OFFICE OF INSPECTOR GENERAL

AUDIT OF USAID/AFGHANISTAN'S ON-BUDGET FUNDING ASSISTANCE TO THE MINISTRY OF PUBLIC HEALTH

IN SUPPORT OF THE PARTNERSHIP CONTRACTS FOR HEALTH SERVICES PROGRAM

AUDIT REPORT NO. F-306-11-004-P
SEPTEMBER 29, 2011

KABUL, AFGHANISTAN

Office of Inspector General

September 29, 2011

MEMORANDUM

TO: USAID/Afghanistan Mission Director, S. Ken Yamashita

FROM: Acting OIG/Afghanistan Director, David A Thomanek /s/

SUBJECT: Audit of USAID/Afghanistan's On-Budget Funding Assistance to the Ministry of Public Health in Support of the Partnership Contracts for Health Services Program (Report No. F-306-11-004-P)

This memorandum transmits our final report on the subject audit. In finalizing the report, we carefully considered your comments on the draft report and have included the comments in Appendix II.

This report contains 13 recommendations to assist USAID/Afghanistan and the Afghan Ministry of Public Health in improving implementation of health-care activities under the Partnership Contracts for Health Services Program. Management decisions have been reached on 12 recommendations, but no management decision was reached on Recommendation 12. A management decision for Recommendation 12 can be recorded when USAID/Afghanistan develops procedures for validating data input into Afghan Info.

A determination of final action for Recommendations 1 through 11 and 13 will be made by the Audit Performance and Compliance Division on completion of the proposed corrective actions.

Thank you and your staff for the cooperation and courtesy extended to us during the audit.

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Abbreviations

The following abbreviations appear in this report:

ADS	Automated Directives System
AOTR	agreement officer's technical representative
BPHS	Basic Package of Health Services
EPHS	Essential Package of Hospital Services
FY	fiscal year
GPS	global positioning system
HMIS	Health Management Information System
MoF	Ministry of Finance
MoPH	Ministry of Public Health
NGO	nongovernmental organization
OIG	Office of Inspector General
PCH	Partnership Contracts for Health Services
PMP	performance management plan

SUMMARY OF RESULTS

Since 2003, USAID/Afghanistan has implemented programs to help Afghanistan rebuild its health system after decades of war and neglect. The mission has been supporting the operational costs of health facilities delivering basic health services to mainly rural populations. Initially, USAID/Afghanistan provided funding through an implementing partner, but in 2008 the mission certified the Ministry of Public Health (MoPH) to manage U.S. Government funds for implementing health services through nongovernmental organizations (NGOs) under host-country contracting mechanisms.

In July 2008, USAID/Afghanistan signed an implementation letter with the Government of the Islamic Republic of Afghanistan to provide the mission's first on-budget funding assistance[1] to MoPH in support of the Partnership Contracts for Health Services (PCH) Program. Under this host-country contracting program, the mission was to provide MoPH with up to $236 million in on-budget assistance over 5 years to support the delivery of standardized health services in 13 target provinces. In fiscal year (FY) 2009, 20 percent of USAID's development assistance to Afghanistan was on-budget; in FY 2010, 40 percent of assistance was on-budget.

Afghanistan's standardized health services include the Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS), which are national strategies for rebuilding the Afghan health system. BPHS is a standardized package of basic health services that forms the core of service delivery in all primary health-care facilities, like the one pictured below. EPHS defines all the necessary elements of services, staff, facilities, equipment, and drugs for each type of hospital at the provincial level in Afghanistan and promotes a health referral system that integrates the BPHS with hospitals.

This basic health center in Badakhshan Province serves about 11,700 people. (Photo by OIG, May 9, 2011)

[1] Development assistance channeled through the host country's core budget.

MoPH, with substantial technical assistance from USAID, established a Grants and Contracts Management Unit to manage the PCH program and contract with NGOs to implement BPHS and EPHS. The unit was staffed by consultants financed under another USAID program. In November 2009, MoPH awarded contracts to ten NGOs totaling about $80 million to provide standardized health services in more than 500 health facilities and 5,500 health posts[2] throughout the 13 target provinces. The contracts were for 2 years, with an optional 1-year extension for NGOs meeting or exceeding specified targets. At the time of the audit, about 1.5 years into implementation, the unit managed 18 contracts with ten NGO contractors.

USAID uses the cash advance and liquidation mode of payment to MoPH. As of May 31, 2011, USAID had obligated $56 million, disbursed $47 million, and advanced $3 million for the PCH program.

According to USAID's implementation letter with the Government of the Islamic Republic of Afghanistan, the expected outcomes from the PCH program were to improve access, quality, and use of services to improve health status and contribute to meeting Afghanistan's national health objectives:

- Increasing BPHS coverage[3] to more than 90 percent.
- Reducing the maternal mortality ratio to 1,360 deaths per 100,000 live births per year.
- Reducing the mortality rate for children under 5 to 168 deaths per 1,000 live births per year.
- Reducing the infant mortality rate to 104 deaths per 1,000 live births per year.
- Increasing vaccination coverage of children 12-23 months of age to exceed 80 percent (vaccination with three doses of the diphtheria, pertussis, and tetanus vaccine).

USAID's Office of Inspector General (OIG) conducted this audit to determine whether MoPH, with USAID/Afghanistan's assistance, was implementing standardized packages of health services that contribute to meeting Afghanistan's national health objectives.

The PCH program has contributed to the achievement of the MOPH health objectives. The majority of PCH health facilities visited were exceeding their patient capacity, demonstrating that communities, especially women and their children, were increasingly seeking out health services. PCH-funded physicians interviewed attributed accomplishments in the reduction of maternal and infant mortality in part to the PCH program's community outreach program. The health education provided by the outreach program in remote areas has been emphasizing the benefits of delivering babies at health facilities rather than at home, and as a result, physicians stated that the majority of women in their service areas are now delivering at the health clinics and hospitals.

USAID's on-budget funding assistance to MoPH supported the ministry's implementation of standardized packages of health services under the PCH program. Auditors found evidence that the PCH program has contributed to meeting Afghanistan's national health objectives.

[2] Health posts each serve approximately 100–150 rural families, equal to 1,000–1,500 people. Posts are ideally staffed by a male and a female community health worker, delivering services from their homes.
[3] Coverage refers to the percentage of the population able to access services, in this case those living within a 2-hour walking distance from a health facility.

However, measurement of the magnitude of USAID's contribution to the national objectives could be made only indirectly using proxy indicators because no current demographic information or health statistics were available to measure health outcomes directly. The mission was in the process of analyzing data to measure the effectiveness of its investments in increasing access to essential health services that improve health outcomes.

To address the lack of population data, USAID, in collaboration with other donors, funded the first-ever mortality survey in Afghanistan in 2010, but its release date is uncertain. Also, during the audit, MoPH created a working group with USAID participation to determine how to measure progress toward achieving national health objectives. With these efforts, MoPH should be in a better position to evaluate its achievements against health objectives, and USAID should be able to estimate the PCH program's contribution to national efforts with some degree of accuracy.

In the meantime, MoPH and USAID primarily relied on proxy indicators in activity reports submitted by health facilities, along with findings in a recent household survey report, to measure progress made by the PCH program. The following proxy indicators, as reported by MoPH, provided an indirect measure of USAID's contribution to Afghanistan's national health objectives in 2010 (taking into consideration the 20–30 percent error rate acknowledged by MoPH as well as the data quality problems discussed in the finding beginning on page 10):

- *Increasing BPHS coverage*. The number of PCH-financed facilities offering health services increased by 8 percent from 484 in 2009 to 523 in 2010 and the number of health posts increased from 5,500 to 5,676. While there was an increase in the number of facilities providing health services and consequently the population covered, there were no data available to measure progress toward increasing coverage to 90 percent of the population.

- *Reducing the maternal mortality ratio*. The number of deliveries by a skilled attendant at PCH-financed health facilities increased by 3 percent from 2009 to 2010 and mothers who received at least two doses of tetanus toxoid during their pregnancy increased by 4 percent. These proxy indicators suggested that maternal mortality might be falling in areas served by the PCH program because more women are having institutional attended births and using health services.

- *Reducing the under-5 mortality rate.* To measure child mortality, the mission used proxy indicators such as the number of children under 5 who received vaccinations and the number who received vitamin A therapy through the PCH program. Both numbers declined, by 5 percent and 11 percent respectively, from 2009 to 2010.

- *Reducing the infant mortality rate*. To measure infant mortality, the mission used the number of infants who were breastfeeding and the number of mothers reporting appropriate care-seeking behavior. The number of infants who were breastfeeding increased by 4 percent from 2009 to 2010, but the number of mothers reporting appropriate care-seeking behavior decreased by 10 percent in PCH program areas.

- *Increasing vaccination coverage*. As stated above, the PCH program provided diphtheria, pertussis, and tetanus vaccinations, but the number of children who received them under the program declined by 5 percent from 2009 to 2010.

Although the PCH program has made significant accomplishments, such as the increased use of health facilities and reductions in mortality, certain elements of the program could be strengthened in order to ensure continued success. Several aspects of quality care had varying levels of problems. For example, activity reports from PCH health facilities tested during the audit contained inaccuracies, possibly affecting the accuracy of the reported results above. Insufficient data could hinder both MoPH's ability to manage the PCH program and USAID's monitoring of the cost-effectiveness of its on-budget investments in Afghanistan's health sector, including how well those investments are achieving their intended goals compared with those of other donors such as the World Bank and European Commission.

Sustainability has emerged as a risk to USAID investments in Afghanistan's health sector. About 94 percent of the Afghan Government's expenditures on health-care programs are donor supported. The government's extremely low contribution to health care raises questions about the long-term sustainability of health sector improvements. With shrinking donor support in the foreseeable future, the Afghan Government's ability to increase health-care coverage to 90 percent of the population appears unlikely, while its ability to sustain the current level of coverage remains uncertain. Unless the Afghan Government is able to generate sufficient revenue to cover its health-care costs, the health sector's dependency on donor support will continue.

The Audit Findings section of this report discusses the following issues:

- Quality deficiencies observed in 11 health facilities. While the PCH program has contributed to increasing BPHS coverage and improving access and use of health services, auditors found varying quality deficiencies at all 11 health facilities visited. For example, old equipment needed repair, drugs and medical supplies were in short supply, doctors and staff members were overwhelmed with serving a population up to twice the capacity of their facilities, facilities were crowded, buildings needed repair or renovation, staff members lacked training, and controls over patient records and activity reports were poor. While several of these quality deficiencies were within the PCH scope or could be directly addressed by USAID, other deficiencies noted were systemic and beyond the control of USAID (page 7).

- Accurate data needed to measure program progress. MoPH relied on proxy indicators based on activity reports submitted from its health facilities as well as health surveys to provide some indication of progress. However, audit testing of the activity reports revealed several instances where supporting documentation was lacking, as well as the reporting of incorrect amounts. Additionally, MoPH disclosed that the data submitted by its health facilities had a national error rate of 20-30 percent and about 15 percent (240) of the 1,634 health facilities did not submit monthly reports in 2010, though the reporting rate for PCH program health facilities was much better, at almost 100 percent (page 10).

- Building ministry's sustainable capacity was delayed. MoPH's unit managing the PCH program was staffed by USAID-funded consultants. USAID's implementation letter requires USAID and MoPH to establish a work plan for capacity development that would begin transferring consultants and their functions to MoPH. To date, no functions have been transferred, but a plan has been developed and USAID officials expect completion of the transfer by September 2011 (page 12).

- Absence of a cost-effectiveness analysis on donor-supported health-care activities. USAID, World Bank, and the European Commission are the major donors supporting MoPH in implementing standardized packages of health services throughout Afghanistan. While the mission had begun an analysis to compare the cost-effectiveness of health-care delivery by the major donors it has not been completed. Such analysis could provide insight on waste or inefficiencies and on best practices employed to provide quality health care at the lowest practical costs (page 14).

- Cumbersome processes delayed payments. The Afghan government's payment process (cash advance and liquidation) across MoPH and the Ministry of Finance (MoF) was a continuously changing, cumbersome ordeal, requiring layers of redundant review and up to 34 signatures per request. The process delayed payments to NGO contractors and in turn caused late salary payments to health staff members. Consequently, health staff members were demoralized, staff turnover increased, potentially affecting the quality of care (page 15).

- Program management needs to be tightened. The mission has had little experience managing on-budget assistance activities implemented by host-government ministries. The mission lacked a formal mission order outlining duties and responsibilities among offices. No formal designation letter was issued for the PCH program manager, and the mission was taking a hands-off approach to program management. (page 17).

- Program lacked an approved performance management plan. At the time of the audit, the PCH program did not yet have an approved performance management plan, almost 3 years after the implementation letter was countersigned. Preparation of this plan, however, was under way (page 18).

- Indicators in management information system were not accurate or complete. USAID's PCH program implementation letter states that MoPH was to provide at least quarterly updates by entering certain activity information into Afghan Info (the mission's system for monitoring development projects) over an Internet Web site. However, audit testing revealed discrepancies with nine of the ten indicators reported in Afghan Info (page 19).

The report recommends that USAID/Afghanistan:

1. In collaboration with MoPH, develop and implement a plan that (1) improves the NGO contractors' supervision, monitoring, and problem solving at their health facilities; and (2) verifies the successful implementation of a reliable quality assurance mechanism by the NGO contractors, including the establishment of quality assurance committees at each of the health facilities (page 10).

2. Assist MoPH in establishing and implementing a plan to ensure that NGO contractors are verifying that the requirement of second-person verification is being effectively implemented at health facilities (page 12).

3. In collaboration with MoPH, develop a plan to (1) identify a pool of qualified civil service employees who would benefit from capacity building training in order to sustain the ministry's capacity for managing the PCH program and (2) provide the training (page 14).

4. Work with MoPH and the Ministry of Finance (MoF) to streamline the payment process to

accelerate payments to NGO contractors and health workers (page 16).

5. Work with MoPH and MoF to (1) implement written policies and procedures that clearly define the roles, responsibilities, and approval authorities for the payment process; and (2) provide them with further training on the advance/liquidation mode of payment (page 16).

6. Work with MoPH and MoF to implement procedures limiting the frequency of changes made to the payment process and providing sufficient notification and clear instructions to NGO contractors on any changes (page 17).

7. Review its internal administrative procedures, such as the processing of implementation letters, to ensure the smooth and timely flow of the payment process for on-budget assistance agreements (page 17).

8. Issue a mission order to provide an organizational framework with clearly defined roles and responsibilities of all mission offices responsible for managing on-budget assistance activities (page 18).

9. Provide a formal designation letter similar to the designation letter for an agreement officer's technical representative (AOTR) to staff monitoring implementation of on-budget assistance agreements (page 18).

10. Work with MoPH to prepare a performance management plan for the PCH program (page 19).

11. Provide MoPH with clearly written definitions of Afghan Info performance indicators (page 20).

12. Implement procedures to review and verify the accuracy of data entered into Afghan Info and provide timely feedback to users (page 20).

13. In collaboration with MoPH, implement a plan to confirm and document accurate global positioning system (GPS) coordinates for the ministry's health facilities (page 20).

Detailed findings follow. Our evaluation of management comments is on page 21. The audit scope and methodology are described in Appendix I, and USAID/Afghanistan's comments are reproduced in Appendix II.

AUDIT FINDINGS

Quality Deficiencies Observed in 11 Health Facilities

According to MoPH's contract with NGO service providers:

> Good quality care is important both because it assures the best possible outcome and because it encourages people to continue using health care with confidence. The three main components of quality include the facilities with their equipment and supplies, the technical skills of the health staff, and the quality and adequacy of communications between the health worker and the client.

The contract also states: "Through active supervision and monitoring, the service provider will be actively and regularly improving quality of care," and "The service provider needs to establish and maintain a reliable service quality assurance mechanism based on MoPH guidelines." With respect to training, the contract states, "The service provider should organize and conduct sessions to transfer the skills and knowledge learned to their provincial and health facility staff."

Though the PCH program has contributed to increasing BPHS coverage, access, and use of health services, auditors noted quality deficiencies at all 11 health facilities visited (table).[4] While several of these quality deficiencies were within the PCH scope or could be directly addressed by USAID, other deficiencies noted were systemic and beyond the control of USAID.

Quality Deficiencies Observed in 11 Health Facilities

Quality Deficiencies Observed in Health Facilities	Number of Health Facilities Visited With Findings	Percentage of Health Facilities Visited
Facility Management		
• Exceeding patient capacity of facility and staff	5	45
• Lack of space or waiting area for patients	7	64
• Building needs repair or renovation	3	27
• No regular visits by NGO	2	18
Equipment and Supplies		
• Old equipment needs repair or replacement	4	36
• New equipment, but staff need training to use it	1	9
• Shortage of drug supplies	7	64
• Shortage of medical supplies	1	9
Staff		
• High staff turnover or understaffed	2	18
• Shortage of female staff	2	18
• Lack of training	3	27
• Delay in salaries	5	45

[4] Appendix III lists the 11 selected health facilities, NGOs, and provinces visited during the audit.

Quality Deficiencies Observed in Health Facilities	Number of Health Facilities Visited With Findings	Percentage of Health Facilities Visited
Data Quality		
• Inaccurate data in monthly reports	2	18
• No supporting documents	2	18
• No double-checking of data	8	73
• Incorrect GPS coordinates	8	73

- *Patient capacity*. Doctors and staff at five (45 percent) of the health facilities visited complained that they were serving a volume of patients up to twice their capacity to handle. While the increased volume of patients shows a willingness by Afghans to seek medical assistance—some patients interviewed took from 2 to 5 hours to get to the facility—one doctor interviewed said facilities have had to turn patients away for lack of time and staff. USAID has limited control over the capacity of health facilities. For example, the PCH contracts with NGOs anticipate only a 5 percent annual increase in the number of health facilities.

Women and children huddle in a makeshift waiting area at a basic health center in Badakhshan Province. (Photo by OIG, May 9, 2011)

- *Space*. Auditors observed a lack of space or waiting area for patients at seven (64 percent) of the health facilities visited. At one clinic in Badakhshan Province, when it started to rain hard, the patients—mostly women and children—had to wait outside (as shown in the photo above) or cram into the clinic's small entryway. Patients informed us that they waited about 4–5 hours before receiving medical services, while others who could not wait that long left without receiving treatment. Construction, however, is not within the scope of the PCH program.

- *Equipment*. Four (36 percent) of the health facilities had old equipment that needed repair or replacement. One health facility had a new anesthesia machine donated by the United Arab Emirates, but none of the hospital staff knew how to use it. Repeated requests for

training on the new machine were ignored by the responsible NGO contractor. Meanwhile, the new machine sat idle. Recognizing the need for new equipment, USAID has worked with MoPH to assess equipment requirements and define specifications to ensure standardization of equipment across provinces. The mission plans to provide funding to NGOs for purchasing new equipment.

- *Drugs and medical supplies*. Doctors and staff at seven (64 percent) of the health facilities visited complained about shortages of commonly prescribed drugs such as antibiotics and antiparasitics. One clinic consistently depleted its month's supply of the most commonly used antibiotics and antiparasitic drugs within the first 10 days of the month. Another clinic had shortages of dressing supplies. Clinic staff attributed shortages to increased demand. Alternatively, workers at three health facilities visited in Herat advised that they do not experience setbacks from drug shortages. USAID provides dedicated technical assistance in pharmaceutical quantification and forecasting. This capacity is increasingly important as demand for health services increases. An implementing partner conducts regular monitoring of drug inventories at health facilities, and this capacity, too, should be transferred to MoPH in coming years, according to USAID officials.

- *Buildings*. While none of the buildings visited met western standards, three (27 percent) of the buildings were in poor condition, requiring repairs and renovation of floors and roofs and painting. Toilets and washrooms were the most neglected.

- *Staff*. Two (18 percent) of the health facilities visited experienced high staff turnover. Staff members usually left after the clinic provided them training. Three (27 percent) of the health facilities visited faced staff shortages, and two of the three had difficulties finding female doctors and nurses. These shortages of staff were attributed to low salaries. Though such salaries are not within the control of the mission, USAID participates in the National Salary Policy Working Group in the Ministry of Public Health that is working on the revision of the national salary policy to address this problem. Additionally, staff at three (27 percent) of the health facilities reported they had not received training from their responsible NGO contractor, which they said had ignored repeated requests for training. One of the risk factors compromising quality of health-care is a lack of competent female health-care providers, particularly in remote rural areas. USAID has responded by developing the Community Midwifery Education and Community Nursing Program. Such community-based training programs for health workers are regarded nationally and internationally as a best practice because they produce competent health workers with a high rate of deployment in the field.

- *Salaries*. Five (45 percent) of the health facilities visited reported delays in receiving salaries for their staff. Salary payments were 1–4 months late. At one clinic, staff went on strike to protest the late payments, disrupting delivery of health services for several days. Eventually they were paid by their responsible NGO contractor, and clinic operations resumed.

- *Data*. The audit disclosed discrepancies in activity reports at four (36 percent) health facilities visited. Specifically, two facilities did not have detailed patient records to support their March 2011 reports; clinic staff claimed to have misplaced or lost the records. The other two facilities had errors in their March 2011 reports because of mathematical mistakes. Most (73 percent) of the health facilities visited did not double-check their figures before submitting the reports to MoPH. Additionally, GPS coordinates for most (73 percent) of the health facilities visited were not those reported by MoPH.

Some of these quality deficiences—such as construction, overuse of facilities, high staff turnover, and shortages of female staff—are beyond the mission's control or outside the PCH program. Nevertheless, the remaining quality deficiencies described above might have been prevented if the responsible NGO contractors had provided proactive supervision, monitoring, and problem solving at their health facilities. Quality assurance committees at the health facilities are an important part of the quality assurance mechanism, and according to the NGOs' contracts, committees were to be made up of representatives of health staff at the facilities, community members, and the Provincial Health Office team. NGO contractors were to ensure that the committees had been established at each health facility and were functioning well.

However, there was no evidence at the 11 health faciltiies visited that NGO contractors had established and maintained a reliable quality assurance mechanism based on MoPH guidelines. Some health facility staff members gave the impression that NGO contractors provided only the minimum level of support. To address this problem, the PCH program regulary monitors health facilities using the national monitoring checklist, provides feedback to NGO contractors, and helps them develop plans for corrective action.

Over the last 4 years, USAID has provided technical assistance to develop and implement a quality assurance system for health facilities in 21 provinces. Adoption of quality assurance mechanisms was at different stages at different facilities. According to USAID officials, the mission continues to provide assistance to institutionalize the quality assurance process at all levels of the BPHS, including identifying standards of care, developing a plan to correct deficiencies, and assessing progress and guiding improvement in achieving standards.

According to MoPH's BPHS document revised in July 2010, "If the quality of services is inadequate, the population will not continue to support BPHS, and the foundation of the health system will crumble."

> ***Recommendation 1.*** *We recommend that USAID/Afghanistan, in collaboration with the Ministry of Public Health, develop and implement a plan that (1) improves the nongovernmental organization contractors' supervision, monitoring, and problem solving at their health facilities; and (2) verifies the successful implementation of a reliable quality assurance mechanism by the nongovernmental organization contractors, including the establishment of quality assurance committees at each of the health facilities.*

Accurate Data Needed to Measure Program Progress and Outcomes

According to MoPH's PCH 2010 Household Survey:

> The majority of public health program managers need local level measures of the health outcomes in the areas where they operate. National surveys are expensive and normally implemented by highly sophisticated experts. Results of these surveys are also often not available to users for at least a year. In countries like Afghanistan, because of lack of robust information infrastructures such as district boundaries, accurate population estimates and household listings that are normally generated through national censuses, sampling of national surveys can be subject to significant biases.

At the time of the audit, MoPH did not have current population statistics, demographic information, or other national data available to measure outcomes from its health-care activities. The ministry and USAID primarily relied on proxy indicators reported by its health facilities and on the results in the household survey report to measure progress under the PCH program.

MoPH health facilities are required to report on their health-care activities in accordance with the ministry's Health Management Information System (HMIS) requirements. According to the ministry's *HMIS Procedures Manual*, Parts I & II, dated March 2011:

> HMIS is a system based on qualitative and quantitative indicators in which routine health information is collected, processed, analyzed, interpreted, disseminated, and used to improve the provision of health services according to the MoPH's priorities and ultimately to improve the health of the population. The system collects information from both the health facility and community-level service providers.

The following is a listing of HMIS forms and reports that health facilities are required to complete and submit to MoPH on a monthly basis:

- Pictorial Tally Sheet
- Monthly Activity Report (Health Posts)
- Monthly Aggregated Activity Report
- General Register – Facilities
- Monthly Facility Tally Sheet
- Monthly Integrated Activity Reports (shown on the next page)
- Hospital Monthly Inpatient Report (Hospitals and larger facilities with inpatient care)
- Hospital Monthly Tally Sheet

MoPH's contract with NGO service providers under the PCH program requires that they adhere to HMIS requirements by compiling accurate data, generating informative reports from the data, and analyzing the information to identify program strengths and weaknesses. Additionally, NGO contractors must use this information to take corrective action in areas that need improvement. Quarterly reports submitted to MoPH should summarize the analyses and provide evidence of corrective actions taken.

However, the audit disclosed discrepancies in activity reports at 4 (36 percent) of the 11 health facilities visited. Specifically, two of the facilities did not have detailed patient records to support their March 2011 reports. Clinic staff members said that they had misplaced or lost the records. The other two facilities had errors in their March 2011 reports because of mathematical mistakes.

Additionally, MoPH disclosed that the data submitted by its health facilities had an error rate of 20–30 percent, and about 15 percent (240) of the 1,634 health facilities did not submit monthly reports in 2010, though the reporting rate for PCH program health facilities was much better, almost 100 percent.

A staff member explains data reported on a Monthly Integrated Activity Report. (Photo by OIG, May 2, 2011)

Binders of HMIS reports and health records line the shelves at a provincial hospital in Badakhshan. (Photo by OIG, May 8, 2011)

Auditors found that the process for completing the required HMIS reports was inherently prone to errors because information was compiled manually on paper. Health facilities located in remote rural areas had no electricity and no computers. Workers at most (73 percent) of the health facilities visited did not double-check their figures before submitting the reports to MoPH. Having a second person double-check data is considered a best practice to minimize errors.

According to USAID officials, these error and submission rates were comparable to world benchmarks in developing counties, where data quality is usually below 50 percent. Despite the limitations in data, HMIS provides useful data for monitoring trends and identifying gaps and improvements in service.

Because MoPH's Afghanistan Mortality Survey 2010 is expected to provide current demographic health information, we did not make a recommendation regarding the lack of current population statistics, demographic information, or other national data to measure outcomes from the ministry's health-care activities. However, to improve the accuracy of HMIS activity reports, we make the following recommendation.

> ***Recommendation 2.*** *We recommend that USAID/Afghanistan assist the Ministry of Public Health in establishing and implementing a plan to ensure that nongovernmental organization contractors are verifying that the requirement of second-person verification is being effectively implemented at health facilities.*

Building Ministry's Sustainable Capacity Was Delayed

The *Afghanistan and Pakistan Regional Stabilization Strategy,* updated in February 2010 by the Office of the Special Representative for Afghanistan and Pakistan, and the "Afghan First" initiative both call for empowering Afghan institutions to take the leading role in the development and reconstruction of the country. To that end, the PCH program was to focus on building

sustained capacity within the MoPH to plan, procure, manage, and report on the performance of NGO contractors who deliver health services.

According to USAID's PCH program implementation letter:

> MoPH and USAID will establish, within 120 days of countersigning this implementation letter, a capacity development work plan that will begin transferring the planning and management capability of the Grants and Contracts Management Unit consultants to the permanent MoPH procurement staff. USAID will finance technical assistance to aid the MoPH in the development of this permanent capacity.

MoPH countersigned the implementation letter on July 16, 2008.

The capacity of MoPH's civil service employees to plan, procure, manage, and report on the ministry's health-care activities was to be increased so that the freestanding Grants and Contracts Management Unit would be merged into the normal MoPH workforce. However, MoPH and USAID did not have an approved work plan for capacity development until June 2010, about 2 years after the implementation letter was signed. The lack of an approved plan for 2 years caused delays in transferring PCH consultants and their functions to MoPH and consequently resulted in delays in building MoPH's capacity.

USAID officials explained that, although they were pursuing several strategies to build the capacity of MoPH civil service employees and affect the transfer of the PCH consultants and their management functions, the process has taken much longer than expected. As one official said, "It can't happen overnight." Mission officials also had not identified a pool of appropriate civil servants who could benefit from capacity building and training. Officials explained that many of the better-qualified technical staff members at MoPH, such as the employees working in the HMIS department, were actually embedded consultants funded by other donors.

Further complicating the transfer of functions from PCH consultants to MoPH civil service employees was the need to increase civil service salaries, which were last revised in 2005. According to USAID and MoPH, the 2005 civil service pay scales do not reflect current economic realities. As a result, it could be difficult for the ministry to attract highly qualified personnel such as the PCH consultants working in the Grants and Contracts Management Unit whose higher salaries USAID financed. MoPH and USAID have been able to attract and retain highly qualified Afghan consultants by paying them much higher salaries than the civil service could offer. Many of the Afghan consultants managing the PCH program were medical doctors with extensive experience.

Delays in implementing the capacity development work plan could jeopardize the PCH program's sustainability efforts. As donor funding recedes, MoPH will not be in a position to retain highly paid consultants, and the ministry's civil servants lack the capacity to manage health-care activities effectively. Without highly qualified staff members managing MoPH's health-care activities, the achievements of those activities could be reversed.

Despite the delays, MoPH and USAID did make some progress implementing the capacity development work plan. Specifically, the Grants and Contracts Management Unit was moved from the Health and Economics Financing Directorate to the Procurement Directorate. Also, financial consultants from the unit were integrated with the Development Budget Unit. According to USAID, this was an important move that furthered the absorption of the unit into

the MoPH structure. The mission also was actively working with MoPH to identify options to move the PCH consultants to the civil service.

According to USAID officials, they were 90 percent certain that by the end of September 2011 the PCH consultants and their functions would have been transferred to MoPH, but this was dependent on the following conditions:

- MoPH's Executive Board approving the transfer plan.

- MOPH's Executive Board approving the approach for determining what salaries and allowances to offer the consultants that transfer (not just for the PCH program, but all consultants that transfer as part of the on-budget plan).

- USAID approving the plan. USAID would need to decide whether the transfer of the PCH consultants should include operational support.

- USAID obtaining funding, and USAID and MoPH agreeing on an implementation letter that would allocate funding for the PCH transfer.

Because the mission has worked with MoPH on developing a plan to transfer PCH consultants and their functions from PCH consultants to MoPH civil service employees, as well as to build ministry capacity, we did not make a recommendation in this area. However, to expedite the process, we make the following recommendation.

> ***Recommendation 3.*** *We recommend that USAID/Afghanistan, in collaboration with the Ministry of Public Health, develop a plan to (1) identify a pool of qualified civil service employees who would benefit from capacity building training in order to sustain the ministry's capacity for managing the PCH program and (2) provide the training.*

Absence of a Cost-Effectiveness Analysis on Donor-Supported Health-Care Activities

Many USAID program activities are designed to improve the socioeconomic infrastructure of the country. Activities in education, health, family planning, and even agriculture (e.g., research and extension) often do not generate revenues to cover the costs of the activities. With shrinking program budgets in the foreseeable future, implementing these activities to achieve intended results in the most cost-effective manner is imperative.

USAID's Automated Directives System (ADS) 201.3.9.1 states that cost-effectiveness analysis helps to determine whether a program's intended results are appropriate, whether the tactics to achieve results are the most suitable and cost-effective, and whether the plan can be implemented in the time frame proposed and with the available resources, given the host country's social, economic, and political situation.

USAID, the World Bank, and the European Commission are the major donors supporting MoPH to implement standardized packages of health services all over Afghanistan. An analysis to compare the cost-effectiveness of the delivery of health services by the major donors had not been conducted at the time of the audit. Specifically, no comparative analysis had been done of

the average cost per unit of outputs for the various health services provided, such as cost per patient or cost per health facility, measured against quality scores.

Since 2004, MoPH, with technical assistance from The Johns Hopkins University and the Indian Institute for Health Management Research, has used a "balanced scorecard" to evaluate the quality of service performance at all donor-supported health facilities in Afghanistan. The scorecard, however, does not include a cost analysis in the evaluation of service performance.

An empirical analysis of the 2009–2010 balanced scorecard showed that the quality of health care in USAID provinces was on par with that in European Commission-supported provinces and slightly better than that in World Bank-supported provinces. Though a cost comparison among the three major donors had not been conducted, a mission analysis showed that USAID spends approximately $3.60 per person covered, while the World Bank spends at least $4.00 per person covered. While the mission's analysis was not representative or conclusive, it does suggest a need for a more in-depth analysis, which would ideally identify inefficiencies as well as cost-effective best practices to be adopted by all the donors. A European Commission official stated that such an analysis "is extremely important."

In conducting a cost-effectiveness analysis, MoPH, USAID, and other donors would have valuable comparative information on best practices and opportunities to provide quality health-care at the lowest practical cost. Though MoPH, USAID, and the other donors had not conducted a cost-effectiveness analysis prior to the end of audit fieldwork, the European Commission has been working on a contract to conduct a study comparing international donors' support of BPHS and EPHS that will look at aspects of project implementation and outcomes, including cost efficiency.

Additionally, USAID has begun a study to compare the costs of BPHS 2005 with those of BPHS 2010, taking into account the incremental services that have been added. The study will (1) determine provider (health facility) unit costs per patient-visit for existing and new interventions; (2) use the "ingredients approach" for each service, which adds the cost of labor, drugs and supplies, equipment, and other costs incurred by a health facility for treating each patient; and (3) examine cost variations across geographic areas. Preliminary work on this study began in July 2011 and is expected to be completed by early November 2011. Because of the cost analyses under way, we make no recommendation.

Cumbersome Processes Delayed Payments

According to USAID's PCH program implementation letter, USAID was to finance the PCH program using the cash advance and liquidation mode of payment with funds disbursed to the MoPH through MoF. Each 45-day period required submission of a payment request through several organizations for processing and approval before disbursement of funds. The implementation letter and NGO contracts set deadlines for the submission of the requests. The smooth flow and timeliness of the payment cycle is vital to ensure the continuity and quality of health-care delivery.

The audit revealed that MoPH was unable to pay its NGO contractors in a timely manner. In turn, NGO contractors were often unable to cover the costs of their health facilities because of the delays. Payment delays to NGO contractors have ranged from 1 to 4 months. Several Afghan NGO contractors explained that international NGOs were able to cover their costs

because they had access to funding from their headquarters. Some Afghan NGOs shifted funds from other projects, but most Afghan NGOs were not in a position to cover costs.

The delays in payments happened because the current advance and liquidation payment process across the two ministries was a continuously changing, cumbersome ordeal, requiring layers of redundant review and up to 34 signatures per request. Inherently, the process does not allow timely payments to NGO contractors because MoF's turnaround time for paying NGO contractors after receiving USAID funds was never factored into the 45-day payment cycle. Ministry and USAID staffs had difficulty explaining the lengthy and complicated process, and we could not find anyone who could explain the process from start to finish. Staff members attempted to explain the process within their own areas of responsibility, but they contradicted one another, and most were not sure what happened outside of their own areas.

Further, no written policies or procedures defined roles and responsibilities or indicated who should approve the payment requests at MoPH. NGO contractors complained that the forms to process the advance and liquidation payment requests changed several times without sufficient notice or clear instructions on the changes. USAID mission officials and PCH consultants had raised concerns about the need for continued strengthening of the financial management team handling the PCH program.

The mission's processing of payment requests also contributed to delays in paying the NGO contractors. The PCH program implementation letter states: "To ensure timely receipt of funds, USAID will process each cash advance SF-1034 within 15 calendar days prior to the beginning of each 45-day period for which the cash advance is required." The processing time for 3 (21 percent) of the 14 cash advance requests since the start of the PCH program by the mission exceeded the 15 days allowed to process them. Mission officials attributed the lengthy processing time to administrative delays such as unavailability of funding, liquidation requests not being submitted as required, a lengthy process for funding implementation letters, and problems with the currency exchange rate. Additionally, the time needed for funds to transit through the banking system, from the U.S. Government to the Afghan Government, also contributed to delays, though this was out of USAID's control.

The payment delays ultimately affected the doctors and other health workers at the PCH facilities because the NGO contractors were unable to pay their salaries on time. More often than not, health workers received their salaries late—as much as 4 months late. Consequently, workers were demoralized, turnover increased, and the quality of care decreased. As one health worker put it, "Why work if no pay?" As discussed earlier in this report, some health workers went on strike to protest the late payments, disrupting delivery of health services for several days.

Without steady and timely salary payments to health workers, MoPH could not ensure the continuity and quality of health-care delivery.

> ***Recommendation 4.*** *We recommend that USAID/Afghanistan work with the Ministry of Public Health and the Ministry of Finance to streamline the payment process to accelerate payments to nongovernmental organization contractors and health workers.*

> ***Recommendation 5.*** *We recommend that USAID/Afghanistan work with the Ministry of Public Health and the Ministry of Finance to (1) implement written policies and procedures that clearly define the roles, responsibilities, and approval authorities for the*

payment process and (2) provide further training on the advance/liquidation mode of payment process.

Recommendation 6. *We recommend that USAID/Afghanistan work with the Ministry of Public Health and the Ministry of Finance to implement procedures limiting the frequency of changes made to the payment process and providing sufficient notification and clear instructions to nongovernmental organization contractors on any changes.*

Recommendation 7. *We recommend that USAID/Afghanistan review its internal administrative procedures, such as the processing of implementation letters, to ensure the smooth and timely flow of the payment process for on-budget assistance agreements.*

Program Management Needs to Be Tightened

ADS Chapter 305, "Host Country Contracts," provides policy on USAID-financed host-country contracting, but offers no operational guidance to assist project officers at USAID missions who are implementing on-budget assistance. Considered a best practice during the 1990s when USAID delivered more on-budget assistance, the Agency's *Guidebook for Host Country Contracting Handbook* presents a comprehensive description of the roles and responsibilities of mission personnel managing on-budget assistance activities. With USAID/Afghanistan increasing its on-budget assistance activities, it is critically important for the mission to have clearly defined roles and responsibilities for those managing them.

Because USAID/Afghanistan has limited experience in managing on-budget assistance activities, since July 2008 when the mission signed its first on-budget assistance with the Afghan Government, mission offices have operated in a very "stove-piped," "hands-off" manner. USAID offices have executed their individual responsibilities with great diligence, focusing on oversight, compliance with approval processes for procurements and contractual modifications, and facilitating the financial/payment processes, but have placed somewhat less emphasis on monitoring the results and impacts of assistance activities.

This pattern occurred because USAID/Afghanistan lacked a formal and documented organizational framework that clearly defined roles and responsibilities among the various mission offices for managing on-budget assistance activities. The current setup was an outgrowth of ad hoc processes over the past 2 years. Although Mission Order 201.01 provides guidance on the design and approval of on-budget assistance agreements, it does not provide guidance on specific roles and responsibilities.

For example, the mission lacked an equivalent to a formal AOTR designation letter for managers of on-budget assistance agreements. Issuing a designation letter was a standard USAID practice according to the agency's *Guidebook for Host Country Contracting Handbook*. The handbook states:

> All designations of project officers must be made in writing with both AID/W and the concerned Mission to be informed concurrently of such appointments. This is important in view of the fact that bilateral projects require the closest possible communication and coordination at various stages in the project development and implementation cycle.

According to USAID's PCH program manager, he did not receive a designation letter equivalent to a formal AOTR designation letter or any document clearly defining roles and responsibilities for managing this on-budget agreement. The technical team in the Office of Social Sector Development often referred to its two-page, "Host Country SafeGuards" document, but it offers little guidance for the mission or MoPH.

Additionally, confusion over who responds to MoPH's technical inquiries has led to delayed responses or inadequate feedback from USAID. For example, MoPH asked USAID to provide clarity about performance indicators. However, the Office of Social Sector Development expected that the Office of Program and Project Development would respond to this request, while the Office of Program and Project Development understood this to be the role of the Office of Social Sector Development. As a result, neither office responded, leading to inaccurate reporting.

The mission has not delegated to particular offices or staff members responsibility for helping ministries resolve policy and implementation issues. For example, the Afghan Government's cumbersome system of advance and liquidation payments was well known within USAID. The Office of Social Sector Development believed that the issue required higher-level intervention from the mission director. Meanwhile, the mission's on-budget assistance specialist agreed that higher-level intervention was necessary, but she thought the matter required the ambassador's attention. To date, no mission officials have attempted to resolve this issue.

> ***Recommendation 8.*** *We recommend that USAID/Afghanistan issue a mission order to provide an organizational framework with clearly defined roles and responsibilities of all mission offices responsible for managing on-budget assistance activities.*

> ***Recommendation 9.*** *We recommend that USAID/Afghanistan provide a formal designation letter similar to an officer's technical representative designation letter to staff members monitoring implementation of on-budget assistance agreements.*

Program Lacked an Approved Performance Management Plan

ADS 203.3.2 states that performance management is the systematic process of monitoring the achievements of program operations; collecting and analyzing performance information to track progress toward planned results; using performance information and evaluations to influence assistance objective decision making and resource allocation; and communicating results achieved, or not attained, to advance organizational learning and tell the Agency's story. As defined in ADS 200.6, a performance management plan (PMP) is a tool to plan and manage the process of monitoring, evaluating, and reporting progress toward achieving an assistance objective.

According to USAID/Afghanistan's activity approval document for the PCH program, MoPH was to prepare an appropriate PMP for monitoring and reporting on results within 120 days of countersigning the implementation letter. At the time of the audit, the PCH program did not yet have an approved PMP, almost 3 years after the implementation letter was countersigned.

The lack of an approved PMP happened because the requirement to have one was vague to begin with, and in turn, USAID personnel were unsure about it. Although the mission's activity approval document for the PCH program clearly stated that a PMP was required, the

implementation letter signed with the Afghan Government did not include the requirement. Nevertheless, ADS 203.3.3 states that PMPs must be prepared to assess progress throughout a program.

The mission neither clarified nor followed up on this ambiguity. With no PMP, USAID primarily relied on the PCH program's semiannual and annual reports and annual surveys to monitor progress, yet these documents contained limited performance information to make informed decisions. USAID officials recognized the need to have a PMP for the PCH program and initiated discussions with MoPH on developing one.

> ***Recommendation 10.*** *We recommend that USAID/Afghanistan work with the Ministry of Public Health to prepare a performance management plan for the Partnership Contracts for Health Services program.*

Indicators in Management Information System Were Not Accurate or Complete

USAID/Afghanistan uses a management information system called Afghan Info to track program and project information for all mission-funded activities. The system is to monitor development projects, while maintaining coordination among USAID/Afghanistan, USAID/Washington, Congress, implementing partners, the Afghan Government, and other donors.

According to USAID's PCH program implementation letter, MoPH was to provide at least quarterly updates by entering activity information into Afghan Info over the Internet. USAID was to provide the ministry with an Internet address, a user ID and password, and training on using the system. MoPH was to provide data on ten Aid Effectiveness indicators and GPS coordinates for the ministry's health facilities. MoPH confirmed that it participated in USAID-provided technical training on Afghan Info in October 2010 and completed its first electronic data submission in February 2011.

However, the audit disclosed discrepancies in nine of the ten indicators reported in Afghan Info for the third quarter of fiscal year 2010. Examples follow:

- For the indicator *Number of Afghan graduates/interns hired by the PCH program*, MoPH reported four recent university graduates hired to work on the PCH program. In contrast, USAID defined this indicator as the number of part-time or short-term staff members employed through the PCH program. As a result, the indicator was overstated by four, a difference of 100 percent.

- Similarly, MoPH reported that one American graduate/intern was hired by the PCH program, but in fact none was hired.

- MoPH reported that 6,350 Afghans were employed by the PCH program, but documentation supported only 5,615, a difference of 12 percent.

- The values of nonlocal procurements and the value of procurements were missing and could not be tested.

In addition, as discussed previously, audit testing revealed that most (73 percent) of the health

facilities visited did not have accurate GPS coordinates as reported by MoPH.

These discrepancies occurred largely because MoPH did not understand the data collection and reporting requirements for each indicator. According to MoPH officials, USAID did not provide written definitions of the indicators or timely feedback on the ministry's questions about the indicators. Additionally, the discrepancies could have been identified and corrected by USAID had the mission verified the data reported by MoPH. Mission officials explained that it was unclear who should review and verify the data in Afghan Info—the technical office or the program office that managed Afghan Info.

Recommendation 11. *We recommend that USAID/Afghanistan provide the Ministry of Public Health with clearly written definitions of Afghan Info performance indicators.*

Recommendation 12. *We recommend that USAID/Afghanistan implement procedures to review and verify the accuracy of data entered into Afghan Info and provide timely feedback to users.*

Recommendation 13. *We recommend that USAID/Afghanistan, in collaboration with the Ministry of Public Health, implement a plan to confirm and document accurate GPS coordinates for the ministry's health facilities.*

EVALUATION OF MANAGEMENT COMMENTS

OIG has reviewed the mission's response to the draft report and determined that management decisions have been reached on all recommendations except Recommendation 12. The following paragraphs provide our evaluation of mission comments on each recommendation.

Recommendation 1. The mission agreed to work in collaboration with the Ministry of Public Health to develop and implement a plan that (1) improves the nongovernmental organization contractors' supervision, monitoring, and problem solving at their health facilities and (2) verifies the successful implementation of a reliable quality assurance mechanism by the nongovernmental organization contractors. USAID plans to work with Ministry of Public Health to develop and implement a plan that identifies which elements the nongovernmental organization contractors should address. USAID/Afghanistan will also work with the Ministry of Public Health to ensure that nongovernmental organizations' roles and responsibilities related to quality assurance are clearly defined and articulated and are in line with established guidance on quality assurance . The mission will also work to ensure that the Ministry of Public Health's monitoring plans cover quality assurance issues. The mission intends to implement this plan by February 29, 2012. Based on these actions, a management decision has been reached.

Recommendation 2. The mission agreed to assist the Ministry of Public Health in establishing and implementing a plan to ensure that nongovernmental organization contractors are verifying that the requirement of second person verification is being effectively implemented at health facilities. The mission will work with the Ministry of Public Health to develop a plan to reinforce verification guidelines and to incorporate monitoring of implementation of the verification guidelines into the Ministry of Public Health's facility monitoring plan. The mission anticipates completion and implementation of the plan by March 31, 2012. Based on the proposed action, the mission has reached a management decision.

Recommendation 3. The mission agreed to collaborate with the Ministry of Public Health to (1) identify a pool of qualified civil service employees who would benefit from capacity building training in order to sustain the ministry's capacity for managing the PCH program and (2) provide the training. The mission anticipates working with the Ministry of Public Health to develop a plan to identify and assign civil-service counterparts for training by PCH long-term external advisers. The mission anticipates completing action on this recommendation by March 31, 2012. Based on the proposed action, a management decision has been reached.

Recommendation 4. The mission agreed to work with the Ministry of Public Health and the Ministry of Finance to streamline the payment process to accelerate payments to nongovernmental organization contractors and health workers. Specifically, the mission will conduct an assessment of Ministry of Public Health systems, policies, and procedures and use the results of the assessment to streamline the payment process. The mission intends to complete this task by February 29, 2012. Based on the proposed actions, a management decision has been reached.

Recommendation 5. The mission agreed to work with the Ministry of Public Health and the Ministry of Finance to (1) implement written policies and procedures that clearly define the roles,

responsibilities, and approval authorities for the payment process and (2) provide further training on the advance/liquidation mode of payment. The mission plans to work with the Ministry of Public Health and the Ministry of Finance to implement written policies and procedures covering the payment process. USAID/Afghanistan also plans to provide further training to ministry staff on the advance/liquidation mode of payment. The mission anticipates completing this work by February 29, 2012. Based on the proposed actions, a management decision has been reached.

Recommendation 6. The mission agreed to work with Ministry of Public Health and the Ministry of Finance to implement procedures limiting the frequency of changes made to the payment process and providing sufficient notification and clear instructions to nongovernmental organization contractors on any changes. As mentioned in the response to Recommendation 4, the mission will conduct an assessment of Ministry of Public Health systems, policies, and procedures. The Mission will draw on the results of the assessment in working with Ministry of Public Health and Ministry of Finance to implement policies and procedures regarding changes in the payment process and issuance of instructions on such changes. The mission intends to complete these tasks by February 29, 2012. Based on the proposed actions, a management decision has been reached.

Recommendation 7. The mission agreed to review its internal administrative procedures, such as the processing of implementation letters, to ensure the smooth and timely flow of the payment process for on-budget assistance agreements. The mission anticipates completing this review and modifying its procedures by February 29, 2012. Based on these proposed actions, a management decision has been reached.

Recommendation 8. The mission agreed to issue a mission order to provide an organizational framework with clearly defined roles and responsibilities of all offices responsible for managing on-budget assistance activities. The mission intends to complete this task by February 29, 2012. Based on the proposed actions, a management decision has been reached.

Recommendation 9. The mission agreed to provide a formal designation letter similar to an officer's technical representative designation letter to staff members monitoring implementation of on-budget assistance agreements. The mission will include a provision related to the designation of activity or project managers for government-to-government assistance mechanisms in its revised mission order referred to in Recommendation 8. The mission anticipates completing this mission order by February 29, 2012. Based on the proposed action, a management decision has been reached.

Recommendation 10. The mission agreed with Recommendation 10, which recommended that it work with the Ministry of Public Health to prepare a performance management plan for the PCH program., Work is under way, with a target completion date of March 31, 2012. Based on the proposed action, a management decision has been reached.

Recommendation 11. The mission agreed to provide the Ministry of Public Health with clearly written definitions of Afghan Info performance indicators. The mission will provide the Ministry of Public Health with a list of Afghan Info performance indicators and their associated definitions by February 29, 2012. A management decision has been reached based on this proposed action.

Recommendation 12. The mission agreed to implement procedures to review and verify the accuracy of data entered into Afghan Info and provide timely feedback to users. The mission plans to provide PCH consultants with orientation to and training in utilizing the Afghan Info

database, with a target completion date of February 29, 2012. However, while the training will address the needs of PCH, the mission's actions do not address the verification aspect of the recommendation. Accordingly, a management decision has not been reached.

Recommendation 13. The mission agreed to work with the Ministry of Public Health to implement a plan to confirm and document accurate GPS coordinates for the ministry's health facilities. The mission plans to request implementing partner assistance in updating GPS coordinates for health facilities and in developing a plan for completion of all GPS requirements. The plan is to be completed by February 29, 2012, and the updated GPS coordinates by March 31, 2012. Based on the proposed actions, a management decision has been reached.

SCOPE AND METHODOLOGY

Scope

The OIG/Afghanistan Country Office conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions in accordance with our audit objective. We believe that the evidence obtained provides that reasonable basis.

The objective of the audit was to determine whether MoPH, with USAID/Afghanistan's assistance, was implementing standardized packages of health services that contribute to national health objectives. The audit covered $47 million of on-budget funding provided by USAID/Afghanistan to MoPH for the PCH program.

The audit was performed in Afghanistan from April 17 through June 30, 2011. It covered the period from the start of the program on July 16, 2008, to the end of our fieldwork on June 30, 2011, which was about halfway through the program's 5-year implementation schedule. Fieldwork was conducted at USAID/Afghanistan and MoPH, and because of security restrictions, NGO contractors came to the U.S. Embassy compound for meetings.

Fieldwork also included site visits to 11 judgmentally selected health facilities from the universe of 523 active facilities in 13 provinces. The 11 selected health facilities were managed by four of the ten NGOs contracted by MoPH to implement PCH standardized packages of health services in three provinces. The key factors for selection included the types of health facilities and services, the number of people covered by a health facility, travel logistics, and security considerations. The audit originally selected 16 health facilities in four provinces, but the provincial reconstruction team in Bamyan Province could not support our visit to four health facilities because of other commitments, and a visit to a health facility in Herat Province was cancelled because of a last-minute Embassy Air flight schedule change. Appendix III lists the 11 selected health facilities, NGOs, and provinces visited during the audit. Because the results of our visits to 11 facilities cannot be projected to the entire population of 523 facilities, we limited our conclusions to the facilities we visited.

In planning and performing the audit, we assessed the significant internal controls used by USAID/Afghanistan to monitor program activities, including monitoring and evaluation plans, performance management plans, progress and financial reports, and meetings and other contacts between officials at USAID/Afghanistan and MoPH. We also assessed significant internal controls used by MoPH to monitor its program implementers and health facilities. We reviewed USAID/Afghanistan's Federal Managers' Financial Integrity Act report for fiscal year 2010 and prior audit reports to identify internal control and other issues that could be relevant to the current audit.

Methodology

To answer the audit objective, we interviewed USAID/Afghanistan officials, MoPH staff members, NGO program implementers, health facility workers, and program beneficiaries. We

also analyzed relevant documentation, including contracts and agreements, plans, reports, training agendas and participant lists, and financial records.

During the site visits to health facilities, we verified the implementation of BPHS and EPHS and evaluated whether such activities were contributing to achievement of Afghanistan's national objectives. At each health facility visited, we interviewed workers and patients on the quality of health services provided, reviewed internal controls over HMIS data and reporting, tested a random sample of HMIS reports to assess the accuracy of data reported to MoPH, conducted walk-throughs, evaluated patient management and flow, took photographs, and tested the accuracy of GPS coordinates submitted to USAID.

MANAGEMENT COMMENTS

MEMORANDUM

TO:	Nathan Lokos, OIG/Afghanistan Director
FROM:	S. Ken Yamashita, Mission Director /s/
DATE:	September 19, 2011
SUBJECT:	Audit of USAID/Afghanistan's On-Budget Funding Assistance to the Ministry of Public Health in Support of the Partnership Contracts for Health Services Program (Audit Report No. F-306-11-XXX-P)
REFERENCE:	TCox/KYamashita Memo dated July 23, 2011

Thank you for providing the Mission with the opportunity to review the subject draft audit report. Discussed below are the Mission's comments on the findings and recommendations in the report.

I. General Comments

USAID/Afghanistan is committed to assisting the Islamic Republic of Afghanistan's (GIRoA) Ministry of Public Health (MoPH) to improve the quality of health services in Afghanistan and has supported quality assurance (QA) interventions through the Partnership Contracts for Health (PCH) Project. The PCH Project initiated implementation of host-country contracts in November 2009.

As referenced in the audit report, the MoPH's contract with NGO providers states that:

The three components of quality include the facilities with their equipment and supplies, the technical skills of the health staff, and the quality and adequacy of communications between the health worker and the client.

In line with global best practices and in alignment with the MoPH Improving Quality in Health Care national strategy, USAID-supported quality-assurance interventions at the facility level give primary focus to the second two quality components in order to improve the quality of services provision and processes. That said, USAID/Afghanistan acknowledges structural deficiencies identified in the report exist at MoPH health facilities, and we are working with the

MoPH to address many of these issues, as described below. We must note, however, that several of OIG's findings flow from observations that extend beyond the scope of the PCH project. For example, PCH project requirements do not include the construction or renovation of health facilities. Similarly, at present, the PCH project provides limited funding for expendable facility supplies (e.g., bandages, syringes) and small equipment, but does not fund all non-expendable equipment. Thus, the draft report's reference to a new, unused anesthesia machine is inappropriate, as the machine was provided by an external donor, the United Arab Emirates, and is not an input through the PCH program.

Although many of the OIG's findings in the report fall outside of PCH requirements, the Mission is working with the MoPH to build local capacity to address structural quality issues in ways that are sustainable over the long term. For example, since the MoPH lacks the resources to undertake or contract for large-scale renovations and refurbishments at its health facilities, USAID has begun to encourage the MoPH to mobilize resources from the communities they serve and other donors to meet these needs. The provincial hospital in Paktika province provides one successful example. Hospital management and its community board – comprised of elders and local leaders – agreed to build a needed storage facility for medical supplies by raising funds from the community to meet the resource shortfall, enabling the community to take further ownership of one of its most valuable resources.

In addition, MoPH contractors have raised the issue of the lack of adequate, well-functioning equipment. In response, the Mission is considering including a component within the PCH to authorize the procurement of necessary non-expendable medical equipment, in accordance with the Basic Package of Health Services equipment guidelines.

Staff vacancies at MoPH facilities are a nationwide challenge, as is recruiting qualified female service providers. The Mission is working with MoPH to identify and address the primary reasons for female-provider vacancies and attrition. Current approaches include revision of GIRoA's health-provider salary scales to include allowances and incentives for insecure or remote posts and strengthening recruitment of female providers through community-based midwifery and nursing training programs. Reports by facility staff that their requests for training were ignored by the NGO contractor have to be explored further to confirm whether training requests fell in line with MoPH- and contractor-approved training plans.

Numerous factors cause shortages or stock-outs of pharmaceuticals at MoPH health facilities including the irrational use of drugs and inaccurate forecasting due to increasing patient loads, wastage or leakage. Currently, facility pharmaceutical needs are estimated based on historical patient-utilization data from the Health Management Information System (HMIS). To ensure the ongoing availability of pharmaceutical stocks, the Drug Management Unit (DMU) of USAID's TechServe project conducts regular drug inventory monitoring at health facilities. As a result, over the past 10 months (309 days), on average, PCH health facilities had 7.19 % stock-out of items, which is equal to an average of 2.2 days stock-out of certain drugs per month per health facility. In response, the Mission is providing technical assistance to health providers in rational drug use and is building the capacity of the MoPH and NGOs to perform more-accurate forecasting of drug needs. The drug shortages reported by the audit report would have to be

assessed in more detail to understand factors such as which drugs had shortfalls and over what period of time.

The draft report notes an absence of QA practices in the facilities visited by OIG auditors. USAID/Afghanistan would like to emphasize that through the Health Services Support Project (HSSP), we have helped the MoPH and its contractors establish a QA system at the health-facility level, where the overall goal is to institutionalize a QA system both within the MoPH and within the day-to-day operations of the MoPH health facilities. Currently, 387 facilities (out of a total of 457 eligible BPHS facilities) in the thirteen USAID-supported provinces are implementing QA processes. Facilities are at different stages of implementation and capacity, a point the draft report fails to sufficiently emphasize.

HSSP utilizes several mechanisms to build implementer capacity in QA. This includes the provision of formal training programs, technical support in conducting quality assessments, and on-the-job training in the field based on the gaps identified. To date, quality standards have been developed in the following areas, related to services implemented through the Basic Package of Health Services:

- Birth Spacing/ Family Planning
- Antenatal Care
- Normal Labor and Childbirth
- Postpartum/Postnatal Care
- Management of Maternal Complications
- Sick Newborn Care
- Integrated Management of Childhood Illness
- Expanded Program in Immunization
- Tuberculosis
- Infection Prevention
- Health Facility Management
- Drug Management
- Behavior Change Communication
- Gender

New standards are being developed for other areas, including malaria, nutrition and mental health.

To ensure standards are implemented effectively, the QA process supported by USAID utilizes continual assessments that include:

• **Self-assessments**, which are conducted by individual providers to measure the effectiveness of their own work against expected standards. Providers use the performance assessment tool as a job aid to verify they are adhering to the recommended standardized steps during the provision of care. These assessments can be performed as frequently as desired or needed.

• **Internal assessments**, which are implemented internally by facility staff. These assessments take the form of either peer assessments or internal monitoring assessments, in which managers or providers use the tool more comprehensively to periodically assess the services being provided by staff.
• **External assessments**, which are implemented by persons external to the facility. Representatives from the Provincial Quality Assurance Team (composed of the Provincial Public Health Director, NGO managers, Provincial Health Officers, Provincial Health Advisors, Provincial Coordinators, Afghan Midwifery Association Provincial Representative, and Community Midwifery Education Coordinator) usually conduct these assessments. There are two forms of external assessments conducted by the Provincial QA team:

- **Facilitative supervision,** which is conducted when the purpose of the visit and assessment is to assist in the identification of performance gaps and interventions.
- **Verification assessment,** which is conducted when the purpose of the visit is to confirm compliance with recommended standards of care. In the case of verification assessments, it is desirable that representatives of the clients and communities served are involved in the process in an appropriate way. For example, a representative from the health shura could participate on the team conducting the assessment of the facility. Client feedback (provided during or after the provision of services) might also be considered part of the external assessment of facility performance, and so should be taken into account by providers and managers.

II. Response to Audit Recommendations

Recommendation 1. *We recommend USAID/Afghanistan, in collaboration with the Ministry of Public Health, develop and implement a plan that (1) improves the NGO contractors' supervision, monitoring, and problem-solving at their health facilities; and (2) verifies the successful implementation of a reliable quality assurance mechanism by the NGO contractors, including the establishment of QA committees at each of the health facilities.*

Mission Response: USAID/Afghanistan concurs with this recommendation but would like to reiterate the strategic focus of the current MoPH quality assurance (QA) process that is supported by USAID.

The auditors identified quality in terms of both the physical structures within which providers deliver health care (e.g., overcrowded facilities in poor repair) and the material resources available for health care (e.g., old equipment, insufficient supply of drugs). However, USAID-supported quality assurance interventions at the facility level give primary focus to supporting improvements in service delivery processes and outcomes. This aligns with the MoPH Improving Quality in Health Care (IQHC) Strategy, which aims to enhance clinical practices, provide client-centered services, improve patient outcomes, strengthen data recording and reporting, and build capacity to continuously improve quality.

NGO contractor-led supervision, monitoring and corrective actions are already an integral part of the quality assurance process implemented in PCH facilities. The role of the NGOs, as outlined in the QA field implementation guidance, is to:

- Lead and conduct QA trainings for health providers, NGO managers, and supervisors at the provincial level;
- Participate in and support assessments of health facilities;
- Develop NGO action plans to bridge gaps between actual and desired performance;
- Support facilities in the implementation of interventions to bridge gaps between actual and desired performance, such as resource mobilization (e.g. human resources, materials, infrastructure) and capacity strengthening (e.g., identification of formal trainings for health providers);
- Lead recognition activities for providers implementing quality services at health facility and community level
- Enter, manage, and analyze assessment data into provincial level QA database as well as provide feedback to health facilities based on assessment results.

In line with QA field implementation guidance, responsibility for QA lies at various levels of the health system, including facilities. The facility-level QA teams include a senior representative of the MoPH contractor and a multi-disciplinary team of health facility staff (e.g. head of facility, midwives).

USAID agrees to continue to work with the MoPH to further strengthen and institutionalize the QA process at the facility level to improve clinical and managerial performance and to encourage the MoPH to emphasize a local response to infrastructure improvement. Acknowledging resource constraints, USAID will work with MoPH to identify additional support from the local private sector and communities.

Actions Planned: USAID will work with MoPH to develop and implement a plan. As part of this, a determination will be made regarding: 1) what elements of contractors' supervision, monitoring, and problem-solving identified in the OIG's draft report are not the responsibility of NGO contractors and should be addressed by the MoPH directly and 2) which elements fall within the scope of NGO contracts (including any proposed amendments to the scopes) for the operation and management of health facilities and thus should be addressed by NGO contractors. To further institutionalize QA in the practices of the NGO contractors and based on the exercise described above, USAID Afghanistan will work with the MoPH to ensure that NGO roles and responsibilities related to quality assurance are clearly defined and articulated in the contract and in line with the established QA guidance and are reflected in MoPH monitoring plans.

Target Completion Date: February 29, 2012. The Mission deems that a management decision has been reached on Recommendation 1.

Recommendation 2. *We recommend USAID/Afghanistan assist the Ministry of Public Health in establishing and implementing a plan to ensure that NGO contractors are verifying that the requirement of second person verification is being effectively implemented at health facilities.*

Mission Response: USAID/Afghanistan concurs with this recommendation and fully agrees that accurate data is critical to effectively measure program progress and outcomes.

In response to the audit report's discussion on the use of proxy indicators, USAID/Afghanistan would like to emphasize that, globally, long-term outcome/impact indicators, such as mortality rates, are only collected every 3-5 years due to the cost and complexity of directly measuring such indicators. Thus, proxy indicators are a valid and globally-accepted standard by which Ministries of Health, USAID and other donors use to monitor achievements in health programs. In Afghanistan, USAID has seen a general improvement in proxy output and outcome indicators in the thirteen USAID-supported provinces over the last eight years, and many of these indicators are above the national averages.

Although the auditors identified data errors in 4 of 11 facilities visited, it should be noted that a system is already in place to ensure that data recorded at the facility level is verified by a second person. That said, USAID acknowledges that it is vital to continue to reinforce and institutionalize use of this system through regular training and oversight processes.

The PCH project implements a comprehensive data management system to ensure the validity and quality of data reported throughout the country. The MoPH Health Management Information Systems (HMIS) Department is responsible for the collection, collation and dissemination of routine health information from approximately 2,024 health facilities in 34 provinces nationwide. During the 2nd quarter of 2011, the MoPH reported an impressive national level HMIS submission rate of 87%, while the PCH facility HMIS submission rate was greater than 99%. Procedures for HMIS data collection, processing, reporting and use through a MoPH feedback mechanism are outlined in the HMIS procedure manual and data use manual. As the health system grows in size and complexity and as data needs increase, the MoPH is leading an iterative process to continually improve data collection, quality and use.

In addition to the required check by a second person, there are routine data quality checks at each collation point within the HMIS reporting process:

- At the provincial level, HMIS officers from NGO contractors and Provincial Public Health Officers review the forms submitted by health facilities to verify that the facility manager has signed the form as well as to identify data outliers and data omissions prior to submission to the central MoPH.
- On a quarterly basis, the MoPH HMIS department in Kabul reviews the HMIS data with the PCH Grants and Contract Management Unit (GCMU) and provides feedback to the provincial level.
- On receipt of feedback at the provincial level, the HMIS sub-committee of the Provincial Public Health Coordination Committee reviews MoPH HMIS reports to analyze health facility utilization and data quality, and determines the most appropriate strategies to improve poor performance related to any indicator.

Finally, during routine site visits, PCH project monitors conduct assessments of HMIS data quality (as part of a National Monitoring Checklist (NMC)) by cross-matching monthly activity reports submitted to the MoPH with the source of data at the facility level

In an effort to maintain the relevance and effectiveness of HMIS data in monitoring progress towards targets, during September - October 2010, the HMIS Department conducted a series of surveys to assess conformity with HMIS guidelines and procedures. One survey evaluated data quality for four key national indicators by assessing the collection, collation and dissemination of routine HMIS information in nine health facilities in six provinces. While survey results indicated the need to make a number of adjustments to the HMIS to enhance data accuracy, it is noteworthy to mention that reports from all facilities surveyed by the MoPH HMIS Department were substantiated by clinic records at health facilities. Overall, the survey demonstrated that when compared to health registry and patient records information, monthly report data had a 78% accuracy rate, which is better than or on par with other developing and even middle income countries. USAID/Afghanistan asserts that the MoPH HMIS system provides valid, reliable data as input for programmatic and policy decisions and as stated in the audit report, "HMIS data provides useful data for monitor trends and indentifying gaps and improvements in services."

In addition, annual training of health facility staff on HMIS processes and procedures emphasizes the need to double check data and to review data for outliers prior to report submission. The manager of the health facility is expected to review reports for missing data and other anomalies, note in writing comments regarding significant trends or problems in the catchment area, and dispatch it to the Provincial Public Health Officers (PPHO) within 7 days of the end of each month. Ultimately, each NGO contractor is responsible to ensure the quality and accuracy of the reports submitted from its facilities.

USAID/Afghanistan, in coordination with MoPH, will continue to provide technical assistance to the MoPH HMIS department to conduct annual data quality assessment (DQA) surveys of identified indicators in a sample of facilities. As the DQA survey tool is tested and adopted, NGOs will be required to complete annual data quality checks on a sample of their facilities using this tool.

Actions Planned: By supporting current processes as outlined in HMIS guidelines, USAID agrees to continue to work with the MoPH to ensure its facilities fully comply with the requirement to verify monthly inputs into the HMIS. As indicated by an almost 80% accuracy rate among monthly reports, the procedures in place to ensure accuracy of facility level data are effective and the data is reliable for use in programmatic and policy decisions. However, with the understanding that processes can be strengthened, USAID will work with the MoPH to develop a plan to reinforce verification guidelines and to incorporate monitoring of implementation of the verification guidelines into the MoPH's facility monitoring plan.

Target Completion Date: March 31, 2012. The Mission deems that a management decision has been reached on Recommendation 2.

Recommendation 3. *We recommend USAID/Afghanistan in collaboration with the Ministry of Public Health, develop a plan to (1) identify a pool of qualified civil service employees who would benefit from capacity building training in order to sustain the ministry's capacity for managing the PCH program; and (2) provide the training.*

Mission Comments: USAID/Afghanistan concurs with this recommendation and acknowledges the need to build internal MoPH capacity to plan, implement and monitor the PCH program.

Planned Action: In developing its expanded on-budget program, USAID will work with the MoPH to develop a plan to identify and assign civil-service counterparts for PCH long-term external advisors placed within the MoPH to provide training.

Target Completion Date: March 31, 2012. Based on the above, the Mission deems that a management decision has been reached on Recommendation 3.

Recommendation 4: *We recommend that USAID/Afghanistan work with Ministry of Public Health and Ministry of Finance to streamline the payment process to speed up payments to NGO contractors and health workers.*

Mission Response: USAID/Afghanistan concurs with this recommendation.

Planned Action: USAID/Afghanistan will conduct an assessment of MoPH systems, policies, and procedures. Based on results of the assessment, the Mission will work with the MoPH and the MoF on streamlining the payment process.

Target Completion Date: February 29, 2012

Recommendation 5. *We recommend that USAID/Afghanistan work with Ministry of Public Health and Ministry of Finance to (1) implement written policies and procedures that clearly define the roles, responsibilities, and approval authorities for the payment process; and (2) provide them with further training on the advance/liquidation mode of payment.*

Mission Response: USAID/Afghanistan concurs with this recommendation.

Planned Action: As mentioned in the response to Recommendation 4, USAID/Afghanistan will conduct an assessment of MoPH systems, policies, and procedures. Based on the results of this assessment, USAID/Afghanistan will work with the MoPH and the MoF to implement written policies and procedures of the payment process. As part of this, the Mission will provide further training on the advance/liquidation mode of payment.

Target Completion Date: February 29, 2012

Recommendation 6. *We recommend that USAID/Afghanistan work with the ministry of Public Health and Ministry of Finance to implement procedures limiting the frequency of changes made to the payment process and providing sufficient notification and clear instructions to NGO contractors on any changes.*

Mission Response: USAID/Afghanistan concurs with this recommendation.

Planned Action: As mentioned in the response to Recommendation 4, USAID/Afghanistan will conduct an assessment of MoPH systems, policies, and procedures. Based on the results of this

assessment, USAID/Afghanistan will work with the MoPH and the MoF to implement policies and procedures regarding changes in the payment process and issuance of instructions on such changes.

Target Completion Date: February 29, 2012

Recommendation 7. *We recommend that USAID/Afghanistan review its internal administrative procedures, such as the processing of implementation letters, to ensure the smooth and timely flow of the payment process for on-budget assistance agreements.*

Mission Response: USAID/Afghanistan concurs with this recommendation.

Actions Planned: The Mission will perform a review of its internal administrative procedures and implement changes as deemed appropriate.

Target Completion Date: February 29, 2012

Recommendation 8. *We recommend that USAID/Afghanistan issue a mission order to provide an organizational framework with clearly defined roles and responsibilities of all mission offices responsible for managing on-budget assistance activities.*

Mission Response: The Mission concurs with this recommendation. An organizational framework already exists for managing all Agency activities, ADS 200 Series, in particular ADS 202 (Achieving). This framework applies to projects and activities implemented through a government-to-government assistance mechanism to the same extent as other activities. We do agree additional Mission-specific guidelines are appropriate to supplement Agency-wide requirements, policy and procedures set forth, including the newly issued ADS 220 (Use of Reliable Partner Country Systems for Direct Management and Implementation of Assistance) and existing Mission-specific requirements.

Planned Action: The Mission will develop and issue a new Mission Order to re-confirm existing management and oversight roles and responsibilities for Mission activities, which will includes an explanation of the existing roles and responsibilities for activities implemented under various types of government-to-government assistance mechanisms.

Target Completion Date: February 29, 2012.

Recommendation 9. *We recommend that USAID/Afghanistan provide a formal designation letter similar to an officer's technical representative designation letter to staff monitoring implementation of on-budget assistance agreements.*

Mission Response: USAID/Afghanistan concurs with this recommendation. A Mission technical office director should designate, in writing, a person to serve as the USAID Activity or Project Manager for each activity implemented under a government-to-government assistance mechanism managed by their office. A technical office director also may designate a person to serve as Alternate Activity or Project Manager for such activity. This will be articulated in the Mission Order referred to in our response to Recommendation 8.

Planned Action: See Mission's plan of action for Recommendation 8. The referenced Mission Order will include a provision related to the designation of Activity or Project Managers for government-to-government assistance mechanisms in supplement to ADS 202.3.4.3.

Target Completion Date: February 29, 2012

Recommendation 10. *We recommend that USAID/Afghanistan work with the Ministry of Public Health to prepare a performance management plan for the PCH program.*

Mission Response: The Mission concurs with this recommendation, and work is already underway to finalize a PMP for the PCH program.

Planned Action: The plan is in development and should be completed by the end of the first quarter of CY 2012.

Target Completion Date: March 31, 2012

Recommendation 11. *We recommend that USAID/Afghanistan provide the Ministry of Public Health with clearly written definitions of Afghan Info performance indicators.*

Mission Response: The Mission concurs with this recommendation.

Planned Action: USAID will provide the MoPH with Afghan Info performance indicators and their associated definitions.

Target Completion Date: February 29, 2012

Recommendation 12. *We recommend that USAID/Afghanistan implement procedures to review and verify the accuracy of data entered into Afghan Info and provide timely feedback to users.*

Mission Response: The Mission concurs with this recommendation.

Planned Action: The Mission plans to provide PCH consultants with orientation to and training in utilizing and reporting into Afghan Info database.

Target Completion Date: February 29, 2012

Recommendation 13. *We recommend USAID/Afghanistan in collaboration with the Ministry of Public Health, implement a plan to confirm and document accurate GPS coordinates for the ministry's health facilities.*

Mission Response: The Mission concurs with this recommendation.

Planned Action: The Mission will request implementing partner assistance in updating GPS coordinates for health facilities and work with implementing partners to develop a plan for completion of all GPS requirements.

Target Completion Date: Plan completed by February 29, 2012; GPS coordinates updated by March 31, 2012.

HEALTH FACILITIES VISITED BY AUDITORS

Health Facility	Type	NGO	Province	Date of Visit
1. Qara Bagh Hospital	District Hospital	BRAC	Kabul	May 1, 2011
2. Bagh Alam Clinic	Basic Health Center	BRAC	Kabul	May 1, 2011
3. Kalakan Clinic	Comprehensive Health Center	BRAC	Kabul	May 2, 2011
4. Dako Clinic	Basic Health Center	BRAC	Kabul	May 2, 2011
5. Faizabad Hospital	Provincial Hospital	AKDN	Badakhshan	May 8, 2011
6. Attin Jalaw Clinic	Basic Health Center	CAF/BARAN	Badakhshan	May 9, 2011
7. Samar Qandi Clinic	Basic Health Center	CAF/BARAN	Badakhshan	May 9, 2011
8. Kishim Hospital	District Hospital	CAF/BARAN	Badakhshan	May 9, 2011
9. Minaret Clinic	Comprehensive Health Center	BDN	Herat	May 15, 2011
10. Zenda Jan Clinic	Comprehensive Health Center	BDN	Herat	May 16, 2011
11. Shakiban Clinic	Basic Health Center	BDN	Herat	May 16, 2011

NGO names are as follows:

AKDN Aga Khan Development Network
BARAN Bu Ali Rehabilitation Aid Network
BDN Bakhtar Development Network
BRAC Bangladesh Rural Advancement Committee
CAF Care of Afghan Families

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