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Global Public Health

An International Journal for Research, Policy and Practice

ISSN: 1744-1692 (Print) 1744-1706 (Online) Journal homepage: https://www.tandfonline.com/loi/rgph20

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To cite this article: Suraya Dalil, William Newbrander, Benjamin Loevinsohn, Ahmad Jan Naeem, James Griffin, Peter Salama & Faiz Mohammad Momand (2014) Aid effectiveness in rebuilding the Afghan health system: A reflection, Global Public Health, 9:sup1, S124-S136, DOI: 10.1080/17441692.2014.918162

To link to this article: https://doi.org/10.1080/17441692.2014.918162

Published online: 12 Jun 2014.

Global Public Health, 2014
Vol. 9, No. S1, S124–S136, http://dx.doi.org/10.1080/17441692.2014.918162

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Aid effectiveness in rebuilding the Afghan health system: A reflection

Suraya Dalil[a], William Newbrander[b]*, Benjamin Loevinsohn[c], Ahmad Jan Naeem[a], James Griffin[d], Peter Salama[e] and Faiz Mohammad Momand[f]

[a]*Ministry of Public Health, Government of Islamic Republic of Afghanistan, Kabul, Afghanistan;* [b]*Management Sciences for Health, Center for Health Services, Medford, MA, USA;* [c]*AFTHE, Africa Region, World Bank, Washington, DC, USA;* [d]*International Relief and Development, Arlington, VA, USA;* [e]*UNICEF Representative Ethiopia, Addis Ababa, Ethiopia;* [f]*US Agency for International Development, Kabul, Afghanistan*

(*Received 12 November 2012; accepted 15 April 2014*)

The Paris Declaration defined five components of aid effectiveness: ownership, alignment, harmonisation, managing for results and mutual accountability. Afghanistan, which has received a high level of donor aid for health since 2002, has seen significant improvements in health indicators, expanded access to health services and an increased range of services. Do the impressive health outcomes in this fragile state mean that aid has been effectively utilised? The factors that contributed to the success of the Ministry of Public Health (MOPH)-donor partnership include as follows: *Ownership*: a realistic role for the MOPH as the steward of the health sector that was clearly articulated to all stakeholders; *Donor alignment*: donor coordination and collaboration initiated by the MOPH; *Joint decisions*: participatory decision-making by the MOPH and donors, such as the major decision to use contracts with non-governmental organisations for health service delivery; *Managing for results*: basing programmes on available evidence, supplementing that evidence where possible and performance monitoring of health-sector activities using multiple data sources; *Reliable aid flows*: the availability of sufficient donor funding for more than 10 years for MOPH priorities, such as the Basic Package of Health Services, and other programmes that boosted system development and capacity building; *Human factors*: these include a critical mass of individuals with the right experience and expertise being deployed at the right time and able to look beyond agency mandates and priorities to support sector reform and results. These factors, which made aid to Afghanistan effective, can be applied in other countries.

Keywords: Afghanistan; aid effectiveness; donors; ownership; donor alignment

Progress in Afghanistan in rebuilding the health system, extending access to more people and improving health indicators has been significant since 2002. The gains have been documented in other articles in this special issue (Ikram *et al*. 2014, Newbrander *et al*. 2014, Rasooly *et al*. 2014) and elsewhere (Waldman *et al*. 2006, Loevinsohn and Sayed 2008, Belay 2010). The question often asked is, 'How did Afghanistan achieve so much so quickly?' Discussions about the necessary conditions for progress in the health systems of fragile states point to factors that include sufficient financial resources, adequate technical assistance and political will (Vaux and Visman 2005, Health and Fragile

*Corresponding author. Email: wnewbrander@msh.org

States Network 2009, Newbrander *et al*. 2011). The Ministry of Public Health (MOPH) of Afghanistan has been fortunate to have many donors and partners—bilateral and multilateral agencies—assisting it financially and technically in rebuilding the health system. Assistance has ranged from building of clinics and hospitals to development of systems, such as the health management information system (HMIS); to provision of expertise for developing midwifery schools and an accreditation programme for midwifery teachers; and to capacity building in pharmaceutical management, specifically to develop a good cold chain system for immunisation.

The concept of a more effective partnership between donors, recipient governments and implementing partners began emerging in 2000. Recipient governments have demanded a greater voice in and control over development priorities and donors' proposed assistance. At the same time, many donors sought more evidence of the results and impact on health of their investments, as well as heightened accountability for the use of their funds. The 2002 International Conference on Financing for Development in Monterrey, Mexico, addressed increasing funding for development, especially to reach the Millennium Development Goals (MDGs). The Monterrey Conference acknowledged that sufficient, regular aid was a necessary condition for development, especially to meet the MDGs (United Nations 2003). It also recognised that more donor assistance was not sufficient, in itself, to achieve results. So it promoted the concept that part of the increase in aid funding had to come from improved aid effectiveness—getting more from the same resources. The advent of global programmes, often vertical or targeted in their focus—such as the global fund to fight AIDS, tuberculosis and malaria, the Global Alliance for Vaccines and Immunization (GAVI Alliance) or the President's Malaria Initiative—added to the complexity of foreign aid in the new millennium (Dodd and Lane 2010).

The common objective of all parties involved in development aid—recipient governments and ministries, donors, implementing partners and nongovernmental organisations (NGOs)—is to use available resources effectively in order to make a positive impact on health in developing countries. Despite the desire to make aid more effective and efforts to harmonise aid among donors within a country, results in Kenya and Ethiopia have shown that aid sometimes makes a minimal impact on health indicators and outcomes (Dodd *et al*. 2007, Piva and Dodd 2009). In South Sudan, for example, very large amounts of external assistance, considerably larger than in Afghanistan on a per capita basis, were invested in the health sector, but results have been disappointing (World Bank 2011).

What was the experience in Afghanistan? Was it similar or different? This paper describes the experience of aid harmonisation in the health sector from 2002 to the present using the principles of the Paris Declaration and other factors discussed in the global literature on aid effectiveness. The paper examines country-level issues that have affected the effectiveness and impact of aid programmes in the health sector. It also reviews the phases of aid in Afghanistan and the characteristics of each phase, lessons learned and ideas for the future in Afghanistan and other countries for reaching a balance of recipient governments' desires with donors' requirements while promoting greater aid effectiveness.

Issues about aid effectiveness

The debate about donors, host countries and development aid effectiveness is not new (Dickinson 2011). The centrality of the issue of aid effectiveness was summarised after the Paris Declaration: 'Increased aid flows are unlikely to make a serious dent into global

poverty if donors do not change the way they go about providing aid and developing countries do not enhance the way they currently manage it' (OECD 2006, p. 54). The three major issues that continue to arise among donors and recipient countries are: (1) not enough aid, (2) aid not provided at the right time and (3) aid that was not effective. Although no common definition of 'aid effectiveness' exists, most of the five principles of aid effectiveness presented below, which were adopted at the meeting that issued the Paris Declaration (OECD 2005), have been accepted. This paper uses the following definition: aid effectiveness in health is achieving the greatest impact on human development and improved health indicators of a country's population from development aid through increased aid transparency and mutual accountability of donors and recipient countries.

The amount of financial resources committed to aid does impact effectiveness—just as a marginal cost curve decreases to a point but at one point begins to increase because of increased costs of coordination and fewer economies of scale. These higher costs and lower savings drive the marginal cost of each additional unit upward.

Thus insufficient aid can reduce aid effectiveness. Conversely, too much aid can also be less than effective if host countries lack the capacity to absorb large flows of aid (Taylor 2005). Although people feared that the global economic crisis that began in 2008 would result in a collapse of aid funding for health in developing countries, the Institute of Health Metrics of the University of Washington reported that development aid for health continued to rise, although at a slower rate than in the period before 2008 (Institute for Health Metrics and Evaluation 2011).

The second issue, aid not provided at the right time, relates to the harm caused by volatility and uncertainty of aid—just when there could be a great increase in the effects or impact of aid, it is decreased or held constant. Foregoing long-term aid commitments can also harm the health sector. If the resources do not continue, much of the previous aid may have been for naught. So the regularity of an aid funding stream as well as its acceleration, at times, is critical in overcoming high-priority health problems in developing countries.

Finally, the effectiveness of aid can be compromised by many factors, including aid delivered in short-term projects that are not well coordinated with an overall development strategy; the inability of recipient countries to meet donors' conditions and terms; and lack of capacity and adequate systems to absorb and manage aid (DFID 2005). A movement to address these issues of aid effectiveness started at the 2002 Monterrey Conference. The Paris Declaration on Aid Effectiveness that followed in 2005 was the culmination of a high-level meeting of donors, bilateral and multilateral organisations and recipient countries designed to make aid more effective in producing development results at the country level. The Declaration's five principles, designed to promote development and overcome impediments to the effectiveness of aid, are (OECD 2005):

(1) Ownership—developing countries must exercise leadership over their own development policies.
(2) Alignment—donors must base their support on countries' own development strategies and systems.
(3) Harmonisation—donors must coordinate their activities and minimise the cost of delivering aid.
(4) Managing for results—developing countries and donors must orient their activities for achieving the desired results.
(5) Mutual accountability—donors and developing countries are accountable to each other for achieving development results.

Despite these attempts to address aid issues, implementation of those commitments has been difficult. Promises for change have been made at the highest leadership levels of governments and their aid agencies. But donors, multilateral agencies and recipient countries do not always practice the principles agreed upon at these high-level meetings. As a result, there remain problems with the effectiveness of aid for health in many countries.

We use these five principles of aid effectiveness as a basis to assess the history of aid effectiveness to the health sector of Afghanistan since 2002.

Afghanistan's donor aid between 2002 and 2012: experience and effectiveness

Experience of donor aid

In Afghanistan, the flow of aid from donors rose sharply and steadily between 2003 and 2009, starting at US$1.8 million in 2003 and reaching US$148.7 million in 2009. Donors more than doubled the 2005 amount of US$32.6 million in 2006, when they gave US$71.6 million. The highest amount to date was US$187.0 million in 2014. The pace of growth in development budgets has slowed and levelled off more recently: from US$148.7 million in 2009 to US$139.7 million to US$164.7 million to US$169.0 million in from 2010 to 2012. Over time, the amount of donor support for MOPH provided directly to government through on-budget support has increased. As donors have gained confidence in the MOPH ability to manage resources and technical intervention, they have shifted their support from funding of projects and providing off-budget support to various on-budget funding mechanisms (Table 1).

Examining aid since 2002 reveals several broad phases (see Table 2): an intensive period from 2002 through 2004, when much attention and aid focused on Afghanistan; a period of continuing aid and progress, 2005–2007; and the period 2008–2011, with continuing aid levelling off and not growing.

Effectiveness of donor aid

The impact made in terms of gains in health indicators and health system development has been significant. Major gains made by the MOPH with the assistance of donors during this period include:

- health indicators improved;
- capacity of Afghans to run the health system effectively increased;
- coordination between the MOPH and donors established and sustained;
- strong MOPH leadership developed;
- MOPH adjusted to its role as the steward of the health system rather than the provider of the health services.

But how effective was the aid compared to the five principles of aid effectiveness?

Table 1. Health sector funding from donors for the development budget of the MOPH, 2003–2012.

Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
MOPH development budget (US$ millions)	1.8	22.3	32.6	71.6	102.6	110.6	148.7	139.6	164.7	169.0

Table 2. Afghanistan's experience with donor aid, 2002–2011.

	Phase 1 2002–2004	Phase 2 2005–2007	Phase 3 2008–2011
Aid efforts for health	• Much attention and aid provided • Reasonable security situation	• Aid continuing and maturing • Pockets of insecurity starting to emerge	• Aid beginning to plateau • Areas of insecurity increased
Stewardship	Focused	Focus refined	Expansion causing loss of focus
Aid flows	Great deal of financial aid from large and small donors	Some decrease in number of donors and amount of aid	Aid still substantial but starting to decrease
Targeted aid	• Reducing maternal and child mortality • Health system infrastructure rebuilt • BPHS developed • Priorities and policies developed and supported	• Maternal and child mortality • Continued health system infrastructure rebuilding but at slower pace • BPHS supported by three major donors	• Maternal and child mortality • Decrease in infrastructure building • Continued support for BPHS implementation and some for Essential Package of Hospital Services
Capacity building	Capacity building for: • Grants and Contracts Management Unit (GCMU) for contracting with NGOs • HMIS Department • Policy and Planning Department • Reproductive health	Capacity building for: • GCMU for contracting with NGOs • HMIS • Policy and planning	Capacity building for: • Human resources for health • Health Economics and Financing Department • Child and Adolescent Health Department Lagging: • Pharmaceutical management • Procurement and finance • Nutrition

Table 2 (*Continued*)

	Phase 1 2002–2004	Phase 2 2005–2007	Phase 3 2008–2011
Health system strengthening	• Focused on extending BPHS services • National definitions of tasks of various health workers developed	• Access continues to increase • Stronger training of health workers	• Modification of BPHS to add other services • Establishment of standards begun • National health financing policy adopted
Donor coordination and collaboration	Good coordination led by donors	MOPH starting to take the lead for coordination	Renewed effort for donor collaboration
Impact on access	Great increase	Further expansion	Increased demands for access
Impact on health indicators	Foundations laid, results not evident	Evidence of gains emerging	• Positive gains continued • Acceleration of effects
Security	Travel to any province possible	Insecurity in some places, slight restrictions in travel	Insecurity spreading to most provinces

Ownership

There was strong ownership by the Government of Afghanistan in the developments of the health sector as the MOPH successfully led the process. This was helped by a few specific actions. Foremost, the MOPH, with assistance from its development partners, developed the Basic Package of Health Services (BPHS), which served as a unifying strategy and approach to health system development. The BPHS comprised: (1) a limited set of priority health services; (2) a small number of key indicators of success related to the priority services; and (3) a clear description of the staffing, supplies, medicines and equipment needed in the various types of health facilities for the health services to be provided.

Second, contracts directly between the Afghan government and NGO service providers meant that the MOPH was the client. The contracts defined the services to be prioritised, the indicators of success and the providers assigned to a well-delineated geographical area for which they were responsible. The combination of these factors ensured that service providers were accountable to the government for their results.

Third, the government, with donor funding, established a Grants and Contracts Management Unit (GCMU) within the MOPH to coordinate the efforts of diverse development partners and helped to ensure that service providers (NGOs) remained accountable to the MOPH. The GCMU was staffed almost entirely by Afghan consultants, who were competitively recruited and paid market salaries. This helped to strengthen the capacity of the MOPH ('brain gain') and enhanced the credibility of the government's strategic approaches.

Alignment

There appeared to be little difficulty in ensuring that the major donors aligned their assistance with the government's strategy, perhaps because of the high quality of the MOPH's strategy and the credibility that the MOPH (including the GCMU) enjoyed. During this time, the introduction of BPHS was essential, because it provided a clear statement of MOPH priorities, strategy and direction that stakeholders could rally around.

Harmonisation

Although there were relatively few major donors to the health sector in Afghanistan, coordination of activities was important and appeared to be very successful, especially compared to progress in other sectors, such as education. Harmonisation was facilitated by four factors: a geographic approach to coverage, coordination through regular meetings, strengthening of MOPH systems and programmes and finally, a set of critical human factors.

First, in a geographical approach to donor financing, whole provinces were 'assigned' to specific donors, essentially three—US Agency for International Development (USAID), the European Commission and the World Bank. This assigning of only one donor to be responsible for funding of BPHS in each province allowed the MOPH to know who was responsible where and allowed some diversity of approach within the context of the BPHS. The importance of this approach can be seen in its counterfactuals: (1) provinces where multiple donors were involved tended to perform poorly and (2) sectors that used a thematic approach—for example, in which donors focused on themes such as teacher training or curriculum development—fared less well in terms of donor coordination.

The MOPH established a clear mechanism for donor coordination that involved regular meetings with all stakeholders. Just as important was an innovative series of 'retreats' that the MOPH held with major development partners, in which key strategic issues were openly discussed. The retreats provided the government with a diverse set of opinions and insights.

The GCMU facilitated harmonisation as it helped to ensure that there was almost complete geographical coverage of the country with BPHS services. The MOPH also worked with other development partners, especially UNICEF and WHO, to strengthen technical programmes in the MOPH.

Finally, at a critical stage in sector development and reform, the major partners in the health sector–notably, UNICEF, USAID, World Bank and Management Sciences for Health – were represented by a small group of individuals with some key characteristics in common: they enjoyed the full trust of the government; they had strong experience and relevant expertise in fragile states; and they had an excellent working relationship that prioritised sector results over narrow institutional agendas and mandates (Suraya Dalil, Minister of Health, personal communication, November 15, 2012).

Managing for results

The consensus among close observers of the situation is that the Government in Afghanistan did an outstanding job of focusing on results, possibly more so than any other post-conflict state to date. A number of initiatives supported the results focus of the MOPH.

First, some critical studies were done in 2002 and 2003 that helped to determine the key gaps in the health system and the key areas for priority investment (Assefa *et al*. 2001, Cheung *et al*. 2003, Bartlett *et al*. 2005, Vijayaraghavan *et al*. 2006). In particular, the maternal mortality survey carried out by UNICEF and Centers for Disease Control and Prevention (the first such survey documented in Afghanistan) and the baseline survey of health facilities carried out by UNICEF, Columbia University, and JHPIEGO (formerly Johns Hopkins Program for International Education in Gynecology and Obstetrics) helped to demonstrate the magnitude of the maternal and child health problem in the country and the lack of access to life-saving information from surveys, particularly in rural parts of the country. Such dramatic evidence, as some of the highest maternal mortality ratios recorded in the medical literature, was critical in constructing arguments for prioritising primary health care and rural facilities through implementing a basic package of services rather than more visible, and politically attractive, new tertiary care institutions in urban areas, which were often proposed in 2002 and 2003.

Health facility surveys, carried out nearly each year since 2004, provided an independent assessment of how well services were being delivered. The surveys also provided an objective means for assessing quality of care and made available other information about the process of care, such as absenteeism of health workers.

Even as security deteriorated, the MOPH and its partners ensured that regular household surveys were carried out, particularly to track outcomes and the coverage of key services. While surveys were conducted in 2003, 2005, 2006, 2008 and 2010, they were financed from diverse sources and used methodologies and questionnaires different enough to make comparisons challenging. This is an area that should be strengthened.

The HMIS was not only developed but also scaled up nationwide because of the steady flow of aid and the commitment of the MOPH. The HMIS that existed when the

Taliban fell was in disarray, so considerable effort was put into strengthening the system and making data readily available at all levels.

In many other low-income countries, having data is insufficient because data analysis remains a major constraint. Fortunately, the MOPH developed capacity in data analysis that was further bolstered by support and staff from various development partners.

The MOPH and its donor partners invested resources in testing and carefully evaluating important innovations. These included the training and deployment of community midwives and the introduction of health sub-centres, which were introduced in 2006. This evidence-based approach helped to retain a focus on how to improve service delivery and outcomes.

The MOPH, mostly through the GCMU, maintained a contract and performance management system that held contractors accountable for the results they achieved. For example, one NGO had its contract terminated for inadequate performance. Service providers were fully aware that poor performance would lead to difficult meetings with MOPH officials in which they would have to explain why results were suboptimal and provide specific plans for improving their results.

Mutual accountability

A number of the factors described earlier, such as the geographical focus of donors supporting BPHS development, the importance given to carefully tracking results and the open dialogue between the MOPH and its donors, fostered a high degree of mutual accountability.

Key factors in Afghanistan's aid effectiveness

Donor aid to Afghanistan appears to have been effective in supporting health gains because:

- the MOPH and donors made saving lives a first priority. This commitment was based on data-driven decisions about the real health needs of Afghans;
- major donors were committed to the long-term development of the health system in Afghanistan;
- donors supported the BPHS as an MOPH priority from the start. Adoption of the basic package helped the MOPH to establish its stewardship role and its relationships with donors;
- the MOPH and donors agreed on having NGOs provide health services rather than attempting to rebuild the government health service delivery system. This decision facilitated quick implementation of the BPHS and served as a mechanism for developing Afghan NGOs in the health sector for the long term;
- the MOPH stressed community-based approaches in order to extend access to services;
- donors placed experienced and dedicated technical experts on the ground for extended periods beginning in 2002;
- the MOPH and donors built up the entire health sector, both public and private.

Lessons learned

Several lessons emerged as the donors and Afghan government worked together. First was the need to accept certain realities, rather than fighting about insurmountable issues,

such as trying to compel all donors to contribute to a sector-wide approach if some donors do not have the freedom to do so. Recipient governments regularly talk about the burden that the varied reporting and monitoring requirements of different donors represents for them. Their preference would be a common approach by all donors and simplified and unified reporting procedures and formats. But, because donors represent their home governments' structures and multilateral partners represent their stakeholders, the procedures and regulations they have established have to be met. Donor governments do not wish to relinquish their autonomy or relax their reporting and oversight requirements, because they must be accountable to their citizens, who expect that their governments' procedures will be followed to ensure that the donor money they have contributed is safeguarded. Rather than seeking to change donor governments, recipient governments should develop their capacity to be responsive to the reporting and financial audit requirements of the donor.

Second, the allocation of donor aid must be based on evidence of where the needs are greatest, what the proven, effective interventions are and where they can be successfully scaled up. If donor aid is based on a dialogue with the recipient government, is consistent with government priorities and is technically sound—or, when it is an innovation, demonstrates potential for success—then there will be confidence that a real partnership between the donor and the recipient ministry exists.

Furthermore, donors are best served by having capable and technically qualified in-country staff who can work with the ministry and NGOs to develop their skills and capacity. This facilitates more effective use of their aid and discussions with the recipient government in which the donor representatives are recognised as technically capable and equal partners. The Minister of Public Health reflected in 2012 that there have been tremendous gains in building the capacity of the MOPH. She noted that this progress has been uneven, however, because some key departments have lagged behind in terms of their capacity because some areas of the MOPH did not receive the same attention for building capacity as others.

Finally, community-based approaches are crucial not only for improving access, especially in remote areas, but also for promoting proven health interventions that are simple but cost-effective in dealing with major health problems. In addition to access being a priority, the quality of the care provided was also important in the MOPH strategy. The in-country staff of donors often have difficulty in promoting such interventions because they are not 'quick impact' or as visible as building a hospital in an urban area.

Looking forward

A number of challenges lie ahead for the health system in Afghanistan, which will be affected by what happens to the assistance the country receives from its donors. Some of the concerns are that there will probably be a reduction in external aid flows to all sectors, including health, as foreign troops leave Afghanistan. Since domestic resources for health will not likely rise rapidly enough to match the reduction in aid, there may be fewer financial resources available for the sector.

As domestic resources become more important, attention may shift substantially towards hospital-based and urban services. The concerns of elected officials have been concentrated on hospitals. This could have a substantial impact on equity, since fewer funds will be available for rural areas and primary health care.

The decrease in external funding for health may also lead to a significant change in the nature of service delivery. Since domestic resources will account for a larger proportion of funding, it is possible, even likely, that more services will be directly delivered by the government and that there will be less contracting with NGOs. Civil society (most contractors are now Afghan NGOs) and the interests of elected representatives and local elites will influence the extent of this shift.

A final concern is that, while there have been many sources of innovation in the health sector in Afghanistan, donors and NGOs have contributed many of the most important ones. As the donor presence diminishes and NGOs become less important in terms of service delivery, it is unclear how this openness to innovation will be maintained.

How have the gains made due to the partnership of the MOPH and donors affected the health system and services? Some major changes and accompanying lessons have emerged as follows:

- As access has steadily been expanded, the country's population now expects access. This expectation has put pressure on the MOPH to build more sub-health centres and basic health centres in many villages and communities—just as donors' commitment to extend the health system infrastructure is waning and they are concerned about sustainability as aid begins to decrease.
- As the quantity of health services has grown significantly, the MOPH and donors are faced with the population's demand for a renewed focus on improving the quality of health care.
- With the success of the BPHS in helping to improve health indicators, the push to include more and more services in the basic package has increased. Adding many more services, however, would divert the health sector from the need for continued emphasis on its key priority: reduction of mortality among children and women. The MOPH feels the pressure to add services that may not impact mortality or morbidity much or are for a very limited segment of the population.
- Capacity development is still a great need, despite the capacity development that has already taken place with the help of donors. It has been uneven, and some neglected areas must now receive more attention. These include development of adequate pharmaceutical supply systems that will provide quality drugs for the BPHS.
- Inter-ministerial coordination by the MOPH was critical in obtaining buy-in across the government. If a ministry sets its own priorities and develops a strategy to implement them without working with other relevant ministries in setting their direction, the ministry risks creating barriers that will stymie strategy implementation at each step.

Conclusions

The factors that contributed to the success of the MOPH-donor partnership in Afghanistan present a reasonable set of expectations that may be applied in other countries. Among the factors that made success possible were:

- ownership through a clear and realistic role for the MOPH as the steward of the health sector that was consistently articulated at all levels of the health system and to all stakeholders;

- donor alignment through sufficient donor coordination and collaboration among donors initiated and demanded by the MOPH. They believed this coordination and collaboration were essential for successful implementation of their priorities;
- harmonisation through collaborative decision-making by the MOPH and donors, such as the decision to contract out to NGOs for the delivery of health services;
- managing for results through performance monitoring of health-sector activities and use of multiple data sources–some regular, such as the national HMIS, and others special third-party evaluations;
- participatory decision-making at all levels of the health system, which allowed the MOPH to obtain buy-in to its priorities from donors as well as provincial authorities and communities;
- clear joint priorities with the establishment of the BPHS, the existence of a sound framework and strategy that guided the MOPH and its stakeholders, including donors, in how the health system would be designed and function;
- reliable aid flows due to the availability of sufficient donor funding for more than 10 years for MOPH priorities, such as the BPHS, and other programmes that boosted system development and capacity building;
- accountability through open discussions that fostered strong relationships among the key players of the health system: the MOPH, donors and national NGOs.

Development partners should continue to seek innovative means for governments and donors to work together that include incentives for donors to collaborate more and work flexibly to fit within the priorities of the recipient government. It has been evident from many countries–such as Haiti–that good intentions are not sufficient to promote effective donor coordination. There must be not only intent but also effective mechanisms and structures to facilitate coordination. A strong recipient ministry that recognises its stewardship role in the health sector and insists that donors have a dialogue with ministry leaders as equals is a first step.

Further study of the relationship between the MOPH and donors and how it facilitated the great advances the Afghan population and health system have made in the past decade is important to refine a list of conditions for making bilateral donor aid more effective.

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