Independent Joint Anti-Corruption
Monitoring & Evaluation Committee (MEC)

END STATE REPORT OF VULNERABILITY TO CORRUPTION ASSESSMENT IN THE AFGHAN MINISTRY OF PUBLIC HEALTH

October 10, 2019

Kabul, Afghanistan

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ACRONYMS

AGO	Attorney General's Office
AHS	Afghanistan Health Survey
ANHAO	Afghanistan National Health Accreditation Organization
BHC	Basic Health Center
BPHS	Basic Package of Health Services
CC	Citizen Charter
CCNPP	Citizen Charter National Priority Program
CHC	Comprehensive Health Center
COI	Conflict of Interest
CSO	Central Statistics Organization
CSOs	Civil Society Organizations
DHS	Demographic and Health Survey
DPR	Directorate of Public Relations
DPSC	Directorate of Private Sector Coordination
EPHS	Essential Package of Hospital Services
EU	European Union
GDCM	General Directorate of Curative Medicine
GDEHIS	General Directorate of Evaluation and Health Information System
GDHR	General Directorate of Human Resources
GDPS	General Directorate of Pharmaceutical Services
GoIRA	Government of the Islamic Republic of Afghanistan
GRM	Citizens' Charter Grievances Redressal Mechanism
HCO	Health Complaint Handling Office

HCOHSI	High Council on Oversight of Health Sector Integrity
HLHOC	Hight Level Health Oversight Committee
HMIS	Health Management Information System
HR	Human Resources
HSOO	Health Sector Ombudsmen Office
IAD	Internal Audit Department
IARCSC	Independent Administration Reform and Civil Services Commission
ICAHO	Independent Commission on Accrediting Health Organizations
ICHSAR	Independent Commission on Health Sector Accountability and Reporting
ISO	International Organization for Standardization
KIT	Royal Tropical Institute, Netherlands
KPI	Key Performance Indicators
M&E	Monitoring and Evaluation
MEC	Independent Joint Anti-Corruption Monitoring and Evaluation Committee
MoJ	Ministry of Justice
MoLSAMD	Ministry of Labor, Social Affairs and Martyrs and Disabled
MoPH	Ministry of Public Health
MRRD	Ministry of Rural Rehabilitation and Development
MSS	Minimum Service Standards
NGO	Non-Governmental Organization
NMHRA	National Medicine and Health products Regulatory Authority
OOP	Out of Pocket
PPHD	Provincial Public Health Directorate
PSD	Pharmaceutical Services Directorate

QC	Quality Control
SMART	Specific, Measurable, Achievable, Results-oriented, Time-bound
SOP	Standard Operating Procedures
TI	Transparency International
UNDP	United Nations Development Program
USAID	United States Agency for International Development
VCA	Vulnerability to Corruption Assessment
WHO	World Health Organization

Executive Summary

Objectives

To assess the progress toward achieving the outputs, outcomes and impact addressed in MEC's 2016 MoPH VCA, as well as eight quarters of monitoring by the MEC Active Follow-Up Team.

Background

MEC conducted an MVCA in the MoPH in 2016 and suggested 115 corrective actions. Following the report MoPH identified the priority areas and established working groups to work on its implementation. During the implementation modifications were made to 52 recommendations. MEC follow up team has been monitoring implementation of the activities through data collection and verification of results for eight quarters after which the job has been handed over to MEC M&E team.

Methodology

A desk review of all available documents was undertaken. Outputs, outcome and impact with its indicators and means of verification were defined. Interviews and FGD have been conducted with MEC, MoPH at central and provincial level, community members, donors, NGOs and partner agencies such as AMC and CCNPP. In addition, evidenced to verify the achievements were requested and analyzed. Processes were observed when appropriate.

Findings & Conclusion

This assessment followed up the status of remaining 112 recommendations as per the MEC eight monitoring report. The MoPH submissions were reviewed and verified which indicates that MOPH has been successful to fully implement 80% of the recommendations, while another 4% has been partially implemented and implementation of another 16% of the recommendations is pending.

MoPH has achieved remarkable results in producing the outputs such as establishing the NMHRA with investment in human and technical resources, establishment of a database for proforma registration, revision of Pharmaceutical Law, initiating QC of Pharmaceuticals in the capital, producing the related SOP, guidelines and regulations, strengthening monitoring capacity and processing procurement of necessary equipment.

To strengthen the M&E a data warehouse (DHIS2) has been created and access to it has been provided to the MoPH staff at the periphery and staff have been trained on its use. This achievement was one of the criteria for which the MoPH Minister received the Best Minister's

award in Dubai. Supplemental auditing of health services by the CCNPP has been implemented for the first time which measures the quality of health service delivery and ensures maximum community participation and dialogue with health service providers. To empower Health Shuras in monitoring of health services their ToR has been revised and they are currently being actively involved in the CCNPP monitoring and evaluation.

The AMC has been established in 2017 which aims to ensure patient's safety and satisfaction. This institution is thriving to improve quality of health services through strengthening educational standards for medical staff and so far, has been able to receive and process 29 complaints from the clients. Similarly, the ANHAO has been established which aims to accredit health facilities according to the internationally accepted standards.

The PRD has improved its working relationship with other MoPH departments and has been using social media and MoPH website for educating community on MoPH achievements. MoPH has translated all its policy and strategy documents into local language and it was confirmed by the stakeholders that MoPH policy development follows a standard guideline and is participatory. Most of those documents are available in MoPH website.

MoPH started to effectively manage health staff absenteeism by installing the finger scanners and increasing oversight over staff availability in BPHS/EPHS facilities. As per the MEC monitoring reports 72 MoPH employees have been detected and punished for absenteeism in one quarter only.

MoPH has developed an anti-corruption strategy followed by a COI policy, implementation of which has already started. Patient referral guideline and SOP have been developed and are currently being in use. Only during the MEC eighth monitoring period 272 cases of breach in the guideline by implementing NGOs were found and followed by disciplinary actions. Private use of ambulances has been monitored by GCMU and the GDCM. GDCM have also assigned a committee which acts on the results of their monitoring. To improve quality of health service delivery a performance-based management of BPHS/EPHS contracts using KPI and targets has been initiated in SEHATMANDI project.

To strengthen human rights and combat discrimination the HCO has been established which works collaboratively with similar entities in AMC and NMHRA inside MoPH. To educate community they have had several interviews in private TV stations and are receiving complaints through phone, email, Facebook, Twitter and complaint boxes including a feedback mechanism. The HCO available data shows that around half of the complaints relates to staff behavior followed by issues with quality of care and availability of medicine, equipment and staff. Similarly, Patient Representative Offices have been established in tertiary hospitals and are currently receiving patients' concerns and provide information to the clients. Likewise, the GRM in the

community level has been created to serve the community needs and listen to their voices. To prevent nepotism and abuse of power a committee in the HR reviews the job applicant credentials and have been detecting and dealing with fraud, falsification and forgery.

Despite the considerable progress, areas have been identified which has not made any progress. An independent oversight over several activities such as staff absenteeism and COI in referrals does not exist. Other gaps include lack of any training to AGO staff, poor case tracking by IAD, absence of a systematic approach to staff training, resource and inventory management and auditing and lack of KPI for MoPH staff and departments. Publicizing MoPH progress in integrity, good governance, transparency and accountability has not been adequate and systematic. In the last 4 years MoPH procurement entities including the GCMU and the NGOs have not been accredited by an independent institution to deliver their mandate. Integrity system assessment of HR and finance department has not been conducted and an independent audit of the recruitment of higher MOPH positions covering the last 2 years is still pending.

The assessment also showed that the establishment of two entities namely ICHSAR and ANHAO or similar entities with structure, ToR and scope as defined by MEC recommendations are beyond the authority of MoPH.

To measure achievements of outcomes indicators such as client satisfaction, volume of health services, new outpatient visit concentration index, quality of health services and HMIS use and for impact assessment access to health services, cost of health services to the families and Public and Stakeholder's trust have been examined.

Outcome results are generally encouraging as over half of respondents were satisfied with the health services while this was much higher at 90% for Kabul hospitals; new outpatient visit concentration index referring to promoting human rights and lack of discrimination has been on continuous and steady rise and over half of health facilities as measured by CCNPP met all the MSSs. However, volume of maternal health indicators and child immunizations at national level has either been stagnant or slightly declined; HMIS use has slightly declined and there have not been any improvements in health facility management functionality index.

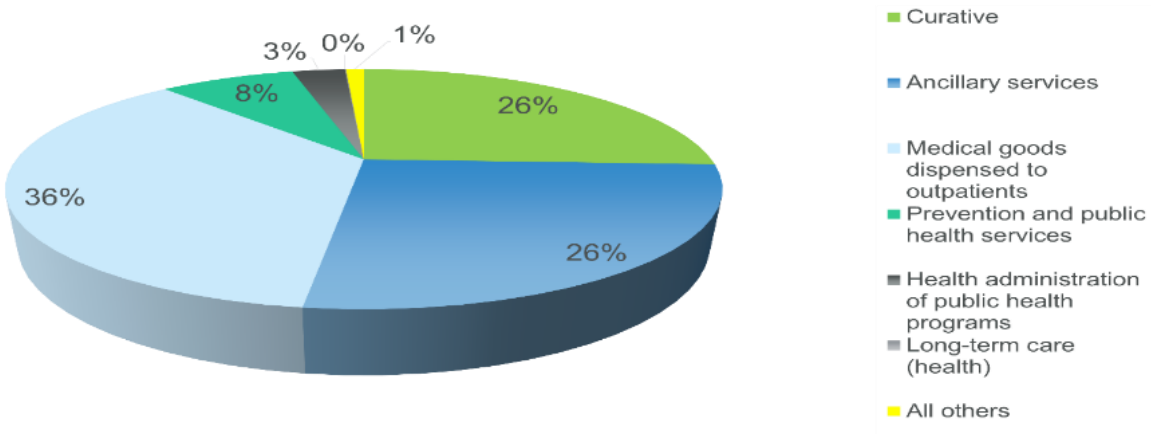
Access to health services has slightly declined over the last 3 years prior to the survey, half of respondents mentioned they chose public health facilities for childbirth as opposed to 10% opting for private health facilities which is encouraging. The discouraging impact has been a steady increase in OOP health expenditure by households that poses serious risk to their economic status as it puts them at risk of falling into poverty. The highest expense being the pharmaceuticals which could be linked to the problem with management of medicines. The improvements in health impact need to be interpreted cautiously as it takes much longer for impact to be improved and several factors outside control of the MoPH affect the results

Introduction

Afghanistan has made remarkable improvements in health indicators. According to the latest AHS 2018 majority of respondents (56.6%) could reach a health facility within 30 minutes and cumulatively, 90.6% could reach a facility within two hours. Despite the progress Afghanistan still faces huge challenges to further improving health indicators and ensuring the delivery of quality and affordable health services to its citizens (MoPH, 2017). High rates of corruption in the country, combined with its tough geographical terrain and extreme weather conditions, have affected access to health services. Moreover, Afghanistan insecurity has been on the rise, further hindering the ability of ordinary Afghans to reach health services.

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. At the household level the greatest health expenditure goes to purchase of medicine (36%) followed by ancillary medicine (26%), curative medicine (26%), prevention and public health services (8%), health administration and long-term care (MoPH, 2019).

Figure 1. Private (OOP) Health Expenditure as Proportion of Total Health Expenditure (MoPH, 2019)



Source: NHA 2019

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.

Afghanistan remains highly vulnerable to corruption. Transparency International ranked Afghanistan 172 of 180 countries in its Corruption Perception Index (TI, 2018), which in the context of fear, pain/suffering, uncertainty and death, increases the toll on families and households where they have to pay bribes, and left largely voiceless. Given their vulnerability they are often taken advantage of by inappropriate referrals to the health provider's private practice. Over the last 10 years factors such as poor governance of the health sector, weak monitoring of health service delivery, emphasis on contract management over performance management, the presence of actual or perceived conflicts of interest, lack of enforcement of transparency and accountability, and unavailability of information openly to everyone, have combined to create systematic opportunities for corruption in the health sector (MoPH, 2017). In addition, the legal and institutional framework to fight corruption is weak in Afghanistan. Therefore, these vulnerabilities require the Afghan Government to implement strategies to tackle the problems in order to improve health outcomes for the people of Afghanistan (Transparency International, 2019).

Background

MEC conducted a pharmaceutical importation process Vulnerability to Corruption Assessment (VCA) in 2014. Later, at the request of the Minstar of Public Health, Dr Ferozuddin Feroz, MEC conducted an Ministry-wide Vulnerability to Corruption Assessment (MVCA) in 2016 with the aim to identify the extent of corruption risk, identify where vulnerabilities existed, define lessons learned and recommend corrective actions (MEC, 2016). The report of the MoPH MVCA summarizes the lessons learned and recommended actions under the following 19 areas:

1. M&E
2. Pharmaceutical importation
3. Independent accreditation organization
4. Liaison with AGO
5. Policies
6. HR management
   Contracts
7. Embezzlement
8. Resource management and auditing
   Nepotism/abuse of power
9. Training and professional development – Afghan Medical Council
10. Quality assurance/Quality control
11. Human rights and discrimination
    Health *Shura* empowerment
12. Extortion

13. Fraud/falsification/fakes/forgery
14. Conflicts of interest
15. Integrity of contracts
16. Bribery

The MoPH MVCA proposed 115 recommendations to correct the shortcomings. Of these, 11 major recommendations intended to enhance coordination and cooperation with stakeholders within and outside the health sector. The recommendations covered the following areas: Health *Shuras*; expanded independent oversight; overhauled auditing; establishing three new health sector bodies namely Independent Council on Health Sector Accountability and Reporting (ICHSAR), Independent Commission on Accrediting Health Organizations (ICAHO) and High Council on Oversight of Health Sector Integrity (HCOHSI); liaising with the AGO; liaising with the Afghan Independent Human Rights Commission; establishing a robust contracting review group; independent oversight and monitoring of all senior MoPH appointments, and improving the quality of imported pharmaceuticals. Similarly, to ensure observation of human rights and prevent discrimination, an Health Sector Ombudsmen Office (HSOO) was proposed. More broadly, recommendation were developed across all areas of MoPH to tackle priority systemic, leadership and integrity issues.

The following three recommendations were later deemed not feasible and dropped:

1.1.4 ICHSAR offices must be independently funded to retain their impartiality from the MOPH management structure.

2.4 Licensed National Pharmaceutical Products List must be updated annually.

13.4 HSOO offices must be independently funded to retain their impartiality from the MOPH management structure.

The MoPH welcomed the original MVCA report and its leadership proposed a committee to work on implementation of MEC's recommendations. The committee developed criteria such as importance, feasibility, relevancy, affordability, follow-up requirement, capacity to implement and time – and prioritized them for action.

Reports of their accomplishments were collected regularly by the MoPH focal points; these reports and the supporting evidence were compiled into Monitoring Reports each quarter by a MEC Active Follow-Up Team. This Team conducted regular monitoring visits to the relevant institutions and conducted field missions to verify implementation through review of documents, key informant interviews, Direct Observation and Focus Group Discussions. The Monitoring Reports covered the period from July 2016 to June 2018. By the 4th quarter of MEC's monitoring,

52 of MEC's Recommendations had been modified to reflect the shift of implementation within the roles and responsibilities of the existing MoPH entities (MEC, 2017).

After the eighth quarter of monitoring, the task of following-up and verifying implementation status was transferred to the MEC M&E Team. The M&E Team track the implementation status of the recommendation through a more typical reporting system consisting of communications to MoPH Focal Points and documenting their responses. Prior to launching this End-State Assessment, no reports of achievements have been submitted to the MEC M&E team by the MoPH.

Methodology

In 2019 MEC committed to conduct an "End-State Assessment of the Outputs, Outcomes, and Progress Toward Impact Resulting from the Ministry of Public Health's Implementation of MEC's Recommendations". The End-State Assessment is intended to determine to what extent MEC's recommendations have supported the Ministry of Public Health to achieve immediate and short-term results such as products or productiveness (outputs), changes that are detectable within the timeframe of the MoPH active monitoring (outcomes), and document any long term changes (progress toward impact) from an anti-corruption-perspective.

This Assessment has examined the progress MoPH has made since establishing the baseline in the 2016 MoPH MVCA in regards to achieving outputs, outcomes and progress towards the impact as a result of the recommendations. This End-State Assessment will establish a new model for MEC's approach to the closure of its active follow-up of recommendations as the responsibility for monitoring progress on implementation shifts to the MEC Monitoring and Evaluation Team as part of their continuous monitoring process.

The Assessment initially consisted of desk review of documents including MEC's VCA on MoPH Pharmaceutical Importation Processes, MEC's full MVCA examining all of the MoPH, the MoPH quarterly Monitoring Reports and other supporting documents submitted by the MoPH focal points. For individual recommendations, the outputs, outcomes and progress toward impact, along with respective indicators, were each identified (see Annex XX.)

An update of achievements since the final Monitoring Report by MEC, along with additional supporting documents, have also been collected. Interviews were conducted with relevant staff and managers at MEC, 12 NGO managers, 7 donor representatives and another 35 MoPH senior staff including managers and directors at central level and 12 at the PPHOs for this assessment. In addition, the other partners such as the staff at the Afghan Medical Council, MRRD, and community members have also been interviewed.

Findings

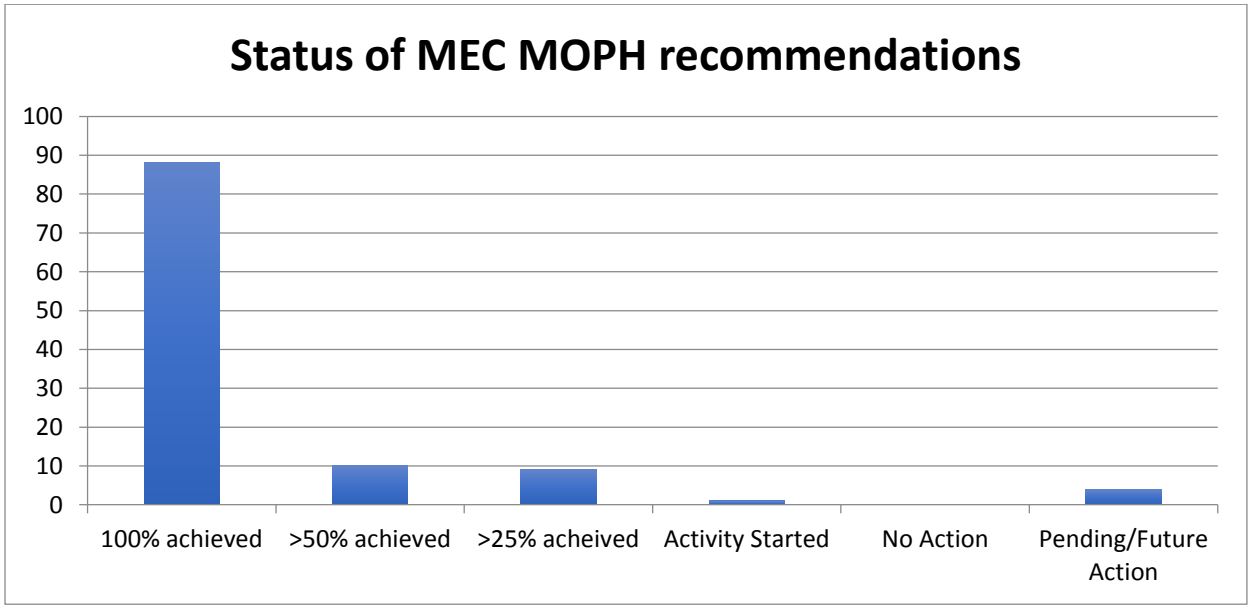
The MoPH has made considerable progress in achieving implementation in a short period of time, as reported in the eighth quarterly Monitoring Report, and verified by the MEC Team:

The status of the 112* remaining recommendations as reported by MEC in the eighth Monitoring Report includes:

- 88 (79%) have been fully implemented.
- 20 (18%) have been partially implemented. These are further broken down as follows:
    - 1 started or study underway
    - 9 achieved up to 25%
    - 10 achieved up to 50%

- Four recommendations (4%) are either pending, or for future implementation. In two of these remaining cases there are substantiated reasons for delay. Notably, all four with pending/future implementation status are related to human resource management.

Figure 2. status of MEC MOPH recommendations (MEC, 2018)



During the implementation 52 recommendations were modified (see annex II); some of which have shifted to different entities (within the Ministry) or have reflected recognition that the original recommendation was essentially unachievable. For instance, MEC shifted some

recommendations from proposed new entities to existing Departments or Directorates which perform (or should perform) those functions.

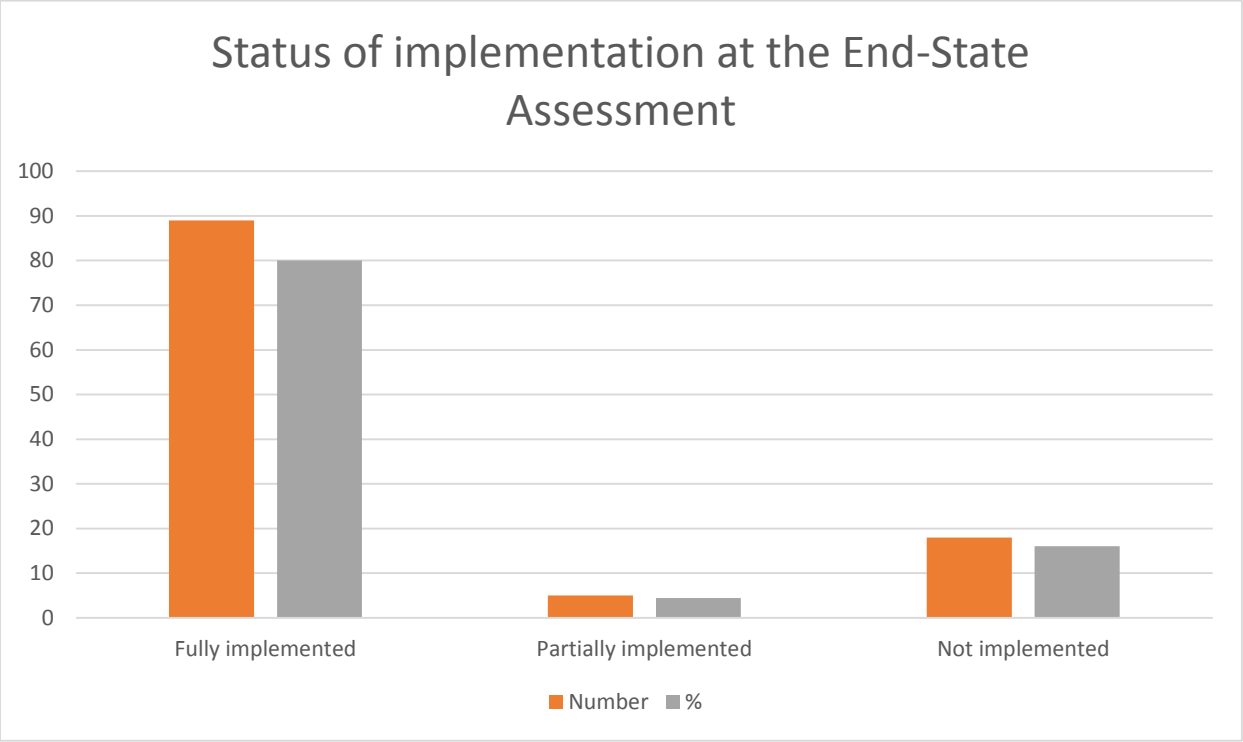
MEC also accepted that the recommendations related to the originally proposed Independent Committee on Health Sector Accountability and Reporting (ICHSAR) and Independent Commission on Accrediting Health Organizations (ICAHO) would (instead) be dealt with through entities that are not actually "independent" – because the Ministry did not have the scope to establish Independent Commissions. Likewise, MEC accepted that the recommendations related to the originally proposed High Commission on Oversight of Health Sector Integrity (HCOHSI) would instead be dealt with through a High Level Health Oversight Committee, which the Ministry was able to establish within its remit[1].

These name changes for these entities were unexpected compromises from the original recommendations and resulted in a significant lesson learned for MEC: Recommendations must be a*chievable*. This observation led to MEC adopting the routine practice of rigorous "SMART-testing" all proposed MEC recommendations. SMART-testing is a structured approach to analysis of draft recommendations, with each letter of the SMART acronym relating to a unique aspect of the deliverability and feasibility of the actions: S for *Specific*, M for *Measurable*, A for *Achievable*, R for *Results-oriented*, and T for *Time-bound*. While there are other ways that the SMART acronym has been defined, this set of definitions is the agreed usage within MEC.

Following the eighth quarterly Monitoring Report the MEC M&E team sent MoPH a list of 25 recommendations that had been classified as partially implemented or not implemented. The MoPH responded with updates, and following the review of their submission, this Assessment showed the following results:

[1] Institutional conventions in Afghanistan meant that the Ministry could legitimately establish a High-Level Committee, but not a *High Commission*, which is a unique type of entity. Notably, even with the new more appropriate name, and despite encouragement from MEC, the High Level Health Oversight Committee did not involve representatives of the community, as originally recommended by MEC.

Figure 3. Status of implementation of MEC MOPH recommendations at the End-State Assessment



As indicated in the graph, MoPH has so far successfully implemented 80% of the recommendations, while 4% are partially implemented, and another 16% have not been implemented.

Table 1. Status of 25 MEC MOPH recommendations that were pending in the eighth quarterly Monitoring Report

Category	Recommendation number	Recommended action	Status	Explanation
M&E – auditing and reporting	1.1.5	Engage ICHSAR to draw the public's attention to examples of good quality of care, integrity, and reliability in the health sector. MODIFIED IN 4TH QUARTER: Engage Department of Public Relations to draw the public's attention to examples of good		Department of Public Relations (DPR) has been involved in some respects, such as quality of care, but its role needs

		quality of care, integrity, and reliability in the health sector.		strengthening in other areas.
Pharmaceutical Importation Process	2.2	Reform the Pharmaceutical Law to adequately regulate the increased volume and diversity of pharmaceuticals entering the country.		The law allows it
	2.3	Reform the Pharmaceutical Law to prohibit government staff from having conflicts of interest in pharmaceutical companies.		The Pharmaceutical Law does not cover it.
	2.18	Invest in equipment and technical training to enable MOPH to conduct quality analyses of samples.		It is a work in progress
Transparency, Governance and accountability	3.3	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. MODIFIED IN 4TH QUARTER: Accreditation from Afghan Healthcare Accreditation Organization 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		The ToR of AHAO does not cover accrediting contracting agencies.

		to AHAO on achievement of Action Plans		
	3.4	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). MODIFIED IN 4TH QUARTER: Engage Department of Public Relations 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).		It is a work in progress
	4.2	Training on health sector specific issues for the Kabul AGO should be implemented by 1-2 international Technical/Legal Advisors with health sector backgrounds.		No evidence of any actions taken
Human Resource management	6.1.2	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,		Suitable systems are in place and have been working.

		and other electronic tools which could be implemented throughout the health sector.		
	6.1.5	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. MODIFIED IN 4TH QUARTER: Engage the Strategic Health Coordinating Committee to monitor absenteeism during official working times within MOPH and in BPHS and EPHS services on a Provincial level and a national level.		Monitoring of absenteeism is not included in the ToR of the Strategic Health Coordinating Committee
	6.2.7	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. MODIFIED IN 4TH QUARTER: Engage Health Shuras and the Department of Public Relations to draw the public's attention to examples of good practice and integrity in the management of patient referrals.		MEC has not received any evidence to support this
Contracts	7.3	Engage the Independent Commission on Health Sector		"Uncovering, overturning,

		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. MODIFIED IN 4TH QUARTE: Engage the Strategic Health Coordinating Committee 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.		and preventing conflicts of interest as a routine matter within the GCMU" is not included in the ToR of the Strategic Health Coordinating Committee
Embezzlement	8.3	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.		MEC has not been supplied any evidence in support of this action.
Resource Management and Inventory	9.1	Initiate reform of the internal audit functions in the Ministry and in every province.		MEC has not been supplied any evidence in support of this action.
	9.2	Engage the Independent Council on Health Sector Auditing and Reporting (ICHSAR) to examine		It is not included in the ToR of the

		current practices in the management of resources and inventory in the health sector. Engage the Strategic Health Coordinating Committee to identify gaps in the implementation of health sector auditing, checks, and controls.		Strategic Health Coordinating Committee
	9.3	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. MODIFIED IN 4TH QUARTER: Engage the Strategic Health Coordinating Committee to articulate opportunities to standardize robust health sector auditing and resource and inventory management systems.		It is not included in the ToR of the Strategic Health Coordinating Committee
	9.4	Engage ICHSAR to identify gaps in the implementation of health sector auditing, checks, and controls. MODIFIED IN 4TH QUARTER -- Further Analyses: Engage the Strategic Health Coordinating Committee to identify gaps in the implementation of health sector auditing, checks, and controls		It is not included in the ToR of the Strategic Health Coordinating Committee
	9.5	Engage ICHSAR to articulate opportunities to standardize robust health sector auditing and		It is not included in the ToR of the

		resource and inventory management systems MODIFIED IN 4TH QUARTER: Engage the Strategic Health Coordinating Committee to articulate opportunities to standardize robust health sector auditing and resource and inventory management systems.		Strategic Health Coordinating Committee
	9.7	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. Engage the Department of Public Relations to draw the public's attention to examples of good practice and integrity in the management of the public's health sector assets, especially ambulances.		No evidence has been provided to MEC to support this
Nepotism/abuse of power	10.1.3	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. MODIFIED IN 4TH QUARTER: Engage the Afghan Healthcare Accreditation Organization in ensuring that the Human Resource Recruitment Office's workforce, organizational capacity, and		No evidence has been provided to MEC to support this

		processes are clarified, transparent, and reliable.		
Training and Professional Development	11.1	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. MODIFIED IN 4TH QUARTER: Engage the Afghan Healthcare Accreditation Organization in ensuring that Training Needs Assessment processes within MOPH and BPHS and EPHS contract holding agencies are clarified, transparent, and reliable.		It does not fall into the ToR of AHAO
	11.2	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. MODIFIED IN 4TH QUARTER: Engage the Afghan Healthcare Accreditation Organization in ensuring that favoritism and discrimination in access to training are uncovered, overturned, and prevented as a routine matter		MEC has not received any evidence to support it.

		within the MOPH and BPHS and EPHS contract holding agencies.		
	11.3	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. MODIFIED IN 4TH QUARTER: Engage the Strategic Health Coordinating Committee in ensuring opportunities to standardize the resource management systems for health sector clinical and technical training and professional development.		MEC has not received any evidence to support it.
Fraud / Falsification / Fakes / Forgery	16	Establish a reliable, transparent, and coordinated system for assessing Certificates and Diplomas:		Evidence for this assessment exists but it is not systematic
	16.2	Engage the ICAHO to strengthen management and coordination of assessing Certificates and Diplomas within MOPH Human Resource Recruitment Office. MODIFIED IN 4TH QUARTER: Engage the Strategic Health Coordinating Committee to strengthen management and coordination of assessing		This action does not fall into the ToR of the Strategic Health Coordinating Committee

		Certificates and Diplomas within MOPH Human Resource Recruitment Office.		
Bribery	19.1.3	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.		This is covered in MoPH staff recruitment agreement; however, the evidence to support its publicizing have not been supplied to MEC

As you can see in the above table the major gaps in implementation has been in resource management and inventory followed by training and professional development. Other areas of concerns have been human resource management; transparency, governance and accountability; pharmaceutical importation; embezzlement; nepotism/abuse of power and fraud/falsification, fakes and forgery. Reasons for this lack of progress has been lack of appropriate organizations and entities to carry out the work. Some modifications in the recommendations has replaced some entities such as the AHAO and Strategic Health Coordinating Committee which do not cover the task in their ToR (see table 1 for more details).

Major Achievements in Outputs:

Importation of Pharmaceuticals:

Establishment of National Medicine and Health products Regulatory Authority (NMHRA)

The organization to regulate pharmaceuticals and health products has been established in July 2016, demonstrating MoPH commitment to improving surveillance and oversight capacity of the pharmaceutical and health products, including authorization of medicines, health care products, medical devices, and pharmaceutical facilities (MoPH , 2017). This initiative includes the reorganization of relevant Departments and revision of more than 300 terms. Thirty-Four new technical positions have been recruited in NMHRA to expedite the process of importer re-registration (MEC, 2017). In addition, the Pooled Procurement Management Unit in the MoPH has been established and a separate pooled pharmaceutical procurement procedure is being implemented. The pooled procurement

procedure has recently been adopted for purchase of pharmaceuticals for tertiary and specialized hospitals.

The Pharmaceutical Law has been revised and is pending approval by MoJ (MEC, 2016). However, to date, this Law has not been approved by the MoJ and is long overdue. The Law allows robust competition in the market to increase the availability and quality of diverse pharmaceuticals. A Licensed National Pharmaceutical Products List has been developed in 2017, and will be revised every five years. Any additions or deletions deemed to be necessary before the five-year period will be dealt with according to the established rules. The Law limits purchase of pharmaceuticals to those included in the National Pharmaceutical Products List.

For the first time a database to facilitate the registration of the importing companies has been created and the Licensed National Pharmaceutical Products List have been linked to the *pro forma* registration process. The database known as Pharmaceutical Registration Information System (PRIS) records all medicine imported and manufactured inside Afghanistan along with the specification of importing company and manufacturers. With this database, NMHRA will be able to estimate the demand for pharmaceuticals and assure balance between its demand and supply in the coming years – this task was supposed to be done by the PSD for which no evidence has been supplied to MEC. The NMHRA website is operational now, and the data transfer with details of all approved medicines, is in progress.

A guideline on Pharmaceutical post- and pre-marketing sampling has been developed and is in use. Assessing the quality of pharmaceuticals in Afghanistan is being launched for the first time in accordance with the set standards prior to being marketed. NMHRA uses all the three namely primary, secondary and tertiary Pharmaceuticals sampling for quality control (QC). Construction of four QC labs (one in each of four regions) have begun. A sampling Standard Operating Procedure (SOP) is in the process of being finalized. A Department of Advertisement Promotion and Control is functioning within the NMHRA which receives the requests for promotions and provides approvals.

Training capacity in quality control and quality monitoring of pharmaceuticals has been improved as the NMHRA and PSD have been providing training to the pharmacists and the NHMRA Quality Control Lab workers. Further staff training on QC is pending purchase of the QC equipment. An equipment inventory was completed by NMHRA for Laboratory items that were apparently untaxed (and uninspected) on their entry into the country (MEC, 2018).

The NMHRA is conducting regular monitoring of pharmaceutical institutions; latest results of which show that close to 80% of those institutions comply with quality standards, as specified in their checklist. An improvement in the results have been observed compared to last year.

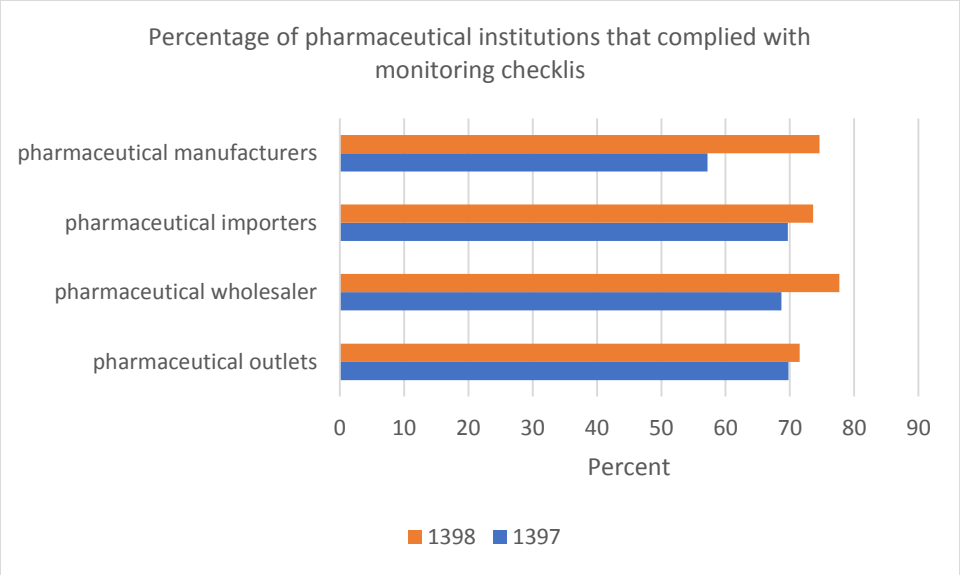


Figure 4. Percentage of pharmaceutical institutions that complied with monitoring checklist

The first market survey on medicine was conducted in Kabul by newly assigned NMHRA staff during the fifth monitoring period. In the sixth MOPH quarterly reporting period, more than 800 pharmaceutical and medical product importers were declared illegal and their licenses for importation cancelled [press conference at Government Media Information Center; link of Azadi Radio: https://da.azadiradio.com/a/28820931.html.]

Monitoring reports indicate that, compared to last year, an substantial increase has been observed in the number of pharmaceutical wholesalers and importers with at least one medicine outside the Licensed National Pharmaceutical Products List; however, for the outlets the opposite has happened. This is a concerning development and leads MEC to question both the sustainability of the Licensed National Pharmaceutical Products List, and the effective intervention powers of NMHRA to prevent (or stop) the practice of selling non-listed items.

Figure 5. Percentage of pharmaceutical institutions with at least one medicine outside the Licensed National Pharmaceutical Products List

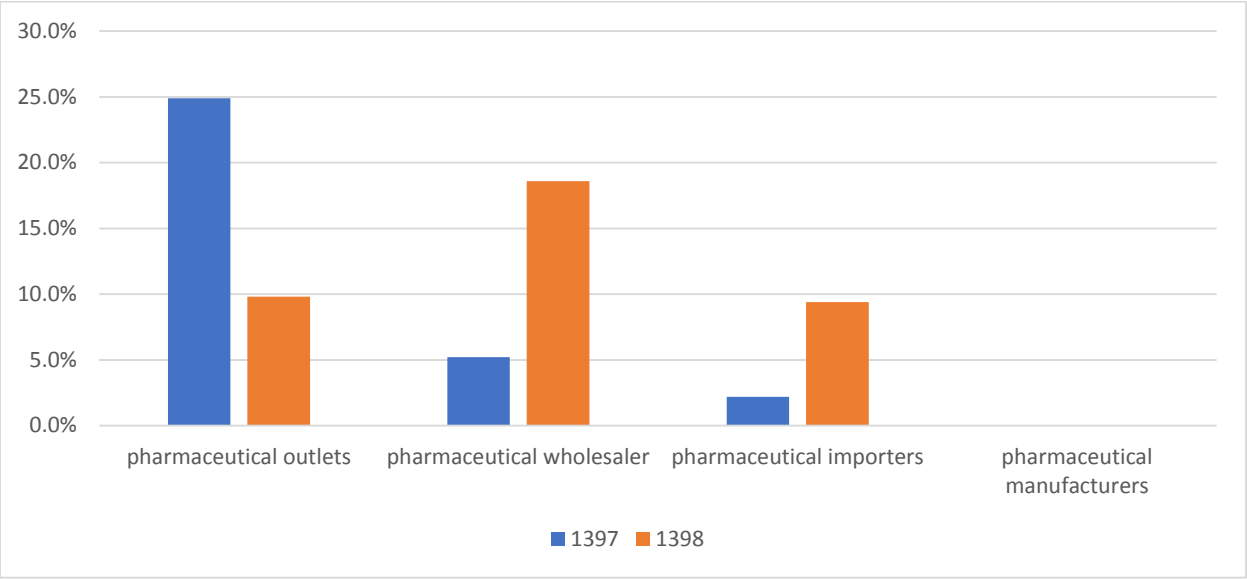
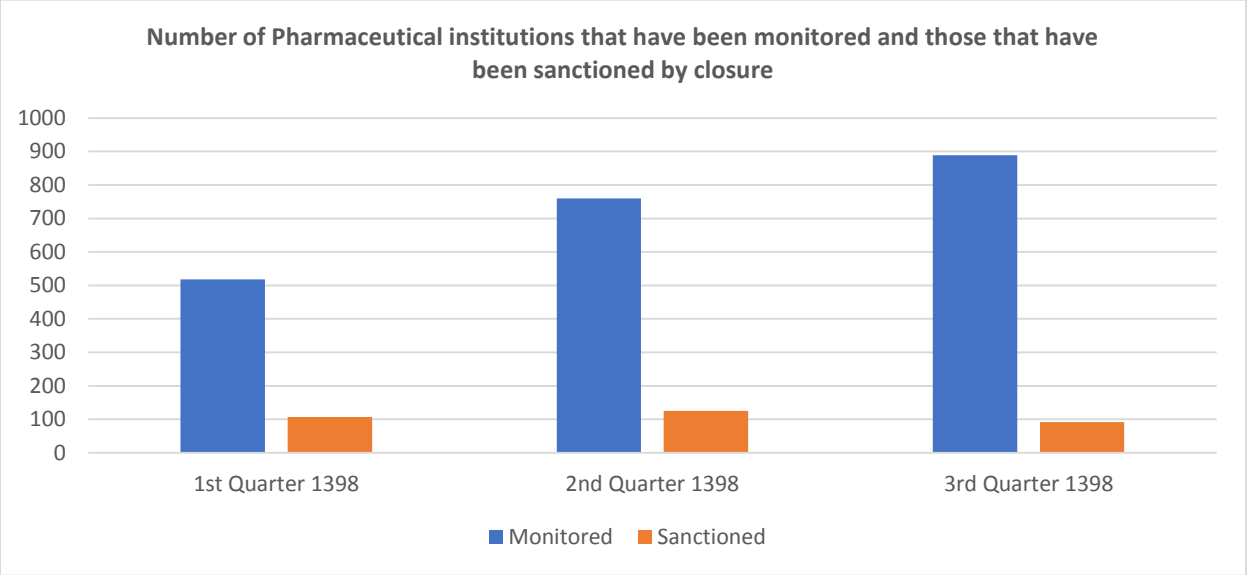


Figure 6.Number of Pharmaceutical institutions that have been monitored and those that have been sanctioned by closure

Overall the volume of monitoring has been increasing while the number of pharmaceutical institutions who breach the Laws and regulations have been going down.



NMHRA continues to systematically tackle both internal and customer service complaints through a 3-tiered system of escalations, focused on accountability at each higher level or authority (MEC, 2017).

QC of pharmaceuticals in Kabul by NMHRA

The PSD has been working on improving quality of pharmaceutical management. They have established a Pharmacy Council to take actions on professional development pathways, expanded training capacity, and increased the number achieving Pharmacy qualifications; 17 sessions of Provincial Field Trainings have now taken place providing 88 days of Pharmacy technical instruction in Balkh, Herat, Kabul, Kandahar, Nangarhar, and Takhar (MEC, 2017). However, outcome for these trainings have not been assessed and established and it is not clear how they have contributed to improved pharmaceutical management and rational use of drugs.

Monitoring and Evaluation

Health service delivery is regularly monitored and periodically evaluated by a Third Party Monitoring (TPM) entity – the Dutch Royal Institute of Tropical Medicine (KIT) – to ensure impartiality and independence. While the impartiality and independence could be challenged given that its financial support, contract award and compliance with the deliverables are each managed by the MoPH, the findings of the TPM evaluation are widely shared and discussed among a diverse group of independent stakeholders for decision-making at different levels. At central MoPH the following forums composed of MoPH and its stakeholders carry out the role: A

WHO-led Health Development Partners Forum (HDPF) meets regularly at MoPH where the Third Party Monitor is a regular member. In addition, the TPM has also become member of Hight Level Health Sector Oversight Committee meeting headed by HE the Minister. A supportive collaboration has been established through formal links among GDEHIS, GCMU, and independent TPM entities for collation of performance management and contracts compliance in the health sector of Afghanistan.

Establishing the Data Warehouse ("DHIS2")

The General Directorate of Evaluation and Health Information Systems (GDEHIS) has initiated implementation of the MoPH data warehouse (DHIS2) for health-related data, unifying the sources of health information for decision-making purposes (MEC, 2017). This activity could potentially link MoPH indicators and Key Performance Indicators (KPIs) to the wider Government's performance monitoring activities, though MEC did not see evidence of this having happened, so far. Tracking of health indicators has improved using the DHIS2. With this great potential for collation of data, MoPH could establish the KPI for its different Departments and appraise their performance using their KPIs. One of the indicators for which HE the Minister competed with 6 finalist Ministers in Dubai, and ultimately contributed to him winning "The Best Minister Award," had been the establishment of the DHIS2 in Afghanistan.

"Best Minister" Award to Ferozuddin Feroz

In seventh monitoring period, the DHIS2 Data Warehouse user policy in GDEHIS enabled almost 100 users to gain access to the DHIS2 across MoPH Departments and other health-related organizations. HMIS DHIS2 software was installed and appropriate training was delivered. Access to Provincial Public Health Departments was also assured.

Decisions were taken to include surveillance data in DHIS2 and to foster the use of data to facilitate establishment of a coordinated e-surveillance system in the country. This system helps in timely detection of the occurrence of fatal diseases and quick response to prevent complications and deaths and stop further disease spread.

All of HMIS data (2017) has been imported in DHIS2 with 75 million records. Meetings have been conducted with MoPH Departments to create 12 distinct dashboards showing health status data for programs. MOPH Departments and donor technical monitoring and evaluation focal points were provided access to DHIS2. Additionally, the Start-up Mortality List (SMoL) database for the Vital Statistics Department and *Minimum Required Standard Checklist* for the Monitoring Department have been integrated with DHIS2. The SMoL informs the process of setting public

health priorities and tracking progress towards national and international targets and goals. MEC believes this advancement has been a powerful indicator of GDEHIS progress in improving transparency and oversight in MOPH and among its contract implementers.

Photos from the Eighth Health Results Conference of 1398

Results Conference in Kabul

*Supplemental Auditing – **Citizens' Charter National Priority Program (CCNPP)***

In addition to the MoPH HMIS system that covers the routine data collection from Public Health services, MEC has verified the HMIS data collection forms that has been developed to collect data from the private hospitals. However, due to lack of capacity and resources, the MoPH has yet to launch the system for the private sector.

Another important component of HMIS and evaluation of health services has been the Community Scorecard. This was launched and is being implemented by the Ministry of Rehabilitation and Rural Development (MRRD) and CCNP; MoPH had a key role in establishing the system, procedures and tools (MRRD and IDLG, 2017):

- To assess and rate the services provision for the communities through a simple, but systematic approach
- To get the voices of the community on services standards and maintain a productive discussion between services users and services providers

The local Scorecard Committees complete the Health Scorecard by meeting the service providers, service users, and conducting physical checks for filling Health Minimum Service Standards (MSS) Scorecard relevant to their local community. Facts and mutually developed consensus are used to fill out the Scorecard.

The Scorecard data are available on the CCNPP website (www.ccnpp.org/cc) for the line Ministries. The data-sharing will occur at different levels and in the field for decision-making and services improvement. Health Scorecards are implemented at the facility-level (one per clinic).

After getting feedback from communities it is shared to the facility management and the results are shared with the larger community (MRRD, 2019). Finally, the findings are shared to Government officials by Districts, Provinces, and nation-wide. This system works to gather and distribute information from bottom-up, linking individuals within communities with health providers, service managers and policy makers.

Transparency, Governance and Accountability

Establishment of Afghan Medical Council

Based on recommendations from donors and partners, the Afghan Medical Council (AMC) was established in June 2017. Its vision is to ensure the highest level of patient and of doctors' safety and public satisfaction. AMC reports to the President's office but for now receives operational budget through the MoPH. AMC is composed of its Board and Departments.

The main areas of intervention from the AMC that concern MEC recommendations include registering and issuing work permits to doctors, setting professional standards, enhancing medical ethics for doctors, and handling clients and doctors' complaints and professional errors (MoJ, 2018). AMC has trained 115 master trainers in 1397 to roll out medical ethics training to all parts of Afghanistan. AMC has also defined and drafted complaint management and Accreditation Guidelines, and transparent billing procedures. A Memo of Understanding has been signed among AMC, the Attorney General's Office (AGO) and MoPH to coordinate the complaint management process. A Commission on Complaint Management and Medical Misconduct has also been verified as functioning.

An analysis of the recent AMC report indicates that their Complaint Management Office has received 29 complaints, 14 of which has been resolved and the 15 are under process; 16 of these complaints have been submitted in person, while another 13 complaints have been referred by MoPH and AGO. Most of the complaints (17) have come from private health institutions. Twenty complaints have been attributed to improper patient treatment, while 6 were due to staff misconduct.

Results Conference in Kabul

Public Awareness by the Department of Public Relations

The Department of Public Relations has embraced the task of informing the public about the Ministry's efforts to promote transparency, good governance, accountability, and system integrity, including management of referrals (General Directorate of Private Sector Coordination/GDPSC), discipline of MOPH staff and management (General Directorate of Human Resources/GDHR), routine monitoring for implementation quality and program completeness (Grants and Contracts Management Unit/GCMU), and Quality Assurance-Quality Control monitoring and oversight (General Directorate of Evaluation and Health Information Systems/GDEHIS).

The Department of Public Relations described their activities, which were verified by MEC, and has continued to draw the public's attention to the activities of the Ministry through posts on the MoPH website, MoPH's Facebook page and other social media outlets, as well as through traditional broadcast media (MEC, 2018).

Policies

During this period MoPH has made considerable progress in policy area. MoPH developed an Anti-Corruption Strategy 2017-2020 (MoPH , 2017) in 2017 and a Conflict of Interest policy 2018-2022 (MoPH, 2018) in 2018. The Anti-Corruption Strategy is a response to the MEC MVCA, which specifies 6 key risk areas in the MoPH: Health regulatory management, delivery of health services, product distribution and storage, marketing of health products, procurement and financial and workforce management – These align quite precisely with MEC's MVCA research. The Strategy also identifies strategic approaches to the Ministry's health regulatory management, regulatory implementation and the role of stakeholders, and an M&E Framework (MEC, 2016).

Most of the newly policies are posted in the MoPH website; all of them are shared as hard copy and via email to all MoPH Departments at the central level and to the PPHO and to all key

stakeholders. Further, all the MoPH policy and strategy documents have been translated into local language. Following the development of a new policy and Strategy, the relevant central MoPH and PPHD staff received training to increase their understanding and promote use of the new policy, Strategy and Laws pertaining to health. This has been verified by MEC in this assessment along with availability of all translated policy-related documents.

HR Management

Patient Referrals

A National Referral Guideline (in local language) was developed in 2013, and has now been distributed to the management of all the hospitals and the NGOs for use at MoPH's contracted facilities which implement both the Basic Package of Healthcare Services and the Essential Package of Hospital Services (BPHS/EPHS). The Guideline aims to facilitate appropriate patient care and improve effective and transparent collaboration between the public and private sector.

The Referral Guidelines include a Referral Checklist and referrals-focused Standard Operating Procedures. These were finalized, printed, and distributed among the management teams of 2° and 3° hospitals (both public and private facilities) in Kabul to ensure On Duty staffs know the referrals procedure (MEC, 2018). Implementation of the Guidelines will require coordination among DPSC, GCMU, EHIS, and CHO (MEC, 2018). This Assessment determined that the GCMU has been monitoring the implementation of the referrals policy to prevent patients being refereed from the public to private facilities, and so far, they have terminated contracts of several employees in breach of the policy.

During the fifth Monitoring period, 45 MoPH monitoring missions were conducted in different Province. Based on the established checklist all the contract requirements, including patient referrals, were monitored. The feedback was shared with the implementing NGOs to take necessary action and cover the gaps. MEC has assessed that there is good coordination between GCMU and the M&E Directorate regarding field monitoring missions. For example, a joint monitoring mission was conducted with GCMU and the M&E Directorate in Baghlan Province. However, MEC did not see evidence of coordination between GCMU and Department of Public Relation which could enable highlighting this transparency- and governance-related activity for the public.

Presence of Staff During Official Working Time

Evidence of enforcement of working times at the BPHE/EPHS facility level has been presented to MEC by GCMU and General Directorate of Curative Medicine (GDCM). Reports on the monitoring activities of GCMU, including their findings, are regularly being publicly shared through GCMU Facebook page (www.facebook.com/afghanistan.GCMU) (MEC, 2018). MEC verified the policy has been enforced and disciplinary actions have

been made to improve staff presence during official working times. Based on GCMU monitoring of BPHS/EPHS implementers, 272 cases were found by implementing NGOs and disciplinary actions have been taken against them. The actions include salary deduction (251 cases), warnings (9 cases), changing the job location of staff (6 cases), and termination of the staff contract (6 cases). MEC reviewed evidence of a shared communications group in Viber established for distributing the information among health stakeholders, including the BPHS and EPHS implementing NGOs and INGOs (MEC, 2018).

Health Workforce Absenteeism

A fingerprint scanning system to track worker arrivals and departures has been installed in central MoPH as well as all the Ministry's specialized hospitals. Similarly, the implementing partners of BPHS/EPHS has been regularly monitoring staff attendance and a penalty system has been implemented for which evidence has been supplied to the GCMU. This matter is not of such a huge importance for the managers and staff in PPHDs as they are expected to spend a far higher percentage of their time each week outside the office, compared to MoPH HQ (MEC, 2018). Their role in Provinces specifies monitoring and overseeing the services implementation of NGOs and INGOs – and this will necessarily impact on the efficiency and effectiveness of PPHD-based finger-scanning systems at the start and end of each working day.

MoPH systems have been verified to enforce working times and punish absenteeism, including all new employee signatures on the MoLSAMD sanctioned *Code of Conduct* (MEC, 2018). Further, the GDHR provided evidence it had detected and punished 72 MoPH employees for absenteeism during a single Quarter at the initial installation of the scanning system.

Finger scanning device to track employee attendance

Independent Accreditation Organization

Establishment of National Healthcare Accreditation and Quality Improvement Organization (ANHAO)

> The Afghan National Healthcare Accreditation Organization (ANHAO) established a regulatory framework with input from donors and health sector stakeholders as part of the MoPH organizational structure in 2019 with a vision to:
>
> "Every Afghan citizen will have access to health services that meet internationally accepted standards of care and ensure that a culture of continuous quality improvement and safety is an integral part of their day-to-day operations (MoPH, 2017)."

The ANHAO objective is to improve quality of health services in Afghanistan. ANHAO aims to accomplish the vision by assessing and issuing a license to accredit each and every health facility in the country. A pre-requisite for this however is ANHAO firstly need to be certified by ISQUa and then Initially it will focus on public, private, and military hospitals, with eventual expansion to all NGO/INGO contracted health facilities and private sector health service providers (MEC, 2018). MEC had originally proposed an independent entity for this task; however, as noted above this was not achievable on a technical level. ANHAO is managed by a Leadership Board and an executive team. ANHAO is currently funded by MoPH but is expected to either independence or semi-independence in 2-3 years. The ANHAO Director denied any role for the organization in accrediting MoPH Departments such as the GCMU.

Health *Shura* Empowerment

findings of the HSR Citizen Engagement Study in 2017 recommended specific improvements on accessible feedback and complaints systems; in principle, this was focused on increasing acceptance, visibility and effectiveness of Health *Shura* monitoring roles and identifying synergies with Citizens Charter National Priority Program (CCNPP) activities. Each of these were supported by MEC's MVCA findings and reflected in the MEC recommendations. Changes were incorporated into the MoPH's proposed revisions to *Terms of Reference* for Health *Shuras* (MEC, 2017). Following the approved modifications to the *Terms of Reference* for Health *Shuras*, new opportunities for community participation in monitoring and feedback of clinics, hospitals, ambulances, and referrals have been created. A Focus Group Discussion with Provincial Public Health Directorates (PPHDs) indicates that Health *Shuras* are currently involved in monitoring of health services. However, to train all the Health *Shuras* in the country the Community-Based Health Care Department needs funding, for which they have approached several organizations, but without success so far.

The CCNPP has also initiated the Community Based Monitoring System and the third party Functionality Index for health facilities, for external monitoring (MEC, 2017).

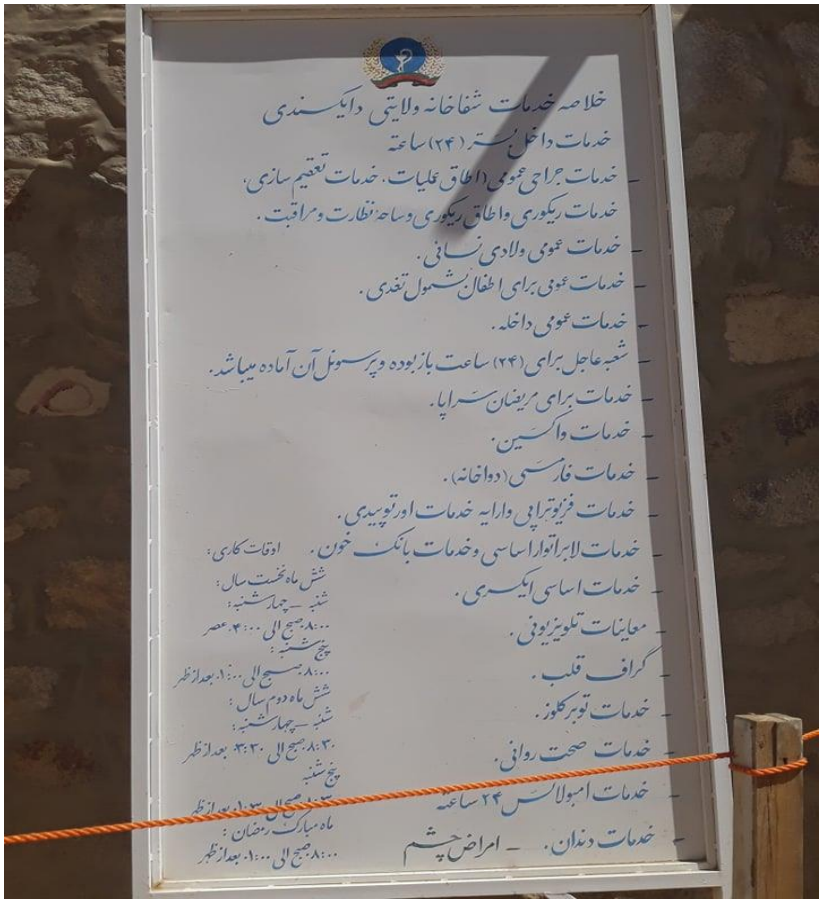
Community meetings on handling complaints

Community Hospital Boards at the hospital levels have been expanded and there are more opportunities for local communities to actively participate in the planning and monitoring of health services at hospitals.

A Hospital Community Board meets in Kabul

Conflicts of Interest (CoI)

MoPH has developed a Conflict of Interest policy which has been widely shared with stakeholders. This Assessment verified that all MoPH senior managers had signed CoI Declaration Forms for 2018 and the copies have been kept in file. However, the designation of a committee to assess and manage any declared conflicts of interest has not occurred; and, as per the MoPH CoI policy, the required Declaration Forms have not been signed for the current year. The interviews conducted with PPHDs for this Assessment show that the CoI policy has been shared with Provinces, but not yet implemented at the Provincial level.



Sign boards to inform community members about services

Embezzlement

Contractually, the implementing NGOs are obliged to provide fully equipped and functional ambulances, as per BPHS and EPHS Guidelines – And to prevent their misuse. During the monitoring missions, GCMU monitors functionality and availability of ambulances based on abovementioned Guidelines. All the ambulances must have logbooks with the idea that monitoring the ambulance logbooks will indicate the proper/improper use of ambulances.

The General Directorate of Curative Medicine has now fully incorporated ambulance usage into routine Hospitals Monitoring Checklists (MEC, 2018). The GDCM reports: “There is a Disciplinary Committee within Kabul Ambulance Department of GDCM; the Committee’s main responsibility is to regularly monitor ambulance functionality, based on checklists, to ensure proper utilization of ambulances for referral purposes. In case there is any malpractice or inappropriate use of ambulances, the Committee issues required punishment to the responsible person.”

MEC has seen evidence of disciplinary action taken by the Kabul Ambulance Department regarding inappropriate use of ambulances.

Ambulances that deliver health services to the community

Extortion

High Council on Oversight of Health Sector Integrity

Recommendation 15.1 was modified in the 4th quarter of monitoring, as described above, with the already-existing Strategic Health Coordinating Committee (SHCC) taking on this responsibility instead. The originally proposed recommendation indicated that the entity should be 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, and that the SHCC should meet Quarterly, at a minimum.

Subsequently, the SHCC was re-named the High-Level Health Oversight Committee (HLHOC), though the participants did not include representatives from civil society or Health *Shuras*. The Minister established the HLHOC with a remit of 1) Decision-making, 2) Resource allocation, 3) Resource coordination, 4) Monitoring financial issues (MEC, 2018), which roughly corresponded with MEC's intention on improving accountability related to oversight functions.

Nepotism/Abuse of Power

MoPH has made considerable improvement in ensuring transparency in staff recruitment. Employment for vacancies are announced and a committee comprising of the Independent Administrative Reform and Civil Service Commission (IARCSC) actively participates in recruitment

processes. For senior positions there is a committee composed of external agencies who attend the interviews and participate in the selection process.

Quality Assurance/Quality Control

Performance monitoring within MOPH:

The MOPH Executive Committee now accepts the practical differentiation of *performance monitoring* from *financial auditing* (MEC, 2017). MoPH has shifted the accountability on performance monitoring (the focus of 38 MEC recommendations) will now link directly to the High Level Health Oversight Committee, with its participation by leaders from both GCMU and GDEHIS, rather than the MOPH Internal Audit Department (IAD).

MOPH has launched a performance-based contract model to reward the BPHS/EPHS implementing agencies in accordance with the set KPIs that are defined in their respective contracts. This creates a culture of managing organizations' performance based on KPIs which could later be adopted by all of the MoPH Departments and staff. With establishment of a data warehouse at the MoPH, and by extending its use to the Provincial offices, the staff both at the central and Provincial levels have access to their health output and outcome indicators; however, this has yet to be included in the staff contract agreement.

Human Rights and Discrimination

Health Complaint Handling Office (HCO)

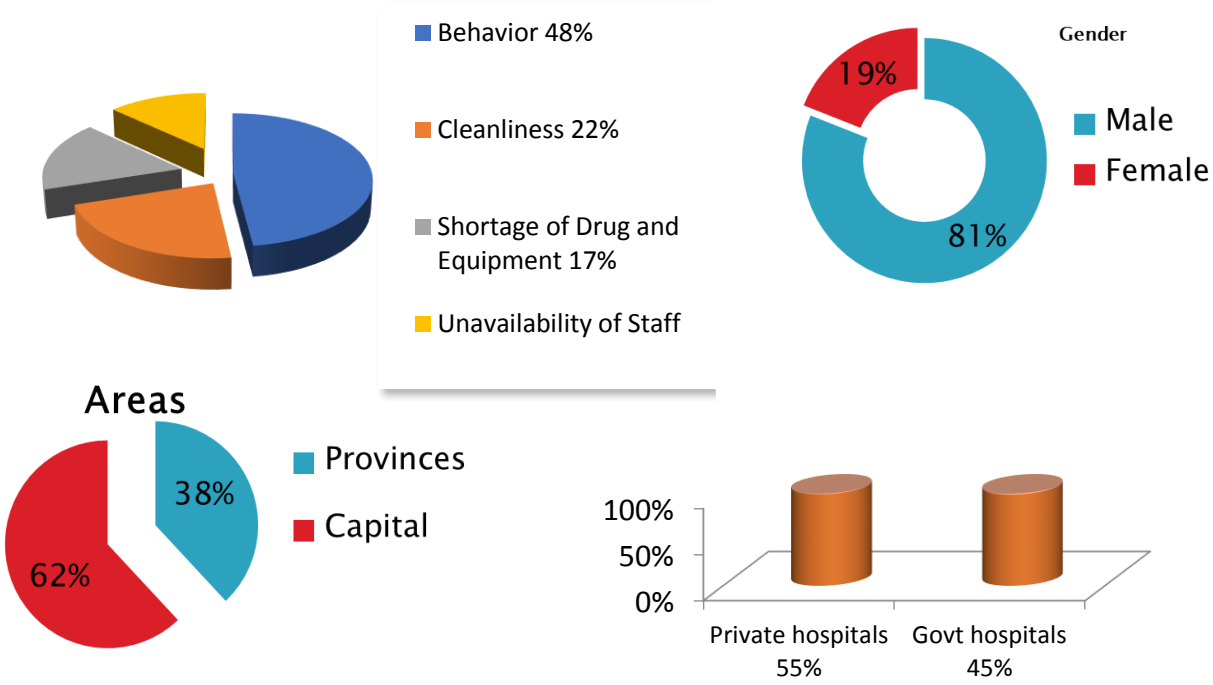
The MoPH has established a Health Complaint Handling Office (HCO) to receive and resolve complaints of staff, clients and community in case of breach in quality of services, staff misconduct, medical negligence, discrimination and bribery. This Office is receiving the complaints by different means such as phone calls, Facebook, physical complaint boxes, and through emails. MEC verified that significant work of MoPH in advocating the use of the service.

MoPH Facebook and Twitter pages

Likewise, Patient Representative Offices have been established in tertiary and specialized hospitals to provide information to the clients and receive and address their concerns and complaints. Part of the task is performed by the AMC where an MoU has already been signed among the AMC, MOPH and AGO to avoid duplication and improve coordination. Further, MOPH HCO has provided evidence of action to liaise between MOPH and the Afghanistan Independent Human Rights Commission (AIHRC). This new committee is comprised of the MOPH CHO, the AIHRC, representatives from civil society, the Health Committee of Parliament, and health forums and associations (MEC, 2017). Installation of physical complaint boxes and the Grievances Redressal Mechanism (GRM) through CCNPP has further developed community engagement with health services to enhance accountability for health providers and health service managers.

As indicated in the graph, 55 per cent of complaints (from 2018) related to private hospitals. 81 per cent of complaints were lodged by men, though this may be a function of men being more likely to represent family concerns in these circumstances, due to cultural factors. The majority of complaints (62 per cent) are from the capital and only 38 per cent come from Provinces. The analysis also shows that close to half of complaints relate to staff behavior, which makes improving the adoption and understanding of the Code of Ethics an essential element of staff training. Quality of care, as measured by cleanliness, also scored low (22 per cent) among the reasons for complaints. Shortage of drugs and equipment was reported by 17 per cent of complainants. Thirteen per cent complained about staff absenteeism, though it would be likely that the measures to tackle this will take more time to have an effect.

Figure 7. HCO data analysis



The HCO has continued to draw the public's awareness of their activities and soliciting formal complaints, including on social media platforms (Facebook, Twitter), publishing and distributing brochures, fixing dozens of explanatory signboards in health facilities and the Ministry itself, and

participating in interviews on traditional broadcast media outlets (1TV, *Shamshad* TV, *Meshrano Jerga* TV, and *Watandar* radio) (MEC, 2018).

CHO interviews with private TV channels

Source: MOPH HCO

Patients' Representative Office serving the clients

HCO has been strengthened with new, permanent infrastructure to house its Call Center inside the Ministry, and HCO Focal Points are now identified in all 34 Provinces (MEC, 2017).

CHO in the hospitals and health facilities

The HCO have adopted standardized formats for management of complaints that are received through calls, in written form, and the official webpages for lodging complaints. By mid-2017, the HCO had managed 628 formal complaints from the public, received through all mechanisms (MEC, 2017).

A separate complaint handling process has also been established in the NMHRA which is in the process of being expanded to Provinces outside Kabul; the Balkh Province team provided MEC with extensive documentary evidence of their work in managing complaints (MEC, 2017). The feedback and reporting systems of the HCO and NMHRA have been verified as robust and are being implemented reliably. Modifications (and proposals for modifications) to the respective *Terms of References* for each of these entities indicate that they are viable alternatives to the new entities proposed in MEC's MVCA recommendations in 2016 (MEC, 2017).

Complaint boxes in health facilities

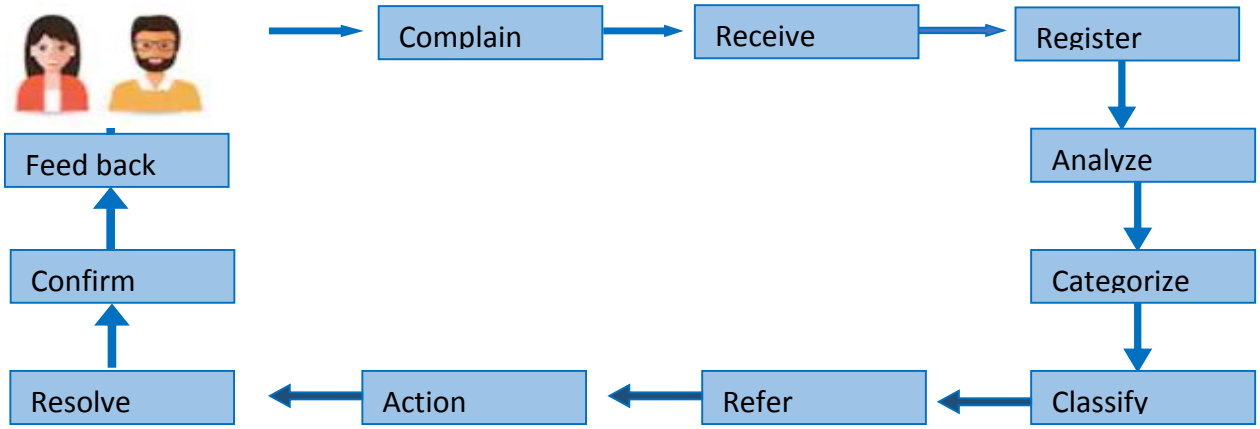
The core issues of these complaints continue to be focused on quality of care, all aspects of access to care, quality of medicines, patient transport, and referrals management (including perceptions of conflicts of interest.)

The Grievances Redressal Mechanism (GRM) in CCNPP

The Citizens' Charter National Priority Program (CCNPP) Grievances Redressal Mechanism is designed to listen to community concerns about CCNPP developments or governance. The GRM is intended to improve accountability of the Government – in this case the MoPH – as it related to Health *Shuras*. The GRM is expected to increase people's confidence in the Government (CCNPP, 2018). The CCNPP has established a Grievance Redressal Committee, with core principles of accessibility, predictability, fairness/equitability, transparency, and provision of feedback.

The GRM uses different means to collect grievances such as physical boxes, personal visits, a telephone hotline with all-hours messaging, petition email options, and a web portal. They will consider all of the complaints anonymously. Similar to the MoPH's HCO, the complaints cover all issues including staff and services availability, opening hours, any problem with staff conduct and behavior of staff, inequality and other similar issues. The relevant individuals and authorities will initially handle the grievances and refer them to relevant authorities for follow-up, which starts at village level and could reach to the central level if not resolved in the first level.

Figure 8. Grievance Resolution Mechanism process diagram (CCNPP, 2018)



No reports of the GRM has been submitted to MEC for analysis.

The Department of Public Relations

The MoPH Department of Public Relations (DPR) has a three part responsibility: On a political level, the DPR shares information about the Minister and the Ministry's work; additionally, on a reactive level, the DPR Team provides the public with information as and when events or incidents occur; finally, in line with MEC's multiple recommendations related to strategic communications, the DPR Team raises the public's awareness about specific Ant-Corruption achievements and activities to influence the community's perception, trust, and confidence in the health sector. During the two years of MEC's Active Follow-up, there were many examples of these three responsibilities being embraced, ranging from highlighting HE the Minister's specific statements against corruption and promoting good governance, publicity on MoPH's success at completing Competency-Based Recruitments in 6th quarter (MEC, 2018), and the development and implementation of AC-related policies.

Fraud/Falsification/Fakes/Forgery

In the recruitment process a committee in the MoPH Human Resources Department (HRD) reviews all credentials of the applicants to determine whether the documents have been issued by any valid institution inside or outside the country. MEC monitoring teams verified the achievement of establishing a robust system for this review. MoPH HRD thus has identified falsified documents which included degrees from non-existent training entities, faked attestation stamps, and faked signatures.

MoPH systems have been verified to successfully detect fraudulent certificates, Diplomas, and credentials from applicants. Evidence of specific cases of fraud were individually presented to MEC.

Work In Progress / Pending Actions

Monitoring and Evaluation

MoPH has established the Data Warehouse ("DHIS2"), which has provided access to indicators for individual Units and Directorates at the MoPH, but it is yet to be incorporated into the individual Departments' Terms of Reference as a Key Performance Indicator for their appraisal.

Supplemental auditing by the CCNPP has been initiated and has been successfully implemented but there is limited evidence of a strong working relationship and coordination between the MoPH and CCNPP – This needs further strengthening. MoPH CBHC is yet to implement training to Health *Shuras* on monitoring of health services by the community, due entirely to funding problems, though CBHC has been quite active in pursuing technical and financial support.

GDEHIS has designed a simple form to collected HMIS from private hospitals, but they lack the institutional and financial capacity to implement it, even in facilities within Kabul.

Department of Public Relations (DPR) has been involved in some respects in drawing the public's attention to examples of good quality of care in the health sector; but their role needs to be strengthened in areas such as integrity and reliability in the sector, and additional resources would be required to launch a broad and consistent campaign across the country.

Importation of Pharmaceuticals

The new Pharmaceutical Law has yet to be endorsed by the Ministry of Justice (MoJ) – It has been under review at MoJ since at least early 2018. This Law does not specifically discuss the concerns around Conflict of Interest of staff, nor how to manage it. On the technical side, NMHRA has been more successful in garnering resources; however, investment in equipment-related technical training to enable MoPH to conduct quality analyses of samples has yet to be implemented. Quality assessment of imported pharmaceuticals is only being conducted in Kabul, and as yet, has not been implemented in other Provinces. The NMHRA has not implemented an independent third party sampling of pharmaceutical and medical product, which has been envisioned, though the procurement process for the monitoring has been completed by signing an MoU with an Indian company.

The NMHRA Quality Control Laboratories have not been certified yet which is expected to be done in the next 2 years. Further, the Quality Control (QC) procedures are being carried out only in the capitol. In the 4 other regions, construction work has not been completed. Long pending purchases of new equipment for NMHRA's Quality Control Laboratories are reportedly still "in process" by UNDP.

Conflict of interest language has not been introduced into the Pharmaceutical Law to require disclosure and abstentions for NHMRA's High Level Board and Executive Committee members; this increases the risks of corruption.

Transparency, Governance, and Accountability

The General Directorate of Curative Medicine has established Patient's Representative Offices in tertiary hospitals. These serve as information desks at hospitals and have assigned responsibility to staff. However, evidence that this has led to offering patients and their families a list of available medicines, and doctors and staff on duty, have not been presented to MEC. Nor was any evidence presented that proves MoPH is applying penalties for lack of compliance.

MEC has not received evidence in support of engagement by Department of Public Relations in drawing 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). The publication has not been systematic or regular, in accordance with criteria, to ensure all areas of activity are reflected.

Health Shura Empowerment

Following the approved modifications by the Community Based Health Care Department to the *Terms of Reference* for Health *Shuras*, there will be new opportunities for community participation in monitoring and feedback of clinics, hospitals, ambulances, and referrals. However, the lack of financial resources to implement the new ToR remains an impediment to this being achieved (MEC, 2017).

Independent Accreditation Organization

The Afghan National Healthcare Accreditation Organization establishment is a significant step in improving quality of care by certifying the health facilities. However, as recommended by the original MVCA Report, there is no evidence such an entity is conducting assessments of MoPH Departments and Units -- particularly the GCMU – And therefore gaps in accreditation persist.

Human Resources Management

Training and Professional Development

MEC has verified establishment of an induction package of orientation and training for new employees by the MoPH Human Resources Department. This covers the areas of policy, Code of Conduct, conflict of interest, management of referrals and other issues. However, there is not yet a system and resources to reliably implement it for all new hires.

Resource Management and Auditing

The original MVCA emphasized the risk of not effectively managing resources – Though there had been some findings of stock and supplies being overseen effectively, while there were also perceptions that this was inconsistent from setting to setting. After a long-standing struggle to record a full-inventory of its diagnostic equipment and devices, an inventory was taken by the NMHRA in 2018. MEC also saw evidence that NGOs implementing health services regularly take the inventory of their equipment and supplies.

Quality Assurance / Quality Control

A 'league table' of private and public hospitals and clinics, based on standard indicators and patient/visitor surveys, has not been developed to encourage service providers to "race to the top." This would discourage sustaining low quality services and reduced information asymmetry for patients and their families. The establishment of the Afghan National Healthcare Accreditation Organization is an initial step toward accrediting health services. However, the design, effective implementation, and monitoring of Key Performance Indicators that would make this feasible have, so far, not materialized.

Extortion

The original MVCA highlighted the risks of extortion in the consideration and awarding of health services contracts to NGOs and INGOs. The MVCA recommendations sought to keep the issue on the agenda of MoPH's most senior leaders. While MEC welcomes the MoPH initiative to establish the High-Level Health Oversight Committee, which would have included this concern as part of its oversight, MEC remains concerned over the lack of participation and representation on the Committee by members of the community, civil society, or the Attorney General.

Nepotism/Abuse of Power

In the course of this End-State Assessment, MEC interviewed MoPH stakeholders and determined that although MoPH recruitment committees have representation from the Independent Administrative Reform and Civil Service Committee; recruitment is still being affected by inappropriate influences. MoPH has put in place controls intended to prevent nepotism and promote competency-based recruitments; however, the stakeholders interviewed for this End-State Assessment were skeptical about the system's effectiveness. This would adversely affect MoPH's ability to identify political interference in a recruitment process.

Fraud/Falsification/Fakes/Forgery

General Directorate of Public Relations support to improve public awareness of achievements in the fight against corruption in the Ministry and the health sector (MEC, 2017) has been weak, non-inclusive and not systematic. MEC found no evidence of the Ministry informing the public

that MoPH Human Resources has successfully uncovered multiple instances of fraudulent or faked Diplomas and certificates from applicants.

Additionally MEC did not receive any evidence to verify that the Grants and Contracts Management Unit is effectively vetting and verifying certificates to prevent fraud in the health services contract holders' own recruitment and hiring (MEC, 2018).

Human Rights and Discrimination

While within-MoPH coordination on strategic messaging increased in the 6th Quarter, it remained at a very limited level (Complaint Handling Office, NMHRA, RMNCAH). This affects how community is made aware of MoPH actions on human rights violation and discrimination.

Conflict of Interest

MoPH has claimed – but not supplied evidence for – improved transparency in the management of private sector referrals by public health facilities. As per the MoPH Conflict of Interest policy, copies of signed Declaration of Conflict of Interest forms for senior MoPH staff have been presented to MEC. It however does not cover all relevant staff and is not systematically reviewed at regular intervals in a Fiscal Year, with the generation of publicly available periodic reports.

MoPH has not organized training on Conflict of Interest for all staff involved in regulation and other key functions. Neither copies of signed forms for all staff, or at least for relevant Departments and health service providers, have been presented to MEC, nor have Declared Conflict of Interest forms been filed. MEC did not see evidence for any sanctions for non-compliance. The General Directorate for Policy and Planning has presented records of Declaration of CoI from MoPH Departments, but records for MoPH stakeholders and clients (such as partner NGOs, INGOs, and private entities) have not been collected. Despite developing the CoI policy, the lack of training capacity to implement it, and missing mechanisms and procedures means this remains a concerning area.

Bribery

Evidence has been supplied to MEC for presence of policies and staff contract having articles against bribery. However, evidence of enforcing penalties for violating the policies against bribery, for example as a Term and Condition BPHS and EPHS contracts, has not been presented. MEC saw no evidence that here has been any publicity around detecting violations or levying successful penalties, which would act as a deterrent to others.

Areas of Concern - Areas Without Detectable Progress

Importation of Pharmaceuticals

Pharmaceutical companies do not provide information labeling, including medicine retail prices.

The NMHRA plan to encourage current pharmaceutical importers to join and form corporate companies, and an NMHRA's *Concept Note for Limitation of Importing Companies*, has been rejected by the Administrative Office of the President.

Transparency, Governance, and Accountability

The new Pharmaceutical Law will not tackle the presence of Government staff and potential conflicts of interest within pharmaceutical companies.

There is no evidence that the Strategic Health Coordinating Committee (or the High-Level Health Oversight Committee) has supported the monitoring of absenteeism during official working hours within MoPH and in BPHS and EPHS services on a Provincial level and at national level. The ToR of the HLHOC does not spell out the oversight task.

MEC has not been provided any evidence to verify the training of AGO Kabul staff on health sector specific issues. Similarly, MEC remains concerned about lack of a clear mechanism to notify the public on the outcome of cases referred to the AGO by MoPH's Internal Audit Department.

Development and Oversight of Key Performance Indicators (KPIs)

There is no evidence that KPIs for staff or Departments have been developed and implemented.

Despite the activities evidently taking place, MEC has not been provided evidence for any improvements in MOPH's *public awareness efforts* to highlight accomplishments in the areas of integrity and reliability of the health system.

HR Management

A review of all recruitment for positions of Grades 1 and 2, as proposed by MEC, has not been done because accreditation processes have not been applied to the Ministry itself, so far, and it would be a potential conflict of interest for the MoPH Human Resources Department to assess its own work.

Resource Management and Auditing

MEC has not been provided with any evidence that MoPH is widely conducting an inventory and resource management system in its institutions and health facilities. After three years, this has still been left to individual NGOs and INGOs to develop and implement.

Training and Professional Development

MEC has not been presented evidence to support a systematic approach to regularly conducting Training Needs Assessment of the health workforce and allocating training according to the identified needs. Interviews with partners indicated that this allocation of training does not often follow the nominated staff needs or scope of work, but rather training allocation is still based on a list of whose turn is it to go for a training.

Engagement by the ANHAO in ensuring that Training Needs Assessment processes within MOPH and BPHS and EPHS contract holding agencies are clarified, transparent, and reliable remains outside the ANHAO ToR. Similarly, there has been no engagement of ANHAO in ensuring opportunities to standardize the resource management systems for health sector clinical and technical training and professional development, or 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; both these responsibilities remain outside the ANHAO ToR.

Health *Shura* Empowerment

MEC still remains concerned about High-Level Health Oversight Committee participation and representation opportunities for members of the community, civil society organizations, and health sector advocates. Health *Shura* development – clearly an option for increasing participation and representation in health issue considerations – has been limited to due to funding requirements for the implementation.

Extortion

There has been poor case-tracking by MoPH Internal Audit Department after referral of suspected cases to the AGO. Likewise, there is no evidence that training on health sector specific issues was conducted for the Kabul AGO staff.

Policies

The policies on engaging the Strategic Health Coordinating Committee to monitor absenteeism during official working times within MOPH and in BPHS and EPHS services on a Provincial level and on national level have not been implemented. Further, no evidence has been presented showing engagement of Health *Shuras* and the Department of Public Relations in drawing the public's attention to examples of good practice and integrity in the management of patient referrals.

Contracts

Transparent and Effective Grants and Contracts Management Unit

There is no evidence that GCMU institutional capacity has been certified to implement contract management. Such a certification has only been issued once by the CPA, in 2015.

MEC has observed an inconsistency with MoPH approach to regulation; for instance, the Anti-Corruption Strategy has not been shared with all staff. An obvious gap in this instance between policy and its implementation has been noticed.

Further, MEC has not been supplied any evidence to prove that either the Strategic Health Coordinating Committee or HLHOC has been engaged ensuring that conflicts of interest are uncovered, overturned, and prevented as a routine matter within the Grants and Contracts Management Unit and to refer its violations to the Attorney General's Office for official investigation and prosecution.

Further, there has been no evidence to prove that MoPH's Department of Public Relations is drawing the public's attention to examples of good practice and integrity in the management of the public health sector's assets, especially ambulances.

Embezzlement

The MoPH has taken tentative steps in establishing a more productive working relationship with AGO, though broad improvements in their case coordination and communications have yet to happen. The Internal Audit Department has not carried out an internal capacity and system integrity assessment; its working relationship with the Governments' Major Crimes Task Force, AGO, and the courts (to follow up on corruption cases), has not been developed. A case tracking mechanism is not actively being followed.

MEC has not been supplied with evidence that MoPH have set standards for available medicines, inventory and stock management in health services facilities -- and neither has the Ministry proven it has raised awareness and sanctioned non-compliance of BPHS and EPHS implementers.

Internal Audit Department

IAD still requires senior-most MoPH leadership to develop capacities for engagement with AGO (MEC, 2017). It also needs external financial support to implement its capacity development plan, following the itemization of their specific requirements.

Nepotism/Abuse of Power

An integrity system assessment of Human Resources and Finance Departments, involving independent assessors, including a member from civil society, has not been conducted. Likewise, an independent audit of all the positions filled in the last two years, involving independent

assessors, including a member from civil society and independent auditors, has not been carried out.

Human Rights and Discrimination

The Ministry efforts on transparency, governance, accountability, and system integrity have remained largely unknown to the public, including management of referrals (GDPSC), discipline of MOPH staff and management (GDHR), routine monitoring for implementation quality and program completeness (GCMU), referrals of suspected cases of corruption to the AGO (IAD-AGO), and Quality Assurance-Quality Control monitoring and oversight (GDEHIS) (MEC, 2018).

Conflict of Interest

Integrity assessments of GCMU and procurement entities of MoPH involving independent assessors carried out by a representative from a CSO or the National Procurement Authority (similar to the one done in 2015 for GCMU) needs to be renewed.

No evidence has been supplied to prove that Request for Proposals Proceedings now state that information on the conflict-of interest is required to enable a shortlisted bidder to participate in the procurement proceedings and to submit proposals. Evidence for activities such as GCMU developing the capacity of NGOs to implement the policy, and the EHIS role to monitor compliance with it, the Directorate of Private Sector Coordination (DPSC) to disseminate capacity development packages to the private healthcare providers, and making sure that that private healthcare providers follow these procedures (both in their internal businesses and their business dealings with other companies) has not been presented to MEC.

No evidence was provided for employees of the Provincial Public Health Directorates (PPHDs) submitting their declaration of interests at regular intervals. Neither was evidence presented that a separate team or a staff member has taken on the responsibility to regularly check compliance of staff and prepare quarterly reports on the results.

Referrals Guidelines have now been developed and adopted by MOPH, but MEC has not observed enforcement of systematic controls over referrals within the current health service contracts (MEC, 2017).

Transparency, Governance and Accountability

No evidence has been presented to MEC proving that accreditation has been 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. Neither does evidence exist which shows that BPHS and EPHS agency Directors have been held accountable directly on achievement of Action Plans. As mentioned earlier, the two tasks fall outside the ToR of AHAO, nor has a similar entity been assigned to carry out this important role.

Although MoPH has established and has been enforcing strong penalties for absenteeism, it has so far failed to publicly communicate its success at enforcement.

Recommendations Outside the Scope of the MoPH

Regarding the proposed two Commissions (on accountability and accrediting health organizations): These entities were intended to be independent. However, the MoPH could not establish independent entities. The role of MoPH in these recommendations could have been better clarified as *advocacy with higher Government entities to establish the proposed structures and systems*. These are further discussed below:

Independent Council on Health Sector Auditing and Reporting

The recommendations on establishing the ICHSAR was modified in 4th Quarter – instead focusing on an Afghan Medical Council in order to re-build trust in the MoPH. The End-State Assessment shows that the scope of ICHSAR and AMC are not the same, although some of the recommended actions are performed by AMC while others such as "investigate and inspect MOPH and BPHS and EPHS contract holders in all Provinces," is beyond its mandate.

The proposed ICHSAR Investigator/Inspector roles were dropped in favor of external reviews from an entity, such as KIT/SRTRO. However, in this case, a third-party evaluator also could not perform the task independently, due to the risk of conflict of interest as it receives funding from the MoPH and is recruited and monitored for its compliance with a contract by the MoPH.

Independent Commission for Accreditation of Healthcare Organizations

The current scope of AHAO does not cover NGOs and private sector health service providers. There is no evidence that It is engaged in KPI monitoring of NGOs and MoPH core internal management system, in monitoring training needs assessment processes, in standardization of resource management system for health sector and in monitoring compliance with CoI policies.

Progress in Achieving Improved Outcomes

The goal of all interventions in the health sector are to produce outputs and improve health outcomes. The interventions that have been implemented as a result of MEC recommendations in 2016 will result in improvement in around 70 indicators (29 outcomes and 42 with progress toward impact); these have been defined for 19 recommended areas in the 2016 MEC MoPH MVCA report (See annex II for details). To measure the progress in achieving the output indicators, outcome indicators, and progress toward impact, the following steps were taken: The output, outcome and impact and related indicators were defined and in some cases, refined. The original 2016 MoPH MVCA had defined outputs and outcomes (mostly without indicators); in 2016 MoPH suggested some outcomes (see annex I). Means of verification for the indicators were

then identified. These included quantitative and qualitative data sources from the MoPH and those outside MoPH, such as the AMC and CCNPP.

Indicators for outputs, outcomes, and progress toward impact were selected: health access, coverage/volume of services, quality of health care service, U5MR, MMR, OOP expenditure and MoPH trust by the community (MoPH , 2017).

Means of verification for the indicators included Activity Reports from MoPH implementation of MEC recommendations, including HMIS reports and verification reports, GCMU monitoring reports, MEC monitoring reports, third party evaluation of health sector by KIT (including the BPHS and EPHS Balanced Scorecard), Afghanistan Household Surveys in 2018, MoPH policy, Strategy, Guidelines, Laws, regulations and bills; CCNPP community scorecard; individual interviews, Focus Group Discussions and Direct Observation.

A comparison between the status of the indicators in 2016 and those available for 2018 or 2019 have been used to compare the results. Results have been mostly illustrated in graphs; some photos (if available and relevant) have been used.

Client Satisfaction

The anti-corruption vision statement of the MoPH is

“Much greater public confidence in the health sector due to reduced informal payments and bribery, and quality health services: (MoPH , 2017).

And its mission is

”MoPH aims to accomplish reach the vision by regulation, prevention, prosecution and public engagement on corruption.”

Therefore, public confidence could be reflected in their satisfaction with services and the quality of health services – These are the two potentially important measures of health outcomes.

MEC has examined the Afghan Household Survey (2018) and a recent MoPH Patient Satisfaction Survey in Kabul hospitals. The AHS is country-wide and covers the BPHS and EPHS facilities, while the latter was only conducted in Kabul and just covers hospitals.

From the 2018 AHS, the overall mean satisfaction score was composed of the following indicators: convenience of travel to the facility, cleanliness of facility, respectfulness of providers, how health workers explained the patient’s illness and treatment, availability of drugs, cost of drugs, privacy of the facility, the time health worker spent with the client, opening hours and waiting time. This score includes many important areas that are covered by the MEC recommendations which makes it a useful index. The overall mean satisfaction score of those

who visited a health facility has been 60.2 per cent; however, MoPH health facilities has shown a slightly lower score of 57 per cent. Overall, many respondents are satisfied with health services. The national median score for client satisfaction in 2019 has slightly increased.

As reported by the 2019 AHS, over half of the community members interviewed trust their healthcare provider. Though the overall trust in the healthcare provider (table 3.2-8) has been high, a slight difference can be observed between MoPH clinics (mean total score of 57.9) and MoPH hospitals and private clinics/hospitals (66.4 and 66.1 respectively) (MoPH, 2018). Data were unavailable for comparison to the situation prior to MEC's MoPH MVCA.

Table 2. Mean community perception scores of health facilities (by facility type).

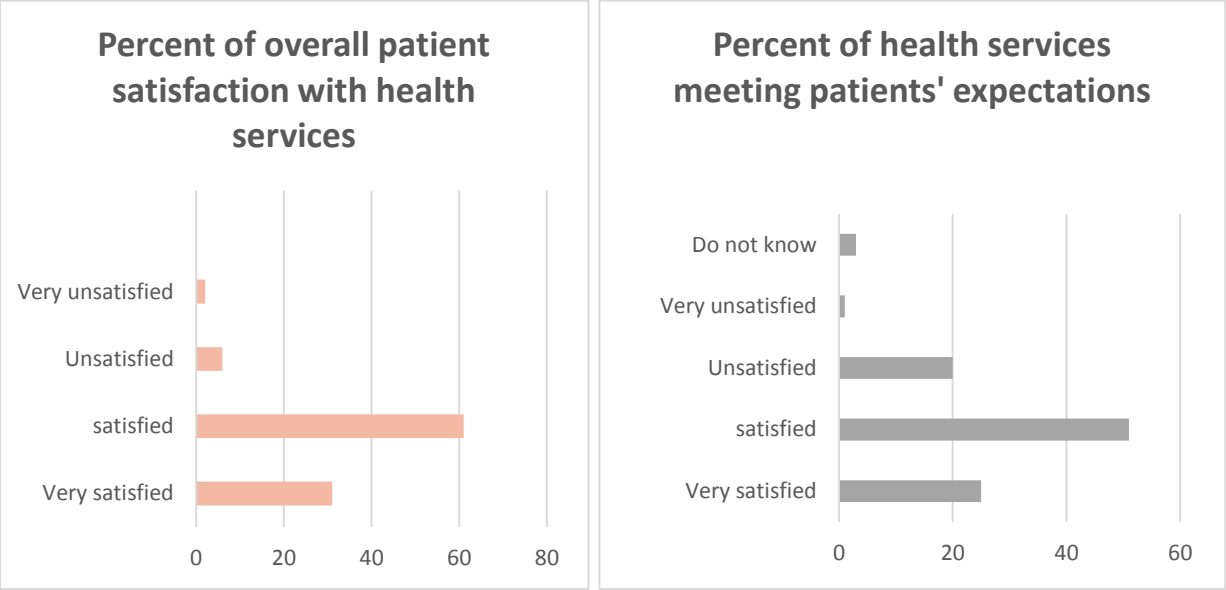
Satisfaction and trust	MoPH clinic	MOPH hospital	Private clinic/facilities
Respondents [1]	2008.7	614.1	1586.3
Satisfaction with the visit to the facility			
Convenience of travel to the facility	49.2	53.5	48.2
Cleanliness of facility	61.0	65.9	66.4
Respectfulness of provider	53.1	59.1	64.2
Health worker explained the illness	56.5	60.9	64.8
Health worker explained treatment	55.0	61.2	63.8
Availability of drugs	50.3	55.6	63.6
Cost of drugs	51.9	56.1	45.3
Privacy	63.3	68.8	67.2
Time health worker spent with you	55.1	58.4	63.3
Opening hours	56.1	65.5	63.2

Waiting time	48.9	53.3	56.9
Overall satisfaction	57.0	62.0	64.5
Overall trust with the facility staff			
Trust in skills of provider	58.0	64.1	66.4
Trust decisions about medical treatment	57.3	64.9	64.5
Staff act differently toward rich and poor people	52.2	58.6	57.2
Will come back in the future	61.5	66.9	66.8
Overall trust	57.9	66.4	66.1

The trust score is an aggregate of scores around the following trust-related issues: trust in skills of provider, trust in decisions about medical treatment, staff act differently toward rich and poor people, willingness to return in the future (MoPH, 2018). This index demonstrates a summary where important indicators of outcome are covered and has shown a satisfactory result. Over half of the community trust the health services; the degree however has been highest with public hospitals followed by private health facilities and then public health clinics.

A 2019 survey conducted by the MoPH, which covered 422 clients/patients in 20 public and private hospitals in Kabul city and Districts, aimed to ascertain patient satisfaction, waiting time, staff conduct, quality of services, presence of medicines and diagnostic services and observing patients' rights (MoPH, 2019). The results showed that in general patient satisfaction from the hospitals has been high at 61 per cent; half of clients mentioned that the hospital met most of their expectations and one in five respondents said it met some of their expectation. Overall, 3 in 4 patients mentioned that health services met their expectation.

Figure 9. Patient satisfaction and trust in hospitals in Kabul



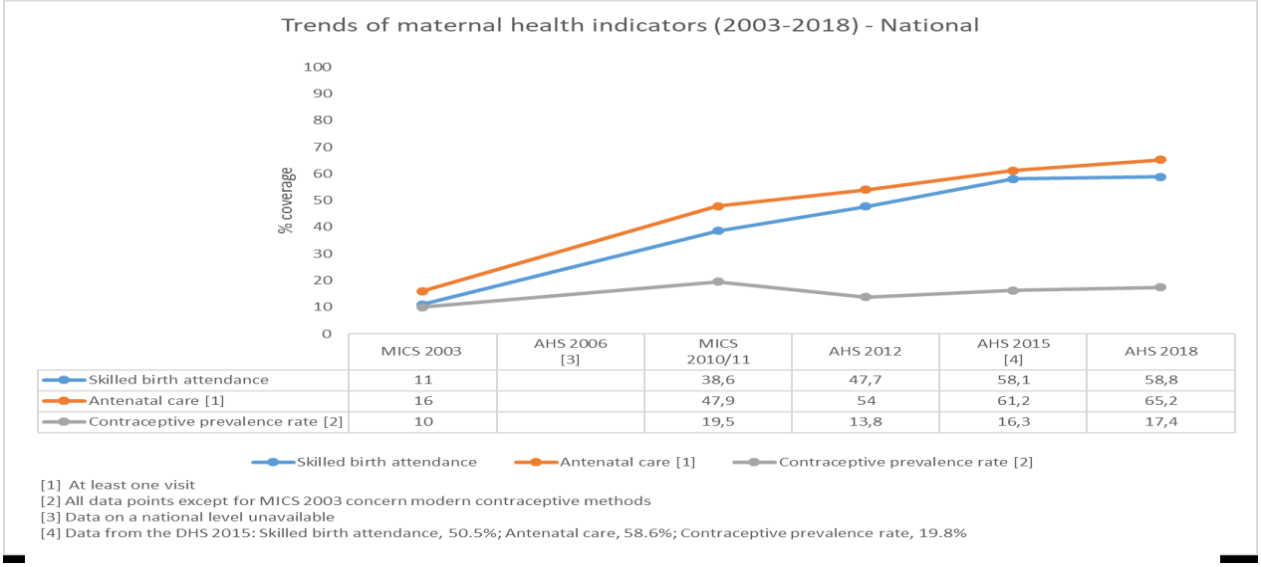
Community awareness of MoPH anti-corruption actions play an important role in influencing the public's willingness to seek services or launch complaints. MEC has noticed that limited information about what anti-corruption actions have taken place in MoPH means community members and other stakeholders remain highly skeptical (MEC, 2017) in 2017. None of the community members interviewed (and few NGO and INGO managers) had any information about anti-corruption actions taken by MoPH. To date no recent data is available to see progress on this at the community level; however, increased access to complaint handling services at the community and central MoPH is likely to have raised such awareness.

Volume of Health Services

Maternal and Child Health Coverage Indicators

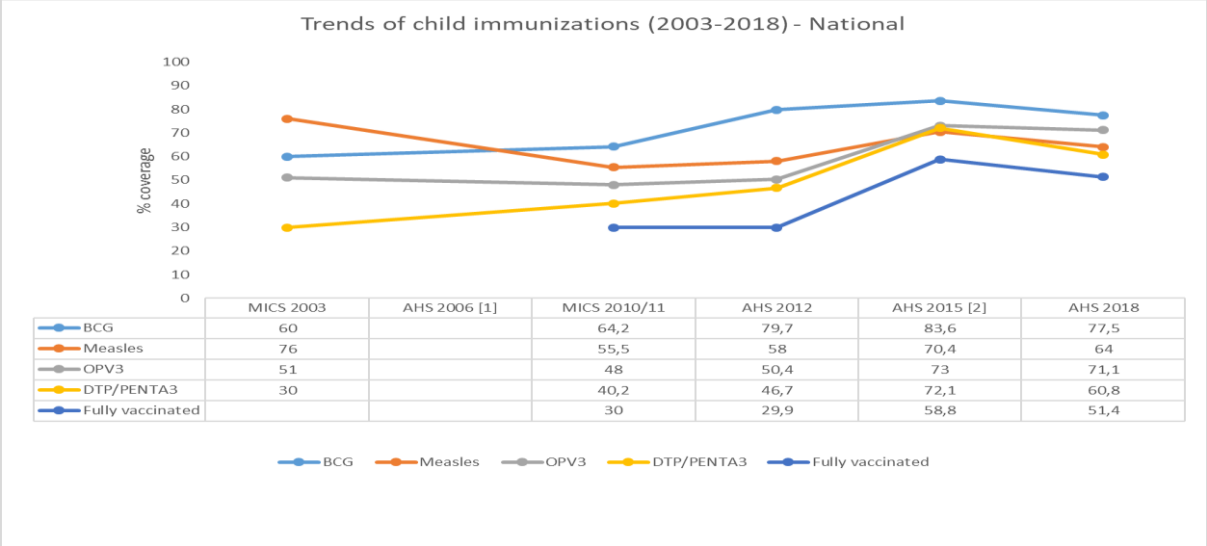
Although the indicator levels are still high; the majority of the maternal health indicators dipped in 2018, compared with the 2015 (MoPH, 2015); likewise, there has been a general improvement in the immunization coverage, nationally, for all antigens through 2015, and then a dip was detected for 2018 (See figures 11 and 12).

Figure 10. Trend of Maternal Health Indicators (2003-2018) (MoPH, 2018)



	MICS 2003	AHS 2006 [3]	MICS 2010/11	AHS 2012	AHS 2015 [4]	AHS 2018
Skilled birth attendance	11		38,6	47,7	58,1	58,8
Antenatal care [1]	16		47,9	54	61,2	65,2
Contraceptive prevalence rate [2]	10		19,5	13,8	16,3	17,4

Figure 11. Trends of child immunization (2003-2018) (MoPH, 2018)



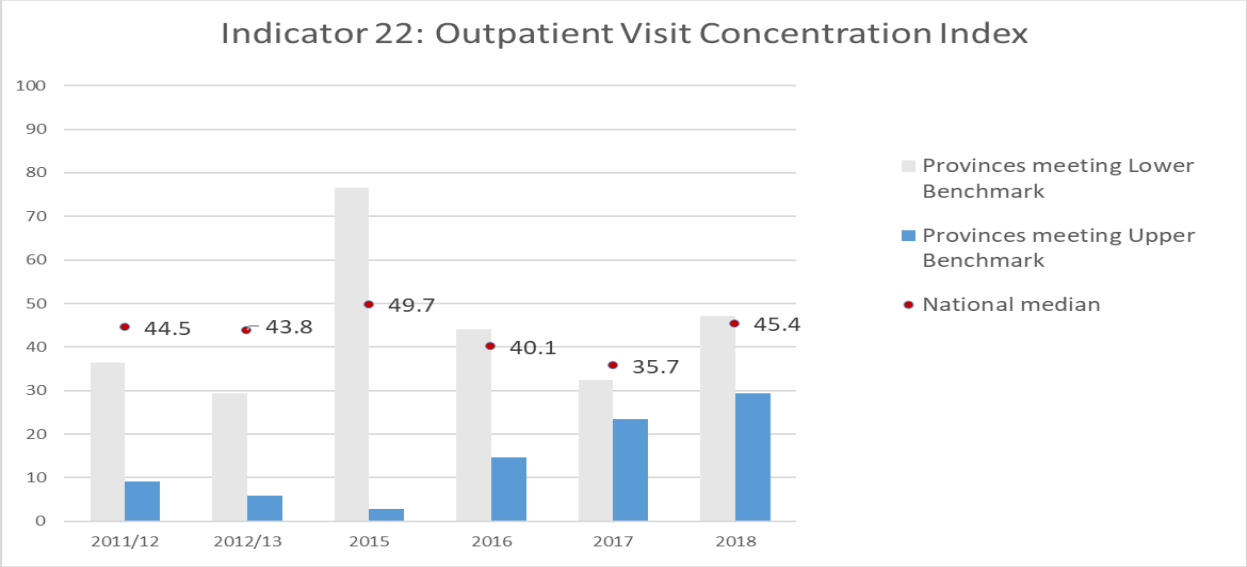
	MICS 2003	AHS 2006 [1]	MICS 2010/11	AHS 2012	AHS 2015 [2]	AHS 2018
BCG	60		64,2	79,7	83,6	77,5
Measles	76		55,5	58	70,4	64
OPV3	51		48	50,4	73	71,1
DTP/PENTA3	30		40,2	46,7	72,1	60,8
Fully vaccinated			30	29,9	58,8	51,4

New Outpatient Visit Concentration Index

The source for this indicator has been the BPHS Balanced Scorecard which is a means to measure performance in the delivery of Basic Package of Health Services (BPHS) throughout Afghanistan by observing patient-provider interactions and patient exit interviews, and interviews with health workers. This indicator assesses equity in access to outpatient services through measuring the wealth status of clients in health facilities (MoPH, 2018). Data on the wealth status of clients were collected during exit interviews through asking a series of questions about household assets, sources of income, access to water, electricity, and other necessities. The national median score stands at 45.4; the outcomes have been steadily and constantly improving since 2016. This

finding shows not only improvement in equity but also relates to MEC's recommendation on promotion of human rights and deterrence from discrimination.

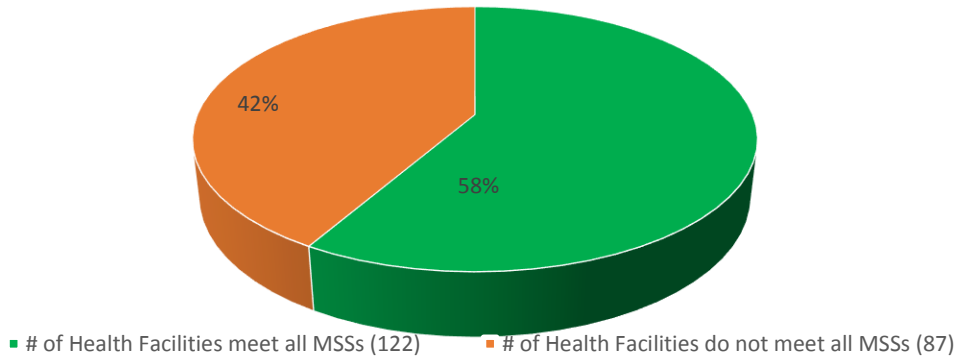
Figure 12. Outpatient Visit Concentration Index



Quality of Health Services

Here MEC has used the results of the CCNPP Minimum Services Standard (MSSs), the BPHS Balanced Scorecard 2018 and Kabul Hospitals Patient Satisfaction Survey 2019.

Figure 13. Status of Health MSSs

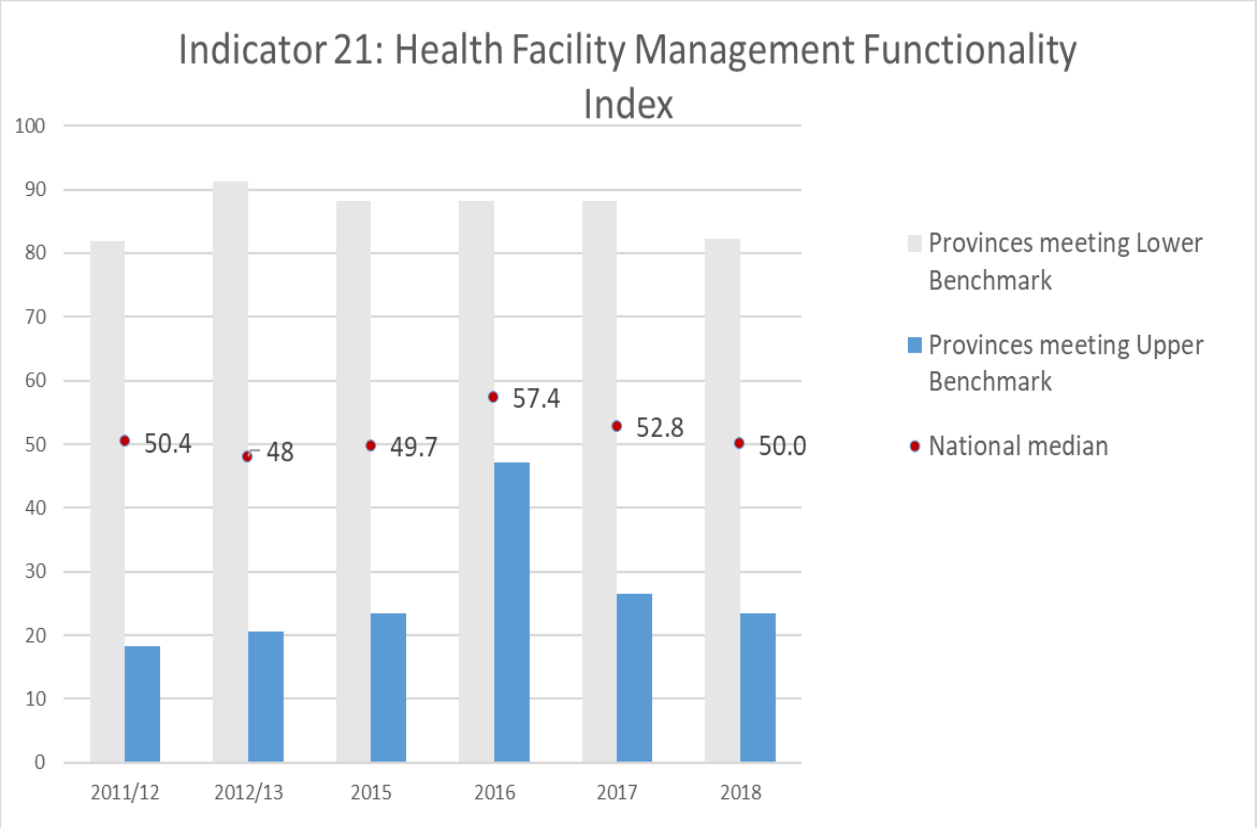


The CCNPP MSS quality measures include areas such as clearly indicated services at the information board, working hours, staffing availability, service availability for pregnant women, immunization, family planning, Tuberculosis detection and referral, Malaria- and diarrhea-related services (depending on the type of health service facility). In the Score Card report covering June through October 2018 for Health the following observations were made: Total 209

Score Cards were reported for different types of health facilities. It is encouraging to note that over half (58 per cent) of the health facilities met all MSS.

The BPHS Balanced Scorecard 2018 Health Facility Management Functionality Index assessed various administrative and managerial functions including up to date inventory of drugs, furniture and equipment. The results show a consistent and continuous decline with the index which is consistent with MEC finding of a weak and inconsistently applied system of inventory management.

Figure 14. Resource and inventory management in BPHS facilities



The Patient Satisfaction Survey in Kabul hospitals have indicated that around 90 per cent of clients were either satisfied or very satisfied with cleanliness of health institution (MoPH, 2019) and three out of four staff have responded appropriately and timely to the patients' needs. These two indicators are the proxy measures of quality of care.

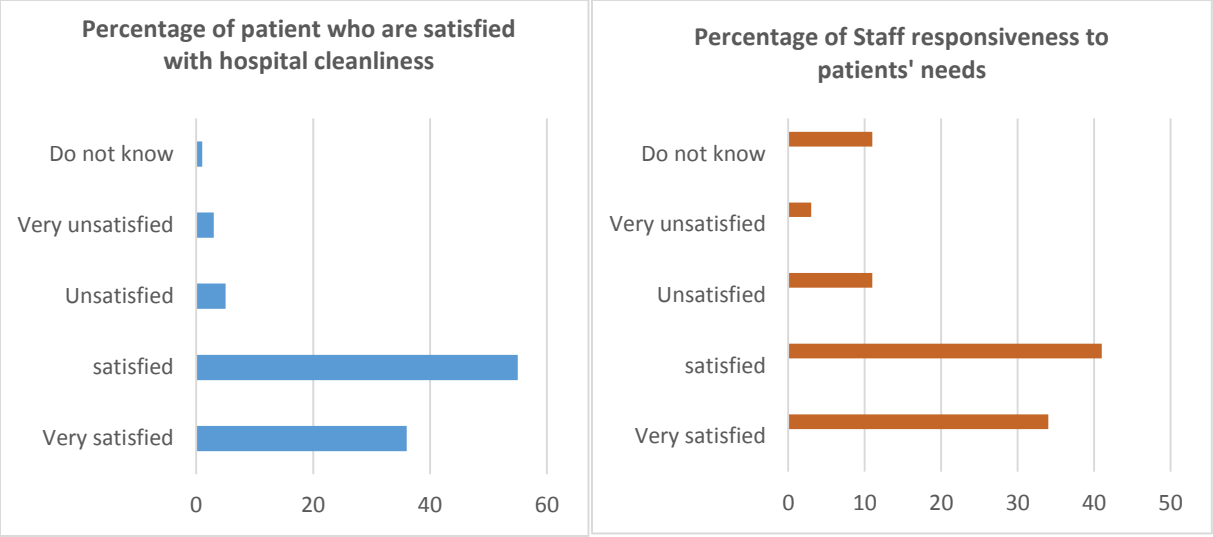
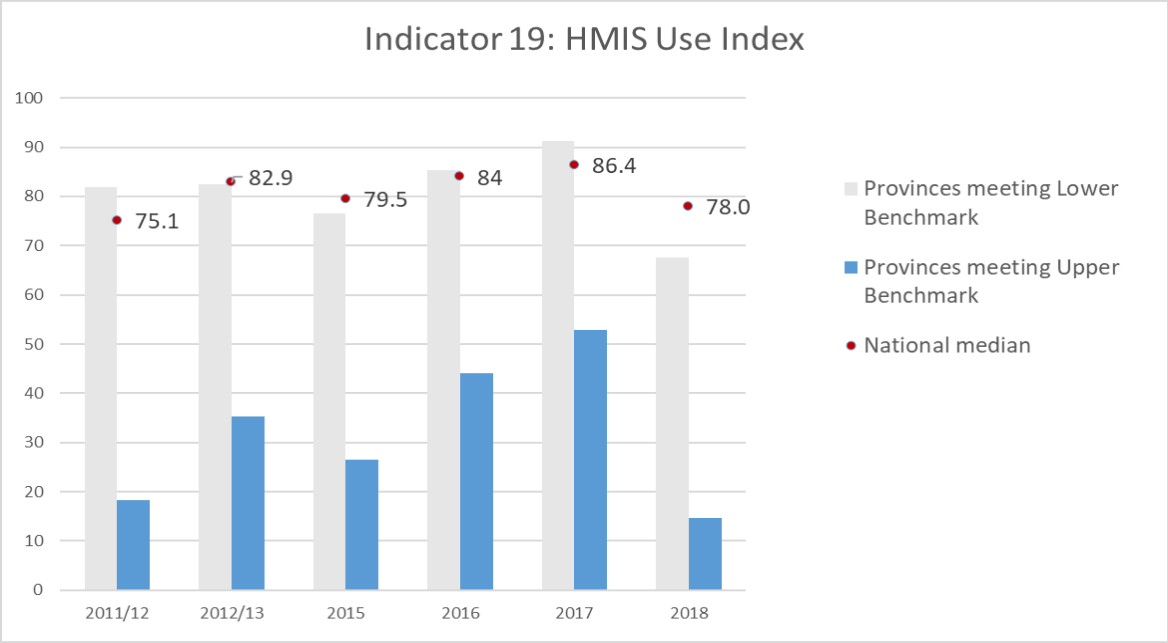


Figure 15. Perception of community on quality of care in Kabul hospitals

HMIS Use

This indicator assesses availability and use of HMIS in health facilities (MoPH, 2018). The national median for this indicator in 2018 was 78, down from 84 in 2016, which shows although the HMIS use has been in overall better position but has had a slight decline.

Figure 16. HMIS Use index in BPHS facilities



Progress in Achieving Impact in the Health Sector

Impact indicators are generally affected by a multitude of different interventions, including changes in other sectors outside health, and require much longer to establish evidence of change (at least 5-10 years). Therefore, measuring true impact at this stage is immature. We recommend caution to be exercised while interpreting the results.

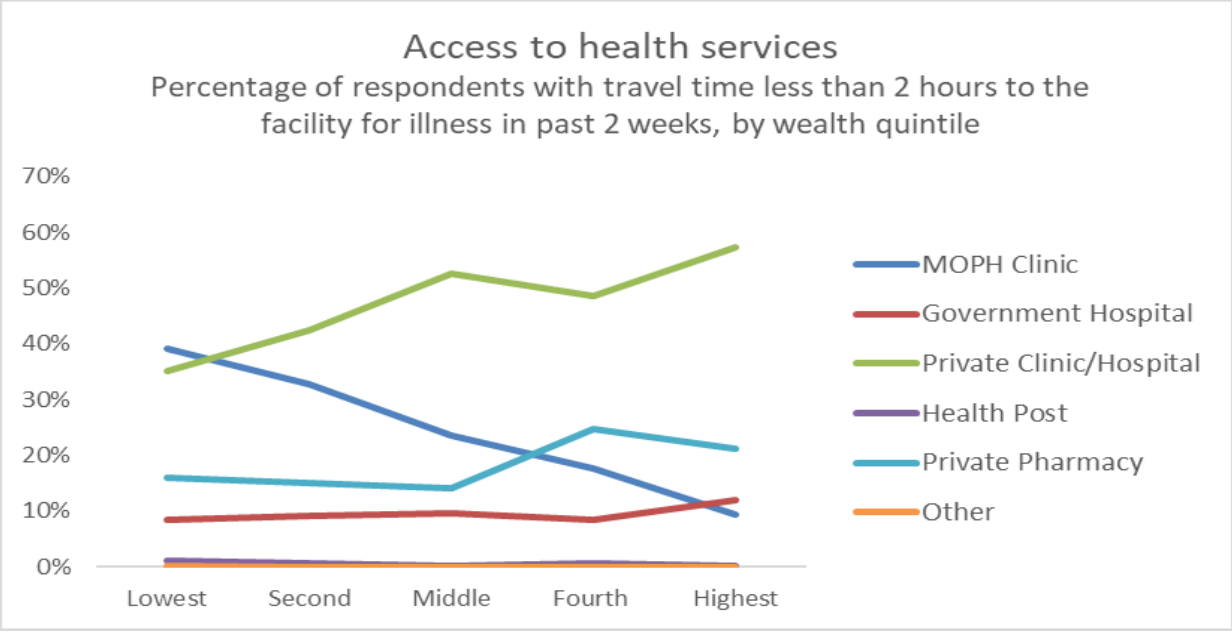
For this assessment only certain impact indicators have been analyzed due to scarcity of verification data, time constraints, and ease of understanding by general public. Thus only access to health care services, certain health coverage indicators, Out-Of-Pocket expenditure on health, and community and donor trust of MoPH, have been used.

Health Indicators

Access to Health Services

Access to health services is an important health indicator which has been measured in household surveys and is defined as the per cent of the population in Afghanistan who lives within a range of 2 hours from a public clinic. A facility that is not built or not being staffed, equipped or the resources are being misused, could not provide access to the population – therefore it cuts across different areas covered under the Anti-Corruption Strategy of MoPH. This indicator has slightly dropped from 93.2 per cent in 2016 (IRA, 2017) to only 90.6 per cent in 2018 (MoPH, 2018) – a slight decline over the 3 year period.

Figure 17. Access to health services (MoPH, 2018)



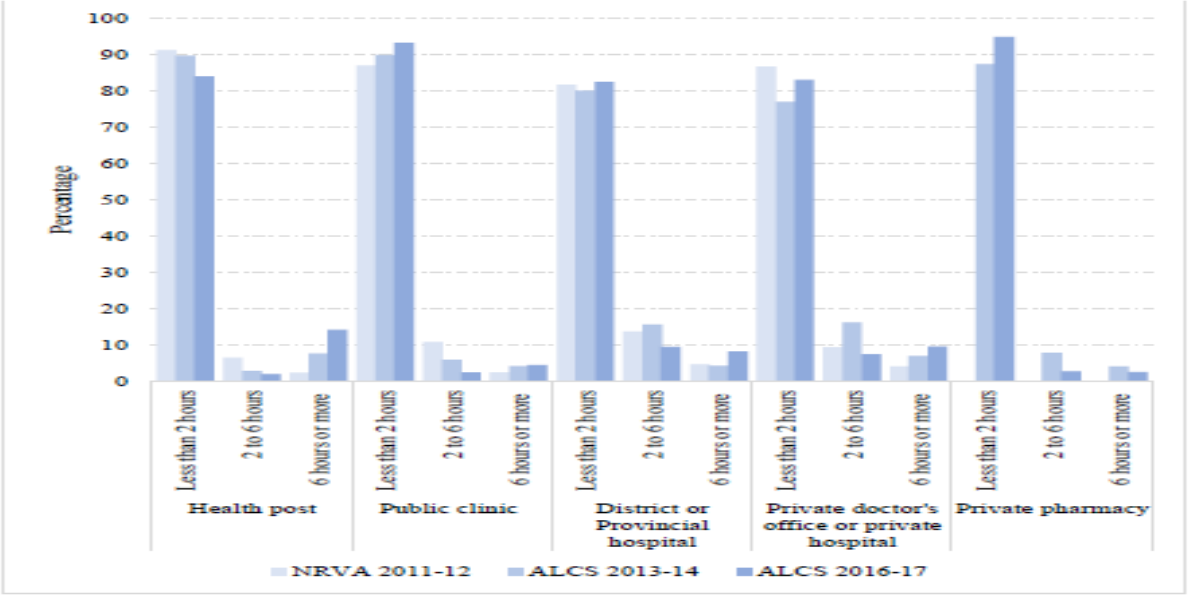
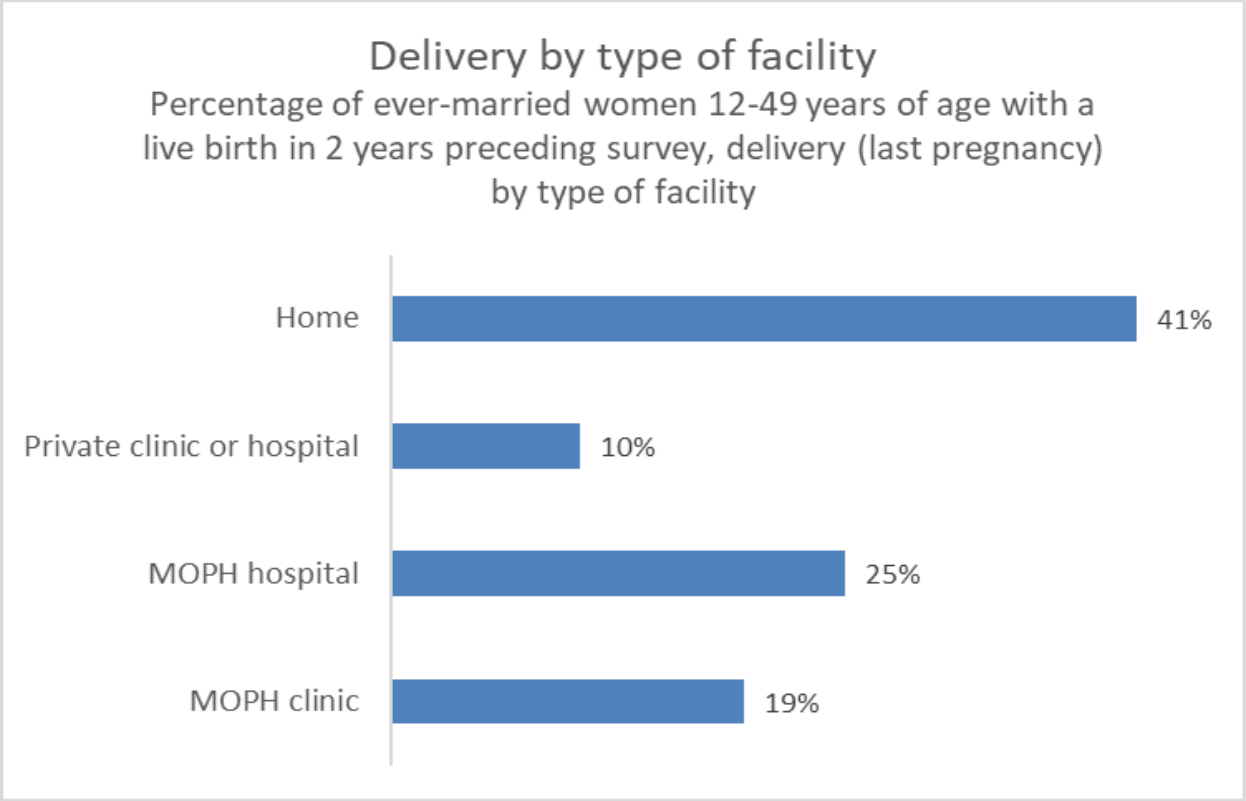


Figure 18. Population, by type of health facility, travel time to health facility by any means of transport, and by survey (in percentages) (IRA, 2017)

Table 3: Access to health services. [1] Transportation/travel time	Overall
Respondents [1]	20,367.3
Travel time to the facility	
Less than 30 minutes	56.6
From 30 minutes to 2 hours	34.0
From 2 hours to half a day	7.0
More than half a day	2.2
Total	99.8 [2]
Accessed facilities	
Travel time less than two hours	90.6
[1] Respondents who were ill and sought treatment outside home in the past two weeks [2] Percentages do not add up to 100 due to missing data	

Percentage of ever-married women 12-49 years of age, with a live birth in 2 years preceding survey, that have been delivered in different settings demonstrates that close to half of the women use the MoPH clinic or hospital. (MoPH, 2018). This is a proxy indicator of how much trust women and families have on to their locally available health care services.

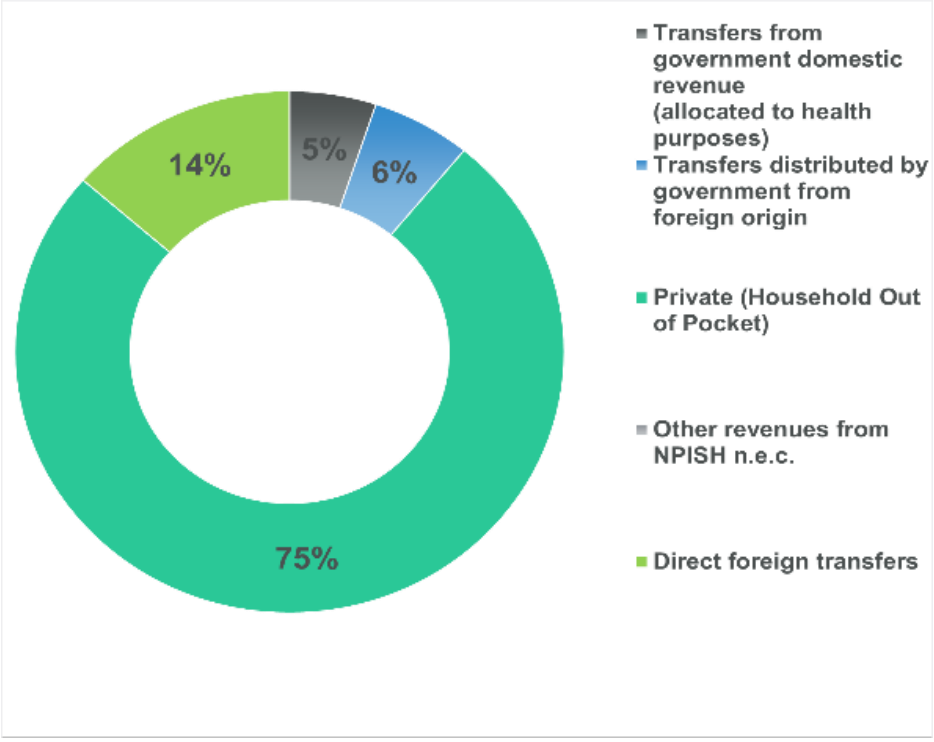
Figure 19. Delivery by type of health facility (MoPH, 2018)



Cost of Health Services to the Population

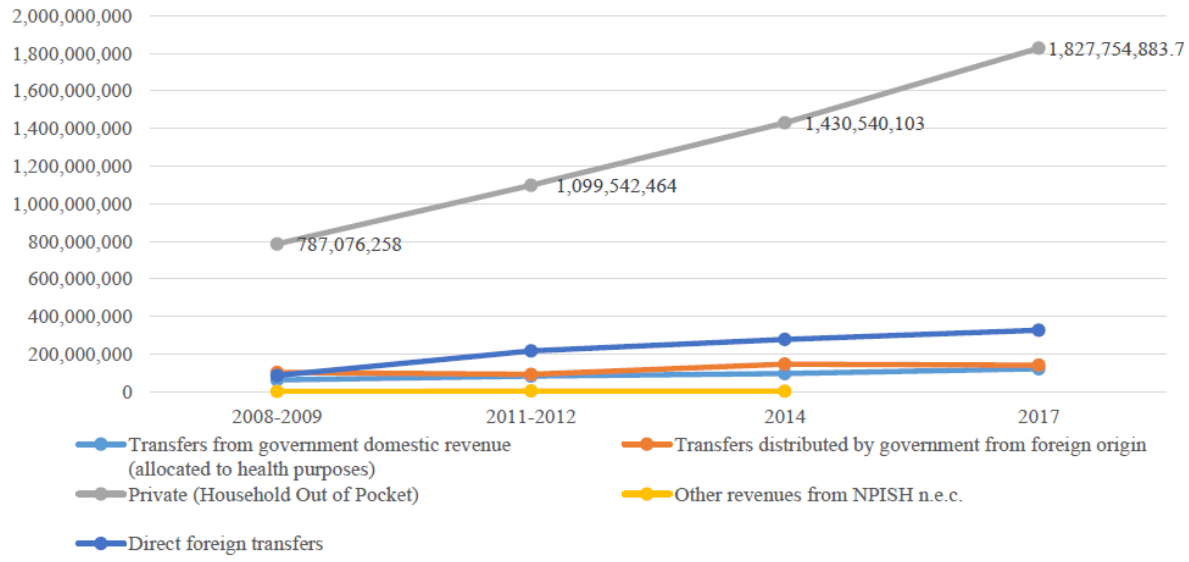
Several factors including lack of access to public facilities, referral of patients to private facilities, bribery, embezzlement, human rights violations and discrimination, misuse of public assets and Improper marketing relations might lead to higher costs for the health users. Another key factor is higher medicine and consumable/diagnostic procedure costs partly due to increased drug consumption by the population (through over-prescription, line-extension, or over-medicalization). Measurement of private *out-of-pocket* expenditure (OOP) on health provides much valuable information on this. The private OOP expenditure on health constitute 75 per cent of total health expenditures, which means out of 100Afs spent on health by a household 75Afs is paid by the people. The OOP on health has slightly increased, compared to 3 years before (See figures 20 and 21). This is a very discouraging result indicating vulnerability of the people as a result of health spending.

Figure 20. Sources of Financing for Health (MoPH, 2019)



Out-Of-Pocket expenditure on health has been gradually and steadily increasing.

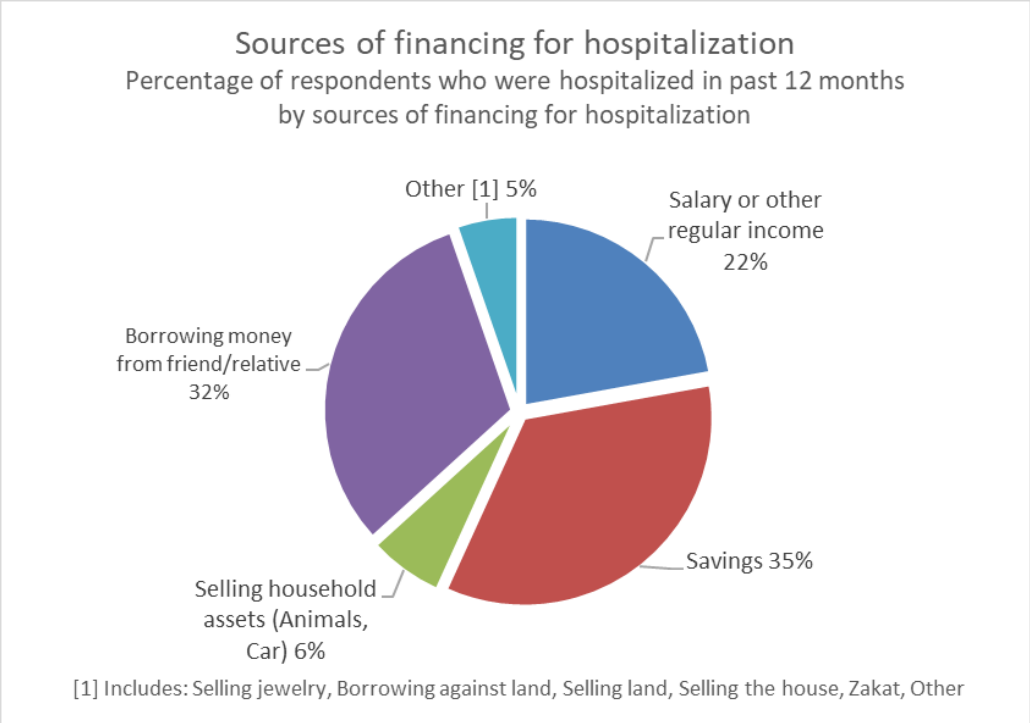
Figure 21 Out of Pocket (OOP) Health Expenditure on Health (MoPH, 2019)



There is a link between health expenditure and poverty as sources of financing for hospitalization included savings and loans from friends and family followed by money from income and the sale

of household assets. This leads to a distressed financing rate of 46.8 per cent and a severely distressed financing rate of 9.1 per cent (MoPH, 2019).

Figure 22 Sources of payment for hospitalization (AHS 2018)



Public and Stakeholder's Trust

MEC 2nd monitoring report has expressed concerns over health services ability in securing the public's trust and building their confidence (MEC, 2017). It adds that shifting the public's perceptions is affected by their experience and overall availability of services. The report indicates that messages about MOPH's trust-building and anti-corruption intervention achievements have not been shared as widely as and as soon as possible. MOPH Department of Public Relations has not demonstrated an active and systematic role to assert control of the messaging, internally and externally, to communicate changes and improvements so the public will be better informed.

In its 5th MoPH Monitoring Report, MEC has raised its concerns again that until the public observes MoPH action in ensuring quality medicines are offered, the negative perception is likely to persist – and confidence in MoPH's role as 'steward of the health sector' will suffer. Despite several interventions by the MEC Active Follow-Up Team, the MoPH effectiveness at publicizing its own actions remains weak.

As mentioned under access to health services, close to half of the women chose to use public health facilities to deliver their babies, and slightly more than half of the respondents (see table 2) indicated that overall they trusted the health services (MoPH, 2018).

Views from the donors and NGOs were similar: While they generally trust the recruitment of service providers by the GCMU, they have serious concerns over procurement of goods and other service, recruitment of staff, allocation of training, resources management and quality and access to medicines.

Partly those low-trust concerns relate to lack of a wider public recognition of improvements. Several of the recent interventions have produced positive changes and have the potential to effect public perception as well as the public's routine engagement with the health sector.

Conclusion

MoPH has started its own anti-corruption initiative to make formal statements and paving the road for MEC's MVCA in 2016. The current assessment of progress since 2016, focusing not only on outputs but also outcome and towards impact, shows that initially the implementation has been challenging as there has been resistance from inside and much controversy over Ministry's capability and willingness to act.

However, MoPH has made significant achievements in fighting corruption through implementing a range of activities including establishing the NMHRA and the AMC, creating the data warehouse, translating all its policy and strategy documents into local languages and distributing them to health facilities and PHDs, strengthening proper patient referrals, enforcing staff availability through use of finger scanning systems to track on-time attendance, developing an Anti-Corruption Strategy, a Code of Conduct Guideline, and a Conflict of Interest policy.

In addition, the MoPH and AMC has been reinforcing the Health Complaints Handling activities through development of Standard Operating Procedures, Guidelines, allocation of appropriate resources, and creation of feedback loops. Feedback to the complainants are being provided to ensure integrity of the system and to build public trust (MoPH, 2017).

As a result, to date, MoPH has fully implemented 84 per cent of MEC's recommendations and only 16 per cent have not been implemented. MoPH has established the AHAO as a key step to accredit the health facilities in the country and improve quality of care. MoPH has started tackling Conflicts of Interest by introducing the policy and enforcing its implementation. Use of ambulances for patient transport (rather than personal needs) has been strengthened. Recruitment of staff has been improved and made more transparent through a collaborative

effort with IARCSC. Performance-based contracting focusing on Key Performance Indicators has been launched by GCMU to oversee implementation of BPHS/EPHS.

Areas that MoPH is lagging behind and is of concern include: delay in supply of NMHRA lab equipment and lack of QC facilities at the Provinces, lack of training of AGO staff on health sector issues and poor use of the IAD's case tracking system, lack of KPI for MoPH Departments and staff, lack of a systematic resource and inventory management system in MoPH institutions and public hospitals, no regular or structured Training Needs Assessments and a lack of a proper allocation system for training; lack of an independent accreditation of MOPH procurement entities and the contracted NGOs and INGOs; weak involvement of community in Health *Shura* decision-making and monitoring of health services; inadequate public education on MoPH anti-corruption progress through social media, serious shortcomings in managing potential and actual Conflicts of Interest; the poor relationship between the MoPH's IAD and the AGO with the lack of an active follow-up system to allow MoPH to track the final results of individual cases.

Outcome measurements show that over half of respondents were satisfied with health services; there has also been a slight increase of client satisfaction concentration index over the baseline. Similar results have been reported in overall trust of the health care provider. Three in four respondents expressed an overall patient satisfaction from the hospitals. The volume of maternal and child health indicators has been stagnant or declined over the baseline. The new outpatient visit concentration index, which related to promotion of human rights and deterrence from discrimination, has been increasing.

Likewise, quality of health services was assessed as satisfactory by over half of the respondents in CCNPP MSS assessment, with much higher rates reported for Kabul hospitals. However, health facility management functionality index has been steadily and continuously declining, which is of concern. The measure refers to resource and inventory management. The HMIS use has seen a decline in 2018, after it had increased in 2017.

The impact assessment shows that access to health services has not much changed over the baseline; however, the cost of health services paid by the community and household has been on the rise – the big portion of which goes to purchase of medicines and fees for diagnostic services, followed by transportation. It is disturbing to see that community members must resort to selling their household assets to pay for medical services. Public and stakeholders' trust in the health system remains low, with key areas of concern the management and procurement of health resources and pharmaceuticals, human resources management, capacity development, public awareness and education on MoPH anti-corruption achievements, community monitoring and reporting.

Annexes

Annex I. List of outcomes from the original VCA in the MoPH

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. MEC: VULNERABILITY TO CORRUPTION IN THE AFGHAN MINISTRY OF PUBLIC HEALTH 24

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. MEC: VULNERABILITY TO CORRUPTION IN THE AFGHAN MINISTRY OF PUBLIC HEALTH 25

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. MEC: VULNERABILITY TO CORRUPTION IN THE AFGHAN MINISTRY OF PUBLIC HEALTH 27

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.

Annex II. List of MoPH output, outcome and impact indicators

Outcome indicators

1. Improved quality of care, integrity and reliability in health services

2. Management structures, administrative processes and service delivery at BPHS/EPHS facilities meet the standards of care
3. An independent investigation of health service delivery is conducted on a regular basis
4. An analysis of the periodic findings consistently demonstrates improved quality of care, community satisfaction and coverage of health services
5. HMIS data is used for decision making at central level and the provinces
6. HMIS tools developed to assess services delivered by private sector esp the private and national hospitals
7. Donors allocate funding to supplemental auditing elements into HMIS
8. The hardware and software have increased the scope, accuracy and reliability of HMIS monitoring
9. The pharmaceuticals procurement law implemented and NHMRA monitors its adherence
10. Regular audits show there is not any COI of NHMRA staff with pharmaceutical companies
11. Proportion of companies whose proforma registration and licensing process follows the Licensed National Pharmaceutical Products List
12. Staff at PAD that are trained and equipped with skills to monitor pharmacies
13. M&E system at the PAD regularly monitor transparency in their field and corruption cases are uncovered, reported and dealt with
14. The monitoring entities have regular meeting to share their findings and make corrective action plans and punitive actions
15. Pharmacists and NHMRA staff received the pharmaceutical training
16. Staff with appropriate training filling the positions and promotion received is based on training received
17. Estimation of supplies required based on needs is conducted by NHMRA
18. Licenses of importation companies not meeting the standards are canceled
19. Number of pharmaceutical products manufactured (imported) by foreign companies meeting the quality standards
20. Number of samples of imported pharmaceuticals showing fraudulent results
21. Any approach chosen and proposed for adoption in single source procurement of pharmaceuticals
22. Number of organizations in the health sector that are reviewed and licensed
23. Number of MoPH departments accredited by the AHO is based on the study conducted and provides
24. Number of BPHS/EPHS implementers that have been accredited more benefit in provision of quality of pharmaceuticals
25. Number of MoPH policies that have followed the appropriate policy development process
26. Number of MoPH policies revised, its gaps filled

27. Number of MoPH policies that have been translated into local languages and distributed to the MoPH and implementers
28. New MoPH staff have good understanding of/agreement to enforce current MoPH policies
29. Health services staff and beneficiaries aware of MoPH COI policy and its enforcement

Impact Indicators

1. Increased community trust in the MoPH services
2. Improved level of integrity and reliability in the health sector
3. Proportion of HMIS analysis used that have affected MoPH management and quality of health care service delivery
4. The scope and volume of health care service delivered by the private and national hospitals meet the standards of quality of care
5. Increase in confidence in the data use
6. Technical and financial proposals to the auditing of HMIS verifies the HMIS reliability for decision making
7. Improved health care service access, delivery and quality
8. Pharmaceuticals procured through a transparent system
9. Diverse and quality pharmaceuticals are supplied through the private pharmacies
10. Quality and cheap pharmaceuticals are supplied to the pharmaceutical outlets
11. Companies registered with the NHMRA import only from the Licensed National Pharmaceutical Products List
12. Improved quality of services at private pharmacies thanks to regularly oversight by the PAD monitors
13. Monitoring reports consistently show improved quality of pharmaceutical services in the private sector
14. Monitoring reports show improved knowledge and skills of staff received pharmaceutical training
15. Proportion of pharmaceutical products meeting the quality standards are imported annually
16. Samples of pharmaceuticals meeting the set standards
17. Standardized price of pharmaceuticals
18. Cheaper pharmaceuticals for the beneficiaries
19. Number of MoPH departments complying with minimum standards in contracting of health service delivery
20. Quality of care services offered that comply with the BPHS/EPHS specifications
21. Number of reports of BPHS and EPHS contracts investigated by the trained AGO staff
22. Attaining efficiency in processing of clients' needs

23. Increased community satisfaction with BPHS/EPHS or other services
24. Demonstrable integrity and quality in health service delivery
25. Increased community trust and support.
26. Improved client satisfaction.
27. Decreased mortality rate.
28. Strengthened accreditation and transparency
29. MoPH demonstrates transparency and accountability toward community in managing its assets
30. HR recruitment supports community trust and confidence in MoPH transparency
31. Improved MoPH staff KPI
32. Investment in staff training has contributed to improved work processes, individual KPI results and health improvements
33. Enhanced staff productivity and quality of work
34. Reduced burden of disease in the community
35. Improved health seeking behavior in the community
36. Staff and community are dealt with dignity and free from discrimination and abuse
37. Public are aware of MoPH interventions on protection of human rights in health sector
38. General public is aware of effective role of Health Shuras in improving quality of care
39. Reduce out of pocket health expenditure on health
40. The ICHSAR uncovers, overturns and penalizes and prevents CoI in MoPH and BPHS/EPHS facilities
41. The community is empowered
42. Public are aware of MoPH good practice in avoiding patients to be referred by health providers to their private practice and in avoiding any bribery practice

Recommendation	No	Recommended actions	Output indicator	Outcome indicator	Means of verification	impact indicator
Recommendation 1.1: *MODIFIED IN 4TH Q* -- Establish and empower an Afghan Medical Council in order to re-build trust in the MOPH; *ICHSAR dropped in favor of AMC.*	1.1.1	**MODIFIED IN 4TH QUARTER** -- Significant Systemic Improvement and People and Politics: Establish and empower the **Afghan Medical Council**... ICHSAR dropped in favor of the Afghan Medical Council.	The ICHSAR investigates and inspect the MoPH and NGO run health services	Improved quality of care, integrity and reliability in health services Rebuild public and donor trust in the MoPH	BPHS BSC A1 (A 9 point decline) ; F22, F23 E20+E21 EPHS BSC A1 (Decline of 6.3 point) B1+B2; E1+E2; G2	Increased community trust in the MoPH services Improved community trust and satisfaction with MoPH services
	1.1.2	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement* and *Capacity/Capability*: **a Third Party Monitoring entity** should be staffed with specialist Investigators and Inspectors to handle cases in the Public			Conduct FGD or interviews with Public and donor	

		Health system and the private health sector in the Capitol; initially, this should be composed of one international Audit Advisor, one international Reporting Advisor, six Investigators, and six Inspectors. *Proposed ICHSAR Invesitgator/Inspect or roles dropped in favor of external reviews from an entity, such as KIT/SRTRO, focused on IAD performance and reliability.*				

	1.1.3	***MODIFIED IN 4TH QUARTER*** -- *Capital Spending* and *People and Politics*: Empower a **Third Party Monitoring** entity to investigate and inspect MOPH and BPHS and EPHS contract holders in all Provinces. *Proposed ICHSAR Invesitgator/Inspector roles dropped in favor of KIT/SRTRO for Third Party Monitoring, paired with external accreditation of GCMU's performance and reliability.*	MoPH and BPHS/EPHS implementers are regularly assessed on an annual basis and a report generated and shared to the stakeholders - the assessment report	Management strucures, administrative processes and service delivery at BPHS/EPHS facilities meet the standards of care	BPHS BSC A1 (A 9 point decline) ; F22, F23 E20+E21 EPHS BSC A1 (Decline of 6.3 point) ; B1+B2; E1+E2; G2	

	1.1.4	**DROPPED IN 4TH QUARTER** -- Capital Spending and People and Politics: ICHSAR offices must be independently funded to retain their impartiality from the MOPH management structure. Recommendation dropped due to inability of MOPH to establish an independent/external entity.	ICHSAR has been established and funded as an indepdendant organization and has no reporting or funding connection to the MoPH	Rebuild public and donor trust in the MoPH		
	1.1.5	***MODIFIED IN 4TH QUARTER*** -- Inter-Departmental Coordination and Communication: Engage **Department of Public Relations** to draw the public's attention to examples of good	ICHSAR findings are published and distributed to the stakeholders			

		quality of care, integrity, and reliability in the health sector. *ICHSAR dropped in favor of the Department of Public Relations.*				
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	HMIS is analysed at the local and central level and appropriate plans are made to improve health care service delivery		BPHS BSC E19	HMIS data is used for decision making at central level and the provinces

	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.	Proportion of hospitals submitting their HMIS reports HMIS reports are verified against the registers Private sector HMIS concept, status update report, format Revised HMIS forms and tools; HMIS forms developed; # of Medical records upgraded with electronic system; Referral sheet developed; Monthly coordination meeting; monitoring and supervision is improved and data accuracy is regularly checked	Private sector database Maximize HMIS efficiencies and draw-in private sector	Interview of HMIS staff at central MoPH Review of reports/observation of the database use FGD or interview with donors BPHS BSC E19	The scope and volume of health care service delivered by the private and national hospitals meet the standards of quality of care

	1.2.3	*Capacity/Capability*: Incorporate supplemental auditing elements into HMIS.	HMIS auditing is regularly conducted by the implementing agencies as well as by an independent auditing organization	Accuracy of reporting of the supplemental auditing elements into HMIS verified Maximize HMIS efficiencies and draw-in private sector		Enhanced confidence in HMIS data use
	1.2.4	*Further Analyses*: Itemize the financial and technical resources required for these objectives.	The activity is included in the proposal and contracts awarded for the HMIS verification Donors allocate funding to the activity		HMIS verification report	Technical and financial proposals to the auditing of HMIS verifies the HMIS reliability for decision making
	1.2.5	*Capital Spending*: Invest in the hardware, software, technical supports, and training required to maximize the prospects for HMIS to achieve its	Concept note and first version of DHIS2 Data Warehouse	The hardware and software has increased the scope, accuracy and reliability of HMIS monitoring	AHS 2018 access and coverage data BPHS BSC A1; B7; C10,C11; D16 EPHS BSC B1, B2 B3, B4: C3, C4,C9	Improved health care service access, delivery and quality

		potential in reliable monitoring of management functions, administrative processes, and services delivery.				
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	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*, Oct 2014				

Report: *Pharmaceutical Importation Process*, Oct 2014	2.1	*Significant Systemic Improvement* and *Capacity/Capability*: Establish separate pharmaceutical procurement procedures within the current Public Procurement Law	A separate pharmaceutical procurement procedures within the current Public Procurement Law established A functional PPMU established	The pharmaceuticals procurement law implemented and NHMRA monitors its adherence # of pharmaceuticals procured through a transparent system Increased controls and reduce risks of corruption.	Interview with NHMRA staff Review of procurement documents	
	2.2	*Significant Systemic Improvement*: Reform the Pharmaceutical Law to adequately regulate the increased volume and diversity of pharmaceuticals entering the country.	The issue is properly addressed in the Pharmaceutical Law. The law is finalized and approved by Parliament.	Pharmaceutical imported in the country comes from reputable companies Increase controls and reduce risks of corruption.	Desk review of related law	Diverse and quality pharmaceuticals are supplied through the private pharmacies
	2.3	*Significant Systemic Improvement* and *People and Politics*: Reform the Pharmaceutical Law	The revised Pharmaceutical Law delineates the prohibition of COI	Regular audits show there is not any COI of NHMRA staff with pharmaceutical companies	Desk review of related law	Quality and cheap pharmaceuticals are supplied to

		to prohibit government staff from having conflicts of interest (COI) in pharmaceutical companies.	and how to deal with it	Increase controls and reduce risks of corruption.		the pharmaceutical outlets
	2.4	**DROPPED IN 4TH QUARTER** -- Significant Systemic Improvement and Capacity/Capability: Licensed National Pharmaceutical Products List must be updated annually. Dropped since this update will be undertaken semi-annually and is due again in 2018-2019, as per the NMHRA's plan.	Revised list selects the right medicine (according to need, morbidity, mortality.)	Import, production, and procurement based on need. Improve appropriateness of formulary and increase efficiencies.	Desk review of related law	Strengthened rational use of medicine.

	2.5	*Significant Systemic Improvement* and *Capacity/Capability*: Licensed National Pharmaceutical Products List must be linked to the *pro forma* registration and licensing process.	A digital database developed which links pro forma registration and licensing process to Licensed National Pharmaceutical Products List	Proportion of companies whose proforma registration and licencing process follows the Licensed National Pharmaceutical Products List Improve appropriateness of formulary and increase efficiencies.	Interview of NMHPRA staff	Companies registered with the NHMRA import only from the Licensed National Pharmaceutical Products List
	2.6	*Significant Systemic Improvement* and *Capacity/Capability*: Restructure Pharmacy Affairs Directorate to ensure the human resources are allocated to improve surveillance/oversight capacity.	Organizational structure and roles at the PAD has been revised	Staff at PAD that are trained and equipped with skills to monitor pharmacies	Staff interview	Improved quality of services at private pharmacies thanks to regular monitoring by the PAD staff

	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.	Roles and responsiblities in the PAD are restructured with calrified chain of command	M&E sytstem at the PAD regularly monitor transparency in their field and corruption cases are uncovered, reported and dealt with	PAD structure and monitoring report of pharmacies	Reduced rate of corruption in pharmacutical managemene t practices
	2.8	*Inter-Departmental Coordination*: Establish formal coordination mechanism among Departments to enhance surveillance/monitor ing capacity.	A coordination mechanism is established with Health Law Enforcement, MoPH GDEHIS, PAD, Coordination of Private Sector	The monitoring entities have regular meeting to share their findings and make corrective action plans and punitive actions	Staff interview	Monitoring reports consistently show improved quality of pharmaceutic al services in the private sector
	2.9	*Capacity/Capability*: Pharmaceutical training capacity (qualifications) must be enhanced.	Number of pharmacists who obtained quality pharmacy trainings	Professional development of Pharmacists is promoted	training and capacity development reports	Monitoring reports show improved knowledge and skills of staff received

						pharmaceutical training
	2.10	*Significant Systemic Improvement* and *Further Analyses*: Pharmaceutical training must be re-valued as professional-level for salary determination and promotion purposes.	Staff JD reflects the Pharmaceutical training skills requirement and the training is used to promote and remunerate staff Number staff promoted based on their required skills	staff with appropriate training filling the positions and promotion received is based on training received	Review staff JD and qualitifications	Staff have the motivation to perform their jobs effectively
	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.	ToR for the NHMRA includes coordination of pharmaceuticals supply with the requirements PMIS report prepared and submitted for planning/procurement of pharmaceuticals	Estimation of supplies required based on needs is identified by NHMRA Improve appropriateness of formulary and increase efficiencies.	Staff interview Review of procedures and processes	Report shows that supply of pharmaceuticals shows to be consistent with the needs

	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.	Number of monitoring visits and periodic evaluation of importation companies conducted	Licences of importation companies not meeting the standards are canceled	NMHRA report of activities	Companies importing pharmaceuticals supply medication with standards set by NMHRA
	2.13	*People and Politics*: Leverage anti-corruption resources to investigate and prosecute senior MOPH officials for illicit enrichment.	Number and details of files of named individuals handed over to Atorney General's Office.	Number of disciplinary actions taken for violation of rules	NMHRA report of activities	Number of investigations with clear illicit enrichment of senior MoPH officials

	2.14	*Significant Systemic Improvement* and *Capacity/Capability*: Limit the number of pharmaceutical importation licenses issued/renewed.	Number of pharmaceutical importation licenses issued/renewed.		NMHRA report of activities	
	2.15	*Significant Systemic Improvement* and *Capital Spending*: Conduct Annual Quality Assurance Assessment/audits of pharmaceutical products manufactured (imported) by foreign companies.	Number of quality assurance assessment/audits of pharmaceutical products manufactured (imported) by foreign companies conducted	Number of pharmaceutical products manufactured (imported) by foreign companies meeting the quality standards Improve confidence in the quality of drugs being imported.	NMHRA report of activities, interviewing staff at NMHRA	
	2.16	*Significant Systemic Improvement* and *Capital Spending*: Implement procedures for primary, secondary, and tertiary sampling of imported	Standard operating procedures for primary, secondary, and tertiary sampling of imported pharmaceuticals produced	Number of samples of imported pharmaceuticals showing fraudulent results Improve confidence in the quality of	NMHRA report of activities, interviewing staff at NMHRA	

		pharmaceuticals to minimize fraudulent results.		drugs being imported.		
	2.17	*Significant Systemic Improvement* and *Further Analyses*: Implement procedures for independent sampling of imported pharmaceuticals for auditing purposes.	An idependant organization is assigned to conduct an independent sampling of imported pharmaceuticals for auditing purposes. Two reports of external audits.	Number of imported pharmaceuticals meeting quality standards in the audited samples by the assigned company Improve confidence in the quality of drugs being imported.	NMHRA report of activities, interviewing staff at NMHRA	Samples of pharmaceuticals meeting the set standards
	2.18	*Significant Systemic Improvement* and *Capital Spending*: Invest in equipment and technical training to enable MOPH to conduct quality analyses of samples. [*In addition to original VCA*]	MoPH has purchased all the equipment and trained its staff to conduct quality analyses of samples	Quality Control Lab is certified with ISO certificate.	NMHRA report of activities, interviewing staff at NMHRA	People have confidence in quality and effectiveness of pharmaceuticals supplied in the market

	2.19	*Significant Systemic Improvement* and *Further Analyses*: Consider single-source procurement (or centralized 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. [*In*	A study on feasiblity of single source procurement highlights the benefits and risks of the approach	Any approach chosen and proposed for adoption is based on the study conducted and provides more benefit in provision of quality of pharmaceuticals	Report of the study	Reduction in low quality pharmaceuticals in the market Standardized price of pharmaceuticals Cheaper pharmaceuticals for the beneficiaries Reduced morbidity Reduced mortality

		addition to original VCA]				
	2.2					
Recommendation 3: *MODIFIED IN 4TH Q* -- Establish an accrediting entity to rebuild reliability, thoroughness, and integrity within the health sector: *("Independent" dropped from proposed*	3.1	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement* and *Capacity/Capability*: Establish a healthcare accrediting entity; MOPH pursuing establishment of the **Afghan Healthcare Accreditation Organization**... *ICAHO dropped in favor of AHAO;*	The ICAHO is established as per the defined composition and ToR and is meeting regularly	Number of organizations in the health sector that have been reviewed and licensed	MoPH ANHAO staff interview Review of reports	Number of organizations in the health sector providing health services that meet the accredition requirements

accreditation entity)		*proposed participants include MOPH leaders, international stakeholders, Afghan civil society.*				
	3.2	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement*: Biannual accreditation from **Afghan Healthcare Accreditation Organization** should be imposed on all Departments and Directorates of the MOPH to emphasize transparency, good governance, compliance with minimum standards,	AHAO is established	Number of MoPH depratments accredited by the AHO		Number of MoPH departments complying with minimum standards in contracting of health service delivery

		and accountability in contracting of health service delivery, MOPH management functions including finance systems and human resource systems, and achievement of minimum standards. *ICAHO dropped in favor of Afghan Healthcare Accreditation Organization.*				
	3.3	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement*: Accreditation from **Afghan Healthcare Accreditation Organization** should be imposed as an eligibility prerequisite for new or renewed BPHS	Number of potential BPHS / EPHS applicant/providers reviewed and awarded accreditation	Number of BPHS/EPHS implementers that have been accredited	Interview of MOPH staff Review of documents	Quality of care services offered that comply with the BPHS/EPHS specifications

		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 **AHAO** on achievement of Action Plans. *ICAHO dropped in favor of the Afghan Healthcare Accreditation Organization*.				
	3.4	***MODIFIED IN 4TH QUARTER*** -- *Inter-Departmental Coordination and Communications*: Engage **Department of Public Relations** to draw the public's	ICAHO is established and assigned with information release to public	Number of press release, publication and online posts related to improvement in quality of care,	Interview of MOPH DPR staff Review of documents	Community awareness and satisfaction on improvement in MoPH handling of complaint,

		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). *ICAHO dropped in favor of the Department of Public Relations.*		accountability and reliability		improvement in quality of care
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	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	Number of Investigators and Prosecutors in the AGO in Kabul being trained in BPHS and EPHS structure and functiuons	Number of BPHS and EPHS conracts investigated by trained AGO staff	Review of documents/reports Staff interview	Number of reports of BPHS and EPHS conracts investigated by the trained AGO staff

high-profile examples for enforcement of the Rule of Law in the health sector:		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.	A team of trainers to the Kabul AGO assigned	Number of AGO staff trained on health sector	Review of documents/reports Staff interview	Knowledge and confidence of AGO staff to investigate health services
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	An exprt team is assigned to review all the current MoPH policies	Number of MoPH policies revised, its gaps filled	Review of documents Staff interview	MOPH policies which follows the recommended processes for its development and has been

		policies; remedy gaps with provisional policies on policy development.				assessed to be without any significant gaps
	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 organisation accordingly.	An exprt team is assigned to review the current MoPH policy development process	Number of MoPH policies that have followed the appropriate policy development process	Review of documents Staff interview	

Recommendation 5.2: Improve awareness, technical understanding, and opportunities for implementation of MOPH policies:	5.2	OVERALL: Improve awareness, technical understanding, and opportunities for implementation of MOPH policies	First draft of the guideline for promotion communication materials development and airing developed. Interventions designed, scaled up for achieving desirable healthy behaviors in health, nutrition and sanitation fields Operational Guidelines, training packages, Hygiene Handbook, and communication materials developed	MoPH disseminates information through its website, facebook, systematic way to distribute policies/guidelines and educaing staff on its policies	Review of documents Staff interview	

	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.	An exprt team is assigned to review all the current MoPH policies	Number of MoPH policies revised, their gaps are filled	Review of documents Staff interview	The translated version of all MOPH policies which follows the recommended processes have been distributed and are understandable to the staff and are put in practice
	5.2.2	*Inter-Departmental Coordination and Communications* and *Capital Spending*: Complete a comprehensive translation of all current, approved MOPH policies into local languages.	An exprt team is assigned to translate all current MoPH policy into local languages	Number of MoPH policies that have been translated into local languages and distributed to the MoPH and implementers	Review of documents Staff interview	

	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	***MODIFIED IN 4TH QUARTER*** -- *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,	All MoPH staff signed the code of conduct, and the orientation on Civil Service Law and other rules and regulations New MoPH staff receive formal HR induction on MoPH policies in local languages and obtain updates when there are any modification to them		New MoPH staff have good understanding of and agreement to enforce current MoPH policies Staff, public and stakeholders could access MoPH policies and achievements	Review of MoPH website, facebook, periodical journal and reports	Number of staff who had good understanding of MoPH policies and have agreement to enforce them

		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 should be reported to the Strategic Health Coordinating Committee on an ongoing basis. *ICAHO changed to Strategic Health Coordinating Committee.*	All HR management Laws , rules and regulation are available in the MoPH Website				

	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 publicise these policies.					

Recommendation 6.1: Confront absenteeism during contracted official working times:	6.1.1	*Inter-Departmental Coordination and Communications* and *Significant Systemic Improvement*: 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 publicise these regulations.	The Labor Law on official working hours is strictly enforced Staff official working hours are monitored by the MoPH and BPHS/EPHS implementers MoPH HR provides induction on MoPH official working hours MoPH and BPHS/EPHS implementers working hours are published and publicised		Staff aware of the working hours and feeling reponsible, respectful and aherent to it Improved MoPH staff KPI Health Shura is engaged to monitor absenteeism during official working times within the MOPH and in BPHS and EPHS	Interview of donors BSC: BPHS BSC A1; E20+E21; F22, F23 EPHS BSC A1; B1+B2; E1+E2; G2 Review of documents Staff interview at MOPH	Increased volume of services to clients Demonstrable integrity and quality in health service delivery People are satisfied with the system of public health facilities

	6.1.2	*Inter-Departmental Coordination and Communications*, *Significant Systemic Improvement*, and *Capital Spending*: 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, other	The directors, and line managers are responsible for the application of penalties and dismissal for failures to follow the Terms and Conditions of official working hours are applied according to Labor and Civil Service Law, procedures, rules and regulation Staff working hours is enforced at all level of care and at the central and provincial MoPH Offices including involving the Strategic Health Coordinating Committee MoPH staff adherence to working hours is poublicized and			services at District level.		

		electronic tools which could be implemented throughout the health sector.	promoted The ToR for Health Shura is revised to reflect the monitoring function for health facilities at district level.					
	6.1.3	*Inter-Departmental Coordination and Communications* and *Significant Systemic Improvement*: 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	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvemen*t: Engage the **Strategic Health Coordinating Committee** to monitor absenteeism during official working times within MOPH and in BPHS and EPHS services on a Provincial level and a national level. *ICHSAR dropped in favor of the Strategic*					

		Health Coordinating Committee.					
	6.1.6	***MODIFIED IN 4TH QUARTER*** *-- Inter-Departmental Coordination and Communications*: Engage Health *Shuras* and the **Department of Public Relations** to draw the public's attention to examples of good practice and integrity in the delivery of health services in working times. *ICHSAR has been dropped in favor of Department of Public Relations having this*					

		role of informing the public.				
Recommendation 6.2: Address conflicts of interest in patient management and patient referrals to private sector services:	6.2.1	*Inter-Departmental Coordination and Communications* and *Significant Systemic Improvement*: 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.	A CoI policy is approved and distributed to the staff Human resource induction for new staff covers referrals from public sector to private sector services	Increased accountability of public health service providers.	AHS 2018; BPHS BSC A1 ; E20+E21; F22, F23 EPHS BSC A1; B1+B2; E1+E2; G2	Increased community trust and support. Improved client satisfaction. Decreased mortality rate.

	6.2.2	*Inter-Departmental Coordination and Communications* and *Significant Systemic Improvement*: 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.	Number of community members that has been educated about CoI in staff referral and a mechanism to launch their complaint Referral guideline introduced Newsletter issued by the Public Relation Department; Complaints received and addressed; Signboards published; shift system implemented; PPM introduced; National hospitals reformed; Referral unit established The process for patient referrals from public sector settings to private	Increased accountability of public health service providers.	BPHS BSC A1 ; E20+E21; F22, F23 EPHS BSC A1; B1+B2; E1+E2; G2 AHS 2018	

			sector services for all MOPH Directors, Managers, leaders, and BPHS and EPHS implementers discussed and clarified.			
	6.2.3	*Inter-Departmental Coordination and Communications* and *Significant Systemic Improvement*: Establish Conflicts of Interest policies within Terms and Conditions of BPHS and EPHS contracts to prevent inappropriate	BPHS/EPHS contracts has an article that prohibits inappropriate referral from the public setting to private health services			

		referrals from public sector settings to private sector services.				
	6.2.4	*Inter-Departmental Coordination and Communications* and *Significant Systemic Improvement*: Enforce penalties for violating the Conflicts of Interest policies as a Term and Condition of achieving BPHS and EPHS contracts.	BPHS / EPHS contracts spells out penalties to the implementers in violation of Conflict of Interest Policy (COI) policies	Number of Health Shura members understand and enforce the Conflict of Interest (COI) policy PHA and private health facilities informed and aware on the policy. The relevant public and private health sector stakeholder informed	interview of staff Review of reports	
	6.2.5	*Capacity/Capability*: Engage Health *Shuras* with the power to monitor patient referrals from public sector settings to private	Health Shuras educated on their power to monitor patient referrals from public sector settings to private			

		sector services on a District level.	sector services on a District level			
	6.2.6	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement*: Engage the **Strategic Health Coordinating Committee** to monitor patient referrals in BPHS and EPHS services on a Provincial level and a national level. *ICHSAR dropped in favor of the Strategic Health Coordinating Committtee.*	ICHSAR is engaged to monitor patient referrals in BPHS and EPHS services on a Provincial level and a national level.	Number of ICHSAR monitoring of COI violations found/reported at BPHS/EPHS and at both national and provincial level Strengthened referral system.		
	6.2.7	***MODIFIED IN 4TH QUARTER*** -- *Inter-Departmental Coordination and Communications*:	Report and findings of the monitoring of inappropriate referral Public is aware of	Health services staff and beneficiaries aware of MoPH COI policy and its enforcement		

		Engage Health *Shuras* and the **Department of Public Relations** to draw the public's attention to examples of good practice and integrity in the management of patient referrals. *ICHSAR dropped in favor of Department of Public Relations.*	ICHSAR and Health Shuras role in inappropraite referrals				
Recommendation 7: Undertake a comprehensive independent investigation of the Grants and Contracts Management Unit's systems and organizational capacity, and contract	7.1	***MODIFIED IN 4TH QUARTER*** -- *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,	Report of assessment by the Independent Commission for Accreditation of Healthcare Organizations of Grants and Contracts Management Unit's and MOPH's bid evaluation and negotiation processes		A Conflict of interest uncovered and prevented in procurement processes		Enhanced MoPH trust by the Community Strengthened accreditation and transparency

management beyond the specific scope and remit of the GCMU		standardized, and reliable. Consider engaging the **Strategic Health Coordinating Committee** in oversight of GCMU. *Oversight role proposed for ICAHO dropped in favor of the Strategic Health Coordinating Committee*.					
	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	Prior to contract award by GCMU an independent and integral procurement review group reviews and approves all health contracts An independent entity approves GCMU capability to award transparent health services contracts without				Community has priority for the health service staff

		setting up such a group and ensuring its integrity and independence.	any violation of integrity				
	7.3	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement* and *Capacity/Capability*: Engage the **Strategic Health Coordinating Committee** 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	The Independent Commission for Accreditation of Healthcare Organizations assesses the GCMU for any COI and takes appropriate actions				MoPH demonstrates transparency and accountability toward community in managing its assets

		investigation and prosecution. *Oversight role proposed for ICHSAR dropped in favor of the Strategic Health Coordinating Committee*.					
Recommendation 8: Strictly enforce rules against use of public assets for meeting private needs:	8.1	*Inter-Departmental Coordination and Communications* and *Significant Systemic Improvement*: 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,	MoPH has released and enforced rules that prohibits staff from using public assets for their private gains MoPH HR educates the new staff on this rules at the induction processes	MoPH effectively and efficiently uses its resources	Donors interview BPHS BSC A1 ; E20+E21; F22, F23 EPHS BSC A1; B1+B2; E1+E2; G2 Interview of staff - ambulance service users	Enhanced MoPH trust by the Community Community has priority for the health service staff MoPH demonstrates transparency and accountability toward community in managing its assets MoPH increases its

		with a verifiable record retained of the Induction having been completed for all new employees, and which specifies expectations, requirements, and consequences.				saving on health expenditure
	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.	Number of violation against use of public resources that have been referred to the AGO for investigation and prosecution	Enhanced coordination between the IAD and other government entities	Review of documents BPHS BSC A1 ; E20+E21; F22, F23 EPHS BSC A1; B1+B2; E1+E2; G2	
	8.3	*Inter-Departmental Coordination and Communications* and *Significant Systemic Improvement*:	Comminty members educated on use of public assets for private use and have the knowledge of		Donors interview BPHS BSC A1 ; E20+E21; F22, F23 EPHS BSC A1;	

		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.	how to lodge a complaint when it is violated		B1+B2; E1+E2; G2 Interview of referred patients - ambulance service users	
	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.	Members of Health Shuras monitor use of ambulances and other vehicles at service or management level at all level of health services			
	8.5	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement*: Engage the **Strategic**	ICHSAR monitors use of ambulances and other vehicles at service or management level at	Ambulances are properly used for the purpose of patient		

		Health Coordinating Committee 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. *ICHSAR dropped in favor of Strategic Health Coordinating Committee.*	all level of health services	transferring and referral		
Recommendation 9: Conduct a thorough analysis of auditing practices and the systematic management of	9.1	*Significant Systemic Improvement* and *People and Politics*: Initiate reform of the internal audit functions in the Ministry and in every province.	Internal audit functions in the Ministry and in every province is revised	Number of cases of embezzlement in the health sector uncovered, investigated and legally dealt with	Report of activities Interview with staff Interview with donors increase effectiveness of	Improved providers' and community trust and confidence in MoPH transparency MoPH

resources and inventory to prevent embezzlement in the health sector:	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.	Internal audit department (IAD) in each province is monitored by an external oversight body for its quality, objectivity and scope		IAD shows the capability and neutrality to deal with embezzlement	MOPH control systems enhance cross-Departmental efficiencies	increases its saving on health expenditure
	9.3	***MODIFIED IN 4TH QUARTER*** -- *Further Analyses*: Engage the **Strategic Health Coordinating Committee** to examine current practices in the management of resources and inventory in the health sector. *ICHSAR dropped in favor of Strategic*	The Independent Council on Health Sector Auditing and Reporting (ICHSAR) has examined current practices in the management of resources and inventory in the health sector.		Another independent entity confirms the transparency of the IAD in fighting against corruption		

		Health Coordinating Committee.					
	9.4	***MODIFIED IN 4TH QUARTER*** *-- Further Analyses*: Engage the **Strategic Health Coordinating Committee** to identify gaps in the implementation of health sector auditing, checks, and controls. *ICHSAR dropped in favor of Strategic Health Coordinating Committee.*	The ICHSAR has identified gaps in the implementation of the health sector auditing, checks and controls.		The IAD gaps in performance are identified and corrective actions taken	Report of activities Interview with staff increase effectiveness of MOPH control systems	
	9.5	***MODIFIED IN 4TH QUARTER*** *-- Further Analyses*: Engage the **Strategic Health Coordinating**	ICHSAR has standardized robust health sector auditing and resource and		The auditing and inventory management system complies with standard	Report of documents	

		Committee to articulate opportunities to standardize robust health sector auditing and resource and inventory management systems. *ICHSAR dropped in favor of Strategic Health Coordinating Committee.*	inventory management systems.	government procedures as verified by an independent entity		
	9.6	***MODIFIED IN 4TH QUARTER*** -- *Further Analyses*, *Capacity/Capability*, and *Capital Spending*: Engage the **Strategic Health Coordinating Committee** to itemize the financial and technical resources, and minimum skill set of	An assessment conducted with a report specifying the technical resources, and minimum skill set of human resources, required to achieve these objectives	Regular monitoring of assets management at MoPH confirms the availability of a robust asset maangement system exists and is fully functional		

		human resources, required to achieve these objectives. *ICHSAR dropped in favor of Strategic Health Coordinating Committee.*				
	9.7	***MODIFIED IN 4TH QUARTER*** -- *Inter-Departmental Coordination and Communications*: Engage the **Department of Public Relations** to draw the public's attention to examples of good practice and integrity in the management of the public's health sector assets, especially ambulances. *ICHSAR dropped in favor of*	MoPH has uploaded the tools and results of audits by IAD on the MoPH's website and facebook to enable the public to access information and documents that are clearly showing the improvement on the audit system.		Interview of donors BSC: BPHS BSC A1 ; E20+E21; F22, F23 EPHS BSC A1; B1+B2; E1+E2; G2 Review of documents / reports Staff interview at MOPH	

		Department of Public Relations.				
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	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.	Staff recruitment complies with the selection criteria as identified in the JD	The best qualified staff are recruited to serve in the health sector		HR recruitment supports community trust and confidence in MoPH transparency Improved MoPH staff KPI
	10.1.2	*Significant Systemic Improvement* and *People and Politics*: Invite external oversight bodies to monitor the recruitment and appointment process.	Staff hired for the MoPH is recruited by a competitiv process through a committee that has representation from members external to the MoPH			

leadership recruitments:	10.1.3	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement* and *People and Politics*: Engage the **Afghan Healthcare Accreditation Organization** in ensuring that the Human Resource Recruitment Office's workforce, organizational capacity, and processes are clarified, transparent, and reliable. *ICAHO dropped in favor of the Afghan Healthcare Accreditation Organization*.	An external entity assessment demonstrates that the Human Resource Recruitment Office‟s workforce, organizational capacity, and processes are clarified, transparent, and reliable.			

	10.1.4	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement* and *Capacity/Capability*: Engage the **Strategic Health Coordinating Committee** in ensuring that nepotism is uncovered, overturned, and prevented as a routine matter within the Human Resource Recruitment Office. *ICAHO dropped in favor of Strategic Health Coordinating Committee.*	An independent entity such as the ICHSAR asseses the HR recruitement process for any practices of nepotism	Nepotism is uncovered, overturned, and prevented within the Human Resource Recruitment Office.		
	10.1.5	***MODIFIED IN 5TH QUARTER*** -- *Significant Systemic Improvement* and *Capacity/Capability*: Engage the **Strategic**	An independent entity such as the ICHSAR has reviewed all tier 1 and tier 2 MOPH management recruitments over a	All recruitment process for grade 1 & 2 positions are reviewed		

		Health Coordinating Committee in reviewing all tier 1 and tier 2 MOPH management recruitments for legality and due process over a period of two years. *ICAHO dropped in favor of the Afghan Medical Council,* ***then, subsequently the SHCC****.*	period of two years supports its legality and due process			
Recommendation 10.2: Make a high profile, clear, and unambiguous statement about the need for transparency in Human Resource recruitment in	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	The influence of powerful persons in health sector recruitment is challenged through clear and unambiguous statements to the Parliament and Governors	Enforcement of existing rules and regulations in area of recruitment and appointment is ensured and potential stakeholders are engaged		Community and service providers' trust in transparency in staff recruitment at MoPH in enhanced

the health sector:		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."				
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	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement* and *People and Politics*: Engage the **Afghan Healthcare Accreditation Organization** in ensuring that Training Needs Assessment processes within MOPH and BPHS and EPHS contract holding agencies are clarified, transparent, and reliable. *ICAHO dropped in favor of the Afghan*	Standard TNA is conducted.	A Training Needs Assessment processes within MOPH and BPHS and EPHS contract holding agencies are clarified, transparent, and reliable as verified by an independent assessment	MoPH report and document review Staff interview	Investment in staff training has contributed to improved work processes, individual KPI results and health improvements

		Healthcare Accreditation Organization.				
	11.2	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement* and *Capacity/Capability*: Engage the **Afghan Healthcare Accreditation Organization** 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. *ICAHO dropped in favor of*	A report on the training database	Favoritism and discrimination in access to training are prevented within the MOPH and BPHS and EPHS contract holding agencies.	MoPH report and document review Staff interview	

		the Afghan Healthcare Accreditation Organization.				
	11.3	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement* and *Capacity/Capability*: Engage the ***Strategic Health Coordinating Committee*** in ensuring opportunities to standardize the resource management systems for health sector clinical and technical training and professional development. *ICHSAR dropped in favor of the Strategic*	Provision of opportunities to standardize the resource management systems for health sector clinical and technical training and professional development ensured.	The resource management systems for health sector clinical and technical training and professional development is standardized as confirmed by an indepdent assessment		

		Health Coordinating Committee.				
	11.4	*Further Analyses* and *Capital Spending*: Itemization of the financial and technical resources required to achieve these objectives.	MoPH has been provided the financial and technical resources required to achieve these objectives.			
Recommendation 12: Establish authentic and realistic Key Performance Indicators:	12.1	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement*: Engage the ***Strategic Health Coordinating Committee*** in devising Key Performance Indicators for **MOPH core internal management systems**. This is a continuous process	MoPH HMIS collects the KPI covering the core MoPH management functions and the key health service delivery Status update reports, National Health Strategic Plan	Staff performance appraised against achieving KPI Health service contracts (BPHS and EPHS) are assessed and reimbursed based on achieving KPI	Interviewing MoPH staff Review of documents (performance management system) NGO staff interview Donor interview	Enhanced staff productivity and quality of work Improved health service coverage Reduced burden of disease in the community Improved health seeking

		of quality improvement, with formal Quarterly reporting on achievements against Action Plans. *ICAHO dropped in favor of the Strategic Health Coordinating Committee.*				behavior in the community
	12.2	**MODIFIED IN 4TH QUARTER** -- Significant Systemic Improvement: Engage the **Strategic Health Coordinating Committee** in devising Key Performance Indicators for **BPHS and EPHS contracts**. ICAHO dropped in favor of the Strategic Health Coordinating Committee.	Number of performance review meetings and reports			

	12.3	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement* and *Capacity/Capability*: Neither the proposed ICHSAR, not an alternative entity would be involved with this task of embedding all KPIs into the MOPH HMIS, covering the core MOPH management functions and BPHS and EPHS contracts: *This is curently managed effectively by General Directorate of Evaluation and Health Information Ssystems and the Grants and Contracts Management Unit*.	A SOP for monitoring of contract holders by KPI monitoring is developed and in use Performance review meetings and reports			

	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.	Number of contracts terminated on the basis of performance appraisal	MoPH and Health services contracted staff appropriately achieve settled KPI's		Community has the trust and confidence that service providers are accountable to delivering certain results Reduced morbidity Reduced mortality Improved quality of health care
	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.	Number of monitoring and reporting on Key Performance Indicators by representatives from civil society organizations and Health Shuras Developed concept note and checklist			

	12.6	***MODIFIED IN 4TH QUARTER*** -- *Inter-Departmental Coordination and Communication*: Engage Health *Shuras* and the **Department of Public Relations** to draw the public's attention to examples of achievement of KPIs by MOPH and BPHS and EPHS contract holders.	The revised ToR of CHS Report of Health Shuras engagement to draw the public attentions to KPIs achievements. Report of CHS activities			
Recommendation 13: Implement a unified and independent reporting system for complaints:	13.1	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement* and *Capacity/Capability*: Develop ***a Complaint Handling Office***, with investigatory powers, to manage a complaints system. The ***CHO*** should be	Public Relation Department has been constantly helping the complaint Handling Office in posting their documents on the MoPH's website and Facebook. This has helped the complaint Handling Office to		Health care user interview Interview of users complaining to MoPH	Improved community trust and confidence in health system Improved quality of health care

		operated independently from the BPHS and EPHS contract holding agency management structures currently controlling information about abuses and discrimination. *Development of an independent Health Sector Ombudsman Office (HSOO), inside ICHSAR, dropped in favor a Complaint Handling Office.*	share information and documents with the public and collect feedback from them.			
	13.2	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement* and *Capacity/Capability*: The **Complaint Handling Office** should be staffed with specialist Investigators and	A functional HSOO staffed with the international TAs is in place			

		Inspectors to handle cases in the Public Health system and the private health sector in the Capitol; initially, this should be composed of 1-2 international Technical Advisors, 6-8 Investigators, and 6-8 Inspectors. *Development of an independent Health Sector Ombudsman Office (HSOO), inside ICHSAR, dropped in favor an MOPH Complaint Handling Office, and separate complaint handling procedures within NMHRA and the GDHR-CSC mechanisms within the existing Tashkil.*				

	13.3	**MODIFIED IN 4TH QUARTER** -- Capital Spending and People and Politics: An appropriately sized **Complaint Handling Office** should be established in each Province. Development of an independent Health Sector Ombudsman Office (HSOO), inside ICHSAR, dropped in favor a Complaint Handling Office.	A HSOO is established in each province that implements a unified and independent reporting system for complaints	Complaints from staff and beneficiaries are heard and acted upon		Staff and community are dealt with dignity and free from discrimination and abuse Public are aware of MoPH interventions on protection of human rights in health sector
	13.4	**DROPPED IN 4TH QUARTER** -- Capital Spending and People and Politics: These HSOO offices must be independently funded to retain their impartiality from the MOPH management structure.	The HSOO is independently funded from the MoPH structure			

		Recommendation dropped due to inability of MOPH to establish an independent/external entity.				
	13.5	***MODIFIED IN 4TH QUARTER*** -- *Inter-Departmental Coordination and Communication*: Engage a **Complaint Handling Office** and the **Department of Public Relations** to draw the public's attention to examples of good quality of care, integrity, and reliability in the health sector. *HSOO dropped in favor of Complaint Handling Office; Department of Public Relations*	Public Relation Department has raised awareness on Complaint Handling office via the MoPH's website and Facebook.	Community members are aware of their rights to health services and their right to be dealt with respect, dignity and free from discrimination	Health care user interview Interview of users complaining to MoPH	

		added to support CHO efforts.				
	13.6	*Inter-Departmental Coordination and Communication*: Formally liaise with the Human Rights Commission to encourage cooperation on issues in the health sector.	An MoU established between MoPH and the Human Rights Commission to establish cooperation on issues in the health sector.	Cases of human rights violations are reported to the the Human Rights Commission and followed		
Recommendation 14: Conduct a thorough analysis of the breadth and strength of Health *Shuras*; based on the analyses, expand their	14.1	***MODIFIED IN 4TH QUARTER*** -- *Further Analyses*: Commission a thorough analysis of the current extent of active Health *Shuras*. Consider engaging the **Strategic Health Coordinating Committee** in doing	Completion of the systematic assessment	Evidence on strength of Health Shuras in achieving its ToR Community Health Shuras deal with patients' complaints and address		Improved community satisfaction and trust in health system Improved quality of health care

reach and effectiveness:		this systematic assessment to ensure expansion of Health *Shuras* is suitable, appropriate, and achieves it aims. *ICHSAR dropped in favor or Strategic Health Coordinating Committee participants, including the Department of Community Based Health Care and the General Directorate of Curative Medicine.*		community service delivery concerns		
	14.2	***MODIFIED IN 4TH QUARTER*** -- *Further Analyses*: Engage the **Strategic Health Coordinating Committee** in analysis of the Terms of Reference for existing Health	The ToR is reviewed, analyzed and revised		Health care user interview Interview of users complaining to MoPH Interview Human rights commission	

		Shuras to advocate for community priorities, manage patient complaints, and address community service delivery concerns. *ICHSAR dropped in favor or Strategic Health Coordinating Committee participants, including the Department of Community Based Health Care and the General Directorate of Curative Medicine*.				
	14.3	***MODIFIED IN 4TH QUARTER*** -- *Further Analyses*: Engage the **Strategic Health Coordinating Committee** in analysis of gaps in the coverage areas of existing Health	The analysis of gaps on coverage of areas for existing Health Shuras for all Districts			

		Shuras across all Districts of Afghanistan. *ICHSAR dropped in favor or Strategic Health Coordinating Committee participants, including the Department of Community Based Health Care and the General Directorate of Curative Medicine.*				
	14.4	***MODIFIED IN 4TH QUARTER*** -- *Further Analyses* and *Significant Systemic Improvement*: Engage the **Strategic Health Coordinating Committee** in articulating opportunities to standardize the role and functions of Health *Shuras*.	Standardization of roles and functions of Health Shuras			

		ICHSAR dropped in favor of the Strategic Health Coordinating Committee participants, including the Department of Community Based Health Care and General Directorate of Curative Medicine.				
	14.5	***MODIFIED IN 4TH QUARTER*** -- *Further Analyses*, *Capacity/Capability*, and *People and Politics*: Engage the **Department of Community Health** and the **Department of Community Based Health Care** in establishing new Health *Shuras* in Districts without coverage. *ICHSAR dropped in favor of*	The HSOO is engaged in establishing in districts without any Health Shura	Established Health *Shuras* in Districts without coverage	MoPH Report Staff interview (GCMU)	

		the Department of Community Health and the Department of Community Based Health Care.				
	14.6	***MODIFIED IN 4TH QUARTER*** -- *Further Analyses*, *Capacity/Capability*, and *People and Politics*: Engage the **Department of Community Based Health Care** and the **Department of Community Health** in articulating opportunities to link Health *Shuras* across regions to further strengthen quality of care. *This task will be assigned to Department of Community Based*	Functional Health Shuras exist in all health facilities in all Districts			

		Health Care and Department of Community Health due to their central role in modifying the Health Shura TOR.				
	14.7	***MODIFIED IN 4TH QUARTER*** *-- Inter-Departmental Coordination and Communication*: Engage Health *Shuras* and the **Department of Public Relations** to draw the public's attention to examples of good quality of care, integrity, and reliability in the health sector. *The Department of Public Relations was added as a Focal Point for*	Department of Public Relation sharing the achievements of functional Health Shuras	Health Shuras are functional	Review of MoPH facebook and website , journal, newsletter Staff interveiw	General public is aware of effective role of Health Shuras in improving quality of care

		this Recommendation.				
Recommendation 15: Engage the Strategic Health Coordinating Committee to support a unified resistance to extortion and pressures that compromise health sector effectiveness, quality of care, transparency, and good governance:	15.1	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement and People and Politics*: **The Strategic Health Coordinating Committee** should be 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	A 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 is established		Review of ToR and report of activities	MoPH demonstrates an effective health sector, quality of care, transpareny and good governance Improved community satisfaction and trust in health system Improved quality of health care

		implementers. The SHCC should meet Quarterly, at a minimum. *HCOHSI dropped in favor of the Strategic Health Coordinating Committee participants, including the Department of Community Based Health Care and General Directorate of Curative Medicine.*				

	15.2	***MODIFIED IN 4TH QUARTER*** -- *Inter-Departmental Coordination and Communication*: Engage **The Strategic Health Coordinating Committee**, with support from the ***Department of Public Relations*** to draw the public's attention to examples of good quality of care, integrity, and reliability in the health sector. *ICHSAR dropped in favor of the Strategic Health Coordinating Committee participants, including the Department of Community Based Health Care and*		Public is aware of the MoPH achievements in improving quality of care	Donor interview BPHS BSC A1; B7; C10,C11; D16 EPHS BSC B1, B2 B3, B4: C3, C4,C9	

		General Directorate of Curative Medicine.				
Recommendation 16: Establish a reliable, transparent, and coordinated system for assessing	16	*Significant Systemic Improvement and People and Politics:* Establish a reliable, transparent, and coordinated system for assessing Certificates and Diplomas	All diplomas and certificates are assessed in a transparent, reliable and coordinated manner.	Technical staff working in health sector have the right and credible education and skills to deliver the health services		Improved community satisfaction and trust in health system Improved quality of health care Reduced

Certificates and Diplomas:	16.1	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement* and *People and Politics*: Engage the **Strategic Health Coordinating Committee** 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. *ICAHO dropped in favor of the Strategic Health Coordinating Committee.*	A reliable and transparent system for assessing Certificates and Diplomas. The presence of the participants/Timesheets during the educational period in the educational courses/classes and the implementation of existing curricula's in a licensed educational institute, is strongly considered during the issuing of compilation certificates and diplomas			morbidity Reduced mortality

	16.2	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement* and *Capacity/Capability*: Engage the **Strategic Health Coordinating Committee** to strengthen management and coordination of assessing Certificates and Diplomas within MOPH Human Resource Recruitment Office. *ICAHO dropped in favor of the Strategic Health Coordinating Committee*.				
Recommendation 17: Establish and implement policies on Conflicts of Interest in the	17	Establish and implement policies on Conflicts of Interest in the management of patient referrals to	COI policies in management of patient referral is developed, translated and	Health staff at MoPH and BPHS/EPHS facilities provide adequate care and refer only	Report of activities Staff interview	Improved community satisfaction and trust in health system Improved

management of patient referrals to private sector health services:		private sector health services	sahred with health service providers	eligible cases to private facilities		quality of health care Reduce out of pocket health expenditure on health
	17.1	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement* and *People and Politics*: Engage the **Strategic Health Coordinating Committee** in establishing MOPH Conflicts of Interest policies, including if necessary, termination of MOPH employment agreements and BPHS and EPHS contracts for violations. *ICAHO dropped in favor of the Strategic Health*	Distribution list and report of BPHS/EPHS and other MoPH staff orientation on COI policy	COI policies are disrtibuted and staff have awareness of the policies		

		Coordinating Committee.				
	17.2	*Significant Systemic Improvement* and *Capacity/Capability*: Engage Health *Shuras* with the power to monitor conflicts of interests on a District level.	Revised ToR for Health Shura		Report of activities Staff interview	
	17.3	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement* and *Capacity/Capability*: Engage the **Strategic Health Coordinating Committee** in ensuring that conflicts of interest	The ICHSAR uncover, overturnes, penalizes and prevents CoI at national and provincial level	Conflicts of interest are uncovered, overturned, penalized, and prevented as a routine matter within the MOPH and BPHS and EPHS		

		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. *ICHSAR dropped in favor of the Strategic Health Coordinating Committee.*		contract holding agencies on a Provincial level and a national level.		
Recommendation 18: Establish and implement policies on Conflicts of Interest in relationships between MOPH and external entities including BPHS and EPHS	18.1	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement* and *People and Politics*: Engage the **Strategic Health Coordinating Committee** in establishing MOPH Conflicts of Interest policies, including if necessary,	Community is trainied on the standards of care. Developed tools for quality.	Donor confidence in the health sector will be increased.	Report of activities Staff interview	The ICHSAR uncovers, overturns and penalizes and prevents CoI in MoPH and BPHS/EPHS facilities The community is empowered

contract holders, donors, and other health sector stakeholders:		termination of MOPH employment agreements and BPHS and EPHS contracts for violations. *ICAHO dropped in favor of the Strategic Health Coordinating Committee.*				
	18.2	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement* and *Capacity/Capability*: Engage the **Strategic Health Coordinating Committee** in ensuring that conflicts of interest are uncovered, overturned, and prevented as a routine matter within the MOPH and BPHS and EPHS contract holding	The ICHSAR uncover, overturnes, penalizes and prevents CoI at national and provincial level	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.		

		agencies on a Provincial level and a national level. *ICHSAR dropped in favor of the Strategic Health Coordinating Committee.*				
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 publicise 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.	MoPH has established an anticorruption policy, the local language version has been distributed to all MoPH management and health service provider New MoPH staff receive are educated through HR induction on MoPH anti corruption policies	All Health sector senior. Middle, and low level staff are aware about the policy against bribery.	Report of activities Staff interview	Public are aware of MoPH good practice in avoding patients to be referred by health providers to their private practice and in avoiding any bribery practice Improved community satisfaction and trust in health system

	19.1.2	*Significant Systemic Improvement* and *Inter-Departmental Coordination and Communications*: Educate the community that a) bribery will not be tolerated and b) complaints are welcome; make clear the mechanism for lodging complaints when appropriate.	Clients lodge their complaints againts bribery Public is aware that MoPH has an intolerance policy against corruption			Improved quality of health care Reduced morbidity Reduced mortality Reduced out of pocket expenditure on health
	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 a) retaining MOPH employment and b) retaining BPHS and EPHS contracts.	Terms and conditions of employment at MOPH and securing the BPHS 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 referred to AGO* each month or Quarter.						
Recommendation 19.2 Support and encourage the local Health *Shura*s 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.	Revised Health Shuras ToR Assessment report of Health Shuras monitoring patient complaints about bribery				Interveiw with service users	
	19.2.2	***MODIFIED IN 4TH QUARTER*** -- *Significant Systemic Improvement*: Engage the **Complaints Handling**	HOO report on monitors patient complaints about bribery A report of bribery cases being reported					

		Office to monitor patient complaints about bribery in MOPH and BPHS and EPHS services on a Provincial level and a national level. *HSOO dropped in favor of Complaint Handling Office and NMHRA's complaint management procedures.*	and investigated at Provincial a national level.					
	19.2.3	***MODIFIED IN 4TH QUARTER*** -- *Inter-Departmental Coordination and Communications*: Engage Health *Shuras* and the **Department of Public Relations** to draw the public's attention to examples of good practice and integrity in the management	ICHSAR activities in relation to the complain handling to the public promotes role of MoPH in good practice and integrity in the management of patient referrals.			Donors and public trust the public health system	Interveiw with donors	

		of patient referrals. *ICHSAR dropped in favor of Department of Public Relations.*				

Annex III. List of MoPH Departments interviewed for the assessment

Minister of Public Health

Deputy Minister, Policy and Planning

Deputy Minister, Admin and Finance

DG, Policy and Planning

DG, Curative Medicine

DG, ANPHI

DG, EHIS

Advisor to DG HR

CEO, NMHRA

Technical Advisor, NMHRA

DG, AMC

Director, HMIS

Director, GCMU

Director, ANHAO

Director, Planning and Legislation

Annex IV. Standards included in Health MSS according to different HF level

a. Comprehensive Health Center (CHC) Minimum Service Standards (MSSs):

1. Are Health MSS clearly indicated at the information board at the Comprehensive health Center?
2. Is the comprehensive Health Center open during the official time?
3. Does the Comprehensive Health Center have one doctor, one midwife and one nurse?
4. Does the Comprehensive Health Center provide pre, during, and post delivery services for pregnant women?
5. Does the Comprehensive Health Center provide immunizations?

6. Does the Comprehensive Health Center provide services for any of the following conditions?
7. Diarrhea, Malaria, Tuberculosis Detection and Referral?

b. Basic Health Center (BHC) Minimum Service Standards:

1. Are Health MSS clearly indicated at the information board at the basic health center?
2. Is the Basic Health Center open during the official time?
3. Does the Basic Health Center have one midwife, and one nurse?
4. Does the Basic Health Center provide immunizations?
5. Does the Basic Health Center provide family planning services?
6. Does the Basic Health Center provide services for any the following conditions?
7. Diarrhea, Malaria, Antenatal Care, Tuberculosis Detection and Referral?

c. Health Sub-Center (HSC) Minimum Service Standards (MSSs):

1. Are Health MSS clearly indicated at the information board at the health sub-center?
2. Is the Health Sub-Center open during the official time?
3. Does the Health Sub-Center have one midwife?
4. Does the Health Sub-Center provide family planning?
5. Does the Health Sub-Center provide services for any of the following conditions?
6. Diarrhea, Malaria, Antenatal Care, Tuberculosis Detection and Referral, and Immunizations

Annex V. Complaint Record form – MoPH CHO

Islamic Republic of Afghanistan
Ministry of Public Health
Chive of Staff Office
Health Complaint Office/ HCO

دولت جمهور? اسلام? افغانستان
وزارت صحت عامه
ر?است دفترمقام
دفتر شکا?ات صح?

فورم ثبت شکا?ت صح?
Heath Complaint Form of /HCO

فورم نمبر:( )

تار?خ ثبت شکا?ت:		محل ثبت شکا?ت:		ساعت ثبت شکا?ت:
شکا?ت توسط :	ا?مل	فکس	تل?فون	مستق?م	ر?خ شروع ارز?اب? شکا?ت	

شهرتشکا?ت کننده			آدرس شکا?ت کننده			
اسم	ولد	جنس	ولا?ت	ولسوال?	شماره تماس	ا?م?ل آدرس

مشخصات شکا?ت کننده:

در صورت?که شکا?ت کننده کارمند دولت? باشد		
وظ?فه	اداره مربوطه	موقع?ت وظ?فو?

موضوع شکا?ت	مرجع مربوط شکا?ت	شخص?که ز آن شکا?ت صورت گرفت

معلومات فشرده در مورد شکا?ت

اسم وامضاء ثبت کننده ????? ?????

اقدا?ت رهبر? وزارت صحت عامه در مورد شکا?ت فوق :	ا?جه اجرات در مورد شکا?ت فوق : به تار?خ

Email: HCO@MopH.gov.af . healthcomplaint7@gmail.com phone: 0700267589– 0747242444 Address: MoPH/HCO/Kabul Afghanistan

Annex VI. Minutes of meetings of Health Shuras

(فارم) یادداشت جلسات ماهانه کمیته صحی

تاریخ: ۱۳۹۸/۶/۲۴ ولسوالی: کهستان

کود نمبر مرکز صحی: ۴۰۵۴ ولایت: دایکندی

A) مروری بر فعالیتهای ماه قبلی:

B) مباحثات جهت دریافت راه حل برای مشکلات قبلی: از طرف شورای صحی بحث و گفتگو صورت گرفت درباره

۱.
۲. واکسین معلومات داده شد از مراجعین واکسین در ماه قبلی کم بوده برای ماه بعدی تصمیم گرفته شد که
۳.
۴. در ماه بعدی مشکل حل شود
۵.

C) پلان ماه بعدی: تعقیب جلسه ماه قبلی جلسه صورت گرفت از شورا شد صحبت ... تشکر

۱.
۲. مشوره کردند ادویه جات بصورت کامل در کلینک وجود دارد و هیچ گونه کمبودات
۳.
۴. وجود ندارد. در ماه قبلی کمبودات پطرول وجود داشت تا حال مشکل حل نشده
۵. فیصد قبلی مقدار ۳۰ لیتر بود فعلا پانزده ۱۵ لیتر میباشد دلیل آن چیست

نام و امضای اعضای اشتراک کننده در جلسه.

نام و امضاء	جنسیت عضو اشتراک کننده (مرد یا زن)	امضاء و (یا نشان انگشت)
۱. حاجی جان محمد	رئیس شورا	[signature]
۲. عوض نوار	خالق معاون شورا	[signature]
۳. علی دریاب	...	[signature]
۴. محمد صفر		[signature]
۵. ...		[signature]
۶. معصومه احمدی		[signature]
۷. حلیمه جان داد		[signature]
۸. حاجی داریاب محمد		[signature]

دروغتیایي کمیتي دمیاشتني مجلس راپور

دمجلس ځای: د دالکریم ... کلینیک

داشتراک کوونکو شمیره: ۱۲ نفر

تاریخ: ۱۳۶۸/ ۲/ ۱۹/ ۱

دغونډي موضوعات: ماشومان ولې سوء تغذیه کیږي

په دې باره کې راغلو ګډونوالو ته معلومات ورکړل شو چې ماشومان د نا موزون خوړو او [illegible] زیات [illegible] خوړو له امله سوء تغذیه کیږي -

پریکړه: ټولو ملګرو په دې خبره موافقه وکړه چې د ټولنې خلکو ته دغه معلومات ورسوو. او د ماشوم صفائي، خوړو او علاج ته خاص توجه وکړو چې د سوء تغذیې په لور لاړ نه شي او چې بیمار شي سمدستي یې کلینیک ته معرفي کړي

دبلي غونډي نیټه: 16 /۱۲ /۱۳۹۸

امضاء:

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3. Public Health Law (2007)

5. Afghanistan Public Procurement Law (2008)

6. Pharmaceutical law (2007)

7. Regulation over importing of pharmaceutical products and medical devices (2007)

8. Pharmacy regulation (2007)

9. Licensed national pharmaceutical products list (2008)

14. Interview with 25 staff members in governmental organizations, companies, wholesales and pharmacies in Kabul, Herat, Balkh, Qandahar and Nangarhar

15. Conducting information on consultation meetings and focus groups

Independent Joint Anti-Corruption
Monitoring and Evaluation Committee