necessary to understand the extent to which field-level workers and managers are aware of the targets that have been set. Several factors are of interest here. First, one donor noted that NGOs were taking time to understand the concept of a fixed budget and the measurement of results. Second, in the REACH project, NGOs spoke of the beneficial effects of both setting and monitoring targets, without the need for a financial bonus. Third, some NGOs appeared to be uncomfortable with the idea of being rewarded financially because it did not fit with their humanitarian mandate. Last, the World Bank contract design—lump-sum contracts with flexibility—received very favorable feedback overall. For example, one NGO that was initially strongly opposed to the concept of performance-based partnership agreements converted completely to the new way of doing business. Indeed, several of the NGO representatives interviewed who have experience with all three donor approaches are ardent supporters of pay for performance and suggest that it has stimulated positive changes in how they work.

Afghanistan's experiment with pay for performance is still in its very earliest days. It is important to watch the results over the next few years with care, but also to be aware of the difficulty of isolating the effect of pay for performance without a randomized study design. It is important to note both the similarities and differences in using pay for performance in a postconflict setting compared to a more stable health system. Some issues appear to be the same, such as the strong incentives pay for performance gives to achieve certain target indicators, but in a postconflict setting, external constraints may hinder providers from responding to pay-for-performance incentives appropriately. Similarly, the motives of NGOs that work in a humanitarian setting may be less influenced by the promise of financial gain.

References

Bartlett, L. A., S. Mawji, S. Whitehead, C. Crouse, S. Dalil, D. Ionete, and P. Salama. 2005. "Where Giving Birth Is a Forecast of Death: Maternal Mortality in Four Districts in Afghanistan, 1999–2002." *Lancet* 365 (9462): 864–70.

Fleck, Fiona. 2004. "Pre-Election Insecurity in Afghanistan Hampers Health Service Delivery." *British Medical Journal* 329 (7463): 420.

Ministry of Public Health. 2005. HMIS Health Management Information System. Kabul.

Ministry of Public Health, Johns Hopkins University, and IIHMR (Indian Institute of Health Management Research). 2004. "Afghanistan Health Sector Balanced Scorecard: National and Provincial Results." Kabul.

———. 2006. "Afghanistan Health Sector Balanced Scorecard, 2004 and 2005." Kabul.

Ministry of Public Health, Management Sciences for Health. 2002. "Afghanistan National Health Resources Assessment." Kabul.

———. 2006. "REACH Baseline and End-of-Project Household Surveys: Comparative Results." Kabul.

Strong, Lesley, Abdul Wali, and Egbert Sondorp. 2005. "Health Policy in Afghanistan: Two Years of Rapid Change." London: London School of Hygiene and Tropical Medicine. (www.lshtm.ac.uk/hpu/conflict/files/publications/file_33.pdf [October 2008].)

———. 2006a. *Contracting Health Services in Afghanistan: A Comparison of Donor Models and Perceptions.* Draft report. London: London School of Hygiene and Tropical Medicine (September).

———. 2006b. *Contracting Health Services in Afghanistan: A Summary of the Research and Case Profiles.* Draft report. London: London School of Hygiene and Tropical Medicine (September).

CENTER FOR GLOBAL DEVELOPMENT
1800 Massachusetts Avenue, N.W.
Washington, D.C. 20036
www.cgdev.org

Performance Incentives for Global Health: Potential and Pitfalls may be ordered from:
BROOKINGS INSTITUTION PRESS
c/o HFS, P.O. Box 50370, Baltimore, MD 21211-4370
Tel.: 800/537-5487; 410/516-6956; Fax: 410/516-6998; Internet: www.brookings.edu

Library of Congress Cataloging-in-Publication data
Eichler, Rena.
Performance incentives for global health : potential and pitfalls / Rena Eichler, Ruth Levine and the Performance-Based Incentives Working Group.
p. ; cm.
Includes bibliographical references.
Summary: "Describes the rationale for introducing incentives tied to achievement of specific health-related targets, and provides guidance about designing, implementing, and evaluating programs that provide incentives to health care providers and patients. Presents case studies that focus on recent uses of incentives addressing a range of health conditions in diverse countries"—Provided by publisher.
ISBN 978-1-933286-29-7 (pbk. : alk. paper)
1. Medical economics. 2. World health. 3. Health promotion. I. Levine, Ruth, 1959– II. Center for Global Development. Performance-Based Incentives Working Group. III. Title.
[DNLM: 1. Delivery of Health Care—economics. 2. Program Evaluation—economics. 3. Reimbursement, Incentive—economics. 4. World Health. W 84.1 P4376 2009]
RA410.5.E43 2009
338.4'73621—dc22 2009000907

9 8 7 6 5 4 3 2 1
The paper used in this publication meets minimum requirements of the American National Standard for Information Sciences–Permanence of Paper for Printed Library Materials: ANSI Z39.48-1992.

Typeset in Adobe Garamond

Composition by Circle Graphics, Inc.
Columbia, Maryland

Printed by Versa Press
East Peoria, Illinois