Following up the implementation of recommendations in the MEC report 'Vulnerability to Corruption in the Afghan Ministry of Public Health'

Second Quarterly Monitoring Report January 2017

MEC published its analysis of corruption vulnerabilities in the Ministry of Public Health on June 4th, 2016, making 115 recommendations. The Minister, His Excellency Dr. Feroz, supported the analysis, and, in June 2016, established a Working Group comprised of MOPH senior managers and external health sector stakeholders and chaired by Dr. Azimi, General Director of MOPH Policy & Planning.

This is MEC's second follow-up report. The first follow up report, published on 9th November 2016, was not positive. It concluded that after initial activities, progress in several areas had stalled. Further, several of the MOPH claims could not be verified from the information that was provided at the time.

In contrast, over the past 3 months – October, November, December, MOPH has been extremely active, with many interventions initiated. The evidence shows that the momentum has picked up considerably and that finding solutions to the challenges is being taken seriously. The principal progress has been with the National Health and Medical product Regulatory Authority (NHMRA), which has replaced and superseded the General Directorate of Pharmacy. NHMRA has succeeded in implementing and partially implementing a large number of interventions on critical processes and systems that should significantly reduce corruption.

Overall, progress has been good this quarter. The many MOPH staff who are working on implementing these recommendations should be proud of what they are beginning to achieve.

Status of implementation of the recommendations

MEC reviewed the status of all 115 recommendations:

- 14 (12%) have been fully implemented. 8 of these 14 were concentrated in NHMRA (formerly the Pharmacy Directorate) which had been the subject of the 2014 MEC VCA on Pharmaceutical Importation. This 'head start' on implementation of 17 of MEC's earlier recommendations enabled MOPH to demonstrate progress across key areas to reduce risks of corruption. These are detailed below.

- 63 (55%) have been partially implemented. These can be further broken down as follows:
    - 36 started or study underway
    - 12 achieved up to 25%
    - 15 achieved up to 50%

- 36 have not been started, either pending, or for future implementation. MEC has reviewed the reasons for these non-started recommendations. MEC agrees, in all but a few of these cases, that there are good reasons for MOPH going slower on these activities. Interim steps are indeed prudent, some recommendations correctly require specific precursors to be achieved (*establishment* precedes *expansion*, etc.), and there is also reasonable concern about uncontrolled factors leading to limited implementation in the immediate term.

- There are 4 recommendations without discernible action: Number 4, "Engage in a formal liaison and coordination between MOPH and the Attorney General's Office," Number 6.1, "Confront absenteeism during contracted official working times," Number 9, "Conduct a thorough analysis of auditing practices and the systematic management of resources and inventory to prevent embezzlement in the health sector" and Number 10.2, "Make a high profile, clear, and unambiguous statement about the need for transparency in Human Resource recruitment in the health sector." In each of these cases an explanation was offered for inaction, but not a solution.

Status of implementation according to the priority area: systemic issues, integrity issues and leadership issues

Three priority issues were identified in the original MOPH VCA Special Report, with key Recommendations suggested for their implementation.

Implementation to date:

100%	Up to 50%	Up to 25%	Work/Study started	No Activity	(Pending/Future)

Priority Systemic Issues – *From the original MOPH VCA Special Report*

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

Priority Leadership Issues – *From the original MOPH VCA Special Report*

Action	Recommendation Focus	Status of Relevant Recommendations									
Enforce	Controls Over Absenteeism	1.2	10	12	6.1						
Enforce	Controls to Prevent Nepotism and Promote Competency-Based Recruitment	10.1	16	10.2							
Expand	Health Shuras	12	13	14	15	18	9				
Convene	Commission on Health Sector Integrity	15									

Implementation:

100%	Up to 50%	Up to 25%	Work/Study started	No Activity	(Pending/Future)

Priority Integrity Issues – *From the original MOPH VCA Special Report*

Action	Recommendation Focus	Status of Relevant Recommendations									
Enforce	Reliable Pharmacy Importation, Safe Drug Suply	2	17								
Establish	Liaison within the Attorney General's Office	15	16	17	19	4					
Enforce	Authenticity Checks of Certificates and Diplomas	10.1	16								
Enforce	Transparent Private Sector Referrals	1.2	6.2	12	18						
Enforce	Transparent and Effective Grants and Contracts Management Unit	3	7								
Enforce	Control of Assets (especially ambulances)	1.2	8								
Establish	Reliable Audits and Inspections	1.1	10	12	13	16	17	9			

Note: Not all of the 115 Recommendations appear in these tables since some were not applicable to the stated Priority Issues in the original MOPH VCA Special Report.

Significant achievements

1. **Improvements in Pharmacy.** The National Health and Medical product Regulatory Authority (NHMRA), which has replaced and superceded the General Directorate of Pharmacy, has succeeded in implementing and partially implementing a large number of interventions on critical processes and systems:

- Restructured the Pharmacy Directorate into the NHMRA, including reorganization of Departments and revision of 300+ TORs to improve surveillance and oversight capacity.
- NHMRA implemented separate pooled pharmaceutical procurement procedures, including establishment of the Pooled Procurement Management Unit (PPMU) inside MOPH.
- NHMRA introduced conflict of interest language into the Pharmaceutical Law reforms to require disclosure and abstentions for NHMRA's High Level Board and Executive Committee members.
- Initiated links with the Ministry of Information and Communication for an analysis for digitalization of licensing systems for transparency in pharmaceutical licensing and import.
- Established a Pharmacy Council to take actions on professional development pathways, expand training capacity, and increase the number achieving Pharmacy qualifications; 17 sessions of Provincial Field Trainings have now taken place providing 88 days of Pharmacy technical instruction in Balkh, Herat, Kabul, Kandahar, Nangarhar, and Takhar.
- Proposed to AOP that pharmaceutical importation license issuance/renewal be overhauled, including proactive elimination of registrations for producing companies and products not meeting the standards of their home countries; this proposal is still under consideration at AOP (submitted October 2016.)
- Announced RFP for external independent Quality Assurance of pharmaceutical supply through semiannual market surveys.
- National Policy for [Pharmaceutical] Quality Assurance was developed and approved; Pharmaceutical Sampling Guidelines were drafted. TOR for the Sampling Guidelines is in development.
- Entered MOU negotiations with Central Drugs Standard Control Organization (India) to perform external audits for sampling and registration of imported pharmaceuticals.
- Activated plans with international stakeholders for Central Quality Control Lab upgrade, including specialist procurements to enable new surveillance capacities.

2. **Complaints Handling Office (CHO) is functioning**. The CHO have initiated introductions to Kabul public and private hospitals to explain complaint-handling

procedures. The CHO has resolved 120 formal complaints to date. NHMRA also has a well-mapped complaints handling process in place. There is scope for comparing the approaches taken by these two systems and aligning their best functions. MEC has advised CHO and NHMRA to engage directly with GD Public Affairs about profiling successful resolutions of complaints.

3. Tracking key indicators is improving. The status of the General Directorate of Evaluation and Health Information Systems has been approved and now formally authorized within the MOPH management structure. GDEHIS has initiated implementation of the MOPH data warehouse (DHIS2) for health-related data, unifying the sources of health information for decision-making purposes and setting in motion the linkage of MOPH indicators and Key Performance Indicators to the wider Government's performance monitoring activities. Tracking KPIs as part of monitoring and evaluation systems ensures health sector managers can pinpoint and address gaps in performance, improving the quality of care.

4. **Single functionality index for health facilities is operational**. The latest semi-annual independent verification of selected performance indicators calculated percentages of fully functional health facilities in 34 provinces and 7 HIV Harm Reduction Drop-In Centers (DICs) in Kabul, Herat, Balkh and Jalalabad cities. For functionality verification, the percentages of technical staff availability, equipment functionality, and essential drugs availability were calculated. Based on this, a single functionality index was calculated for that facility. In the first half of 1395, the provincial HMIS verification score for BPHS ranged from a minimum of 66.38 % (Daykundi) to a maximum of 97.83% (Wardak), and an average of 86.85%. For EPHS, the provincial HMIS verification composite score had a minimum of 58.27 % (Badghis) and a maximum of 100% (Laghman, Kunar, and Badakhshan.) KIT and SRTRO have made recommendations to improve the verification rates of HMIS data.

4. **Third party monitoring is functioning** is being conducted regularly to verify HMIS data reported from health facilities. According to evidence provided by Focal Points in GDEHIS, the new Minister's Results Unit (MRU) is established and now reporting on strategic Key Performance Indicators in the National Health Strategy (2016-2020); [GDEHIS provided extensive evidence on their work, including official recognition of their status within MOPH, MRU meeting minutes, routine reports from HIS and HMIS data, the *HSR-DHIS2 Orientation Training Report*, and the approved *DHIS2 Implementation Plan.*] The KIT/SRTRO HMIS Verification Report (November 2016) focused on the functionality of BPHS, EPHS, and DIC facilities implemented by NGOs and the MoPH-Strengthening Mechanism.

5. Confidence within MOPH has risen among those with accurate information Staff, Managers, and Directors within MOPH expressed confidence about the steps taken so far, especially compared to remarks from August and September. During interviews, several knew general information about the efforts underway, but expressed reservations about the technical capacity, resources, and political will of the MOPH to carry out the full program of interventions. Those with less information about activities and achievements were the least confident about changes.

6. **The MOPH anti-corruption working group is functioning effectively.** The MOPH Working Group has continued its work in actively supporting the analyses, implementation planning, and integration of activities across the MOPH. Dr Ahmad Jan Naeem provided additional technical direction to the Working Group, as well as through a smaller more focused coordinating group to support the communications between MEC and MOPH Focal Points. MEC continues to work closely with MOPH colleagues, especially colleagues in Dr Naeem's coordinating group, to ensure efficient and effective communication on the status of MEC's recommendations. Named Focal Points responsible for 113 of the 115 recommendations have been assigned by the Working Group, verified, and successfully contacted regarding the status of the implementation of their respective recommendation(s); this was a major deliverable during this period.

7. **Anti-corruption strategy and action plan finalised**. Dr Abdul Qadir Qadir, General Director for Policy and Planning, shared the final version of the drafted *Anti-Corruption Strategy and Action Plan [dated December 2016]*. The *Strategy and Action Plan* demonstrates a through line from MOPH's original three papers[1] on the topic, to the request for MEC's cooperation in the research, through to this call for substantive and fundamental changes and 'quick win' achievements to demonstrate to the community and health sector workforce that MOPH is taking this seriously. The MOPH *Anti-Corruption Strategy and Action Plan* has been submitted for approval. In a noteworthy and positive result, the latest version of the proposed MOPH *Anti-Corruption Strategy and Action Plan* follows the scope and tone of MEC's Recommendations closely. The alignment of MOPH's *Action Plan* with MEC's Recommendations is welcome.

[1] Statement on Corruption (MOPH: April 2015), Statement on Good Governance in the Health Sector (MOPH: April 2015), Briefing Note Number 1 (MOPH, Office of the Minister: June 2015)

Challenges and constraints

Defeating corruption in MOPH is a big task, the recommendations are difficult, and there are major challenges. Foremost amongst these are the anticipated issues of limited financing, limited capacity, low cooperation by some senior officials across the sector, and variable levels of commitment from senior officials.

1. Financial constraints and inflexibility were cited by several Focal Points as limits on their ability. Particularly affected are Finance Director, HMIS expansion, policy translations, Internal Audit Directorate, and an online Training Needs Assessment system. On the positive side, GDHR, GDEHIS and NHMRA have undertaken extensive discussions among donors and other stakeholders regarding options for financial support.

2. Capacity limitations were cited by several Focal Points:

- GDEHIS requires technical capacity and cooperation of Ministry of Information,
- IAD requires senior-most MOPH leadership to develop capacities for engagement with AGO,
- CBHC requires technical consultation with and agreement from the Citizen Charter Working Group to revise the breadth of capacities in the *Shura* TOR,
- IAD requires external financial support to implement its capacity development plan, and
- The Complaints Handling Office is following its approved implementation plan to focus on increasing capacities for managing complaints in implementing agencies.
- The MEC monitoring process has been slowed in a few cases by low cooperation, miscommunications, or weak levels of political will;
    - Focal Point information remained inaccurate in some cases, complicating the gathering of information.
    - Contradictory answers were received in regard to the existence and enforcement of Conflict of Interest policies, with multiple respondents offering plausible explanations (IAD, GDEHIS, GDHR, GDP&P, GCMU.)
    - More than half of Focal Points did not respond on time to requests for proof or evidence of progress for their assigned Recommendations, and several required multiple requests.

3. Resistance and lack of engagement by senior officials. MEC has concerns that pockets of resistance to substantive and fundamental change need stronger and

consistent leadership from the Minister and his senior management team in pursuing and implementing this agenda. Three Kabul-based MOPH Directors described initiatives and actions they were personally involved with, but none could provide information about MOPH achievements outside their own immediate areas of work. Two of the Directors were critical of senior colleagues at MOPH Headquarters regarding actions to promote transparency or reduce corruption; both mentioned the perception of weak political motivation within MOPH as a long-term issue in successfully delivering reforms. The third Director incorrectly claimed that the Recommendations in MEC's MOPH VCA Special Report had been rejected by MOPH.

An NGO Director active in the health sector said that the Ministry leadership was *"in total chaos right now. No one can tell you anything. They are thinking of how to keep their jobs, nothing else."* Another NGO Manager remarked, *"What have they done? I didn't hear any news."* When presented with details from the MEC MOPH VCA Special Report, and MOPH's statements about progress on achieving MEC Recommendations, an NGO Manager commented, *"No one knows anything about this: If I work inside the health sector, and I'm not in the picture about these actions, how will the community be aware?"*

4. Focal point delays. More than half of the Focal Points struggled to send their information on time, even with repeated reminders. A minority did not provide full answers to specific questions about implementation or challenges, and some were unresponsive when asked directly for proof and/or evidence of claims

5. Community members and other stakeholders in the health sector lack information about MOPH anti-corruption actions and remain sceptical

Limited information about what anti-corruption actions have taken place in MOPH means community members and other stakeholders remain highly skeptical. None of the community members interviewed and few NGO and INGO Managers had any information about anti-corruption actions taken by MOPH. A community member told MEC, *"I haven't heard anything good or bad about the MOPH, except they were rejected by the President when he visited them. They must be weak for his decision to do this."* A Provincial *Shura* member remarked, *"MOPH tells us they are concerned about quality but we have no evidence for this. Our inspections of the Provincial Hospital showed that the people are not satisfied."* Despite being heavily engaged in monitoring the Provincial Hospital, the Shura member was not able to identify any specific anti-corruption or quality-focused actions (planned or implemented) from MOPH since the release of the *MEC MOPH VCA Special Report*.

MOPH's internal messaging and external communication to expand understanding, and improve confidence and trust, will be increasingly important parts of MEC monitoring in the coming Quarters.

6. Changes to Health shuras and Citizens Charter causes uncertainty. MOPH had acknowledged that while Health *Shuras* technically exist in each health facility,

and are very active in some areas, the *Shuras* are only moderately active (or inactive) in other places. MOPH has arranged a gap analysis of Health *Shuras* to fully understand the needs, implement remediation, and maximize participation and community engagement. The roll-out of the new Citizens Charter presents some challenges on advancing the proposed scope and participation of Community Health *Shuras* in monitoring Conflict of Interest, public asset usage, complaint handling, etc. The GCMU, CBHC, and GDP&P each expressed willingness to explore modification of the current CHS TOR, a goal aligned in both the MEC Recommendations and the final version of the MOPH *Anti-Corruption Strategy and Action Plan*. An assessment of Community Health Shuras is underway (UNDP, The Global Fund); CBHC will analyze activity levels to plan for expansion to resolve gaps and support strengthening of less-active *Shuras*. MEC has requested all relevant data from the assessment.

7. Trust can only be built slowly. There is an ongoing problem with securing the public's trust and building their confidence. Shifting the public's perceptions will come from both changes in their experience and in the information they get about what is happening and why. MEC encourages that messages about MOPH's trust-building and anti-corruption intervention achievements are shared as widely as and as soon possible. MOPH Public Affairs needs to actively assert control of the messaging, internally and externally, to communicate changes and improvements so the public will be better informed.

8. Communications. Several of the key achievements deserve wider public recognition. Several of the recent interventions have produced positive changes and have the potential to effect public perception as well as the public's routine engagement with the health sector.

9. Current allegations within MOPH. MEC is aware of current allegations about corruption within MOPH, and that some of these are being investigated. MEC nonetheless expects that MOPH will continue to implement the anti-corruption plan and the MEC recommendations with full vigour.

Unresolved issues

1. The **Internal Audit Directorate** has claims of achievements and success *("…enforced penalties for violating the policies against bribery and Conflict of Interest in EPHS and BPHS contracts," "…sent 64 cases to the AGO including some high profile cases"*) but so far IAD has not provided sufficient evidence or details for MEC to understand the extent of these actions, nor their effectiveness.

2. **Conflict of interest**. In the current reporting period, MEC was informed by one Focal Point that *"Policies of Conflict of interest … already exist,"* and another equally senior Focal Point, *"There is no Conflicts of Interest policy. We will develop this."* Both the MEC Recommendations and MOPH *Anti-Corruption Strategy and Action Plan* articulate the need for a Conflicts of Interest policy, and the need to "…ensure

systematic distribution of policies throughout the MOPH hierarchy and among agencies implementing the BPHS and EPHS contracts…" MEC continues to seek proof of a thorough accounting of all current health policies and gaps in policies, and a systematic approach to informing all staff and management of new or revised policies; GDP&P and GDHR are cooperating closely on achieving this .

3. **Working hours.** MOPH leadership has acknowledged that official working hours inside MOPH are controlled by the supervisors in each Directorate, and as yet there are not ready solutions proposed to address absenteeism (within MOPH, and across BPHS and EPHS contracted services sites) and the public's perception of unreliability in the health sector.

The three proposed Commissions

Regarding the proposed three Commissions on integrity, accountability, and accrediting health organisations:

MOPH has made the case to consider that existing entities can address the MEC Recommendations without establishment of any new entities; recent modifications and proposals for modifications to TORs and *Action Plans* indicate that each of these are viable alternatives.

The original MOPH VCA Special Report recommended establishing ***independent*** bodies to address a number of concerns about conflicts of interest, and to assure that transparency would be protected. MOPH is not able to establish wholly independent entities. Alternative approaches have been proposed by MOPH with particular attention paid to preventing conflicts of interest, assuring multi-stakeholder engagement, and an openness to making modifications to TORs of the existing entities.

Based on existing TORs and other official documentation from Focal Points, the goals and objectives of the four MEC-proposed entities could be achieved by the MOPH-proposed alternatives. MEC is not yet convinced that this is a good alternative to its recommendations, and will enquire further on the details over the next quarter.

It will require TORs to be revised and reporting structures clarified:

MEC recommendations	MOPH-proposed alternatives	Compatibility?
Independent Council on Health Sector Auditing and Reporting (ICHSAR)	Afghan Medical Council (AMC) / Afghan Healthcare Accrediting Organization (AHAO)	**Yes**, with revisions to the AMC and AHAO TORs
Independent Commission on Accrediting Healthcare Organizations (ICAHO)	Afghan Healthcare Accrediting Organization (AHAO)	**Yes**, with revisions to the AHAO TOR
High Council on Oversight of Health	Strategic Health Coordination	**Probably**, with revisions to

Sector Integrity (HCOHSI)	Committee (SHCC)	the SHCC TOR and inclusion of additional participants
And a fourth, Health Sector Ombudsman Office (HSOO) <Recommended as an Office *inside* ICHSAR>	Complaints Handling Office (CHO) / NMHRA's Customer Service & Complaints Teams	**Yes**, if the CHO and NHMRA systems are aligned and gaps in coverage and reporting processes resolved.

i) Independent Council on Health Sector Auditing and Reporting (ICHSAR)

Focal Points offered that both the AHAO and the AMC would cover relevant functions in place of MEC's recommended Independent Commission on Accrediting Healthcare Organizations. Based on existing TORs, there may be scope to assign AHAO accrediting responsibilities for *non*-MOPH health facilities and health related practices, with AMC focused on the internal accrediting of MOPH in Kabul and the Provinces.

The GDP&P describes the AHAO as a *"Quality Management and Accreditations system for accrediting health facilities and health related practices in the health sector."* GDP&P, GDHR, GCMU, and CBHC have each affirmed support for the strengthening of accreditations through implementation of the AHAO systems, including proposing alterations to align precisely with the MEC Recommendations and the proposed *MOPH Anti-Corruption Strategy and Action Plan*.

Opportunities to influence the role and remit of the Afghan Medical Council are now being pursued by the key Focal Points concerned with accreditation, monitoring, and information management. Notably, IAD and the GD Procurement have quality accreditations from sources external to MOPH – and other Departments or Directorates may as well. Verifying and collating the external accrediting information to understand how these opportunities may be more broadly applied to the MOPH will be a MEC priority in the next Monitoring period.

ii) Independent Commission on Accrediting Healthcare Organizations (ICAHO)

GDP&P management of the development process through support to the Steering Committee has helped the AHAO to make rapid progress. The GDP&P in cooperation with other Directorates and Departments has initiated changes so that a*ccreditations are systematic and apply to health facilities and health related practices in the health sector."* GDP&P, GDHR, GCMU, and CBHC have each affirmed support for the strengthening of accreditations through implementation of the AHAO systems, including proposing alterations to align precisely with the MEC Recommendations and the proposed *MOPH Anti-Corruption Strategy and Action Plan*. It is not clear if MOPH will submit to AHAO accrediting the MOPH itself regarding its contracting of health service delivery, direct service provision, MOPH management functions (including finance and human resource systems), and achievement of minimum standards. This is still a point of discussion.

iii) High Council on Oversight of Health Sector Integrity (HCOHSI)

The Strategic Health Coordinating Committee (SHCC) has been suggested by MOPH as the alternate entity. The current SHCC TOR emphasizes multi-stakeholder engagement, including with international stakeholders, and now also civil society, to support actions that will rebuild public and donor trust in the MOPH, improve health sector effectiveness, quality of care, transparency, and good governance. Several Focal Points expressed confidence that they can successfully access the SHCC for coordination and support to implement their assigned Recommendations (GDHR, GDP&P, GDEHIS, GCMU, CBHC.)

And a fourth, Health Sector Ombudsman Office (HSOO)

The Complaint Handling Office explained, *"The CHO comes under the umbrella of MOPH therefore it is not possible for the MOPH to establish an independent entity, such as the HSOO, recommended by MEC. If independence as an absolute requirement for this purpose, we request MEC to discuss with higher entities and we will be happy to provide help and support, as and when needed."* The CHO management team has a clearly articulated TOR, action plans, and reports recording their achievements so far. They have also expressed enthusiasm for the fulfillment of their mission and the support they are receiving from MOPH's senior Leadership.

The National Health and Medical product Regulatory Authority's strategy to manage complaints has been devised with a two-track approach: *Customer Service*, and a *Complaints Team*. This effectively channels the two main types of issues brought forward by patients, families, and others to the teams specialized in expediting solutions. They have a sophisticated system of time management for resolving both types of issues: 3-day, 7-day, and 20-day and utilize a multi-stakeholder reporting structure to annually distribute the details about outcomes and comprehensively documenting learned lessons. NHMRA affirmed their plans to alter this detailed reporting to a Quarterly basis.

Next MEC monitoring report

MEC will continue to monitor progress on anti-corruption in MOPH, and will produce its next report at in April 2017.