Moving toward UHC

Afghanistan

NATIONAL INITIATIVES, KEY CHALLENGES, AND THE ROLE OF COLLABORATIVE ACTIVITIES

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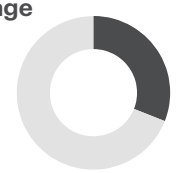
Afghanistan's snapshot

UHC Service Coverage Index *(SDG 3.8.1, 2015)*

31%



Catastrophic OOP health expenditure incidence at the 10% threshold *(SDG 3.8.2, 2007)*

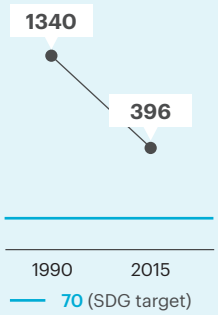
4.8% of households

Results of Joint External Evaluation of core capacities for pandemic preparedness *(JEE, 2016)*

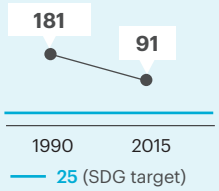
Score (for capacity)		# of indicators (out of 48)
5	Sustainable	0
4	Demonstrated	8
3	Developed	2
2	Limited	19
1	No capacity	19

Health results

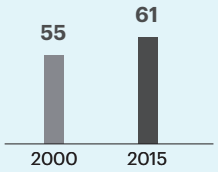
Maternal Mortality Ratio *(WHO)*
Per 100,000 Live Births



Under-Five Mortality Rate *(WHO)*
Per 1,000 Live Births



Life Expectancy at Birth *(WHO)*



Wealth Differential in Under-Five Mortality *(PHCPI, 2015)*

31.5

More deaths in lowest than highest wealth quintile per 1,000 live births

Performance of service delivery – selected indicators *(PHCPI, 2014-2015)*

	Afghanistan	LMIC average
Care-seeking for symptoms of pneumonia	**61.5%**	61.5%
Dropout rate between 1st and 3rd DTP vaccination	**11%**	7.5%
Access barriers due to treatment costs	**66.7%**	47.4%
Access barriers due to distance	**67.2%**	35.8%
Treatment success rate for new TB cases	**87%**	80.1%
Provider absence rate	**NO DATA**	28.9%
Caseload per provider	**NO DATA**	9 per day
Diagnostic accuracy	**NO DATA**	47.9%
Adherence to clinical guidelines	**NO DATA**	33.6%

See page 8 for References and Definitions.

Existing national plans and policies to achieve universal health coverage (UHC)

SERVICE DELIVERY REFORMS

Delivering a free universal package of health services. The Afghanistan government, in its 2016–2020 Health Strategy, committed to achieving universal health coverage (UHC) by providing basic quality health services and hospital services to its entire population. To achieve this goal, the June 2017 Afghanistan Health Presidential Summit set strategies to: (a) increase accountability to communities; (b) shift from contract management to performance management; (c) increase efficiency in service delivery; (d) encourage health management innovations; (e) address emerging challenges in hospitals, health financing, and pharmaceuticals; and (f) improve communications with all stakeholders.

Piloting NGO innovations. Nongovernmental organizations (NGOs) play a large role in the provision of health services in Afghanistan due to unique contracting arrangements. Innovations in service delivery by NGOs remain small scale, and include conditional cash transfers to encourage women to utilize antenatal care (UNICEF) and increase the uptake of childhood vaccinations (Gavi). In some areas, mini-ambulances ("Zaranj") run by community health workers improve the referral and transportation of maternal, newborn and child health patients (UNICEF). The challenge remains to further incentivize local innovation and to scale up those that have been found to be cost-effective, affordable and acceptable across a wider population.

HEALTH FINANCING REFORMS

Establishment of the "2012–2020 Health Financing Policy." The Ministry of Public Health (MoPH) set out a new policy to increase total financing for the health system. This aims to identify ways to mobilize domestic resources through taxation and prepayment mechanisms, increase efficiency and equity in public spending through different financial mechanisms, improve risk pooling through health financing schemes, secure more sustainable external funding, and enhance aid effectiveness for existing health priorities.

The Afghanistan government established a regulatory framework for community engagement in service delivery through the Citizens Charter, providing an opportunity for beneficiaries to collect performance data from over 2,000 facilities to complement existing monitoring data.

GOVERNANCE REFORMS

Engagement of non-state actors in service delivery. The Afghanistan government established a regulatory framework for community engagement in service delivery though the Citizens Charter, providing an opportunity for beneficiaries to collect performance data from over 2,000 facilities to complement existing monitoring data. Health promotion campaigns aim to empower Community Development Councils to play a leading role in the improvement of their local facilities.

Improved coordination and oversight. The MoPH engages with technical departments and provincial health offices in the design, recruitment, and oversight of contracts for delivering the basic package of health services (BPHS) and essential package of hospital services (EPHS). There is a semiannual performance review of contracts that involves all relevant departments and capacity strengthening on data analytics.

Key challenges on the way to UHC

WEAKNESSES AND BOTTLENECKS IN SERVICE DELIVERY

Coverage of essential health services. Afghanistan has made notable progress in maternal, newborn, and child health, intervention coverage, and service availability. From 2000 to 2015, maternal mortality, under-5 mortality, and newborn mortality all declined; coverage for antenatal care, key immunizations, in-facility births, and skilled birth attendance increased most rapidly from 2010–2015. Similar trends at the provincial level show service coverage and health system improvements for nearly all provinces. Despite these advances, health outcomes in Afghanistan are still among the worst in low-income countries. Neonatal mortality and nutritional deficiencies in children remain pressing issues. However, due to existing contract arrangements with NGOs and private entities for the provision of health services, many of which have close ties to local communities, service delivery has generally been resilient to ongoing conflicts.

Pandemic preparedness. A 2016 Joint External Evaluation (JEE) of International Health Regulations (IHR) core capacities identified multiple important aspects of readiness where Afghanistan currently has no capacity: national policy, legislation, and financing; IHR coordination, communication, and advocacy; antimicrobial resistance; food safety; biosafety and biosecurity; points of entry; chemical events; and radiation emergencies. In contrast, Afghanistan has demonstrated capacity in several other areas that only require additional efforts to ensure these capacities are sustainable. These areas include zoonotic diseases; national vaccine access and delivery; laboratory testing for identification of priority diseases; real-time surveillance; and linking public health and security authorities.

In high-conflict provinces, contracting out to NGOs has supported resilience in service delivery, as many contractors retain close ties to, and hire directly from, local communities.

THE STATE OF HEALTH FINANCING

Overall funding for health. Afghanistan has one of the lowest expenditures per capita on health in the region; this is even worse when comparing the proportion of government spending. According to the 2014 National Health Accounts, 72% of health expenditures come from out-of-pocket (OOP) spending; 23% from external aid; and only 5% from the central government. The main challenges for the government in health financing are: (i) increase domestic financing for UHC; (ii) increase efficiency in the execution of the public budget; and (iii) reduce high out-of-pocket (OOP) expenditures. Advocacy is needed to improve the regulatory environment for domestic resource allocation to the health sector. In addition, dependence on external donor funds for the delivery of health services financed through competing mechanisms with limited coordination must be reviewed, especially in contexts where external funds for health could become scarce.

Efficiency in the use of the public funding. Analyses indicate that the execution rate of the public budget is systematically below planned levels. Estimates from a fiscal space analysis sponsored by the MoPH show that increasing the execution rate of the total government budget to 86% could generate an additional US$7.2 million per year over the period of 2017–2021, representing an increase of 3% per year. Potential areas for fiscal space gains include hospital autonomy, procurement, task shifting, and investments in preventive care.

GOVERNANCE CHALLENGES

War and conflict. Armed conflict in Afghanistan has intensified since 2010, and an increasing share of the population lives in areas affected by high levels of conflict. Maintaining health service delivery and responding to health needs remain key challenges, with health facilities in low-conflict provinces able to achieve better coverage. In high-conflict provinces, contracting out to NGOs occurs at the same frequency, supporting some resilience in service delivery as many contractors retain close ties to, and hire directly from, local communities.

Collaborative efforts to accelerate progress toward UHC

EXISTING INITIATIVES SUPPORTED BY EXTERNAL PARTNERS

External partners are engaged in Afghanistan to build national capacity and strengthen the health system. The Tokyo Joint UHC Initiative, supported by the government of Japan and led by the World Bank (WB), in collaboration with the Japan International Cooperation Agency (JICA), the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO), is supporting the government of Afghanistan, and strives to accelerate progress toward UHC. This support will enable strengthening of nationally-led strategic health systems to achieve UHC, as well as pandemic preparedness.

PLANS FOR FUTURE COLLABORATIVE WORK

Policy and Human Resources Development (PHRD)-funded advisory support

The joint work under the Tokyo Joint UHC Initiative falls within four major areas: improving performance management, strengthening the health system, increasing and sustaining health financing, and community engagement. Efforts to improve performance management will include a functional review of the Ministry of Public Health; a review and revision of the monitoring and accountability framework; and a performance review of essential primary health service contracts, of demographic and health surveys, and provincial hospitals. Furthermore, the Tokyo UHC joint work will closely cooperate with other investments in health, such as those by the Global Fund and Gavi, to contribute to health system strengthening. Considering that other sectors, such as nutrition and water and sanitation compose the foundations of heath for all, challenges in these fields also will be considered under the joint work.

Other planned activities

Technical assistance to the MoPH will support analytical work to produce information for policy decisions regarding: (a) increasing and sustaining financing to improve government awareness of investment opportunities for health; (b) analyzing of the Public Spending Budget Efficiency to define strategies to increase efficiency in the use of the public budget and reduce the gap between initial allocations and final spending; and (c) analyzing of OOP spending in search of policies to reduce OOP spending or improve efficiency in the allocation of these resources.

The PHRD activities are very closely tied to the new IDA18 financing for health as the new operation is very much focused upon the same areas of improving performance management, community-based services, and pandemic preparedness, and achieving greater financial sustainability. The PHRD funding therefore will increase the quality of implementation support and potentially impact current and future lending by focusing on areas that are complementary. This also strengthens partnerships with other institutions, thereby increasing the impact of lending through harmonizing the work of different donors.

References & Definitions (page 1 indicators)

UHC Service Coverage Index (2015) – WHO/World Bank index that combines 16 tracer indicators into a single, composite metric of the coverage of essential health services. For more information: WHO/World Bank (2017). Tracking UHC: Second Global Monitoring Report.

Catastrophic out-of-pocket (OOP) health expenditure incidence at the 10% threshold (Single data point, year varies by country) – WHO/World Bank data from Tracking UHC: Second Global Monitoring Report (2017). Catastrophic expenditure defined as annual household health expenditures greater than 10% of annual household total expenditures.

Results of the Joint External Evaluation of core capacities for pandemic preparedness (2016/17, year varies by country) – A voluntary, collaborative assessment of capacities to prevent, detect, and respond to public health threats under the International Health Regulations (2005) and the Global Health Security Agenda. 48 indicators of pandemic preparedness are scored using five levels (1 is no capacity, 5 is sustainable capacity). https://www.ghsagenda.org/assessments

Life Expectancy at Birth (2000-2015), Maternal Mortality Ratio (1990-2015), Under-five Mortality Rate (1990-2015) – WHO Global Health Observatory: http://apps.who.int/gho/data/node.home

Wealth Differential in Under-five Mortality (Single data point, year varies by country) – Indicator used by the Primary Health Care Performance Initiative (PHCPI) to reflect equity in health outcomes. For more information: https://phcperformanceinitiative.org/indicator/equity-under-five-mortality-wealth-differential

Performance of service delivery – selected indicators (Single data points, years vary by country) – Indicators used by the Primary Health Care Performance Initiative (PHCPI) to capture various aspects of service delivery performance. PHCPI synthesizes new and existing data from validated and internationally comparable sources. For definitions of individual indicators: https://phcperformanceinitiative.org/about-us/our-indicators#/

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