



**Independent Joint Anti-Corruption Monitoring and Evaluation Committee  
(MEC)**

**VULNERABILITY TO CORRUPTION  
ASSESSMENT  
IN THE  
AFGHAN MINISTRY OF PUBLIC HEALTH**

**JUNE 4, 2016  
Kabul, Afghanistan**

# TABLE OF CONTENTS

- PREFACE..... 5**
- EXECUTIVE SUMMARY..... 6
- LESSONS LEARNED & RECOMMENDATIONS FOR THE FUTURE..... 10**
  - Monitoring and Evaluation..... 10*
  - Transparency, Governance, and Accountability..... 12*
  - Policies..... 13*
  - Contracts..... 15*
  - Embezzlement..... 16*
  - Nepotism / Abuse of Power..... 17*
  - Quality Assurance / Quality Control..... 18*
  - Human Rights and Discrimination..... 19*
  - Extortion..... 20*
  - Fraud / Falsification / Fakes / Forgery..... 20*
  - Conflicts of Interest..... 21*
  - Bribery..... 22*
  - Sequencing Options and Anticipated Outcomes..... 22*
- MAIN REPORT ..... 28**
- BACKGROUND AND CONTEXT ..... 28**
  - TRANSPARENCY, GOVERNANCE, and ACCOUNTABILITY..... 28*
  - THE MINISTRY OF PUBLIC HEALTH and the HEALTH SECTOR..... 29*
  - “BUILDING BLOCKS” of HEALTH SYSTEMS..... 30*
  - Methodology..... 31*
  - MOPH Directors, Managers, and Leadership..... 32*
  - MOPH Non-Management Employees and Frontline Staff..... 32*
  - Other Stakeholders, Including Health Sector Implementers, Civil Society, Community Leaders, and Politicians..... 32*
  - Patients and their Families..... 32*
  - Former-MOPH Directors, Managers, Leaders, and Frontline Staff..... 32*
  - A. Policies..... 33*
  - B. Contracts..... 33*
  - C. Embezzlement / Theft of Public Goods of Funds for Private Use..... 33*
  - D. Nepotism / Abuse of Power in Hiring, Promotion, and More Generally..... 33*
  - E. Quality Assurance / Quality Control..... 33*
  - F. Human Rights and Discrimination..... 33*
  - G. Extortion..... 33*
  - H. Fraud / Falsification / Fakes / Forgery..... 34*
  - I. Conflicts of Interest..... 34*
  - J. Bribery..... 34*
  - K. “Other Risks” of Corruption..... 34*
    - 1) The Capital versus outside the Capital..... 34*
    - 2) Provinces with at least one large city versus those without any large city..... 34*
    - 3) Provinces with at least one insecure District versus those without insecure Districts..... 34*
    - 4) Provinces with MOPH implementation of services versus NGO and INGO implementation.. 34*
    - 5) Provinces from each of the main geographic regions of the country. .... 35*
- 1. FINDINGS: MOPH DIRECTORS, MANAGERS, AND LEADERSHIP \*.....36**

<i>Policies</i> .....	37
<i>Contracts</i> .....	40
<i>Embezzlement</i> .....	43
<i>Nepotism / Abuse of Power for Personal Benefit</i> .....	46
<i>Quality Assurance / Quality Control</i> .....	49
<i>Human Rights and Discrimination</i> .....	52
<i>Extortion</i> .....	53
<i>Fraud / Falsification / Fakes / Forgery</i> .....	54
<i>Conflicts of Interest</i> .....	56
<i>Bribery</i> .....	58
<i>“Other Risks” of Corruption</i> .....	59
<b>2. FINDINGS: MOPH NON-MANAGEMENT EMPLOYEES AND FRONTLINE STAFF *</b> .....	<b>60</b>
<i>Policies</i> .....	60
<i>Contracts</i> .....	63
<i>Embezzlement</i> .....	65
<i>Nepotism</i> .....	67
<i>Quality Assurance / Quality Control</i> .....	71
<i>Human Rights and Discrimination</i> .....	73
<i>Extortion</i> .....	75
<i>Fraud / Falsification / Fakes / Forgery</i> .....	77
<i>Conflicts of Interest</i> .....	78
<i>Bribery</i> .....	79
<i>“Other Risks” of Corruption</i> .....	81
<b>3. FINDINGS: OTHER STAKEHOLDERS, INCLUDING HEALTH SECTOR IMPLEMENTERS, CIVIL SOCIETY, COMMUNITY LEADERS, AND POLITICIANS *</b> .....	<b>82</b>
<i>Policies</i> .....	82
<i>Contracts</i> .....	86
<i>Embezzlement</i> .....	88
<i>Nepotism / Abuse of Power</i> .....	89
<i>Quality Assurance / Quality Control</i> .....	91
<i>Human Rights and Discrimination</i> .....	94
<i>Extortion</i> .....	97
<i>Fraud / Falsification / Fakes / Forgery</i> .....	98
<i>Conflicts of Interest</i> .....	100
<i>Bribery</i> .....	101
<i>“Other Risks” of Corruption</i> .....	102
<b>4. FINDINGS: PATIENTS AND THEIR FAMILIES *</b> .....	<b>103</b>
<i>Policies</i> .....	103
<i>Contracts</i> .....	105
<i>Embezzlement</i> .....	106
<i>Nepotism / Abuse of Power</i> .....	106
<i>Quality Assurance / Quality Control</i> .....	107
<i>Human Rights and Discrimination</i> .....	109
<i>Extortion</i> .....	110
<i>Fraud / Falsification / Fakes / Forgery</i> .....	111
<i>Conflicts of Interest</i> .....	111
<i>Bribery</i> .....	112
<i>“Other Risks” of Corruption</i> .....	113

**5. FINDINGS: FORMER-MOPH DIRECTORS, MANAGERS, LEADERS, AND FRONTLINE STAFF \***

..... **114**

*Policies*..... 114

*Contracts*..... 118

*Embezzlement* ..... 119

*Nepotism / Abuse of Power for Personal Benefit*..... 120

*Quality Assurance / Quality Control* ..... 121

*Human Rights and Discrimination* ..... 122

*Extortion* ..... 122

*Fraud / Falsification / Fakes / Forgery*..... 123

*Conflicts of Interest* ..... 123

*Bribery*..... 123

*“Other Risks” of Corruption* ..... 123

KEY FINDINGS FROM DIRECT OBSERVATIONS.....124

# PREFACE

This Special Report on **Vulnerability to Corruption in the Afghan Ministry of Public Health** was undertaken by the Independent Joint Anti-Corruption Monitoring and Evaluation Committee (MEC) at the request of the Minister of Public Health, Dr. Ferozudin Feroz. This report was preceded by formal statements and a briefing note issued by the Minister in order to raise awareness about corruption in the health sector as a whole, as well as to demonstrate the Minister’s commitment to confront corruption head on. MEC had already completed an assessment of the “**Pharmaceutical Importation Process**” in October 2014. This Special Report, however, is a much more in-depth and broader examination of the health sector in Afghanistan.

The purpose of this Report is to assess the extent of corruption risks in the Afghan health system; to identify where these vulnerabilities exist; and to draw important lessons and make recommendations on how to counter corruption risks. An assessment team comprising dedicated Afghans and international experts knowledgeable about both the Afghan health sector and anti-corruption work undertook this study. To conduct this assessment, 269 former MOPH officials from all ranks, non-management employees and frontline MOPH staff, health sector implementers, civil society organizations, community leaders, patients and their families throughout the country participated in face-to-face interviews and focus group discussions. Their personal knowledge and experiences vis-à-vis the health system, as well as direct observations of the assessment team formed the basis of this study.

This Special Report illustrates the magnitude of the problem in the Afghan health sector. Patients and their family members experienced corruption in the context of fear, suffering, uncertainty, pain, and death. Corruption in the Afghan health sector covers a range of illegal, unethical and disturbing acts that happen within an environment of systemic failure. Most often, it is entrenched, widespread and a dominant pattern. It affects all stakeholders in the health sector. Officials and employees have often been powerless in the face of corruption, frustrated and with a strong feeling being let down by colleagues and political leadership. Patients have to pay bribes in many wards. Doctors often use the public service to find clients and refer them to their private clinics. Finally, patients and their families feel their voices can’t be heard.

The report provides a powerful justification to undertake measures to restore confidence in, and credibility to, the health ministry’s systems and practices, and to significantly improve health delivery to the Afghan people. It is hoped that the Afghan people’s outpouring of anguish as revealed through the interviews will serve as a powerful motive for the health ministry officials to pursue genuine reform that will lift the health standards of the Afghan society.

Dr. Yama Torabi

Chair – MEC

June 4, 2016



## EXECUTIVE SUMMARY

### Key Facts

- In April 2015, His Excellency Dr. Ferozudin Feroz, Minister of Public Health, issued a formal statement, “*Addressing Corruption in the Health Sector*<sup>1</sup>” to raise awareness among Ministry staff and development partners about his intention to confront corruption in the health sector;
- Also in April 2015, the MOPH issued a “*Statement on Good Governance of the Health Sector*,<sup>2</sup>” followed in June 2015 by an “*Accountability Briefing Note*,<sup>3</sup>” both of which reinforced the Minister’s intentions to promote an effective, efficient, and responsible health sector that will benefit all the people of Afghanistan;
- In May 2016, the Independent Joint Anti-Corruption Monitoring and Evaluation Committee (MEC) published the results of a ‘Vulnerability to Corruption’ Assessment focused on the Ministry of Public Health. This assessment involved 269 in-depth interviews, 13 provinces, 8 focus group discussions, 23 direct observations, and reviews of dozens of documents. The findings of the assessment, along with lessons learned and recommendations are presented in detail in this Special Report.

### Report Summary

Afghanistan remains a fragile State after more than three decades of conflict. The health sector has benefitted from attention and resources to varying degrees since the fall of the Taliban in 2001. The Ministry of Public Health faces serious challenges in its mission to improve the health status of all Afghans, with corruption being only one of many impediments catalogued by observers inside and outside the structures of the Government.

The National Unity Government and the Ministry of Public Health in particular, have openly addressed concerns of transparency, governance, and accountability. His Excellency, Dr. Ferozudin Feroz, the Minister of Public Health, has shown strong leadership in the effort to identify and counter corruption in the health sector. The Ministry of Public Health called for an assessment of the extent of corruption in the sector, with precisely articulated language focused on confronting and solving this challenge.

Worldwide, over the last century, Public Health services have undergone enormous transitions into complex and technical systems that plan, implement, deliver, and monitor the health of populations on a scale that would challenge even the best organized and resourced of societies. In Afghanistan, throughout the past decade and a half, successive Afghan Governments have maintained a focus on achieving these same improved health and Public Health objectives for their people despite armed

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<sup>1</sup> MOPH: Statement on Corruption, April 2015

<sup>2</sup> MOPH: Statement on Good Governance in the Health Sector, April 2015

<sup>3</sup> MOPH, Office of the Minister: Briefing Note Number 1, June 2015

conflict, a multitude of uncertainties linked to economics and security, and limited financial and human resources. External donors and stakeholders in health and Public Health have supported initiatives to enable the MOPH to achieve its objectives, including contributing to funding mechanisms, implementing service delivery, expanding the technical capacities of the MOPH, erecting and upgrading health infrastructure, and providing guidance to develop policies and protocols across the entire spectrum of the systems that underpin the health sector.

Following the specific request from Dr. Feroz, the Independent Joint Anti-Corruption Monitoring and Evaluation Committee has now undertaken a Vulnerability to Corruption Assessment of the Ministry of Public Health. This has been accomplished through a cooperative effort. The assessment was methodologically driven to assist the MOPH in identifying and confronting the risks of corruption in the health sector. To this end, information was gathered from the Ministry of Public Health and other stakeholders to systematically assess the risks of corruption and identify recommendations:

The analysis was carried out across 13 provinces: Badakhshan, Baghlan, Balkh, Bamyan, Herat, Jowzjan, Kabul, Kandahar, Kapisa, Khost, Nangarhar, Paktika, and Samangan. The assessment team spoke in detail to over 270 people from five groups of key stakeholders: MOPH managers; MOPH employees and front-line staff; other health sector stakeholders; patients and their families; and former MOPH directors and managers.

- MOPH Directors, Managers, and leaders, from all parts of the country and in each type of provincial setting described difficulties with corruption, often in great detail. These respondents acknowledged a wide range of problems, missteps, and missed opportunities in managing corruption in the health sector, as well as frustration, disappointment, and of being *'let-down by colleagues who should know better.'* Among the 62 respondents in this category, each one acknowledged vulnerabilities or risks of corruption in one or more of the topics covered in their interview.
- MOPH non-management employees and frontline staff described widespread challenges from corruption, regardless of the setting where they worked, or the role they held within MOPH. These workers acknowledged a broad range of problems stemming from corruption in the health sector. Among the 51 respondents in this category employed in all parts of the country, each identified vulnerabilities or risks of corruption in their interview.
- Other stakeholders, including health sector implementers, civil society agencies, local and international non-governmental organizations, community leaders, and local, provincial, and national politicians described many types of experiences and observations to illustrate the vulnerabilities of corruption in the health sector. 49 respondents from all regions of the country provided information about health sector corruption under every one of the topics covered in their interview.
- Patients and their family members described corruption in the health sector, experienced in the context of fear, suffering, uncertainty, pain, and death. These health sector service utilizers from all parts of the country acknowledged a wide range of illegal, unethical, and disturbing episodes. For nearly every one of the 96 respondents in this category, routine attempts to engage in preventing or solving health issues had been met with frustration and disappointment at also being subject to corruption in addition to the health issue. Their interviews illustrated how commonplace these frustrations and disappointments have become for all Afghans. As with the Directors, Managers, and leaders of MOPH, extensive probing for examples was not required with these respondents.
- Former-MOPH Directors, Managers, leaders, and frontline staff described challenges arising from a wide variety of types of corruption they have observed in the Ministry of Public Health. These 13 respondents provided unique insights and perspective on the vulnerabilities to corruption, often in great detail.

The huge amount of information gathered from all these interviews was collated in two ways:

- First, the information was analyzed according to the systemic corruption issues that were described, according to the key health systems that were not working as they should, and according to the degree of difficulty that would be involved in tackling the specific issues. This analysis has been presented in the report as ‘Lessons and Recommendations.’

Second, the information has been captured in this report by recording the exact words used by the interviewees – such quotes make the problems vivid and directly connected to real life.

The report shows that there are deep and endemic corruption problems on the Public Health Sector. But it also shows the passion of many staff and stakeholders to see the system improve, and the many specific ways in which the problems can be tackled.

This report provides a wealth of proposals and recommendations that the Minister and his colleagues can use as the basis for a thorough action plan. MEC hopes that this report will also enable international donor agencies to work effectively with the Ministry in targeting assistance towards addressing the recommendations.

## Recommendations

In total, this report makes 115 specific recommendations for improvement.

Of these, there are 11 major recommendations to enhance independent oversight. Acting on these Recommendations will strengthen coordination and cooperation within the health sector and between the health sector and other sectors for better transparency and accountability:

1. **Health *Shuras*** – The number, profile, and effectiveness of Health *Shuras* must be improved and their roles significantly expanded in support of greater transparency and quality of care.
2. **Expanded Independent Oversight** – The entire health sector requires an expanded level of independent oversight. This will increase good governance in human resources, grants and contracts, procurement, and asset management, and lead to greater trust in the health sector from the public and donors.
3. **Overhauled Auditing** – Conduct a thorough analysis of auditing practices and the systematic management of resources and inventory to prevent embezzlement in the health sector, including initiating reforms of the internal audit functions in the Ministry and provinces, and inviting independent groups or external oversight bodies to monitor the quality, objectivity and scope of the internal audit departments in every province.

### **Establishing three new Health Sector bodies:**

4. **Independent Council on Health Sector Accountability and Reporting** – ICHSAR will improve health system auditing and reporting. ICHSAR will engage Afghan civil society organizations from outside the health sector, representatives of international donors funding the Afghan health sector, and use investigations and inspections to enhance MOPH internal auditing, utilization of HMIS and data management, and promote reliability in reporting.
5. **Independent Commission on Accrediting Health Organizations** – ICAHO will ensure successful accreditation is imposed on all health sector implementers, as well as Departments and Directorates of the MOPH to emphasize transparency, good governance, and accountability. Independent scrutiny over the contracting will improve health service delivery, MOPH management functions including finance systems and human resource systems, and achievement of minimum standards.

6. **High Council on Oversight of Health Sector Integrity** – HCOHSI will consolidate linkages across key stakeholder institutions and sectors to strengthen coordinated actions on transparency, accountability, Rule of Law, and good governance.
7. **Liaise with the AGO** – A formal link with the AGO will support better understanding of health sector issues and expand opportunities for health sector investigations and prosecutions by the AGO.
8. **Liaise with the Afghanistan Independent Human Rights Commission** – A formal link with the AIHRC would draw attention to health and human rights, and further strengthen the coordination of actions on transparency, accountability, and good governance.
9. **Contracting review group** – Find, confront, overturn and prevent weaknesses and dishonesty in contracting and procurement arrangements in MOPH.
10. **Independent oversight and monitoring of all senior MOPH appointments** – Recruitment and appointments in the health sector must be based on merit, technical skills, and appropriate training for the role; MOPH leadership must be the guiding example for these transparent processes.
11. **Improve the quality of imported Pharmaceuticals** – The public’s trust and their confidence in MOPH professionalism are shaken as long as unsuitable and weak pharmaceuticals are allowed to flood the community unchecked. More than twenty Recommendations relate specifically to pharmaceuticals and procurement processes.

More broadly, there are recommendations across all areas of MOPH, as summarized below:

### Priority Systemic Issues

Action	Recommendation
Integrate	Health Management Information System [1.2, 2.7, 2.11, 6.1, 8, 10, 12]
Establish	Independent Council on Health Sector Auditing and Reporting [1.1, 6.2, 7, 8, 9, 12, 13, 14, 15, 17, 18]
Establish	Independent Commission for Accreditation of Healthcare Organizations [3, 7, 9, 10, 11, 12, 13, 14, 17, 18]
Complete	Translations of all MOPH Policies into Dari and Pashto [5, 6.1]
Integrate	Complaints Mechanisms [1.1, 12, 13, 14, 15]
Integrate	Training Needs Assessments and Allocation of Training Opportunities [10, 11]
Establish	Development and Oversight of Key Performance Indicators [1.1, 6.2, 8, 9, 10, 11, 12, 14, 15]

### Priority Leadership Issues

Action	Recommendation
Enforce	Controls Over Absenteeism [1.2, 6.1, 10, 12]
Enforce	Controls to Prevent Nepotism and Promote Competency-Based Recruitment [10.1, 10.2, 16]
Expand	Health <i>Shuras</i> [9, 12, 13, 14, 15, 18]
Convene	High Council on Oversight of Health Sector Integrity [15]

### Priority Integrity Issues

Action	Recommendation
Enforce	Reliable Pharmacy Importation and Safe Drug Supply [2, 17]
Establish	Liaison within the Attorney General’s Office [4, 15, 16, 17, 20]
Enforce	Authenticity Checks of Certificates and Diplomas [10.1, 16]
Enforce	Transparent Management of Private Sector Referrals [1.2, 6.2, 12, 18]
Enforce	Transparent and Effective Grants and Contracts Management Unit [3, 7]
Enforce	Control of Public Assets (especially use of ambulances) [1.2, 8]
Establish	Reliable Audits and Inspections [1.1, 9, 10, 12, 13, 16, 17]

MEC will be pleased to discuss the recommendations with MOPH, and to assist the Minister and the MOPH in monitoring and following up the progress of their anti-corruption action plan.

# LESSONS LEARNED & RECOMMENDATIONS FOR THE FUTURE

The following section summarizes the main lessons learned from the Vulnerability to Corruption Assessment and the resulting recommendations.

The ‘Lessons Learned’ under each of the topics of particular interest from the assessment are described below. In each case, recommendations are made, which provide substantive suggestions for implementation. These include specific elements such as *Capital Spending*, *Significant Systemic Improvement*, *Capacity/Capability*, *Further Analyses*, *Inter-Departmental Coordination and Communications*, and *People and Politics*. In some instances more than one of these elements is applicable, or they overlap, and this has been indicated in each case.

Following the Lessons Learned and Recommendations, actions are indicated on a Quarterly basis for initiating and achieving the Recommendations. This is followed by a separate section on *Sequencing Options and Anticipated Outcomes*.

## Monitoring and Evaluation

**Lesson Learned 1: The MOPH Health Management Information System (HMIS) is viewed as a valuable asset (and potentially) a reliable source of support for management coherence across the whole of the Public Health system. However, reliable HMIS monitoring of management functions, administrative processes, and services delivery have been compromised system-wide.** All types of stakeholders expressed a generally low level of confidence in the quality and integrity of monitoring and the subsequent evaluations of what has been observed, inspected, and/or formally audited in the management, administration, and provision of care in the health sector.

***Recommendation 1.1: Establish and empower an independent commission on health sector auditing and reporting in order to re-build trust in the MOPH:***

- 1.1.1 *Significant Systemic Improvement* and *People and Politics*: Establish an Independent Council on Health Sector Auditing and Reporting (ICHSAR) in Kabul. Councilors should include the Minister of Public Health, international technical consultants with expertise in health system auditing and reporting, representatives from Afghan civil society organizations from outside the health sector, and representatives of international donors funding the Afghan health sector.
- 1.1.2 *Significant Systemic Improvement* and *Capacity/Capability*: The ICHSAR should be staffed with specialist Investigators and Inspectors to handle cases in the Public Health system and the

private health sector in the Capital; initially, this should be composed of one international Audit Advisor, one international Reporting Advisor, six Investigators, and six Inspectors.

- 1.1.3 *Capital Spending and People and Politics*: Empower ICHSAR to investigate and inspect MOPH and BPHS and EPHS contract holders in all Provinces.
- 1.1.4 *Capital Spending and People and Politics*: ICHSAR offices must be independently funded to retain their impartiality from the MOPH management structure.
- 1.1.5 *Inter-Departmental Coordination and Communication*: Engage ICHSAR to draw the public's attention to examples of good quality of care, integrity, and reliability in the health sector.

**Recommendation 1.2: Analysis of the MOPH Health Management Information System (HMIS):**

- 1.2.1 *Further Analyses*: Independently assess the present functionality of HMIS from the perspectives of MOPH and BPHS/EPHS implementing agency Directors, Managers, and HMIS Officers.
- 1.2.2 *Further Analyses*: Identify gaps in the current implementation and potential additional functionality of HMIS from the perspectives of those same stakeholders, plus donors, which impedes maximum efficiency of the health sector. This should articulate opportunities to incorporate referral mechanisms and patient management across the health sector, including private sector elements such as pharmacies, clinics, hospitals, and specialist diagnostic services.
- 1.2.3 *Capacity/Capability*: Incorporate supplemental auditing elements into HMIS.
- 1.2.4 *Further Analyses*: Itemize the financial and technical resources required for these objectives.
- 1.2.5 *Capital Spending*: Invest in the hardware, software, technical supports, and training required to maximize the prospects for HMIS to achieve its potential in reliable monitoring of management functions, administrative processes, and services delivery.

**Lesson Learned 2: MEC has previously identified vulnerabilities to corruption related to lack of governance on importation of pharmaceuticals into Afghanistan. However, the Recommendations have not been addressed. The scale and scope of fraudulent pharmaceuticals coming into Afghanistan from Pakistan has entirely undermined the confidence of the public in the nation's access to medicines; several hundred industrial facilities in Pakistan currently produce drugs solely for export to Afghanistan and which do not have sufficient quality to be sold inside Pakistan itself. The consequences of allowing this to continue are dire.**

**Recommendation 2: Establish and track Quarterly progress on actions within MOPH on each of the previous MEC recommendations on importation of pharmaceuticals. These were identified in the MEC VCA Report: Pharmaceutical Importation Process, October 2014:**

- 2.1 *Significant Systemic Improvement and Capacity/Capability*: Establish separate pharmaceutical procurement procedures within the current Public Procurement Law.
- 2.2 *Significant Systemic Improvement*: Reform the Pharmaceutical Law to adequately regulate the increased volume and diversity of pharmaceuticals entering the country.
- 2.3 *Significant Systemic Improvement and People and Politics*: Reform the Pharmaceutical Law to prohibit government staff from having conflicts of interest in pharmaceutical companies.
- 2.4 *Significant Systemic Improvement and Capacity/Capability*: Licensed National Pharmaceutical Products List must be updated annually.
- 2.5 *Significant Systemic Improvement and Capacity/Capability*: Licensed National Pharmaceutical Products List must be linked to the pro forma registration and licensing process.
- 2.6 *Significant Systemic Improvement and Capacity/Capability*: Restructure Pharmacy Affairs Directorate to ensure the human resources are allocated to improve surveillance/oversight capacity.
- 2.7 *Inter-Departmental Coordination*: Clarify roles and responsibilities to ensure that chains of command and M&E systems within Departments are better positioned to identify corruption.
- 2.8 *Inter-Departmental Coordination*: Establish formal coordination mechanism among Departments to enhance surveillance/monitoring capacity.

- 2.9 *Capacity/Capability*: Pharmaceutical training capacity (qualifications) must be enhanced.
- 2.10 *Significant Systemic Improvement and Further Analyses*: Pharmaceutical training must be re-valued as professional-level for salary determination and promotion purposes.
- 2.11 *Significant Systemic Improvement and Capital spending*: Creation of data collection system to accurately balance supply with broader public health goals and inform planning processes.
- 2.12 *Significant Systemic Improvement and Further Analyses*: Pharmaceutical importation license issuance/renewal determined from regular monitoring and evaluation of importing companies, particularly for companies not meeting the standards of their home countries.
- 2.13 *People and Politics*: Leverage anti-corruption resources to investigate and prosecute senior MOPH officials for illicit enrichment.
- 2.14 *Significant Systemic Improvement and Capacity/Capability*: Limit the number of pharmaceutical importation licenses issued/renewed.
- 2.15 *Significant Systemic Improvement and Capital Spending*: Conduct Annual quality assurance assessment/audits of pharmaceutical products manufactured (imported) by foreign companies.
- 2.16 *Significant Systemic Improvement and Capital Spending*: Implement procedures for primary, secondary, and tertiary sampling of imported pharmaceuticals to minimize fraudulent results.
- 2.17 *Significant Systemic Improvement and Further Analyses*: Implement procedures for independent sampling of imported pharmaceuticals for auditing purposes.
- 2.18 **Additionally**: *Significant Systemic Improvement and Capital Spending*: Invest in equipment and technical training to enable MOPH to conduct quality analyses of samples.
- 2.19 **Additionally**: *Significant Systemic Improvement and Further Analyses*: Consider single-source procurement to prevent uncontrolled procurement of low quality pharmaceuticals from unreliable manufacturers; engage the Oversight Commission on Health Sector Integrity in examining the benefits and risks of imposing a regionalized or national procurement processes for all pharmaceutical importations.
- 2.20 **Additionally**: *Significant Systemic Improvement and Further Analyses*: Consider centralized procurement of pharmaceuticals.

## Transparency, Governance, and Accountability

**Lesson Learned 3: There was a low level of confidence in the reliability, thoroughness, and integrity of the Public Health system.** Confidence was weak among all types of stakeholders including MOPH Management and its frontline work force, health service implementers, service utilizers, and notably among health sector donors and funders. The Public Health system was described as inconsistently managed by MOPH leadership, suffering from implementation that fails to achieve contracted obligations by NGOs and INGOs, subject to unreliable internal reporting systems, and lacking integrity in its accountability to patients and their families for quality of care.

### **Recommendation 3: Establish an independent accrediting entity to rebuild reliability, thoroughness, and integrity within the health sector:**

- 3.1 *Significant Systemic Improvement and Capacity/Capability*: Establish an Independent Commission on Accrediting Healthcare Organizations (ICAHO). Commissioners should be composed of the Minister of Public Health, international technical consultants with expertise in accrediting healthcare organizations, representatives from Afghan civil society organizations from outside the health sector, and representatives of international donors funding the Afghan health sector. ICAHO meetings must be held on a Quarterly basis for review of achievements against Action Plans.
- 3.2 *Significant Systemic Improvement*: Biannual accreditation from ICAHO should be imposed on all Departments and Directorates of the MOPH to emphasize transparency, good governance, compliance with minimum standards, and accountability in contracting of health service delivery, MOPH management functions including finance systems and human resource systems, and achievement of minimum standards.

- 3.3 *Significant Systemic Improvement*: Accreditation from ICAHO should be imposed as an eligibility prerequisite for new or renewed BPHS and EPHS contracting to emphasize minimum standards of care, patient safety, quality of care, accountability, and reliability. BPHS and EPHS agency Directors must be held accountable directly to ICAHO on achievement of Action Plans.
- 3.4 *Inter-Departmental Coordination and Communications*: Engage ICAHO to draw the public's attention to examples of good quality of care, accountability, and reliability on a regular basis (for example, publishing this information twice yearly, at a minimum).

**Lesson Learned 4: Rule of Law and adherence to regulations in the health sector have been evaded, subverted, and over-ruled by powerful individuals, those willing to use a range of types of threats, and those prepared to undermine the basic tenets of the Public Health system for their own personal benefit or enrichment.** Accountability, transparency, and good governance in the Public Health system each need to be encouraged and reinforced to rebuild public trust.

**Recommendation 4: Engage in a formal liaison and coordination between MOPH and the Attorney General's Office to enable pursuit and prosecution of cases that would serve as high-profile examples for enforcement of the Rule of Law in the health sector:**

- 4.1 *Significant Systemic Improvement and People and Politics*: Provide training for the Investigators and Prosecutors in the AGO in Kabul in order to improve their understanding of the violations of duty related to the functions of the MOPH and implementation by BPHS and EPHS contract holders.
- 4.2 *Significant Systemic Improvement and Capacity/Capability*: Training on health sector specific issues for the Kabul AGO should be implemented by 1-2 international Technical/Legal Advisors with health sector backgrounds.

## Policies

**Lesson learned 5: Successful implementation of policies in the Public Health system has been compromised by a combination of factors including limited understanding of the content and scope of existing policies, and undue influence. This has resulted in a corruption of priorities in MOPH.**

**Recommendation 5.1: Review the current policy-making process**

- 5.1.1 *Inter-Departmental Coordination and Communications and Significant Systemic Improvement*: Use international help to conduct a rapid review of all current policies; remedy gaps with provisional policies on policy development.
- 5.1.2 *Inter-Departmental Coordination and Communications and Significant Systemic Improvement*: Use international help to review the current policy-making and policy review process. Change the MOPH organization accordingly.

**Recommendation 5.2: Improve awareness, technical understanding, and opportunities for implementation of MOPH policies:**

- 5.2.1 *Inter-Departmental Coordination and Communications and Significant Systemic Improvement*: Use international help to conduct a comprehensive review of all policies; remedy remaining gaps with provisional policies where required.
- 5.2.2 *Inter-Departmental Coordination and Communications and Capital Spending*: Complete a comprehensive translation of all current, approved MOPH policies into local languages.
- 5.2.3 *Inter-Departmental Coordination and Communications and Capital Spending*: Ensure systematic distribution of translated policies throughout the MOPH hierarchy and among agencies implementing the BPHS and EPHS contracts.

5.2.4 *Inter-Departmental Coordination and Communications and Significant Systemic Improvement:*

Ensure that induction of all new MOPH Directors, Managers, and leaders includes systematic exposure to, understanding of, and agreement to enforce, current MOPH policies as a routine element of joining the Public Health system through formal Human Resource Induction procedures. Human Resource Induction procedures must be subject to inspection by ICAHO on an ongoing basis.

5.2.5 *Inter-Departmental Coordination and Communications and Significant Systemic Improvement:*

Ensure that all updates to MOPH policies and introduction of new MOPH policies are undertaken in local languages; these updates and additional policies should be incorporated into formal Human Resource Induction procedures for all MOPH Directors, Managers, and leaders. Publish and publicize these policies.

**Lesson Learned 6: Human Resource management has been lax throughout the Public Health system, with clinical and technical employees taking advantage of weak oversight in order to develop parallel private services.** Patient referrals to private sector health services lack transparency. Absenteeism has been cited as a critical factor in lowering public confidence in the health sector, reducing access to care in the public system, and in allowing a serious conflict of interests to emerge. Many individuals engaged in nominal full-time employment in public sector settings (or settings contracted to NGOs and INGOs on behalf of the public sector) systematically refer patients to private sector health services where they stand to gain financially.

**Recommendation 6.1: Confront absenteeism during contracted official working times:**

6.1.1 *Significant Systemic Improvement and Inter-Departmental Coordination and Communications:*

Internally clarify the official working times for all MOPH Directors, Managers, leaders, and BPHS and EPHS implementers. This should also be included in routine Human Resource Induction processes for new employees. Publish and publicize these regulations.

6.1.2 *Significant Systemic Improvement, Capital Spending, and Inter-Departmental Coordination and Communications:*

Enforce official working times as Terms and Conditions of employment within the MOPH, including penalties and dismissal for failures to follow the Terms and Conditions on working times. Seek donor investments to establish suitable mechanisms and systematic methods for tracking absenteeism during working times; these may include fingerprint readers, iris scanners, and other electronic tools which could be implemented throughout the health sector.

6.1.3 *Significant Systemic Improvement and Inter-Departmental Coordination and Communications:*

Enforce official working times as Terms and Conditions of employment among BPHS and EPHS contract holders, including penalties and dismissal for failures to follow the Terms and Conditions.

6.1.4 *Capacity/Capability:* Engage Health *Shuras* with the power to monitor absenteeism during official working times within the MOPH and in BPHS and EPHS services on a District level.

6.1.5 *Significant Systemic Improvement:* Engage the Independent Commission on Health Sector Auditing and Reporting to monitor absenteeism during official working times within MOPH and in BPHS and EPHS services on a Provincial level and a national level.

6.1.6 *Inter-Departmental Coordination and Communications:* Engage Health *Shuras* and the Independent Commission on Health Sector Auditing and Reporting to draw the public's attention to examples of good practice and integrity in the delivery of health services in working times.

**Recommendation 6.2: Address conflicts of interest in patient management and patient referrals to private sector services:**

- 6.2.1 *Significant Systemic Improvement and Inter-Departmental Coordination and Communications:* Internally clarify the process for patient referrals from public sector settings to private sector services for all MOPH Directors, Managers, leaders, and BPHS and EPHS implementers. This should also be included in routine Human Resource Induction processes for new employees.
- 6.2.2 *Significant Systemic Improvement and Inter-Departmental Coordination and Communications:* Publicly clarify the process for patient referrals from public sector settings to private sector services. Educating the community will be an ongoing process, and should include making clear the mechanism for lodging complaints when appropriate.
- 6.2.3 *Significant Systemic Improvement and Inter-Departmental Coordination and Communications:* Establish Conflicts of Interest policies within Terms and Conditions of BPHS and EPHS contracts to prevent inappropriate referrals from public sector settings to private sector services.
- 6.2.4 *Significant Systemic Improvement and Inter-Departmental Coordination and Communications:* Enforce penalties for violating the Conflicts of Interest policies as a Term and Condition of achieving BPHS and EPHS contracts.
- 6.2.5 *Capacity/Capability:* Engage Health *Shuras* with the power to monitor patient referrals from public sector settings to private sector services on a District level.
- 6.2.6 *Significant Systemic Improvement:* Engage ICHSAR to monitor patient referrals in BPHS and EPHS services on a Provincial level and a national level.
- 6.2.7 *Inter-Departmental Coordination and Communications:* Engage Health *Shuras* and the Independent Council on Health Sector Auditing and Reporting to draw the public's attention to examples of good practice and integrity in the management of patient referrals.

## Contracts

**Lesson Learned 7: Contracting processes for BPHS and EPHS have been described as suspect, compromised, corrupted, and inconsistent.** Failures to strengthen these processes have led to disappointment, frustration, suspicion, and weakened trust in the MOPH. Such corruption in contracting can be improved fairly rapidly, as the national procurement commission has shown for other contracts.

**Recommendation 7: Undertake a comprehensive independent investigation of the Grants and Contracts Management Unit's systems and organizational capacity, and contract management beyond the specific scope and remit of the GCMU:**

- 7.1 *Significant Systemic Improvement and People and Politics:* Ensure that the Grants and Contracts Management Unit's and MOPH's bid evaluation and negotiation processes are reviewed, clarified, transparent, standardized, and reliable. Consider engaging the Independent Commission for Accreditation of Healthcare Organizations.
- 7.2 *Significant Systemic Improvement and People and Politics:* Establish a contracts and procurement review group, authorized to review and approve all health contracts. Seek advice from the National Procurement Authority and Commission for setting up such a group and ensuring its integrity and independence.
- 7.3 *Significant Systemic Improvement and Capacity/Capability:* Engage the Independent Commission on Health Sector Auditing and Reporting in ensuring that conflicts of interest are uncovered, overturned, and prevented as a routine matter within the Grants and Contracts Management Unit. Violations must be referred to the Attorney General's Office for official investigation and prosecution.

## Embezzlement

**Lesson Learned 8: Diversion of public goods and money within the health sector for personal benefit was described as routine and unchallenged in all parts of the country.** Use of official vehicles (especially ambulances) and theft of consumables such as fuel, food, and other supplies was especially disturbing considering the degree to which the public suffers when these resources are consistently diverted to support the comfort and convenience of those with power.

**Recommendation 8: Strictly enforce rules against use of public assets for meeting private needs:**

- 8.1 *Significant Systemic Improvement and Inter-Departmental Coordination and Communications:* Internally clarify the rules on private use of public sector assets for all MOPH Directors, Managers, leaders, and BPHS and EPHS implementers. This should also be included in routine and formalized Human Resource Induction processes for new employees, with a verifiable record retained of the Induction having been completed for all new employees, and which specifies expectations, requirements, and consequences.
- 8.2 *Significant Systemic Improvement:* Implement strict enforcement of rules against the use of public assets for private needs, including referral of cases to the Attorney General's Office for investigation and prosecution.
- 8.3 *Significant Systemic Improvement and Inter-Departmental Coordination and Communications:* Publicly clarify the rules on private use of public sector assets. Educating the community will be an ongoing process, and should include making clear the mechanism for lodging complaints when appropriate.
- 8.4 *Capacity/Capability:* Engage *Health Shuras* with the power to monitor use of ambulances and other official vehicles within the MOPH and in BPHS and EPHS services on a District level.
- 8.5 *Significant Systemic Improvement:* Engage the Independent Council on Health Sector Auditing and Reporting to monitor use of ambulances and other official vehicles within MOPH and in BPHS and EPHS services on a Provincial level and a national level.

**Lesson Learned 9: Auditing practices and the systematic management of resources and inventory to prevent embezzlement in the health sector vary widely across the country.** Elements of MOPH, health sector donors, health sector implementers, and the Government of Afghanistan each have a stake in improved and aligned approaches to how audits are implemented and under what standards and expectations. The Auditors themselves must be above suspicion for trust to be restored.

**Recommendation 9: Conduct a thorough analysis of auditing practices and the systematic management of resources and inventory to prevent embezzlement in the health sector:**

- 9.1 *Significant Systemic Improvement and People and Politics:* Initiate reform of the internal audit functions in the Ministry and in every province.
- 9.2 *Significant Systemic Improvement and People and Politics:* Invite independent groups or external oversight bodies to monitor the quality, objectivity and scope of the internal audit departments in every province.
- 9.3 *Further Analyses:* Engage the Independent Council on Health Sector Auditing and Reporting (ICHSAR) to examine current practices in the management of resources and inventory in the health sector.
- 9.4 *Further Analyses:* Engage ICHSAR to identify gaps in the implementation of health sector auditing, checks, and controls.
- 9.5 *Further Analyses:* Engage ICHSAR to articulate opportunities to standardize robust health sector auditing and resource and inventory management systems.
- 9.6 *Further Analyses, Capacity/Capability, and Capital Spending:* Engage ICHSAR to itemize the financial and technical resources, and minimum skill set of human resources, required to achieve these objectives.

9.7 *Inter-Departmental Coordination and Communications*: Engage ICHSAR to draw the public's attention to examples of good practice and integrity in the management of the public's health sector assets.

## **Nepotism / Abuse of Power**

**Lesson Learned 10: Preferential hiring and favoritism in management of human resources was commonplace, systematic, and a routine element of the engagement of powerful persons with the Public Health system.** Health services and health system management in every part of the country were described as having been compromised by nepotism and abuse of power.

**Recommendation 10.1: Undertake a comprehensive independent investigation of the Human Resource Recruitment Office's workforce and organizational capacity, as well as all tier 1 and tier 2 MOPH senior leadership recruitments:**

- 10.1.1 *Significant Systemic Improvement and People and Politics*: Demonstrate publicly that all the senior positions are being appointed on the basis of merit.
- 10.1.2 *Significant Systemic Improvement and People and Politics*: Invite external oversight bodies to monitor the recruitment and appointment process.
- 10.1.3 *Significant Systemic Improvement and People and Politics*: Engage the Independent Commission for Accreditation of Healthcare Organizations in ensuring that the Human Resource Recruitment Office's workforce, organizational capacity, and processes are clarified, transparent, and reliable.
- 10.1.4 *Significant Systemic Improvement and Capacity/Capability*: Engage the Independent Council on Health Sector Auditing and Reporting in ensuring that nepotism is uncovered, overturned, and prevented as a routine matter within the Human Resource Recruitment Office.
- 10.1.5 *Significant Systemic Improvement and Capacity/Capability*: Engage the Independent Council on Health Sector Auditing and Reporting in reviewing all tier 1 and tier 2 MOPH management recruitments for legality and due process over a period of two years.

**Recommendation 10.2: Make a high profile, clear, and unambiguous statement about the need for transparency in Human Resource recruitment in the health sector:**

- 10.2.1 *People and Politics*: Gather allies and supporters inside and outside of Government to publicly challenge the influence of powerful persons in health sector recruitment through clear and unambiguous statements to the Parliament and Governors:

*"For the sake of the health of the nation, you must stop subverting competency-based recruitments in the health sector. Our peoples' lives are at stake. Our health depends on the integrity of the recruitment processes in the health sector. Legitimate qualification and technical competency can be the only standards for hiring and retention in the health sector. Not relationships and not affiliations. Promote educational achievement, promote integrity, and promote the health of our nation."*

**Lesson Learned 11: Employees in every area of the health sector and in all parts of the country expressed disappointment over limited access to clinical and technical training and professional development opportunities.** Preferential treatment and favoritism in controlling access to training and professional development was described as commonplace, systematic, and lacking transparency. These frustrations lower morale, negatively affect motivation, and contribute to the belief that reward mechanisms are managed in an unfair and discriminatory way. Showing staff that training is being permitted on an objective basis may be one of the best ways of demonstrating to staff that the culture of favoritism is changing.

**Recommendation 11: Conduct a thorough analysis of Training Needs Assessment practices and the systematic management of access to these opportunities in the health sector:**

- 11.1 *Significant Systemic Improvement and People and Politics:* Engage the Independent Commission for Accreditation of Healthcare Organizations in ensuring that Training Needs Assessment processes within MOPH and BPHS and EPHS contract holding agencies are clarified, transparent, and reliable.
- 11.2 *Significant Systemic Improvement and Capacity/Capability:* Engage the Independent Council on Health Sector Auditing and Reporting in ensuring that favoritism and discrimination in access to training are uncovered, overturned, and prevented as a routine matter within the MOPH and BPHS and EPHS contract holding agencies.
- 11.3 *Significant Systemic Improvement and Capacity/Capability:* Engage the Independent Council on Health Sector Auditing and Reporting in ensuring opportunities to standardize the resource management systems for health sector clinical and technical training and professional development.
- 11.4 *Further Analyses and Capital Spending:* Itemization of the financial and technical resources required to achieve these objectives.

## Quality Assurance / Quality Control

**Lesson Learned 12: Quality assurance (monitoring processes and verifications of quality checks) was identified as inconsistent at all levels of the health sector.** Quality control (corrective actions and consequences) was described as unreliable and uncoordinated. Quality concerns were pervasive in leadership and governance, finance, human resources, health services delivery, pharmacy and drugs supply, and Health Management Information Systems.

A standardized approach to tracking investments and the resulting outputs and outcomes can be useful in communicating high-level strategy into programmatic and tactical decision-making. In the health sector, particularly when resources are scarce, Key Performance Indicators (KPIs) can assist in communicating progress throughout the management system and to implementing agencies: Using KPIs to monitor and evaluate performance will enable health sector managers to pinpoint and address gaps in performance, while providing meaningful information with which to demonstrate results when justifying budget requests, including requests for increased health sector allocations, through the budget process. KPIs will not only help MOPH to define and track the success of their programs, but also to communicate to the Ministry of Finance, key political decision makers, and the public how resources are being used for the social good.

**Recommendation 12: Establish authentic and realistic Key Performance Indicators:**

- 12.1 *Significant Systemic Improvement:* Engage the Independent Commission for Accreditation of Healthcare Organizations in devising Key Performance Indicators for MOPH core internal management systems. This is a continuous process of quality improvement, with formal Quarterly reporting on achievements against Action Plans.
- 12.2 *Significant Systemic Improvement:* Engage the Independent Commission for Accreditation of Healthcare Organizations in devising Key Performance Indicators for BPHS and EPHS contracts.
- 12.3 *Significant Systemic Improvement and Capacity/Capability:* Engage the Independent Council on Health Sector Auditing and Reporting in embedding all KPIs into the MOPH HMIS, covering the core MOPH management functions and BPHS and EPHS contracts.
- 12.4 *Significant Systemic Improvement and Inter-Departmental Coordination and Communications:* Enforce consequences for failures to achieve KPIs, including termination of employment and termination of contracts.

- 12.5. *Significant Systemic Improvement and Capacity/Capability*: Engage representatives from civil society organizations and Health *Shuras* in monitoring and reporting on Key Performance Indicators.
- 12.6 *Inter-Departmental Coordination and Communication*: Engage Health *Shuras* to draw the public's attention to examples of achievement of KPIs by MOPH and BPHS and EPHS contract holders.

## Human Rights and Discrimination

**Lesson Learned 13: Protection of human rights in the Public Health system related to struggles of patients and their families to be treated with dignity, the perception of preferential treatment, and experience of being exploited, abused, or treated with indifference. Discrimination was cited as a pervasive problem in relation to accessing care equitably, especially for families lacking a contact, connection, or relationship within the health system.**

**Recommendation 13: Implement a unified and independent reporting system for complaints:**

- 13.1 *Significant Systemic Improvement and Capacity/Capability*: Develop an independent Health Sector Ombudsman Office (HSOO) inside the Independent Commission on Health Sector Auditing and Reporting, with investigatory powers, to manage a complaints system. The HSOO should be operated independently from the MOPH and BPHS and EPHS contract holding agency management structures currently controlling information about abuses and discrimination.
- 13.2 *Significant Systemic Improvement and Capacity/Capability*: The HSOO should be staffed with specialist Investigators and Inspectors to handle cases in the Public Health system and the private health sector in the Capital; initially, this should be composed of 1-2 international Technical Advisors, 6-8 Investigators, and 6-8 Inspectors.
- 13.3 *Capital Spending and People and Politics*: An appropriately sized HSOO office should be established in each Province.
- 13.4 *Capital Spending and People and Politics*: These HSOO offices must be independently funded to retain their impartiality from the MOPH management structure.
- 13.5 *Inter-Departmental Coordination and Communication*: Engage HSOO to draw the public's attention to examples of good quality of care, integrity, and reliability in the health sector.
- 13.6 *Inter-Departmental Coordination and Communication*: Formally liaise with the Human Rights Commission to encourage cooperation on issues in the health sector.

**Lesson Learned 14: Health *Shuras* were not familiar to people in many parts of the country.** In places where they were known, patients had varied levels of confidence in the effectiveness of Health *Shuras* in supporting improved quality of care, addressing concerns about service delivery, and articulating community priorities. The system of Health *Shuras* needs to be strongly encouraged and supported, so that they become a recognized part of the oversight of public health.

**Recommendation 14: Conduct a thorough analysis of the breadth and strength of Health *Shuras*; based on the analyses, expand their reach and effectiveness:**

- 14.1 *Further Analyses*: Commission a thorough analysis of the current extent of active Health *Shuras*. Consider engaging the Independent Council on Health Sector Auditing and Reporting (ICH SAR) in doing this systematic assessment to ensure expansion of Health *Shuras* is suitable, appropriate, and achieves its aims.

- 14.2 *Further Analyses*: Engage the ICHSAR in analysis of the Terms of Reference for existing Health *Shuras* to advocate for community priorities, manage patient complaints, and address community service delivery concerns.
- 14.3 *Further Analyses*: Engage the ICHSAR in analysis of gaps in the coverage areas of existing Health *Shuras* across all Districts of Afghanistan.
- 14.4 *Further Analyses and Significant Systemic Improvement*: Engage ICHSAR in articulating opportunities to standardize the role and functions of Health *Shuras*.
- 14.5 *Further Analyses, Capacity/Capability, and People and Politics*: Engage the Health Sector Ombudsman Office (HSOO) in establishing new Health *Shuras* in Districts without coverage.
- 14.6 *Further Analyses, Capacity/Capability, and People and Politics*: Engage the HSOO in articulating opportunities to link Health *Shuras* across regions to further strengthen quality of care.
- 14.7 *Inter-Departmental Coordination and Communication*: Engage Health *Shuras* to draw the public's attention to examples of good quality of care, integrity, and reliability in the health sector.

## Extortion

**Lesson Learned 15: Extortion and illegal pressures on decision-making were cited at all levels of the Public Health system, particularly around human resources and procurement.** Extortion and pressure were being used in every part of the country and in all types of settings from MOPH HQ through Basic Health Centers in remote Districts.

**Recommendation 15: Convene a High Council on Oversight of Health Sector Integrity to support a unified resistance to extortion and pressures that compromise health sector effectiveness, quality of care, transparency, and good governance:**

- 15.1 *Significant Systemic Improvement and People and Politics*: Convene a High Council on Oversight of Health Sector Integrity (HCOHSI) composed of the Minister of Public Health, the highest levels of MOPH Senior Leadership, the Attorney General, health sector donors, civil society, Health *Shura* representatives, and BPHS and EPHS contract implementers. The HCOHSI should meet Quarterly, at a minimum.
- 15.2 *Inter-Departmental Coordination and Communication*: Engage HCOHSI to draw the public's attention to examples of good quality of care, integrity, and reliability in the health sector.

## Fraud / Falsification / Fakes / Forgery

**Lesson Learned 16: Fraud, falsification, fakes, and forgeries have become a routine aspect of documentation in the Public Health sector.** This has had dire consequences for the integrity and reliability of each of the main elements of the health system: Leadership and governance, finance, human resources, health services delivery, pharmacy and drugs supply, and Health Management Information Systems.

**Recommendation 16: Establish a reliable, transparent, and coordinated system for assessing Certificates and Diplomas:**

- 16.1 *Significant Systemic Improvement and People and Politics*: Engage the ICAHO to establish a reliable and transparent system for assessing Certificates and Diplomas. Work through liaison among MOPH and Ministry of Education, Ministry of Higher Education, Ministry of Foreign Affairs, Attorney General's Office, and the Civil Service Commission.

16.2 *Significant Systemic Improvement and Capacity/Capability*: Engage the ICAHO to strengthen management and coordination of assessing Certificates and Diplomas within MOPH Human Resource Recruitment Office.

## Conflicts of Interest

**Lesson Learned 17: Failures to confront conflicts of interest have severely compromised the trust of the public in their Public Health system.** This was observed from the many negative comments about the promotion of parallel private sector health services when public sector health services remain under-funded and of questionable quality. To many in the community, there is a strong belief that accumulating wealth has been prioritized over the delivery of impartial and quality-focused public services.

In order to rebuild public trust, there must be consequences when employees in the public sector are found to be undermining public sector health services and simultaneously promoting private sector alternatives. Exploitation of sickness and suffering should be confronted.

**Recommendation 17: Establish and implement policies on Conflicts of Interest in the management of patient referrals to private sector health services:**

- 17.1 *Significant Systemic Improvement and People and Politics*: Engage ICAHO in establishing MOPH Conflicts of Interest policies, including if necessary, termination of MOPH employment agreements and BPHS and EPHS contracts for violations.
- 17.2 *Significant Systemic Improvement and Capacity/Capability*: Engage Health Shuras with the power to monitor conflicts of interests on a District level.
- 17.3 *Significant Systemic Improvement and Capacity/Capability*: Engage ICHSAR in ensuring that conflicts of interest are uncovered, overturned, penalized, and prevented as a routine matter within the MOPH and BPHS and EPHS contract holding agencies on a Provincial level and a national level.

**Lesson Learned 18: There are strong indications that contracting decisions in MOPH to implement the BPHS and EPHS contracts have been made according to the financial interests of those with a stake in the outcomes.** To many stakeholders inside and outside the MOPH, including donors, it appears that accumulating wealth has been prioritized over maintaining the integrity of the Ministry of Public Health and the reliability of its functions in managing and coordinating the health sector in the public's interest. In order to rebuild donor trust, there must be consequences when employees in the public sector are found to be benefiting from BPHS and EPHS contracting processes. Exploitation of the generosity and good will of donors should be confronted.

**Recommendation 18: Establish and implement policies on Conflicts of Interest in relationships between MOPH and external entities including BPHS and EPHS contract holders, donors, and other health sector stakeholders:**

- 18.1 *Significant Systemic Improvement and People and Politics*: Engage ICAHO in establishing MOPH Conflicts of Interest policies, including if necessary, termination of MOPH employment agreements and BPHS and EPHS contracts for violations.
- 18.2 *Significant Systemic Improvement and Capacity/Capability*: Engage ICHSAR in ensuring that conflicts of interest are uncovered, overturned, and prevented as a routine matter within the MOPH and BPHS and EPHS contract holding agencies on a Provincial level and a national level.

## Bribery

**Lesson Learned 19: Bribery in the health sector is considered routine, commonplace, and ‘normal’ in all parts of the country.** Transactions of cash or gifts for performance of duties, to ensure better care, to guarantee access to employment, in consideration of requests, to assure cooperation, and to remove obstacles have all contributed to the perception that the functionality of the entire Public Health system is dependent on these transactions.

**Recommendation 19.1: Investigate, prosecute, and publicize high profile cases of punishment for bribery among all levels of staff and management:**

*19.1.1 Significant Systemic Improvement and Inter-Departmental Coordination and Communications:*

Internally clarify, publish and publicize the policies against bribery for all MOPH Directors, Managers, leaders, and BPHS and EPHS implementers. This should also be included in routine Human Resource Induction processes for all new employees.

*19.1.2 Significant Systemic Improvement and Inter-Departmental Coordination and Communications:*

Educate the community that bribery will not be tolerated and that complaints are welcome. Make clear the mechanism for lodging complaints when appropriate.

*19.1.3 Significant Systemic Improvement and Inter-Departmental Coordination and Communications:*

Enforce penalties for violating the policies against bribery as a Term and Condition of retaining MOPH employment and BPHS and EPHS contracts. Ensure enforcement is widely publicized as a deterrent to other violations; these need not be ‘named perpetrators’ but could be numbers or cases identified and dealt with each month or Quarter.

*Recommendation 19.2* Support and encourage the local Health *Shuras* to take an active role in coordinating complaints and in challenging the routine acceptance of bribery

*19.2.1 Capacity/Capability:* Engage Health *Shuras* with the power to monitor patient complaints about bribery in MOPH and BPHS and EPHS services on a District level.

*19.2.2 Significant Systemic Improvement:* Engage the Health Sector Ombudsman Office to monitor patient complaints about bribery in MOPH and BPHS and EPHS services on a Provincial level and a national level.

*19.2.3 Inter-Departmental Coordination and Communications:* Engage Health *Shuras* and the Independent Council on Health Sector Auditing and Reporting to draw the public’s attention to examples of good practice and integrity in the management of patient referrals.

## Sequencing Options and Anticipated Outcomes

MEC recognizes that it will not be possible for MOPH to undertake all the above reforms simultaneously. As MOPH puts together its anti-corruption action plan, it will need to make its own decisions on sequencing, and which recommendations to priorities.

The sequencing depends on some very diverse factors:

- Which areas can be improved relatively easily and/or rapidly
- Some improvements will be fundamental for many other reforms (e.g., the reliability and integrity of the HMIS)
- Which changes will be most visible to staff and public, and therefore help with motivation for further change (e.g., the integrity of the senior managers and directors)
- Whether it makes sense to prioritize certain geographical areas, as a way of showing that significant progress against corruption can be made, even though the overall MOPH problems are huge

- Whether it makes sense to tackle some of the worst areas first – because the abuses are so blatant – or last, because they will be so tough to reform (e.g., forensics)
- The extent of the political support for reform - inside MOPH, inside the government, and across the provinces

MEC has not tried to provide guidance on these choices. But MEC has made some suggestions below on which of the recommendations should be started at an early stage, and which could be considered for later.

## **GROUP ONE: Immediate Actions in First Quarter, ‘Easy’ Actions, Pre-Conditions**

**Recommendation 1.1.1, 1.1.4:** Establish and empower an Independent Council on Health Sector Auditing and Reporting (ICHSAR) in Kabul; obtain donor funding for staffing and operations.

Anticipated Outcome: Rebuild public and donor trust in the MOPH.

**Recommendation 1.2.1, 1.2.2, 1.2.3:** Assess functionality and identify gaps in HMIS.

Anticipated Outcome: Maximize HMIS efficiencies and draw-in private sector.

**Recommendation 2.1, 2.2, 2.3:** Reform the Public Procurement Law and Pharmaceutical Law.

Anticipated Outcome: Increase controls and reduce risks of corruption.

**Recommendation 2.4, 2.5, 2.11:** Update the Licensed National Pharmaceutical Products List and link to *pro forma* registration process to the Products List; incorporate expanded HMIS to accurately balance supply, goals, and overall Public Health planning objectives.

Anticipated Outcome: Improve appropriateness of formulary and increase efficiencies.

**Recommendation 2.15, 2.16, 2.17:** Implement redundant procedures for sampling and independent sampling and analyses of imported pharmaceuticals.

Anticipated Outcome: Improve confidence in the quality of drugs being imported.

**Recommendation 3:** Establish and empower an Independent Commission on Accrediting Healthcare Organizations (ICAHO).

Anticipated Outcomes: Rebuild health sector reliability, thoroughness, and integrity; assures MOPH is fit for purpose; lowers risk of weak NGOs and INGOs obtaining contracts.

**Recommendation 4.1, 4.2:** Improve the understanding on health sector-specific issues in the Attorney General’s Office.

Anticipated Outcomes: Rebuild health sector accountability, transparency, and good governance; lowers risk of powerful persons evading prosecutions.

**Recommendation 5.1.1, 5.1.2, 6.2.3:** Assess coverage of current MOPH policies; implement provisional policies as required; engage a policy development review.

Anticipated Outcomes: Improve awareness, technical understanding, and opportunities for implementation of MOPH policies; reduce risks of corruption, improve system integrity.

**Recommendation 5.2.1, 5.2.2:** Translate all current MOPH policies into Dari and Pashto.

Anticipated Outcomes: Improve awareness, technical understanding, and opportunities for implementation of MOPH policies; reduce risks of corruption.

**Recommendation 6.1.1, 6.1.2:** Confront absenteeism in MOPH during contracted official working times. Seek donor support for tackling absenteeism through investments in suitable systems that support efficient monitoring of employees presence and absence during contracted working times.

Anticipated Outcomes: Improve public confidence in the health sector.

**Recommendation 6.2.1, 6.2.2:** Internally and publicly clarify the referrals policy and expected practices; address conflicts of interest that arise when public patients are inappropriately referred to private healthcare.

Anticipated Outcomes: Improve public confidence in the health sector, reduce exploitation.

**Recommendation 7.1:** Engage ICAHO to undertake a comprehensive independent investigation of the Grants and Contracts Management Unit's systems and organizational capacity.

Anticipated Outcomes: Improve public and donor confidence in the health sector.

**Recommendation 8.1, 8.2:** Internally and publicly clarify the rules on private use of public assets; strictly enforce rules against use of public assets for meeting private needs.

Anticipated Outcomes: Improve public access to ambulance services, increase public and donor confidence in the public health system.

**Recommendation 9.1, 9.2:** Initiate reform of MOPH internal audit in Kabul and provincial level; engage external stakeholders for monitoring quality, objectivity, and scope of Audit Departments.

Anticipated Outcomes: Improve the standardization of audits, increase effectiveness of MOPH control systems, enhance cross-Departmental efficiencies, and improve donor confidence in the health sector.

**Recommendation 10.1.1, 10.1.2:** Make high profile, clear, and unambiguous statements about the need for transparency in Human Resource recruitment in the health sector.

Anticipated Outcomes: Minister of Public Health's stance on health sector recruitment processes is clarified, transparent, and supported by allies and colleagues in and outside of Government.

**Recommendation 13.1:** Establish a unified and independent reporting system for complaints through development of a Health Sector Ombudsman Office inside ICHSAR, and through affiliation with expanded and empowered Health *Shuras*.

Anticipated Outcomes: Rebuild health sector accountability, transparency, and good governance; increase opportunity for patients and their families to be treated with dignity; reduce risks of being exploited, abused, or treated with indifference.

**Recommendation 14:** Engage ICHSAR and HSOO to support development and expansion of Health *Shuras* in all Districts; standardize, strengthen, and empower the Health *Shuras* to maximize their effectiveness.

Anticipated Outcomes: Restore confidence in the health sector; rebuild health sector accountability, transparency, and good governance; increase opportunity for patients and their families to be treated with dignity.

**Recommendation 15:** Convene a High Council on Oversight of Health Sector Integrity (HCOHSI).

Anticipated Outcome: Rebuild public and donor trust in the MOPH; improve health sector effectiveness, quality of care, transparency, and good governance.

**Recommendation 16:** Engage the ICAHO to establish a reliable, transparent, and coordinated system for assessing Certificates and Diplomas through liaison among MOPH and Ministry of Education, Ministry of Higher Education, Ministry of Foreign Affairs, Attorney General's Office, and the Civil Service Commission.  
Anticipated Outcome: Rebuild public and donor trust in the suitability and professionalism of MOPH staff and management; improve health sector effectiveness, quality of care, transparency, and good governance; reduce risks from fraudulent Certificates and Diplomas.

**Recommendation 18.1:** Engage ICAHO to establish and implement policies on Conflicts of Interest in the relationships between MOPH and external entities including BPHS and EPHS contract holders, donors, and other health sector stakeholders.

Anticipated Outcome: Donor confidence in the health sector will be increased.

## **GROUP TWO: Near- and Long-Term Sustained Activities, Third Quarter and Later**

**Recommendation 1.1.5, 3.4, 6.1.6, 6.2.7, 9.7, 12.6, 13.5, 14.7, 15.3, 19.2.3:** Engage ICHSAR to draw the public's attention to examples of good quality of care, integrity, and reliability in the health sector.

Anticipated Outcome: Rebuild public and donor trust in the MOPH.

**Recommendation 1.1.2:** Hire teams for ICHSAR in Kabul office and three initial Provinces.

Anticipated Outcome: Rebuild public and donor trust in the MOPH.

**Recommendation 1.1.3:** Empower ICHSAR to investigate and inspect MOPH and BPHS and EPHS implementers in all Provinces.

Anticipated Outcome: Rebuild public and donor trust in the MOPH.

**Recommendation 1.2.4, 1.2.5:** Identify funding and technical requirements to expand HMIS, secure donor commitments.

Anticipated Outcome: Maximize efficiencies and draw-in private sector.

**Recommendation 2.6, 2.7, 2.8, 2.9, 2.10:** Restructure Pharmacy Affairs Directorate, clarify roles and lines of reporting, enhance cross-Departmental coordination, enhance training opportunities, and improve the status of professional Pharmacy training and credentials.

Anticipated Outcome: Improve effectiveness of the Directorate and increase efficiencies.

**Recommendation 2.12, 2.13, 2.14:** Assess transparency, integrity, and reliability of importation licensing processes for imported pharmaceuticals; pursue investigations and prosecutions.

Anticipated Outcome: Improve licensing performance of the Directorate and increase efficiencies.

**Recommendation 2.18:** Invest in technical equipment and training to enable analyses of drug samples for imported pharmaceuticals.

Anticipated Outcome: Improve screening performance of the Directorate in detecting fakes.

**Recommendation 2.19, 2.20:** Analyze options and consider single-source procurement in a regional or national process; consider centralized procurement of pharmaceuticals.

Anticipated Outcome: Understanding of risk/benefits of efficiencies versus inflexibility.

**Recommendation 5.2.3, 5.2.4, 5.2.5:** Ensure systematic distribution of MOPH policies translated into Dari and Pashto; recipients must include MOPH hierarchy and BPHS and EPHS contract holders, as well as

future new employees through formal Human Resource Induction Procedures; ensure future policy developments are in local languages from the start.

Anticipated Outcomes: Improve awareness, technical understanding, and opportunities for implementation of MOPH policies, reduces risks of corruption.

**Recommendation 6.1.3, 6.1.4, 6.1.5:** Confront absenteeism in BPHS and EPHS sites during contracted official working times; engage ICHSAR and empower Health *Shuras* to participate in monitoring of health sector absenteeism.

Anticipated Outcomes: Improve public confidence in the health sector.

**Recommendation 6.2.4, 6.2.5, 6.2.6:** Enforce policies on conflicts of interest to prevent public patients being referred inappropriately to private care; engage ICHSAR and empower Health *Shuras* to participate in monitoring of conflicts of interest.

Anticipated Outcomes: Improve public confidence in the health sector, reduce exploitation.

**Recommendation 7.2, 7.3:** Establish a contracts and procurement review group; engage ICAHO in investigating, overturning, and preventing conflicts of interest in the Grants and Contracts Management Unit.

Anticipated Outcomes: Rebuild health sector accountability, transparency, and good governance.

**Recommendation 8.2, 8.3, 8.4, 8.5:** Enforce rules against use of public assets for meeting private needs; engage ICHSAR and empower Health *Shuras* to participate in monitoring of ambulance usage.

Anticipated Outcomes: Improve public access to ambulance services, increase public confidence in the public health system; improved donor confidence in auditing and reporting in the health sector.

**Recommendation 9.3, 9.4, 9.5, 9.6, 9.7:** Engage ICHSAR to investigate MOPH resource management, auditing, inventory controls, cross-Departmental coordination on these actions, and suggest technical training.

Anticipated Outcomes: Improve the standardization of audits, increase effectiveness of MOPH control systems, enhance cross-Departmental efficiencies, and improve donor confidence in the health sector.

**Recommendation 10.1.3, 10.1.4, 10.1.5:** Engage ICAHO to undertake a comprehensive independent investigation of the Human Resource Recruitment Office's workforce and organizational capacity; engage ICHSAR to uncover, overturn, and prevent nepotism.

Anticipated Outcomes: MOPH recruitment processes are clarified, transparent, and reliable.

**Recommendation 10.1.1, 10.1.2:** Invite external oversight bodies to monitor recruitment and appointment processes.

Anticipated Outcomes: Minister of Public Health's recruitment process is clarified, transparent, and reliable; confidence in the health sector increases.

**Recommendation 11:** Engage ICAHO to undertake an analysis of Training Needs Assessment practices and the systematic management of access to these opportunities in the health sector.

Anticipated Outcomes: Health sector Training Needs Assessment practices, and management of training development opportunities, are clarified, transparent, and reliable.

**Recommendation 12.1, 12.2:** Engage ICAHO to undertake an analysis to support development of authentic and realistic Key Performance Indicators for the MOPH.

Anticipated Outcomes: Health sector managers in MOPH and NGOs and INGOs can pinpoint and address gaps in performance, demonstrate results when justifying budget requests including requests for increased health sector allocations; realistic KPIs will help MOPH to communicate to the Ministry of Finance, key political decision makers, and the public how resources are being used for the social good; confidence in the health sector will be increased.

**Recommendation 12.3, 12.4, 12.5, 12.6:** Engage ICAHO, civil society organizations, and Health *Shuras* to participate in monitoring Key Performance Indicators for the MOPH; enforce consequences for failure to achieve KPIs.

Anticipated Outcomes: Quality of care improves; confidence in the health sector will be increased.

**Recommendation 13.2, 13.3, 13.4, 13.6:** Establish appropriately staffed and independently funded Provincial Health Sector Ombudsman Offices in all provinces; formally liaise with the Afghanistan Independent Human Rights Commission to support increased scrutiny of the health sector and MOPH operations.

Anticipated Outcomes: Rebuild health sector accountability, transparency, and good governance; increase opportunity for patients and their families to be treated with dignity; reduce risks of being exploited, abused, or treated with indifference.

**Recommendation 14.2, 14.3, 14.4, 14.5, 14.6:** Engage ICHSAR and HSOO to analyze the current TORs of Health *Shuras* in all Districts; standardize, strengthen, and empower the Health *Shuras* to maximize their effectiveness; establish additional Health *Shuras* and promote regionalized communications and coordination of Health *Shura* activities.

Anticipated Outcomes: Restore confidence in the health sector; rebuild health sector accountability, transparency, and good governance; increase opportunity for patients and their families to be treated with dignity.

**Recommendation 17:** Engage ICAHO to establish and implement policies on Conflicts of Interest in the management of patient referrals to private sector health services; engage ICHSAR and Health *Shuras* in monitoring conflicts of interest.

Anticipated Outcome: Public confidence in the health sector will be increased.

**Recommendation 18.2:** Engage ICHSAR in ensuring that conflicts of interest are uncovered, overturned, and prevented as a routine matter within the MOPH and BPHS and EPHS contract holding agencies on a Provincial level and a national level.

Anticipated Outcome: Public confidence in the health sector will be increased.

**Recommendation 19.1.1, 19.1.2, 19.1.3:** Internally clarify, publish and publicize the policies against bribery for all MOPH Directors, Managers, leaders, and BPHS and EPHS implementers; educate the community; enforce penalties for violations of policies..

Anticipated Outcomes: Increase public and donor confidence in the public health system.

**Recommendation 19.2.1, 19.2.2, 19.2.3:** Engage Health *Shuras* to participate in monitoring of requests or demands for bribes; engage HSOO to investigate, prosecute, and publicize high profile cases of punishment for bribery among all levels of staff and management in MOPH and BPHS and EPHS contract holders on Provincial and national level.

Anticipated Outcomes: Increase public and donor confidence in the public health system.

# MAIN REPORT

## BACKGROUND AND CONTEXT

More than 30 years of war has greatly hampered social and economic development in Afghanistan. Since the fall of the Taliban in 2001, an influx of international development aid funding and support has helped to improve the health status of Afghans. Yet despite these investments and supports, Afghanistan remains one of the world's poorest countries and is dependent on foreign aid to provide even the most basic level of health care to its population. Private expenditures on health constitute 76% of total health expenditures, of which household out of pocket expenditure is approximately 99.7%. Donor contributions represent 75% of total public expenditures on health, indicating that health care priorities remain largely donor driven<sup>4</sup>.

While reliable health statistics for Afghanistan are scarce, life expectancy at birth is estimated at just 47.1 years for men and 47.4 years for women according to the UN<sup>5</sup>. Due to extraordinarily high maternal mortality, Afghanistan had been the only country in the world where women had shorter average life expectancies than men as recently as 2010. Following aggressive donor-funded expansion of midwifery services in some of the most impoverished Afghan provinces between 2005 and 2010, life expectancy for Afghan women has improved to rates now slightly better than for men, though the country remains in the bottom 1% of world rankings in regards to maternal mortality. By 2012 Afghanistan's maternal mortality rate had just eclipsed six African States facing extreme poverty, despite more than 10 years of heavy international investment in the health sector to target this issue.

Access to health care in Afghanistan remains a huge challenge in many parts of the country due to limited service provision on account of geography and weather, insecurity, and service sites with inappropriate staffing, inadequate equipment, and unreliable medication supplies. After some years of recovery in the early 2000s, Afghanistan grew increasingly insecure and the Afghan Government and International Security Assistance Force (ISAF) have largely failed to control the growth of Taliban territory, as well as the new challenge of previously secured areas coming under influence or control of fighters aligned with Islamic State, further hindering the ability of ordinary Afghans to reach health services.

Geographic distribution of health services across Afghanistan has steadily increased since 2001, though to date; there have been no comprehensive explorations of patient satisfaction with the quality of these health services. Systematic review of service provision has focused on coverage and reach, rather than quality, and the monitoring and evaluation function of the Ministry of Public Health remains one of the lesser-well-funded components of its oversight role. Most Afghans still rely on access to health care services and pharmaceuticals through the private sector, which remains marginally regulated outside of the largest cities but well entrenched as an alternative to Government-run or Government-affiliated services, even in the least-developed provinces. Trust in both public sector and private sector health services also remains unexplored, though the reportedly high usage of health services outside Afghanistan is an indicator of the level of confidence most Afghans have in the services available in their own country<sup>6</sup>.

## TRANSPARENCY, GOVERNANCE, and ACCOUNTABILITY

In 2014, one of the predominant concerns of the new National Unity Government and the international community was confronting endemic corruption. At the December London Conference on Afghanistan, President Ashraf Ghani announced a "*jihad against corruption*" by the National Unity Government. He

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<sup>4</sup> Afghanistan Health Financing Policy 2012-2020, MOPH

<sup>5</sup> *World Population Prospects 2010-2015, The 2015 Revision*, the United Nations [UNDESA]

<sup>6</sup> "*Too good to be true? An assessment of health system progress in Afghanistan (2002-2010)*," University of Queensland / DANIDA: Markus Michael, July 2011

further declared zero tolerance of corrupt officials and vowed to tackle the problems of irresponsible and unaccountable behavior in Government.

In Spring 2015, following this lead from the President, the new Minister of Public Health, Dr. Ferozudin Feroz, announced the next step from the MOPH towards the reduction and eventual eradication of corruption in all health facilities and among stakeholders: A risk assessment and development an anti-corruption strategy and work plan for his Ministry. The Ministry issued a formal statement, “*Addressing Corruption in the Health Sector*”<sup>7</sup> to raise awareness among Ministry staff and development partners about his intention to confront corruption in the health sector. This was followed quickly by a “*Statement on Good Governance of the Health Sector*,”<sup>8</sup> and in June 2015, by an “*Accountability Briefing Note*,”<sup>9</sup> both of which reinforced the Minister’s intentions to promote an effective, efficient, and responsible health sector that will benefit all the people of Afghanistan.

During 2015, the Independent Joint Anti-Corruption Monitoring and Evaluation Committee announced it would initiate a Vulnerability to Corruption Assessment focused on the Ministry of Public Health. This comprehensive assessment of the MOPH would complement MEC’s first health sector assessment, produced in October 2014 and entitled, “*Pharmaceutical Importation Process*”<sup>10</sup>. For the assessment, MEC determined that subject matter experts from the field of public health would be required. An assessment team was recruited, comprised of four Afghans with professional public health backgrounds, and one international public health consultant with experience in both anti-corruption activity and the Afghan health sector.

## THE MINISTRY OF PUBLIC HEALTH and the HEALTH SECTOR

In its drive to improve the health status of Afghans, the Ministry of Public Health must manage an array of difficulties that span from inadequate funding from the National Budget, the longstanding and persistent prevalence of preventable and infectious diseases, low levels of health and nutrition information in the population, widespread poverty and illiteracy, deficient or wholly absent health infrastructure, inadequate human resources for health services delivery, and a limited government reach regarding security which impedes access to existing health service sites. Many of these difficulties contribute to the risks of corruption in the health sector.

Fortunately, the development of health and Public Health have been explicit priorities of successive Governments in Afghanistan, particularly since the fall of the Taliban. These can also be characterized as development of “the health sector” and “the Ministry of Public Health,” and some distinction is called for.

- The *Ministry of Public Health* is the official and formal institution of the State, with the authority and responsibility to protect and provide for the health of the community. The Ministry supports and is supported by the many interconnected elements of the Government, and reflects the dynamic and complicated relationship of the community to those who hold and exercise power from positions of local, regional, and national authority.
- The *health sector*, on the other hand, is a broad collection of people and organizations with an interest (or a stake) in health. The health sector includes the Ministry of Public Health, naturally, but in the broadest definition, the sector also contains elements whose activities are driven explicitly by personal interest, profit-making, commercial advantage, entrepreneurial approaches to illness and health, as well as health-focused charities, international institutions, and non-governmental organizations.

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<sup>7</sup> MOPH: Statement on Corruption, April 2015

<sup>8</sup> MOPH: Statement on Good Governance in the Health Sector, April 2015

<sup>9</sup> MOPH, Office of the Minister: Briefing Note Number 1, June 2015

<sup>10</sup> MEC VCA: Pharmaceutical Importation Process, October 2014

The distinction is important. The Ministry of Public Health supports the vision of the Government of Afghanistan in pursuing a stable, prosperous, secure, and healthy future for all Afghans. Actors within the broader health sector may or may not have these objectives, and cannot be assumed to act in any specific manner toward meeting these objectives. The Ministry of Public Health is responsible to oversee, inspect, monitor, evaluate, accredit, validate, authorize, and approve of what is happening within the health sector. The Ministry plans, acts, and coordinates accordingly. Ideally, the Ministry takes decisions based on evidence and in the interest of the public’s health. Stakeholders in the health sector are subject to these functions of the Ministry of Public Health, and therefore, the Ministry will be held to a higher standard of transparency, accountability, and governance in order to maintain the trust and confidence of the populace. Without this trust and confidence, the Ministry’s authority will naturally be compromised.

Corruption, or *the perception of corruption*, is a risk to the authority of the Ministry and its mission to provide a coherent system of health services and supports for the community. This is the clear justification (and explanation) for undertaking the Vulnerability to Corruption Assessment of the Ministry of Public Health, and also frames the context of the Ministry calling for an assessment of the risks of corruption within the health sector. In a country with pressing and persistent health problems, a strong, functional, respected, and *trusted* Ministry of Public Health at the helm of the health system is essential for achieving the stable, prosperous, secure, and healthy future for all its citizens.

**“BUILDING BLOCKS” of HEALTH SYSTEMS**

In 2007 the World Health Organization published, *“Everybody’s Business – Strengthening Health Systems to Improve Health Outcomes”<sup>11</sup>*, and included six “building blocks” of health systems. The World Health Organization subsequently published *“Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies”<sup>12</sup>*, in October 2010.

In preparing for the VCA-MOPH, these health system elements were refined by the VCA-MOPH Team; an additional component of Quality Assurance / Quality Control was added to reflect the particular interests and concerns of many Afghans about the state of the health sector in Afghanistan:

<b>Original from WHO</b>	<b>Refined by VCA-MOPH Team</b>
Service delivery	<i>Health Services Delivery</i>
Health workforce	<i>Human Resources for Health</i>
Information	<i>Health Management Information System</i>
Medical products, vaccines & technologies	<i>Pharmaceuticals and Medical Supplies</i>
Financing	<i>Health Finance System</i>
Leadership & governance (stewardship)	<i>Leadership and Governance</i>
--	<i>Quality Assurance / Quality Control</i>

In each case, the refinement by the assessment team could be considered partly semantic and partly practical. As an example, “Information” became “Health Management Information System” to align this element with the contemporary thinking and approach to how information is gathered and used. The gathering and use of information are management functions and help to emphasize the evidence-

<sup>11</sup> WHO: “Everybody’s Business,” 2007  
<sup>12</sup> WHO: “Monitoring the Building Blocks of Health Systems,” October 2010

based approach to decision-making that the Ministry of Public Health upholds as the responsible authority overseeing the health sector. Each of these original WHO “building blocks,” plus Quality Assurance / Quality Control, were considered as core elements for the development of the assessment Interview Guides.

**This report is split into key sections comprised of methodology to assess vulnerability to corruption, groups and topics of particular interest in assessing these risks, the findings, and lessons learned with recommendations.**

## Methodology

An assessment of vulnerability to corruption was proposed as a process of identifying risks and perceptions of stakeholders in the health sector. To achieve a comprehensive picture of the vulnerability of the Ministry of Public Health, the assessment was approached in systematic way, engaging a range of types of individuals with first hand exposures, in a process of eliciting descriptions of their experiences. The identification of areas of vulnerability to corruption was an exploratory process of discussions with health sector professionals, research into past efforts at defining risks of corruption in the Afghan health sector, and careful analysis of the previous statements and papers issued by the MOPH. The vulnerability to corruption assessment was conducted through four types of information gathering: key informant / in-depth interviews, focus group discussions, direct observations, and document reviews.

**Key Informant / In-Depth Interviews** ... Interviews were conducted face-to-face, on a 1:1 basis by trained interviewers utilizing a semi-structured Interview Guide developed for each targeted group of interest. The interviews were approached as opportunities to explore and discuss a range of topics rather than strictly formatted questionnaire-style data collection encounters. This *semi-structured* approach, with many open-ended areas of exploration, was determined to be the most likely to result in experiences being relayed to the interviewers, allowing for the interviewer to actively pursue details in topics where respondents could relay their understanding of the risks and vulnerabilities to corruption across a range of health care situations and settings.

Notes from key informant / in-depth interviews were prepared by the interviewers using the Interview Guide as a template for recording responses.

**Focus Group Discussions** ... Discussions were held among ‘natural groups,’ meaning, among participants already familiar to each other, from the settings where they had some form of pre-existing affinity. This approach, rather than assembling groups of strangers into a discussion, lent itself to greater opportunities to check consensus and in-group agreement about risks and vulnerabilities to corruption in the health sector. Focus group discussions were guided by the same set of topics as key informant / in-depth interviews.

Notes from focus group discussions were prepared by the facilitators using the Interview Guide as a template for recording the comments from the participants, noting any areas where disagreement had been observed.

**Direct Observations** ... Observations were undertaken informally in a wide variety of settings and situations. The assessment team made observations a routine element of engaging with participants for key informant / in-depth interviews and focus group discussions.

Notes from direct observations were prepared by assessment team members in a simple narrative, descriptive format. These often included quotes from those in the vicinity of the observation.

**Document Reviews** ... Documents were reviewed and analyzed by members of the assessment team as a means of gaining clarity on the assertions from interview participants about policies and procedures, as well as to verify descriptions of situations or circumstances that had been revealed in interviews, focus group discussions, or direct observations.

**GROUPS OF PARTICULAR INTEREST** The groups focused on for key informant / in-depth interviews and focus group discussions in the assessment were determined prior to initiation of the data gathering and after discussions among assessment team members, MEC colleagues, and initial meetings at the Ministry of Public Health.

### **MOPH Directors, Managers, and Leadership**

Persons with authority and power in the Ministry of Public Health – and who can leverage influence across the health sector – will have particular insights into the vulnerabilities and risks of corruption in their own sphere of influence. This category is composed of current Directors, Managers, and anyone else in a leadership role inside the Ministry of Public Health.

### **MOPH Non-Management Employees and Frontline Staff**

Persons without power or authority in the Ministry of Public Health – and who are subject to the influence and authority of others inside the Ministry – will (potentially) have unique insights into the vulnerabilities and risks of corruption among the Managers, Directors, and leaders *above them* in the hierarchy of the Ministry. This category is composed of current non-management employees and frontline staff inside the Ministry of Public Health.

### **Other Stakeholders, Including Health Sector Implementers, Civil Society, Community Leaders, and Politicians**

Persons from various other organizations and agencies, both inside and outside the health sector, who have had some type of engagement with health sector activities or the Ministry of Public Health, will (potentially) have insights into the vulnerabilities and risks of corruption in the Ministry of Public Health. This category is composed of persons with experience in working relationships in the health sector, including managers or employees in health services implementing NGOs and INGOs, private sector clinics and hospitals, civil society agencies and organizations, community leaders<sup>13</sup>, politicians, and non-Afghans who had professional engagement in (or with) the Afghan health sector.

### **Patients and their Families**

Persons with first-hand experience in the health sector as service utilizers and consumers, or their family members, will (potentially) have been through situations where corruption may have been experienced or observed. This category is composed of persons willing to describe personal experience in the health sector, rather than professional experience.

### **Former-MOPH Directors, Managers, Leaders, and Frontline Staff**

Persons who *previously* held positions of authority or power in the Ministry of Public Health, or had worked as non-management employees or frontline staff of the Ministry will have particular insights into the vulnerabilities and risks of corruption in the Ministry of Public Health. This category is composed of former-MOPH Directors, Managers, leaders, employees and frontline staff from inside the Ministry of Public Health.

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<sup>13</sup> ‘Community leaders’ are individuals with authority in, or on behalf of, a community and reflects their influence, whether through formal selection, community consensus, or perceived social status in a tribe, clan or ethnic group.

**TOPICS OF PARTICULAR INTEREST** The topics focused on in the assessment were determined based on the initial *Statement on Corruption in the Health Sector* from the MOPH, which outlined specific areas of concern, and after discussions among assessment team members, MEC colleagues, and initial meetings at the Ministry of Public Health. Not all topics were covered with each interview or focus group participant due to limited information, limited personal experience, or in some cases, refusal to respond or time constraints.

The topics listed below were explored within the assessment team as the Interview Guides were developed and then further refined following additional discussions with colleagues from across the health sector. In all cases, the topics were intended to be a “starting point” for discussion of the issue, rather than a confirmation or denial of this being a point of vulnerability regarding corruption:

### **A. Policies**

This element of the Interview Guides explored the role of MOPH policies in combatting, or failing to effectively combat, vulnerabilities to corruption. Questions in this section were aimed broadly at the role of policies, as well as focused more specifically to determine areas of weaknesses and risks in the implementation of particular policies within MOPH.

### **B. Contracts**

This element of the Interview Guides explored processes and relationships to understand how formal agreements have been managed between MOPH and health sector implementers, and MOPH and its donors and funders.

### **C. Embezzlement / Theft of Public Goods or Funds for Private Use**

This element of the Interview Guides sought to determine the extent of public funds or public goods in the health sector being diverted for personal gain and enrichment. Diversion of resources was also considered an aspect of this topic.

### **D. Nepotism / Abuse of Power in Hiring, Promotion, and More Generally**

This element of the Interview Guides explored recruitment, hiring practices in MOPH, as well as promotions and human resources practices where power and influence could be a factor in shaping processes or outcomes. Notably, the topic of power being wielded within human resource processes often led to unsolicited comments, remarks, and stories from respondents about dynamics in the health sector where power or the perception of influence had resulted in an outcome.

### **E. Quality Assurance / Quality Control**

This element of the Interview Guides sought to determine the role of quality checks and systems of accountability in controlling quality within MOPH and the health sector. This topic was closely linked to issues raised under the heading of Fraud / Falsification / Fakes / Forgery.

### **F. Human Rights and Discrimination**

This element of the Interview Guides explored concerns around differential treatment, discrimination, and human rights within the MOPH and the health sector.

### **G. Extortion**

This element of the Interview Guides was focused on experience of pressure, threats, and coercion and was not limited to issues related to cash or monetary transactions.

## H. Fraud / Falsification / Fakes / Forgery

This element of the Interview Guides explored the extent of experience with fraudulent acts and falsified, faked, or forged documents or data. Quality checks and systems of accountability were frequently raised by respondents during discussion in this section of topics.

## I. Conflicts of Interest

This element of the Interview Guides sought information about situations where conflicts of interest have been observed and the consequences when these situations are addressed or not addressed.

## J. Bribery

This element of the Interview Guides explored the extent of bribery as a feature of how problems are solved, delays are reduced, or obstacles are overcome.

## K. “Other Risks” of Corruption

This element of the Interview Guides was an open-ended request for any other types of risks of corruption that respondents wanted to describe from their experience in the health sector.

**DETERMINATION OF PROVINCES FOR DATA COLLECTION** The assessment was not planned as a nationwide activity due to time and financial resource constraints. Instead, a selection of provinces was determined based on several factors assessed as potentially influencing the experience of corruption. The selection factors were based on assumptions that the experience with corruption “*could be* different” in different types of settings. These assumptions included:

### 1) The Capital *versus* outside the Capital

Assumption: The experience with corruption in the health sector could be different in settings within Kabul, compared to those outside Kabul, due to the perceived relative imbalance of available human resources for health services, financial resources, political pressures, presence of donors and funding agencies, and degree of urbanization.

### 2) Provinces with at least one large city *versus* those without any large city

Assumption: The experience with corruption in the health sector could be different in settings of relatively lower socioeconomic development, compared to those with higher levels, due to differences in access to resources of all types and degree of urbanization.

### 3) Provinces with at least one insecure District *versus* those without insecure Districts

Assumption: The experience with corruption in the health sector could be different in settings with lower levels of personal safety and security, compared to those with higher relative levels of safety and security, due to constraints on accessing health care sites, practical decisions about risk management, and the existence of barriers which could not be overcome due to armed conflict.

### 4) Provinces with MOPH implementation of services *versus* NGO and INGO implementation

Assumption: The experience with corruption in the health sector could be different in settings implemented directly through MOPH management, compared to those with implementation through NGOs and INGOs, due to variation in technical skills, salary structures, missions and objectives, and exposures to external management structures and systems.

## 5) Provinces from each of the main geographic regions of the country.

Assumption: The experience with corruption in the health sector could be better understood by assuring that all main geographic regions were represented in the information gathering process.

A final determination of targeted provinces was made after discussions among assessment team members, MEC colleagues, and included considerations of relative security, and time and financial resources to be able to collect data. The selected provinces were Badakhshan, Baghlan, Balkh, Bamyan, Herat, Jowzjan, Kabul, Kandahar, Kapisa, Khost, Nangarhar, Paktika, and Samangan:

	Badakhshan	Baghlan	Balkh	Bamyan	Herat	Jowzjan	Kabul	Kandahar	Kapisa	Khost	Nangarhar	Paktika	Samangan
The Capital							X						
Provinces with at least one very large city			X		X		X	X			X		
Provinces without any very large cities	X	X		X		X			X	X		X	X
Provinces with some insecure Districts	X	X	X	X	X	X	X	X	X	X	X	X	X
Provinces with MOPH direct services implementation							X		X				
Provinces with NGO/INGO services implementation	X	X	X	X	X	X	X	X	X	X	X	X	X
Region: North			X			X							X
Region: South								X				X	
Region: West					X								
Region: East										X	X		
Region: Northeast	X	X											
Region: Center				X			X		X				

# 1. FINDINGS: MOPH DIRECTORS, MANAGERS, AND LEADERSHIP \*

**OVERVIEW:** MOPH Directors, Managers, and leaders from all parts of the country and in each type of provincial setting described difficulties with corruption, often in great detail. These leaders acknowledged a wide range of problems, missteps, and missed opportunities in managing corruption in the health sector, as well as frustration, disappointment, and of being *'let-down by colleagues who should know better.'* Among the 62 respondents in this category, each one acknowledged vulnerabilities or risks of corruption in one or more of the topics covered in their interview.

Many respondents gave candid answers and articulated specific vulnerabilities and risks to corruption across each of these topics of particular interest. Extensive probing for examples was not required: Respondents understood the objective of the assessment and freely offered first-hand accounts to illustrate their answers. Several of the most senior leaders described having a strong emotional reaction to this information being gathered about corruption in their professional field and of its consequences on the public's trust of the health sector.

During six of the interviews in this category, our Team noted that an initial response, which had been freely given while a respondent's colleagues were present in the room, was subsequently retracted or countered – often within moments – to correct the respondent's intentional misstatement once the colleague or colleagues left the area. These included: Effectiveness of MOPH policies in managing human resources, denial of embezzlement, denial of nepotism, denial of falsification, denial of fraud, and denial of extortion.

On a positive note regarding this category of respondents: More than half cited examples of at least one element of the Ministry of Public that is not vulnerable to corruption, or that they felt had robust and reliable counter-measures in place to prevent or reduce corruption for that particular issue. These included: The utilization of inventory lists as a means of tracking and controlling assets, the role of the Health Management Information System in providing uniformity and comparability of health service data across a wide range of types of settings and regions, consequences for misbehavior were widely known, and the now commonplace practice of announcing vacancies in recruitment processes to allow interested potential candidates to pursue employment in MOPH. While each of these counter-measures was subject to some negative comments and skepticism, they were frequently mentioned in a positive context across all parts of the country.

## **The most detailed comments about risks of corruption related to:**

**1. Leadership and Governance:** Conflicts of interest, influence from powerful persons, and complex policy challenges related to coordination and control systems.

**2. Finance:** Lack of transparency, contracting issues.

**3. Human Resources:** Lack of transparency in recruitment and termination processes, and influence from powerful persons.

**4. Health Management Information Systems:** The integrity and reliability of data, and use of HMIS for quality assurance and quality control.

Notably, these comments were largely focused on conflicts of interest.

\* Details that could identify individual respondents have been omitted.

## Policies

**“How are MOPH policies reducing or increasing the risks of corruption?”**

**“Is this vulnerability related to implementation, resources, or something else?”**

- > Respondents described missed opportunities where policy could have reduced the risk of corruption, but the vulnerability to corruption persists because policies are not known, misunderstood, ignored, inappropriate, or someone in a leadership role or with authority has sidestepped the policy intentionally.
- > External factors and cultural priorities that increase vulnerability to corruption were also cited as explanations of why policies have not been followed or have been ineffective.
- > Vulnerabilities were cited in the development process of policies, weak information sharing about new or modified policies, lack of high-level coordination, inadequate resources, and, gaps in the monitoring of implementation of policies or policy changes.
- > Respondents (in Kabul and several provinces) expressed frustration about policies from other countries that were translated into local languages and adopted by MOPH under pressure from international donors – despite these being irrelevant or unrealistic in the Afghan context.

Some selected quotes from interviews:

- *“Policies are not correct. Or, when they are correct, the implementation is not correct.”*
- *“The policy on Financial Autonomy of Hospitals...has not solved the problems of when funds are not being disbursed on time. Corruption follows.”*
- *“The Autonomy policy gives us the chance to do our own purchasing, but the money is not here in our hand anyway. We saw that Dr.<XXX>, the Head of <XXX>, chose to fraction the budget into four different parts, even though the money was provided to our hospital, by name, from <XXX>.”*
- *“MOPH priorities are not followed in our hospital – in fact – the priorities have not existed at all.”*
- *“Procurement policies are problematic. We have procedures that result in the wrong resources being procured. This leads directly to corruption of our strategy.”*
- *“The weaknesses of current policies are that these are just translations from foreign countries and not matching the situations on the country; most parts the policies are not clearly described and capacity for implementing policies is not well developed ... The important consideration is the selection of a specialist team for preparing a policy. Policies have defects due to lack of specialist teams when these were prepared and designed for MOPH by foreigners.”*
- *“Policies are the best foundation for controlling corruption... The chances of corruption will be lowered if policies are implemented in a stepwise way. But this is not our habit.”*
- *“Some of our policies are made based on policies transmitted from other places and they are forced on us. However they cannot be implemented here. For example, USAID brings policy from America and is pressured onto us by force. No one thinks whether it is implementable or not. When it fails, the donors tell us we are weak or ineffective.”*
- *“...Security problems, under developed skills, tribal and sectorial relations, nepotism, and special group preferences as well as political pressures on the MOPH; all cause weakness in implementing our existing policies.”*

**“How can a standardized HMIS policy promote evidence-based decisions and reduce financial corruption in annual budgets?”**

- > HMIS was described as a valuable tool, though also as under-utilized and poorly integrated.

- > There was greater enthusiasm for the potential benefit of a strong and reliable *future* HMIS by respondents based outside of Kabul, compared with those based inside Kabul mentioning the lack of development of the *current* system and its operational weaknesses to date.
- > The proportion of care accessed in the private sector, compounded by its lack of alignment with the HMIS policies and procedures of MOPH were cited as a risk and concern.

Some selected quotes from interviews:

- *“Medicines and medical consumables purchasing at the hospital level is based on HMIS reports and bidding evaluations – but I’m disappointed in the procurement at the end of the process.”*
- *“HMIS has the essential role for reducing corruption: Weaknesses are prevented and strengths are promoted – if the data is truly and realistically collected. Real-time data in HMIS can promote quick decisions.”*
- *“Yes, HMIS has indirect role in reducing risks of corruption. But HMIS is implemented with very basic indicators... Budget estimation and Treatment Guidelines revisions according to HMIS are not implemented here in our facility. So this is still a gap.”*
- *“Medicines are not provided at the level to match the needs of our Wards; bed linens, and so on, are not matching our HMIS reports.”*
- *“...HMIS is not having any role on the annual budget allocation.”*
- *“Yes, it would help, but the MOPH does not count our reporting to the center as they are not interested in correspondence with us. Most of our record keeping is good for our own domestic use that we can track disease from one area to another area. [If they did communicate from the center to us] it would help very much during an epidemic or outbreak. Furthermore, we use HMIS records for distribution of the resources of the hospital such as food, medicines and etc.”*  
 >> Response from a province without any large cities.

**“Do you believe health services are delivered according to MOPH policies and strategies?”**

- > Leaders in particular specialist areas were frustrated by the services under their control and management not being delivered according to MOPH policy and strategy – but in interviews this problem was linked to *limited resources* and *inefficiency* as often as *skewed priorities* or *corruption*.
- > Monitoring of implementation of policies on health services delivery seems to have been detached from evaluation of the implementation – Respondents, especially at MOPH HQ, indicated they would benefit from better and more consistent use of evaluations on policy implementation, rather than simply counting the number of health service sites where a policy was initiated.
- > Complaints about the difficulties of the Procurement Policies of MOPH were raised many times.

Some selected quotes from interviews:

- *“Treatment Guidelines are developed by our Ward staff; these might be according to MOPH policy, or they might not.”*
- *“Medicines are not in accordance to standard requirements: Patients purchase medicines and medical/surgical consumables from outside. Even for emergency medicines such as Adrenalin and consumables like endotracheal tube the family has to provide from the market.”*
- *“Nowadays policies on health services delivery are being promoted. However they need regular monitoring and evaluation to see how much they are practically implemented. It is not simply, ‘Yes or No, was the policy implemented?’”*
- *“Yes. Health services are delivered according to MOPH policies but delays in receiving supplies, which is directly related to Procurement Policy, creates problems for healthcare providers. We are under immense pressure of community in the health service delivery. We are obliged to prescribe*

*medicines from bazaar since we have no stock on hand. In response, they are telling us, 'If you are prescribing from bazaar, then why we should not go direct to private sector?' And this situation is very hard to explain to our colleagues at MOPH HQ. They say, 'You must follow Procurement Policy,' so we have this two-direction problem to manage."*

- *"In the Procurement Law it is written, 'Buy your requirements for the lowest price,' so we have to buy the worst materials which have low quality from these low prices... this influences the quality of the health services we provide. However, in 1395 we are going to have good quality drugs in our drugstore, because we contract with high standard companies by the system of Autonomy of Hospitals. But in 1396, the procurement processes are transmitted again to the MOPH and hospitals will have no control on procurement procedures when the system is given again to MOPH."*

**"Do you believe Human Resources are managed according to MOPH policy and strategy?"**

- > Human Resources policy and practices are under constant pressure, especially from Members of Parliament, who come with specific demands (these are rarely presented as requests.)
- > The most senior level Directors and leaders in Kabul were adamant that while there are very real problems and pressures in the area of human resources – and they acknowledge serious risks if they resist – the message coming from Dr. Feroz has been clear: MOPH Directors, Managers and leaders must not yield to the influence and threats from powerful people.

Some selected quotes from interviews:

- *"No. There is a serious problem, very serious. Trust is low because there are vacancies that were filled by unqualified non-technical people for political reasons. This goes directly against our strategy of building a high quality system that will be reliable. How can it be reliable now?"*
- *"This is our greatest difficulty. Politics power is the decision-maker, they have the influence."*
- *"In most parts it has been managed according to policy – but political pressures exist."*
- *"No appointments are happening by order of the Minister... Yes, there is pressure on MOPH from Parliament Members, but we had a meeting regarding this issue with the Minister and had an agreement. Then the Minister made a decision and distributed a formal letter to all Directorates and emphasized that we should not act illegally. In the Minister's letter he wrote 'Whenever due to any pressure I sign a letter for any of the Parliament Members and if you have noticed that it is not legal, therefore you have to reject my order. Instead you all have to act based on the rules and law and write on their letters that 'this cannot be accepted due to these laws and rules,' and if you do not reject any illegal order, then you will be responsible.'"*
- *"The policy of formally posting and announcing vacancies is one step toward reducing favoritism and nepotism."*
- *"The Human Resource Manager posts vacancies for the two-week period, as required by procedure. Before, this was not open system of recruitment for anyone to make application."*

**"What do you believe are the risks of corruption in Human Resources policies?"**

- > These respondents were uniformly aware of risks that result from corrupted policies in human resources, including weakened trust from the public, emboldened actions by powerful people, dangerous outcomes for patients, loss of confidence among donors, and a collapse in morale among health sector workers at all levels from being forced to endure working conditions among unsuitable colleagues.

Some selected quotes from interviews:

- *"Nepotism is a catastrophe. This kind of forced recruitment by powerful people is illegal."*

- *“Under-skilled and nonprofessional employment, political pressures for some posts, lack of patriotism, lack of enthusiasm to deliver health services, and lack of knowledge on deep meaning of health service delivery. These all make the final outcome as failure.”*
- *“A few days before, there was the exam of specialized posts. On the day of the exam and during the exam, the authorities of the Government and the Parliament Members were calling me, ‘Give the chance for my candidate,’ but we passed this exam transparently and did not allow corruption. I tell you this to explain: The corruption is in high levels, not in low levels. And the high level employees of the Government encourage corruption in low levels; therefore, the low level finds the courage and justification for corruption.”*

**“What are the risks of corruption in MOPH Financial Resource policies?”**

- > Only a small proportion of these respondents had direct management control over financial resources within MOPH HQ as part of their current role.
- > Most of the Directors, Managers, and leaders outside of Kabul who participated in these interviews were frustrated by elements of the system that they could not control or influence: The vastness of the MOPH bureaucracy, apparent lethargy within the Ministry of Finance in addressing how resources move within elements of the Government, the overall lack of funds, and lack of autonomy in setting, following, or adjusting budgets.

Some selected quotes from interviews:

- *“Lack of well-defined budget lines, lack of transparent audit, and inconsistent monitoring, each make the Ministry vulnerable to corruption.”*
- *“In most cases the official budget is not matched with the requirement; in some departments managers do not clearly understand their own budget.”*
- *“The slowness and lack of efficient process makes for corruption happening.”*
- *“There is not sufficient budget for MOPH salary levels to compete with NGOs and INGOs.”*

**“How well-matched is the MOPH official budget with the requirement and needs announced by each Department?”**

- > These were uniformly negative responses in all interviews.

Some selected quotes from interviews:

- *“There is no connection. No one has ever asked me about my Department requirements. I have been here for six years and we cannot manage any of these years with this amount. Look at our office. It’s the same with all the offices down this hall: None of these Departments have any priority or authority to say what is required or needed.”*
- *“It’s not matching with requirement or needs of health facilities, for instance, we are constantly told of the struggle of low budget being allocated for bed patient food on inpatient wards.”*

## Contracts

**“Have MOPH priorities been ignored because of corruption?”**

- > There were several comments about the lack of connection between stated priorities of the MOPH and the effects of endemic corruption on achieving these priorities.
- > Most comments were regarding specific areas of management control and influence of the respondents, rather than the overall mission or priorities of the Ministry.

Some selected quotes from interviews:

- *“Yes. In some issues, like radiology films, these were postponed for three years due to contract delays. This affects the services negatively. Our priorities are corrupted by contract delays.”*
- *“Staff doesn’t know about the priorities. All contracts on hospital level are arranged based on relations with senior decision makers: Food is provided on grade-3 level and medicines are the same, while in the policies these goods must be procured at grade-1, the best quality. This is not a mistake; it is corruption for financial benefit.”*
- *“When making contract for new equipment, because of financial limitations, the Administration has not taken the responsibility to arrange for training of the employees after the installation of new machines. This shows the weakness. During the procurement of these new materials, there was not a technical person. If there was technician in Procurement Team, they would know what to buy, the proper cost of installation and training, and priority for maintenance. Because no technical person on Procurement Team, these priorities were left out and the new machines are useless to us now.”*
- *“It is just my opinion, but it seems we have been let-down by colleagues who should have known better. When individuals have the choice to keep the priority of quality service development at the front of their agenda, but instead, allow their own personal gain to become a priority, I feel very disappointed. These people do not belong in our Public Health system. The rest of us here are left to constantly explain why these choices are made, choices that these people know very well are not defensible. We need to bring back the right thinking about what the Public Services are about instead of defending corrupt behaviors... I want a brighter future for our country. Our children deserve it. When someone is only thinking of themselves and their own pocket, then I hope they will leave this place and let us to reach our success.”*

**“What are the risks of corruption in the financial part of the contracting processes for health care services to NGOs and INGOs?”**

- > Respondents from all parts of the country cited lack of transparency in contracting as a risk.
- > Many respondents were especially critical of the weak assessment and evaluation of NGOs and INGOs which were allowed to bid for service contracts.
- > Respondents from all parts of the country expressed frustration that the results were predictable when weak organizations were awarded BPHS and EPHS contracts: unfulfilled service delivery, community complaints, and problems which ‘could have been avoided.’
- > Comments related to the Grants and Contracts Management Unit were uniformly negative.

Some selected quotes from interviews:

- *“All conditions and requirements are considered while contracting, but after it is awarded the implementation is not progressed by the NGO as agreed. For example, in remote provinces, most health centers do not have MOPH-certified and skilled staff. Essential capacities are not considered when the contract is awarded; it can be said, ‘The service is delivered,’ but the quality is questionable. Our strategy is corrupted by this error of contracting to incapable NGOs.”*
- *“We received a truck full of the medicines from <XXX> for emergency situations. I didn’t have information about the price and specification of the medicines because the contract was not released to me for checking – that information went to the Director of the <XXX> and I could not verify the sources, or the quality, or what was supposed to be on the truck.”*
- *“There are some deals they make for who will win the contract: <XXX> makes sure of that, it is their interest to manage the NGOs and foreign NGOs on this issue of contracts.”*
- *“What are we supposed to do if GCMU will not consider the weakness of these NGOs? How they win contract after contract and they cannot do their work even in one District?”*

- *“Most the contracts are drafted and signed in the center [MOPH HQ] and they are exclusively administered by the GCMU. They have their own parallel system of monitoring and evaluation that pretty much have their own data collection. That is not clear to the Provincial Health Office and we have no idea about the content or price of the contract and it makes it very difficult for us to set our expectation from the NGO implementing here.”*

>> Response from a province without any large cities.

**“What are the risks of corruption in the MOPH contracting process of Human Resources?”**

- > Many respondents described frustration at the selection processes in human resources which have been corrupted by external influences including powerful persons inside Government, among donors, and from the senior ranks of MOPH Directors, Managers, and leaders.
- > Outside of Kabul, in all other provincial settings, the human resource process is subject to coercion, threats, intimidation, pressure, and all manner of persistence from local power brokers and those wielding influence in the community.
- > Inappropriate interventions on the status of existing MOPH employees was also described several times in regards to performance appraisal, upgrades, funded training opportunities, transfers, and promotions.

Some selected quotes from interviews:

- *“Posts are announced for vacancy while the person is already hired. In the essential service of Intensive Care at <XXX> Hospital, newly designed and modified by MOPH, most posts are already given to those who do not have specialty certificates; meanwhile, actual certified specialists are in applying process but will never get these positions. This is corruption.”*
- *“...Lack of monitoring by MOPH HQ on this means our local situation is corrupt.”*
- *“The MOPH only has contracts for Technical Advisors in which there are some openly discussed problems.” [He avoided explaining these problems] “In some Directorates, when there is no need for Advisers – there are several, but the Directorate of <XXX> seriously needs a Technical Adviser, and there is not a single one.”*
- *“The performance appraisal is not implemented as it should be. This year when during the period of my Directorate, I have seen that none of the employees has scored less than 20. All had scores more than 20. It shows that there is falsification in the reporting and scoring of performance appraisal. In the procedure of the performance appraisal the direct manager of an employee scores him/her, there is no role of the representative of the Civil Servant Commission. Therefore this process needs to be monitored. All Directorates need monitoring... During my working period in MOPH, I have not seen that any of the employees introduced to the capacity building programs due to his/her weak performances, because all employees get good scores and no one seems to be weak! This cannot be accurate in any possible way...”*
- *There is big problem regarding trainings and scholarships. The good scholarships and outside trainings are divided in the Directorate of <XXX> for their own relatives. The ‘worse’ scholarships are then sent to <XXX> to introduce some employees ... Another problem is that the letter for the scholarships is received late, sometimes just two days before its deadline. So in these two days it is impossible to propose and introduce a person from the provinces, because in two days he/she cannot receive that scholarship. The provinces have such a small chance to benefit...”*

**“Do you believe MOPH leaders are aware of these problems?”**

- > This was acknowledged by all but one of the respondents in this category.

Some selected quotes from interviews:

- *“According to the reports, yes.”*
- *“Information about the deficiencies and problems are collected – and reporting to the leadership of MOPH is required. Each department has to make reports to MOPH, but there is the risk about the transparency and accountability of the reports being clear and realistic.”*
- *Yes, definitely they are aware on each of these problems.*

## Embezzlement

### **“What are the Leadership failures related to embezzlement and theft in MOPH?”**

- > The complaints of respondents about leadership failures were mainly related to procurement and lack of coordinated implementation of oversight processes to prevent embezzlement.
- > Some respondents suspected collusion was occurring, citing complaints that had been ignored or dismissed by superiors.
- > External factors, including implementing agencies with weak procedures and persistent insecurity in some part of the country, were also mentioned as risks.

Some selected quotes from interviews:

- *“Equipment and goods are not purchased according to the essential need and requirements.”*
- *“Equipment is purchased for a Center where no one has the skill on how to use it. The consequence is damage to the equipment and finally out-listing it from the circulation as junk while a lot of money is spent on it and wasted.”*
- *“At the implementer level, with unknown reasons, they are allowing illegal handling of supplies to lead to theft...this is a vulnerability to corruption.”*
- *“Lack of security – and because of that, the monitoring and evaluation is not done well and not realistic. Some of MOPH worker use from this situation for their personal benefits or write 20 prescriptions without any of the patients existing and obtain the drugs from hospital drug store. The medicines are sold by them in the bazaar.”*

### **“Where has there been Leadership success in stopping embezzlement and theft in MOPH?”**

- > Most respondents could not specify an instance of success in stopping embezzlement or theft.
- > Several respondents were able to describe particular monitoring processes they had seen or were familiar with as playing a role in reducing risks.

Some selected quotes from interviews:

- *“Close monitoring and evaluation of the provincial activities by the central MOPH: This has been a good step to improve our system here in <XXX>. However, I have been hearing complaints from the shops and clinics in the bazaar that <XXX> are involved in the corruption during monitoring. They are taking money from the private sector when they come from Kabul and make demands.”*
- *“We have standard checklists for inventory to prevent theft of supplies.”*
- *“When a Midwife was caught asking for money after delivery in the Provincial Hospital, she was warned and when it happened again and was terminated, this became example for others.”*

### **“Do you believe that there are MOPH staff involved in embezzlement of public goods?”**

- > Embezzlement and theft were widely acknowledged.
- > Embezzlement was described as occurring at every level of the MOPH as well as among staff and Managers at contracted NGO and INGO health sector services implementing agencies.

> Several respondents stated that theft was not possible and/or not happening in their Department or work area on account of systems that effectively prevent it.

Some selected quotes from interviews:

- *“Absolutely theft is happening. Even they stole our surgical instruments from Emergency Room. Medicines are stolen and this is why patients purchase the medicines from outside market.”*
- *“Yes. It is considered acceptable. Otherwise, how can staff with a salary from public service make so many estates and properties?”*
- *“Doctors are giving medicines to their family members and there is no stopping them.”*
- *“I have observed the use of the MOPH ambulance to take the Director’s children to school; his family is using our public service like private resource and everyone can see it. He is not afraid of any consequences or punishment. Who will punish this here?”*
- *“Everyday small things are taken all the time: Rice, fuel, paint; I have seen it many times. These staff have low salaries and no chance to solve their problems without doing this theft. The Director does it, too, and even he is dividing up the fuel and oil among his friends.”*
- *“At our hospital there is no chance for theft and embezzlement of public goods.”*

**“Is there routine and reliable inventory of MOPH assets to prevent embezzlement?”**

- > Systems were reported as being in place and followed, as well as absent and routinely ignored.
- > Lack of oversight and failure of monitoring processes have resulted in systems that are not reliable.

Some selected quotes from interviews:

- *“No, there is no list of the inventory in the supply rooms.”*
- *“Inventory is filed based on Invoice and equipment specifications to prevent embezzlement of MOPH assets.”*
- *“The nurses receive medical equipment and they are responsible for it since they have signed for it; they can’t take these away. The nurse could only receive new items when they are damaged.”*
- *“All the tools in the surgery room are registered under the name of the surgeon.”*
- *“We only have the bed and its accessory, which is very difficult to steal.”*
- *“In Public Health settings, yes [it is routine and reliable], but about NGOs it is not clear. It should exist systematically... In some circumstances, like donations by organizations, then the lists are not very concise. If the equipment donated with Invoice, then it is entered to the inventory. But if it is used, and without the Invoice, then equipment is not listed in inventory and can lead to theft. It is susceptible to corruption.”*
- *Yes, everyone is responsible for the things registered in his/her name. These inventory lists are audited by panel which is made of three members of Management Team and also by our Administration. There is transparency because the members in this panel are changed and rotated.*

**“In cases when there are charges to patients, where does it happen? Who decides the charges? Where does this money go?”**

- > Despite being forbidden (and illegal), informal and under-the-table charges were reported as commonplace by many respondents.
- > Some respondents also mentioned clinicians or technicians making extortionate demand for payment from families. These usually resulted in warnings and punishments, and occasionally, in termination.

> There was acknowledgement from several MOPH HQ-based respondents that the overall sustainability of the Public Health system is in question if all services are free in all cases.

Some selected quotes from interviews:

- *“A committee is planned to work on a draft of “User Fee” in accordance to recently revised regulations on patient charges. But at the moment, utilizers complain about this issue of ‘under table’ payments.”*
- *“There was a system of charges in <XXX> on some procedures and for patient Registration Card in their Outpatient Department, but it was stopped.”*
- *“Surgical staff are telling patients’ families, ‘Go and bring us kebab. We are trying to save your relative and we need to eat to have a successful operation on him.’ This is demand accepted by the people who are in a bad situation.”*
- *“The surgeons are taking patient payment outside the hospital for their work. It is against rules and regulations, but they demand it. It is going to their pocket, of course, and they complain of low salary to the patient and families. It is shameful. They are working for their own profit, not for the benefit of the people here.”*
- *“Informally, patients are giving a kind of gift to midwives after successful delivery, larger if it is a boy baby, and this not a Clinic charging system. It is the way of midwives to always ask for it.”*
- *“We are not permitting any charges to patients. This is against the Constitution. However, for a sustainable public service we have to solve the issue of how we provide financing to our system so that salaries are at right levels, medicines can be procured and administered, and equipment and infrastructure paid for and managed. If everything is free to patients, how can we sustain our system into the future? Donors will not provide funding for all elements for all the future. I am not sure of the way forward without some kind of User Fee or patient charges.”*
- *“I do not agree with this system where wealthy families demand free services. They have the ability to pay and support the costs so why are we not making tariff structure based on ability to pay? We cannot keep the services free for all in the future if the donor commitment is reduced. NGOs and INGOs will not take up contracts for BPHS and EPHS if there is no donor waiting with money for them to implement the contract. We have to consider our future.”*

**“Do staff receive any types of contribution or compensation in addition to MOPH salary? Does this risk corruption?”**

> Many instances were cited by respondents, including examples in Kabul MOPH HQ, in other Ministries, and in provinces.

Some selected quotes from interviews:

- *“Yes. The project of <XXX> pays the Director of the <XXX> an amount of salary in addition to his own salary from the Ministry of <XXX>.”*
- *“I believe they are earning also on the private sector; it is common.”*
- *“It is not officially forbidden to do this. Many many of our Directors have other sources of income and interests in the health sector, including in the operations of NGOs and INGOs. No one can stop this from happening of the salary on the Tashkeel is low.”*
- *“There is another Director here who has position at <XXX>, too. He is paid by them and he is on MOPH Tashkeel at the same time. <XXX> gets a benefit of having a special point of contact and influence inside our Directorate of <XXX>, and he is only coming here for meetings sometimes because his main work is with <XXX>. This will be a kind of risk for corruption. <XXX> have their own interests in the health sector, of course.”*

### **“Do you believe MOPH Leaders are aware of these problems?”**

> Most respondents in this category affirmed that MOPH leadership is aware of – and attempting to address – the range of problems associated with embezzlement.

Some selected quotes from interviews:

- *“Yes, they are all well aware of everything.”*
- *“Yes, definitely, no doubt.”*
- *“It is certain.”*
- *“Everyone now knows Dr. Feroz is making this issue a priority. Even you are here for this assessment because he is asking for proof of this problem existing in our sector.”*
- *“There is no accountability to ask and evaluate the situation.”*
- *“I cannot say for certain if all our leaders are aware, but I believe His Excellency Dr. Feroz will show them that embezzlement is not acceptable and it must be stopped.”*
- *“Who denies it? Where have they been working in this Ministry if they deny it?”*
- *“I am not sure myself.”*

### **Nepotism / Abuse of Power for Personal Benefit**

#### **“How is nepotism a risk for good governance in MOPH?”**

> Respondents catalogued many examples of risk to good governance from engaging in nepotism.  
> Examples included reduced trust, weakened management systems, and poor quality of services.

Some selected quotes from interviews:

- *“Employing non-professional staff for key posts brings up vulnerability to corruption. Under developed staff causes failure in proper implementation of policies and strategies.”*
- *“Pressures and abuse of power from politicians and/or local leaders happens in some recruitment for key posts. There is no trust when this happens.”*
- *“Our employment is managed directly by the HR Headquarters in MOPH and commissioned by the HR Directorate; our Hospital has no authority in the process.”*
- *“At our Hospital Directorate level nepotism doesn’t exist. At departmental levels it is controlled by the Directorate. We have no problems.”*
- *“This is very crucial because if relatives are working in same Department they will hide things which they are doing illegally in the office, or will not work properly according to MOPH policies.”*
- *“Our service quality is lowest in facilities with the highest degree of nepotism. This is the outcome.”*
- *“We try to keep this bad practice low in our hospital. Most of our employees are <XXX> and it is due to the ethnic dominance of this group and we can’t do anything about it. If we see qualified individuals we would definitely recruitment them regardless of ethnic or geographical factors.”*  
>> Response from a province without any large cities.

#### **“Do you believe MOPH staff gives priority to their relatives / friends / own group when providing health services to patients?”**

> Abuse of power was widely regarded as routine.

> Many respondents in this category acknowledged this type of corruption and some described it is a commonplace problem in all societies.

Some selected quotes from interviews:

- *“Political leaders are frequently calling, ‘Provide services to my relatives as soon as possible.’”*
- *“This is an issue in all cultures around the world and Afghanistan is also a part.”*
- *“It is common in most cultures worldwide but health service is delivered equally to all in our country.”*

**“Which specific parts of MOPH are at risk of abuse of power?”**

- > Respondents in this category were able to list specific areas of risk, sources of the abuse, and cite specific examples from their own experience.
- > Interventions by high level politicians, and Members of Parliament in particular, were cited most frequently by respondents in this category; the focus on the interventions in MOPH were diverse, ranging from hiring, promotion, and training opportunities with MOPH, decisions for health service delivery contracts, criminal cases, accessing expedient care for themselves or constituents, and determinations of where new infrastructure would (or should) be built.
- > Abuse of power to exert influence in the health sector and within MOPH was noted as a serious and ongoing problem in every part of the country.

Some selected quotes from interviews:

- *“Finance, procurement, construction procurement, and in some cases, professional posts.”*
- *“Abuse of power is at the highest levels: Politicians, Parliament Members, and General Directors of MOPH, all of them. We have had cases when these powerful people are patients and they curse and use violence against the workers – one even bit the duty staff – and the Ministry never took any action against him. On the contrary, it happened that the Ministry ordered the staff to apologize to this violent man who continued to threaten more violence! After, one of the Directors in our Ministry sent warnings to the doctors to convene the local leaders and politicians to control the staff from any complaining. The staff are abused by powerful people in this way.”*
- *“The powerful individuals control our province in every way, including health sector. If they want the only functional ambulance, they take it. When the Commander from <XXX> brings his family members to the Hospital for treatment, the Public Health Director himself comes to put pressure on the staff for him. He can make anything he wants by his power.”*
- *“Who can punish <XXX>? His title as Member of Parliament gives his family control of all staff at Provincial Health Department. Our Director will follow his orders each time he gives command. We are very afraid of making any mistake with treatments to his family members. This is natural.”*

**“How does MOPH ensure NGOs/INGOs are prevented from practicing nepotism, favoritism, or abuse of power?”**

- > Respondents described a confidence in mandated monitoring and reporting systems, with some concerns raised about integrity and transparency by those in less populated provinces.
- > NGOs and INGOs were not considered ‘more clean’ or free from the difficulties and accusations frequently leveled at the MOPH regarding nepotism and favoritism.

Some selected quotes from interviews:

- *“HMIS reporting, direct monitoring, and from utilizer’s complaints.”*
- *“Our reporting system is transparent as long as they are honest in their data.”*

- *“We aren’t preventing nepotism or favoritism in the NGOs and INGOs. They have this same habit as every other business.”*
- *“My brother is Managing Director of an NGO in <XXX> and I am aware they have these same practices. He is doing what he wants. The big difference between us: I am under pressure from Members of Parliament about my staff and he is not. Also, he earns ten times my salary.”*
- *“MOPH has no control on them. They are doing their own way in each relationship. If they have some way, it is clear they make some arrangement to have contract. We can see it.”*

**“Do you believe MOPH Manager / employees gives priority to their relatives / friends / own group when recruiting new staff?”**

> This was widely acknowledged by respondents in this category, though there were a few denials of the practice, mostly from senior Directors at MOPH HQ in Kabul.

Some selected quotes from interviews:

- *“Yes, there are different ways. They prevent vacancy from being posted. They name the preferred candidate directly so he is selected. They control the exam process and derange the exam markings. If this is their plan, no one can stop them.”*
- *“Not in our office, no, it is not happening, but I saw it a lot in <XXX> when I was there for four years. The Director was having his friends from his class in each Department. How can all the Managers come from one class and it be honest way for our public service?”*
- *“I have seen that our Directorate has almost every single worker from one family group; they are coming from <XXX> and the Director is controlling this. His choice is the only way. I was here before him and I am suffering and must choose if I can handle this stress of his pressure. What should I do? His nephew or uncle will have the promise of my job on the day I resign, that is clear.”*
- *“No, I don’t believe it is a problem. There are different ethnicities here. Two of our managers are <XXX>, there is not one ethnicity that dominates the hospital by preference of the ones making a plan for hiring; we are jointly working together.”*
- *“I am not sure. From my own position, I completely deny it.”*
- *“When I was giving exam for this position, the Provincial Public Health Director came and directly told me, ‘I selected another person, not you,’ but when his preferred candidate rejected the job, then I was selected for this position.”*

**“Do you believe MOPH leaders are aware of these problems?”**

> Most respondents in this category affirmed that MOPH leadership is aware of – and attempting to address – nepotism and preferential decision making in human resources.

Some selected quotes from interviews:

- *“They are supporting it!”*
- *“Yes, they are all from our sector and know these issues too well.”*
- *“MOPH leadership, especially <XXX> Directorate, is absolutely involved in staff hiring corruption.”*
- *“Leadership is not concisely aware of it. Some know, but not to admit it.”*
- *“Dr. Feroz can stop it, and we hope it can happen. He makes his statement to end it.”*

- *“We have heard other Ministers talk about transparency and accountability. I am hopeful our new leader does action by his own hand. How else do I have any hope for the future?”*

## Quality Assurance / Quality Control

### **“How do you perceive the accountability and transparency mechanisms in MOPH on its own Leadership?”**

- > There were divergent views about this, and these were observed across all areas of the country. Respondents in the category offered opinions on accountability and transparency that ranged from complete denial (a minority) to total acceptance (more than half), with several mid-level Managers emphasizing the systems in place to promote or encourage transparency.
- > The public statements from Dr. Feroz and the MOPH on corruption, on accountability, and on governance were well known among Directors and Managers from every part of the country.
- > Among the respondents, there was also acknowledgement that confronting corrupt elements within the MOPH hierarchy will have a de-stabilizing effect – which cannot be solved immediately.

Some selected quotes from interviews:

- *“Permanent staff are not doing wrong things but those working for short term are creating problems and involved in the corruption.”*
- *“There is no accountability, no evaluation, and neither any action for correction of the situation.”*
- *“We have quarterly based internal audit and there are auditors coming from the MOPH in Kabul who inform us about the problems here at the hospital.”*
- *“The leadership level of MOPH has succeeded in accountability: Decision-making in leadership level is stringent. The weaknesses are related to the transparency and accountability of Managers: If managers are reporting ‘Everything is transparent’ and the leadership accepts it, then our system is not holding these managers to the same level of accountability.”*
- *“Current leadership is strict on regulations; our previous leadership was more conservative.”*
- *“Every Director and every employee are aware of others doing wrong things. This is the reality of our culture and our habit. Only the most very senior Directors at MOPH HQ feel political pressure to have accountable relationships with their actions. We must follow the example of Dr. Feroz in this and reject the pressures to do wrong behavior.”*
- *“You know better than me the situation in the MOPH and no need for further elaboration. The Minister has sacked a half a dozen of its chief Directors without prior warning that it has create huge leadership problem for the Ministry. New Directors have not been able to occupy their position due to political pressure and ambiguous reason.”*

### **“What are the controls MOPH Leadership can use when they find intentional lack of transparency?”**

- > Respondents described current controls and systems by name and function, indicating that they are known and understood as the tools intended to promote transparency in MOPH.
- > Respondents from across the country were skeptical that individuals would be held accountable for misbehavior, given the resistance to enforcement is often linked to powerful people and threats of violence.
- > Several respondents from MOPH HQ specifically called for consequences for the failure to preserve transparency and integrity, and in the same remark, expressed concern about repercussions for the personal safety of those who enforce those consequences.

Some selected quotes from interviews:

- *“There must be consequences and punishment, and it should be known publicly. This is difficult to do it since powerful persons are making intervention to stop any consequences.”*
- *“We have reliance on Directorate of Monitoring and Evaluation, Directorate of Evaluation on Implementation of Health Regulations, Directorate of Internal Audit. This is their duty.”*
- *“I am not sure there are options for them. We are controlled by threats from Parliament.”*
- *“I know the private sector parts very well: We have three departments. One is Directorate of the review of the implementation of health rules, which is responsible for looking after all private sector. Whereas the second one is the Monitoring and Evaluation Directorate and which monitoring all activities of implementing private sector, and thirdly have Internal Audit Department. In all, these departments monitor and evaluate the private sector and reporting to high authority for further decision regarding private sector. I cannot say if each one is working honestly for transparency. How should we be sure?”*
- *“There are three Departments are involved in the monitoring and evaluation of the all four pillars of leadership, human resources, health services delivery, and finance. In private sector, we have some areas of concern: Processing of documentation of hospitals, radiology clinic, or diagnostic centers after they are established is a problem; we do not have the right to monitor or evaluate their activities. This is the responsibility of above mentioned departments. Our responsibility is giving work permission to private sector.”*
- *“I am worried for our colleagues in this struggle. We all are facing threats if we raise our voice against the violent ones with plans for their enrichment and power. It happens. How can we pretend to not be concerned that they will ‘disappear us’ for our effort at transparency in health sector?”*
- *“I am trusting in His Excellency Dr. Feroz in this. We have to make our correct behavior and give the encouragement for right behavior. He will support us.”*
- *“<XXX> has said very directly he will come and kill us if resist this contract to his supplies. He has his own contacts in Security system and he can do exactly as he describes. How then?”*
- *“Where are the protections for the Directors who say ‘No more’ to these problems? Should I tell ‘Goodbye’ to my wife and children each day for this?”*

**“How do you perceive the accountability and transparency mechanisms in MOPH procurement processes?”**

> While systems and controls for accountability and transparency in procurement were mentioned by several respondents, weaknesses were also commonly pointed out.

Some selected quotes from interviews:

- *“Procurement for technical equipment and supplies should, of course, have systematic approach to avoid any corruption. When I was Director at <XXX> we had this kind of approach in place and it was successful. Now I understand that the new Director there has made some weak decisions about who will be on the Procurement Panel and this is not correct. If he is selecting each one by his preference, then there is less accountability – and they are spending huge amounts of donor funding there these days.”*
- *“Procurement of contracts for BPHS needs much stronger control to prevent the weak NGOs from winning these competitions. They have never delivered successfully on any previous contracts so why are they allowed to compete? This is a serious weakness.”*
- *“These Directorates for M&E, and Evaluation of Implementation, and especially the one for Internal Audit, all have some dealings and corruption to be solved. If the Auditor goes to each Provincial Hospital and demands money for clean results of his inspection, this is obvious that we*

*cannot win in our struggle against low quality. Who can our colleagues in the Provinces trust if HQ sends corrupt people who are demanding money?"*

- *"Problems exist in procurement: Delays in contracts processing and they are not finalized in suitable time; Procurement Department are awarding special contracts to some specific groups and companies."*
- *"About the donors, it should be clear that they are financing MOPH according to specific programs. The budgetary lines are not revised for most of projects; that really requires attention."*

**"How do you perceive the accountability of the relationship between MOPH and its donors?"**

> Respondents in this category expressed frustrations and concerns about how they are perceived by donors, disappointment over how their progress inside MOPH is judged by donors, and concern that donor organizations view accountability as a one-way relationship.

Some selected quotes from interviews:

- *"Donors insist on their programs rather than focusing on the actual needs of the country."*
- *"Neither <XXX> nor other donors provide finance to the Curative part of MOPH, while the complaints of the service utilizers is focused on this."*
- *"The Leadership level of MOPH has succeeded in accountability: Decision-making in Leadership level is stringent. The weaknesses are related to the transparency and accountability of managers: If managers are reporting 'Everything is transparent' and the Leadership accepts it, then our system is not holding these managers to the same level of accountability. Our donors are in this loop."*
- *"The ideas of our biggest donors to MOPH should be respected, but honestly, they have no understanding of the reality of threats against us – threats of death – that we are facing from any challenge to powerful people if we resist their pressure and agendas. Will the donors who are visiting us for a meeting agree to live with this kind of threat against their children every day?"*
- *"One of my staff now works in the offices of <XXX> and I hear from him what is being said about us and our weaknesses in this situation. He cannot argue with them because of his place. When he explained to me they are worried about the progress we make here in <XXX>, I tried to be calm, but I am also more than a small amount of frustrated. We have a long struggle to achieve health improvements here. The people from <XXX> in <XXX> will leave and go back to their countries and I am not leaving. My country is my home and I am trying my 100% best effort to improve this sector. If <XXX> only can count the indicators from their reporting framework as any kind of progress, how do we make working relationship for success? We will not have success in every domain in each reporting period and this does not mean my team is failing. I'm sorry this is too difficult for me now."*
- *"When will I have my opportunity to score the donor on their reliability and their integrity? This is a part of what is happening that we are not allowed to question, and I cannot explain to our younger professional staff that they must learn to be open to having accountable relationships in a dynamic sector like Public Health, when I am not permitted the same with those who control our future progress. I have worked in Public Health for more than twenty years. My thoughts on this did not come this morning during my breakfast."*

**"Do you think there is any political pressure on MOPH about the implementation of health services?"**

> This was acknowledged by all but two of the respondents in this category.

Some selected quotes from interviews:

- *“Our colleagues in the Provinces are facing pressure from local Commanders and Provincial Council Members and MPs about where clinics should be built, and what kinds of services to have, plus recruitment of staff of course. They are under pressure, it is political, but also there is threat and danger from these people, too. They threaten that there must be a new clinic or they will make it impossible for MOPH to function in the community. They can do this.”*
- *“Yes, of course political pressure is on the Provincial Public Health Directorate and the implementing NGOs in service delivery, and as well as in their recruitment processes.”*
- *“Yes, and it also comes from opposition, by this I mean Talib Commander; all powerful groups in our area have some agenda of what should happen, should not happen, how, where, etc.”*
- *“Political pressure cannot derange the normal flow of service delivery at hospital level.”*

**“In MOPH, how often does ‘The right person works at the right job,’ meaning, their skills match the requirements?”**

- > There were many discrepancies among respondents in this category; most believe that workers are skilled at levels below or far below what is required for their role.
- > Examples of were given of cases from every level of responsibility in the health sector, ranging from the most senior Directors of Departments in MOPH HQ in Kabul, to frontline staff employed in Basic Health Centers in remote provinces.

Some selected quotes from interviews:

- *“Probably less than half the time in our province. As example, I observed this situation: The documents for qualification by a young man were brought to MOPH from Pakistan. He had been at first a driver, then promoted with his new document, he became vaccinator, and suddenly without any time, he became nurse. All this change in higher and higher qualification happened is less than two months. The MOPH accepted his documents from Pakistan and make demand we hire him. Now, there is no correct belief he is ‘the right person’ in this job of nurse.”*
- *“In this province, probably half.”*
- *“Most are not skilled to high enough level, but we have not enough staff willing to work in this province. The security is not reliable and it is a barrier to high-skilled people accepting to come here for their work.”*
- *“Personally, I think most are the right one in their job. But I am not assessing this.”*
- *“Employment in MOPH is strongly based on skill and requirements.”*

## Human Rights and Discrimination

**“How would you describe the role of community leaders in addressing (or causing) discrimination in MOPH?”**

- > The role of community leaders was characterized by descriptions of dynamic relationships.
- > Leaders were noted for advocating on behalf of their constituents, influencing decisions of health authorities, defending traditional social structures through discrimination or favoritism, and brokering power, generally.

Some selected quotes from interviews:

- *“Local community leaders and Commanders have their potential for influencing decisions on health service delivery, whether they use it negatively or positively. Unfortunately, each local leader or Commander is acting as president of the area.”*

- *“Community leaders can force MOPH to change the location of health centers; they can succeed in this and it will be for the benefit of their own group and the danger of their enemies.”*
- *“I know of a discrimination case by tribe, when a person referred to the <XXX> Department for his recruitment in <XXX> province. But the Director of this Department told him to his face, ‘Sorry, we do not recruit <XXX> people in our directorate.’ This is from control of community leaders.”*
- *“It is not related to MOPH HQ, but at the rural areas the community leaders and Commanders have vital role in the decision making process. This can prevent or promote discrimination, both ways.”*

**“Is there any political pressure on MOPH Leadership about Human Resources? Describe it.”**

> Human Resources decisions are under constant pressure, especially from Members of Parliament.

Some selected quotes from interviews:

- *“Yes. In recruitment and dismissal processes, even if it is about an ordinary worker post, a Minister or a Member of Parliament could be involved. Of course, you have to consider about their pressure on selection or removal for all high-ranking posts.”*
- *“There is nothing else but their pressure. Never encouragement for good work or accomplishments. Political pressure and threats are about one thing at HQ: Human resources. I have stacks and stacks of demanding letters from high ranking politicians about ‘Hire this one in this place,’ or ‘Sack him immediately. If you don’t, I will come there and show you who I am.’ With this kind of behavior, our politicians are criminals, really.”*
- *“We are under pressure even before we take up our post. When it is clear we will be selected and known what is our name, the calls are coming immediately: ‘Give this man from <XXX> faculty the responsibility for <XXX> in <XXX>.’ They are just sitting with their list of who should be appointed to which post in each place. It’s impossible.”*

## Extortion

**“How does MOPH Leadership manage pressure or extortion? Has managing this been a successful process?”**

- > The Respondents described several instances of facing pressure, sometimes with threats of violence, and tactical reactions ranged from acceding to demands, negotiating on a compromise, drawing support from other authorities, requesting help from security services, and simply enduring the situation because there was no alternative.
- > Several of the MOPH HQ-based respondents described the Ministry of Public as directly and proactively addressing these situations since Dr. Feroz assumed his role as Minister, with advice that they notify his office and seek guidance on resolving the issue.

Some selected quotes from interviews:

- *“Implementing of regulations and obedience to MOPH priorities is challenging sometimes. In some cases, MOPH steps back because they have no real choice: A group of Parliament Members forces MOPH to recruit their selected person as Department Head, otherwise they will injure the other Director, or they may call the Minister to Parliament. These are real threats of safety.”*
- *“Through direct discussion with community leaders (or any kind of source creating problems) but if not possible in direct discussion, then we go for Security Department of police to solve the problem. It is happening too much, actually.”*
- *“The Minister can’t stand against Parliament Members and powerful person. One week ago one Parliament Member came shouting and beat me and no one tell him, ‘Stop.’”*

- “With the coming of new Government and Minister of MOPH, they are on the staff side. He is says, ‘If anyone facing pressure from political or community leaders, inform us and put us in the loop.’”

**“Is there any pressure on MOPH from community leaders about obtaining health services? Describe it.”**

> This was affirmed by all 62 respondents in this category.

Some selected quotes from interviews:

- “The leaders from community come to us and demand clinics are built in this specific place, on this spot. We have a planning and development process, and there are limits to what donors will agree in these issues. The leaders are not offering any way to cover cost of construction or operation budget of the clinic – They are only thinking of the announcement they will make to their people, ‘I forced authorities to make this clinic in this spot’ and this is a derangement of our system. No one can sustain the operation of a clinic made under threat like this... We know these leaders will next demand to control the workers in the clinic, even if they have no qualification.”
- “Our Governor is telling me. ‘Make agreement for new Comprehensive Health Center in <XXX> District or we will have security problems from those <XXX> people.’ How will convince NGO or INGO to agree working there if the CHC is not appropriate for that small size village and there is known threat of violence if the leaders in the valley do not get their demand each hour?”
- “Yes. Even if the requirements for a Health Center are not matching the demand of the leaders from the community, they force for it, and it consumes the budget of the health service. These can be violent threats and protests.”
- “Yes, they have effect, but their role is not negative. It has positive part in control of bad behavior of MOPH in this area. People complain about problems in Provincial Health Directorate and community leaders bring pressure to control the problems.”

### **Fraud / Falsification / Fakes / Forgery**

**“Do you believe there is any falsification of internal reporting systems within MOPH?”**

> All but three of the 62 respondents believed this was happening, or at risk of happening.

> Several respondents provided examples of intentional falsification and evasion of controls.

Some selected quotes from interviews:

- “I do not deny this is an issue.”
- “The administrative or HR Manager assign some of our staff as ‘absent’ when present but he does not assign ‘absent’ his relatives or the people who are in their corrupted group.”
- “Yes, the reports we prepare can be changed within <XXX>; for changing the reports there are different levels of money paid for a different result: The police are involved, or the Attorney, the patient, or their family.”
- “Some staff are making false report about timing of arrival and departure.”
- “There is no falsification in hospital reporting. I am sure the reports in MOPH are also transparent.”

**“Do you believe there is any falsification of external reporting systems of MOPH?”**

**“For example, to donors or GoIRA authorities?”**

> The difference in responses to this question about external reporting, compared to internal reporting was striking: Only one respondent believed that external reporting *might be* falsified, but was unable to provide any examples when asked.

Some selected quotes from interviews:

- *“Never heard of this happening. There are too many solid systems to prevent it.”*
- *“None. It does not happen.”*
- *“The Departments under my authority report true and realistic: Even the faults that show vulnerability to corruption are described in my reports. This issue better to be monitored in each single department.”*
- *“No. It is not possible for MOPH to intentionally give false reports, or allow release of data known to be inaccurate. There are too many consequences from external stakeholders.”*

**“Do you believe there is falsification in MOPH reporting systems on health service delivery?”**

> This question yielded similar results to the query about falsified internal reporting: There were some affirmations from respondents and several more expressed suspicions about it happening.

Some selected quotes from interviews:

- *“I accept it exist in lower levels. From utilizer’s complaints about Health Centers we know there are routine delays in the services that are harming the clients. Some also refer their patients for diagnosis out to the private sector. These all are vulnerabilities of fraud related to reporting; corruption in public offices is usually committed in the shadows of our regulations. True reporting on complaints, delays, and referrals would show a different picture.”*
- *“When I have compared what was sent from <XXX> with what my own Assistant observed in <XXX> during a field mission last month, I have to say, ‘Yes: It is probably happening.’ Naturally, we took steps to correct this and have plans now for closer monitoring of <XXX>.”*
- *“Probably. There is some motivation for BPHS implementers to submit a better picture than is actually happening. We do a lot of verification. When we see discrepancies, I cannot assume it is their attempt to falsify reporting data without some proof. There are many cases where figures are revised. With one of the NGOs in <XXX> they revise every single time and it’s a habit.”*

**“How big is the problem of fraud / falsification / fakes / forgery in MOPH Human Resource hiring and promotion?”**

> The vast majority of respondents stated this is was an issue, a problem, or a big problem.  
> Several respondents pointed out that reliability of processes and documentation are a concern in all sectors, not just the health sector or MOPH.

Some selected quotes from interviews:

- *“There is a market for these fake documents where anyone can pay for certificate of Medical Doctor or Nurse or any other profession.”*
- *“One of my colleagues went to Pakistan with this plan to buy a faked Diploma of Medical Faculty so he could achieve an MOPH job in <XXX>. I advised him against it, but he went, spent a small sum, and was successful. It is very bad for our system when these things are happening.”*
- *“Most people are recruited in <XXX> based on fake documents. They have got work licensures and work in private sectors while their documents are fakes.”*

- *“The Civil Servant Commission itself is involved in the corruption because they are selecting people who do not know how to use computer or even cannot write in English. These are somehow getting higher marks in exam than those who can use computer and read and write English very well.”*
- *“Yes, of course; it is a problem in education sector, too.”*

**“What is your perception about quality of pharmaceuticals procured by NGOs and INGOs?”**

- > Nearly all respondents believed that pharmaceuticals procured by NGOs and INGOs were of a low quality or unreliable quality, despite packaging stating otherwise.
- > An exception to this theme of generally negative responses: Procurements by NGOs and INGOs through International Dispensary Association (IDA) were regarded as higher quality and reliable.

Some selected quotes from interviews:

- *“Quality, at the first step, is affected by procurement regulations: It orders the required goods selected by lowest price. The quality directly depends on the price. In the second step, the quality control, the analysis, should happen in our MOPH laboratories but they are technically not well equipped for complex analyses to determine the actual quality.”*
- *“Medicines from fraud factories in Pakistan do not care about the health of our people and send these worthless medicines to us.”*
- *“The quality is usually very low. Consequently, clinical improvement of patients often fails, and meanwhile the liability to corruption is broadened.”*
- *“We have no complaints from our procurement through IDA. <XXX> has been using IDA since 2007 and our only issue is that they are not covering all the medicines on our official Formulary.”*
- *“I have not seen significantly low quality drugs here, and we are trying to use our best drugs, but we can’t afford better medicines, for example Turkish or Arabic medicines, which are very expensive.”*
- *“We suffer from the import of low quality medications from Pakistan. The local community cannot distinguish the quality, but they make decision based on cost. Sellers know this, and raise the prices of the fake items from Pakistan with international-sounding names on the package, and it tricks the people. It is shameful practice to do this, and our Pharmacy Focal Point cannot cover this whole province by himself. The sellers in <XXX> District know he cannot get to them because of insecurity on the roads. They are dealing in fake medicine but how to stop them?”*

## Conflicts of Interest

**“Do you believe there are links between the private sector and public officials that are focused on weakening the Public Health system?”**

- > With just three denials out of 51 respondents, there was general agreement that some public officials in the health sector have (or are suspected of having) links to the private sector.
- > The strenuous rejection of this possible link was more focused on the legitimate role of the private sector in providing additional capacity than in the intention of any Public Sector practitioners referring their patients for monetary reasons.

Some selected quotes from interviews:

- *“Yes, there are some doctors who want to strengthen private sector and weaken public sector, for example, I found that one of our doctors damaged the ultrasound machine in the hospital so he can refer patients to his private sector clinic. I wanted to refer him to the Attorney General, but other colleagues interfere and stopped me. The doctor could make threats or be violent, so I was quiet.”*

- *“Yes. For various reasons, including the possibility of losing their job, they may try to be slow in activities so it can never be achieved fully and completed.”*
- *“Some have found a secure place for long-term business in the private sector, and because they are eager to be successful in their personal life, they cause failure of public services.”*
- *“Doctors hand out their business cards to patients so they will visit their private clinic in the afternoon. Even our Public Health Directorate staff visit them in their clinics and know about this.”*
- *“Will anyone deny this is happening? How can they when the doctors in the bazaar advertise on the signboard, ‘Doctor <XXX> from Provincial Hospital, practicing with strongest equipment and full services’ – There can be no mistake what this means!”*
- *“No one can reject the truth of low salaries being paid to Public Sector workers. They are doing private work on the side for this reason, and the undermining of trust in Public Sector is a side effect instead of the plan or the intention. This is my belief.”*
- *“I am rejecting this, totally, because we have a department by the name of Coordination Department, which builds rapport between private sector and Public Health sector. Once the public hospitals in Kabul were built for a population of just 1 million but now the population is more than 5 million. Kabul Hospitals remain in the same condition – for that reason – private sector is promoted to provide services to the people in Kabul province: The private sector reduces load on Public Health sector.”*
- *“No, not at all. In our province we have strong control over the private sector pharmacies. There are only <XXX> private pharmacies in our province, and in one year we have fined <XXX> [67%] of them for not having proper qualified workers dispensing medication and for selling expired medicines to the people. We cannot allow health to be ruined by private sector for their only idea of profit. The Pharmacy Department in our Directorate of Public Health is protecting this situation...But we are not forcing them to closedown: If we don’t let them continue their work we receive hundreds of phone call and pressure to let their work go on. The big problem is the distance between the pharmacies in <XXX> and the community becomes very angry.”*  
 >> Response from a province without any large cities.

**“What are the risks to MOPH’s credibility when the Leadership ignores cases of conflict of interest?”**

> Respondents named several risks when conflict of interest cases are not dealt with: Lack of reliability, lowered motivation, reduced trust and confidence.

Some selected quotes from interviews:

- *“Loss of national reliability.”*
- *“Our integrity is questioned. Who can rightly trust us?”*
- *“Dormancy and meager motivation makes the active people in MOPH frustrated.”*
- *“Patients and families are bored with late and incomplete results and that consequently discredits the service delivery in public sector – and also increases mortality and disability.”*
- *“More cases of conflict of interest will come and come again: There is no consequence, so these choices are giving confidence for more of the same behavior in other people.”*

**“What are the risks of corruption when Public Health workers refer patients to private sector for diagnosis or treatment?”**

> Respondents named several risks of corruption and emphasized the destructive power of this choice by Public Sector workers: Reliability may be undermined intentionally or unintentionally, the

public's trust and confidence may be lowered, patient referrals could be made purely on the basis of personal profit, and patients' and families' fears could be exploited.

Some selected quotes from interviews:

- *“The first risk is to endanger patients and families as they cannot afford economic burden. The second victim of this risk is expending of MOPH financial resources on a public sector workforce with no effective outcomes to the community. The derangement of Governmental budget through this way is embezzlement.”*
- *“These employees show their betrayal by this kind of behavior. They risk the ruin of the Public system for their own gain. Some will even work actively to degrade the reputation of the Public system so they can profit personally. This is a shame and against our values.”*
- *“MOPH and governmental reliability is lost while our budget is spent employing people who are focused on their own earnings instead of the stability and quality of the public services.”*
- *“The trust of the Public system is ruined.”*
- *“The same as what happens if families are sent by teachers to pursue education through private schools: They stop believing that public education has any value.”*
- *“We lose the motivation of quality inside our Public hospitals when the staff are focused on only giving the patient a private clinic address for their actual treatment. The Public system becomes a place for attracting sources of private income.”*

## **Bribery**

**“What is the official policy about MOPH staff asking for (or demanding) bribes from patients and their family members?”**

> Respondents provided clear and articulate descriptions of policy and practice in these situations.

Some selected quotes from interviews:

- *“The official rules and policies, jurisdictional regulations, and the principles of rewards and punishments as per the Civil Servants Law are implementable in these cases. But abuse of power, political extortion, and unfounded accusations are intervening in the successful implementation of the regulations and the Law. And this, in turn, deteriorates service quality, as well as discrediting national reliability of the Public Health system.”*
- *“It is forbidden, but still it is happening. Especially in surgical cases.”*
- *“If they are some higher rank authority, the only punishment is to give warnings to them.”*
- *“We first warn them orally, then in written form, and if necessary we refer them to prosecutors.”*

**“How big is the problem of ‘extra payments’ or bribes in the public health sector?”**

> There was a broad range of opinion in response to this question, from the presumption that it is a universal experience to dismissive rejection of the issue.

> More than half of respondents mentioned ‘*sherinee*,’ or gifts to health workers as commonplace.

Some selected quotes from interviews:

- *“Every single Afghan knows the answer to that.”*
- *“The parts of MOPH with greatest risks of corruption through bribery are procurements, recruitment including administrative reforms and Civil Service Commission, and food quality”*

control analysis... Also, on the service utilizer side, there are extra payments by the patients and families to health staff for good and quick care. Families are routinely expected to hand-over cash or gifts.”

- *“I believe that departments working on private sector coordination are clearly involved in bribery.”*
- *“Extreme bureaucratic systems in MOPH have the most important role in vulnerability to bribery. These exist in all parts of the public services, not just health sector.”*
- *“Our patients face the problem of pressure to give ‘sherinee,’ or gifts to midwives or Doctors.”*
- *“‘Sherinee’ is harmless and happening everywhere, all the time. It’s usually a small amount, a kind of appreciation for good work.”*
- *“There is no bribery: Punishment regulations are implemented. We have shortened the punishment steps to ‘warning’ and ‘direct firing’ if any case is caught.”*
- *“The risk of bribery is strongly controlled.”*

### **“Other Risks” of Corruption**

#### **“What can you tell us about any other risks of corruption in the Public Health system?”**

> Additional risks or vulnerabilities were described by respondents, including that attention to corruption without suitable corrective actions to counter it can unintentionally embolden perpetrators, and, that confusion and lack of standardization around titles and position within hierarchies can inadvertently lead to risks of corruption.

Some selected quotes from interviews:

- *“We have experienced the monitoring and evaluation against corruption, supervision on implementation of laws, and various other committees that made surveys and interviews, collected a lot of documents and proof, and made files of recommendations. But implementing corrective actions and conducting the rewards and punishment processes never took place; even they did not punish one single accused or corrupt person. The biggest outcome of those earlier evaluations was to promote the corrupt people to higher ranks! Considering this practice of the Government, even the honest people may be encouraged to commit corruption. And this is an offense: a betrayal to our Afghan nation who have endured these miseries since more than 40 years. I hope your respected organization do not concentrate only on data collection about corruption; perhaps bring some actions for practical changes through the Final Report... Long live Afghanistan!”*
- *“There is confusion about titles and hierarchy: In some hospitals the Head of hospital is a Director and in some, not. For example the Head of hospital in <XXX> is a Director, but in <XXX> that is a Manager... It can create problems between the Director of the hospital and the Director of the Public Health Directorate. This issue has to be a priority in the strategy. In some provinces, even Director of the hospital and Director of the PHD are both demanding to participate in the administrative meeting of the Governor. This is a leadership struggle and causes corruption.”*
- *“There are many times that it happens that politicians try to get some posts for their group or family, but there are honest people to struggle against it also. I am sure by standing in line with the honest and transparent colleagues we will have a nice future for the country.”*
  - >> Notably, this respondent denied that any risks of corruption existed in MOPH throughout the entire interview. Yet in the final moment, this person in a senior level leadership role in Kabul took the opportunity to acknowledge a specific risk of nepotism in MOPH Human Resource processes that was described by all 61 of the other people in this category.

## 2. FINDINGS: MOPH NON-MANAGEMENT EMPLOYEES AND FRONTLINE STAFF \*

**OVERVIEW:** MOPH non-management employees and frontline staff described widespread challenges from corruption. These workers acknowledged a broad range of problems resulting in risks and vulnerabilities to corruption in the health sector, with financial gain being the most frequently mentioned motivator of corrupted actions.

Among the 51 respondents in this category employed in all parts of the country, each identified vulnerabilities or risks of corruption in their interview, regardless of the setting where they worked, or the role they held. Respondents commented on being subjected to the interests and influence of powerful persons, including a broad range of arbitrary decisions, intimidation, threats, and violence. These difficulties add unnecessary complications to an already complex working environment.

**The most detailed comments about risks of corruption related to:**

- 1. Leadership and governance:** Conflicts of interest in contracting for health services delivery, influence from powerful persons at all levels of management, weak and inconsistent coordination of services, and unreliable control systems.
- 2. Pharmaceuticals:** The integrity of the drug supply was a serious concern, with suspicions raised about conflicts of interest.
- 3. Human Resources:** Influence from powerful persons resulting in widespread nepotism and favoritism, and frustrations with lack of equitable and fair access to training opportunities.
- 4. Health Services Delivery:** Conflicts of interest in connection to the private sector's role in health services delivery.
- 5. Quality Assurance / Quality Control:** frustrations over weaknesses in control systems and accountability in achieving good governance.

Notably, these comments were largely focused on lack of confidence in leadership and management, a generalized lack of transparency in how management decisions are taken, how human resources processes have been compromised, and a perception of widespread conflicts of interest across all of the health sector.

Frontline staff in all parts of the country were consistently disappointed with the lack of attention or concern from Public Health management to the gaining the trust of the public in the integrity of the Public Health system; widespread misuse of ambulances and other official vehicles for personal travel in this context was a frequently cited example of management arrogance and indifference.

\* Details that could identify individual respondents have been omitted.

### Policies

**“How are MOPH policies reducing or increasing the risks of corruption? Is this related to implementation, resources, or something else?”**

> The vast majority of respondents in this category cited *implementation failures* as the most common factor in why policies did not effectively reduce corruption including intentional resistance from

- within MOPH, opposition and obstruction from powerful persons external to MOPH, and systemic weaknesses related to rule of law and/or insufficient resources.
- > The second most commonly cited issues were *implementation difficulties*, including obstacles to timely resource mobilization, weak coordination, lack of technical information, and inconsistent monitoring and feedback.
  - > Respondents in all parts of the country expressed the belief that imposing consequences for failures to implement policies would have a beneficial effect. Notably, this was a call for consequences for failures to follow policy at all levels of the health system, from Senior Directors and Managers at MOPH HQ through all ranks to the lowest grades of support staff in frontline roles.

Some selected quotes from interviews:

- *“Of course we will avoid corruption if policies are implemented according to MOPH standards.”*
- *“Policy has vital role in the reduction of corruption, but the problem is with improper implementation by NGOs. In the contracting, MOPH mentions everything but when the time of implementation comes, NGOs are saying, ‘We do not have enough budget to do everything.’ They can win these contracts due to knowing someone in the MOPH, and after getting the contract, paying amounts to those people so they become quiet and not say anything about the implementation of the project by the policy or not. How this happening?”*
- *“Policies are weak and make our system vulnerable to corruption.”*
- *“We must see consequences. Otherwise corruption will continue on and on.”*

**“Do you believe services have been delivered according to the MOPH policies and strategies?”**

- > Respondents described multiple impediments to aligning service delivery to policies and strategies, with leadership and management shortcomings named most frequently.
- > Struggles related to resources and coordination were also commonly mentioned.

Some selected quotes from interviews:

- *“Not hundred percent according to MOPH policies because purchasing low quality drugs and recruiting human resources based on giving priority to relatives and friends.”*
- *“Shortage of posts is very critical. For example we should have one nurse post for each three beds in this Ward section but staffing is not matching these criteria.”*
- *“...about the implementation, I can say that NGOs/INGOs are stricter than Government. Their services are three folds better than Governmental management. They are consistent.”*
- *“The hospitals and clinics are not coordinated with each other and with Provincial Public Health Directorate. So service delivery is in a disorganized manner... I don’t know if it is the weakness of policy of MOPH, or cooperation problem in our province. It is not possible to achieve strategy.”*
- *“It is impossible when human resources are not provided sufficiently. How can we provide services according to policies if we are not staffing correctly?”*
- *“We do not have enough diagnostic facilities in public sector. We would have better facilities if we would charge some small amount as fee to cover cost of equipment and facility requirements.”*
- *“No: All nurses are jobless and are at their homes. Here they hire midwives instead of nurses.”*

**“Do you believe human resources have been managed according to the MOPH policies and strategies? What are the risks of corruption in Human Resource Policies?”**

- > Not a single respondent in this category believed Human Resources in the health sector have been managed on the basis of MOPH policy or strategy.
- > Human resources within the Public Health System were described by respondents as being under constant pressure from powerful and corrupted influences, especially Members of Parliament and other high ranking authorities.
- > Respondents described widespread nepotism, favoritism, and preferential human resource management based on relationships and connections, rather than competencies and merit.
- > Many respondents in this category expressed worrying levels of disappointment and mistrust in health sector leaders. Several described their lack of confidence in the ability of the MOPH to confront and end human resources corruption.

Some selected quotes from interviews:

- *“Priority is for relatives and friends, or relatives of political leaders.”*
- *“We miss the recruitment chance for qualified staff and instead we are giving opportunity first to relatives. This is biggest risk of corruption...”*
- *“Special political or group relations and or bribery are the main indicators for recruitment. Graduation certificates and degree are only used to enter the recruitment entrance exam.”*
- *“Several of these colleagues are relatives of the Director. When they are absent, they are marked as ‘Present,’ but the rest of us, if we are absent, it is accurate. The relatives have special benefit.”*
- *“Our Directors want to ignore recruitment because they want to steal the money. Salaries at District levels are paid directly to staff in cash. So who knows if they, in provincial level, filled the posts on paper and take the salaries?”*
- *“We have applied to Provincial Directorate since past <XXX> years but they still did not recruit anyone. There are about more than <XXX> posts empty in Provincial level but still the recruitment is not processed, whether there is some special interests of Directorate in selecting the staff/employees, or the risk of ‘ghost workers,’ otherwise, in a country where thousands of medical students are graduated and hundreds of certified specialists are jobless, how can a post be empty for <XXX> years? It shows that weak and scattered organization of Provincial Health Directorate has a corruption in Human Resource part also.”*

**“Do you believe financial resources have been managed according to the MOPH policies and strategies? “What are the risks of corruption in MOPH Financial Resource policies?”**

- > Respondents identified several types of corruption related to finance policies they had experienced, observed, and suspected, including salary and wage irregularities, procurement practices, contracting practices, theft, and embezzlement.
- > All respondents expressed concerns about the impact of these risks on the effectiveness of the Public Health system; many also questioned how these vulnerabilities and the perception of unreliability will weaken the delivery of health services in the Public Health system.
- > Several respondents also made clear they have confidence that systematic monitoring and controls can be implemented and that these will strengthen the overall health sector.

Some selected quotes from interviews:

- *“NGOs have contract for a salary level of their staff, but NGOs are giving less than this amount each month to the workers for their salary. It is not checked: What are the employees receiving and does it match with the agreement? No. And no monitoring is happening.”*
- *“They give us monthly salaries on quarterly basis...postponed risks the services to corruption.”*
- *“Well, when the specifications and prices are not according to procurement policies then it means corruption is governing the process. For example in this year Provincial Finance Department*

*procured gas for heating of Provincial Health Directorate offices with a price of Af55/Kg, while the same gas price from quotations by Health Directorate directly was a price of Af45/Kg in the same week and dates. So it means the financial resources are extremely vulnerable to corruption in provincial level. This is just one transaction. Consider the amount of all transactions and you see the risks of weakening financial position of whole public system.”*

- *“The essential risk is from the staff being completely out of money: When they are not paid for about four months, if equipment not procured, and if consumables are not provided then for, then yes, sure the risks of corruption is huge. I have watched: The staff ask for money, they refer patients to other centers, most important, there is some risks when the money is finally disbursed from MOPH accounts but it does not reach workers here <XXX>.”*
- *“Monitoring and audit functions can protect our Public Health system if they will be supported and made a priority. The dishonest people must be kept out of these control functions.”*

## Contracts

### **“Have MOPH priorities been ignored because of corruption?”**

- > This was uniformly affirmed by respondents from all parts of the country and in all settings.
- > Respondent remarks about why MOPH’s stated priorities have been ignored were centered on two main themes: The lack of resources (including lack of *appropriate* resources), and pressure or influence from those with power who seek to exert control over processes and resources.
- > Almost half believed priorities were ignored as a consequence of multiple factors that combine to create overwhelming obstacles: mismanagement, insecurity, scarce resources, lack of commitment, external pressures, and poor coordination.

Some selected quotes from interviews:

- *“Whatever medical equipment and consumables are required at the hospital is supplied by the implementing NGO. But since last four months, medicines were not supplied by them, so, the healthcare providers prescribe medicines from bazaar. This is against their NGO contract. It also makes a conflict with the priority of MOPH to demand that contract holders provide what the patient requires for the primary care. I’m not sure of this is because of ignoring MOPH priority or they are not competent to manage procurement effectively...”*
- *“Yes because sometimes political pressure is not allowing MOPH staff to perform their planned activities and they have to obey recommendations or demands of political leaders.”*
- *“Yes. The system is managed by people with their own personal priorities, mostly focused on money, and our services are facing corruption this way.”*

### **“What are the risks of corruption in the contracting process of health care services to implementing NGOs and INGOs?”**

- > Many respondents expressed confidence or certainty that contracting processes at MOPH HQ had been compromised by either weak oversight of bidding processes, or because personal relationships had been leveraged for financial gain – though none of these non-management and frontline staff offered evidence to support these assertions.
- > Several respondents gave examples of incomplete contract implementation in their area, often in specific detail; some described BPHS and EPHS contracts that had been renewed despite failure of the NGO or INGO to deliver results.
- > NGOs and INGOs were also described as following processes of contracting elements of their work in ways that were clearly corrupted by those with financial motivations, including pharmacy procurement, infrastructure, and special projects for training of staff.

Some selected quotes from interviews:

- *“If the NGO does not fulfill contract obligation, are there consequences? Since last ten years the renovation work of <XXX> is not done by the implementing NGO in one of our BPHS contracts, but their contract with MOPH says, ‘We will do renovation work of the health facilities.’ How are they keeping this contract?”*
- *“After our contract, MOPH have processed a letter so that we cannot have any overtime. They have manipulated the situation with this letter and omitted us from overtime. In fact it can be said that omitting us from overtime privileges is a type of corruption.”*
- *“Who is controlling this competition for BPHS contract in Kabul? How can NGO with no experience in health sector in Afghanistan be chosen? Is it possible to achieve the scope of services of our contract when they are making agreement with NGOs who say they have lowest price?”*
- *“The Director of our hospital and the Head of the Pharmacy Department have been involved in drug corruption. The owner of the drug company for our supplies is the son of our Director. He brought us the wrong drugs. I told them that the drug written in the supply contract is different from the drug they brought, and I rejected those drugs, which led to many problems. My situation has been struggle since then. This corruption will lead to negative result of my employment.”*
- *“<XXX> made contract for skills development and upgrade of technical staff in their Lab Units at all their sites. This was not the correct way. The NGO paid the contract with donor money for the training and then we heard that the number in the sessions was half of the number reported to the donor for the project. There was some dealing between training agency and clinic staff on this. No one had even one photo of the full room of trainees. How can this be possible?”*

**“Do you believe MOPH leaders are aware of these problems?”**

> Respondents were skeptical that MOPH could be unaware – Only 3 of 51 respondents denied any possibility of MOPH leaders being unaware and an additional 3 respondents were unsure.

Some selected quotes from interviews:

- *“Yes, they are well aware of everything. In this province, we listen to them complain a lot.”*
- *“They are in the picture and part of it.”*
- *“Yes, MOPH leadership is well aware of all matters to exist at the provincial levels.”*

**“Do line managers misuse the TOR statement, ‘Employee must perform any task given by the manager’?”**

> The respondents were evenly split between certainty of this occurring and certainty that it is not occurring; a small number were not sure if it is happening.  
 > This practice was reported by several people at one setting, or as often, by no one at all, implying that the stance of upper management dictated if it became widespread or not.  
 > The misuse of the statement had a particularly disturbing quality in some of the settings, where lower grades of staff were forced into inappropriate situations, threatened with termination, and pressured to perform dangerous or highly risky tasks without suitable protection or safeguards.

Some selected quotes from interviews:

- *“Absolutely not. In our hospital it is impossible. We are staff of this Public Service system, not the private goods of the management.”*
- *“All our staff are following TOR of contract. Managers cannot succeed with these ideas.”*
- *“Never. We will fight the Manager if he tries it. He will not even try.”*

- *“The Manager in <XXX> is using his authority to force extra work from the staff, with tasks definitely outside their TORs. How does he justify his wrong actions? No one is asking him.”*
- *“We are facing so much pressure for tasks that are not in our TORs. How can we stop it?”*
- *“Our Director has forced the <XXX> to handle the <XXX> without any personal protective equipment. They can suffer terrible results if an accident happens. But they were threatened to be replaced because ‘must perform any task’ was used against them. It is very wrong.”*
- *“I was not told I should have mask and gloves. She made me do this part of the work of <XXX> and later one of the doctors told to me, ‘It is not your work and too dangerous to handle that without protections,’ but my Supervisor pressured me... I cannot leave this job.”*

## Embezzlement

### **“Is there routine and reliable inventory of MOPH assets to prevent embezzlement?”**

- > Inventory of assets was a uniformly positive point across all parts of the country: Processes were described as routine, systematic, and robust.
- > The responsibility for Inventory lists is generally concentrated in a small number of roles (typically Administration/Operations/Facilities, Pharmacy, Bio-Medical Engineering), or is managed as a task for a specified focal point within larger teams (Nursing, Surgical Departments, Sterilizers, Cleaning/Housekeeping, Stationery/Clerical) – These also involve articulated checklists and timetables.
- > The reliability factor of Inventory was less robust since the external checking and auditing functions were sometimes described as incoherent, uncoordinated, or lacking in verification: Once Inventories were prepared and checked locally, there were many respondents who described gaps and lack of reliability in the higher-level management functions to control embezzlement.

Some selected quotes from interviews:

- *“Yes, inventory system of public assets is available and posted on the door of each room. In observation visits, this was randomly checked and was available in each room.”*
- *“Yes, we have it. Our system is controlled and monitored but reporting is less reliable.”*
- *“Yes, we keep Inventory Lists, same as in all hospitals. Our problem is lack of practical solution to be able to use equipment: We have <XXX> X-ray machines, each is listed, but technical repairs are required and the hospital cannot afford it. We have to send out patients out for X-ray.”*
- *“The system is reliable and there are three signatures required for the Audit Committee to approve the monthly report. It is taking a lot of time to inventory every item, but it is more benefit to do this each month and it is planned in work planning of these staff.”*
- *“We have all Inventory Checklists on file and controlled to prevent embezzlement. These have never been inspected by the Auditors because they do not come and visit our site.”*  
 >> *Response from a province with no large cities*

### **“What are the controls MOPH leaders can use when they find inventory processes are not followed correctly?”**

- > Consequences were mentioned by several respondents, with the risk of corruption arising from weak management or lack of commitment to processes at the levels above the respondent.

Some selected quotes from interviews:

- *“Any violation of the process is a warning, first, same as other administration parts. I have not seen any issues with our inventory process. No one can steal from this way.”*

- *“Inventory should be audited routinely and if any case of stealing is found then investigations from relevant department is started. Strict monitoring is the best way.”*
- *“Medical Equipment is not maintained properly: Damaged machines are marked ‘junk,’ then stolen, and then repaired in bazaar for private use. The Manager knows this and does nothing.”*
- *“Inventory controls are done correctly here. Central MOPH HQ is not in the picture however.”*
- *“Our process to monitor inventory is very strong. There is not any corruption from inventory side. The corruption is before this stage, at procurement.”*
- *“They should be visiting our facility, by face to face inspection.”*

**“Do you believe MOPH Managers / staff are involved in embezzlement of public goods?”**

- > More than half of non-management employees and frontline staff in the health sector believe that MOPH Managers and / or staff are engaged in embezzlement of goods; this proportion was seen in all parts of the country and across all types of settings.
- > Respondents reported first-hand accounts of several types of embezzlement including theft of public money, equipment and supplies, and consumable resources, and dishonest management of public funds for personal benefit.
- > Among those that *do not* believe embezzlement is happening, there was a lower rate of acknowledging risks of all kinds of corruption in the health sector.

Some selected quotes from interviews:

- *“Not from the public hospitals, but they are taking goods, medicines, money and equipment from private sector hospitals and from the drugs companies. They are not hiding this at all.”*
- *“Yes, up to the senior level, they are involved in the embezzlement of public goods: Using vehicles for their children sometimes carry other personal goods in the public vehicles.”*
- *“At the Provincial Health Directorate, I think there are some corruptions because they get overtime while you cannot find them after 14:00 in afternoon.”*
- *“According to presidential Decree and salary policies Administrative staffs cannot get overtime. But here in <XXX> province, Administrative staffs are also getting overtime, even for Fridays, while they are not present nor do they need for it because the work is not so overloaded to give overtime. This also can be an embezzlement of public funds.”*
- *“The Provincial Director himself is complaining about the <XXX> Program, and then he cannot stop them. It means that the embezzlement is originated at MOPH leadership level.”*
- *“Yes they are involved, but I cannot specify because I am afraid.”*
- *“Our own Director is involved: Hospital food supplies and fuels are stolen regularly.”*

**“Is overtime distributed based on volume / quantity and quality of work?”**

- > While many respondents had no information and no opinion, a significant minority (about one third, from all areas of the country) cited specific examples of problems related to overtime.

Some selected quotes from interviews:

- *“The Administrative staff have overtime, but are not available even after 12:00 on official days then how can we say they are distributing the overtime according to quantity and quality?”*
- *“No. The system is unfair. All Specialists are listed for overtime pay. None of our support staff have this privilege. The arrangement is made from relations with Director.”*

- *“Our staff are confused because the lists do not match the real situation. Some are getting 100% overtime pay and they are not doing this at all; low level Ward staff do not get any opportunity for extra pay but they are doing the extra hours and night shifts each week.”*

**“Are there risks of corruption in how overtime is paid?”**

- > The cash payments for overtime were cited as the chief risk of corruption, compared to regular salaries that are generally paid through transparent channels.
- > Respondents also described overtime pay as subject to arbitrary or unexplained delays, mismanagement, and discrimination.

Some selected quotes from interviews:

- *“When overtime is a contradiction to policies then surely payments are also corrupted. For example they pay to ambulance driver half of the amount that is paid to the driver of Health Director, who is never on night duty. The ambulance driver is working many nights each week to cover demand.”*
- *“They are not paying us on time for overtime and this is corruption.”*
- *“It is paid by cash, so they are taking some of payment from each person in their own hand. The more that is earned, the more they will take.”*
- *“Yes. But the reports and procedures are not matching. The night duty fees are distributed to all enlisted, if they are on duty or not.”*
- *“According to regulations managerial offices should not get overtime but Administrative employees get it at hospitals while they are not having any night duty.”*
- *“...central Audit Officers only check reports; signed report are always considered transparent by them, even though it is clearly not correct.”*
- *“No, there is no risk of corruption in the payment system of overtime, but, if hospital staff wants to receive overtime pay without difficulties, they are giving 20-100 Afghanis to the Cashier...”*

**“Do you think MOPH leaders are aware of these problems?”**

- > All respondents whom had cited examples of problems with overtime were confident (or adamant) that MOPH leaders are aware of the practices.

Some selected quotes from interviews:

- *“Yes, MOPH leaders are aware of such problems: They are telling staff, ‘Do not give gifts or extra money to the Cashier because it is his job to distribute compensation money to the hospital staff. They get their own salary for this purpose.’ But they do not control the situation.”*
- *“Yes, they are discussing at Provincial Health Department themselves.”*
- *“Of course, all know this situation.”*
- *“Yes, because they are doing these things.”*

## **Nepotism**

**“Do you believe MOPH Managers / staff give priority to their relatives / friends / own group when hiring staff?”**

- > Nearly all respondents in this category affirmed that there are instances when relatives, friends, or other in-group associates are given priority in hiring of staff, including several who noted this had been a feature of their own hiring process.

- > Many commented that the practice is considered commonplace, routine, or a regular part of human resource management where they work.
- > The practice of giving priority or preference in hiring was described by respondents from all parts of the country, in all settings, and often explained in terms of sustaining particular needs for trust in the workplace, promoting reliability and cooperation, and fulfilling in-group responsibilities and obligations.
- > Those respondents who had endured previous rejections in a hiring processes, frequently pointed to the inverse of these same factors: Not having had a discernible connection, not sharing any affiliation, or having been from a different tribe, Party or other group from the decision-maker.

Some selected quotes from interviews:

- *“This is routine, normal, regular way.”*
- *“Everyone is facing this situation. All levels of workers must have connection or they will be the one without any hope of joining. It is the reality.”*
- *“Yes, some of the time they give priority to their relatives and friends in recruitment.”*
- *“Yes, they are doing such things; whenever positions are vacant they are deploying their relatives and friends. Even my position of <XXX> was given to someone else and I have more than 8 years’ experience in this position. <XXX> was trying to recruit his relative, then, I call one of the political leaders and he pressurized him and I succeeded to join in this position.”*
- *“Of course. How else can all the Managers under the Provincial Director be his relatives?”*
- *“In hospitals the work must be a team work. But at upper level of management, the teams are set in accordance to special group or political interests and gathered into same working groups. It means the teams are not based on work, but work is based on groups.”*
- *“It was impossible. Even though I am also <XXX>, I was not from his Party, so there was no chance for me. I could not succeed even with my qualification and exam result.”*

**“Do you believe MOPH Managers / staff give priority to their relatives / friends / own group in providing health services?”**

- > Respondents had more diverse beliefs about whether priority is given to relatives, friends or in-group associates in health services delivery, compared to hiring.
- > The majority of respondents described this as being a commonplace occurrence.
- > A small number of respondents denied knowledge of relatives, friends, or other associates receiving any preferential treatment; notably, these respondents worked in roles outside of service delivery.
- > A few respondents were unsure or did not know.

Some selected quotes from interviews:

- *“Yes, some give priority to their relatives.”*
- *“I have seen that some provide support for faster service for their relatives, but other health service delivery is the same for all patients. I think these relatives should wait for their turn.”*
- *“It is common in Afghanistan.”*
- *“Every day. In all parts.”*
- *“It is not happening in our clinic because we are distributing numbers and based on the numbering checking the patients in correct order.”*
- *“Priority to relatives and family members is a part of culture now, but services are delivered equally. There is no preference for relatives if an emergency comes to our facility.”*

- *“The system is deranged by MOPH Directors coming with a friend or relative, ‘Take care of my close relative,’ and making the community wait. We cannot argue or they fight and yell.”*

**“What are the controls MOPH employees can use when they find there is a violation of Human Resources policy?”**

- > Respondents in this category, from their position as non-management members of the workforce, reported limited and non-existent options to address violations of Human Resource policy.
- > Several respondents expressed fears and concerns about consequences if they were to draw attention to violations of policy.

Some selected quotes from interviews:

- *“From Directors and Managers side: Frequent monitoring and evaluation by the implementing NGO, Provincial Public Health Department staff, and sometimes by the MOPH central M&E staff; from employee side, like me: Zero, nothing. How should I have any power here?”*
- *“No one will do anything.”*
- *“Nothing. We have to be silent or we lose our job.”*
- *“Not clear. It is always insisted by the Managers, ‘We will implement the policies,’ but the percentage of deviations is higher than the actual policy implementation.”*
- *“How will keep this job if I say something to criticize my Manager’s behavior?”*
- *“Before, we had Comments Box on the wall near Administration Office. There were some few complaints from patients, and there were many complaints from staff about each other and the Manager. The Box was removed after only one month!”*

**“Are applicants informed about vacant posts with enough notice to make applications? Is this a risk of corruption? How?”**

- > Respondent comments were generally negative and reflected suspicion about the lack of transparency in the process of posting vacancy notices.
- > Respondents from outside Kabul were especially critical of the lack of information on vacancies and the short timescales to make applications.

Some selected quotes from interviews:

- *“This process is not transparent. Whatever they want will happen in their favor, just this is some kind of game... or putting soil to other eyes that we are taking exam and based on competency selecting staff... this all is just cheating with MOPH.”*
- *“My position was only posted for two days and a colleague at MOPH called me to tell it so I still had my chance for making application. Without a friend to give notice of posting, how can anyone visit their office each hour for such processes? This is designed to prevent fair competition. They are protecting vacancies for their close friends.”*
- *“The Human Resource Department is careful to control timing of these notices of vacancy. How can we believe this is transparent if the notice is posted for less than one full day?”*
- *“I think this should be enough time when they make announcement. Still some complain.”*

**“Do you believe removing (‘cutting’) names from written exams prevents corruption?”**

> In early interviews, exam processes, as part of hiring, had been described as being vulnerable to corruption and discrimination. The removal of names from exam papers (effectively making them anonymous) was considered a viable approach to reducing risks of corruption, though this tactic was not universally regarded as likely to solve the vulnerabilities.

Some selected quotes from interviews:

- *“Yes, it prevents corruption and discrimination.”*
- *“No, there is no cutting system at the provincial level. There is risk of corruption even in the cutting system as well.”*
- *“It should help.”*
- *“It can prevent corruption in exam process.”*
- *“I hope it will prevent bad behavior, but those with this goal will find another way.”*
- *“No: Job is already given to some other one due to other reasons, not exam process.”*

**“Do you believe MOPH leaders are aware of these problems?”**

> Among respondents in the category, only a few believed that MOPH leaders were (or might be) unaware of these problems with nepotism or abuse of power in human resource management.

Some selected quotes from interviews:

- *“Yes, well aware in all cases.”*
- *“For sure.”*
- *“If they deny this they are liars.”*
- *“Maybe they are. I am not sure. It will be hard to see how they do not know.”*

**“How would you describe the availability and fairness of employee privileges and benefits? (training opportunities, incentives)?”**

> Respondents in this category were uniformly frustrated and disappointed with access to training.  
> Several respondents gave accounts of first hand observations from their workplace that demonstrated favoritism and preferences based on affiliation and relationships.

Some selected quotes from interviews:

- *“The training opportunities are only for the relatives of the Director. He is giving reward to his family and friends. The system is controlled.”*
- *“We are not receiving training opportunities. The MOPH HQ does not notify our doctors of abroad trainings, they have a reason, I am sure, but I believe it is for friends and relatives working in their offices. How can no one from <XXX> in <XXX> be selected in four years, but the staff in <XXX> in HQ have gone more than once some of them?”*
- *“Trainings are privileges and kept mostly for General Directors and Managers at MOPH HQ. For training abroad, even the hospitals are not informed or the Hospital Directors are directly contacted and selected. For training workshops held inside the country mostly hospitals and or Provincial Health Directorates are informed. And at hospital level again good relations with the Directors controls the decisions.”*

- *“Capacity building is an honor given usually to General Managers and Directors; for lower Managers and Officers it is an incidental luck.”*

## Quality Assurance / Quality Control

### **“How do you perceive the accountability and transparency mechanisms in MOPH on its Leadership, health services delivery, human resources management, or its financial management?”**

- > The mechanisms that promote accountability and transparency were generally well known or familiar to the respondents in this category: Many were able to describe different types of systems to monitor its processes and control its resources.
- > Most respondents were critical of the reliability or the coordination of these systems.

Some selected quotes from interviews:

- *“The health facility has been supervised and monitored on regular basis by Provincial Public Health Officers, central M&E staff, implementing NGO, and even monitored by provincial council members as well.”*
- *“Not hundred percent accountability and transparency in all areas because the leadership problems exist: They are recruiting their relatives at the Ministry level, such as Human Resource Manager, which in this province is a close relative of <XXX>. In this situation, how can someone stop nepotism at the provincial level if it was nepotism that is responsible for staffing selection in each area? We are facing problems like this and hardly ever will find transparency in the financial management or human resource management or health services delivery.”*
- *“No one is monitoring remote health facilities – only nearby health facilities been monitored.”*
- *“It is not clear: Either we are mutes, or MOPH is deaf.”*
- *“I only can say that corruption is governing the system. There is no transparency at all. Reports are manipulated, and accountability is not implemented in any way: Political relations, close friendship with Directors, and so on, are more preferred than reality.”*

### **“What can staff do if they find lack of accountability or transparency by the Managers or other MOPH workers?”**

- > Most respondents expressed frustration and disappointment in the limited options available to them for taking action if they face lack of accountability or transparency.

Some selected quotes from interviews:

- *“If we observe such lack of accountability or transparency in the management, we will discuss with other Managers directly, or if not resolved, then inform MOPH authorities regarding this kind of problem in the management of the hospital.”*
- *“Nothing.”*
- *“Lower staff doing nothing regarding lacking of system for transparency and accountability. We can see that every Director is supported by some Parliament Members or higher management at MOPH: Silence is better to keep the post for longer time.”*
- *“We are discussing with our Manager, but they are not listening to this issue.”*
- *“On weekly basis we have Provincial Health Office meetings and in these exchanges, we are discussing any issue available at the province.”*

**“Are posts filled on the order of the MOPH leadership instead of on a competency basis?”**

- > Respondents in this category were roughly equally divided into three opinions about how hiring decisions are made: Leadership decisions prevail; competency is the main factor, or combinations of both factors.
- > Only a handful of respondents with any opinion on this issue believed that competency-based exams are the sole factor in hiring processes.

Some selected quotes from interviews:

- *“Provincial positions are filled by the order of the Provincial Director.”*
- *“It looks like a combination in this province.”*
- *“Exams are a transparent process. I achieved my position this way.”*
- *“The question must be answered by the Minister, or at least the Human Resource Director.”*

**“Are weak employees referred to capacity building programs?”**

- > Nearly all non-management employees and frontline staff were dismissive of any opportunity to participate in capacity building programs when workers are found to have weaknesses.

Some selected quotes from interviews:

- *“Unhappily, the capacity building for Administrative part is not taken seriously.”*
- *“Never.”*
- *“They are advised to improve their work, but that is all.”*
- *“My experience has been that this does not happen.”*

**“How often does ‘The right person work at the right job,’ meaning, their skills match the requirements?”**

- > Despite insistence from two respondents out of 51, the vast majority of replies were negative or dismissive about the suitable match between skills of post-holders and requirements of the job.

Some selected quotes from interviews:

- *“Maybe 50%.”*
- *“Less than half.”*
- *“Not often, at least not in administrative level. You are here and you witness that our Manager and Officers even do not know how to calculate overtime and salary scales of the staffs.”*
- *“Anyone can see that this is a small amount if their eyes are open.”*
- *“There is no concern about how well skills match role; the criterion is relationship or not.”*
- *“Not very much, sadly.”*
- *“It could be 60%, but still this is not enough.”*
- *“I’m sure it is 100%, but still some will always complain.”*

## Human Rights and Discrimination

### **“How would you describe the role of community leaders in influencing MOPH Managers: Positive or Negative?”**

- > The comments about the influence of community leaders over MOPH Managers were mixed, with many reflecting on the potential for positive and negative effects: Positive influence was concerned with advocating for improved quality and expanded range of services in their respective communities; negative influence was related to violence, discrimination, and threats to achieve specific objectives (service delivery, construction of facilities, hiring and firing of employees.)

Some selected quotes from interviews:

- *“They have both positive and negative role in the health service delivery because they want their rights but sometimes create problems for healthcare providers; they want things which are not available or not mentioned in the MOPH policy.”*
- *“They have negative effect. They force health workers and threaten them.”*
- *“They can have very positive role but unfortunately they are always thinking of self, not nation.”*
- *“They have negative role. They come during the night and threaten all the doctors. They make us nervous. They have bad behavior with us.”*

### **“When have MOPH Managers successfully resisted the influence of community leaders?”**

- > These respondents described resistance to the influence of community leaders (often armed Commanders) as risky, negative, and having dire consequences – especially compared to responses from Director, Managers, and leaders on this same issue.
- > Many of these frontline staff had first-hand experience of being threatened or subjected to violent reactions when they had been faced with a community leader trying to influence them.

Some selected quotes from interviews:

- *“No one can resist against community leaders because they have the power and are supported by the MOPH leadership as well.”*
- *“Rarely. Our MOPH Managers have adapted with the requirement of community leaders.”*
- *“There is no answer for this. Hospital Directors and or General Directors in MOPH HQ are supported by community leaders and MPs. The Minister is just lowering the political pressure because Director of <XXX> Hospital is brother of an MP, Director of <XXX> Hospital is son in law of another MP, our Director of <XXX> Provincial Health Directorate is son in law of the Governor, and so it goes on and on.”*
- *“They cannot resist.”*

### **“How would you describe the role of community leaders in influencing health service delivery?”**

- > As above, respondents were generally negative about the influence of community leaders regarding health services delivery.
- > Most respondent comments were concerned about threats, violence, and pressure motivated by localized contexts, and a few pointing to the potential for pressure that could be focused on improving quality.
- > Most of the mixed positive/negative comments came from respondents in provinces without any large cities; notably, first-hand accounts of a large number of physical assaults against health sector workers came from these same settings.

Some selected quotes from interviews:

- *“Whatever they want they will get it.”*
- *“...there is pressure on the health facility staff from community leaders – and the supervisors listen to community leaders, not to the staff in these cases.”*
- *“They can change the decision of MOPH about location of a health center from one place to another. They can swerve budget lines, and even they can ban health service delivery at a hospital level. So they have power, and if used positively, can develop programs and support achieving assigned tasks of MOPH very successfully. They can also completely destroy integrity and impartial basis of MOPH service delivery.”*
- *A lot of pressure from powerful persons exists at health service deliveries. We are daily victims of violence if a patient dies.”*

**“Is there political pressure on management of health services delivery? Is it helpful or harmful?”**

- > In every part of the country and each type of setting, respondents affirmed that there have been political pressures on the management of health services delivery.
- > The descriptions of political pressure were varied, with a majority negative (distractions, diversions of resources, pressure to change service configurations, and human resource decisions related to service delivery roles), though positive influences were also described (resolving security issues and promoting an emphasis on greater gender balance among workers in remote communities.)

Some selected quotes from interviews:

- *“Political leaders have helpful and harmful role in the recruitment process and also in the health service delivery.”*
- *“Yes, it is harmful because sometimes we have to leave our priority and give chance of control to political leaders.”*
- *“There were some negative pressures from police forces in our clinic but we shared the issue with NGO headquarters, Provincial Health Directorate, District Governor, and community elders; that resolved the conflicts.”*

**“Do you believe these pressures and influence reduce discrimination or promote discrimination?”**

- > Nearly every respondent in this category described the pressures and influence of powerful persons as likely to increase or promote discrimination.
- > Notably, many of these non-management employees and frontline staff had first-hand experience of negative pressure and influence from powerful persons, including physical violence, so it is not unexpected that there are few mentions of positive outcomes from their interventions.

Some selected quotes from interviews:

- *“It will increase discrimination because they will give priority to one ethnicity and ignore another.”*
- *“Yes it increases discrimination because giving priority to one leader and their relatives is not giving priority to whole community.”*
- *“They are thinking and behaving for the interest of their own group and nothing else. Definitely it is to make sure that discrimination is enforced.”*

**“What is the role of community leaders in management of MOPH human resources?”**

> As above, respondents were generally negative about the influence of community leaders regarding human resources.

Some selected quotes from interviews:

- *“Community leaders have a role in the human resource management especially at the health facility in the selection of Community Health Workers and vaccinators.”*
- *“They can put so much pressure that MOPH will follow their ideas, no arguing.”*
- *“Community leaders are too powerful here. If they say ‘sack him,’ the person is gone the same day.”*
- *“They are putting pressures on our Directors a lot. Our last Director resigned from so much difficulty from community leaders. He could not control their ideas and now we just expect them to have the influence so it is perfectly clear about the power in this District.”*

#### **“Is there political pressure on management of MOPH human resources?”**

> Most respondent comments were concerned about pressure and intimidation over hiring and firing.

Some selected quotes from interviews:

- *“Yes, absolutely hundred percent political pressure has a role in the human resource management of MOPH.”*
- *“There is no question about this: If I am found to be explaining any details about this situation, I will be killed for telling the truth. <XXX> is violent and dangerous.”*
- *“Of course. They can make all decisions with this kind of relationships at management level.”*
- *“The Parliament Member who lives near <XXX> has the best chance to control the Director from their close friendship and relationship. Whatever his idea, it will happen. He tells everyone in the community, ‘You cannot make any decision without my approval,’ and it’s true.”*

#### **“Do some employees receive certificates without attending (or completing) the workshop/training?”**

> Respondents reported a broad range of reactions to this question, from absolute denials that it could happen to admission that they themselves had personally experienced it.

Some selected quotes from interviews:

- *“Yes. I attended a workshop only for two days, the first and the last day, while it was for one week and I received my certificate.”*
- *“I don’t think so.”*
- *“Naturally, this is happening. They do not control the attendance sheet very strongly.”*
- *“The list is signed by one hand for each person, and they are not attending themselves. When I asked, ‘Where are the other participants from yesterday?’ My colleague just laughed at me. They had all gone shopping and to visit relatives. The training in Kabul was reward and holiday for them. It was technical training, so I was disappointed.”*

## **Extortion**

#### **“How do MOPH workers manage pressure, threats, or extortion?”**

- > Nearly all respondents expressed worries or concerns about the issue of pressure, threats, and extortion they face as a routine part of their jobs in the health sector. These comments were gathered from every part of the country and in all settings.
- > Non-management employees and frontline staff reported resigning, abandoning their jobs without giving expected notice, avoiding roles that were associated with higher exposure and risks, fear, and emotional distress.
- > Several respondents described warnings from Managers or Supervisors that the employee should stop complaining about pressure, threats, or other types of workplace abuse.

Some selected quotes from interviews:

- *“It is very difficult to manage pressure or threats from political leaders; sometimes staff leaving their job because of a lot of pressure from the political leaders.”*
- *“We cannot do anything. If we resist, there is violent action.”*
- *“I am so afraid of what can happen. I do what I have to do for safety in these cases. Gunmen are allowed to come into our Emergency Department when powerful person is here with his relations. They are shouting and dangerous.”*
- *“If a powerful person from Government comes here, they will make threats of writing complaint against us to MOPH HQ and have us sacked. It has happened. Dr. <XXX> was sacked after he did treatment of the Commander from <XXX> and it was very difficult. Dr. <XXX> did nothing wrong. But the Commander was feeling pain and used his relationship to get revenge on him. We were so sad from this happening.”*
- *“I have asked for support from my Manager, but he told, ‘Stop this because you are making trouble for me with Dr. <XXX> at Public Health Directorate. Do what he says. Stop complaining about his having this behavior.’ Why should we be forced to accept the yelling and threats from powerful person because of pain they have? Other patients in the Ward were afraid and asked to be discharged too soon. No one wanted to do their shift when Dr. <XXX> was there.”*

**“What are the risks or benefits of resisting extortion?”**

- > Respondents described resisting extortion as a risk in all cases, including violent repercussions.

Some selected quotes from interviews:

- *“If resist and not succeed we may lose our job. It can be violence sometimes. Who is not worried?”*
- *“Resisting against extortion have both risks and benefits, if staff resists and there will be pressure on them may become upset and not perform well or leave the job. But if success in the resistance, they will never face such problem in future and will be happy forever.”*
- *“Have to leave job or accept their requirement.”*
- *“There is problem of the situation becoming worse when we try to resist. These are violent people who make demands.”*
- *“If the Minister himself would accept this behavior for his son or relative treating powerful person, maybe I will be changed. But we know that leaders here put us in the front when a patient is making some threat to kill everyone because of their pain. Our two cleaners have been struck several times and attacked by patients. How can a cleaner solve the problems of pain for the patient if the doctors themselves are afraid and will not come to the Ward? The sons of one Commander here kept telling me, ‘Go and get stronger medicine for my Father or I will kill all of you.’ It is not safe here.”*

## Fraud / Falsification / Fakes / Forgery

### **“What is your perception about quality of drugs procured by National NGOs and INGOs?”**

- > Among non-management employees and frontline staff, there was near universal criticism of the quality of drugs and pharmaceuticals.
- > Neutral and positive comments came from respondents working in settings where pharmaceuticals had been sourced from International Dispensary Association (IDA), however, none could comment on the actual level of quality since they had not been involved in laboratory analyses of these items, nor had any of these frontline staff seen quality control reports on these items.

Some selected quotes from interviews:

- *“Drugs are procured by Drug Committee which is consisting of three staff. Various companies are importing drugs and there is proper system to do quality controlling, but somehow, I am not sure, quality of drugs are usually compromised. So, our Committee is purchasing low quality drugs to fulfill the requirement of community. These are not effective.”*
- *“It is our concern because patients are not getting cured with drugs available in the health facilities and they are going to neighbor country for treatment.”*
- *“Drugs quality is low all over the country. It is better to solve this problem very seriously through MOPH directors in Kabul.”*
- *“It’s no so bad. I still have worries about it sometimes.”*
- *“We are getting our drugs from IDA system and they are better, I think, but I am not chemist.”*

### **“How strong or weak are the financial audit processes of MOPH financial resources? Is there risk of corruption?”**

- > As non-management employees and frontline staff, this category of respondents frequently responded, *“I don’t know”* or *“I’m not sure,”* though several were able to articulate specific risks and vulnerabilities despite several control system and protocols designed to prevent corruption.

Some selected quotes from interviews:

- *“Implementing NGOs finance process is very strong because looking for every single Afghani.”*
- *“The Auditors cannot visit the remote clinics since the security is worse. They are still making their report to central MOPH with approval of our reports.”*
- *“We could not manage without our payment of salary for three months. But still the Finance Director is approved for special benefits and support by the Director. He is having some relationship with the Auditor from Kabul, but I’m not aware what it is. We cannot see the real situation.”*

### **“Do you believe there is any falsification in the reporting systems on health services delivery?”**

- > There were widely varied responses to this question, ranging from absolute denials, to specific examples within areas of a respondent’s workplace where falsifications in reporting were commonplace and considered routine.
- > Perceptions about system integrity and reliability varied, with some respondents citing many layers of checks and re-checks that ensure the consistency of accurate reporting and others describing a vast scale of misreporting or misrepresenting data within their Department, Unit, or facility, some with the knowledge or complicity of their superiors.

Some selected quotes from interviews:

- *“I think it is not possible for the reporting to be incorrect. The central MOPH inspectors are coming to see each detail.”*
- *“HMIS is implemented and we report all our services according to it. How it is used by upper management is not clear.”*
- *“No. Never. It is not happening. All reports are checked and checked again.”*
- *“Yes. Falsifications in detecting mortality causes, fake reports showing higher rates of service delivery, and forgery in budget expenses.”*
- *“There are falsified results every day. The situation is difficult. Powerful people can control these processes with threats. Money is making a bad situation in this. I am afraid.”*
- *“Definitely, yes, the vaccinator cannot be reaching the target of 20 persons and still he writes ‘20’ on his sheet so his payments are not cut. I asked his actual number and he said, ‘not 10.’ How do we have trust if the Manager then reports the 20 and no one is aware?”*
- *“The Laboratory is supposed to have some units of whole blood at all times for emergency cases, and this is written on their Log as ‘complete’ but when we have nothing, it is still ‘complete.’”*

**“How big is the problem of fraud / falsification / fakes / forgery in MOPH Human Resource hiring and promotion?”**

- > The vast majority of respondents from this category described these problems as serious or widespread; a few denied there were any risks.
- > Several respondents believed that the extent of fraud, falsifications, fakes, and or forgeries in the health sector undermines the quality of patient care.

Some selected quotes from interviews:

- *“Extraordinary types of forgery and fakes exist. At MOPH HQ there are many files filled with these forged certificates and fake medical degrees.”*
- *“Many of our doctors have falsified documents to join specialist program. It is normal.”*
- *“Who is thinking these are correct and true? It is simple process for buying certificate.”*
- *“Very big issue, I think. When they came from <XXX> to check on our files, the leader of their team said he was surprised that every file had some false documents or suspect documents in it.”*
- *“There is no risk of corruption in recruitment or hiring at this hospital.”*
- *“I don’t think this is a problem. I don’t think so, no.”*

## Conflicts of Interest

**“What are the risks when Public Health providers refer their patients to private sector for diagnosis or treatment?”**

- > Most respondents acknowledged that referrals from the Public Health clinicians to their private sector services are happening; however frontline staff from more remote provinces with low levels of development pointed out that there are few private sector health services in their area, so these referrals are infrequent.
- > Respondents believed there were different risks from this referral pathway: Weakened community trust, public sector health services being undermined, and the perception that referrals are being made for purely financial gain.

Some selected quotes from interviews:

- *“Here the doctors do not refer patients, because here are less private clinics.”*
- *“The risks for corruption are facilitated by lack of diagnostic tools in public hospitals.”*
- *“The salary of hospital staff is low, so they are sending patients their private clinic or hospital for getting more money. If MOPH gives enough amount of salary, why will staff refer patients to their private sector clinic?”*
- *“A huge amount of money is spent from the pocket of patients for examinations in private sectors, and the public sector doctors and nurses get their commission fee from the private sector for referring the patients.”*
- *“Public resources get spoilt, and service effectiveness in public service centers are lowered.”*
- *“People are not taking a strong and serious step against the issue and consequently MOPH leadership also ignores taking any action. Even they are excusing it by explanation of ‘Low salaries on Public Sector is to blame.’ The conclusive outcome of this is firstly affecting the people, and then by extension, goes to international unreliability.”*

## **Bribery**

### **“How big is the problem of ‘extra payments’ or bribes in the Public Health sector?”**

> Most respondents cited examples of ‘extra payments,’ but only a few expressed opinions about if this is a problem or how important it might be; if they did express an opinion, it was often strong.

Some selected quotes from interviews:

- *“In some of the Departments it is very big problem...”*
- *“Particularly the Gynecology and Obstetrics Ward: Support staff are demanding money.”*
- *“No times have families had surgery here unless they give some money to the surgeon or his team. If they refuse, it is a bad situation.”*
- *“The surgeon, Dr. <XXX>, is always complaining, ‘The people here are too poor and cannot pay me the correct amount.’ But he is on hospital salary and also getting overtime pay and benefit from <XXX>, the donor of Specialist Training Program here. He is earning so much and makes bad comments about the poor people. We are ashamed by him.”*
- *“The OB/GYN doctor and her husband who is surgeon are both very angry if anyone refuses payment to them for fast service. They are lazy and only want more money even after they get salary and benefit from having relationship with Director of Public Health.”*

### **“What are the risks of ‘extra payments’ or bribes in the public health sector?”**

> Non-management employees and frontline staff described transactions between colleagues and patients or their families, small amounts of cash or gifts were received following procedures or deliveries. These were referred to as routine, normal, and commonplace, and not associated with any risks by most of the respondents; some insisted these were not a form of corruption.

> There were also instances when the respondents in this category described episodes when very large amounts of cash were sought by higher-level clinical staff and Specialists, generally ahead of performing their work, and many of these were cited as examples of when Management took action to enforce consequences and punishments.

Some selected quotes from interviews:

- *“At the health facility, staff is not taking money from the patients, but taking ‘sherinee’ or gifts from the patients after baby is delivered.”*
- *“We are having risk of every piece and part touching some kind of corruption.”*
- *“The changing of the drugs from agreed quality to lower quality by payment to these companies is shameful. It is making risk for all patients and their recovery. No one will trust the Pharmacist; he is business man, not having any technical background.”*
- *“Our midwives are asking for ‘sherinee’ after delivery. This is part of their income and they are earning extra money each day in here. It is known and accepted by our Manager. This is proof that our Public Sector leaders will not be interested to stop corruption.”*
- *“There are the ‘sherinee’ gifts, but it isn’t corruption, just a gift for good work.”*
- *“One of our <XXX> doctors was sent to Prosecutor for demanding Afs30,000 from his patient for the treatment.”*
- *“It is usually so small of amount and families are offering ‘sherinee’ by choice... A surgeon was asking Afs20,000 and he was handled by Manager for this; he was taken to prosecutor.”*

**“What is the official policy about MOPH staff asking for (or demanding) bribes from patients or their families?”**

- > All respondents who answered this questions were able to articulate that asking for (or demanding) bribes is a punishable offense based on rules, official policy, or Law; no respondents stated that such behavior is allowed or should be acceptable.
- > In practice, the rules, official policy, and Law are selectively enforced; in particular, traditions related to ‘sherinee’ or gifts were often (but not always) considered minor infractions, harmless, or unimportant.

Some selected quotes from interviews:

- *“Policies require punishment for bribery in public services but it is not implemented.”*
- *“Policy is clear and the committed person must be reported to jurisdictional departments. But no one is doing this.”*
- *“It is not allowed. Still it is happening every single day.”*
- *“Everyone knows it is against rules. Our previous Manager had a lot of fighting with staff in every part of the hospital because community was complaining all the time about ‘sherinee’ and gifts and bribes. He was threatened on by MOPH for stopping the ‘sherinee’ in OB/GYN.”*

**“Do Human Resource staff take bribes to limit delays in the recruitment process?”**

- > Respondent answers were in two groups: The majority affirming this practice, often with a first-hand account, and a small minority stating they do not know if it is happening or not.

Some selected quotes from interviews:

- *“At Ministry level such things are happening. I had to do it or maybe never achieve my position.”*
- *“In the Ministry they are taking money against difficulties in the recruitment process. They are taking 3,000-5,000 Afghanis to accelerate the process.”*
- *“When I was trying to have my position here, the Human Resource worker at MOPH told me he was too busy and not paid enough. He wanted me to agree some amount to him so I could get this job and I did pay it. If I don’t then he will never put my papers for signature. It is the usual way.”*

- *“Of course.”*
- *“Where is this not happening? You are asking the question but you know already that there is no other way.”*

### **“Other Risks” of Corruption**

**“What can you tell us about any other risks of corruption in the Public Health system?”**

> There were no unique additional risks of corruption identified by these respondents.

# 3. FINDINGS: OTHER STAKEHOLDERS, INCLUDING HEALTH SECTOR IMPLEMENTERS, CIVIL SOCIETY, COMMUNITY LEADERS, AND POLITICIANS \*

**OVERVIEW:** Other stakeholders, including health sector implementers, civil society agencies, local and international non-governmental organizations, community leaders, and local, provincial, and national politicians described many types of experiences and observations to illustrate the vulnerabilities of corruption in the health sector. 49 respondents from all regions of the country provided information about health sector corruption under every one of the topics covered in their interview.

**The most detailed comments about risks of corruption related to:**

**1. Leadership and governance:** Conflicts of interest, influence from powerful persons, weakness of contract enforcement, lack of will to impose coordination across multiple actors and stakeholders, failure to address the low level of cooperation among health sector implementers.

**2. Finance:** Lack of transparency in NGO and INGO contracting processes.

**3. Human Resources:** The pervasiveness of nepotism, lack of transparency and conflicts of interest in recruitment and hiring, and the influence from powerful persons.

**4. Health Service Delivery:** The integrity and reliability of monitoring, the enforcement of consequences for failures in fulfillment of contracts, and mixed perspectives on the negative and potentially positive role of community leaders.

Notably, the respondents were largely focused on the perception of conflicts of interest and the lack of transparency in management of the health sector. More than half of these respondents were Directors, Managers, or frontline staff in NGOs and INGOs and they were among the most critical in their comments about the lack of transparency in health service delivery contracting, often regarding the relationships of their own agencies to MOPH Directors, Managers and leaders and to donors.

\* Details that could identify individual respondents have been omitted.

## Policies

**“How are MOPH policies reducing or increasing the risks of corruption? Is this related to implementation, resources, or something else?”**

> Most respondents in this category cited *implementation failures* as a common factor in why policies did not effectively reduce corruption including intentional resistance from within MOPH, opposition and obstruction from powerful persons external to MOPH, and systemic weaknesses related to rule of law and/or insufficient resources.

- > Additional issues mentioned were *implementation difficulties*, including incompleteness of policies, obstacles to timely resource mobilization, weak coordination, and lack of technical information among Managers, lack of information among communities, and inconsistent monitoring and feedback.
- > A few respondents had particularly emotional reactions to the opportunity to describe their observations and perspectives.

Some selected quotes from interviews:

- *“They have positive effect in decreasing corruption if implementation is done well.”*
- *“HR policies, for example, when a person is resigning, the gap for replacing someone is far too long and creates risks; the nationally-set criterion for any role is inappropriate for each Province, but unfortunately the standards of what is recruited here needs a different level; salary level is not variable by Province but it makes recruitment impossible if there are no exception. Local MOPH does not agree to flexible standards or any change in rules. The local PHD Team does not agree to challenge with MOPH HQ in Kabul and this leads to weakness in Provinces.”*
- *“The policies of the MOPH are not implementable for us, since they are very strict and inflexible. MOPH policies discourage private sector from investment... If we want to follow the MOPH regulation, our businesses won’t be profitable at all and we have to spend all our resources on meeting the regulation... Medical tourism has become a huge sources of revenue for India; Afghanistan can easily prevent this huge flow of patient to India by supporting domestic private health sector, which unfortunately, we are seeing just the opposite of that.”*
- *“Lack of coordination among MOPH, BPHS and EPHS implementers, private sector, and other stakeholders is increasing risk of corruption in health services delivery.”*
- *“Policies are available but should be strictly followed and evaluated to avoid risk of corruption. Personnel should be oriented regarding the existing MOPH policies for their adherence.”*
- *“Problem is mainly in Act of “health service delivery free of charges,” because free from charges means neither the patient trusts the services, nor the provider feels importance of his work and it lowers the quality since he ignores delivering the services enthusiastically.”*
- *“Policies are incomplete, they need to be revised, renewed and developed to match the community demands...”*

**“Do you believe services have been delivered according to the MOPH policies and strategies?”**

- > Respondents described multiple impediments to aligning service delivery to policies and strategies, with leadership shortcomings and lack of cooperation or coordination frequently cited.

Some selected quotes from interviews:

- *“No, absolutely not. I actually took the time to find out the MOPH strategy for primary care and the actual delivery here in <XXX> does not at all match in any way with that. The local MOPH leadership have been weak and unable to get the implementers to stick to what had been agreed in Kabul for the provinces. The NGOs simply make excuses for not delivering on the BPHS contract BPHS and the strategy is then left on the bookshelf as a result.”*
- *“There are no consequences if the NGOs are refusing to coordinate effectively.”*
- *“We have Districts where there are no female physicians on staff in clinics. Why are the NGOs allowed to keep their contracts? It’s no wonder we have such disappointed local communities when it comes to primary care: Families will not compromise on the requirement of female doctors and nurses for their female family members, but NGOs are allowed to compromise on the staff they provide to these communities.”*

- *“No, there is not any follow-up from inspections, and outreach support to the Districts is weak. Also, no ambulance services are regularly provided.”*

**“Do you believe human resources have been managed according to the MOPH policies and strategies? What are the risks of corruption in Human Resource Policies?”**

- > No respondents in this category believed Human Resources in the health sector have been managed on the basis of MOPH policy or strategy.
- > Respondents from all parts of the country described human resources within the health sector as being under constant pressure from powerful and corrupted influences, especially Members of Parliament and other high ranking authorities.
- > Respondents described widespread nepotism, favoritism, and preferential human resource management based on relationships and connections, rather than competencies and merit.

Some selected quotes from interviews:

- *“Transfer of professional person from one place to other place, nepotism, and discrimination.”*
- *“I cannot find any proof of the MOPH enforcing consequences when contract holders fail to deliver in health services delivery. If they are required to provide a certain set of services, using a specific kind of mix of staff, but don’t, nothing happens.”*
- *“Absolutely not. When I go with our project staff and beneficiaries to the clinics in our District, there are no staff present, or they are not fully qualified. Why would the local community members have to accept that?” Failure to enforce contract requirements, that’s risk for sure. If MOPH are monitoring the service delivery, then how could they be following the policies?*
- *“The implementer NGOs give priority to their families and favorite persons in recruitment process.”*
- *“At least 50% s by policy but whatever provincial Directors or political leaders want will take place in the hiring process of human resources at the provincial level.”*
- *“Not verifying the certificates from Ministry of Higher Education for forgeries and fakes.”*
- *“The only vulnerable part of MOPH in <XXX> is nepotism: There are <XXX> persons from one family... according to normal procedure, it could be a few, but not <XXX> from one family.”*

**“Do you believe financial resources have been managed according to the MOPH policies and strategies? “What are the risks of corruption in MOPH Financial Resource policies?”**

- > Respondents identified several types of risks of corruption related to finance policies including, procurement practices, contracting practices, unreliability of monitoring systems, and weak controls.
- > Some respondents in less-developed provinces mentioned the existence of champions of quality or coordination in their working environments, with wide-reaching benefits to the overall health sector from the steps taken by these individuals.

Some selected quotes from interviews:

- *“Problem is in Procurement Section because it takes so long.”*
- *“Yes, fortunately, we have very active, qualified, honest PHD at the provincial level. He is qualified in a sense that he has command of proposal writing and understanding. He knows about staffing and contracting process as well. We have very good coordination, and he is eager to sit with us, and even during procurement of medicines he is helping us. Last month a delegation from the Internal Audit Department came and evaluated that budget process.”*

- *“No. Because the Parties want to bring their own group inside the Finance Departments of the Ministry. They succeed at this and it means they are putting their own relatives in these days – and the talented people are available but they are not allowed into these jobs. The jobs are for people from their own Party or group instead.”*
- *“Clearly, there is some kind of serious problem in the procurement system if the clinics in our District do not have the required basic medicines on hand at all times. It is not difficult to see that the procurement process is totally mismanaged. And MOPH is blamed for the clinic being weak.”*
- *“I don’t think the donors even know these risks. When the agencies that want to implement the contracts make their proposals to MOPH for the services, the staff in MOPH must get a percentage of the contract for themselves or the proposal will not be recommended to the donor. This is even at the very high level inside MOPH... The cut for helping to get approval of the proposal can be from 10% to 20% to 30% off the top. Without this cooperation, the MOPH will never recommend the agency to the donor for the contract.”*
- *“I want to mention here a point which is not a risk of corruption, but overall, has a very bad effect on the quality of health service delivery. That is, ‘least-cost’ criteria for winning the health projects. I suggest MOPH to determine a level, a red-line that no one can offer less than this amount. We have seen many NGOS that offer something very different and then while get the contract they embezzled and stole different parts of the project. They do not pay enough salary for their employees, they do not rent cars, they supply very bad quality medicines to save something for themselves and run the office. Therefore, the financial criteria of ‘least-cost’ should be changed.”*
- *“I have seen that our Provincial Director is focused a lot on quality. It gives encouragement.”*

**“Which policy of health service provision is most at risk and least at risk of corruption: BPHS, EPHS, Specialty Hospitals, and Private Sector?”**

- > There was not a consensus among respondents: Each of the Basic Package of Health Services, Expanded Package of Hospital Services, specialty hospitals, and the private sector policies were cited as ‘most at risk’ and also as ‘least at risk,’ according to their individual experience.

Some selected quotes from interviews:

- *“Provincial Health Department level monitoring staffs are not high enough capacity to supervise. They have low salary and low level of qualification and even these are not real in many cases. BPHS is suffering corruption from this.”*
- *“EPHS is very successful policy, compared to others, with less corruption.”*
- *“BPHS policy has more risk, because of security measures, could not be regularly monitored and evaluated by MOPH and other stakeholders in the country. Private sector is also highly corrupted because of political pressure on the MOPH and taking permission without implementing at least minimum standards of MOPH.”*
- *“EPHS and specialty hospitals have less risk as they are mainly located at the capital of the provinces and each individual have access to it and can be easily monitored and evaluated at any time of the day or nights.”*
- *“...without strict evaluation and law enforcement, then the policies are each at risk. Specifically, the regulations of private sector make it very risky for corruption.”*
- *“EPHS policy is most at risk of corruption because the big bulk of procurement is there, such as medical equipment, medicines, ambulances, fuel expenses.”*

## Contracts

### **“Have MOPH priorities been ignored because of corruption?”**

> This was affirmed by many respondents and associated with a lack of resources, pressure or influence from those with power who seek to exert control over processes and resources, mismanagement, and poor coordination.

Some selected quotes from interviews:

- *“Yes and the community suffers directly as a result. We have no specialists in the province which are required by EPHS and BPHS but the NGOs still have their contracts and will probably be allowed to renew.”*
- *“Yes. In the past, we faced a big struggle over quality because a number of our doctors had connection and link with private sector and we fired them. For the moment, I don’t think there is any kind of connection between hospital doctors and private pharmacies.”*
- *“Our system should be focused on healthy conditions. MOPH should more be focused on clinics and hospital buildings as correct infrastructure. So far, MOPH did not monitor construction projects and the buildings are in a very poor quality; in some Districts the buildings are destroyed even before its opening, in cold places, the warming systems are using coal and wood in the rooms which is not healthy for patients. These mistakes are against MOPH priorities.”*
- *“All steps of private hospitals permit issuing process is vulnerable to corruption and without paying bribe it is impossible to get the permit. Our system has allowed the development of parallel services to grow from corrupt process.”*

### **“What are the risks of corruption in the contracting process of health care services to implementing NGOs and INGOs?”**

> Respondents expressed frustrations and disappointment that health services contracting processes appeared to be technically compromised, driven by pre-existing relationships, or leveraged for financial gain of those involved in decision-making roles.

> Examples were cited of incomplete contract implementation and failure to deliver results; several respondents expressed concerns about weak or inconsistent monitoring by MOPH, and failures to impose consequences when implementation had not been achieved.

Some selected quotes from interviews:

- *“Lack of monitoring after implementation of contract from the side of MOPH.”*
- *“Corruption risk is from the implementation side.”*
- *“Clearly, failure to deliver is not an impediment, and quality controls are not accounted for at all – or we would have a different group of NGOs holding contracts of the primary care services here. If it’s not corruption within MOPH, then it’s incompetence, which is also a sign that MOPH itself must be corrupt to keep incompetent staff in place who are not overturning failed contracts or forcing performance changes by these implementers.”*
- *“The bidding and contracts process are at risk of corruption.”*
- *“There is risk of corruption with NGOs because most of the times MOPH is contracting with only a few NGOs, changing the provinces, and ignoring other NGOs who want opportunity.”*
- *“They are not going to do according to policy – they are not efficient to find the talented or committed organization who want the contract; they are choosing the ones that are offering the bribe. Then, those NGOs will not implement according to the contract because they are not hiring by policy, not buying medicine according to procedure; the MOPH are not controlling the NGOs with weak implementation because they have paid some money to this person inside MOPH. The*

*community may complain to MOPH about the new implementer, but the MOPH will not take action because they had relationship of money to give the contract: If the people try to raise this complaint to local Government they will also not succeed because they have a connection to the high level politician or MOPH in Kabul which will lead to complaints being ignored.”*

- *“The risk is about the money. The staffs in the INGOs are pressured to give some part of the money to the MOPH to get this contract. The internationals inside the INGOs may not know this is happening with the local staff, but they are involved. Even in the donors, there are Afghans making some deals for the agreement of the contracts for their own benefit. It is very large amounts of money. I told one of the donors, <XXX>, at <XXX>, about this.”*

> What did <XXX> say?

*“She was angry and told me ‘This is a huge disappointment.’ I said to her, ‘Also for us!’ She was upset because the funding they give to Afghanistan is from the taxpayers in her country and they want honest behavior. She told me they will make a Proposal Evaluation Committee inside <XXX> to look closely at all the different proposals without the input from MOPH about the best one. This was her idea to prevent corruption of contracting.”*

> But if this is the method <XXX> uses to cut out corruption, doesn’t this also remove the authority of MOPH from these selection processes?

*“There is no other way but to hand this process to the ones who are outside the hope of any personal benefit – they are looking honestly at the decision. If it is in the hands of the MOPH, they will be finding the way to pressure for some personal benefit to themselves.”*

> The informant became too upset to continue.

**“What are the risks of corruption in the contracting process of Human Resources at MOPH?”**

- > Many respondents cited examples of human resource issues being mismanaged and roles filled by individuals unsuited to the position; several expressed disappointment that human resource processes were driven by personal relationships and connections rather than technical competencies.
- > Adhering to and enforcing contracts was mentioned as critical for delivering quality; many respondents were frustrated that clinical or technical staff were routinely permitted to leave their workplace during normal working times to operate private clinics or work in private hospitals.

Some selected quotes from interviews:

- *“In Provincial Health Department, Officers do not have suitable qualification for their roles – They have these positions based on relationship or experience, not qualification. But even 30 years of experiences is not enough, they need qualification. Younger people with qualification are available but not selected.”*
- *“If employment contracts are not followed, there is risk of weakness in service delivery. I heard that our doctors were leaving hospital in the official hours and going to private clinics; I brought some changes at the hospital by opening the <XXX> door only for emergency cases, whereas the <XXX> door is open only for the public and the <XXX> door is open only for <XXX> Clinic and, through each of these being strictly monitored, it has been totally controlled and no one can go in official hours to their private clinics. A systematic approach is required.”*
- *“Even they are failing with this most important part when we see the most weak non-technical person in a technical job. How do they explain this? No one can explain it.”*
- *“When you come to the Hospital at 14.00 there are no doctors. They are under contract until 16.00 each working day but go to their private practice to see patients instead. The contract has requirement but they are doing this behavior outside of contract.”*

**“Do you believe MOPH leaders are aware of these problems?”**

- > Respondents were skeptical that MOPH leaders could be unaware of these difficulties.

Some selected quotes from interviews:

- *“Yes, they aware but didn’t give any attention to it.”*
- *“Absolutely they are aware and they somehow manage to excuse the problems or accept feeble explanations that do nothing to solve the situation.”*
- *“The MOPH is not about operations – they are not experienced with operations and this is their weakness, they cannot detect who is weak in these important Provincial roles.”*
- *“Yes, they are informed. The MOPH leaders are involved in corruption cases, otherwise they could prevent corruption.”*
- *“Yes, of course. But they are under pressure from MPs to leave the implementers alone, or they are also involved themselves in the corruption and this prevents improvement after a complaint.”*

## Embezzlement

**“Is there routine and reliable inventory of MOPH assets to prevent embezzlement?”**

- > Inventory of health sector assets was described as well-organized across all parts of the country: Processes were described as routine, systematic, and robust.

Some selected quotes from interviews:

- *“We are very serious with the inventory and have taken all the percussion to block any path way to steal the office assets. It is to mention that we have an inventory list on the wall of each room and also an inventory list of all the equipment and assets such as ambulance, cars, and printers that we check them regularly.”*
- *“Yes, they have inventory system: Whenever we are giving something they first receive it from us and entering to list. In the past, most of the things were stolen by MOPH staff, but currently due to strict inventory system, it’s not possible to steal something like furniture or equipment. I cannot say anything about drugs.”*
- *“We have a very strong inventory system and in each six months we update this list. We physically check the public goods and there is no risk of corruption. All items at the hospital have been tagged.”*
- *“We in the clinics keep clear record of our tools and equipment. We not only keep them current but we check them to make sure they are working appropriately. We are private sector and try our best to have our equipment clean and new otherwise they won’t come to our clinics for treatment. Furthermore in the private clinics we take the issues of missing and damage tools very seriously because we are not the government and can’t allow our equipment go missing.”*

**“Do you believe MOPH Managers / staff are involved in embezzlement of public goods?”**

- > Most respondents in this category believe that MOPH Managers and / or staff are engaged in embezzlement of goods; this proportion was seen in all parts of the country and across all types of settings.
- > Respondents reported observations of misuse of official vehicles and ambulances as a routine and regular occurrence, as well as theft of consumables and supplies, including food items.

Some selected quotes from interviews:

- *“We see the MOPH managers and Department Heads using the very few ambulances we have here in <XXX> for their own transportation instead of for patient movements. It’s criminal. These are*

*extremely poor communities. There are not hire car services in the Districts. The patients need proper medical support to get to the Provincial Hospital in order to save lives and this never ever happens. I have been here for three years and I have never once heard of a local patient being transported by MOPH ambulance to the Hospital. But I see the ambulance in the Bazaar sometimes, or taking MOPH staff and their families somewhere. Seriously. It's not even hidden. They claim they have no fuel, but by miracle when they want to take a group on a picnic, they have fuel for the ambulance."*

- *"Vehicle parts. Most of the employees are misusing vehicles, including ambulances."*
- *"Yes, but donors are coordinating with NGOs directly to solve the problem now and equipment is getting into the District Hospital, Provincial Hospital, Comprehensive Health Centers. And local coordination is strong among implementers."*
- *"Yes, absolutely. Especially use of official vehicles."*
- *"About medicines, it is clear that no hospital is distributing the medicines for free as per protocols and they are getting payment for it."*
- *"Yes, I know they are using. An example: There is supposed to be an ambulance for the people, but it only used by MOPH staff for their relatives if they are sick or for shopping or other things. They sell the new vehicles and keep the money, and they keep the maintenance budget of the vehicles for themselves, too. Also, equipment, medicines, supplies, they are using for themselves. The MOPH was charging the donor for the fuel and maintenance of the generator but there was not actually any generator in the facility so they were getting this benefit for their families."*
- *"In the <XXX> Program, the pregnant women were supposed to get oil, wheat, and other supplies but these went to the Clinic teams in the community instead of the women. This was a kind of corruption because the M&E staff checking the <XXX> Program knew it was happening when they did their monitoring and found that the targeted individuals did not receive the items at all."*

#### **"Do you think MOPH leaders are aware of these problems?"**

> All respondents with an opinion believed that MOPH leaders are aware of the practices.

Some selected quotes from interviews:

- *"Yes, MOPH leaders give explanation [about using ambulances for private activities] of 'Our salary is less, so what should we do?'"*
- *"Yes. The other Directors are now afraid of making mistake or corruption, or they will be dismissed or put into the jail. The employees of the Hospital also know this story."*
- *"Yes, and the Provincial Director and Focal Points are coming here for visits without announcement. It's not clear if they will continue to come and inspect. The previous Director of MOPH also knew everything and was very compromised in decisions and relationships with the other health sector implementers. It was very clear to everyone that this was the case, including among MOPH office at Provincial level, and the Governor and Provincial Council."*
- *"Yes, they are also benefiting. They do not call this 'a problem.'"*

#### **Nepotism / Abuse of Power**

##### **"Do you believe MOPH Managers / staff give priority to their relatives / friends / own group when hiring staff?"**

> Nearly all respondents in this category affirmed that there are instances when relatives, friends, or other in-group associates are given priority in hiring of staff, including several who noted this had been a feature of hiring in their own agencies.

- > Many commented that the practice is considered commonplace, routine, or a regular part of human resource management in all sectors, not just the health sector.
- > The practice of giving priority or preference in hiring was described by respondents from all parts of the country, in all settings, and often explained in terms of sustaining particular needs for trust in the workplace, promoting reliability and cooperation, and fulfilling in-group responsibilities and obligations.

Some selected quotes from interviews:

- *“I have seen that relatives of MOPH staff were put forward for training spots on the Midwifery Course, but they were rejected. These were two young girls without a level of literacy or a commitment to health care as a career. I asked how this was explained and it was described that the families of the girls would receive a training stipend, so this was the motivation. It had nothing to do with eventually becoming a midwife.”*
- *“Yes. I know it is happening. It has probably always happened here in this District. It would be difficult for an outside person from another area to get any job at all. So we have several under-qualified people and non-qualified people on staff as a result.”*
- *“We face different problem of too many vacancy slots so this means not hiring relatives here.”*
- *“We don’t engage in such practices. For us, only working qualification of the individual doctors and nurses are important. We also prefer to have multi-ethnic organization in order to attract customers.”*
  - > Private hospital frontline employee
- *“Here in <XXX>, I don’t think it happen. Because we are facing with lack of qualified doctors and therefore, most of the staffs are from other provinces.”*
- *“Absolutely such a priority is considered. Blood relations, political relations, and at the mid-ranks, plain bribery.”*
- *“No, this is now not a problem at all, and the Governor has made sure that this is the case. There are no problems that I have seen, of this happening. There might be some low level, non-technical staff like Cooks or Cleaners, but this is normal in all of Afghanistan. But Clinical and Department Head and Focal Points roles, no, I don’t believe so.”*
- *“As I said, yes, this is normal way. This is happening in every sector.”*
  - > And in your agency, is this also happening?
  - I think there are two sides to this situation of nepotism, and it’s not the same for an agency operating in a remote area and comparing it to the MOPH HQ. For us, there are cases where we look for the relative to be in a position with us because of trust. We have to operate in places where we must have this trust, for our safety, to survive each day. We bring the relative with the skills to be in our organization and we can do our work because we know he can be trusted.*
  - > How is this different for Deputy Ministers at MOPH? Don’t they also need trust?
  - It’s not the same. They are doing this hiring of a friend or from their own group for financial reason, for a benefit like that. They are not thinking about that new person working inside MOPH HQ that he can be a thief or a criminal. This is our risk; we face this in the Provinces. With MOPH senior Managers, they are thinking very clearly, ‘I will hire this one and he will pay me this amount, that one will pay me that amount,’ like this. The nepotism is about money and even from their own group, there is money they will earn from each position. It is not a personal security or trust issue. Even I have heard of a Deputy Minister who hired someone he knew very well was untrustworthy but he did it because of the money he was given for it, that was his reason to select him. Now he is facing daily problems with that man, but the money was given, so, the agreement is done.”*

**“Do you believe MOPH Managers / staff give priority to their relatives / friends / own group in providing health services?”**

- > Respondents had more diverse beliefs about whether priority is given to relatives, friends or in-group associates in health services delivery, compared to hiring.
- > The majority of respondents described this as being a commonplace occurrence.
- > A small number of respondents denied that relatives, friends, or other associates receive any preferential treatment though powerful persons were described as trying to make this happen.

Some selected quotes from interviews:

- *“Yes, definitely. They try, but I’m not sure they always succeed.”*
- *“This is now a culture in all aspects of management. Especially in our big cities, whenever a patient goes to hospital, the family members make some call and set everything prior to reach the hospital.”*
- *“Frequently it is the goal, but not always happening.”*
- *“We as doctors provide our services regardless of ethnicities since our professional responsibility requires us to do so – even we treat the unarmed Taliban in our clinics. But there are some cases in the center, and it does exist.”*

#### **“Which specific parts of MOPH are at risk of abuse of power?”**

Some selected quotes from interviews:

- *“Basically, all of it. I have lost my hope about the priorities of the MOPH here. They seem totally uninterested and just complain about their low salaries and having too much work. When a group came with a campaign for vaccinations, these same staff demanded that their home District get the visits first, before anywhere else. Even though they had already had it and pushed their own people to the front of the line.”*
- *“...allowing illegal entrance of medicines and taking money from the medicines companies.”*
- *“Taking money from private hospitals which are not meeting minimum standards of MOPH policies.”*

#### **“Do you believe MOPH leaders are aware of these problems?”**

- > All respondents with an opinion believed that MOPH leaders are aware of the practices

Some selected quotes from interviews:

- *“I’m not sure, but I would not be surprised if they did.”*
- *“It is widely known. There have been complaints.”*
- *“We have shared all these problems many times with the MOPH officials and they know, however, fighting corruption is not easy in a country like Afghanistan.”*
- *“Yes, they are aware, and there are many complaints, but it makes no change.”*

### **Quality Assurance / Quality Control**

**“How do you perceive the accountability and transparency mechanisms in MOPH on its Leadership, health services delivery, human resources management, or its financial management?”**

- > The mechanisms that could (or *should*) promote accountability and transparency were familiar to the respondents in this category: Many were able to describe different types of systems to monitor processes and control resources.
- > Several respondents were critical of the reliability or the coordination of these systems.

Some selected quotes from interviews:

- *“The new leadership in MOPH is trying to make more transparency and accountability.”*
- *“There are different systems and supports. MOPH HQ is now managing different teams that are responsible for these processes. We have had visits from them. If anything will happen, I don’t know since there has not been much time yet.”*
- *“As I mentioned already: There does not appear to be any accountability with MOPH leadership. They have ignored failures in health services delivery completely, and it is costing them their reputation in the community. Local people know when there is something wrong; there should be a female doctor in the community and there isn’t one. The doctor is not qualified and is considered weak. The clinic does not have medicines on hand that it should, and patients are told to go to the bazaar to buy what they need for treatment.”*
- *“We expect the MOPH official to train our staff in different fields. When a training program is held in the Health Directorate we want our doctors and nurses be invited so that they can receive those training and there should not be distinction between doctor in each field, public or private, because the bottom line is that we both working in the same field. Private sector is acting as a support body for the public hospitals as the public hospital would refer their patient to private hospitals when they can’t treat them in Provincial Hospital.”*
- *“Generally there is a problem nationwide in the country and it is very difficult to say, ‘Well, there is no corruption.’ This phenomenon is systemic and it does not exclude MOPH. I think there is corruption in the procurement of goods and building of hospitals and in appointments.”*
- *“Audit and M&E are functions supported from MOPH HQ and also on provincial level, and our <XXX> HQ in <XXX> is also coordinating with them on regular basis.”*

**“What can staff do if they find lack of accountability or transparency by the Managers or other MOPH workers?”**

- > Many respondents expressed disappointment in the limited options available to them for taking action if they face lack of accountability or transparency.
- > Due to their roles, these respondents had varied levels of experience with MOPH management.

Some selected quotes from interviews:

- *“The MOPH have not done so far in this regard.”*
- *“They cannot do anything, if do so will be punished or terminated.”*
- *“I am not clear if they have any solution – The Managers are also part of this problem. They are not accountable to anyone. If the highest level is also refusing to be responsible for their actions, or their inactions, then how can the staff without any power solve this?”*
- *“If there is any issue of accountability or transparency in the project, firstly discuss with Line Manager at the central level, but if not solved then discussing with PHD and then they discuss it with MOPH relevant Departments.”*

**“What do you believe is the level of patient satisfaction with the quality of MOPH health services delivery? Why?”**

- > Most respondents in this category believed that patient satisfaction was low.

> Several respondents commented that patients did not have a well-informed basis for their high expectations on either the range of services they wanted in their local health service delivery, nor in the level of quality that might be expected there.

Some selected quotes from interviews:

- *“Not good. The situation in center of the province, it means in the Provincial Hospital, is very good. But, in District level, in clinics, because of shortage of doctors, medicines and facilities, people cannot be satisfied. I know the cases that families had been waiting 8 hours to get one kind of tablet although these families have been living very far from the where the clinic is located.”*
- *“Level of satisfaction is low from Public Health services that is why people are going to other countries for treatment and do not trust their own health system.”*
- *“People are expecting services which are not in the BPHS policy and we can’t offer them.”*
- *“Patients in community are not satisfied with District Hospitals or Clinics, and not satisfied with the reaction of MOPH because they are not solving it or making any changes to the situation.”*
- *“This is different in each place. Patients have some good services and some weak services in every region. We all expect the services will be high quality: It is our right. But the situation is not in the control of the Provinces if they have weak support and limited budget to deliver services.”*

**“How often in MOPH does ‘The right person work at the right job,’ meaning, their skills match the requirements?”**

> Most respondent replies were negative about the suitable match between skills of post-holders and requirements of the job.

Some selected quotes from interviews:

- *“Maybe 50-60%.”*
- *“Here, in this Province, we face a big problem of the wrong person in important jobs but this is a manpower and solutions problem. There are low salaries and high expectations about qualification. Unavailability is a challenge that cannot be overcome without cooperation on qualification or salary or location. It is remote area in geographic region without development, and weak security.”*
- *“Not enough. The employees are not recruited according required qualifications. Most of the employees consider here as a place for practicing and learning.”*
- *“About 80% of staff hired according to required skills of job description.”*
- *“Doctors and nurses, even administrative staffs, are employed through application, examination, interviews, and so it must be clear. But you know it is Afghanistan, everything to be transparent is almost a dream. We are not living in a dream.”*
- *“They are not even technical persons at all. This is not happening. The Leaders of MOPH know this situation.”*
- *“So far, in three years here, it is extremely rare. When MOPH sent someone to inspect the clinic near where I am, I asked what he was looking for in the inspection because I was genuinely curious what it might be. He said, ‘I’m here to check the quality. The staff should not be sleeping or sitting doing nothing.’ He had no checklist. He had no criteria. He was supposed to be doing monitoring of quality, but he had no clue what quality would consist of in a clinical setting in a remote community like ours. It was very disappointing, to be honest. How could this be the right person conducting a quality check?”*

## Human Rights and Discrimination

### **“How would you describe the level of respect for human rights in the Public Health system?”**

> Comments about respect for human rights from respondents in this category were generally positive.

Some selected quotes from interviews:

- *“Mostly, they are good. No accusations of human rights violations – these are solved now. We have hired OPD Coordinator and the problems are addressed by a systematic way to avoid discrimination and promote transparency.”*
- *“There is a good level of respect. For example, the rights of female staff are correctly respected. The situation is better than before.”*
- *“No problems, I think.”*

### **“How would you describe the level of discrimination in the Public Health system?”**

> Many respondents expressed a range of hopes and aspirations about what ‘*should be*’ the norm of providing care to all, without concern for gender, tribal affiliation, or other status.

> Less than half of respondents cited examples of discrimination.

Some selected quotes from interviews:

- *“I have not observed any type of discrimination in Public Health.”*
- *“There isn’t much discrimination. We are treating all people from different groups very well. In Kabul it’s important to have some contact inside the staff for getting treatment – but this is about the contact, not about the group they belong to.”*
- *“At the hiring of workers there can be examples of discrimination against some groups, and for <XXX>, very actively, but this is not the case of the Doctors and Nurses and other staff discriminating against some groups in treatments. The people maybe will have complaining about the service they receive, but this is also related to the speed or the order they are treated in, but this is also about the connection or lack of connection.”*
- *“Here we have a problem. If a patient has no connection in the facility, or to anyone inside MOPH, he will not get proper treatment or referral. It is a lack of humility among the staff. This needs to be made part of their training to work in the health sector. They should be more aware of the importance of humility in how they treat people who have suffering and fear.”*

### **“How would you describe the role of community leaders in influencing health service delivery?”**

> Respondent comments were mixed about the influence of community leaders regarding health services delivery.

> Respondents commented about threats, violence, and pressures motivated by localized contexts, including the potential for pressure focused on improving quality or expanding services.

Some selected quotes from interviews:

- *“They have positive effect.”*
- *“Community leaders have the role in the implementation of services and even requesting the provincial Directors to establish health facilities in the catchment areas. But the Directors send a delegation for investigating the areas, and after that, they give their opinion to establish health facility or not.”*

- *“This exists from the community because the community does not have awareness of where a clinic should be or how the decisions are made for deciding about locations of new construction. They are writing letters to Government in their province, and Provincial Public Health Directorate and MOPH can only succeed if they explain the process and how the policy of MOPH is active in all of Afghanistan. If it can be explained, then they are accepting this situation.”*
- *“The only pressure that we are facing is the load of patients due to suicide attacks in the province. Local Commanders coming to hospital with weapons which create problems for health care providers. Several times have been discussed with provincial Governor and other authorities but could not succeed in stopping them. We are resisting against them and not listening to their speech but they beat us, especially when their relatives die in the hospital.”*
- *“From what I have seen and heard, the local community does complain in the Center about what’s happened in our District. They have told the MOPH Director that the staff is weak and the people are not happy with this situation. It does not seem to have made any difference. But they did make the point of telling the MOPH Director as representatives of the community, so this is at least fulfilling their role as leaders.”*
- *“NGOs have decentralized system and all authority has been given to Project Managers at province level. We are not seriously under pressure of community leaders in the health service delivery, whereas they are supporting us in the health service delivery in insecure areas of the province. We are trying to do more than what is mentioned in the project proposal; even we spent money from the admin cost for the service provision to satisfy community people.”*
- *“We have very nice relations with community social activists as ‘Molawis<sup>14</sup>,’ peace-seeking elders, and socially accepted leaders. They help the health programs in health education, vaccination campaigns, and so on, supporting our staff to be secure among the villages. We get people’s cooperation in those localities where community council members are cooperative with health policies and services.”*

**“Is there political pressure on management of health services delivery? Is it helpful or harmful?”**

> The descriptions of political pressure on health services delivery were varied, with a majority negative (distractions, diversions of resources, pressure to change service configurations, and human resource decisions related to service delivery roles), though there were a few comments indicating that influences had the *potential* to be positive.

Some selected quotes from interviews:

- *“Not enough, or the situation would be better.”*
- *“I can’t think of any examples. I did hear that the Parliament stopped the charges of patients for basic services in the Hospital since the law says it should be free for the people. Everyone here is very very poor. And if the MOPH was allowing charges, then it was correct for the politicians to stop this from happening.”*
- *“Hundred percent political pressure on the management MOPH for recruitment of human resources, and private sector as well.”*
- *“All of us in health sector are having experience of political pressure.”*
- *“Pressure to improve will help our system.”*
- *“I think our MOPH colleagues face pressure in their work because they have limited resources to achieve their goals.”*

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<sup>14</sup> A type of religious leader.

- > But what about when they use their limited resources in wrong ways, or make decisions which do not help MOPH achieve its goals?

*“These are difficult situations. They may have Managers who do not support their right actions. I hear them complain about the pressure to do this, to do that, but how?”*

**“What is the role of community leaders in management of MOPH human resources?”**

- > As above, respondents were generally negative about the influence of community leaders regarding human resources in Public Health (diversion from competency-based hiring processes, pressure to hire or fire specific individuals); a few comments were not specifically negative or positive.

Some selected quotes from interviews:

- *“Very effective.”*
- *“The community leaders influence in recruitment process to hire their favorite persons.”*
- *“Yes, pressure about hiring female doctors, but not threats, not that I am aware of. Everyone knows that there are female doctors in the Center and in other clinics in other Districts, but none are here, so it’s a frustration. How much pressure can these local people bring on MOPH? Not much really.”*
- *“Of course, this is happening everywhere. It can be for the good reason or the incorrect reason. We are pressured to do incorrect actions all the time.”*
  - > What would be the ‘good reason’?*“If the MOPH is not managing some problems about discrimination in hiring, then community pressure can show attention to this. It has negative part, too, when the leaders can demand that MOPH not hire someone because they are from outside the community or a different group.”*

**“Is there political pressure on management of MOPH human resources?”**

- > Respondent comments were concerned about pressure and intimidation over hiring and firing, gender balance in the workforce, and favoritism.

Some selected quotes from interviews:

- *“Yes 100%.”*
- *“Members of Parliament spend a very large amount of their time each week on these pressure visits to control the hiring of people in their Party or from their group.”*
- *“Warlords and strongmen interfere in our work very much and they normally reject our candidate for health position. We have Health Committee (Shura and Mullah) that it is a problem and they introduce people to us for appointment... and even the Governor’s office introduces people to us for occupying job positions.”*
- *“Definitely, if you consider the lack of females working in doctor roles in the District, there is pressure from community leaders about MOPH actions in human resources. I don’t believe that MOPH has the answers about how to solve this though. If no female doctors want to work in remote communities, then the situation is very difficult to change. But I also am unaware if the NGO implementing here has actually made any effort to actively recruit females to the staff.”*
- *“There is pressure from the strongmen and warlords particularly in the appointment of the doctors, nurses and even Admin staff.”*

## Extortion

### **“How would describe the level of pressure, threats, or extortion in the Public Health system?”**

> Respondents from every part of the country and in all settings expressed concerns about the issue of pressure, threats, and extortion they face as a routine part of their jobs in the health sector.

Some selected quotes from interviews:

- *“Health service delivery is under pressure of politicians, Parliament Member, and powerful Commanders.”*
- *“We have this problem in our daily work, but new leaders are trying to remove to this problem.”*
- *“I can just say that there are many pressures in different parts of health sector. No exception.”*
- *“I don’t see any such practice in this hospital and all the services are for free to all citizens.”*
- *“We have no pressure in implementing NGOs in comparison to what is faced by government staff.”*
- *“This might be a bigger problem of the rural areas, where the power is concentrated in a few people who control many things. I know of MOPH Director in <XXX> who faced extreme pressure to build a new clinic in one area and he was threatened when he resisted. But he has no budget for construction of clinics. He has no donor ready to build in that place and no one could operate the clinic, even if it was built. The local leaders threatened violence on him if he did not give agreement and take action. So, yes, he gave agreement from this kind of extortion and now he faces more pressure to find a donor to build and operate this new place. The MOPH in Kabul never gave approval and told him, ‘You should refuse,’ but how can he refuse?”*

### **“What are the risks or benefits of resisting extortion?”**

> Respondents described resisting extortion as a risk in all cases, including violent repercussions.

Some selected quotes from interviews:

- *“I was witness that while the nurse reacted, the community leaders fought with nurse and hospital staffs.”*
- *“The people will lose the trust that the Government is listening to their complaint and ideas; then there is risk if the people losing trust that MOPH is doing their work in providing health services for the community. There is also some risk of violence or more insecurity.”*
- *“Threats, violence, being killed, being accused of dishonesty, all happen if we resist pressures. I remember that the people in <XXX> closed the roads in their valley as protest when the District Hospital was left standing empty without any services. They made many threats against the authorities and stopped movement of everyone in their area, but this failed. What NGO would agree to go and work in this kind of place, if the local people are threatening violence about establishing new services? No one could recruit staff in this kind of situation!”*

### **“Which particular parts of the Public Health system are at risk of extortion?”**

> Respondents described extortion over human resources, development of services, or access to goods and materials.

Some selected quotes from interviews:

- *“Recruitment of human resource and development of private hospitals at the provinces.”*
- *“Local Police Commanders, powerful community Commanders, Provincial Council members and jihadi Commanders are putting pressure on various issues, for example, they want us to provide*

*them extra infusion fluids, or on a community they level support one staff against the other. Sometimes they want a doctor to go to their home...*

- *“Military forces are sometimes ignoring the neutrality of health centers in conflicts: They install their military posts inside or beside health centers and endangering the health staffs. They may take stretchers and blankets from the hospital and never return it.”*

#### **“What are the risks of resisting these pressures?”**

> Respondents described resisting extortion as a risk in all cases, including threats of violence and loss of employment.

Some selected quotes from interviews:

- *“Abuse from these powerful people.”*
- *“Losing the job.”*
- *“I know of the case where we are working that the leader of <XXX> demanded the Hospital and MOPH to give jobs to the people from their Party. These were not skilled or technical people and had no training, but the Party insisted the jobs must be given to their members. Even MOPH tried to force the Hospital Manager to accept the workers so the situation would be calm. He resisted and then he lost his own job. When the new Manager was hired, MOPH had already put these Party members into the jobs of the Hospital. They are not thinking ‘This will make a new kind of problem,’ truly, they are just trying to solve the pressure from the Party. But the people suffer when the Hospital has weak and unqualified workers on the staff.”*

#### **Fraud / Falsification / Fakes / Forgery**

##### **“What is your perception about quality of drugs procured by National NGOs and INGOs?”**

> Aside from positive remarks about International Dispensary Association (IDA) as a supplier, there was near universal criticism of the quality of drugs and pharmaceuticals.

Some selected quotes from interviews:

- *“I have heard many many complaints from our local community that the medicines are ‘not real’ or they are expired. This is true also in the pharmacies in the Center and I think most people accept that the situation is not good in our whole area, not just this District. It contributes to less trust when people know that the medicines are fake or low quality.”*
- *“<XXX> has a contract with IDA and based on that contract they are providing medicine up to now in their services. These medicines are high quality. I think it is impossible to sell them in the bazaar because of labeling.”*
- *“Really low quality drugs are purchased by the implementing NGOs because Government allows every type of companies to bring drugs to the country.”*
- *“We were told that every single drug from local markets analyzed by MOPH Quality Control Laboratory was measured as having low quality. I preferably suggest to MOPH to stop the wrong concept of ‘Open Market Policy’ and intervene in medicinal import. If MOPH provide the medicines from IDA then surely the quality of medicines will be guaranteed. I don’t know these costs.”*
- *“The quality of the drugs we have is good, here, but at the other parts of the health sector are purchasing from places where the quality is known to be low. The risks for the patient are that they will have increased illnesses or death.”*

**“Do you believe there is any falsification in the reporting systems on health services delivery?”**

> There were widely varied responses to this question.

Some selected quotes from interviews:

- *“I would not be surprised, but I have no direct proof of that.”*
- *“We have problem in insecure Districts that we sometimes can’t rely on their report. We have a lack of access to the clinics and reporting. I am not sure about the accuracy of the reports.”*
- *“I cannot say anything. I am not aware about such case.”*
- *“No, there is no falsification in the HMIS reporting system and other financial or human resources. Our NGO has its own database and all items are entered to the database and then we send to country office and from there they are sending it to MOPH.”*
- *“Yes, and trust is lost. We see the cases where no one will have any trust at all in what one of the implementers in our area is saying about their own work. They are also making accusations about the other implementers, and even against MOPH! But they are the most dishonest in their reporting and have created a situation where there will be some very hard difficulty to trust other agencies. On the community side, the effect is the same: They lose their trust in the clinics and the staff and the medicines... We saw the case of the Clinic in <XXX> reporting that they sent their Vaccinators to each of the villages in their catchment area and had total compliance in their work. But this was impossible: My own family is living in both sides of the <XXX> village and no Vaccinator ever went to their homes. No children were vaccinated. How they can report ‘total compliance’? We don’t trust any of their reports.”*

**“How big is the problem of fraud / falsification / fakes / forgery in MOPH Human Resource hiring and promotion?”**

> Few non-MOPH respondents expressed opinions on this question; those that did were negative.

Some selected quotes from interviews:

- *“Employment of workers in this situation is a big problem. We have it in our NGO, too.”*
- *“There are always these cases where we hear ‘so-and-so is not a real doctor’ and there is a general lack of trust that the MOPH is making sure people sent to our local area are really as qualified as they should be. There is definitely the perception that doctors are more likely to be strong or really qualified if you go to the Center. Personally, I’m not so sure.”*

**“How big is the problem of ‘ghost workers’ in the health sector?”**

> The vast majority of respondents from this category did not have any first-hand experience with the issue of ghost workers.

> The few respondents expressing concern about health sector ghost workers in remote areas were from Kabul; respondents from remote and less-developed provinces denied any issues.

Some selected quotes from interviews:

- *“There are no ghost workers, I don’t know about this issue.”*
- *“There are no ghost workers at hospital level. I mean all have their physical existence. But absenteeism is the major problem. All nurses, orderlies and new doctors are present but specialists*

*and professors are always time-corrupted people. They work about one or two hours a day but then they are absent.”*

- *“It is impossible to have ghost workers in our projects. We may have vacant posts in Basic Health Center and Comprehensive Health Center levels, and even at District Hospital levels in non-secure areas, but there are no ghost workers at all.”*
- *“Community is complaining of any absenteeism and there is Health Shura to also accept the checking processing of staff being regularly present or not. There is not a ghost worker problem.”*
- *“It could be a problem in the insecure places because there is no monitoring on regular basis, but not in <XXX>, not in this area.”*
- *“Very much of a concern.”*

## **Conflicts of Interest**

**“Do you believe MOPH Managers or colleagues give priority to their own interests instead of the needs of patients?”**

> Most respondents affirmed that there are problems with public sector health workers maintaining private sector interests in addition to their Government role, including clinics, pharmacies, diagnostic services, and pharmaceutical supply.

Some selected quotes from interviews:

- *“Frankly speaking some of our doctors are working in private hospital and clinics after official hours and we have cases that our staff own pharmacies in the town.”*
- *“We all know the answer.”*
- *“Some of this Provincial Public Health Directorate’s officials have links with private sector.”*
- *“There are some health care providers supporting private sector: We have <XXX> machine at the hospital and there are some people who are trying to damage this machine to be able to refer our patients to their own service in private sector. If I find such personnel I will terminate or introduce them to attorney general.”*
- *“All doctors from Provincial Hospital are leaving to their private clinic after lunch.”*
- *“Nurses pressure the surgical patients to go to have procedures at private hospital run by the Surgeon in the bazaar. It is a big issue of cost for the poor patients.”*

**“What are the risks when Public Health providers refer their patients to private sector for diagnosis or treatment?”**

> Respondents described reduced community trust in the public sector, lowered confidence that the Public Health system is capable of treating them, and financial costs from paying out of pocket.  
> Respondents also noted that clinicians and technicians are resistant and oppositional to strict enforcement, risking the integrity of the management authority of health sector leaders.

Some selected quotes from interviews:

- *“It is a problem. We have a policy regarding preventing conflict of interest, but it is not useful and the doctors have private clinics. If we enforce it, no one will work with us.”*
- *“We receive referrals from the Provincial Hospital because they don’t have enough medical equipment in the Public Sector hospital and they refer some of their customers for treatment, such as CT scan. We take this opportunity as a privilege and treat our patients with respect.”*

- *“Referring patients to private sector by Public Health providers for diagnosis and treatment is a great challenge in the country because the population is poor and cannot afford money for private sector – so they have to borrow or sell their own property to get diagnosis or treat their patients in private sector.”*
- *“The trust of the public system is less after the community sees that the doctors are interested in the money in their pocket more than the good medical treatment for them.”*
- *“Each time this referral is made, quietly, the doctor shows he does not care about the quality of the public services. He is thinking of the quality in his private clinic. The people see this well.”*
- *“We don’t have any private clinics here that I am aware of, but I know in the Center this is happening. One of my staff went to the Hospital and the doctor said to go to his private clinic in the afternoon for the treatment. Of course it was for a cost. The story was told as an example of the corruption of the doctors at the Hospital because they want to earn extra money in their private clinic. The person who told me followed the advice for the treatment.”*

## Bribery

### **“How big is the problem of ‘extra payments’ or bribes in the Public Health sector?”**

> Most respondents cited examples of ‘extra payments,’ but only a few expressed opinions about if this is a problem or how important it might be.

Some selected quotes from interviews:

- *“This might be happening in the Center, or in Kabul, but I’ve never seen it here or heard about it in our local clinic.”*
- *“In surgery or gynecology and obstetrics wards, health providers getting some amount for performing surgery or conducting delivery.”*
- *“All hospitals have this challenge. It must be disposed, frankly. Especially Surgery Wards are at the top in bribery, diagnostic branches do it in some tricky ways, and then the orderlies are only getting bakhshesh.”*
- *“Only for success, after a treatment – Never before, this is not happening. The Operating Team is asking for kebab from patient relatives instead of eating our hospital food. They are not asking for money.”*
- *“I just heard one case that a nurse did misbehavior and asked bribe from a patient: she/he fired from her/his position.”*

### **“What are the consequences for staff if they are caught asking for (or demanding) bribes?”**

> All respondents who answered this questions were able to articulate that asking for (or demanding) bribes is a punishable offense based on rules, official policy, or Law; no respondents stated that such behavior is allowed or should be acceptable.

Some selected quotes from interviews:

- *“In our NGO: If someone has been involved in bribery they will be terminated on the spot.”*
- *“Warning, transfer to other area, and then fired.”*
- *“MOPH? Nothing.”*  
> Provincial Council Member response

## “Other Risks” of Corruption

### “What can you tell us about any other risks of corruption in the Public Health system?”

- > The most unique of the ‘other risk’ comments was the final one in this section, focused on accountability between MOPH and donors to the health sector.

Some selected quotes from interviews:

- *“Competition for BPHS and EPHS contracts was weak but wrong decisions came because of recommendation of local PHD to GCMU; community will see the quality is now lower. They will come to know that previous NGO had given extra services beyond the BPHS contract and there is dissatisfaction now. There is no Lab, no ambulance, and community can see the difference.”*
- *“To open a private clinic or hospital or pharmacy the official requires some payment for cooperation about this. This amount will vary by the benefit they can get from each type of situation, as well as the contacts they have in Government or inside MOPH they can easily get it.”*
- *“Private medical facility requires payment to powerful people or you will not get certificate.”*
- *“The ambulance support for the inpatients in Hospital to go to Kabul is not provided after the first 5 patients each month because of limited budget. If the patient can’t use the Hospital ambulance, they must use private car. The people are uneducated and unaware of the EPHS contract requirement, and they have some chance of negative reaction, but no one in MOPH is following this outcome.”*
- *“This issue of corruption is everywhere in our country and it makes everyone sad and frustrated and angry. But it is not worse in health sector than other sectors. We face a special kind of risk, I believe, in logistics, like any other sector because there are many chances for the responsible persons to divert the money or derange the process for their own benefit.”*
- *“We have this problem of MOPH ambulance being used only for the transport of dead bodies, after some money is paid, never for free. The ambulance does not function to bring the very sick patient to the clinic or hospital. The ambulance is mostly used by staff for their own benefit. The donors do not even realize this is happening! They have given many ambulances to our country because the people are poor and need help but these are used by staff instead and never go to collect sick patients. It’s possible that military or security forces have their own ambulances for their injured officers, but this is not happening for civilians in Afghanistan. Never.”*
- *“I have seen many difficulties with accountability. The donors, who also fund my program, clearly explain about transparency and honesty in all actions that involve their funds. But their own staff are involved in corruption.*

> You mean the staff of the donor agencies are also corrupt?

*Yes: Corruption by the Afghan staff working in the donor agencies. When we met with <XXX> about our proposal, there were international and Afghan staff from the donor in the meeting with us. Everything was clear and we understood their ideas. In the afternoon, I received call from the senior Afghan who sat in the meeting. He told me, ‘I am coming to see you in your office about this proposal.’ When he came to us, he said our proposal was strong and can win the approval. This was for more than one million euros. He said very clearly, ‘I can support your proposal for this project. You will give me 20% of the budget.’ I refused. He said, ‘There is the other group, <XXX>, and they will win the approval if you decide you are not cooperating.’ I heard from the Director of <XXX> they won the approval after that. The donors are not in the picture that their Afghan senior staff are doing this when they are even telling us, ‘be honest and you will be rewarded,’ but we know this is not correct. If we are honest, we are punished.”*

> He again became very emotional and we ended the interview.

# 4. FINDINGS: PATIENTS AND THEIR FAMILIES \*

**OVERVIEW:** Patients and their family members described corruption in the health sector, experienced in the context of fear, suffering, uncertainty, pain, and death. These health sector service utilizers from all parts of the country acknowledged a wide range of illegal, unethical, and disturbing episodes.

For nearly every one of the 96 respondents in this category, routine attempts to engage in preventing or solving health issues had been met with frustration and disappointment at also being subject to corruption in addition to the health issue. Their interviews illustrated how commonplace these frustrations and disappointments have become for all Afghans. As with the Directors, Managers, and leaders of MOPH, extensive probing for examples was not required with these respondents.

**The most detailed comments about risks of corruption related to:**

**1. Leadership and Governance:** Failure to ensure access to free and reliable medicines, and the perception of weakness in enforcing rules against corruption, especially regarding requests and demands for extra payments and the misuse of ambulances and other public vehicles by the health sector workforce.

**2. Finance:** Failure to provide free medicine, free patient transportation, and pressures to fund private sector referrals, medicines, and treatments as out of pocket expenses.

**3. Health Service Delivery:** Conflicts of interest associated with referrals to the private sector for diagnostics, care, or pharmaceuticals, and, overcrowded and under-resourced services.

**4. Quality Assurance and Quality Controls:** The integrity and reliability of medicines, and the lack of options when faced with misbehavior by health sector workers.

Notably, the respondents in this category were largely focused on issues related to their own lack of power or influence as health consumers when faced with the low trustworthiness of health sector management, the questionable quality of medicines they were able to access, and perceived conflicts of interest in health service delivery, mainly related to the private sector.

On a positive note, there was a widespread level of knowledge about the existence and function of Health *Shuras*, though confidence in the effectiveness of these mechanisms was varied.

\* Details that could identify individual respondents have been omitted.

## Policies

**“Are health services provided free of charges in the Public Health system, as mentioned in the Afghanistan Constitution?”**

> A very small number of respondents stated health services are free of charges, or *should be* free of charges, with nearly all respondents in all part of the country describing the need to pay for diagnostic procedures, medicines, and treatments.

Some selected quotes from interviews:

- “No. Medicines are prescribed from the bazaar. Only serum is free of charges in the hospital.”

- *“If you know a doctor, they will provide the medicine from the hospital; otherwise it is impossible to receive the medicine from the governmental hospital.”*
- *“...in hospital the nurse used to take Afs10 or Afs20 for each time she was injecting.”*
- *“No, whenever we are bringing patients to hospital, doctors prescribing what should purchased from the market; even they are prescribing syringe, which is the cheapest item among the medicine.”*
- *“No, we buy all our medicines outside the hospital.”*
- *“To give free of cost medicines at the hospital will be better. Since three months we are bringing patients here but doctors are telling us, ‘Medicines are not available’ so they are prescribing from the private medical stores.”*
- *“I spend more than Afs5,000 in one night for treatment.”*
- *“Examination can be free, but not medicine and not treatments.”*
- *“Yes medicines are given free of charges in this clinic.”*

**“What policies or rules lower the risk of corruption in health service delivery?”**

> Only a few respondents had opinions on policies or rules to lower the risk of corruption in health service delivery; their ideas focused on monitoring and consequences for infractions.

Some selected quotes from interviews:

- *“Punishment for corrupt workers.”*
- *“Regular monitoring.”*
- *“I think to fire all these corrupt officials will solve the problem.”*
- *“Tight control over private sector.”*

**“How big is the problem of absenteeism of employees during operating hours in the Public Health sector?”**

> Most respondents expressed frustrations about employee absenteeism in the Public Health sector resulting in difficulty accessing diagnostic and assessment services, or in solving issues with their ongoing care.

> A small number of respondents from provinces where there are lower levels of private sector health services did not report the same problems with absenteeism.

Some selected quotes from interviews:

- *“The workers are not at the job in the normal working times. We face difficulties from this.”*
- *“According hospital law, the doctor must work from 8:00 to 4:00, but after 1:30 we can’t find any doctor in government hospital. They are in private practices.”*
- *“We are looking everywhere for the doctor. They are not in this place.”*
- *“We have found that doctors are available 24 hours at the hospital.”*
- *“They always come on time to their private clinic job.”*

**“Do you believe MOPH Leaders are aware of these problems?”**

> Nearly all respondents believe that MOPH leaders are aware of problems of absenteeism.

Some selected quotes from interviews:

- *“Yes, but these doctors have relationships with local officials.”*
- *“I think every hospital Director surely is aware of the absenteeism, but they ignore it. Even the Directors are not on job regularly.”*
- *“Of course they know this situation.”*

**“MOPH clinics and hospitals are supposed to make referrals when patients need higher levels of care – Does this happen?”**

> Respondents described several situations where patients had been referred to more advanced services, though transportation difficulties were raised by many.

Some selected quotes from interviews:

- *“Never happened with us.”*
- *“Once my relative was referred to Regional Hospital by ambulance.”*
- *“The doctor made referral for <XXX> private hospital, not the specialty hospital of <XXX>.”*
- *“This health facility does not have ambulance to take patients to Provincial Hospital. We were sent by taxi to Provincial Hospital.”*
- *“From referral, we have to carry our patients to Provincial Hospital and there we do not know anyone and facing lot of problem in receiving health services.”*
- *“Referring patients but we have to pay for the transportation.”*
- *“Yes, they are referring patients but without ambulances. At night they are saying ‘Go by local transport. Government vehicle is not allowed at night because on the way will be stolen by thieves.’”*

## Contracts

**“What is the effect of Public Health facilities only operating for part of the day, or with only limited services?”**

> Respondents described practical examples (limited access to suitable clinical supports) and reduced satisfaction and confidence.

Some selected quotes from interviews:

- *“At night midwives are not available to conduct delivery at the health facility.”*
- *“This <XXX> hospital is open 24 hours but some doctors leaving earlier to their private clinics and new or trainee doctors are staying in the hospital who do not have skills and knowledge; they do not know how to manage serious patients.”*
- *“Often it makes us wandering here and there to try and solve our problems.”*
- *“The health situation will get worse in the country.”*
- *“There will be outbreaks of many diseases.”*
- *“People will not be satisfied.”*
- *“Our belief in MOPH is lower.”*

## Embezzlement

**“Do you believe public goods have been stolen or used by MOPH Managers or staff for their own personal benefit?”**

> Respondents reported observations of misuse of official vehicles and ambulances as a routine and regular occurrence.

Some selected quotes from interviews:

- *“Yes, they are using public vehicles for personal benefit and going to wedding or sightseeing.”*
- *“Of course. Several times I observed that ambulances are used for their own benefit. They are not taking emergency patients... They tell us, ‘Hire a taxi and take your patient to other hospital.’”*
- *“...vehicles are used for their children to go to schools.”*
- *“Saw directors taking their children for school in the public vehicles.”*
- *“Yes, at the provincial level, public vehicles have been used for personal benefits by the health care providers. Bring things to their houses such as wood and other materials.”*

## Nepotism / Abuse of Power

**“Have you ever noticed if health workers treat their relatives / friends before other clients at the clinics or hospitals?”**

> More than half of patients or their families had observed preferential treatment being given to relatives or friends of health workers.

> A small number of patients coming from clinics in less-developed provinces reported that this was not happening where they received their care.

Some selected quotes from interviews:

- *“It is common in Afghanistan that doctors are giving priority to their relatives.”*
- *“Of course.”*
- *“It is regular to give this treatment to relatives first.”*
- *“There is a number system here. They are following that correctly.”*

**“Do you believe MOPH Managers are aware of this problem?”**

> There was no consensus of opinion on whether Managers were aware of this happening.

Some selected quotes from interviews:

- *“No. The Manager is not coming in this waiting room to see it.”*
- *“Maybe.”*
- *“Yes, as I mentioned before they are giving opportunity to their relatives and friends and who are working at the Ministry.”*
- *“Definitely they are aware.”*

**“Do health staff refer patients to their private practices during office hours?”**

> Most respondents agreed that referrals to private practice health services are occurring.

> Some respondents from remote areas in less-developed provinces pointed out that there are limited private sector health services for this kind of referrals.

Some selected quotes from interviews:

- *“Lab technician was not available today and the midwife told to us, ‘If you pay Afs100, I will perform lab examination for you.’”*
- *“After 12.00 sending patients to private clinics and giving us their business cards ‘Come to this clinic with this address.’”*
- *“Yes, they are referring patients to private sector in office hours because of their relationship with private sector and getting percentage from the private clinics and medical store, and diagnostic centers as well.”*
- *“Yes, but not in office hours.”*
- *“Doctors told me, ‘My duty is finished in the hospital so please come to my private clinic where I can treat you better than here.’”*
- *“There are not many of these private clinics in <XXX>.”*
- *“No private hospitals here for them to do this.”*
- *“There are not any private clinics in this District.”*

**“Do you believe MOPH managers are aware of this happening?”**

> Nearly all respondents with an opinion believed Managers were aware of this happening.

Some selected quotes from interviews:

- *“Yes, why not.”*
- *“Everyone is doing this from hospital Director to doctors, nurses and midwives. So who will stop them from doing such things, if Director is corrupt? Why he will stop the subordinates?”*
- *“Yes, the hospital Director knows after 1:00 doctors leave the hospital. He is the Director.”*

## Quality Assurance / Quality Control

**“What are community mechanisms for the people to monitor or give feedback about health activities?”**

> Respondents either did not know about the existence of community mechanisms for monitoring and feedback about health services or they could specify one such as a representative, a community council, or a health *shura*.

> There was variability in how respondents described the accountability or effectiveness of these mechanisms.

Some selected quotes from interviews:

- *“I do not think there is such a thing, because if such mechanism was in place they may behave well with poor patients.”*
- *“I do not know. The men know these things.”*
- *“I don’t know. We don’t live in the town; we are living far away from here.”*
- *“To who we should discuss our problem? No one will listen.”*

- *“We have a representative, but he has not served us. We have told him our complaints many times, but he has not considered them.”*
- *“We have a Health Council. They raise our issues with the hospital.”*
- *“There is a health shura in each District.”*
- *“We have a health Shura, however they are not working properly.”*

**“What can people do when they become frustrated by their experience in health facilities?”**

> There were several negative responses about what people in the community can do if they are frustrated by experience in health facilities; some of these cited the risk of negative consequences in the care or treatment of patients.

Some selected quotes from interviews:

- *“Not much.”*
- *“Nothing.”*
- *“People can’t do anything; they can only leave the hospital.”*
- *“Nothing. Several times people shouted but nobody listens to them. And the doctors are telling us, ‘If you create problem, I will not check your patient.’”*
- *“We cannot argue with healthcare providers otherwise they will not check our patients in the health facility and we have to take our patients to private clinic for treatment.”*
- *“We are sharing our feedback with health council, but it doesn’t affect or doesn’t enhance the quality of health services.”*
- *“Complain to the Provincial Health Directorate: He is a good guy.”*

**“Are you satisfied with the quality of MOPH health service delivery?”**

> The vast majority of respondents were positive or had mixed feelings about the quality of health services delivery.

> Specific examples of dissatisfaction were noted about medicines, slowness of services, and armed conflicts compromising access to care.

Some selected quotes from interviews:

- *“Yes, they are doing what they can do.”*
- *“Yes, they are doing a great job with surgical deliveries and other operations.”*
- *“I not satisfied with quality of services provided here, because prescribing medicines from bazaar and I do not have enough money to purchase that amount of medicines and sometimes borrowing money from relatives or friends to treat our patients.”*
- *“We always have to wait. It is a waste of our time here.”*
- *“Medicines are weak, but staff are trying to help us.”*
- *“After the fighting in <XXX> District, soldiers took all the beds and the nurse came and told my patient, ‘Leave or we will all face problems.’ What should we do?”*
- *“Why the Police are not using their own Clinic? We lose our service when they demand the doctor to help them with the injuries.”*

- *“Some part is okay, some is not very good for us.”*

## Human Rights and Discrimination

### **“How would you describe the level of respect for human rights in the Public Health system?”**

> Only a few respondents had opinions about respect for human rights in the Public Health system and these were largely related to behavior and attitude of health care workers.

Some selected quotes from interviews:

- *“Sometimes healthcare providers behave badly with patients and their family members during healthcare provision.”*
- *“Rude behavior by healthcare providers with patients and their family members.”*
- *“They do not respect patients. In <XXX> Department, a female doctor threw the prescription in my face and said ‘We do not have time. Buy the medicine from outside and do not come back.’”*
- *“They have good behavior. The nurse even gives apples to my son.”*
- *“I have not seen problems.”*

### **“How would you describe the level of discrimination in the Public Health system?”**

> Only a few respondents had opinions about discrimination in the Public Health system.

Some selected quotes from interviews:

- *“I have not seen any kind of racial discrimination, but there is gender discrimination.”*
- *“I am not in the picture about this.”*
- *“I don’t want to answer this question because it will create problem for me.”*

### **“Have you seen that health services are provided to a particular group – while another group is excluded on purpose?”**

> Respondents in this category described episodes when powerful persons have had influence over service delivery, including obtaining preferential treatment.

Some selected quotes from interviews:

- *“Because local Commanders are powerful people, anytime they can take advantages.”*
- *“The military men usually force the doctors to prioritize their patients and ignore the public; however, they have no right to cure their patients in public hospitals.”*
- *“We are waiting for hours to get services at the hospital but those have power will be checked in no time... This is delaying patient’s checking, particularly poor people.”*
- *“Yes, anyone who knows <XXX>, he or she will receive better treatment.”*
- *“If you know someone in the public hospital your patients will be treated fairly, otherwise, they will make excuses.”*

### **“Why do you believe this happens?”**

> The main causes of discrimination or rights violations that were cited by patients and their families related to difficulties in resisting the influence of powerful persons, service pressures, and weak oversight of service delivery.

Some selected quotes from interviews:

- *“If the health care providers not do so they will be threatened by the local Commanders and powerful people and even can lose their jobs.”*
- *“Overcrowding of patients may be the cause.”*
- *“It is regular practice here. They are too busy.”*
- *“Because of lack of monitoring.”*

**“Do you believe MOPH managers are aware of this happening?”**

> Nearly all respondents with an opinion believed Managers were aware of these issues.

Some selected quotes from interviews:

- *“Maybe, maybe not.”*
- *“Yes, managers are well aware of such happening in the health sector.”*
- *“Yes, MOPH at central level must be well aware of these issues.”*
- *“Sure they are aware but they cannot do anything.”*

## **Extortion**

**“Can you give some examples of pressure or extortion you personally experienced in the Public Health system?”**

> Many respondents described specific instances of being pressured to pay workers for access to their family members on inpatient Wards, or to deliver food or supplies to them.

> Respondents in all parts of the country reported threats of violence from support staff that forced them to leave inpatient Wards while visiting their family members; this was a very common experience among respondents in Kabul facilities.

Some selected quotes from interviews:

- *“The workers in governmental hospitals do not let the persons who are accompanying the patients to see their patient or bring them food. They want money. Even when we give them the food to give it to our patients they ask for money.”*
- *“I brought diapers and clothes for the new baby and my sister needed these, but the staff demanded money to take to her.”*
- *“The cleaner asked me for money, but I haven’t paid.”*
- *“I don’t want to answer this question.”*
- *“Yes, I have experienced pressure many times here.”*
- *“...she complained her salary was too low and that I should help her. When I refused because we are also very poor, she started yelling at me and my daughters, ‘Leave!’”*
- *“...support staff beat the patient’s family members, ‘Do not stay here, otherwise the Director will terminate us.’”*

- *“Yes, I paid many times.”*

**“What are the risks of resisting extortion?”**

- > Several patients from all parts of the country described their belief that if they resist extortion or pressure for money that the patient’s care will be compromised or withheld.
- > A few patients cited specific personal experiences of threats of violence or actual violence from having resisted extortion.

Some selected quotes from interviews:

- *“The health workers will not examine our patients if we resist against doctors. And what will happen? Nothing. No one will listen to our problems. Today, I am feeling afraid that if they know what I am telling you, they can know and they will not give medicines to us in future.”*
- *“They won’t treat your patient.”*
- *“They will not provide any kind of care.”*
- *“Some people, nothing, but others are taking it very serious and even beating them as well.”*
- *“Even they beat me.”*
  - > The respondent, a patient, then showed the interviewer bruises on her upper arm.

**Fraud / Falsification / Fakes / Forgery**

**“Can you give some examples of fraud (dishonest behavior) or fakes (things) you have seen in the Public Health system?”**

- > Respondents described episodes of dishonest behavior and suspicions that medicines were not legitimate or authentic.

Some selected quotes from interviews:

- *“I cannot read. How should I know if the medicine is real?”*
- *“I can’t read the date of medicine.”*
- *“Patients are not improving with the medicines given at the hospital or clinics so we are purchasing medicines from Market.”*
- *“The doctor took tablets I brought from pharmacy, put them in his case, and gave different ones to me from his pocket.”*
- *“One day I took my patient to hospital for fractured <XXX>. The doctor prescribed required drugs and materials and a similar patient was there and prescribed drugs and materials for him as well. When I brought the prescribed items, the doctor treated both patients with one prescription and what was leftover the doctor kept it for himself after plastering both patients.”*
- *“The medicine is weak. Patients are not improving with medicines at the Provincial Hospital or the Clinic in the village.”*
- *“We are not sure about the medicines that we are getting. Is it correct tablets? Are they helping?”*

**Conflicts of Interest**

**“Have you observed MOPH health workers referring patients to their private clinic for diagnosis or treatment?”**

- > Most respondents affirmed this practice is happening, with a majority of those in more well-developed provinces (those with at least one large city) expressing near universal confirmation.
- > Respondents from less well-developed provinces had not experienced this and several noted that there are not private health services in their District or Province.

Some selected quotes from interviews:

- *“They are prescribing medicines from particular pharmacy because they have share in it.”*
- *“The doctors are referring the patients to a private hospital. We don’t know if it is needed or not.”*
- *“Yes. The doctors ask the patient to come many times in order to attract the customers and for the first time in government hospital they give the patient the drugs which do not have good quality in order to force the patient to go to the doctor’s private clinic.”*
- *“They have referred me many times.”*
- *“Yes, the doctors and midwives referring patients to private clinic or hospital for treatment and telling patients and their family members, ‘Your patient will deteriorate if he remains in the public hospital so please bring to private sector to provide better treatment.’”*
- *“Here the doctors write prescriptions in a way that only a specific pharmacy can know what is written. It means that each doctor has connection with each pharmacy.”*
- *“There are not private clinics in our District.”*

**“Why do you believe they are doing this kind of referral?”**

- > The majority of respondents responded ‘Don’t know’ or ‘Not sure,’ and those with opinions often cited financial gain as the motivation for referrals to the private sector.

Some selected quotes from interviews:

- *“Due to their relationship with private clinics and drug stores and getting their percentage from those mentioned clinics.”*
- *“I think they refer patients to their private clinics for fees in order to collect more money.”*
- *“For money.”*
- *“To some extent it is needed and MOPH should allow it.”*

## **Bribery**

**“Have workers from the Public Health system asked for (or demanded) bribes from you or your family? Can you give some examples of this kind of situation?”**

- > Most respondents cited examples of requests for ‘extra payments,’ ‘bakhsheesh,’ or ‘sherinee.’

Some selected quotes from interviews:

- *“Only talking to doctors is free of charges. For treatment, surgery, and medicines we are not paying to the hospital or government, but giving to the doctors, nurses, and pharmacy – outside of the Clinic. This is a kind of bakhsheesh.”*
- *“At the Obstetrics and Gynecology Wards staff is asking for money.”*
- *“One of my relative had an appendectomy operation here, the surgeon asked for money.”*
- *“They will never ask you to give them bribe; however they will ask you to give them a gift.”*

- *“Directly the doctors are not asking for money, but support staff is asking for candy after the birth of boys: They are demanding more for boys, up to Afs500, but for girls Afs100-200. Support staff asking for money to allow us to go inside the hospital to visit our patients outside visiting hours.”*
- *“It is different between hospitals. For example I went to <XXX> Hospital two times for my wife’s delivery and the doctor asked me for Afs1,000 on daily basis. At <XXX> Hospital, I myself gave some money to orderlies, but at <XXX> Hospital the orderlies asked me to pay them and the nurse on duty asked to pay Afs500 every night my child was there.”*
- *“Compared to other sectors, the health sector is not bad.”*

**“What are the bribes achieving for the patient or the family?”**

> Bribes, or ‘*bakhsheesh*,’ (as cash or gifts) were explained as away to guarantee performance of duties, to garner respect, to ensure better care, to assure cooperation, and to remove obstacles.

Some selected quotes from interviews:

- *“The patients will be respected by health care providers after giving fees.”*
- *“They receive the attention of the health worker.”*
- *“We can get to see our patient.”*
- *“Respect.”*
- *“They are coming to us when we say, ‘Check about our patient.’”*

**“What are the consequences for MOPH Managers / staff if they are caught asking for (or demanding) bribes?”**

> Among 96 patients and their families, there were zero respondents who described consequences if Managers or staff are caught asking for (or demanding) bribes in the health sector.

Some selected quotes from interviews:

- *“No one will be caught.”*
- *“Nothing.”*
- *“There is no punishment and reward system in the country at all.”*
- *“I do not think the Government has taken any practical decision on this.”*
- *“Nothing. No one has seen any case in court or media.”*

**“Other Risks” of Corruption**

> Among patients and their families, there were no other unique risks of corruption in the Public Health sector raised in interviews or focus groups.

# 5. FINDINGS: FORMER-MOPH DIRECTORS, MANAGERS, LEADERS, AND FRONTLINE STAFF \*

**OVERVIEW:** Former-MOPH Directors, Managers, leaders, and frontline staff described challenges arising from a wide variety of types of corruption and challenges related to the risks of corruption they have observed within the Ministry of Public Health.

These 13 respondents provided unique insights and perspective on the vulnerabilities to corruption, often in great detail.

**The most detailed comments about risks of corruption related to:**

- 1. Leadership and Governance:** Conflicts of interest, influence from powerful persons, and failure to implement control systems that would reduce or eliminate corruption.
- 2. Finance:** Lack of transparency, contracting issues with NGOs, INGOs, and donors, and especially compromised procurement processes.
- 3. Health Management Information Systems:** Failure to fully implement and integrate HMIS.
- 4. Human Resources:** Lack of transparency in recruitment and termination processes, and influence from powerful persons.
- 5. Health Services Delivery:** Failure to coordinate among implementing NGOs, INGOs, and donors.
- 6. Quality Assurance / Quality Control:** Failure to fully implement monitoring systems that are intended to combat conflicts of interest.

Notably, the comments were mainly focused on perceived conflicts of interest and the lack of transparency. Even though all but one of these respondents were ‘forced-out’ of their MOPH role, this emphasis on conflicts of interest and lack of transparency was also reflected among current MOPH Directors, Managers, leaders, and frontline staff.

\* Details that could identify individual respondents have been omitted.

## Policies

**“How are MOPH policies reducing or increasing the risks of corruption?”**

**“Is this vulnerability related to implementation, resources, or something else?”**

- > Respondents described serious challenges in combatting corruption because policies are not appropriate, or, because of language barriers, they are misunderstood.
- > Vulnerabilities were cited in the development process of policies, lack of high-level coordination, and, gaps in the monitoring of implementation of policies both in MOPH and among the NGOS and INGOs delivering health services.

Some selected quotes from interviews:

- *“Most policies exist only in English, which is not understood by 90% of our officials. These were written by foreigners.”*
- *“In general: Policies are not doing either positive or negative effects on corruption because they’re not following the policies. In the case of procurement, the policies increase the risks of corruption because of the huge amount of paperwork and slow process.”*
- *“In policies, effectiveness and efficiency both have problems: Policies are not developed correctly based on evidence and research from our own country’s situation. Because of this, they are not efficient. They are not translated into our languages. Middle level employees do not know English well enough and have to rely on others for understanding the technical parts to be able to implement these policies. It is a design for inefficiency and also corruption. Which is easier? Teach all our staff English, a foreign language they will never use, or translate the policies and adjust them to the context of our health system and our culture?”*
- *“450 HQ workers make policies, but 40,000 others are implementing these policies. This huge number are facing struggle since they do not have clear implementation support because policies are not interpreted to local languages for them.”*

**“How can a standardized HMIS policy promote evidence-based decisions and reduce financial corruption in annual budgets?”**

> HMIS was described as a valuable tool, though also as under utilized in regards to quality assurance and quality controls, and poorly integrated compared to its potential.

Some selected quotes from interviews:

- *“If HMIS is standardized across all of MOPH and all implementers, we will see a reduction in corruption because our health services data reporting will be clean and free from falsification. The Provincial HMIS Focal Point in <XXX> did not have a strong reaction to the weakness of reporting by some implementers in our Province. The weakness was missing data or data which anyone could see could not possibly be correct. He allowed these agencies to give excuse for weakness of missing data. He did not improve the standardization across all our Provinces. He showed that non-standard data would be accepted.”*
- *“HMIS has always been discussed among the senior management of the MOPH, ‘We can’t implement the HMIS with the high standard. The reports coming from the NGOs have problems.’ The reality is the health service data from the NGOs, implementing almost 90% of our services, were not correct or complete information about their activities. At some point this system is just imaginary data. To a large extent, it is not reality.”*
- *“HMIS is not developed well enough and parts of it have needless duplication. There is no HMIS reporting system for the private sector’s data. Human Resources Management Information System is not integrated with HMIS and this could be solved and make more efficiency for Directors and the Minister.”*
- *“Data is not used correctly: No real analysis is happening, and therefore, no feedback to have positive effect on service delivery. HMIS has expert employees, who are recruited by Management Sciences for Health, but this resource needs more integration for the whole of the MOPH to benefit.”*
- *“HMIS should be monitored and evaluated because it has not enough monitoring and evaluation.”*

**“Do you believe health services are delivered according to MOPH policies and strategies?”**

> Respondents described disappointment with how health services delivery has been developed and managed without regard to MOPH policy and strategy.

> Frustrations were also expressed about NGO and INGO implementation, weak leadership and management in MOPH, and conflicts of interest in MOPH senior management.

Some selected quotes from interviews:

- *“No, policies are ignored and strategies are forgotten as soon as they are announced.”*
- *“Services have been delivered according to the benefit and interests of the Directors of the different Departments. I also saw that the international advisor in <XXX> was giving very bad advice to the MOPH staff in that Department: S/He became frustrated by the situation and disappointed. The advising that the Department received was focused on controlling the groups s/he did not agree with. S/He used the position to cause problems for the agencies s/he did not like in that sector and this showed very bad examples for the staff in <XXX>. Why come to this country and do this? How is this helping us in the health sector?”*
- *“No. There has not been a high quality delivery in our health care centers. Service delivery has not been according to the health care policy of the MOPH: If policies were implemented in a correct way we should have a standard hospital in each province. We have a rise in the number of the sick individuals being taken outside of the country for treatment. Without standard hospitals in each province, facilities that follow the policy of MOPH, we can expect that our citizens go abroad for their care.”*
- *“NGOs and INGOs are not reliably monitored and there is no stewardship to make sure they will be delivering our strategies – They work with their own goals and objectives. Afghan NGOs are profit-making businesses, not non-profit like INGOs. Because Afghan NGOs recruit MOPH Managers and Directors as their employees, they have MOPH decision-makers on their staff, which makes clear opportunity for corruption. They are thinking of the profit of my work in this NGO, not the achievement of the goals of MOPH. Strategy of MOPH is not the priority in this situation.”*

**“Do you believe Financial Resources are managed according to MOPH policy and strategy?”**

- > Financial Resource management practices were described as unnecessarily complicated and lacking in transparency.
- > Contracting issues for NGOs and INGOs, as well as procurement, were mentioned as especially at risk of corruption.

Some selected quotes from interviews:

- *“Who can say how these health service delivery contracts are decided? We face such difficulty with contracting and our resources are used in ways that do not make much sense.*
- *“MOPH will not solve its difficulties with implementing its strategy until there is real transparency in how funding is directed and controlled. There have been so many decisions on how to manage financial resources that were against our long term development strategies, that it is a big disappointment to all of us who know these situations. How has it gone wrong in too many ways, I can not give the right answer. It is not the fault of Dr Feroz; really, he inherited a ship with so many different kinds of leaks that it is in danger of sinking. None of ‘the crew’ are trying to solve the leaks, in fact, they are each focused on their own issues and concerns, and not working as a team to keep it stable. His work is very very difficult in this condition. I don’t know if he is even in the picture about what some of his Directors are doing against his success.”*
- *“Procurement and contracting are so difficult, I am not confident that there are many senior Director-level Managers who have the strength to promote transparency anymore. Everyone is just trying to do their own tasks, and of course, without transparency, the decisions about financial resources are not trusted. Always, always this idea that each person is focused on getting money.*

- *“There is no relationship at all. The Departments can say the exact situation of what is needed and it is ignored. They can say something totally wrong and it is also ignored.”*

> Why do you think they are ignored, whether they are right or wrong?

*“The decisions about the budget will not be connected to the requirements of the Departments because the decision makers have no confidence that the Departments are competent. The Directors assume the Departments are self-interested and this means their requests and the needs they say they have will be ignored. It goes both ways: The Departments ignore the Directors and say what they want, and the Directors ignore the Departments because they have no confidence in what they say. This is the impossible situation because there is not trust in these relationships.”*

**“Do you believe Human Resources are managed according to MOPH policy and strategy?”**

- > Human Resource policy and practices were criticized, especially the perceived lack of transparency in recruitment and terminations, as well as neglect of prioritizing candidates with suitable technical qualifications.
- > Respondents also described the influence of powerful persons, especially Members of Parliament.

Some selected quotes from interviews:

- *“Competency Based Recruitment is not a reality in MOPH HQ. Obviously. Look at the people now in key responsible roles; so many are not at all qualified and can not be described as having even the minimum of correct qualifications. The decisions on recruitment and firing are based only connections and relationships. This is against our policy in the Public Health system, but it is exactly correct according to local tradition and practice.”*
- *“Members of Parliament are using their power, naturally, as this is our habit here. We have many negative results in Kabul HQ and also in provinces; many many non-technical people have found some route to employment through the support of Parliament Members.”*
- *“No, mainly I think there’s been the very big problem of nepotism. Directors have the struggle with obligations because of relationships with powerful people and the groups they belong to.”*

**“What do you believe are the risks of corruption in Human Resources policies?”**

- > These respondents were uniformly aware of risks that result from corrupted policies in human resources, including nepotism, favoritism, lack of legitimately qualified people achieving key roles, and conflicts of interest.

Some selected quotes from interviews:

- *“Nepotism and favoritism.”*
- *“Unwillingness to solve the problems with recruitment. We still have real struggle in managing Diplomas and Certificates and discovering which are real and which are fakes. When fakes are found, how can our Directors justify not searching for these sources? They will keep bringing more and more false documents until we stop accepting them and shut-down the system producing them.”*
- *“Our Directors are under the control of Members of Parliament – So we have too many wrong people in important responsible roles.”*
- *“There is not a transparency and accountability. Appointing their friends in high positions through nepotism and cronyism. Why a staff is removed from his position against the law of the Civil Servant Commission? The Advisors around the Minister are the sources of nepotism since he has the authority to appoint and remove staff.”*

- *“There are many Directors and senior Managers who are receiving salaries from different sources and you can know that they have different agendas. This is not helping MOPH with this kind of corruption of our priorities. It is plainly a conflict of interest.”*

## Contracts

### **“Have MOPH priorities been ignored because of corruption?”**

> Comments reflected perceptions of conflict of interest and MOPH leadership having been distracted from MOPH’s priorities by the priorities of its donors.

Some selected quotes from interviews:

- *“Transactions takes place out of view; senior managers of MOPH are in key positions of NGOs.”*
- *“This has happened in so many different ways I could not list them all without wasting your time.”*
- *“We have always needed a reliable system of recording births and deaths, but these were not the priority of donors, and our own leaders have been thinking of other things. Because we have no registry of these events, we can’t describe the extent of health problems by age and sex in our populations, and we have no idea about basic epidemiology. Epidemiology should be the basis of exploring evidence and making sound decisions. We have let corruption distract us from these priorities.”*
- *“MOPH will do what <XXX> tells them to do. Until a Ministry has its own funding, the donor makes the priority decisions.”*
- *“Senior staff at HQ are protecting each other in these corrupt relationships. They are thinking of the money for themselves. The reason for decisions is the money, not the success of MOPH.”*

### **“What are the risks of corruption in the financial part of the contracting processes for health care services to NGOs and INGOs?”**

> Respondents cited lack of transparency in contracting as a risk, from each of the perspectives of bidding, implementation, and monitoring.

Some selected quotes from interviews:

- *“A lack of transparency in the bidding process of contracts.”*
- *“The lack of monitoring on the implementation of projects in the capital and in the provinces.”*
- *“Contracting from the Ministry by one entity, and then third party implementation of the service.”*
- *“The lack of a system of regular inspections of the Ministry to examine its funding for implementation by NGOs.”*

### **“What are the risks of corruption in the MOPH contracting process of Human Resources?”**

> Respondents described human resource processes that have been compromised internally from weak enforcement of MOPH policies (or Civil Service Commission rules), and externally, from the influences of powerful persons.

Some selected quotes from interviews:

- *“MOPH Managers and Directors having two jobs simultaneously.”*

- *“We are not in the picture about INGO and NGO salary and benefits. These agencies implement almost all of the health services in our country, but we are not clearly understanding how each of them are dealing with their human resource issues. It makes tension between MOPH and implementers. These agencies might have not developed any rules against having two employment contracts at one, but this is against our internal regulations as a public system.”*
- *“The successful candidate for a special Technical Advisor contract will be the candidate with contacts in the circle of the Minister, or the interested Members of Parliament.”*

## Embezzlement

### **“Where has there been Leadership success in stopping embezzlement and theft in MOPH?”**

- > Several respondents mentioned the official statements released by MOPH in 2015 regarding health sector corruption, good governance, and accountability.
- > One respondent described the effectiveness of Inventory lists to control assets, as had been mentioned by respondents in other categories.

Some selected quotes from interviews:

- *“So far, only talking.”*
- *“The new Minister is a courageous and determined person, but the problem is with the people surrounding him.”*
- *“The ‘Statement on Corruption in the Health Sector’ was a surprise. If it will be for actions and fighting these issues, better.”*
- *“There has been some success for individual staff, some senior Managers. For example, some Hospital Directors, especially in Kabul, they have made progress to focus on qualified people in these key jobs to get quality performance in their facility.”*
- *“Asset management in hospitals: There are specific lists for medical equipment that register them, item by item, but the system is not efficient above that level.”*

### **“What are the Leadership failures related to embezzlement and theft in MOPH?”**

- > The remarks from respondents about leadership failures were related to the external influence of powerful people in decisions on health service delivery contracts, and lack of coordinated implementation of oversight processes to prevent embezzlement.

Some selected quotes from interviews:

- *“The interference of powerful people. The most powerful have the strong control over health service delivery contracts with their own NGOs.”*
- *“The lack of coordinated financial controls make you crazy and creates corruption. It is not organized and there is very little cooperation, you can become angry and frustrated in everything you want to do.”*

### **“Do you believe that there are MOPH staffs involved in embezzlement of public goods?”**

- > Embezzlement and theft were reported (or suspected) by all respondents in this category.

Some selected quotes from interviews:

- *“Yes. Medication which are allocated to patients is being sold in their private pharmacies.”*

- *“Yes, sometimes it happens.”*
- *“I believe it will be how they are supporting their families.”*
- *“In overtime funding it is a real concern. The budget is managed locally and there are so many cases where the amount is handled by the most corrupted person at that site – This means there is skimming off the top of each payment, some ‘ghost hours’ are happening, and totally fraudulent entries onto the Overtime Sheets, too. This needs an army of oversee-ers to prevent all these steps from developing into a parallel system of embezzlement.”*
- *“It is normal. They believe it is their benefit, especially using official vehicles.”*

**“What are the parts of MOPH financial systems which are most vulnerable to corruption? And least vulnerable?”**

- > Procurement was mentioned by most of the respondents in this category.
- > Lack of oversight and failure of monitoring processes have resulted in systems that are vulnerable to corruption.

Some selected quotes from interviews:

- *“Procurement is most vulnerable, overtime is next after that.”*
- *“Procurement Department is the most vulnerable but during the last three years it has decreased due to the decentralization system, meaning, the hospitals directly purchase and procure rather the Ministry itself. Hospital autonomy, as it is called, still has these risks of corruption, so I believe that high-level oversight system for making the guarantee of transparency and honesty of the local decisions will keep control of the dishonest behavior. This means, naturally, that the high-level people doing this oversight must be prevented from making deals on approvals that are benefitting them in other ways. Transparency is very difficult at all these different transactions, but it should be possible.”*
- *“Purchasing and procurement for a single item will take months and months. It has huge bureaucracy. The numbers of steps and signatures will give many different opportunities, and motivation, for corruption to happen.”*

## **Nepotism / Abuse of Power for Personal Benefit**

**“How is nepotism a risk for good governance in MOPH?”**

- > Respondents catalogued many examples of risk to good governance from engaging in nepotism.
- > Examples included reduced trust, weakened management systems, and poor quality of services.

Some selected quotes from interviews:

- *“No one can trust our Public services because they see we have brought only our own group into the key jobs, even when they are weak or totally ill-suited to the responsibility.”*
- *“It is a huge problem. With every change of the Minister there would be a huge illegal changes and removals and appointments in the Ministry. It is the same in all Ministries. This is the culture of rewarding friends and associates and bringing into positions the people you trust and can consider reliable. But many of these are not trustworthy technical people – they are classmates or Party members and it has a negative result.”*
  - > Why will it have a negative result?
- *“Those individuals are then having the next part of influence and if they themselves are non-technical or non-performing, they will have different priority in who they give the support to for the ones they bring into additional roles. This is how we have a result of whole sections or Units where*

*the initial nepotism of a non-technical, unqualified choice leads to disaster. It can be an actual disaster. This is the HEALTH sector after all.”*

- *It is not only our country, even though I am the first to say, ‘We have a massive problem.’ Look at the WHO and the UN: They are high responsibility international organizations and they suffer from these exact same risks of weakened governance because of nepotism and favoritism in selecting candidates for key technical jobs. It is difficult to stop this from happening.”*
- *“Services suffer. The quality is reduced. Administration is about relationships and keeping power and control, not about delivering good health care. Health care delivery quality is reduced.”*

#### **“Which specific parts of MOPH are at risk of abuse of power?”**

> Respondents in this category cited examples they believed were abuse of power; all the comments were related to human resources.

Some selected quotes from interviews:

- *“Human resource is the most at risk of abuse of power. This is happening at all facilities and for many different jobs where the powerful person will have influence and decisions.”*
- *“All of the Ministry, in all Departments. In hospitals, many Directors were removed and now they are jobless. <XXX> Directors in the Ministry were removed by <XXX> and his team. All these got new appointments; all these removals were against the Civil Servant Law.”*
- *“Overtime is a very big problem.”*

#### **“Do you believe MOPH Manager / employees gives priority to their relatives / friends / own group when recruiting new staff?”**

> This was acknowledged by all respondents in this category.

Some selected quotes from interviews:

- *“Yes.”*
- *“It is a principal. Managers and staff practice it widely in the Ministry.”*
- *“I was in my own position due to this approach of recruitment. All of us were. It is expected.”*
- *“No one can have the high level role without this priority from the Leaders.”*

### **Quality Assurance / Quality Control**

#### **“How do you perceive the accountability and transparency mechanisms in MOPH on its own Leadership?”**

> Among respondents who expressed an opinion, perceptions were negative on the accountability and transparency of MOPH on its own leadership.

Some selected quotes from interviews:

- *“No, it is not according to the rule and regulation of the Government. There is not an appropriate system in MOPH. The lack of a coordinated system gives opportunity to the staff to engage in corruption. Advisors have tried to develop it, but we don’t have a system, it is not coordinated and there are no consequences if some individuals do not cooperate.”*

- *“In Human Resources, this is the exact example of the problem: There isn’t a correct system to regulate medical certificates or Diplomas. Many of these are purchased and have been made as fakes. How can Human Resources be accountable to the rest of the MOPH management if they are not using a systematic method of checking and vetting certificates and Diplomas?”*
- *“Directors and Managers are linked to Members of Parliament and international donors. These situations do not led to accountability or transparency; they actually, in reality, help to avoid accountability and transparency. Our public system is more hidden in this case.”*

## Human Rights and Discrimination

### “How would you describe the role of community leaders in addressing (or causing) problems in MOPH?”

> The role of community leaders was characterized as influencing decisions of health authorities in health services delivery and human resources, and potentially as both positive or negative.

Some selected quotes from interviews:

- *“Except for influence on Human Resources, not very much in Kabul. They play a huge role with MOPH and health services delivery in the provinces.”*
- *“Community leaders can play a good role for the health management, to put focus on better quality based on the desires and the complaints of the community. They are also making difficulty about recruitment, of course, like all people with power.”*
- *“They can create pressures on MOPH that lead to corruption, especially about health facilities and procurement. These are situations that MOPH and health sector NGOs and INGOs are dealing with on an hour by hour and day by day basis. However they will give directions on the local services, the MOPH will support it, even if it is against the contract agreed with MOPH HQ and recommended for approval by the Provincial Health Directorate before that moment. There is no possibility to resist these kinds of community leader pressures or they can become a threat.”*

## Extortion

### “How does MOPH Leadership manage pressure or extortion?”

> Two Respondents described situations when colleagues in MOPH faced pressure related to contracting decisions for health service delivery with NGOs and INGOs.

Some selected quotes from interviews:

- *“When I was in the <XXX> Department, we had many difficult discussions about the demand of <XXX> that his preferred NGO should receive the Basic Package of Health Services contract in <XXX>. This was not actually discussion, it was his clear demand. He was so angry that there was any question from our Director about this contract. It was not many days until our Director gave agreement.”*
- *“We received official letter from <XXX> that they expected a final decision on the hospital contract in <XXX> in some small number of days. After we had some discussions in our Unit, the two local staff working at <XXX> in Health Section came to our office. They were very frustrated that we did not select <XXX> for the contract and we explained the marks system for the score of the bid. One of them was angry and left to call <XXX> and he came to our office in the afternoon with <XXX> and our Director changed the decision. He told me, ‘Don’t worry about this. They have agreement on the situation in <XXX>.’”*

## Fraud / Falsification / Fakes / Forgery

**“Do you believe there is any falsification of internal reporting systems within MOPH?”**

> Half of respondents replied that they believed this was happening, or at risk of happening.

Some selected quotes from interviews:

- *“I believe it is happening.”*
- *“The reporting from NGOs to MOPH HQ is not closely checked each time for all of these agencies to verify that the NGO has made accurate reporting. This could make gap for falsifications.”*

**“Do you believe there is any falsification of external reporting systems of MOPH?”**

**“For example, to donors or GoIRA authorities?”**

> Only one respondent believed that external reporting *might be* falsified.

Some selected quotes from interviews:

- *“This might happen, but I am not in the picture.”*

## Conflicts of Interest

**“What are the risks to MOPH’s credibility when the Leadership ignores cases of conflict of interest?”**

> Respondents cited the risk of reduced reliability in the eyes of health sector donors when conflict of interest cases are not dealt with.

Some selected quotes from interviews:

- *“The MOPH is proving to all foreigners in the donors that we are not reliable as partners in managing the health sector effectively for our own community. We appear to be only interested in money, not health status of our people. Why should the <XXX> help us? If we don’t care enough ourselves, why should they?”*
- *“Strategic plans would consider this issue and implement monitoring and controls. The Ministry has directly addressed this in its rules, and has the authority to enforce Afghan laws. But the Ministry does it very rarely. The senior Managers and Directors of the Ministry are themselves employed in NGOs, and have many personal and professional connections, so they are not interested to prevent these things, or to challenge the NGOs.”*

## Bribery

> This topic was covered under other questions.

## “Other Risks” of Corruption

> No additional or unique vulnerabilities were described by respondents.

## KEY FINDINGS FROM DIRECT OBSERVATIONS

**OVERVIEW – Many more direct observations took place than are reported here.**

**> Influence and pressure about recruitment and hiring was observed, in person as well as through written and telephone methods:**

- *“During interview session, one Member of Parliament and another member of the Government came into the respondent’s office and pressured him/her to accept their preferred candidate for a role in this Department. The Member of Parliament also handed the respondent a stamped letter providing this candidate’s details.”*
- *“During the interview, we were interrupted by several calls to the respondent from persons trying to convince him/her that a specific person should be selected for a Trainee position at <XXX>.”*
- *“When I entered this office, a girl and two men were sitting there so I sat there as well. From their discussion, I learned that the two men had a patient in <XXX> Hospital. The Director told them that he will introduce them as the relatives of <XXX>, a Member of Parliament.*

*Then the Director had a call and he said, ‘She is the <XXX> of Parliament Member and should succeed in this request. I have talked to <XXX> regarding this issue.’ I spoke with the girl who was sitting there. She had graduated from <XXX> faculty from <XXX>. She wanted to be introduced to <XXX> Hospital together with her classmates for practical work. She has brought a letter from one of the Parliament Members to the Director. He had refused at first, but after she brought a letter from Member of Parliament who is related to this Director, she succeeded in getting the recommendation for her practical work.”*

**> Inventory processes were being followed in almost all observations:**

- *“I observed that the Inventory list was posted, as described by the respondent, and had been duly signed and dated by the Unit Manager.”*
- *“The Inventory list was present and previous lists were also on the same clipboard for inspection.”*
- *“The Stationery Inventory List was checked and had been signed-off by the Manager.”*
- *“Furniture in the Department had all been tagged with name of the Hospital, and I was shown the Inventory list that corresponded to these items.”*
- *“The Inventory list was present, but not updated.”*
- *“Whole blood units were marked as ‘Present X 4’ but none were found in the refrigerator.”*

**> An episode of embezzlement was observed:**

- *“When I was sitting in one of the Departments of <XXX>, in the female staffs’ room, I saw that the female doctors brought the blank prescriptions and called the female pharmacist. They told the pharmacist, ‘We need some drugs for our family, will you sign these prescriptions?’ They wrote prescriptions together and registered them by the name of patients. Then they put the drugs in their bags and left.”*

**> Failures to follow standard safety precautions were observed:**

- *“I observed in a private clinic that while a patient was receiving x-rays, the other male and female family members of the patient were allowed to stand nearby in the same room without any protections or advice about taking precautions.”*
- *“The temperature on the medical supply refrigerator had not been checked/recorded in more than one month.”*

**> Absenteeism was observed on several occasions:**

- *“I returned to the Outpatient Department at 14.00 and remained there until 16.30 and did not see any doctors return to their offices during the afternoon session. Two nurses were present, and they accepted patients into Exam Rooms, but these were without any doctors present in the Clinic.”*
- *“Health care providers were not present after 12:30 pm in the hospital.”*
- *“...patients were told to go to a specific private sector clinic by the supporting staff.”*

**> Referral to a private sector company was observed; the doctor was a shareholder:**

- *“I observed that family of a patient was told he needed diagnostic examination and they should go to a particular company; the details of the location of the company were given to the family. When examining the business card, the Father asked, ‘Who is this Dr. <XXX>?’ the staff told him, ‘He is our doctor here.’”*

**> Comments from Clinic staff that they had never received a formal training needs assessment were verified after reviewing personnel files at the Clinic:**

- *“After examining HR files, I determined that none of the clinical staff at <XXX> Comprehensive Health Center had ever had a training needs assessment for their clinical skills.”*

**> Medicines on hand in a Regional Hospital were checked for expiry dates:**

- *“I checked the dates on medicines in the Pharmacy Department and observed many of these were out of date and expired.”*

**> After receiving reports from community members that Comprehensive Health Center in their District only had male employees on staff, an on-site visit was conducted:**

- *“The Clinic did not have a female doctor.”*

