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PUBLIC EXPENDITURE TRACKING SURVEY (PETS) IN KABUL NATIONAL HOSPITALS

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EXECUTIVE SUMMARY

The Public Expenditure Tracking Survey (PETS) examined the expenditure chain through the various levels of government, from the central to the service provider levels, to identify the effective allocation of resources, assess the fidelity of funds, and determine the extent to which resources actually reach the target groups. The PETS examined the manner, quantity, and timing of the release of resources to different levels of implementation units, particularly to those responsible for the delivery of services. In Afghanistan, the pilot PETS focused on two financial years—2012 (1391) and 2013 (1392). It should be noted that the data for 2012 covered nine months, whereas for 2013, data covered 12 months.

The objective of the pilot PETS in Afghanistan was to track the flow of funds from the central level (from the Ministry of Finance [MoF]) to the Ministry of Public Health (MoPH) to the 16 national hospitals of Kabul city. At each level, the survey investigated the budget processes of preparation, approval, allotment, transfer, utilization, and delays, as well as leakages in the budget process. The survey also looked into the autonomy granted to hospitals for the procurement of drugs and services at the decentralized levels, and challenges in the transition from a centralized to a decentralized procurement system in 2013. The survey also assessed the quality of service delivery, performance of hospitals and health workers, and staff and patient satisfaction.

Budget preparation at MoPH comprises four steps. These are (1) formulation, (2) approval, (3) implementation, and (4) monitoring. MoPH receives the budgeting forms from MoF. The forms pertaining to national hospitals then are disseminated to all of them. After filling out the budget forms, the hospitals send them back to MoPH, where they are compiled and sent to MoF. After MoF gives approval to MoPH, the implementation of the budget begins. MoPH informs the national hospitals of the approved budget. The hospitals then begin implementing the activities planned in the budget. Disbursement of budget funds is done at the beginning of each quarter via direct bank transfers to national hospitals from MoF, after MoPH gives approval based on an expense statement the hospitals submit every month. MoPH plays a monitoring role in the entire process of budget allotment and the national hospitals' utilization/expenditures.

The MoPH core budget consists of the operating budget and the development budget. The operating budget forms part of Afghanistan's general public expenditure; the development budget consists of assistance from various donor agencies to the government of the Islamic Republic of Afghanistan (GoIRA). According to information related to the budget request, the 16 national hospitals are funded through the operating budget component.

The total budget (inclusive of all sectors) of the GoIRA was 133,690 million Afghan afghanis (Afs) in 2012 and 354,077 million Afs in 2013. The government health budget—that is, the MoPH core budget—was 10,488 million Afs in 2012 and 13,221 million Afs in 2013. The actual budget spent was 1,799 million Afs in 2012 and increased to 3,115 million Afs in 2013. One of the indicators of a government's commitment to health in any country is the share of public health expenditure in the country's total public expenditure. The share of MoPH budget as a proportion of total government expenditure was 7.8 percent and 3.8 percent in 2012 and 2013, respectively.

The MoPH development assistance budget was 8,490 million Afs in 2012 and 9,746 million Afs in 2013. The MoPH core budget was 10,488 million Afs in 2012 and 13,221 million Afs in 2013. Regarding the overall budget share, the development budget was 81 percent of the MoPH core budget in 2012 and 74 percent in 2013.

The MoPH operating budget covers not just the central ministry, but also the budget for all of the national hospitals of Kabul and the health departments in the provinces. In 2012, MoPH requested a sum of 1,998

million Afs from the MoF as an operating budget; the MoF approved and allotted this amount. The MoPH's actual expenditure, however, was 1,799 million Afs (90%) in 2012. Similarly, the MoPH's budget request in 2013 was 3,474 million Afs, which the MoF approved and allotted. The MoPH's actual expenditure was 3,115 million Afs (89%) in 2013.

In 2012, 69 percent of the approved MoPH budget was for salaries, 28.3 percent for services, and 3 percent for assets. This changed in 2013, when the share of salaries was 57.1 percent and apparent increases of 38.5 percent in services and 4 percent in assets occurred. The actual expenditure against the approved amount in 2012 showed that 70 percent was for salaries, 28 percent for services, and 2 percent for assets. In 2013, 62 percent of the total expenditure was for salaries, 35 percent for services, and 2 percent for assets.

The trend of budget expenditure was almost the same in 2012 and 2013. In 2012, recurrent expenditure amounted to 98 percent and capital expenditure to 2 percent, whereas in 2012, these percentages were 98.4 percent and 1.6 percent, respectively. Comparing the overall MoPH budget spent with the budget allotted shows that 90 percent of funds were utilized in 2102 and 2013. The rate of expenditure was above 80 percent for salaries and services; for assets, it was 51.2 percent in 2012 and 47.1 percent in 2013.

In 2012, the overall budget request for the 16 hospitals was 591 million Afs; the MoF approved this amount in the budget. Of this, 585 million Afs (99%) were allotted, and the actual amount spent was 533 million Afs—91 percent of the budget allotted. In 2013, the budget request was 1,574 million Afs, and the MoF approved 1,476 million Afs (94%). Of this amount, 1,448 million Afs (98%) comprised the allotted budget and 1,276 million Afs (88%) was the total amount utilized of the allotted budget. Five hospitals— Wazir Akbar Khan, Rabia Balkhi, Indira Gandhi, Malalai, and Esteqlal—each accounted for more than an 8 percent share of the budget in both 2012 and 2013. In comparison, the Dasht-e-Barchi and Ehayaye Mojadad tuberculosis hospitals each have a budget share of less than 3 percent of the total budget. Most of the hospitals had a utilization ratio of more than 80 percent of the approved budget in these two years.

Leakages and Delays

The study found that a shortage of funds was the main challenge at the MoF level, which led to delays in the budget chain down to the hospital level. The delays occurred during MoF's fund approval for the MoPH and in fund disbursement from the MoPH to the national hospitals. Although MoF/MoPH officials reported in discussions that the delays had not hampered the operations of the hospitals, the hospitals reported the delays as a major concern. Budget allotment delays for the national hospitals affect facility operations, especially in service delivery, leading drug stockouts and late contracting of vendors. The survey did not find any major evidence of leakage between approval and allotment at the MoF and MoPH levels. However, instances occurred in which the MoPH was unable to execute the budget of the national hospitals because funds were adjusted away from them and channeled to Presidential funds by Presidential decree. Moreover, the funds allotted by MoPH often were not received by hospitals as per the data; the reason cited was irregular reconciliation of the allotted budget at the hospitals' end due to a gap in communication between them and the MoPH.

Quality and Availability of Financial Data

Budget data often were inconsistent at the national hospital level. There were differences in the budget data between the MoPH and national hospitals for the two study years. Further, as the level of disaggregation of data increased, the availability and consistency of the reported data were limited further. The inconsistency was mainly due to the adjustment of MoPH budget heads at the end of the fiscal year and a lack of communication of these changes to the national hospitals. The unavailability of reliable records was a major constraint, especially on procurement information for goods and services. Many hospitals had little information on the quantities and amounts of procured drugs and services. The

comprehensiveness of data also was an issue; significant gaps existed in how external contributions to hospitals were documented.

The MoF and the MoPH use the Afghanistan Financial Management Information System (AFMIS) for budget processes, but the national hospitals do not. This hampers effective monitoring of expenditures within the hospitals, and between them and the central level.

Hospital Autonomy and Procurement

The national hospitals' autonomy in procuring drugs and services may have led to increased budget utilization in 2013. This has reduced the delay in procurement; each hospital now buys drugs according to its individual need. However, they are not well equipped to handle the procurement process—tender management, quality control, and monitoring of supply chain management. The absence of IT systems for procurement management also works as an impediment to a transparent system.

According to qualitative interviews with hospital directors, autonomy has helped national hospitals improve the quality of health services, since they are able to meet their basic requirements faster.

Human Resources

There has been a substantial increase in the annual patient load in most hospitals—both inpatients and outpatients. The number of service providers has remained the same, however. The hospitals lack adequate nurses and anesthetists. The aggregate number of anesthetists available across the 16 hospitals is much less than the sanctioned number. The available number of nurses also is much less than the recommended nurse-to-bed ratio; this was also highlighted in the *Cost Analysis Study of the National Hospitals* carried out in 2012. The doctors-to-bed ratio, though, is higher because of the presence of students doctors doing their internships at the national hospitals in Kabul. However, the positions of specialist doctors for tertiary care are vacant. During interviews, staff members said they were dissatisfied; they reiterated issues that arose during the previous Balanced Score Card (BSC) survey regarding benefits and allowances, and being rewarded for work.[1]

Recommendations

MoF to MoPH

One of the key issues PETS identified is delay in MoF approval of budget allocations to MoPH, which in turn delays the transfer of funds to the national hospitals. This delay needs to be reduced to streamline the budget processes and improve the flow of funds to the spending units. The budget processes at the MoF level need to be improved to reduce delays in transferring the budget to MoPH. This can be attained by defining the time limit for approving the budget and transferring funds to MoPH from MoF.

MoPH to Hospitals

One of the main requirements for an efficient funding flow at various levels is systematic reporting of expenditure data. PETS found that, although there are systems at the MoPH level, they are not robust enough for continuous monitoring of these data down the line to service delivery points. Thus, the recommendation is to develop a standardized template for capturing expenditure from MoPH to the national hospital level. This will help MoPH to capture expenditure data on a real-time basis and monitor the fund flow to national hospitals. Information on the final budget needs to flow from MoPH to the national hospitals to reduce the inconsistency in expenditure data at the national hospital level.

Along with implementing routine expenditure recording systems and improving two-way communications between MoPH and the national hospitals, building the capacity of staff at the central and hospital levels is necessary. HEFD and experts from MoPH—with the help of development

partners—can develop training modules in the Expenditure Management Information System (EMIS), budget processes, expenditure tracking, financial management information systems, and procurement processes. After developing the training modules, MoPH, along with HEFD, can initiate training for hospital managers and core staff of the national hospitals using the Training-of-Trainers (ToT) mode; the trainers in turn can impart trainings at each national hospital.

Although decentralizing the procurement system has enabled it to be responsive to hospitals' needs, the system needs strategic revamping to make it more effective. Currently, the institutional framework for procurement at the hospital level is weak, and the capacity of hospitals to manage the procurement process is also inadequate. There needs to be standardization of tender processes, including tender documents, a quality control mechanism, and monitoring systems for procurement of drugs and equipment.

A procurement system needs to be put in place for the 16 national hospitals. It should be decentralized regarding finances and distribution but centralized regarding management of procurement. The first step will be to prepare a list of essential medicines and equipment required for the national hospitals. The second step will be demand estimation of each hospital based on the previous year's consumption pattern; this would serve as a benchmark for estimating the current year's consumption level and budget for each hospital.

MoPH should set up a committee to develop a drug purchase policy, quality policy, and tendering process. The committee should empanel suppliers for essential medicines and equipment; these suppliers would need to fulfill the required quality standards fixed by the committee. The national hospitals will procure the medicines and equipment from the empanelled suppliers of MoPH; this will help in enhancing quality, controlling costs, and monitoring the procurement system more effectively. The MoPH procurement directorate should devise a mechanism for a national testing lab for drug quality testing and monitoring to check on the quality of supplies provided by approved vendors. National hospitals can take advantage of economies of scale, improving efficiency in using available funds for procurement while also reducing leakages in the system.

With regard to the quality of services, MoPH must define the service delivery package of each national hospital. Based on these defined service packages, requirements need to be estimated for human resources, hospital equipment, ancillary services, and infrastructure. This will lead to more efficient use of resources. MoPH must also define the service entitlements for the population—that is, the minimum services guaranteed to citizens accessing national hospitals. MoPH should conduct regular monitoring of national hospitals and give feedback to the facilities. Media and civil society organizations also should play an important role in improving service delivery at hospitals.

National Hospital Level

The foremost recommendation is to institutionalize the EMIS at the hospital level to streamline funding flow. Hospitals should generate quarterly reports based on the EMIS, as this will help in monitoring overall expenditure management and monitoring for each line item or budget code. This will also help in identifying the mismatch, if any, of budget codes between the budgets approved from MoPH and those allotted to national hospitals.

With regard to procurement of medicine, the national hospitals should put in place a passbook system for procurement of essential medicines. The system will take into account the current stock of each essential medicine and help in improving drug availability and reducing drug stockouts at the hospital level. Further, this will help to bring about transparency in drug procurement and the demand estimations for essential medicines. Also, all national hospitals should implement Management Information Systems

(MIS) for supply chain management, as this will help in analyzing drug stocks and expenditures at the individual hospital level.

The national hospitals should also implement Human Resources Management Information Systems (HRMIS) for improving the efficiency of existing hospital staff. The main objective of an HRMIS is to create an information base of all employees working in the hospital and details regarding personnel. This will enhance the decision support system of the organization. The system will also help in managing the pay processes of all employees and conducting performance appraisals. In addition, such a system can help in the periodic assessment of the human resources status, reduce absenteeism, and improve monitoring of human resources performance.

With regard to improving service delivery, each hospital should develop a quality policy and management protocols to enhance performance. To improve the patient experience, the national hospitals should institutionalize grievance redressal mechanisms and introduce these at each hospital. A Citizen's Charter, which details the service delivery entitlements and offers scope for feedback, can help in improving the quality of service.

ABBREVIATIONS

AFs	Afghan afghanis (currency)
AFMIS	Afghanistan Financial Management Information System
ALOS	Average Length of Stay
ANC	Antenatal Care
BHC	Basic Health Centre
BIT	Budget Implementation Team
BOR	Bed Occupancy Rate
BPHS	Basic Package of Health Services
BSC	Balanced Score Card
CBR	Crude Birth Rate
CDR	Crude Death Rate
CHC	Comprehensive Health Center
CHWs	Community Health Workers
EMIS	Expenditure Management Information System
FY	Fiscal Year
GCMU	Grants and Contracts Management Unit
GDP	Gross Domestic Product
GoIRA	Government of the Islamic Republic of Afghanistan
HEFD	Health Economics and Financing Directorate
HP	Health Post
HPP	Health Policy Project
HRMIS	Human Resources Management Information System
HSC	Health Sub-centers
IMR	Infant Mortality Rate
MIS	Management Information Systems
MMR	Maternal Mortality Ratio
MoF	Ministry of Finance
MoPH	Ministry of Public Health
NHA	National Health Accounts
Obs & Gyne	Obstetrics and Gynecology
OOP	Out-of-pocket Expenditure
PETS	Public Expenditure Tracking Survey

PH	Provincial Hospital
TFR	Total Fertility Rate
THE	Total Health Expenditure
TOT	Training of Trainers
U-5	Children under five years of age
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development

INTRODUCTION AND BACKGROUND

Delivering quality care requires efficient and equitable use of public resources. It has been observed across many countries how weak expenditure systems and the lack of reliable mechanisms to track and monitor resources lead to poor quality of care. In such cases, health system managers often are not sure if public resources are being used efficiently or if they are even reaching the intended beneficiaries at all. The reason is the disconnection between public spending and its outcomes, as insufficient information is available regarding the flow of resources and their utilization.

Many tools and techniques have been developed over the years to improve the quality of information on the use of public resources and strengthen accountability. The Public Expenditure Tracking Surveys (PETS) emerged in the 1990s. The first systematic PETS was conducted in Uganda in 1996 to determine whether the funds disbursed for the country's primary schools actually reached the schools.

PETS is a tool used for tracking the flow of public resources. The purpose of this PETS is to examine the flow of resources disbursed to 16 national hospitals in Kabul, tracking them from point of origin to point of use. It is an assessment of government planning, allocations, and disbursement of resources and their utilization by the hospitals. The survey thus can help identify glitches in governance and bottlenecks, delays, and leakage of public funds.

PETS is used mainly to accomplish the following:

- Gauge the quality of public services;

- Assess inefficiencies and bottlenecks in public expenditure systems;

- Improve accountability and fill the information gap in public expenditure and resource use by tracing the flow of resources down to the end user; and

- Improve transparency and budget allotments.

Since its initiation in Uganda in 1996, PETS has been implemented in more than 50 countries, a large majority of which are in Africa. Initially, the tool was used mostly in the health and education sectors; over the past decade, its use has broadened to water and sanitation, poverty reduction, agriculture, and other sectors.[2]

The present study was the first PETS in Afghanistan; it was conducted in 16 national hospitals in Kabul.

Rationale

Afghanistan's Hospital Sector Strategy (2011) recognized the vital role of secondary and tertiary care hospitals located in Kabul but said that the country's national and specialty hospitals are severely underfunded, undersupplied, and lack resources. It also indicated that the donor support for these facilities is limited. This policy document further pointed out a scarcity of drugs, medical supplies, and utilities in the national hospitals. As a result, it found that their quality of care is poor and the hospital-based health services inadequate.[3]

According to Afghanistan's National Health Accounts (NHA) report, 24 percent of the total health expenditure (THE) occurred at the hospital level; 73 percent of the total health expenditure is paid by the patients as out-of-pocket expenditures (OOP) at the time of receiving care. The Health Care Financing and Sustainability Strategy of the Ministry of Public Health (MoPH) has outlined low per-capita public health expenditure and limited data as challenges hindering informed health financing decisions.

As a first step toward efficiency, Afghanistan's Hospital Sector Strategy gave greater autonomy to the national hospitals, making them fully autonomous state-owned institutions. In 2012, the government granted partial autonomy to 14 national hospitals through release of untied funds; in 2013, 15 national hospitals became fully autonomous, with full control over procurement of material resources.

The MoPH and Health Policy Project (HPP) decided to carry out a pilot PETS of 16 national hospitals for fiscal years (FY) 2012 (1392) and 2013 (1392); of these, 15 received full autonomy in 2012.

Objective

This PETS sought to measure the extent to which nationally allocated resources reach the target—in this case, the national hospitals.

The PETS had the following objectives:

- Assess the process and procedures involved in the budget for the national hospitals—planning, approval, disbursement, and allotment;

- Determine the reasons for delay in allotment of the budget at each step;

- Identify leakages, if any, or diversions of fund flow;

- Determine how much of the approved funds are spent on the service delivery units for which they are intended; and

- Assess the impact of budget allotment delays and possible leakages on the adequacy and efficiency of resources, and the quantity and quality of service delivery at the national hospitals.

The PETS was aimed at capturing the reality on the ground with regard to hospital efficiency as a precursor to creating cost-effective mechanisms of public accountability.

METHODOLOGY

Study Approach

PETS was intended to track the flow of public resources, both funds and materials, from the highest levels of government (MoF) to the service providers (national hospitals) as they pass through the administrative hierarchy. The key purpose was to determine how much of the originally approved resources reach each level and how long they take to get there. This involved assessing and evaluating the budgeting process—planning, approval, disbursement, and implementation—and then assessing the impact of the budget.

The survey first assessed:

1. The inputs
2. The process
3. The outputs

Figure 1: Elements Assessed to Evaluate the Budgeting Process

INPUT – Resources   PROCESS and PROCEDURES   OUTPUT
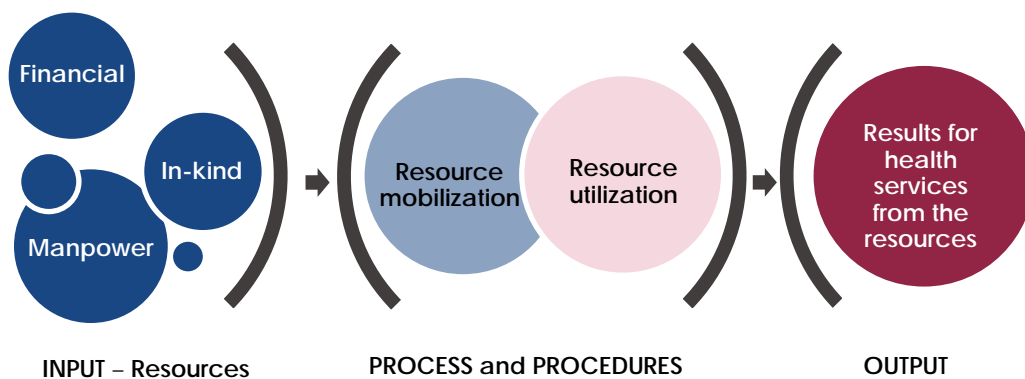
Essentially, there are three components of PETS:

1. Tracking, which seeks to assess delays and gaps in the allotment of the approved budget for national hospitals
2. Identifying leakages of financial resources, if any from point of origin through the intermediary administrative levels in MoPH to the national hospitals
3. Assessing the impact of delays and leakages on health services

Tracking the overall budget

For the Afghanistan PETS, this meant tracing expenditures against financial transfers through different levels in the system—from MoF through MoPH to the point of final receipt at the national hospitals. The survey thus covered the budget request, budget approval, budget disbursement, and budget spent.

Tracking the procurement budget

This meant tracking the fund flow for procurement by the hospitals, starting at the central level down to the hospital level, as well as the procurement process followed in the hospitals.

Delays and shortfalls in budget allotment

This measured delays and leakages by recording the date and amount of financial approvals. The surveyors then aligned these with the amounts received and when they were received at each point through which the resource passed until it reached the individual facility.

This component also examined the bottlenecks in the disbursement of approved resources for salaries, allowances, materials, equipment, drugs, vaccines, and so on, as these have an impact on quality of services and staff morale.

Leakages in approved budget

Leakage of financial resources is the share of resources intended for but not received by the front-line provider.[2]

This component measured the amount of the in-and-out flow of resources at each hierarchical level of distribution, from their origin in MoF through the intermediary administrative levels in MoPH to the national hospitals. The survey then triangulated the data to assess leakages of financial resources, delays, and other factors affecting efficiency in the movement of resources.

In particular, the survey looks into the following:

1. Leakages between MoF and MoPH
2. Leakages between MoPH and the national hospitals

Leakage is calculated as the percentage of budgeted funding reaching the point of services.

Impact of delays and leakages on health service delivery

This component examines the key performance indicators of the national hospitals to:

1. Analyze the impact of delays and leakages on budget allotment; and
2. Assess the quality of health service, including the structural input of the hospitals, process of service delivery, and patient and staff satisfaction.

Delays and leakages in financial resources lead to poor planning, stockouts of drugs and consumables, improper maintenance of equipment, low staff morale, and legal issues. All of these affect quality of care and add to the burden of morbidity and mortality.

Methodology

The study used a mix of both quantitative and qualitative research methods. This included collection of primary and secondary data.

- **Primary data collection**: These include both qualitative and quantitative data. Surveyors collected primary data from the selected hospitals on hospital characteristics, human resources, procurement, financing, institutional mechanisms, service delivery, and systems of accountability. They also interviewed doctors, nurses, midwives, technicians, and patients. The study also included stakeholders—key personnel from MoF and MoPH, donors, and community representatives.

- **Secondary data collection**: The study used existing data from the Balanced Score Card (BSC) to analyze patient satisfaction for 11 national hospitals.

Study area, sampling strategy, and sample size

The study was conducted in Kabul; 16 national hospitals were selected from a total of 20 in the city (Annexure – Table 25). The selection was made using a purposive sampling technique, as the national hospitals do not have uniform characteristics, making comparative analysis difficult.

Study respondents, study technique, study tools, and ethical considerations

The following respondents were selected for PETS:

- **National hospitals**: Respondents were selected as a source of quantitative and qualitative data at each of the 16 national hospitals.

  - *Hospital management* – Surveyors interviewed hospital directors/key management personnel who have responsibilities for and access to financial information. The survey gathered information on hospital characteristics from direct on-site observation and review of hospital data.

    Study tool – The survey used a semi-structured interview schedule (Module 1: Hospital management). The schedule contained questions related to hospital characteristics, human resources, financing for 2012 and 2013, and service delivery and utilization.

    Surveyors followed an in-depth interview guide (Qualitative 5: Stakeholder ─ hospital management) to conduct interviews of hospital directors so as to understand the budget spending process, delays and leakages and their possible reasons, quality of service provided, the role of MoPH in supervision and monitoring, key challenges met, and recommendations.

  - *Health facility staff* – Health facility staff, including doctors, nurses, midwives, and technicians, were selected randomly from each hospital. A total of 320 health facility staff members were to be interviewed, including 20 from each hospital. Of these, 317 health facility staff members were interviewed, including 17 staff members from the Tuberculosis Hospital, 19 each from Ehayaye Mojadad, Jamhoriat, and Wazir Akbar Khan Hospitals, 21 from Dasht-e-Barchi Hospital, 22 from the Mental Health Hospital, and 20 staff members from each of the remaining 10 hospitals. These 317 health facility staff members included 55 management personnel, 55 doctors, 56 nurses, 25 pharmacists, 58 health technicians, nine midwives, and 59 support staff. No minors, other than patients, were included in the survey.

    Study tool – A structured interview schedule (Module 2: Health facility staff) was used to collect information related to compensation, benefits, salary structure, delays in receiving salary, supervision, and staff satisfaction.

  - *Hospital procurement staff* – The key purpose of interviewing the hospital procurement staff was to understand the procurement system and financing related to procurement for 2012 and 2013. Surveyors administered a questionnaire to each hospital.

    Study tool – Interviewers structured interview schedule (Module 3: Hospital procurement) was administered to gather information related to the procurement budget, procurement system, drugs and consumables procured, and delays.

  - *Patients* – The survey included interviews with both inpatients and outpatients. The outpatient exit interviews were classified further as Under-5 (U-5) and Over-5 years to capture services for children. Interviews with patients were conducted at only five national hospitals; for the remaining 11 hospitals, the study used the 2011–2012 BSC Balanced Score Card data. The respondents to the U-5 category were parents/caregivers who accompanied the patient to the hospital.

Study tools – Surveyors used structured interview schedules (Module 4: Exit interview-U-5, Module 5: Exit interview-Over 5; Module 6: Inpatient interview) for the interviews with patients. The purpose was to gather information related to patient satisfaction and perception of the quality of care received.

- **MoF, MoPH, and other stakeholders**: Surveyors interviewed key management personnel from MoF and MoPH and other stakeholders, including donors and community representatives. The Health Economics and Financing Directorate (HEFD) of MoPH identified the respondents in the respective government ministries and the community. A total of 23 persons were contacted, but only 19 could be interviewed. Surveyors conducted these recorded interviews in Dari; the transcripts then were translated into English.

A detailed list of the respondents selected for qualitative and quantitative data collection is given below:

- *MoF* – Three senior management personnel were selected from MoF and the Budget Directorate. The purpose was to understand the budgeting process and collect information about the budget.

  Study tools – The study used both qualitative and quantitative research tools (Qualitative 2: MoF; Module 8: MoF). An in-depth interview guide was administered to the Deputy Minister for Finance, the General Director of Finance, and the Director of Budget and Reform to understand the interaction between MoF and MoPH. In addition, surveyors used a structured interview schedule for information related to the government budget, the budget as related to MoPH, and leakages and delays.

- *MoPH* – Surveyors conducted nine qualitative interviews with the Deputy Ministers of MOPH, and government officials from the General Directorate of Policy and Planning, HEFD, the Procurement Department, and the Finance Department. Moreover, they conducted two quantitative interviews at the Procurement and Finance Department of MoPH.

  Study tools – The team conducted qualitative interviews using an in-depth interview schedule (Qualitative 1: MoPH) and a structured questionnaire (Module 7: MoPH Procurement, Module 9: MoPH Finance). Surveyors administered these tools to Procurement and Finance Department personnel.

- *Other Stakeholders* – Other stakeholders who were involved in the survey included representatives from Parliament, public-private partnership stakeholders, the Afghanistan Private Hospitals Association, the Kabul Provincial Council, the United States Agency for International Development (USAID), and the European Commission. The purpose was to understand the budgeting process of donors, possible delays and leakages, and quality of services delivered by the national hospitals.

  Study tool – An in-depth interview schedule (Qualitative 3: Stakeholders, Donors) was administered to the stakeholders.

Surveyors provided a written consent form to all of the survey participants before the interviews; whenever required, the interviewer read the consent form to the participant. Once a participant made up his/her mind to be part of the study, the interviewer obtained verbal consent and signed the form as a witness to the consent. They conducted the interviews at the convenience of participants. See Annexure Tables 26 and 27 for the list of key respondents.

Recruitment and training of field team

The data collection team was selected with support from two research organizations in Kabul—the Organization of Fast Relief & Development and the Health Protection and Research Organization. These organizations have experience in facility-based data collection in Afghanistan. Medica Synergie facilitated the training of data collectors, along with the Health Policy Project (HPP) and the HEFD of MoPH. The data collectors went through three days of rigorous classroom training on December 1–2 and 7, 2013. On December 3, 2013, Medica Synergie and the research team conducted field testing of the survey tools in the Central Polyclinic, which was not included in the sample of 16 national hospitals.

The training methods were a mix of presentations and exercises. The classroom training stressed conceptual understanding of PETS and a thorough understanding of the different questionnaires, respondents, stakeholders, and the MoPH budgeting system for the national hospitals. Field testing allowed for fine-tuning of the toolkit to make it more country specific and provided hands-on training to the data collectors. The team was trained on both English and Dari versions of the toolkit.

Thereafter, a two-day training was arranged for five data entry personnel on December 9 and 10, 2013. The first day of training covered the toolkits and the Epi data software; the second day introduced data entry interfaces created using the tools. Trainers then used filled-in questionnaires to give hands-on training on data entry.

Picture 1: Training and Pilot Testing of Study Tools

Photos by Health Policy Project

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Data collection

The data collection in the 16 national hospitals started on December 9, 2013 and continued until January 1, 2014; the interviews with MoF, MoPH personnel, and donors took place between December 9, 2013 and January 4, 2014.

Two teams were formed to collect data from the 16 national hospitals. Each team comprised one supervisor and three data collectors. These teams gathered data related to the facility, procurement, staff, and patients. An additional person was assigned to conduct the qualitative interviews with hospital directors across all of the 16 hospitals. A team of three members was formed to conduct interviews and collect the required information from the two ministries and the other stakeholders.

The toolkit used for data collection at the hospitals, MoPH, and MoF was in Dari.

Data entry, verification, and analysis

The quantitative data entry began on December 11, 2013 and continued until January 4, 2014. The team members entered quantitative data in Epi data software, within which they applied the principles of "controlled data entry." Thereafter, valid values, value labels, ranges, and checks for each variable were specified to get a warning during data entry if a team member entered any outlier. SPSS software then was used to clean and analyze the quantitative data, whereas the qualitative data were subjected to content analysis.

Data verification and validation, Stage I ─ As a first stage of data verification, the data collection team identified key PETS indicators and collected and triangulated the relevant information from various sources. These included the national hospitals (Module 1), MoPH (Module 9), and MoF (Module 8). Further, the data related to financial resources were shared with the finance personnel of the 16 national hospitals and with identified data point persons in MoPH and MoF to validate and confirm the information collected via email and/or telephone.

Data verification and validation Stage II ─ The consultants from the Medica Synergie team visited Kabul to verify and validate the data pertaining to key PETS indicators. Consultants met with HPP staff to chart out the plan of action and discuss any issues that still existed. Along with HPP staff, the consultants met with the HEFD team. The Medica data from all the levels (MoF, MoPH, and the 16 national hospitals) were shared and compared to the HEFD data. The data matched with only insignificant differences; however, outliers did exist. The consultants and staff discussed the outliers. The approach adopted to address the challenges is charted out below.

Efforts to Address Challenges

The efforts made to address existing challenges regarding the data were as follows:

- MoF-level data were verified with an official from MoF. He directed the Medica team that surveyed the finance personnel of MoF. As a means of verification, the MoF data drew from the Budget Expenditure Report collected from MoF. The figures for the allotted and approved budget were substantially different from those included in earlier versions of the data.

- MOPH-level data were verified through a joint meeting with two officials from MoPH. They shared the MoPH total annual budget and expenditures, the core budget, the developing budget (which had been unavailable earlier), and the 2012 and 2013 budget details for the 16 national hospitals, as consolidated at MoPH. The MOPH final budget expenditure statement by the Finance Directorate, MoPH, was collected as a means of verification.

- Differences between hospital- and MoPH-level consolidated data existed. The team used as a benchmark the data collected from MoPH for the 16 national hospitals. To validate the 2013

budget figures of the hospitals, a meeting was organized with financial representatives from the hospitals at MOPH. The finance representatives gave hospital budget details for the year 2013, supported the data with documentation, and signed off on behalf of the hospital directors. In more than 80 percent of the cases, the expense data reported by hospitals for 2013 were higher than the expense data received from MoPH.

- For 2012 budget details, survey personnel revisited all 16 national hospitals and met with the hospital directors by appointment. The hospitals had different versions of expense statements for 2012 and failed to provide a final statement. Medica Consultants used the documents received from MoPH to identify a final statement of expenses from the hospitals. The documents were collected as a means of verification.

- To identify the reasons behind the differences in MoPH and national hospital-level data, a meeting was organized at MOPH to discuss the issue of these budget data variances. The differences between the MoPH and hospital data were attributable mostly to reallocation of the funds by MoPH from the hospital budgets that were not subsequently recorded at the hospital level; hence, the hospitals showed higher budgetary approval and spending figures compared to the MoPH numbers.

Challenges

- The study was conducted for two fiscal years—2012 and 2013. In 2012, the system of financing national hospitals underwent a change. As a step toward autonomy and decentralization, the national hospitals were given a limited amount of untied funds to spend on their own. This financial year comprised nine months. In 2013, the national hospitals were given full autonomy to manage their finances and procurement; this fiscal year comprised 12 months. Hence, the data may not be sufficient to establish trends between the two years and explain any significant changes in the pattern of budget and expenditures.

- The survey was conducted via predesigned, standardized PETS questionnaires (qualitative and quantitative) customized by HEFD and HPP in the country context, with simultaneous implementation. The qualitative tools have limitations in seeking explanations for the findings from the survey. Nevertheless, the purpose of the qualitative assessment was to understand the existing budget processes, perceptions of delays and leakages, and experiences during the hospital autonomy process. To obtain explanations for questions arising from the survey results, the qualitative assessment ideally would have been conducted after the survey results became available. Due to time and resource constraints, this was not possible.

- Non-availability of reliable sources of data at the collection points and inconsistency in the existing data at different levels were two of the challenges in the data collection process and analysis.

PROFILE OF THE AFGHANISTAN HEALTH SYSTEM

Afghanistan Health System

In March 2003, the MoPH of Afghanistan released the Basic Package of Health Services (BPHS)—the culmination of a process that determined priority health services for addressing the people's most immediate needs. The BPHS is offered for the four standard types of Afghanistan health facilities—Health Posts (HPs), Basic Health Centers (BHCs), Comprehensive Health Centers (CHCs), and District Hospitals (DHs).

HPs operate at the grassroots/community level; community health workers (CHWs) offer basic healthcare at these facilities. HPs cover a catchment area of 1,000 to 1,500 people in 100 to 150 families; ideally, they are staffed by one male and one female CHW. CHWs offer limited curative care. This package includes diagnosis and treatment of malaria, diarrhea, and acute respiratory infections (ARI); preventive care—family planning services, Directly Observed Treatment, the Short-course (DOTS) for the treatment of tuberculosis (TB); and health awareness.

A notch above HPs are the Health Sub-centers (HSCs), intended to increase access to health services for under-served populations residing in remote areas. These cover a population of about 3,000 to 7,000. Ideally, HSCs are staffed by a male nurse, a community midwife, and a cleaner/guard. These facilities provide health education, immunization, antenatal care (ANC), family planning services, TB case detection and referral, follow-up on TB cases, and treatment of such diseases as diarrhea and pneumonia.

The BHCs operate at a higher level in the healthcare system. They offer the same services as an HSC, but with more complex outpatient care. Usually they are staffed by a nurse, a CHW, and two vaccinators, and cover a population of 15,000–30,000. However, depending on the services being provided, two additional healthcare workers may be appointed. Next are the CHCs, serving a population of 30,000 to 100,000. CHCs are staffed by a male and female doctor, along with male and female nurses, midwives, laboratory technicians, and a pharmacist. Besides outpatient services, the CHCs have inpatient facilities and laboratory services. At the top are the DHs, which provide all of the services of the BPHS. These facilities cover a population of approximately 100,000 to 300,000 residing in one to four districts. DHs are intended to have a staff of a female obstetrician/gynecologist, a surgeon, an anesthetist, a pediatrician, midwives, laboratory and X-ray technicians, a pharmacist, a dentist, and a dental technician.

In 2005, the essential package of hospital services (EPHS) was modeled to complement BPHS and support the referral system. EPHS identified the following elements for each level of hospitals to standardize needed inputs or resources:

- Diagnostics and treatment for various conditions
- Diagnostic tests
- Staffing
- Equipment and supplies
- Essential drugs

For a second line of referral, the Provincial Public Healthcare System has the Provincial Hospitals (PHs), which are the final referral point for patients referred from the districts; however, if required, a PH may refer patients to higher-level facilities, such as Regional Hospitals (RHs) or specialty/national hospitals.

The national/specialty hospitals are intended to be the referral point for secondary and tertiary care, and are required to adhere to EPHS norms as a minimum level of care in each service area they provided. These hospitals are located mainly in Kabul.

Picture 2: Healthcare Delivery System of Afghanistan
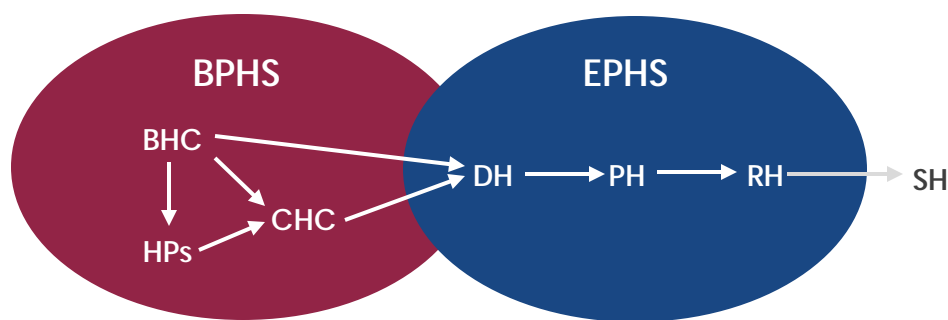
The healthcare system, especially in the hospital sector, has had to face several devastating challenges and instability, resulting in repeated interruptions of its operation and management. However, in recent times, substantial progress has been in making healthcare more accessible across the country. The THE has increased, and people's general health status has improved markedly.

Demography[4]

The estimated population of Afghanistan is 26,955,000, of which 1,459,000 are nomadic peoples. The male population is 13,850,000, and the female population 13,105,000, with an overall sex ratio of 106 males per 100 females. Of the total population, 22.7 percent is settled in urban areas, and 71.8 percent is in rural areas. The estimated decadal population growth rate is 2.03 percent.

The age-sex population pyramid of Afghanistan shows a very young nation, with 48.4 percent (13 million) under 15 years, whereas older people—65 years and above—represent only 2.5 percent of the total population; this signifies a high ratio of dependency.

With a total fertility rate (TFR) of 5.0 and a crude birth rate (CBR) of 35.6 per 1,000 population, the next three to five decades will see an exponential increase in population in the economically productive age group of 25–54 years and also an increase in the aging population, indicating the need for greater investment in healthcare. The average household size of the country now is 7.4.

Table 1: Demography of Afghanistan

Indicator	Number
Total population (in thousands)[4]	26,955
Male	13,850
Female	13,105
Sex Ratio[4]	106
Population Growth Rate	2.03%
Average Household Size	7.4
TFR[5]	**5.0**
CBR[5]	**35.6/1000**
CDR[5]	**8.1/1000**
Literacy[4]	**31.4**
Male	45.4
Female	17.0

Adult literacy rates in Afghanistan are very low; only 31.4 percent of the population is literate; literacy among women is drastically lower, at 17.0 percent, compared to 45.4 percent among men.

Health Status Indicators

Providing required healthcare services is challenging for countries globally, irrespective of their economy. Developed nations like the United States and United Kingdom are facing the challenges of ever increasing healthcare costs, long waiting periods for services, and the need for alternative financing mechanisms; developing nations are contending with infrastructure deficiency and the dual challenges of catering to the healthcare needs generated by both communicable and non-communicable diseases. Afghanistan is in the latter category, having a multitude of challenges, such as the following:

- Lack of adequate infrastructure

- Lack of sufficient funds to finance infrastructure and facility operations

- Lack of skilled human resources

- Lack of medicine and consumable supplies

- Burden of communicable and non-communicable diseases

- Low-capacity of population to pay for health services and lack of alternative payment mechanisms

- Lack of policies and integrated healthcare programs

Table 2: Health Indicators of Afghanistan

Health Indicators of Afghanistan	
Maternal Mortality Ratio[4]	1,600
IMR[4]	48
Under-5 Mortality Rate[4]	91
Neonatal Mortality Rate[6]	40
Full ANC Coverage (4 visits) %[4]	9.9
At Least One ANC Coverage %[4]	51.2
Immunization Coverage (12–23 months) %[7]	18
Institutional Delivery (%)[4]	36
Underweight (%)[7]	31.2

These challenges necessitate rigorous healthcare reforms. The country's political issues further strain the situation. However, the Afghanistan government, with support from international agencies, has been striving to implement reforms that may change the nation's healthcare landscape.

Good health is positively correlated with a country's economic development, and access to healthcare, nutrition, and clean water remains severely limited in Afghanistan. All health-related indicators, including access to healthcare; care of pregnant women; immunization coverage; and nutrition, morbidity, and mortality rates are significantly behind those of other low-income developing countries in the region. One Afghan woman dies approximately every two hours from pregnancy-related causes[5]. Child mortality continues to be high in Afghanistan, although there has been a marked decline in the past decade.

Health Workforce

Shortage in the healthcare workforce is common globally; it is critical in areas with poor health indicators. The *Health Workforce Plan 2012–16*[8] of Afghanistan reported that the ratio of qualified health workers, including management/technical support and volunteer community health workers, is only 22 per 10,000 population. Moreover, the available number of doctors, nurses, and midwives (combined) is as low as 7.26 per 10,000 people—far below the required number of 23, as recommended by the World Health Organization (WHO).

The limited available healthcare workforce is concentrated mainly in urban areas; rural areas are reported to have only 16.7 public health workers (including unqualified support staff), compared to 36 workers per 10,000 people in urban areas.

Socioeconomic Trends

Afghanistan is a landlocked country with a high dependency on foreign aid. Much of the population continues to suffer from shortages of housing, clean water, electricity, medical care, and jobs.

Lack of infrastructure and ever-increasing security concerns pose huge challenges to future economic growth. As a result, Afghanistan's living standards are among the lowest in the world.

Table 3: Socioeconomic indicators of Afghanistan

Socioeconomic Indicators of Afghanistan[9]	
GDP (million Afs)	1,028,111
Economy Growth	9.8%
Per Capita Income (US$)	640

Health Financing in Afghanistan

The healthcare system of Afghanistan has undergone significant transition over the years. The performance of Afghanistan's economy also has improved, and total health spending rose significantly between 2002 and 2008, from 4.7 percent of gross domestic product (GDP) to 7.0 percent.[10]

The major financiers of Afghanistan's health system, as reported in NHA 2011–12, are private sources, which contribute nearly three-quarters of the THE (73.6%), followed by funding from the rest of the world, accounting for nearly 21 percent of the THE. However, central government financing was as low as 5.6 percent of the health expenditure in 2011–12.

OOP constitutes the highest proportion of the total health expenditure, as per NHA 2011–12. As reported, the OOP contribution showed a slight decrease from 75 percent of THE in 2009–10. However, the total spending actually increased from US$787,076,258 to US$1,099,542,464. High levels of OOP discourage individuals, particularly the poor and vulnerable, from seeking healthcare. As a result, this may increase the incidence of disease and cause other adverse health conditions and delays in treatment, allowing conditions to worsen over time and driving up costs further.

Afghanistan's National Strategy on Healthcare Financing and Sustainability 2009–2014 has highlighted the pressing need to introduce financial risk protection mechanisms to control surging OOP. Risk pooling through insurance can lower some financial barriers and, in the process, increase access to services by ensuring that all members of the pool—individuals of varying degrees of health status—contribute to the financial resources needed to cover the costs of health services. With no current health insurance or risk-pooling system in place, private expenditure on health consist almost entirely of out-of pocket payments made at the time of service use.

OVERVIEW OF THE HEALTH BUDGET IN AFGHANISTAN

This section deals with the overall health budget of Afghanistan, the budget process, and an analysis of the fund flow from MoF to MoPH during the survey period. This section also highlights the composition of the MoPH budget, rate of budget growth and trends in budget approved, budget allotment, and actual spending on health for 2012 and 2013.

The MoPH core budget consists of the operating budget and the development budget. The operating budget forms part of the general public expenditure of Afghanistan; the development budget consists of the assistance from various donor agencies to the government. Information related to the budget requested, approved, allotted, and the actual amounts spent were obtained from MoF and MoPH sources; the findings are presented in the sections that follow.

Process of Preparation of Health Budget

The budget is prepared in two stages at MoF. The first stage is a budget prediction for the next three to five years. All departments and possible resources are taken into consideration during this exercise. Plans are made such that they are financially executable, taking into consideration both government and donor support. The second stage is a budget estimation for a one-year budget, following the same framework. MoF does the budget estimation in coordination with the various ministries.

The budget preparation process starts with MOF issuing the budget timetable—as summarized in brief in Figure 2. The detailed timetable is supplemented by an action plan that MoF circulates in Budget Circular 1, which specifies the actions to be taken at various stages of the budget preparation process and suggests deadlines by which various actions must be taken. It is essential for all line ministries and budgetary units to comply with the deadlines and information requirements specified in the various timetable documents. MoF compiles these documents from individual ministries to be sent to Parliament for approval.

To comply with the timetable and produce a budget that meets the government's priorities, individual ministries and budgetary units set up a multidisciplinary Budget Implementation Team (BIT). This requirement applies to all ministries/budgetary units. This team, under the overall supervision of the minister or budgetary unit head, is responsible for developing and implementing the budget. MoF organizes workshops to orient ministries on budget preparation procedures. The role of BIT is to control the whole budget process, from program structuring through coordinating the drafting of narratives to supervising the work of budget costing and estimating. After necessary instructions, MoF sends the budget forms to the budgeting units and donors; they come back to MoF duly completed by the recipients.

The budget process starts with budget preparation by ministries, followed by budget circulation, budget committee formation, budget hearings, cabinet approval, parliamentary approval, and finally the signing of the budget by the president.

Budget preparation at MoPH comprises four steps. The first step is budget formulation and the second is budget approval. The third step is implementation and the fourth is monitoring. MoPH receives the budgeting forms from MoF. The forms pertaining to national hospitals then are disseminated to all of the national hospitals. After filling out the budget forms, the hospitals send them back to MoPH, where all forms are compiled and sent to MOF.

Figure 2: MoF's Budget Timetable

March
MoF confirms budget allocations to individual ministries and budgetary units

1 May
Budget Circular 1 sent to line ministries and budgetary units

Ministries and budgetary units create proposed priorities and spending plans

31 May
Submission of *responses to Budget Circular 1* to MoF by line ministries and budgetary units

January/February
Parliament considers, debates, and approves the budget, subject to agreed-upon amendments

Mid-June to August
MoF uses information on development project spending plans to engage in discussions with donors

December/January
MoF compiles final draft of national budget and incorporates it into the annual budget report to Parliament

Early August
MoF submits *Budget Circular* 2 to line ministries and budgetary units

October/November
Budget hearings held with individual ministries/budgetary units on details of budget proposals

Early August
MoF presents *draft budget ceiling* to line ministries and budgetary units

Late October
MoF assembles first draft of budget

Mid-October
Line ministries and budgetary units submit detailed budget proposals to MoF

After the budget is finally prepared, it is forwarded to the Cabinet for approval. After the approval from the Cabinet, MoF sends the approved budget to MoPH for its consent. In case of budget deductions, the ministry negotiates its budget requirements with MoF. However, the final call is that of the budgeting committee, which is headed by the Minister of Finance. The revised budget is sent to the Cabinet for approval. The Cabinet, after discussion and negotiation, can change and modify the budget. Finally, it goes to the President for approval. After approval, it comes back to MoF, which then informs MoPH of the final approved budget.

After approval, the implementation of the budget begins. MoPH informs the national hospitals of the approved budget. The hospitals then start implementing the activities planned in the budget. Disbursement of the budget is done at the beginning of each quarter through direct bank transfers to the national hospitals from MoF, but before that MoPH gives the go-ahead, on the basis of an expense statement the hospitals submit every month. MoPH plays a monitoring role in the whole process of budget allotment and budget utilization/expenditure by national hospitals.

Total Government Budget and MoPH Budget

The total budget (inclusive of all sectors) of the government of the Islamic Republic of Afghanistan (GoIRA) was 133,690 million Afs in 2012, which increased to 354,077 million Afs in 2013. The government health budget—that is, the MoPH core budget—increased from 10,488 million Afs in 2012 to 13,221 million Afs in 2013. The actual budget funds spent totaled 1,79,9 million Afs in 2012, increasing to 3,11,5 million Afs in 2013. Table 4 shows the details of the total national budget and the health budget of GoIRA.

Table 4: Total National and Total Health Budget of GoIRA

Budget Details	2012*	2013*
Total Govt. National Budget (million Afs)	133,690	354,077
Total Govt. Health Budget MoPH (Core Budget) (million Afs)	10,488	13,221
Total Govt. Health Budget Expenditure (million Afs)	1,799	3,115

*FY 2012 consisted of nine months, whereas FY 2013 consisted of 12 months.
Source: Budget figures are from MoF documents.

One of the indicators of a government's commitment to health in any country is the share of public health expenditure of the country's total public expenditure. The share of the MoPH core budget as a proportion of total government expenditure was 7.8 percent and 3.8 percent in 2012 and 2013, respectively, as per the figures in Table 4 However, the survey showed that the actual share of the government's revenue to the THE was 4.6 percent in 2012 and 3.6 percent in 2013. The reason is that the total operating budget includes revenue sources, in the form of loans and donor contributions, separate from government revenue. The comparative picture is shown in Figure 3.

Figure 3: Trend in Total Government Expenditure and Health Expenditure in Afghanistan

16
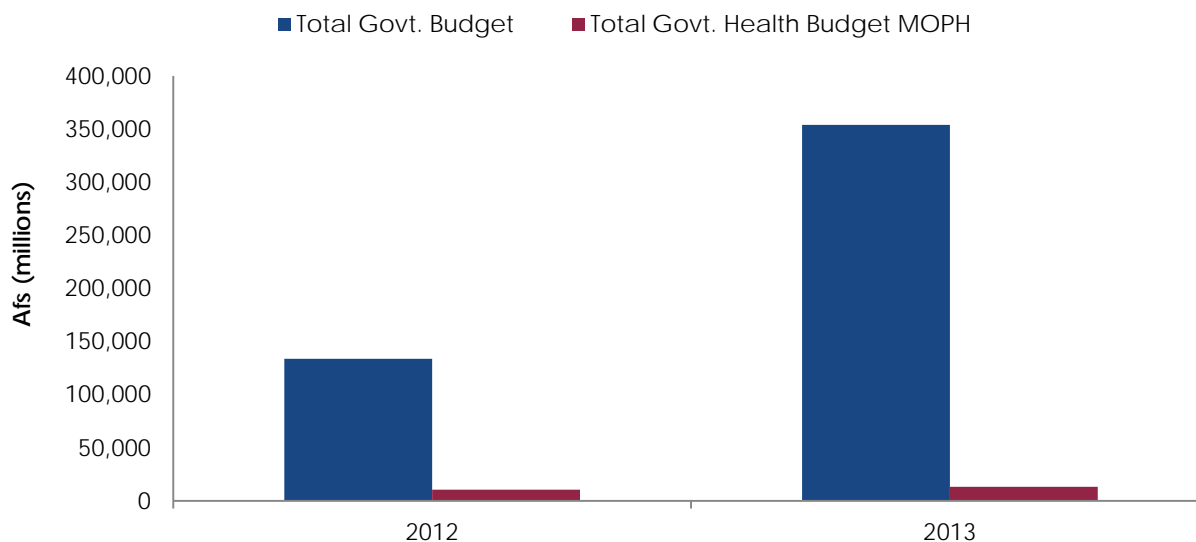
MoPH Core Budget

The total MoPH budget (core budget) consists of the development budget and operating budget. The MoPH development budget was 8,490 million Afs in 2012 and 9,746 million Afs in 2013 (Table 5). The MoPH core budget was 10,488 million Afs in 2012 and 13,221 million Afs in 2013. Regarding budget share, the development budget was 81 percent of the MoPH core budget in 2012 and 74 percent in 2013 (Figure 4).

Table 5: MoPH Core Budget in 2012 and 2013

Budget Details	2012*	2013*
MoPH Operating Budget (million Afs)	1,998	3,475
Development Budget (million Afs)	8,490	9,746
MoPH Core Budget (million Afs)	10,488	13,221

*FY 2012 consisted of nine months, whereas FY 2013 consisted of 12 months.

Figure 4: Share of the Development Budget in MoPH Core Budget, 2012 and 2013

Share of Development Budget in MoPH Core Budget, 2012 (in million Afs)

■ Operating ■ Development

1,998
19%

8,490
81%
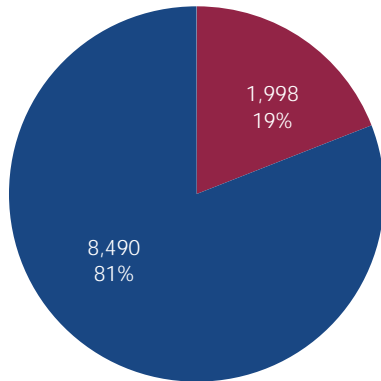
Share of Development Budget in MoPH Core Budget, 2013 (in million Afs)

■ Operating ■ Development

3,475
26%

9,746
74%
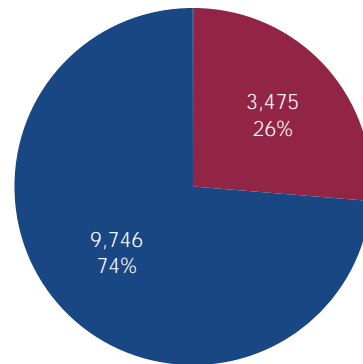
Trends and Composition of the MoPH Operating Budget

The MoPH operating budget covers not just the central ministry, but also the budget for all of the national hospitals of Kabul and the health departments in the provinces. In 2012, MoPH requested a sum of 1,998 million Afs from MoF as an operating budget, which was approved and allotted. MoPH's actual expenditure, though, was 1,799 million Afs (90%) in 2012. Similarly, MoPH's budget request in 2013 was 3,474 million Afs, which the MoF approved and allotted. MoPH's actual expenditure was 3,115 million Afs (89%) in 2013. Table 6 shows the details of the MoPH budget requested, approved, allotted, and spent for 2012 and 2013.

Table 6: Trends in MoPH Operating Budget for 2012 and 2013

Source	Year	Total	Salaries	%	Services	%	Assets	%
Requested (million Afs)	2012	1,998	1,373	69	566	28	60	3
	2013	3,474	1,984	57	1,337	38	152	4
Approved (million Afs)	2012	1,998	1,373	69	566	28	60	3
	2013	3,474	1,984	57	1,337	38	152	4
Allotted (million Afs)	2012	1,998	1,373	69	566	28	60	3
	2013	3,474	1,984	57	1,337	38	152	4
Spent (million Afs)	2012	1,799	1,261	70	508	28	31	2
	2013	3,115	1,941	62	1,103	35	71	2

In 2012, 69 percent of the MoPH budget approved was for salaries, 28 percent for services, and 3 percent for assets. This changed in 2013; the share for salaries was 57 percent and there were apparent increases to 38 percent for services and 4 percent for assets. The actual expenditure against the approved amounts in the 2012 budget shows that 70 percent was for salaries, 28 percent for services, and 2 percent for assets. In 2013, 62 percent of the total expenditure was for salaries, 35 percent for services, and 2 percent for assets. In absolute terms, though, there has been an increase in the amount approved and spent from 2012 to 2013; note that fiscal 2012 was nine months in length and 2013 consisted of 12 months.

The analysis of the recurrent and capital components of the MoPH budget shows that 97 percent of the budget approved was for recurrent expenditure and 3 percent for capital expenditure in 2012. In 2013, the recurrent and capital components approved by MoPH were 96 percent and 4 percent, respectively. The trend of budget expenditure was almost the same in 2012 and 2013. In both years, the composition of recurrent expenditure was 98 percent and capital expenditure 2 percent.

Table 7 shows the trend in the annual rate of growth of the recurrent and non-recurrent components of the MoPH budget in 2013; this was calculated for budget allotted as well as budget spent. The MoPH budget allotted and spent in 2013 was up from 2012 by 42.5 percent and 42.2 percent, respectively. The recurrent expenditure showed an increase of 88.5 percent and capital expenditure of 60.5 percent in 2013 for the allotted budget, and 89 percent and 56.3 percent, respectively, for budget spending.

Table 7: Trends in Annual Rate of Growth of Recurrent and Non-recurrent Budget Components for 2012 and 2013

	Total Budget	Salaries	Services	Assets
Budget Allotment	42.5	30.8	57.7	60.5
Budget Spent	42.2	35.0	53.9	56.3

Analysis of Budget Approved, Allotment, and Spent in MOPH

Table 8 shows a comparison of the MoPH budget approved, budget allotment, and budget spent. In 2012 and 2013, the budget requested and approved, as well as the allotment rate, remained at 100 percent; that is, the budget request by MoPH to MoF was approved for MoPH and fully allotted in both years.

Comparing the overall MoPH budget spent with the budget allotted shows that approximately 90.0 percent of funds were utilized in 2102 and 2013. The rate of expenditure was above 80 percent for salaries and services; in the case of assets, it was 51.2 percent in 2012 and 47.1 percent in 2013 (Table 8).

Table 8: Comparison of MoPH Budget Approval to Budget Allotted and Budget Spent

Year	Approved vs. Allotment				Allotment vs. Spent			
	Total	Salaries	Services	Assets	Total	Salaries	Services	Assets
2012	100	100	100	100	90.0	91.8	89.8	51.2
2013	100	100	100	100	89.7	97.8	82.5	47.1

ANALYSIS OF THE BUDGET FOR THE NATIONAL HOSPITALS

This section describes the flow of funds to the national hospitals of Kabul from MoPH and other sources. As detailed in previous sections, a major part of the financing for the national hospitals is from the government budget, routed through MoPH. The second source of financing is through external funding or assistance from donor agencies and nongovernmental organizations. These contributions can be in the form of cash or in-kind-transfers to the facilities. Some of these hospitals have cost-recovery mechanisms in the form of user fees—another source of financing for hospitals.

Table 9 shows the overall flow of funds to the national hospitals from MoPH. In 2012, the overall budget request for the 16 hospitals was 591 million Afs, and MoF approved that amount. Of this, 585 million Afs (99%) was allotted; the actual amount spent was 533 million Afs, amounting to 91 percent of the budget allotted. In 2013, the 16 national hospitals' budget request to MoF was 1,574 million Afs; MoPH approved 1,476 million Afs (94%). Of this, 1,448 million Afs (98%) was the allotted budget, and 1,276 million Afs (88%) was the total utilization of the allotted budget. Figures 5 and 6 depict the budget requested, approved, allotted, and spent for the 16 national hospitals in comparison to the overall MOPH budget requested, approved, allotted, and spent for 2012 and 2013.

Table 9: Overall Budgets from MoPH to the 16 National Hospitals

Year	Budget Requested	Budget Approved	Budget Allotted	Budget Spent
2012	591	590	585	533
2013	1,574	1,476	1,448	1,276

Note: All figures are in million Afs.

Figure 5: Budget Requested, Approved, Allotted, and Spent for National Hospitals in Comparison with Overall Budget, 2012
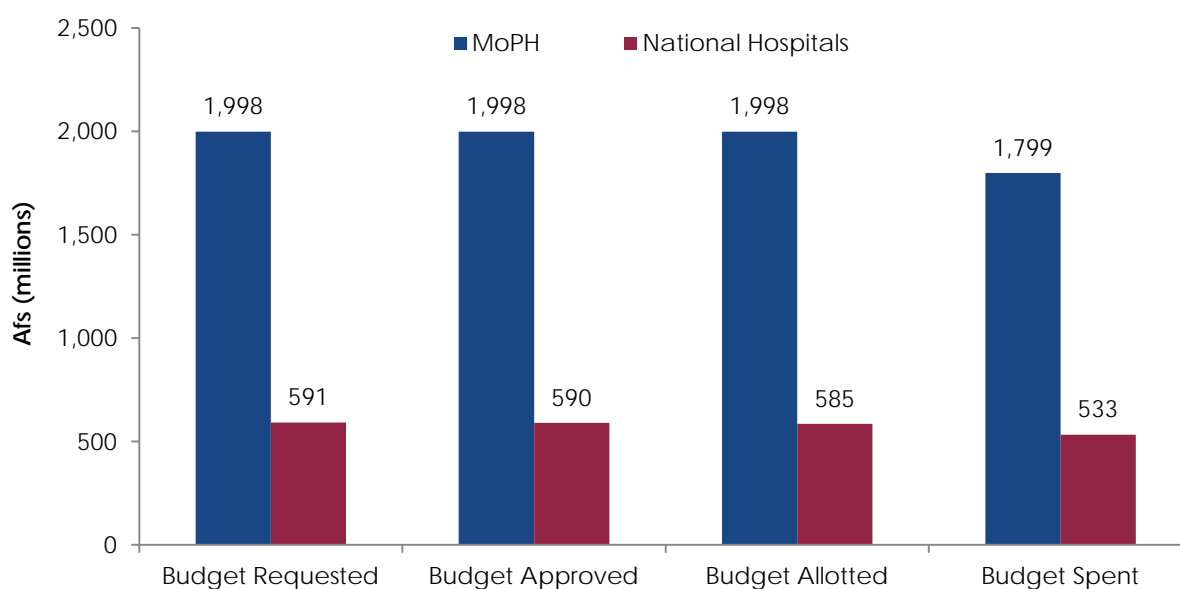
Figure 6: Budget Requested, Approved, Allotted, and Spent for National Hospitals in Comparison with Overall MoPH Budget, 2013
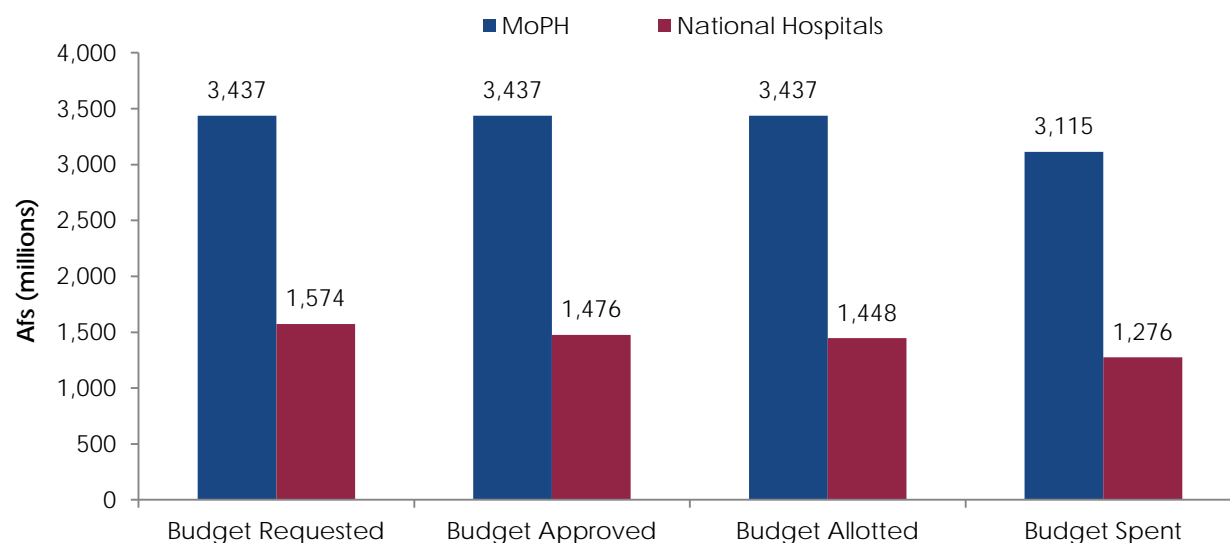
In 2012, the share of the 16 national hospitals in the MoPH budget approved and spent was 29.6 percent. In 2013, their share of the MoPH budget approved increased substantially, to 42.5 percent, and 41.4 percent in total spending.

Budget Requested, Approved, Allotted, and Spent of the 16 National Hospitals

This section presents the details of the budget requested, approved, allotted, and spent for the 16 national hospitals. Tables 10 and 11 show the data for 2012 and 2013.

Table 10: Details of Budget Requested, Approved, Allotted, and Spent for National Hospitals, 2012

National Hospitals	Budget Requested	Budget Approved	Budget Allotted	Budget Spent
	Afs (millions)			
Antani (Infectious Disease)	26.9	26.9	27.5	25.3
Attaturk	33.8	33.8	33.8	31.4
Dasht-e-Barchi	9.0	9.0	9.1	8.6
Ehayaye Mojadad	14.7	14.7	14.7	14.1
Esteqlal	69.8	69.8	69.9	63.5
Ibne Sina Emergency	45.8	45.8	45.8	38.9
Ibne Sina Sadri	25.9	25.9	25.9	21.9
Indira Gandhi	66.1	66.1	66.6	61.5
Jamhoriat	45.3	45.3	43.7	40.4
Malalai	51.9	51.9	52.9	47.7

National Hospitals	Budget Requested	Budget Approved	Budget Allotted	Budget Spent
	Afs (millions)			
Mental Hospital	21.8	21.8	22.2	16.6
Noor Eye	21.5	21.5	21.5	21.5
Rabia Balkhi	47.9	47.7	47.7	44.1
Stomatology	38.3	38.3	31.8	26.1
Tuberculosis	12.7	12.7	12.7	12.7
Wazir Akbar Khan	58.9	58.9	58.9	58.9
Total	**590.5**	**590.4**	**585.0**	**533.2**

Table 11: Details of Budget Requested, Approved, Allotted, and Spent for National Hospitals, 2013

National Hospitals	Budget Requested	Budget Approved	Budget Allotted	Budget Spent
	Afs (millions)			
Antani (Infectious Disease)	60.3	60.3	60.3	57.9
Attaturk	99.3	75.6	75.6	60.5
Dasht-e-Barchi	30.4	25.5	25.3	21.6
Ehayaye Mojadad	46.2	40.1	40.1	33.6
Esteqlal	182.8	182.8	184.8	170.2
Ibne Sina Emergency	151.5	131.5	132.9	124.1
Ibne Sina Sadri	70.7	55.6	56.8	50.8
Indira Gandhi	207.1	195.5	195.6	143.2
Jamhoriat	104.6	104.6	104.6	101.4
Malalai	154.5	147.8	140.9	135.0
Mental Hospital	56.4	56.4	41.3	30.6
Noor Eye	23.0	23.0	23.0	23.0
Rabia Balkhi	117.7	117.7	112.5	109.1
Stomatology	71.7	71.7	71.7	70.0
Tuberculosis	31.4	31.4	31.4	15.6
Wazir Akbar Khan	166.2	156.9	151.0	129.2
Total	**1,574.0**	**1,476.4**	**1,447.9**	**1,275.7**

Table 12 shows the distribution of the budget approved and spent of the 16 national hospitals. Five hospitals—Wazir Akbar Khan, Rabia Balkhi, Indira Gandhi, Malalai, and Esteqlal—accounted for more than an 8 percent share each budget in both 2012 and 2013. In comparison, the Dasht-e-Barchi, Ehayaye Mojadad, and Tuberculosis hospitals had a budget share of less than 3 percent each, out of the total budget. The table also shows the pattern of utilization of the approved budget for 2012 and 2013. Most of the hospitals had a utilization ratio of more than 80 percent of the approved budget in these two years.

For some, the allotted budget was more than the approved budget because these hospitals made additional budget requisitions to MOF later in the year.

Table 12: Percentage Share of Budget Approved and Budget Spent among National Hospitals, 2012 and 2013

National Hospitals	2012		2013	
	Budget Approved (%)	Budget Spent (%)	Budget Approved (%)	Budget Spent (%)
Antani (Infectious Disease)	4.6	4.8	4.1	4.5
Attaturk	5.7	5.9	5.1	4.7
Dasht-e-Barchi	1.5	1.6	1.7	1.7
Ehayaye Mojadad	2.5	2.6	2.7	2.6
Esteqlal	11.8	11.9	12.4	13.3
Ibne Sina Emergency	7.8	7.3	8.9	9.7
Ibne Sina Sadri	4.4	4.1	3.8	4.0
Indira Gandhi	11.2	11.5	13.2	11.2
Jamhoriat	7.7	7.6	7.1	8.0
Malalai	8.8	8.9	10.0	10.6
Mental Hospital	3.7	3.1	3.8	2.4
Noor Eye	3.6	4.0	1.6	1.8
Rabia Balkhi	8.1	8.3	8.0	8.6
Stomatology	6.5	4.9	4.9	5.5
Tuberculosis	2.2	2.4	2.1	1.2
Wazir Akbar Khan	10.0	11.1	10.6	10.1
Total	**100.0**	**100.0**	**100.0**	**100.0**

Budget Composition of National Hospitals

Table 13 shows the composition of the budget, giving recurrent and capital expenditures for the 16 national hospitals. In 2012, within the recurrent budget, the largest component of budget spent was salaries, at 91.9 percent, followed by services, at 7.7 percent, and 0.4 percent for capital expenditures. In 2013, however, the share of salaries in budget spent decreased to 60.0 percent, whereas services increased to 38.4 percent, and capital expenditure was 1.6 percent.

Table 13: Percentage Share of Recurrent and Capital Expenditures in the National Hospital Budget

Source	Year	Salaries (%)	Services (%)	Assets (%)
Requested	2012	87.6	11.3	1.1
	2013	50.1	47.6	2.3
Approved	2012	87.7	11.3	1.1
	2013	53.4	50.7	2.5
Allotted	2012	88.3	10.8	0.9
	2013	53.9	44.4	1.8
Spent	2012	91.9	7.7	0.4
	2013	60.0	38.4	1.6

Note: All figures are percentages.

Tables 14 and 15 show the recurrent and capital expenditures for the 16 national hospitals in 2012 and 2013. In 2012, the distribution of expenditures shows that salaries constituted the bulk of recurrent expenditures in a majority of the hospitals. The capital expenditure was as low as 2 percent to 3 percent of the budget approved; in many hospitals, the actual amount spent on capital expenditures was nil. In 2013, there was a clear change in the distribution of expenditures, with considerable decline in what was spent on salaries and an increase in expenditure on services and assets. The budget approved in 2013 showed an increase in capital expenditures for many national hospitals.

Table 14: Budget Allotted and Spent for the National Hospitals, Showing Recurrent and Capital Expenditures, 2012

National Hospitals	Budget Allotted			Budget Spent		
	Salaries	Services	Assets	Salaries	Services	Assets
Antani (Infectious Disease)	89%	10%	1%	93%	7%	0%
Attaturk	89%	10%	1%	90%	10%	0%
Dasht-e-Barchi	77%	22%	1%	79%	21%	0%
Ehayaye Mojadad	88%	10%	1%	90%	9%	1%
Esteqlal	90%	9%	1%	90%	9%	0%
Ibne Sina Emergency	84%	15%	1%	92%	8%	0%
Ibne Sina Sadri	83%	15%	2%	92%	6%	2%
Indira Gandhi	90%	9%	1%	93%	7%	0%
Jamhoriat	88%	11%	1%	91%	9%	1%

National Hospitals	Budget Allotted			Budget Spent		
	Salaries	Services	Assets	Salaries	Services	Assets
Malalai	85%	14%	2%	90%	10%	0%
Mental Hospital	90%	9%	1%	95%	4%	0%
Noor Eye	100%	0%	0%	100%	0%	0%
Rabia Balkhi	88%	10%	2%	93%	6%	1%
Stomatology	78%	19%	3%	91%	8%	1%
Tuberculosis	63%	37%	0%	63%	37%	0%
Wazir Akbar Khan	100%	0%	0%	100%	0%	0%

Table 15: Budget Allotted and Spent for the National Hospitals, Showing Recurrent and Capital Expenditures, 2013

National Hospitals	Budget Allotted			Budget Spent		
	Salaries	Services	Assets	Salaries	Services	Assets
Antani (Infectious Disease)	60%	33%	7%	61%	32%	7%
Attaturk	56%	41%	2%	69.5%	28%	3%
Dasht-e-Barchi	44%	56%	1%	48%	51%	1%
Ehayaye Mojadad	70%	29%	1%	76%	23%	1%
Esteqlal	55%	44%	2%	59%	40%	2%
Ibne Sina Emergency	53%	44%	3%	56%	42%	1%
Ibne Sina Sadri	52%	42%	6%	56%	38%	6%
Indira Gandhi	44%	55%	1%	59%	41%	1%
Jamhoriat	64%	36%	0%	65%	35%	0%
Malalai	53%	46%	1%	54%	45%	0%
Mental Hospital	47%	53%	1%	63%	37%	0%
Noor Eye	100%	0%	0%	100%	0%	0%
Rabia Balkhi	58%	41%	0%	60%	40%	0%
Stomatology	57%	42%	1%	58%	41%	1%
Tuberculosis	36%	62%	2%	72%	24%	3%
Wazir Akbar Khan	49%	49%	2%	56%	42%	3%

Comparison of Budget Approved vs. Allotted vs. Spent for the National Hospitals in 2012 and 2013

In terms of the overall trend in budget approved against budget requested and budget allotted against approved and spent for all national hospitals, in 2012, 98.9 percent of the approved budget was allotted, and 93.2 percent of the allotted budget was spent. In 2013, the budget approved dropped to 93.8 percent, the budget allotted to 98.6 percent; the budget spent dropped even further, to 88.6 percent. The details for each individual hospital are given in Table 16.

In 2012, all hospitals except the Ibne Sina Sadri and Mental Hospitals had a more than 80 percent utilization rate of the budget allotted for national hospitals. In 2013, barring the Indira Gandhi and Tuberculosis hospitals, all others achieved a more than 80 percent utilization of the budget allotted.

Table 16: Rate of Execution of Budget for the National Hospitals

National Hospitals	2012			2013		
	Requested vs. Approved	Approved vs. Allotted	Allotted vs. Spent	Requested vs. Approved	Approved vs. Allotted	Allotted vs. Spent
Antani (Infectious Disease)	100%	102%	92%	100%	100%	96%
Attaturk	100%	100%	93%	76%	100%	80%
Dasht-e-Barchi	100%	102%	94%	84%	100%	85%
Ehayaye Mojadad	100%	100%	96%	87%	100%	84%
Esteqlal	100%	100%	91%	100%	101%	92%
Ibne Sina Emergency	100%	100%	85%	87%	101%	93%
Ibne Sina Sadri	100%	100%	84%	79%	102%	89%
Indira Gandhi	100%	101%	92%	94%	100%	73%
Jamhoriat	100%	96%	92%	100%	100%	97%
Malalai	100%	102%	90%	96%	95%	96%
Mental Hospital	100%	102%	75%	100%	73%	74%
Noor Eye	100%	100%	100%	100%	100%	100%
Rabia Balkhi	100%	100%	92%	100%	96%	97%
Stomatology	100%	83%	82%	100%	100%	98%
Tuberculosis	100%	100%	100%	100%	100%	50%
Wazir Akbar Khan	100%	100%	100%	94%	96%	86%

*The reason for higher approved vs. allotted is the additional budget requisitions by the hospitals.

Financial Flow to National Hospitals through Cost Recovery

As seen in the section above, the primary source of financing for the national hospitals is the general government budget. Cost recovery is another financing mechanism. Out of the 16 national hospitals, five do cost recovery from patients for both outpatient and inpatient care. These include the Jamhoriat, Indira Gandhi, Noor Eye, Rabia Balkhi, and Stomatology hospitals. The revenue from the cost recovery process for these hospitals is shown in Table 17. It indicates that these five facilities recovered 343,467 Afs in 2012; the amount increased to 625,002 Afs in 2013. Except for Noor Eye, these hospitals generated revenue from diagnostic services, i.e., X-rays. Analysis of the revenue generated also shows that the revenue from the cost recovery done by the hospitals other than Noor Eye was transferred to government general accounts in accordance with GoIRA regulations. Noor Eye uses its revenues for managing its own expenses.

Table 17: Amount of Cost Recovery Done at the National Hospitals

Year	Indira Gandhi	Jamhoriat	Noor Eye	Rabia Balkhi	Stomatology	Total
2012	0.11	0.07	-	0.08	0.09	0.34
2013	0.14	0.06	0.38	0.04	0.005	0.63

Note: All figures are in million Afs.

Financial Flow through External Support to National Hospitals

External support in the form of cash/in-kind transfers is the third source of financing for the national hospitals. The analysis showed that in 2012, all of the sample hospitals except Ehayaye Mojadad reported receiving cash/in-kind support from various organizations; in 2013, 13 hospitals (not including Dasht-e Barchi, Ehayaye Mojadad, and Wazir Akbar Khan) received such support. However, the data lack clarity related to the external funding the hospitals received. Table 18 presents the data on cash and in-kind support that the national hospitals received in 2012 and 2013.

In 2012, total external assistance to national hospitals was 164 million Afs, of which the cash contributions were 5.2 million Afs; the in-kind transfers were equivalent to 158.9 million Afs. In 2013, total external assistance declined to 26.8 million Afs, with 13.1 million Afs in cash contributions and 13.6 million Afs in in-kind contributions. The details of the external support for each hospital in 2012 and 2013 are shown in Table 18.

Table 18: External Support to National Hospitals in 2012 and 2013

National hospitals	2012		2013	
	Cash	In-kind	Cash	In-kind
Antani (Infectious Disease)	0.0	0.1	0.01	0.02
Attaturk	0.0	3.6	1.5	0.0
Dasht-e-Barchi	0.0	0.2	0.0	0.0
Ehayaye Mojadad	0.0	0,0	0.0	0.0
Esteqlal	0.0	1.8	0.0	0.0
Ibne Sina Emergency	0.0	6.3	4.2	0.0

National hospitals	2012		2013	
	Cash	In-kind	Cash	In-kind
Ibne Sina Sadri	0.0	0.0	0.0	0.7
Indira Gandhi	0.0	0.9	0.0	0.0
Jamhoriat	0.0	1.7	0.0	0.0
Malalai	0.0	1.5	0.0	3.7
Mental Hospital	4.0	4.9	0.0	0.0
Noor Eye	0.0	0.0	7.4	0.0
Rabia Balkhi	0.0	0.3	0.0	0.0
Stomatology	0.0	0.3	0.0	0.0
Tuberculosis	0.0	137.3	0.0	9.2
Wazir Akbar Khan	1.2	0.0	0.0	0.0
Total	5.2	158.9	13.1	13.6

Note: All figures are in million Afs.

Procurement of Drugs and Equipment in National Hospitals

In 2012, MoPH directly managed the process of procuring drugs and consumables for the national hospitals. The hospitals reported delays in procurement and inadequate supplies. Subsequently, all of the hospitals except Noor Eye were made autonomous in 2013; henceforth, the facilities were free to carry out their own procurement of drugs and consumables. Even though the entire budget was transferred to the hospitals in 2013, the Directorate of Central Hospitals Department monitored their procurement processes.

The procurement division of MoPH developed the norms and guidelines for procurement and its monitoring for the national hospitals. As per the system, the hospitals submit their procurement requirements to MoPH at the end of each year; based on the requirements of each, the procurement division of MoPH then prepares a consolidated procurement budget. The procurement budget for each hospital is finalized based on its current request and the previous year's budget.

The procurement process changed after the national hospitals became autonomous in 2013. A uniform purchasing policy was formulated. Purchasing is now done based on the requirement of the hospitals. Before 2013, MoPH did all procurement; the hospitals had no role. In 2012, some of the hospitals were granted partial autonomy and given funds for procurement on an experimental basis. These hospitals proved their efficiency in using these funds. In 2013, 15 of the 16 national hospitals were granted autonomy to procure drugs and equipment; MoPH was no longer responsible.

The status of the hospital procurement is summarized in Table 19.

Table 19: Hospital Procurement Status

Parameters	No. of Hospitals
Hospitals made autonomous	15
Hospitals that received greater autonomy over their budget and procurement	15
Hospitals procuring their own commodities, FY 2013	16
Hospitals maintaining records of expenditure receipts	16
Hospitals having procurement teams in 2013	16
Hospitals in which a procurement team procures drugs, 2013	16
Hospitals to which MoPH sent drugs, 2013	0
Hospitals to which MoPH sent drugs, 2012	15
Hospitals that received the quantities of drugs and medical supplies as per their procurement requests, 2012	4
Hospitals that experienced delays in receiving drugs from MoPH, 2012	8

Fifteen hospitals (Noor Eye excepted) are under the national hospital reform program and have been granted autonomy. These hospitals now are responsible for carrying out their procurements. They submit their expenditure statements to MoPH every month and submit an overall statement at the end of each fiscal year.

All of the 15 autonomous hospitals reported having a procurement team in 2013. These teams did the procuring for the hospitals for that year. In the case of Noor Eye Hospital, MoPH did not provide drugs and other supplies; the hospital did the procuring on its own from the revenue it generated.

In 2012, all of the hospitals except Noor Eye received drugs from MoPH. Only four hospitals received drugs and other medical supplies as per their request, and eight hospitals stated that they experienced delays in receiving these supplies from MoPH. Inadequate supply and delay were their major concerns in 2012.

Procurement Budget of the National Hospitals in 2012 and 2013

This section deals with the procurement budget of MoPH and the national hospitals in 2012 and 2013. As mentioned in the previous section, some hospitals received partial autonomy in 2012 and were given 0.5 million Afs for procurement of drugs and supplies. The total procurement budget of the 16 national hospitals was 8 million Afs in 2012. In 2013, when the hospitals began procuring on their own, the actual spending was 213 million Afs. Table 20 shows the detailed breakdown of procurement budgets of all hospitals in 2012 and 2013.

Table 20: Budget Spent on Procurement by the 16 National Hospitals

National Hospitals	2012	2013
Antani (Infectious Disease)	0.5	5.5
Attaturk	0.5	0.3
Dasht-e-Barchi	0.5	4.3
Ehayaye Mojadad	0.5	2.9
Esteqlal	0.5	38.3
Ibne Sina Emergency	0.5	32.9
Ibne Sina Sadri	0.5	7.3
Indira Gandhi	0.5	9.8
Jamhoriat	0.5	11.2
Malalai	0.5	35.2
Mental Hospital	0.5	0.0
Noor Eye	0.5	0.0
Rabia Balkhi	0.5	22.0
Stomatology	0.5	9.4
Tuberculosis	0.5	0.0
Wazir Akbar Khan	0.5	33.6
Total	**8.0**	**212.8**

Note: All figures are in million Afs.

BUDGET AND PROCUREMENT CHALLENGES

Delays in the Budget Process of MoPH and the National Hospitals

A critical aspect of any budgetary process is the timely flow of the approved budget to the spent units and timely utilization of funds for the budgeted activities by the spent units. This section analyzes the delays in the budgetary process at the ministry and at hospital levels, the reasons for the delay at each stage, and the impact of the delay.

The first delay in the budget process was at the central level, during the transfer of funds from MoF to MoPH. In both years, there was a delay in releasing funds from MoF to MoPH. The main reasons for this delay were late requests by the hospitals, late budget compilation at MoPH, and delays in receiving approval from Parliament. Other reasons cited were problems in cash flow and availability of limited funds. The delay in the release of funds after approval of the budget was approximately two months.

The next level of delay was caused by the flow of funds from MoPH to the national hospitals. Figure 7 shows that, of the 16 national hospitals, eight reported delays in receiving funds from MoPH in 2012 and nine reported this problem in 2013. The national hospitals that reported delays in receiving funds in 2012 and 2013 are listed below (Table 21).

Figure 7: National Hospitals Reporting Delays in Receiving Funds from MoPH, 2012 and 2013
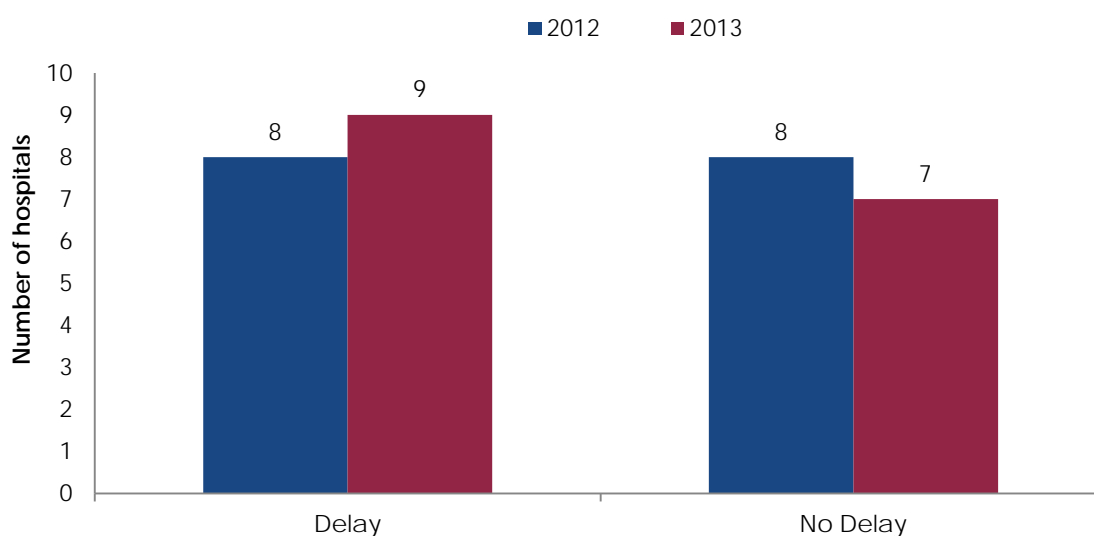
Table 21: National Hospitals Reporting Delays in Receiving Funds from MoPH

2012	2013
Attaturk	Antani (Infectious Disease)
Dasht-e-Barchi	Attaturk
Ibne Sina Sadri	Dasht-e-Barchi
Indira Gandhi	Ibne Sina Sadri
Malalai	Indira Gandhi
Mental Hospital	Malalai

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2012	2013
Rabia Balkhi	Mental Hospital
Stomatology	Rabia Balkhi
	Wazir Akbar Khan

The reasons for the delays in the transfer of funds from MoPH to the hospitals were ranked in order of their importance. According to the national hospitals, the prime reasons for the delays in 2012 were problems with the budgeting process of MoPH, lack of available funds for release, and cash flow constraints. Figure 8 shows the various reasons for delays in 2012 in their order of importance, as reported by the national hospitals. The reasons cited for the delays were the same in 2013 (Figure 9).

Figure 8: Reasons for Delay in Receipt of Budgets by the National Hospitals, 2012
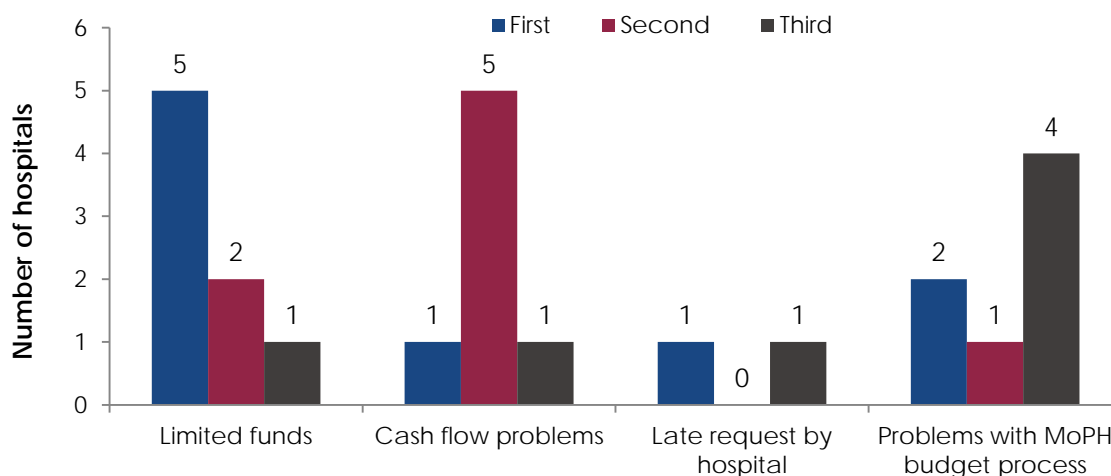
Figure 9: Reasons for Delays in Receiving Funds by the National Hospitals, 2013

32
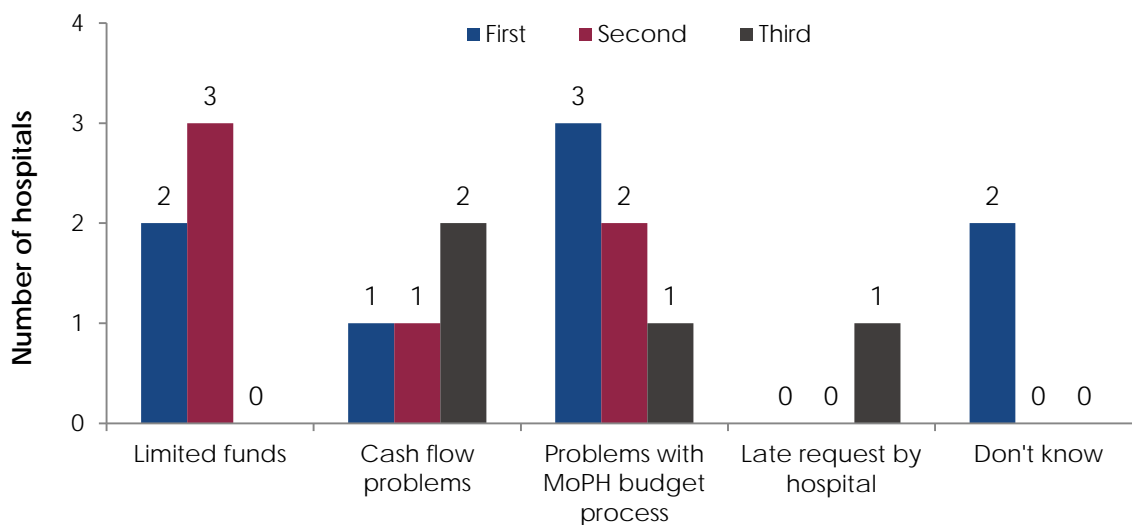
The average gap between a budget request by the hospitals and its approval, and between budget approval and disbursement, is presented in Table 22. Three national hospitals reported delays of more than 40 days in budget approval in 2012; two hospitals said there were delays of more than 40 days for the disbursement of funds from MoPH. Five national hospitals reported delays of more than 40 days in budget approval in 2013; three hospitals cited late disbursement of funds from MoPH. Two national hospitals reported a delay of around 30 days in budget approval, and three noted that budget disbursement was delayed in 2013.

Table 22: Delays in Budget Approval Process for National Hospitals

Delays, in Days	2012		2013	
	Budget Requested to Approved	Budget Approval to Disbursement	Budget Requested to Approved	Budget Approval to Disbursement
0–15	0	1	2	3
15–30	1	0	2	3
30–35	0	0	0	0
35–40	0	0	0	0
>40	3	2	5	3
Don't know	4	5	0	0
Total	**8**	**8**	**9**	**9**

One of the key concerns that emerged during discussions with hospital managers was the impact of these delays on the hospitals' service delivery. Of the eight hospitals that faced delays in budget approval in 2012, six reported an adverse impact on the quality of care. All nine hospitals that faced delays in the budget process in 2013 said it adversely impacted their quality of care.

Qualitative interviews pointed out that budget approval by MoF takes the longest time and causes the maximum delay, followed by disbursement of the budget. Since MoF needs Parliament's approval of its budget and this often results in additional delays, the budget approved to MoPH is even further delayed. During disbursement, approval of documents submitted by hospitals for release of money takes considerable time. MoF often approves only a curtailed budget, leaving the national hospitals with inadequate funds.

Hospital managers said that delays in receiving funds affect national hospitals' budget cycles and planning. Hospitals are unable to make timely payments to vendors, thus disrupting the flow of drugs, food for patients, and other essential supplies. These delays also disrupt the supply of fuel, consumables, and medical equipment, thus affecting hospital services. A hospital manager explained how ultrasonography services were disrupted at a national hospital as the result of a delay in budget disbursement. Due to the delay, the hospital could not procure an ultrasound scanner; patients had to be sent to private clinics for ultrasound scans. Some hospitals pointed out that as a result of such delays, many staff members do not receive their salaries on time.

To summarize, the delay in the budget approved for national hospitals adversely impacts the hospital's quality of care, as it leads to shortage of medicines, food, fuel, and medical equipment.

Leakages in the Budget Process

One of the key aspects of PETS is estimation of leakages. These can be identified at each stage of the expenditure chain by comparing the amount disbursed by the higher link in the budget chain and the amount received by the next link down in the chain. In this case, the links are MoF, MoPH, and the national hospitals. The study also shows that no embezzlement of funds occurs during the transfer from MoF to MoPH.

On several occasions, Parliament has curtailed funds under certain heads and increased them under others in the planned MoF budget. The budget thus may differ from the original amount of funds approved.

Following budget approval by MoF, MoPH executes the budget to the national hospitals. Table 23 shows that in most cases, MoPH allots more than the approved budget on the basis of interim budget requests by the hospitals. For hospitals whose allotment of the MoPH's intended budget was lower, this difference may be due to leakage. When interviewers asked MoPH officials about the possible reasons for the allotment being lower, the most commonly cited reason was the shifting of funds from hospital heads due to instructions from the President's office to make contributions to certain causes it identified.

Table 23 below clearly shows that the hospitals did not receive the approved budget allotted by MoPH. The reasons detected during onsite visits to the hospitals mostly involved reconciliation of funds at the MoPH level to adjust the interim budgets and the hospitals not updating their consolidated financial figures regularly, as per MoPH. However, this may be viewed as leakage within the system, wherein hospitals have not received the budget funds allotted by MoPH or have received the funds, but have not accounted for them. The hospital-level data on the budget approved and allotted show no significant difference, as can be seen in Table 23. The leakage, if it exists, may be at the MoPH level, since funds may remain unallotted or adjustments may occur at MoPH. Hospitals often are not informed about curtailments or additions to the approved and/or allotted budget. The scenario has been explained in detail in the "Discussion" section of this report, which includes a case study.

Table 23: Leakage in Budget Execution Process for National Hospitals

National Hospitals	Year	Total Budget Approved			Total Budget Allotted				Overall Leakage	Total Budget Spent				
		MoPH (A)	Hospital (D)	A/D	MoPH (B)	Hospital (E)	E/B	1-E/B	(B-E)/B	MoPH (C)	Hospital (F)	F/C	1-F/C	(C-F)/C
Antani (Infectious Disease)	1391	26,941,334	26,941,334	1	27,547,345	26,941,334	0.98	0.02	2%	25,341,743	25,683,642	1.01	-0.01	-1%
	1392	60,261,031	60,261,031	1	60,261,031	60,261,031	1.00	0.00	0%	57,863,475	57,886,874	1.00	0.00	0%
Attaturk	1391	33,820,000	33,820,000	1	33,820,000	33,820,000	1.00	0.00	0%	31,388,804	31,696,330	1.01	-0.01	-1%
	1392	75,625,488	75,625,488	1	75,631,328	75,625,488	1.00	0.00	0%	60,510,141	61,451,935	1.02	-0.01	-2%
Dasht-e-Barchi	1391	8,994,463	8,994,463	1	9,139,774	8,994,463	0.98	0.02	2%	8,607,367	8,681,099	1.01	-1.01	-1%
	1392	25,456,228	25,456,228	1	25,338,277	25,456,228	1.00	0.00	0%	21,567,078	21,989,978	1.02	-1.02	-2%
Ehayaye Mojadad	1391	14,710,000	14,710,000	1	14,710,000	14,710,000	1.00	0.00	0%	14,058,060	14,082,870	1.00	-1.00	0%
	1392	40,082,596	40,082,596	1	40,089,230	40,082,596	1.00	0.00	0%	33,600,833	33,702,640	1.00	-1.00	0%
Esteqlal	1391	69,840,000	69,840,000	1	69,891,938	69,840,000	1.00	0.00	0%	63,474,346	63,090,912	0.99	-0.99	1%
	1392	182,772,621	182,772,621	1	184,838,105	182,772,621	0.99	0.01	1%	170,246,571	169,996,727	1.00	-1.00	0%
Ibne Sina Emergency	1391	45,770,000	45,770,000	1	45,788,900	45,770,000	1.00	0.00	0%	38,941,953	41,567,802	1.07	-1.07	-7%
	1392	131,543,431	131,543,431	1	132,890,749	131,543,431	0.99	0.01	1%	124,087,295	124,559,681	1.00	-1.00	0%
Ibne Sina Sadri	1391	25,920,000	25,920,000	1	25,948,049	25,920,000	1.00	0.00	0%	21,886,654	20,285,563	0.93	-0.93	7%
	1392	55,607,722	55,607,722	1	56,807,721	55,607,722	0.98	0.02	2%	50,794,560	50,862,192	1.00	-1.00	0%
Indira Gandhi	1391	66,126,667	66,126,667	1	66,602,221	66,126,667	0.99	0.01	1%	61,461,140	63,859,573	1.04	-1.04	-4%
	1392	195,475,631	195,475,631	1	195,587,114	195,475,631	1.00	0.00	0%	143,151,813	141,610,790	0.99	-0.99	1%
Jamhoriat	1391	45,336,455	45,336,455	1	43,720,000	45,336,455	1.04	-0.04	-4%	40,423,898	43,622,959	1.08	-1.08	-8%
	1392	104,574,897	104,574,897	1	104,574,897	104,574,897	1.00	0.00	0%	101,417,603	100,820,950	0.99	-0.99	1%
Malalai	1391	51,932,333	51,932,333	1	52,900,000	51,932,333	0.98	0.02	2%	47,694,700	47,681,014	1.00	-1.00	0%
	1392	147,757,613	147,757,613	1	140,921,988	140,757,613	1.00	0.00	0%	134,960,914	135,127,100	1.00	-1.00	0%
Mental Hospital	1391	21,830,000	21,830,000	1	22,190,000	21,830,000	0.98	0.02	2%	16,584,043	16,641,816	1.00	-1.00	0%
	1392	56,435,391	56,435,391	1	41,282,434	56,435,391	1.37	-0.37	-37%	30,559,660	45,064,455	1.47	-1.47	-47%

Public Expenditure Tracking Survey (PETS) in Kabul National Hospitals

National Hospitals	Year	Total Budget Approved		A/D	Total Budget Allotted		E/B	1-E/B	Overall Leakage	Total Budget Spent		F/C	1-F/C	(C-F)/C
		MoPH (A)	Hospital (D)		MoPH (B)	Hospital (E)			(B-E)/B	MoPH (C)	Hospital (F)			
Noor Eye	1391	21,534,036	21,534,036	1	21,534,036	21,534,036	1.00	0.00	0%	21,534,036	21,534,036	1.00	-1.00	0%
	1392	23,048,436	23,048,436	1	23,048,436	23,048,436	1.00	0.00	0%	23,048,436	23,048,436	1.00	-1.00	0%
Rabia Balkhi	1391	47,729,105	47,851,272	1	47,729,105	47,851,272	1.00	0.00	0%	44,103,799	46,279,055	1.05	-1.05	-5%
	1392	117,736,000	117,736,000	1	112,543,247	110,543,247	0.98	0.02	2%	109,129,965	108,459,520	0.99	-0.99	1%
Stomatology	1391	38,299,457	38,299,457	1	31,810,000	31,810,000	1.00	0.00	0%	26,077,970	27,825,813	1.07	-1.07	-7%
	1392	71,736,358	71,736,358	1	71,736,358	71,736,358	1.00	0.00	0%	69,964,541	70,115,759	1.00	-1.00	0%
Tuberculosis	1391	12,698,521	12,698,521	1	12,698,521	12,698,521	1.00	0.00	0%	12,698,521	12,698,521	1.00	-1.00	0%
	1392	31,410,501	31,410,501	1	31,410,501	31,410,501	1.00	0.00	0%	15,586,231	15,586,231	1.00	-1.00	0%
Wazir Akbar Khan	1391	58,929,004	58,929,004	1	58,929,004	58,929,004	1.00	0.00	0%	58,929,004	58,929,004	1.00	-1.00	0%
	1392	156,915,907	156,915,907	1	150,955,452	150,915,907	1.00	0.00	0%	129,196,843	129,485,533	1.00	-1.00	0%

Issues and Challenges in the Procurement Process

The procurement system faced many challenges when centralized procurement existed. This prevailed until 2012, a fact that emerged during the in-depth discussions with MoPH procurement officials and hospital managers. They cited delays in processing hospital requests at MoPH and in receiving procurement requests from the hospitals as the major reasons for delays in the supply of drugs and consumables to the hospitals.

The centralized procurement process was fraught with inefficiency on many counts. Hospitals often were supplied drugs they did not need, thus unnecessarily adding to their workloads. Contractors frequently delayed delivery and supplied sub-standard drugs that did not have quality certificates. Many of these drugs had to be sent to labs for quality testing. Hospitals did not have the authority to manage their budget or contracts under the procurement process as it existed until 2012.

MoPH officials said autonomous procurement has worked out well and made the hospitals more efficient. Hospitals can now purchase drugs according to their need; supplies are procured in small quantities (as per requirements), and not in bulk, as occurred under the centralized procurement system. This has reduced wastage due to improper storage, expiry, and other causes.

However, the current procurement process also faces certain challenges because it is new and still evolving. One of the main challenges is streamlining the tendering process at the hospital level. The second issue is the capacity of the hospitals to undertake the procurement process independently. Third, there is a failure to achieve economies of scale and efficiency. The lack of capacity of the hospital staff to conduct the procurement process needs to be addressed. The selection and management of the contracts awarded through the tender process also needs investigation. Many of the vendors are local shops that may not have the capacity to supply drugs on the required scale.

Hospitals now need to evolve systems for monitoring contracts and streamlining the selection of vendors. They also need an effective supply management system, including inventory management. Table 24 shows the major observations about the procurement process that emerged from the qualitative interviews conducted with MoPH and hospital staff.

Table 24: Assessment of Procurement Process from the Qualitative Interviews

Procurement System	Strengths	Weaknesses	Issues and Challenges
• The procurement system was decentralized to the national hospitals, and the hospitals were made autonomous as to procuring medicines and supplies. All procurements are currently carried out by each individual hospital based on its need and demand.	• Decentralization of the procurement process and autonomy for procurement at the local level • Procurement process consistency with the needs of each national hospital • Reduction in length of delays on procurement due to better decisionmaking process at the hospital level	• Lack of capacity among the national hospitals to manage the procurement process • Lack of knowledge of the tendering and contract awarding processes • Very few suppliers for a wide range of drugs and equipment • Minimal quality control; most of the suppliers are local	• Building the capacity of the national hospitals for setting up the procurement team for formulating guidelines • Making robust the monitoring of the tendering and procurement process • Building the database and MIS with IT platform • Training for the hospital staff in

Procurement System	Strengths	Weaknesses	Issues and Challenges
	• Enhanced utilization of the procurement budget due to the decentralized decisionmaking process	• Lack of technical knowledge on the drugs and supplies to be procured	procurement guidelines and procedures

DISCUSSION

This section provides a summary of the survey's main findings and discusses issues and challenges that need attention from a policy perspective.

At the central level, the survey tracked public expenditures for 2012 and 2013 and found that the government's contribution to the health budget is low. However, when the MoPH core budget, which includes development assistance, is considered, it is 4 percent of the total GoIRA budget. Most health spending is dependent on external donor agencies and includes in-kind and cash assistance. Though the tracking of the development budget was beyond the purview of PETS, the analysis considered the cash and in-kind direct assistance from donors at the facility level. Owing to a lack of records at the facility level, especially regarding the in-kind transfers, these could not be accurately ascertained.

The main expenditure chain the survey analyzed is the MoPH operating budget that finances the 16 national hospitals. The MoPH operating budget showed a significant increase of 42 percent in 2013 compared to 2012; however, 2012 comprised nine months compared to 12 months in 2013. The increase is visible in both the recurrent and non-recurrent components of the operating budget. The composition of the overall budget shows that the percentage of salaries decreased due to increase of the total budget while the expenditure on services increased significantly, along with a marginal increase in assets. In absolute terms, expenditures on salaries, services, and assets has increased, with a significant increase in expenditure on services and assets in 2013.

Regarding the budget process, at the central level, the major impediment is a shortage of funds available for MoPH. This is due to the constraints MoF faces. Discussions with the central ministry officials revealed that, in addition to a lack of available funds, there are delays in budget approval and disbursement at MoF. The main reason is the delay in getting Parliament's approval of the budget submitted by MoF.

Delays occur at two levels—from MoF to MoPH during budget approval, and from MoF to national hospitals during fund disbursement. The discussions with MoF and MoPH officials pointed out that this delay does not hamper the hospitals' functioning; at the hospital level, though, it is an important issue. The delay in budget allotment for the national hospitals affects the facilities' functioning, especially in the execution of contracts granted to vendors and service delivery.

The survey did not find any major evidence of leakages at the MOF and MOPH level. The discussions with MoF and MoPH officials revealed that the issue is not one of leakage, but of adjustments in budget heads in some of the budget codes at the MoF and MoPH level. However, there have been instances when MoPH has not been able to execute the intended budget for the national hospitals because funds were adjusted from the hospital head and channeled into Presidential funds due to the President's decree. Moreover, the funds allotted by MoPH often were not received by hospitals as per the data; the reason cited was the irregular reconciliation of the allotted budget at the hospitals' end due to a gap in communication between them and MoPH. The possible areas of leakage are shown in detail in Table 23.

The lack of coordination between MoPH and the national hospitals becomes clear when we compare the ministry's data with that of the hospitals. There are differences in the figures reported by MoPH and the hospitals, especially the amounts related to budget allotment and budget spent (see Annexure Tables 28, 29, 31, and 33). The gap was attributable to adjustments done at the MoPH level on the budget codes and a failure to inform the hospitals at the end of the fiscal year.

Mental Health Hospital Case Study:

In 2013, the executed budget for the hospital as per MoPH records was 41,282,434 Afs. At the hospital level, the executed budget was 56,435,391 Afs. The difference of 15 million Afs was due to an adjustment following a President's decree. The amount was deducted by MoF during the execution of funds to the hospital. The adjusted value is available from MoPH; the hospital was not informed of the adjustment.

The issue with the spent budget figures in 2013 was similar. According to MoPH, the spent budget of the hospital was 30,559,660 Afs. At the hospital level, the spent budget was 45,064,455 Afs. The difference resulted from the rejection of supporting vouchers worth 14.5 million received from the hospital in a final utilization statement. MoPH rejected them because no more approved funds were available at MoF, but did not share the final figure with the hospital.

As the level of disaggregation of data increased, getting reliable data became difficult. Many national hospitals did not keep records of their procurement of goods and services and had little information on the volume procured and sums spent. Within the scope of the data collected, no evidence of leakages appeared, but since issues exist in the standard procedure for financial records maintenance and monitoring at the facility level, any possibility of leakage needs to be probed in detail.

AFMIS currently is used at the MoF and MoPH level for budget processes. At the national hospital level, AFMIS is not used; this hampers effective monitoring of the expenditure chain within the hospital and between the hospital and the central level.

The survey found that the autonomy of the national hospitals in the procurement of drugs and services made procurement more efficient; the increased budget utilization for procurement in 2013 corroborates this finding. Autonomy has reduced delays in procurement to a considerable extent compared to the previous years. The decentralization of the procurement system has helped the hospitals to procure drugs based on actual demand, which also has helped to reduce the workload of MoPH staff.

The decentralized procurement system is not without issues, however. The hospitals are not fully equipped to handle the procurement process due to their lack of capacity in tender management, quality control, and monitoring of supply chain management. In addition, the absence of IT systems for procurement management impedes transparency.

As to service delivery in the 16 national hospitals, the survey indicates that there has been a substantial annual increase in patient load, both inpatients and outpatients, in most of the hospitals. The hospitals lack adequate staff, especially nurses and anesthetists, compared to the sanctioned posts. The aggregate number of anesthetists available across the 16 hospitals is much less than the sanctioned number. The available number of nurses is much less than the recommended nurse-to-bed ratio, which also was highlighted in the *Cost Analysis Study of the National Hospitals* (2012). Though the doctors-to-bed ratio was found to be higher in the hospitals, vacancies in the positions of specialist doctors who deliver tertiary care still remain.

Similarly, the dissatisfaction that staff indicated through the survey is pertinent to the issues recorded during the previous Balance Score Card Survey conducted in the country and includes concerns such as rewards for work, benefits, and allowances.

Regarding the quality of services provided by the national hospitals, MoPH officials said health services improved following the introduction of autonomy in procurement. The hospitals now meet their requirements for drugs and supplies in a briefer period of time.

Officials reported that there has been a substantial improvement in the cleanliness—the look and feel—of the hospitals. The number of outpatients and inpatients treated increased from 2012 to 2013, signifying better delivery and utilization of health services. The officials mentioned that, compared to private hospitals, government hospitals provide a better quality of care. The clinical staff is better trained, and the national service the national hospitals provide is safe, assured, and cost effective.

RECOMMENDATIONS

MoF to MoPH

One of the key issues PETS identified is the delay in approval of the budget MoF allocates to MoPH, which in turn delays the transfer of funds to the national hospitals. This delay needs to be reduced to streamline budget processes and improve the flow of funds to the spending units. The budget processes at the MoF level need to be improved so as to reduce the delay in the transfer of the budget to MoPH. This can be attained by defining a time limit for approving the budget and transferring funds to MoPH from MoF.

MoPH to Hospitals

One of the main requirements for an efficient funding flow at the various levels is systematic reporting of expenditure data. PETS found that, although there are systems at the MoPH level, they are not robust enough for continuous monitoring of expenditure data down the line to service delivery points. Hence, the recommendation is to develop a standardized template for capturing expenditures from MoPH to the national hospitals' level. This will help MoPH to capture expenditure data on a real-time basis and monitor the funding flow to the national hospitals. Information on the final budget needs to flow from MoPH to the national hospitals to reduce the inconsistency in expenditure data at the national hospital level.

Along with the implementation of routine expenditure recording systems and improving two-way communications between MoPH and the national hospitals, building the capacity of staff at the central and hospital levels is necessary. HEFD, along with experts from MoPH and the help of development partners can develop training modules in EMIS, budget processes, expenditure tracking, financial management information systems, and procurement processes. After developing the training modules, MoPH and HEFD can initiate the training of the national hospital managers and core staff; this can be done in a ToT mode; the trainers, in turn, can impart trainings at each national hospital.

Although decentralization of the procurement system has enabled the system to be responsive to the needs of the hospitals, it needs a strategic revamp to make it more effective. Currently, the institutional framework for procurement at the hospital level is weak; the capacity of hospitals to manage the procurement process also is inadequate. Tender processes, including tender documents, quality control mechanisms, and monitoring systems for procurement of drugs and equipment, must be standardized.

A procurement system needs to be put in place for the 16 national hospitals. It should be decentralized as to finances and distribution, but centralized as to procurement management. In this regard, the first step is to prepare the list of essential medicines and equipment required for the national hospitals. The second step is demand estimation of each hospital based on the previous year's consumption pattern; this will serve as a benchmark for estimating the current year's consumption level and budget for each hospital.

MoPH should set up a committee to develop a drug purchase policy, quality policy, and tendering process. The committee should empanel suppliers for essential medicines and equipment; these suppliers would need to fulfill the required quality standards fixed by the committee. The national hospitals would procure the medicines and equipment from the MoPH empanelled suppliers; this will help in enhancing quality, controlling costs, and improving the monitoring of the procurement system. The MoPH procurement directorate should devise a mechanism for a national testing lab for drug quality testing and monitoring to keep a check on the quality of supplies provided by approved vendors. The national hospitals can take advantage of economies of scale, increase efficiency in using the funds spent for procurement, and reduce leakages in the system.

With regard to the quality of services, MoPH shall define the service delivery package of each national hospital and, based on this definition, estimate the requirements for human resources, hospital equipment, ancillary services, and infrastructure. This will lead to a more efficient use of resources. MoPH also shall define the service entitlements of the population—that is, the minimum service guaranteed to citizens who access the national hospitals. MoPH should conduct regular monitoring of the national hospitals and provide their feedback to the facilities.

Recommendations at the National Hospital Level

The institutionalization of EMIS at the hospital level is the most significant recommendation at this level for streamlining the funding flow. Hospitals should generate quarterly reports based on the EMIS system, as this will help in monitoring overall expenditure management and also each line item or budget code. This will also help to identify mismatches, if any, for budget codes between the budgets approved from MoPH and the budget allotted for the national hospitals.

With regard to the procurement of medicine, the national hospitals should put in place a passbook system for procuring essential medicines. The passbook system would take into account the current stock of each essential medicine and help improve drug availability and reduce drug stockouts at the hospital level. Further, this would also bring about transparency in drug procurement and demand estimation for essential medicines. In addition, all national hospitals should implement management information systems (MIS) for supply chain management, as this will help in analyzing drug stocks and expenditures at the individual hospital level.

The national hospitals should also implement HRMIS for improving the efficiency of the existing staff of the hospital. The main objective of an HRMIS is to create an information base of all employees working in a hospital, along with their necessary personnel details. This will enhance the decision support system of the organization. The system will also help to manage the pay processes of all employees and conduct their performance appraisals. In addition, it can help in periodic assessments of their human resources (HR) status, reduce absenteeism, and improve monitoring of HR performance.

With regard to improving service delivery, each hospital should develop a quality policy and management protocols to enhance performance. To improve the patient experience, the national hospitals should institutionalize grievance redressal mechanisms and introduce them at each hospital. A "citizen's charter," which details service delivery entitlements and provides scope for feedback, can help in improving the quality of service.

ANNEXURE

Study Sample and Study Respondents

Table 25: Study Sample

Hospital	Year Established
1) Antani (Infectious Disease)	1979
2) Attaturk	1983
3) Dasht-e-Barchi	2006
4) Ehayaye Mojadad	1981
5) Esteqlal	1982
6) Ibne Sina Emergency	1961
7) Ibne Sina Sadri	1962
8) Indira Gandhi	1976
9) Jamhoriat	1975
10) Malalai	1946
11) Mental Health	1989
12) Noor Eye	1947
13) Rabia Balkhi	1991
14) Stomatology	1978
15) Tuberculosis	1931
16) Wazir Akbar Khan	1965

Table 26: Respondents Interviewed at National Hospital Level

Name of the Hospital	Dates of Data Collection	Respondents Covered						
		Hospital Manager	Hospital Procurement	Hospital Staff	Hospital Director	Outpatient – U5	Outpatient – Above 5	Inpatient
Respondents to Be Covered, per Hospital		1	1	20	1	12	12	12
Antani Hospital	Dec 14–15, 2013	1	1	20	1	-	-	-
Attaturk Hospital	Dec 18–21, 2013	1	1	20	1	-	-	-
Dasht-e-Barchi Hospital	Dec 22–24, 2013	1	1	20	1	3	12	10
Ehayaye Mojadad Hospital	Dec 22–24, 2013	1	1	20	1	1	3	12
Esteqlal Hospital	Dec 18–21, 2013	1	1	20	1	-	-	-

Name of the Hospital	Dates of Data Collection	Respondents Covered						
		Hospital Manager	Hospital Procurement	Hospital Staff	Hospital Director	Outpatient – U5	Outpatient – Above 5	Inpatient
Respondents to Be Covered, per Hospital		1	1	20	1	12	12	12
Ibne Sina Emergency Hospital	Dec 16–17, 2013	1	1	20	1	-	-	-
Ibne Sina Sadri Hospital	Dec 9–10, 2013	1	1	20	1	-	-	-
Indira Gandhi Hospital	Dec 25–28, 2013	1	1	20	1	-	-	-
Jamhoriat Hospital	Dec 11–12, 2013	1	1	20	1	-	-	-
Malalai Hospital	Dec 25–28, 2013	1	1	20	1	-	-	-
Mental Health Hospital	Dec 29–30, 2013	1	1	20	1	-	-	-
Noor Eye Clinic	Dec 10–12, 2013	1	1	20	1	6	3	12
Rabia Balkhi Hospital	Dec 16–17, 2013	1	1	20	1	-	-	-
Stomatology Hospital	Dec 14–15, 2013	1	1	20	1	3	12	12
Tuberculosis Hospital	Dec 29–30, 2013 and Jan 1, 2014	1	1	17	1	0	0	4
Wazir Akbar Khan Hospital	Dec 8–9, 2013	1	1	20	1	-	-	-

Table 27: Respondents Interviewed at Line-ministry and Stakeholder Levels

Respondent Category	Designation
MoF	Director of Budget and Reform
	All-Sectors Budget Coordinator
	Health Sector Manager Plus (Module-8)
MoPH	Deputy Minister of Health Service Provision
	Deputy Minister of Administration
	General Directorate of Policy, Planning and International Relations
	Director of Procurement Department
	Director of Central Hospitals Department
	Acting Director of Finance Department
	Head of Health Financing Unit, HEFD
	Advisor of General Directorate of Curative Medicine (Finance Advisor)
	Head of GCMU (Grant Contracting Management Unit)
	Head of Core Budget Department
	Head of Procurement Department, Advisor

Respondent Category	Designation
Stakeholders	Chief of Health Committee, Parliament
	Public-Private Partnership Representative
	Private Hospitals Representative
	Deputy of Kabul Provincial Council
	Official from European Commission

Profile of the National Hospitals Covered by PETS

Antani (Infectious Disease) Hospital: Antani (Infectious Disease) Hospital was established in 1979 as the first specialized infectious disease hospital in Afghanistan. The building has not been renovated since it opened. The hospital has a total of 100 beds, with a bed occupancy rate (BOR) of 46 percent and an average length of stay (ALOS) of two days. The hospital's outpatient department remains open from 8 a.m. until 4 p.m., seven days a week.

Ataturk Hospital: The Ataturk Hospital was founded in 1983 in cooperation with the Turkish government and is one of the largest children's hospitals in Kabul. The hospital has a total of 200 beds, with a BOR of 52 percent and an ALOS of 10 days. The OPD is open from 8 a.m. until 4 p.m., seven days a week. The building was undergoing renovation at the time of the survey.

Dasht-e-Barchi Hospital: The Dasht-e-Barchi Hospital is a 25-bed hospital established in 2006. The hospital provides services in general medicine; obstetrics and gynecology; ear, nose, and throat (ENT); family planning; and pediatric internal medicine. The BOR is 49 percent and the ALOS is 4.8 days. The operating hours for the hospital OPD are 8 a.m. until 4 p.m., five days a week. It is closed on Thursdays and Fridays.

Ehayaye Mojadad Hospital: The Ehayaye Mojadad Hospital was established in 1981; it provides services in medicine, stomatology, ophthalmology, orthopedics, and ENT. The hospital has 30 beds, with a BOR of 18 percent. The ALOS is 10 days. The hospital OPD is open all seven days a week from 8 a.m. until 4 p.m. MoPH recently renovated this hospital.

Esteqlal Hospital: Esteqlal Hospital is a 310-bed facility established in 1982. It provides services in general surgery, internal medicine, burns, and obstetrics and gynecology. It has a BOR of 91 percent and an ALOS of three days. The hospital OPD is open seven days a week from 8 a.m. until 4 p.m. MoPH recently renovated this hospital.

Ibne Sina Emergency Hospital: Established in 1961, Ibne Sina Emergency Hospital is a 200-bed hospital providing services in general surgery, internal medicine, dermatology, ENT, neurosurgery, and vascular specializations. The hospital OPD is open from 8 a.m. until 4 p.m. seven days a week. It has a BOR of 65 percent and an ALOS of four days.

Ibne Sina Sadri Hospital: The Ibne Sina Sadri hospital is a 60-bed hospital that began operating in 1962. The hospital provides specialized cardiac care and internal medicine services. It has a BOR of 71 percent and an ALOS of five days. The hospital OPD is open from Sunday to Wednesday.

Indira Gandhi Hospital: The Indira Gandhi Hospital is a 350-bed pediatric hospital founded in 1976 with assistance from the Indian government. It provides a number of services, including internal medicine, orthopedics, ENT, dermatology, and surgery. The hospital OPD is open five days a week, from Sunday through Wednesday. It has a BOR of more than 100 percent and an ALOS of four days.

Jamhoriat Hospital: Jamhoriat Hospital was established in 1975. The People's Republic of China constructed and equipped a new building for the hospital and handed it over to GoIRA in August 2009. The hospital has 200 inpatient beds. It has a BOR of 35 percent and an ALOS of four days. The OPD is open five days a week and provides services in internal medicine, surgery, ENT, and urology.

Malalai Hospital: Malalai was the first national hospital established for obstetrics and gynecology services in Afghanistan. It was established in 1946 and has 200 inpatient beds. The hospital has a BOR of more than 100 percent and the ALOS is three days. The hospital OPD is open seven days a week.

Mental Health Hospital: Established in 1989, this is the only mental health hospital in Afghanistan. It has 100 inpatient beds, with a BOR of 65 percent and an ALOS of 12 days. It provides mental health services, along with treatment for substance addiction. The OPD is open five days a week.

Noor Eye Hospital: The Noor Eye Hospital is a semi-autonomous ophthalmology specialty hospital established in 1947. The hospital has 75 beds, with a BOR of 13 percent and an ALOS of one day. The hospital OPD is open seven days a week.

Rabia Balkhi Hospital: Established in 1991, Rabia Balkhi is an obstetrics and gynecology hospital with 174 beds. It also provides services in internal medicine and surgery. The hospital has a BOR of 60 percent and an ALOS of one day. The hospital OPD is open seven days a week.

Stomatology Hospital: The Stomatology Hospital, which provides specialized dental services, was built in 1978. It has 30 inpatient beds. The hospital has a BOR of 72 percent and an ALOS of nine days. The Stomatology Hospital OPD is open five days a week.

Tuberculosis Hospital: The Tuberculosis Hospital of Kabul is a 35-bed hospital, established in 1931. The ALOS in the hospital is 62 days and the BOR is 50 percent. The hospital OPD is open five days a week, from Sunday to Wednesday.

Wazir Akbar Khan Hospital: The Wazir Akbar Khan Hospital was established in 1965. It is a 210-bed hospital with a BOR of 75 percent and an ALOS of six days. The hospital provides services in internal medicine, orthopedics, and surgery. The OPD is open seven days a week.

Budget Requested, Approved, Allotted, and Spent at MoPH and Hospital Levels, 2012 and 2013

Table 28: Budget Requested – MoPH and National Hospitals

Hospitals	Year	Total Budget Request											
		MoPH				Hospital				Difference			
		Total	Salaries	Services	Assets	Total	Salaries	Services	Assets	Total	Salaries	Services	Assets
Antani (Infectious Disease)	2012	26,941,334	23,819,667	2,829,167	292,500	26,941,334	23,819,667	2,829,167	292,500	0	0	0	0
	2013	60,261,031	36,358,943	19,774,088	4,128,000	60,261,031	36,358,943	19,774,088	4,128,000	0	0	0	0
Attaturk	2012	33,820,000	30,000,000	3,550,000	270,000	33,820,000	30,000,000	35,50,000	270,000	0	0	0	0
	2013	99,325,143	43,500,000	52,235,143	3,590,000	99,325,143	43,500,000	52,235,143	3,590,000	0	0	0	0
Dasht-e-Barchi	2012	8,994,463	6,904,463	2,000,000	90,000	8,994,463	6,904,463	2,000,000	90,000	0	0	0	0
	2013	30,417,545	11,375,546	18,684,999	357,000	30,417,545	11,375,546	18,684,999	357,000	0	0	0	0
Ehayaye Mojadad	2012	14,710,000	13,000,000	1,530,000	180,000	14,710,000	13,000,000	1,530,000	180,000	0	0	0	0
	2013	46,181,946	29,600,000	16,306,946	275,000	46,181,946	29,600,000	16,306,946	275,000	0	0	0	0
Esteqlal	2012	69,840,000	63,000,000	6,300,000	540,000	69,840,000	63,000,000	6,300,000	54,0000	0	0	0	0
	2013	182,772,621	101,000,000	78,950,621	2,822,000	182,772,621	101,000,000	78,950,621	2,822,000	0	0	0	0
Ibne Sina Emergency	2012	45,770,000	38,500,000	6,770,000	50,0000	45,770,000	38,500,000	6,770,000	500,000	0	0	0	0
	2013	151,486,000	75,000,000	70,442,000	6,044,000	151,486,000	75,000,000	70,442,000	6,044,000	0	0	0	0
Ibne Sina Sadri	2012	25,920,000	21,500,000	3,970,000	450,000	25,920,000	21,500,000	3,970,000	450,000	0	0	0	0
	2013	70,656,264	30,000,000	37,059,264	3,597,000	70,656,264	30,000,000	37,059,264	3,597,000	0	0	0	0
Indira Gandhi	2012	66,126,667	59,400,000	6,336,667	390,000	66,126,667	59,400,000	6,336,667	390,000	0	0	0	0
	2013	207,126,001	85,000,000	116,562,001	5,564,000	207,126,001	85,000,000	116,562,001	5,564,000	0	0	0	0
Jamhoriat	2012	45,336,455	39,931,455	5,112,500	292,500	45,336,455	39,931,455	5,112,500	292,500	0	0	0	0
	2013	104,574,897	66,600,000	37,574,397	400,500	104,574,897	66,600,000	37,574,397	400,500	0	0	0	0
Malalai	2012	51,932,333	43,557,333	7,400,000	975,000	51,932,333	43,557,333	7,400,000	975,000	0	0	0	0
	2013	154,546,999	74,300,000	79,913,999	333,000	154,546,999	74,300,000	79,913,999	333,000	0	0	0	0
Mental Hospital	2012	21,830,000	19,700,000	1,950,000	180,000	21,830,000	19,700,000	1,950,000	180,000	0	0	0	0
	2013	56,435,391	25,000,000	31,128,391	307,000	56,435,391	25,000,000	31,128,391	307,000	0	0	0	0

Hospitals	Year	Total Budget Request											
		MoPH				Hospital				Difference			
		Total	Salaries	Services	Assets	Total	Salaries	Services	Assets	Total	Salaries	Services	Assets
Noor Eye	2012	21,534,036	21,534,036	0	0	21,534,036	21,534,036	0	0	0	0	0	0
	2013	23,048,436	23,048,436	0	0	23,048,436	23,048,436	0	0	0	0	0	0
Rabia Balkhi	2012	47,851,272	42,039,105	5,032,167	780,000	47,851,272	42,039,105	5,032,167	780,000	0	0	0	0
	2013	117,736,000	55,600,000	61,473,000	663,000	117,736,000	55,600,000	61,473,000	663,000	0	0	0	0
Stomatology	2012	38,299,457	27,667,178	9,060,779	1,571,500	38,299,457	27,667,178	9,060,779	1,571,500	0	0	0	0
	2013	71,736,358	41,094,343	29,964,515	677,500	71,736,358	41,094,343	29,964,515	677,500	0	0	0	0
Tuberculosis	2012	12,698,521	8,054,940	4,643,581	0	12,698,521	8,054,940	4,643,581	0	0	0	0	0
	2013	31,410,501	11,342,000	19,515,001	553,500	31,410,501	11,342,000	19,515,001	553,500	0	0	0	0
Wazir Akbar Khan	2012	58,929,004	58,929,004	0	0	58,929,004	58,929,004	0	0	0	0	0	0
	2013	166,249,354	80,000,000	79,124,354	7,125,000	166,249,354	80,000,000	79,124,354	7,125,000	0	0	0	0

Table 29: Budget Approved – MoPH and National Hospitals

Hospitals	Year	Total Budget Approved					
		MoPH	Hospital				Difference
		Total	Total	Salaries	Services	Assets	Total
Antani (Infectious Disease)	2012	26,941,334	26,941,334	23,819,667	2,829,167	292,500	0
	2013	60,261,031	60,261,031	36,358,943	19,774,088	4,128,000	0
Attaturk	2012	33,820,000	33,820,000	30,000,000	3,550,000	270,000	0
	2013	75,625,488	75,625,488	42,500,000	31,330,490	1,794,998	0
Dasht-e-Barchi	2012	8,994,463	8,994,463	6,904,463	2,000,000	90,000	0
	2013	25,456,228	25,456,228	11,375,546	13,902,182	1,78,500	0
Ehayaye Mojadad	2012	14,710,000	14,710,000	13,000,000	1,530,000	180,000	0
	2013	40,082,596	40,082,596	28,100,000	11,707,596	275,000	0
Esteqlal	2012	69,840,000	69,840,000	63,000,000	6,300,000	540,000	0
	2013	182,772,621	182,772,621	101,000,000	78,950,621	2,822,000	0
Ibne Sina Emergency	2012	45,770,000	45,770,000	38,500,000	6,770,000	500,000	0
	2013	131,543,431	131,543,431	70,650,000	55,806,431	5,087,000	0
Ibne Sina Sadri	2012	25,920,000	25,920,000	21,500,000	3,970,000	450,000	0
	2013	55,607,722	55,607,722	28,550,000	23,889,222	3,168,500	0
Indira Gandhi	2012	66,126,667	66,126,667	59,400,000	6,336,667	390,000	0
	2013	195,475,631	195,475,631	85,000,000	107,693,631	2,782,000	0
Jamhoriat	2012	45,336,455	45,336,455	39,931,455	5,112,500	292,500	0
	2013	104,574,897	104,574,897	66,600,000	37,574,397	400,500	0
Malalai	2012	51,932,333	51,932,333	43,557,333	7,400,000	975,000	0
	2013	147,757,613	147,757,613	74,300,000	73,291,113	166,500	0
Mental Hospital	2012	21,830,000	21,830,000	19,700,000	1,950,000	180,000	0
	2013	56,435,391	56,435,391	25,000,000	31,128,391	307,000	0
Noor Eye	2012	21,534,036	21,534,036	21,534,036	0	0	0
	2013	23,048,436	23,048,436	23,048,436	0	0	0

Hospitals	Year	Total Budget Approved					
		MoPH	Hospital				Difference
		Total	Total	Salaries	Services	Assets	Total
Rabia Balkhi	2012	47,729,105	47,851,272	42,039,105	5,032,167	780,000	-122,167
	2013	117,736,000	117,736,000	55,600,000	61,473,000	663,000	0
Stomatology	2012	38,299,457	38,299,457	27,667,178	9,060,779	1,571,500	0
	2013	71,736,358	71,736,358	41,094,343	29,964,515	677,500	0
Tuberculosis	2012	12,698,521	12,698,521	8,054,940	4,643,581	0	0
	2013	31,410,501	31,410,501	11,342,000	19,515,001	553,500	0
Wazir Akbar Khan	2012	58,929,004	58,929,004	58,929,004	0	0	0
	2013	156,915,907	156,915,907	80,000,000	73,353,407	3,562,500	0

Table 30: Budget Allotted – MoPH and National Hospitals

Hospitals	Year	Total Budget Allotted											
		MoPH				Hospital				Difference			
		Total	Salaries	Services	Assets	Total	Salaries	Services	Assets	Total	Salaries	Services	Assets
Antani (Infectious Disease)	2012	27,547,345	24,527,345	2,750,000	270,000	26,941,334	23,819,667	2,829,167	292,500	606,011	707,678	-79,167	-22,500
	2013	60,261,031	36,358,943	19,774,088	4,128,000	60,261,031	36,358,943	19,774,088	4,128,000	0	0	0	0
Attaturk	2012	33,820,000	30,000,000	3,550,000	270,000	33,820,000	30,000,000	3,550,000	270,000	0	0	0	0
	2013	75,631,328	42,505,831	31,330,497	1,795,000	75,625,488	42,500,000	31,330,490	1,794,998	5,840	5,831	7	2
Dasht-e-Barchi	2012	9,139,774	7,049,774	2,000,000	90,000	8,994,463	6,904,463	2,000,000	90,000	145,311	145,311	0	0
	2013	25,338,277	11,060,546	14,099,231	178,500	25,456,228	11,375,546	13,902,182	178,500	-117,951	-315,000	197,049	0
Ehayaye Mojadad	2012	14,710,000	13,000,000	1,530,000	180,000	14,710,000	13,000,000	1,530,000	180,000	0	0	0	0
	2013	40,089,230	28,106,635	11,707,595	275,000	40,082,596	28,100,000	11,707,596	275,000	6,634	6,635	-1	0
Esteqlal	2012	69,891,938	63,051,938	6,300,000	540,000	69,840,000	63,000,000	6,300,000	540,000	51,938	51,938	0	0
	2013	184,838,105	101,065,484	80,950,621	2,822,000	182,772,621	101,000,000	78,950,621	2,822,000	2,065,484	65,484	2,000,000	0
Ibne Sina Emergency	2012	45,788,900	38,518,900	6,770,000	500,000	45,770,000	38,500,000	6,770,000	500,000	18,900	18,900	0	0
	2013	132,890,749	70,650,000	58,831,888	3,408,861	131,543,431	70,650,000	55,806,431	5,087,000	1,347,318	0	3,025,457	-1,678,139
Ibne Sina Sadri	2012	25,948,049	21,528,049	3,970,000	450,000	25,920,000	21,500,000	3,970,000	450,000	28,049	28,049	0	0
	2013	56,807,721	29,650,000	23,989,221	3,168,500	55,607,722	28,550,000	23,889,222	3,168,500	1,199,999	1,100,000	99,999	0
Indira Gandhi	2012	66,602,221	60,042,221	6,200,000	360,000	66,126,667	5,9400,000	6,336,667	390,000	475,554	642,221	-136,667	-30,000
	2013	195,587,114	85,111,484	107,693,630	2,782,000	195,475,631	85,000,000	107,693,631	2,782,000	111,483	111,484	-1	0
Jamhoriat	2012	4,372,0000	38,500,000	4,950,000	270,000	45,336,455	39,931,455	5,112,500	292,500	-1,616,455	-1,431,455	-162,500	-22,500
	2013	104,574,897	66,600,000	37,574,397	400,500	104,574,897	66,600,000	37,574,397	40,0500	0	0	0	0
Malalai	2012	52,900,000	44,800,000	7,200,000	900,000	51,932,333	43,557,333	7,400,000	975,000	967,667	1,242,667	-200,000	-75,000
	2013	140,921,988	74,464,375	65,291,113	1,166,500	140,757,613	74,300,000	65,291,113	1,166,500	164,375	164,375	0	0
Mental Hospital	2012	22,190,000	20,060,000	1,950,000	180,000	21,830,000	19,700,000	1,950,000	180,000	360,000	360,000	0	0
	2013	41,282,434	19,247,044	21,728,390	307,000	56,435,391	25,000,000	31,128,391	307,000	-15,152,957	-5,752,956	-9,400,001	0
Noor Eye	2012	21,534,036	21,534,036	0	0	21,534,036	21,534,036	0	0	0	0	0	0
	2013	23,048,436	23,048,436	0	0	23,048,436	23,048,436	0	0	0	0	0	0

Hospitals	Year	Total Budget Allotted											
		MoPH				Hospital				Difference			
		Total	Salaries	Services	Assets	Total	Salaries	Services	Assets	Total	Salaries	Services	Assets
Rabia Balkhi	2012	47,729,105	42,039,105	4,970,000	720,000	47,851,272	42,039,105	5,032,167	780,000	-122,167	0	-62,167	-60,000
	2013	112,543,247	65,800,000	46,411,747	331,500	110,543,247	65,900,000	44,311,747	331,500	2,000,000	-100,000	2,100,000	0
Stomatology	2012	31,810,000	24,900,000	6,100,000	810,000	31,810,000	24,900,000	6,100,000	810,000	0	0	0	0
	2013	71,736,358	41,094,343	29,964,515	677,500	71,736,358	41,094,343	29,964,515	677,500	0	0	0	0
Tuberculosis	2012	12,698,521	8,054,940	4,643,581	0	12,698,521	8,054,940	4,643,581	0	0	0	0	0
	2013	31,410,501	11,342,000	19,515,001	553,500	31,410,501	11,342,000	19,515,001	553,500	0	0	0	0
Wazir Akbar Khan	2012	58,929,004	58,929,004	0	0	58,929,004	58,929,004	0	0	0	0	0	0
	2013	150,955,452	74,039,545	73,353,407	3,562,500	150,915,907	74,000,000	73,353,407	3,562,500	39,545	39,545	0	0

Table 31: Budget Spent – MoPH and National Hospitals

Hospitals	Year	Total Budget Spent											
		MoPH				Hospital				Difference			
		Total	Salaries	Services	Assets	Total	Salaries	Services	Assets	Total	Salaries	Services	Assets
Antani (Infectious Disease)	2012	25,341,743	23,538,256	1,803,487	0	25,683,642	23,791,685	1,891,957	0	-341,899	-253,429	-88,470	0
	2013	57,863,475	35,272,295	18,605,580	3,985,600	57,886,874	35,387,705	18,513,569	3,985,600	-23,399	-115,410	92,011	0
Attaturk	2012	31,388,804	28,168,740	3,110,114	109950	31,696,330	28,287,116	3,269,214	140,000	-307,526	-118,376	-159,100	-30,050
	2013	60,510,141	42,075,039	16,669,752	1,765,350	61,451,935	42,471,455	17,215,130	1,765,350	-941,794	-396,416	-545,378	0
Dasht-e-Barchi	2012	8,607,367	6,830,731	1,776,636	0	8,681,099	6,904,463	1,776,636	0	-73,732	-73,732	0	0
	2013	21,567,078	10,441,866	10,990,212	135,100	21,989,978	10,823,545	11,028,583	137,850	-422,900	-381,679	-38,371	-2,750
Ehayaye Mojadad	2012	14,058,060	12,652,660	1,231,700	173,700	14,082,870	12,679,369	1,229,801	173,700	-24,810	-26,709	1,899	0
	2013	33,600,833	25,472,790	7,854,043	274,000	33,702,640	25,524,437	7,904,203	274,000	-101,807	-51,647	-50,160	0
Esteqlal	2012	63,474,346	57,347,811	5,935,075	191,460	63,090,912	57,106,296	5,800,156	184,460	383,434	241,515	134,919	7000
	2013	170,246,571	100,146,387	67,519,672	2,580,512	169,996,727	98,693,453	68,586,762	2,716,512	249,844	1,452,934	-1,067,090	-136000
Ibne Sina Emergency	2012	38,941,953	35,652,857	3,289,096	0	41,567,802	37,893,212	3,674,590	0	-2,625,849	-2,240,355	-385,494	0
	2013	124,087,295	69,931,995	52,666,526	1,488,774	124,559,681	70,494,738	52,581,069	1,483,874	-472,386	-562,743	85,457	4,900
Ibne Sina Sadri	2012	21,886,654	20,189,708	1,273,246	423,700	20,285,563	18,528,532	1,333,331	423,700	1,601,091	1,661,176	-60,085	0
	2013	50,794,560	28,427,267	19,295,333	3,071,960	50862,192	28,494,899	19,295,333	3,071,960	-67,632	-67,632	0	0
Indira Gandhi	2012	61,461,140	57,036,297	4,334,843	90,000	63,859,573	59,301,300	4,468,273	90,000	-2,398,433	-2,265,003	-133,430	0
	2013	143,151,813	83,778,381	58,067,832	1,305,600	141,610,790	82,120,086	58,185,104	1,305,600	1,541,023	1,658,295	-117,272	0
Jamhoriat	2012	40,423,898	36,691,922	3,472,796	259,180	4,362,2959	39,931,455	3,484,474	207,030	-3,199,061	-3,239,533	-11,678	52,150
	2013	101,417,603	65,783,959	35,568,394	65,250	100,820,950	64,906,720	35,867,230	47,000	596,653	877,239	-298,836	18,250
Malalai	2012	47,694,700	42,843,481	4,851,219	0	47,681,014	42,826,045	4,466,019	388,950	13,686	17,436	385,200	-388,950
	2013	134,960,914	73,327,250	61,403,189	230,475	135,127,100	73,466,286	61,437,814	22,3000	-166,186	-139,036	-34,625	7,475
Mental Hospital	2012	16,584,043	15,805,800	738,243	40,000	16,641,816	15,831,438	810,378	0	-57,773	-25,638	-72,135	40,000
	2013	30,559,660	19,104,232	11,325,028	130,400	45,064,455	24,998,655	19,935,400	130,400	-14,504,795	-5,894,423	-8,610,372	0
Noor Eye	2012	21,534,036	21,534,036	0	0	21,534,036	21,534,036	0	0	0	0	0	0
	2013	23,048,436	2,3048,436	0	0	23,048,436	23,048,436	0	0	0	0	0	0

Hospitals	Year	Total Budget Spent											
		MoPH				Hospital				Difference			
		Total	Salaries	Services	Assets	Total	Salaries	Services	Assets	Total	Salaries	Services	Assets
Rabia Balkhi	2012	44,103,799	41,117,811	2,493,953	492,035	4,6279,055	43,156,775	2,374,230	748,050	-2,175,256	-2,038,964	119,723	-256,015
	2013	109,129,965	65,231,404	43,582,161	316,400	108,459,520	65,702,802	4,2440,318	316,400	670,445	-471,398	1,141,843	0
Stomatology	2012	26,077,970	23,788,926	1,966,374	322,670	27,825,813	23,979,470	3,090,173	756,170	-1,747,843	-190,544	-1,123,799	-433,500
	2013	69,964,541	40,663,620	28,647,662	653,259	70,115,759	40,772,412	28,693,088	650,259	-151,218	-108,792	-45,426	3,000
Tuberculosis	2012	12,698,521	8,054,940	4,643,581	0	12,698,521	8,054,940	4,643,581	0	0	0	0	0
	2013	15,586,231	11,296,426	3,793,848	495,957	15,586,231	11,296,426	3,793,848	495,957	0	0	0	0
Wazir Akbar Khan	2012	58,929,004	58,929,004	0	0	58,929,004	58,929,004	0	0	0	0	0	0
	2013	129,196,843	71,823,419	53,851,144	3,522,280	129,485,533	69,668,660	56,294,593	3,522,280	-288,690	2,154,759	-2,443,449	0

Service Delivery in the National Hospitals

Service delivery

The national hospitals of Kabul are referral centers for secondary and tertiary care for both the provincial and regional hospitals of Afghanistan. The country has a total of 18 national hospitals; all are located in Kabul. Of these, the 16 national hospitals in the sample are supported by MoPH, while the remaining two are supported by the Ministry of Higher Education (MoHE).

The average number of beds available in the 16 national hospitals is 144. The number of beds ranges from as low as 25 to 30 in the Dasht-e-Barchi, Ehayaye Mojadad, and Stomatology Hospitals to as high as 300 to 350 beds in the Esteqlal and Indira Gandhi Hospitals. Table 32 gives an overview of the existing status of service delivery across the 16 national hospitals under the ambit of this study.

Figure 10: Number of Beds, by Hospital

Hospital	Number of Beds
Indira Gandhi	350
Estaqlal	310
Wazir Akbar Khan	210
Malalai	200
Jamhoriat	200
Ibne Sina Emergency	200
Attaturk	200
Rabia Balkhi	174
Mental Hospital	100
Antani (Infectious Disease)	100
Noor Eye	75
Ibne Sina Sadri	60
Tuberculosis	35
Stomatology	30
Ehayaye Mojadad	30
Dasht-e-Berchi	25
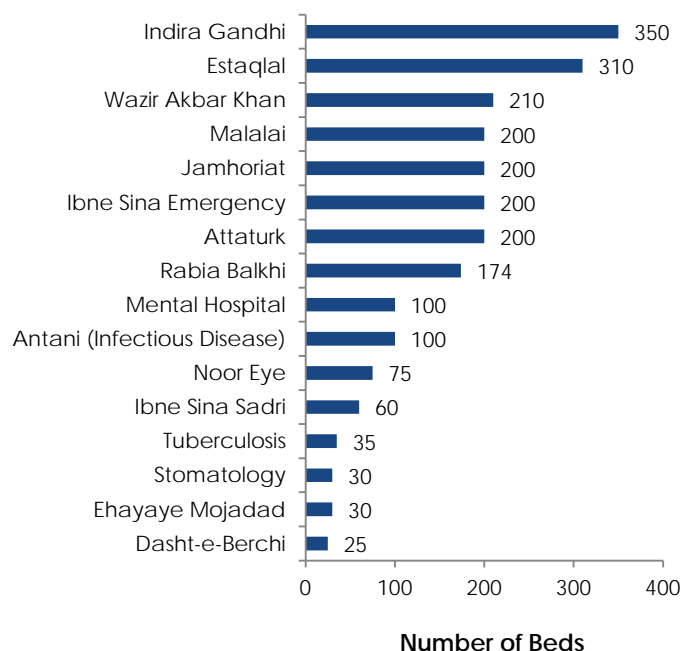
Table 32: Overall Statistics for the 16 National Hospitals

Total number of beds		2,299
Total outpatients who visited in the year	2012	984,487
	2013	1,228,038
Total inpatients who visited in the year	2012	167,627
	2013	195,165

The number of inpatients and outpatients per hospital in 2012 and 2013 is given in Figures11 and 12 below. These figures show that certain hospitals, including Indira Gandhi, Ibne Sina Emergency, Stomatology, and Esteqlal, had a high volume of outpatient visits, whereas Malalai and Rabia Balkhi, along with Indira Gandhi and Esteqlal, had a high volume of inpatient visits. However, the highest percentage increase in the number of outpatient visits occurred at Wazir Akbar Khan Hospital, followed by the Jamhoriat, Mental Health, and Indira Gandhi Hospitals. Similarly, Wazir Akbar Khan also had a high percentage increase in the inpatient visits. The Ataturk Hospital had a percentage decrease in inpatient and outpatient visits because the hospital has been under renovation. The hospital remained open for only the three initial months of 2013.

Figure 11: Number of Outpatients Who Visited the 16 Hospitals

Hospital	2013	2012
Indira Gandhi	265,744	178,203
Ibne Sina Emergency	179,342	140,454
Stomatology	133,965	105,851
Estaqlal	126,432	95,541
Wazir Akbar Khan	84,535	36,049
Noor Eye	82,120	71,065
Rabia Balkhi	77,526	68,561
Malalai	55,080	45,798
Dasht-e-Berchi	47,814	46,466
Jamhoriat	40,190	18,526
Antani	33,995	31,288
Ibne Sina Sadri	32,280	30,622
Mental Hospital	27,238	15,963
Tuberculosis	15,102	11,471
Attaturk	13,352	76,361
Ehayaye Mojadad	13,323	12,268

Figure 12: Number of Inpatients Who Visited the 16 Hospitals

Hospital	2013	2012
Malalai	38,921	31,621
Rabia Balkhi	37,856	30,039
Indira Gandhi	35,444	32,336
Estaqlal	34,188	29,728
Ibne Sina Emergency	11,833	10,637
Wazir Akbar Khan	9,582	3,048
Antani	8,347	7,467
Jamhoriat	6,457	5,259
Noor Eye	3,659	3,451
Ibne Sina Sadri	3,105	2,905
Mental Hospital	1,971	1,534
Dasht-e-Berchi	1,688	1,180
Attaturk	937	7,614
Stomatology	874	512
Ehayaye Mojadad	201	198
Tuberculosis	102	98
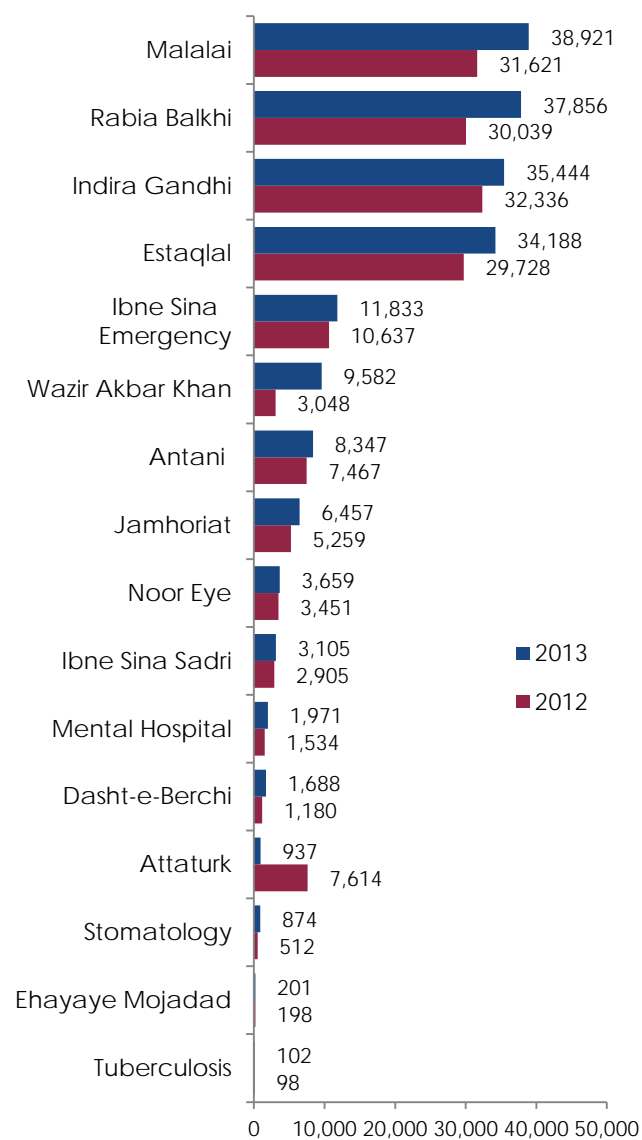
Bed Occupancy Rate (BOR) – BOR indicates the popularity of the hospital in terms of inpatient admissions. It varies according to the number of beds available in the respective hospitals. In the current study, hospitals' BOR was calculated using the total number of registered beds. In Malalai, Indira Gandhi, Dasht-e-Barchi, and Esteqlal Hospitals, the BOR was more than 90 percent. The data show an increase in the BOR of most of the hospitals in 2013 compared to 2012. Figure 13 below shows the BOR of the 16 national hospitals.

Average Length of Stay (ALOS) **–** A hospital's ALOS refers to how long a patient is hospitalized. The information regarding hospitals' ALOS was collected during interviews with hospital directors. It shows that only five hospitals—Rabia Balkhi, Noor Eye, Antani, Malalai, and Esteqlal—had an ALOS of three days or less, while the Stomatology, Ehayaye Mojadad, Attaturk, Mental Health, and Tuberculosis Hospitals had a high ALOS. Figure 14 below shows the ALOS of the national hospitals.

Figure 13: Bed Occupancy Rate at the 16 Hospitals
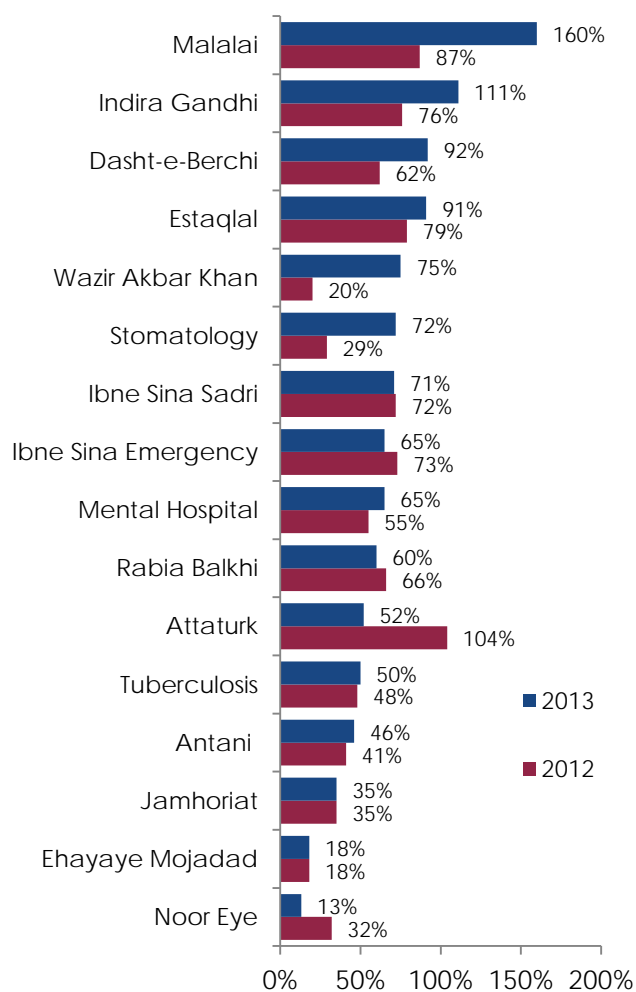
Figure 14: Average Length of Stay at the 16 Hospitals
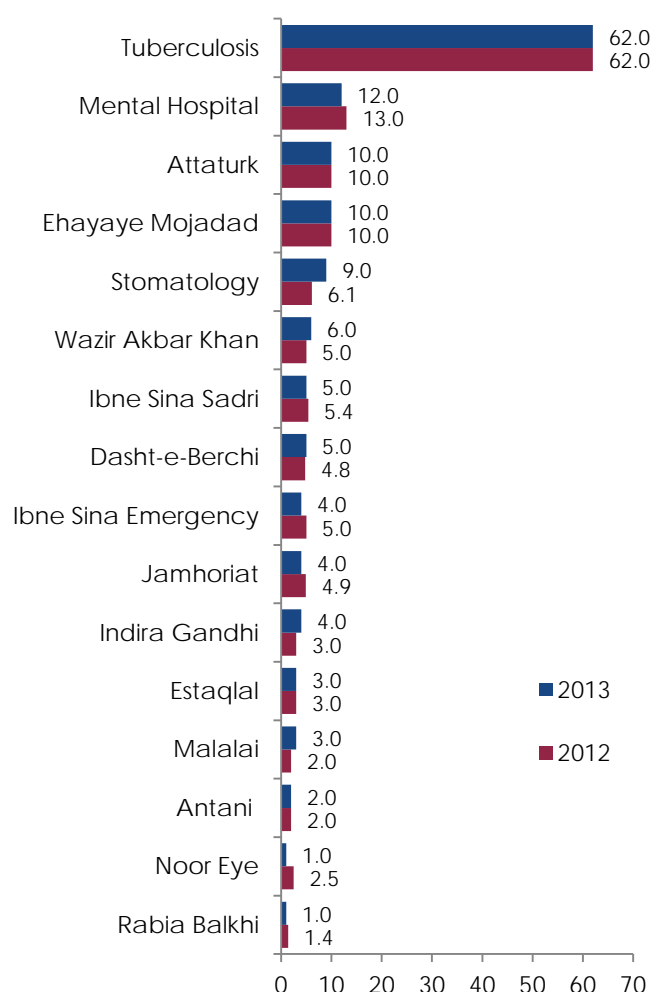
Hospital infrastructure and physical capacity

Building Condition – Hospitals represent very complex building types and cover a wide range of services and functional units. An examination of the physical condition of the 16 hospital buildings revealed that Antani Hospital needs many repairs, as the building has not been renovated since its establishment in 1979. All of the other hospitals have undergone renovation and seemed to be in good condition; some, however, do need a few repairs. Table 33 below represents the existing physical condition of the 16 hospitals.

Table 33: General Condition of National Hospital Buildings

Hospitals	Windows and Doors	Toilets	Facility Exterior Walls	Roof Condition	Lighting	Grounds, Fence/wall	Gate
Antani (Infectious Disease)	Many repairs needed	Many repairs needed	Many repairs needed	Many repairs needed	Many repairs needed	Many repairs needed	Many repairs needed
Attaturk	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs
Dasht-e-Barchi	Many repairs needed	Many repairs needed	Few or no repairs	Many repairs needed	Few or no repairs	Few or no repairs	Few or no repairs
Ehayaye Mojadad	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs
Esteqlal	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs
Ibne Sina Emergency	Few or no repairs	Few or no repairs	Many repairs needed	Few or no repairs	Many repairs needed	Few or no repairs	Many repairs needed
Ibne Sina Sadri	Few or no repairs	Many repairs needed	Many repairs needed	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs
Indira Gandhi	Few or no repairs	Many repairs needed	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs
Jamhoriat	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs
Malalai	Few or no repairs	Many repairs needed	Many repairs needed	Few or no repairs	Few or no repairs	Many repairs needed	Many repairs needed
Mental Hospital	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs
Noor Eye	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs
Rabia Balkhi	Few or no repairs	Many repairs needed	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs
Stomatology	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs
Tuberculosis	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs
Wazir Akbar Khan	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs	Few or no repairs

Legend: ■ Many repairs needed. ■ Few or no repairs needed.

Electricity – All of the 16 hospitals receive electricity from the state electric company. In addition to an alternative power source separated from the other hospital buildings, they all have a functioning fire extinguisher available in the generator room.

Figure 15: Reliability of Main Source of Electricity

Pie chart values:
- 1 or more interuption/day in a month: 2
- No interruptions: 9
- Less than 1 interruption/day in a month: 4
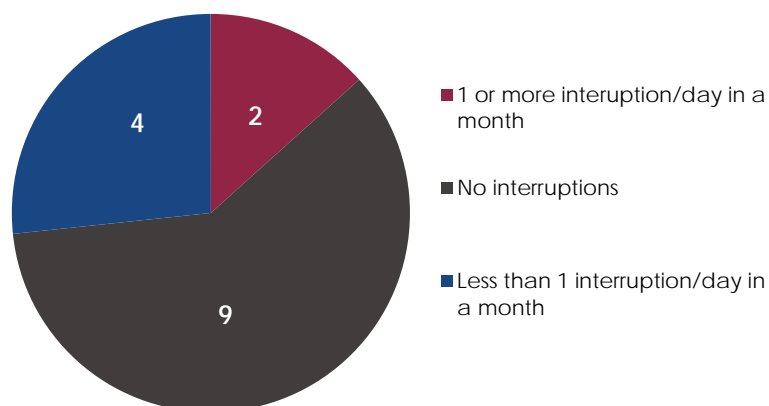
However, the reliability of electricity supply in the hospitals is an area of concern. Out of the 16 hospitals surveyed, seven reported having a problem with power outages. Of these, four hospitals—the Dasht-e-Barchi, Ibne Sina Sadri, Indira Gandhi, and Mental Health—reported having fewer than one outage per day; three hospitals—Malalai, Stomatology and Tuberculosis—cited one or more outages per day. Nevertheless, none of the 16 hospitals reported an interruption in their alternative power sources.

Water – The main source of water for the hospitals is a piped supply (Figure 16).

As in the case of electricity, few hospitals reported interruptions in their water source; Rabia Balkhi and Dasht-e-Barchi cited less than one interruption per day, whereas Noor Eye and Indira Gandhi cited more than one interruption per day.

Communication and Transportation – All of the 16 hospitals said they had functioning phones and/or radio available. The respondents also said that their hospitals had functioning ambulances. However, Dasht-e-Barchi, Ibne Sina Sadri, Mental Health Hospital, and Rabia Balkhi mentioned that the ambulance was most frequently used by their administrative hierarchies rather than by patients. A snapshot of the number of vehicles available in the hospitals is given below in Table 34:

Figure 16: Source of Water for the Hospitals

■ Piped water from city to facility
■ Piped water from own system to facility
■ Piped water from yard/plot
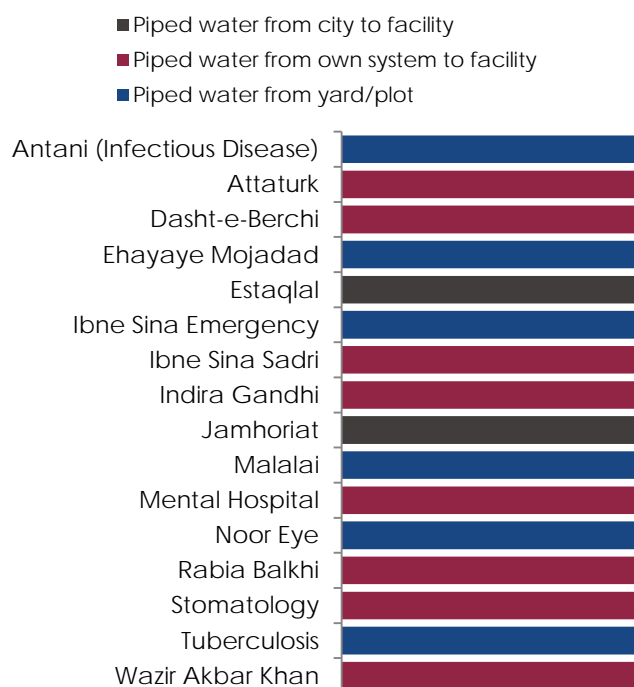
Table 34: Transport Facilities in the 16 National Hospitals

Hospitals	Operating Ambulances	Cars	Motorcycles	Bicycles
	Number			
Antani (Infectious Disease)	1	2	0	1
Attaturk	4	1	0	1
Dasht-e-Barchi	1	1	0	1
Ehayaye Mojadad	1	0	0	2
Esteqlal	1	1	0	0
Ibne Sina Emergency	5	1	0	2
Ibne Sina Sadri	2	1	0	2
Indira Gandhi	1	1	0	1
Jamhoriat	5	0	0	1
Malalai	2	2	0	1
Mental Hospital	1	0	0	0
Noor Eye	1	1	0	1

Hospitals	Operating Ambulances	Cars	Motorcycles	Bicycles
	Number			
Rabia Balkhi	1	2	0	0
Stomatology	1	2	0	0
Tuberculosis	1	1	1	2
Wazir Akbar Khan	4	2	0	0

Human Resources

The human resources of hospitals include the different clinical and non-clinical staff responsible for service delivery. They are key to any health system, as service delivery depends largely upon the knowledge, skills, and motivation of these individuals.

The average working hours as reported by the staff of the national hospitals is around eight hours a day.

The details of the hospitals' HR status and key indicators are described in the section below.

Staffing Pattern and Ratio – This refers to staffing requirements against the authorized positions at the hospitals. Figure 17 shows the proportion of filled and vacant staff position across the 16 hospitals. It shows that the number of anesthetists available is much lower than the required number (13 out of 39 position are vacant), followed by specialist doctors and nurses. Table 35 below shows the vacant staff positions across all 16 hospitals.

Figure 17: Percentage of Filled vs. Vacant Positions across the 16 Hospitals

	In position	Vacant
Doctors:Generalists	96%	4%
Doctors:Specialists	91%	9%
Nurses	92%	8%
Midwives	99%	1%
Anesthetists	67%	33%
Lab assistants/Techinicians	96%	4%
Radiologists	97%	3%
Pharmacists	98%	2%
Dental Specialists	98%	2%
Other Medical Personnel	92%	8%
Admin/Finance	95%	5%
Other personnel	97%	3%

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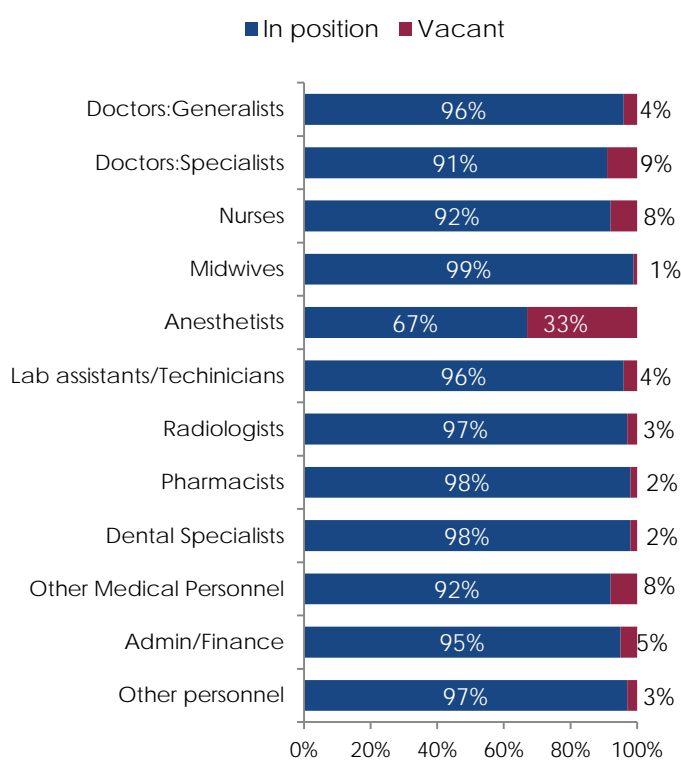
Table 35: Employee Distribution in the 16 National Hospitals, by Type and Occupation

Hospitals		Doctors: Generalists	Doctors: Specialists	Nurses	Midwives	Anesthetist	Radiologist	Lab Assist./Tech	Pharmacist	Dental Specialists	Other Medical Personnel	Admin/Finance	Other Personnel
Antani (Infectious Disease)	Approved	37	19	44			4	7	6		2	19	88
	In position	37	18	41			4	7	6		2	19	86
Attaturk	Approved	38	27	65		5	5	6	6		4	21	76
	In position	36	22	58		5	5	5	6		4	21	75
Dasht-e-Barchi	Approved	2	9	11	3			4	2		3	10	21
	In position	1	4	9	3			4	2		1	8	21
Ehayaye Mojadad	Approved	9	4	8		2	2	2	2	1	4	24	53
	In position	8	3	7		1	2	2	2	1	4	22	53
Esteqlal	Approved	89	46	118	45	4		32	8		13	23	139
	In position	84	42	118	45	2		29	8		12	22	137
Ibne Sina Emergency	Approved	67	50	65		2	7	7	6			24	98
	In position	66	49	65		1	7	7	6			24	98
Ibne Sina Sadri	Approved	19	12	37		3		11	5		1	22	56
	In position	19	12	35		2		11	5		0	21	56
Indira Gandhi	Approved	127	55	147		3	1	40	10	3	14	36	134
	In position	119	53	122		1	0	40	10	2	11	32	134
Jamhoriat	Approved	78	38	74		3		32	9		5	24	95
	In position	76	36	69		2		30	9		3	24	94
Malalai	Approved	126	20	25	105	3	4	8	8		11	28	111
	In position	124	12	25	105	3	4	8	7		11	28	111
Mental Hospital	Approved	15	10	19				2	3		18	21	44
	In position	13	8	19				2	3		18	20	44
Noor Eye	Approved	24	21	31		3		4	6			25	53
	In position	22	19	23		3		4	6			25	53
Rabia Balkhi	Approved	80	42	31	85	5		25	7		24	23	101
	In position	77	40	31	82	1		22	7		24	23	100
Stomatology	Approved	49		14				58	3	36		24	67
	In position	47		13				58	3	36		23	66
Tuberculosis	Approved	10	3	4			2	10	2		7	12	17
	In position	7	3	3			2	10	1		7	10	15

Hospitals		Doctors: Generalists	Doctors: Specialists	Nurses	Midwives	Anesthetist	Radiologist	Lab Assist./Tech	Pharmacist	Dental Specialists	Other Medical Personnel	Admin/ Finance	Other Personnel
Wazir Akbar Khan	Approved	85	43	132	■	6	8	8	8	■	■	24	107
	In position	84	41	121	■	5	8	8	8	■	■	21	81

Another important criterion in delivering quality healthcare is the staff ratio. The need for an adequate staff ratio to ensure quality in patient care is recognized worldwide. The General Directorate Curative Medicine, MoPH, recommends that the national hospitals should, on average, have one doctor per two nurses—one doctor per four beds and one nurse per two beds. Though the recommended staff ratio varies by ward, the ratios mentioned above are overall averages across all wards. Figure 18 shows the staff ratios at the national hospitals.

Figure 18: Staff Ratio at the 16 National Hospitals
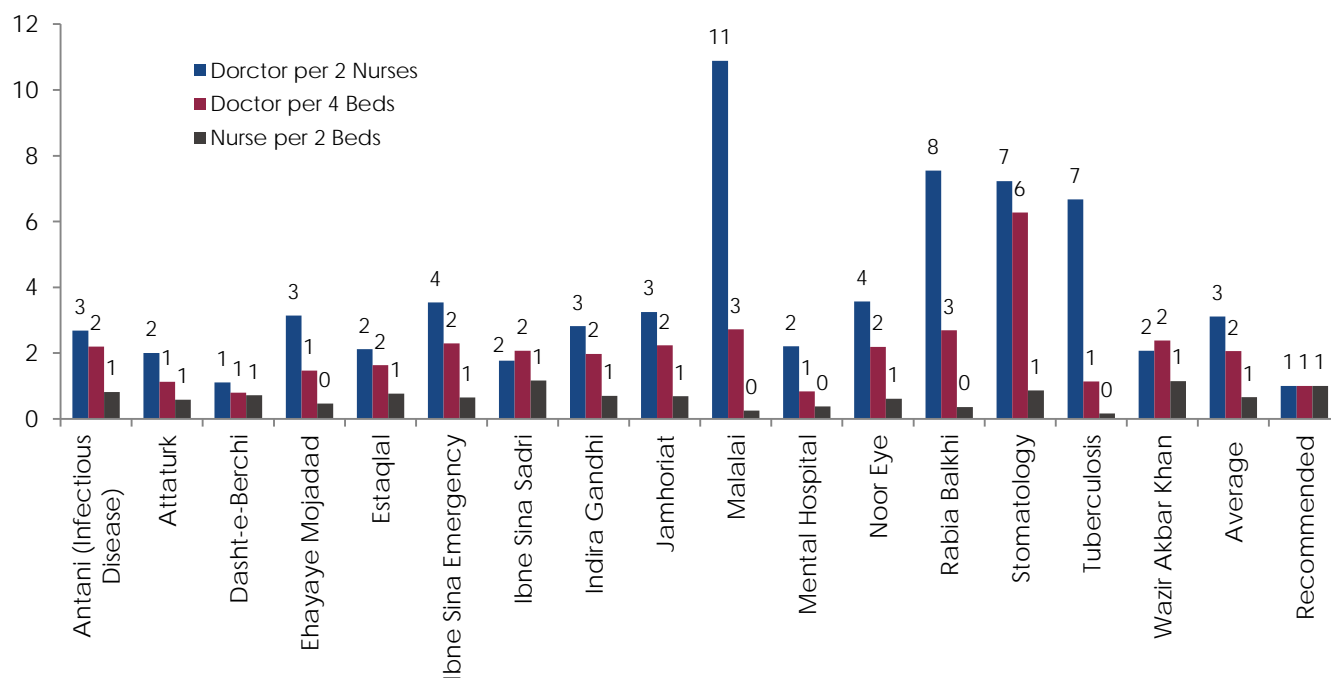
Considering the existing staffing positions, the survey showed that the national hospitals have more doctors and fewer nurses than the required ratio. Contrary to the recommended ratio of 1:2, the national hospitals have a doctor-to-nurse ratio of 3:2, ranging from as high as 11:2 in Malalai Hospital to 1:2 in Dasht-e-Barchi Hospital.

Similarly, the doctor-to-bed ratio in the 16 national hospitals is 2:4, in contrast to the recommended ratio of 1:4. In Stomatology Hospital, the ratio is as high as 6:4, whereas only five of the 16 hospitals have the recommended staff ratio—Attaturk, Dasht-e-Barchi, Ehayaye Mojadad, Mental Health, and Tuberculosis.

In the Malalai Hospital, the doctor-to-bed ratio is 3:4, which is on the high side.

Considering the nurse-to-bed ratio, the survey showed that the national hospitals have fewer nurses per bed than the required proportion of 1:2. As per the data, the hospitals on an average have fewer than one nurse per two beds (0.7:2). This includes hospitals such as Tuberculosis and Malalai, with nurse-to-bed ratios as low as 0.2:2 and 03:2, respectively. However, Ibne Sina Sadri and Wazir Akbar Khan have nurse-to-bed ratios higher than the recommended standard (1.2:2).

Absenteeism – Absenteeism among the health staff can affect the running of a hospital. The survey collected data related to staff absenteeism on the day the survey was administered; the reasons for absenteeism were categorized into separate headings, such as sickness/maternity leave, training, official work, approved absence, working on a different shift, and others. The reasons for absenteeism of the staff (532 out of 4,274) across the 16 national hospitals are shown in Figure 19.

The percentage of absenteeism was calculated excluding the absence of the staff at the time of the survey due to having a different shift. Stomatology had the highest percentage of absenteeism. All other hospitals showed less than 10 percent absenteeism (Figure 20).

Staff Management and Supervision – Supervision plays a crucial role in staff management; a poor quality of supervision can lead to the staff feeling isolated and unsupported, thus affecting the quality of service delivery. Of the total 317 staff members interviewed across the 16 hospitals, 86 percent (273) reported that the hospital supervisor/administrator had talked with them about their work within the last 30 days whereas 10 percent of staff members (33) said that their work had never been supervised by hospital personnel. Lack of proper supervision was reported mostly by the staff of Attaturk Hospital (50% of 20 respondents), followed by Tuberculosis (29% of 17 respondents) and Noor Eye (25% of 20 respondents). Regarding the different staff categories interviewed, nurses represented the majority of those who mentioned lack of supervision (20% of 56 nurses interviewed, including six out of seven nurses of Attaturk and four out of six nurses at Noor Eye).

Figure 19: Reasons for Staff Absenteeism
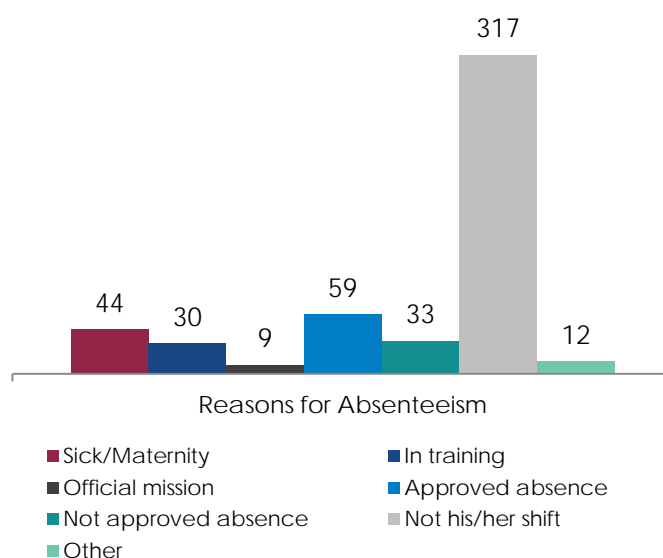
Figure 20: Staff Availability and Absenteeism in the 16 Hospitals
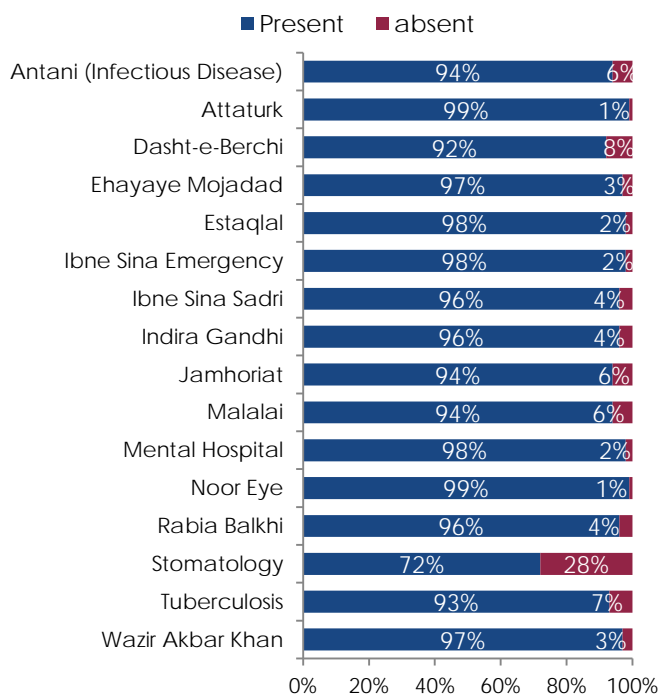
The survey also asked hospital staff about employee the performance assessment mechanism in their respective hospitals. Of the total of 317 staff interviewed, 88 percent (279) said that they had received a formal employee performance assessment in the past year; of these, 74 percent (206 out of 279) mentioned that they received feedback from the assessment.

Staff Satisfaction – The satisfaction level of the hospital staff interviewed was measured against 36 indicators, including work satisfaction, work demands, rewards and benefits, supervision, co-workers, infrastructure and resource availability in the hospital, physical and job security, and so on. The survey used a four-point scale self-reporting questionnaire for this purpose. The weighted average of the responses shows that the health facility staff overall were satisfied with their work (a weighted average of 3.1 out of 4) and are confident in their job abilities. They also seemed satisfied with the supervisory support and resource availability in the hospital.

They expressed dissatisfaction, however, about rewards for work, such benefits as housing and transportation allowances, and the rules for salary payment. The health facility staff of Dasht-e-Barchi Hospital were most dissatisfied, in that they expressed dissatisfaction regarding nine of the 32 indicators; Mental Health staff showed dissatisfaction on three indicators. The consolidated satisfaction levels of the 16 national hospitals are shown in Figure 21. The data by hospital are given in the annexure in Table 36.

Figure 21: Staff Satisfaction in the 16 Hospitals

Statement	Value
Know what is expected of me	3.6
Understand daily duties in job	3.6
Have good working relationships with colleagues	3.6
Job allows to use all skills	3.5
Know how much will be paied at the end of month	3.5
Supervisor is unfair to me	3.2
Work extra to have enough money	3.2
Understand types of benefits that I am supposed to receive	3.2
Can get help from supervisor when needed	3.2
Adequate security avaiable in the hospital	3.1
Overall, I am satisfied with this job	3.1
Hospital provides adequate medicine to provide good quality of care	3
Job allows to use personal judgment	2.9
Unnecessary procedures in job take time away	2.9
Can keep this job as long as I want	2.9
Staff have opportunities to express opinions	2.9
Often asked to do things that are not my duties	2.9
Work assignments are not fully explained	2.9
Job provides adequate opportunities to learn new skills	2.8
Job provides adequate opportunities to participate in training programs	2.7
Have all necessary equipment and tools to do job well	2.7
Receive recognition from supervisor for good job	2.6
People don't have to worry often about getting fired	2.6
Supervisor never gives me any feedback	2.6
People get ahead as fast here as they do in other organizations	2.5
Fair chance of promotion	2.5
Staff have opportunities to participate in developing hospital's budget	2.4
Worry about security	2.3
Too little chance for promotion	2.3
Often work extra hours	2.3
Few rewards	2.2
Management rarely interferes in work	2.2
Physical condition of hospital is adequate	2.2
Rules for salary payments are fair	1.9
Rewarded fairly for the work I do	1.8
Have to work harder because of incompetence of other people	1.4
Benefits received are as good	1.3

Patient

Patient Satisfaction– PETS measured the satisfaction level of patients because it is the key determinant of the quality of care provided in any hospital. The survey was conducted with both inpatients and outpatients. The outpatients were divided further into two categories, patients under-5 years of age and over-5 years of age.

The patients were found to be satisfied overall with the services received at the hospitals (with a score of 3.5 and 3.3 out of 4 among OPD and IPD patients, respectively). The satisfaction level with hospital cleanliness, waiting time, and ease of getting the medicines prescribed was comparatively lower, however.

Figure 22: Under-5 Outpatient Satisfaction in the 16 Hospitals
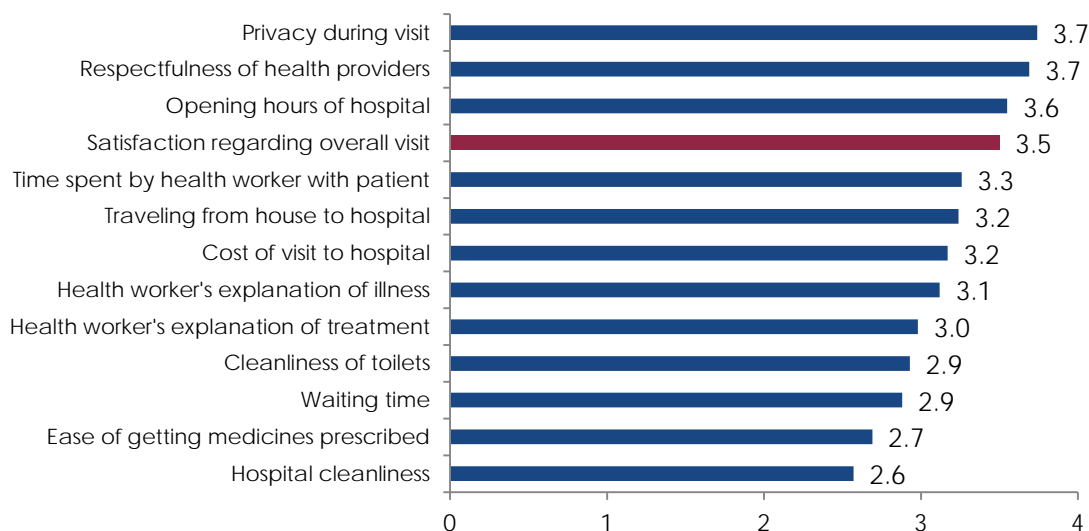
Figure 23: Over-5 Outpatient Satisfaction in the 16 Hospitals

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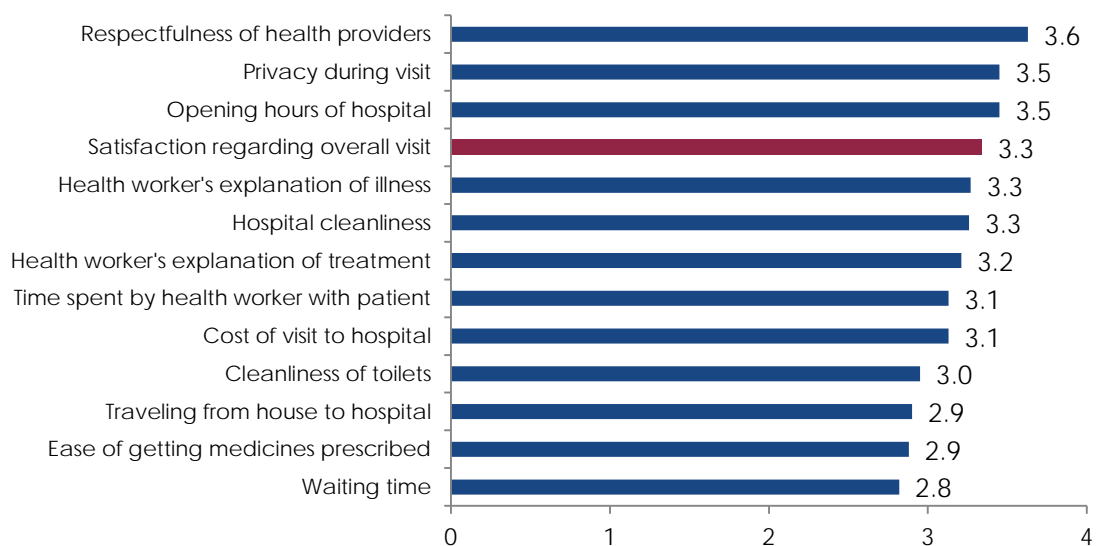
Figure 24: Inpatient Satisfaction in the 16 Hospitals

Category	Value
Hospital cleanliness	3.5
Temperature of ward/room	3.5
Respectfulness of healthcare providers	3.5
Skills & abilities of healthcare providers	3.4
Security from physical danger	3.4
Level of privacy at hospital	3.4
Explanation of treatment	3.4
Overall hospital stay	3.3
Frequency of checks	3.3
Time allowed for attendants	3.3
Explanation of cause of illness	3.3
Waiting time	3.3
Nurse's availability	3.2
Types of services provided	3.2
Cost of treatment	3.2
Medicines brought on time	3.1
Cleanliness of toilets in ward	3.0
Food serviced	2.9

Staff Satisfaction, by Hospital

Table 36: Staff Satisfaction, by Hospital

Indicator	Antani (Infectious Disease)	Attaturk	Dasht-e-Barchi	Ehayaye Mojadad	Esteqlal	Ibne Sina Emergency	Ibne Sina Sadri	Indira Gandhi	Jamhoriat	Malalai	Mental Hospital	Noor Eye	Rabia Balkhi	Stomatology	Tuberculosis	Wazir Akbar Khan	16 National hospitals
Benefits received are good	1.4	1.4	1.5	1.3	1.1	1.3	1.3	1.1	1.3	1.4	1.1	1.5	1.0	1.5	1.1	1.5	1.3
Have to work harder because of incompetence of other people	1.9	1.6	1.1	1.5	1.0	1.8	1.1	1.1	1.3	1.6	1.2	1.6	1.0	1.3	1.5	1.5	1.4
Rewarded fairly for the work I do	1.7	2.1	2.0	1.7	1.9	1.7	1.5	2.0	1.7	1.8	2.1	1.9	1.9	1.7	1.4	1.8	1.8
Rules for salary payments are fair	1.8	1.7	2.6	1.4	2.5	1.7	1.5	2.3	1.9	1.6	2.1	2.3	2.1	2.3	1.1	2.4	1.9
Few rewards	2.2	2.5	1.6	2.7	2.2	2.8	1.9	1.7	2.2	2.5	2.0	2.1	2.2	1.9	2.5	2.0	2.2
Management rarely interferes in work	2.3	2.1	1.5	2.3	2.3	2.2	2.3	2.1	2.4	2.1	2.4	1.9	2.1	2.7	2.2	2.3	2.2
Physical condition of hospital is adequate	1.5	3.2	1.3	1.7	2.2	1.6	2.1	2.8	2.7	2.1	2.7	2.3	2.0	2.6	2.6	2.8	2.2

Weighted average indicating dissatisfaction.

Indicator	Antani (Infectious Disease)	Attaturk	Dasht-e-Barchi	Ehayaye Mojadad	Esteqlal	Ibne Sina Emergency	Ibne Sina Sadri	Indira Gandhi	Jamhoriat	Malalai	Mental Hospital	Noor Eye	Rabia Balkhi	Stomatology	Tuberculosis	Wazir Akbar Khan	16 National hospitals
Worry about security	2.5	2.6	1.8	2.4	1.9	2.5	2.4	2.7	2.8	2.1	2.4	2.3	2.4	2.4	2.1	2.6	2.3
Too little chance for promotion	2.3	2.6	1.9	2.5	2.4	2.4	2.2	2.0	2.6	2.5	2.4	2.3	2.3	2.3	2.1	2.5	2.3
Often work extra hours	2.6	2.6	2.0	2.6	1.8	2.7	2.4	2.1	1.9	2.6	2.3	2.8	1.8	2.3	2.7	2.4	2.3
Staff have opportunities to participate in developing hospital's budget	2.3	2.7	2.8	2.9	2.3	2.2	2.4	2.3	2.5	2.4	2.3	2.2	2.8	2.4	1.3	2.5	2.4
People get ahead as fast here as they do in other organizations	2.3	2.7	2.4	2.7	2.7	2.6	2.2	2.5	2.8	2.5	2.7	2.5	2.6	2.5	2.2	2.6	2.5
Fair chance of promotion	2.1	2.5	2.7	2.5	2.5	2.9	2.8	2.5	2.8	2.5	2.5	2.5	3.1	2.5	2.1	2.3	2.5
Receive recognition from supervisor for good job	2.4	2.5	2.8	2.0	3.1	2.1	2.8	3.1	3.1	2.5	2.6	2.0	3.0	3.1	2.1	2.8	2.6
People don't have to worry often about getting fired	2.5	2.4	3.1	2.3	3.1	2.5	2.6	2.5	2.5	2.3	2.6	2.4	3.3	2.4	2.2	2.6	2.6

Weighted average indicating dissatisfaction.

Public Expenditure Tracking Survey (PETS) in Kabul National Hospitals

Indicator	Antani (Infectious Disease)	Attaturk	Dasht-e-Barchi	Ehayaye Mojadad	Esteqlal	Ibne Sina Emergency	Ibne Sina Sadri	Indira Gandhi	Jamhoriat	Malalai	Mental Hospital	Noor Eye	Rabia Balkhi	Stomatology	Tuberculosis	Wazir Akbar Khan	16 National hospitals
Supervisor never gives any feedback	2.4	2.6	2.8	2.6	3.1	2.5	2.9	2.9	2.6	2.7	2.8	2.3	2.8	2.4	2.4	2.2	2.6
Job provides adequate opportunities to participate in training programs	2.3	2.7	2.8	2.3	3.3	2.0	2.6	3.4	2.9	2.4	3.3	2.3	3.2	3.0	2.2	2.3	2.7
Have all necessary equipment and tools to do job well	2.7	2.8	2.7	2.8	3.3	2.5	2.7	2.4	2.7	2.9	2.8	2.4	2.9	2.9	2.6	3.2	2.7
Job provides adequate opportunities to learn new skills	2.3	2.7	2.7	2.5	3.2	2.6	2.7	3.4	3.6	2.4	3.3	2.2	3.1	3.4	2.2	2.4	2.8
Job allows me to use personal judgment	2.7	2.8	2.9	2.7	3.2	2.9	3.2	3.3	2.9	3.0	2.5	3	3.2	3.0	2.9	2.2	2.9
Unnecessary procedures in job take time away	2.6	3.1	3.2	2.9	3.1	2.8	3.0	3.6	2.8	2.7	3.0	2.9	3.1	3.0	2.6	2.8	2.9

Weighted average indicating dissatisfaction.

Indicator	Antani (Infectious Disease)	Attaturk	Dasht-e-Barchi	Ehayaye Mojadad	Esteqlal	Ibne Sina Emergency	Ibne Sina Sadri	Indira Gandhi	Jamhoriat	Malalai	Mental Hospital	Noor Eye	Rabia Balkhi	Stomatology	Tuberculosis	Wazir Akbar Khan	16 National hospitals
Can keep this job as long as I want	2.8	2.9	3.2	2.9	3.4	2.9	2.8	3.1	2.5	3.0	2.6	2.8	3.3	2.4	2.7	3.2	2.9
Staff have opportunities to express opinions	2.7	2.8	3.1	3.0	3.0	2.8	3.2	2.8	3.3	2.6	2.7	2.8	3.2	3.2	2.8	2.9	2.9
Often asked to do things that are not my duties	2.7	2.7	2.9	2.8	3.4	2.7	3.1	3.4	3.2	2.7	3.0	2.6	3.5	3.1	2.2	2.8	2.9
Work assignments are not fully explained	2.4	2.9	3.6	2.9	3.3	3.0	3.2	3.0	3.1	3.0	2.8	2.6	3.3	2.8	2.9	2.4	2.9
Hospital provides adequate medicine to provide good quality of care	3.0	1.4	3.6	2.9	3.6	2.9	3.4	3.1	3.1	3.1	3.3	2.7	3.6	3.1	2.9	3.1	3.0
Adequate security available in the hospital	2.9	3.0	3.6	3.0	3.6	2.6	2.8	3.5	3.4	2.8	3.1	3.1	3.6	3.4	2.9	2.8	3.1
Overall, I am satisfied with this job	2.9	3.1	3.3	3.2	3.2	3.0	3.2	3.1	3.1	3.0	3.0	3.0	3.3	2.9	2.9	3.2	3.1

Weighted average indicating dissatisfaction.

Public Expenditure Tracking Survey (PETS) in Kabul National Hospitals

Indicator	Antani (Infectious Disease)	Attaturk	Dasht-e-Barchi	Ehayaye Mojadad	Esteqlal	Ibne Sina Emergency	Ibne Sina Sadri	Indira Gandhi	Jamhoriat	Malalai	Mental Hospital	Noor Eye	Rabia Balkhi	Stomatology	Tuberculosis	Wazir Akbar Khan	16 National hospitals
Supervisor is unfair to me	2.8	2.9	3.2	3.0	3.5	3.0	3.1	3.5	2.9	3.1	3.4	3.1	3.7	3.3	3.0	3.1	3.2
Work extra to have enough money	3.0	3.0	3.4	3.1	3.4	3.1	3.4	3.7	3.5	2.9	3.3	3.1	3.3	3.4	3.0	3.2	3.2
Understand types of benefits that I am supposed to receive	3.0	2.9	3.4	3.0	4.0	3.1	3.3	3.4	3.3	3.0	2.9	3.0	3.9	3.7	3.1	2.5	3.2
Can get help from supervisor when needed	3.1	2.8	3.6	2.9	3.8	3.1	3.3	3.6	3.2	2.9	3.2	2.9	3.8	3.3	2.5	3.3	3.2
Job allows me to use all skills	3.1	3.1	3.6	3.1	4	3.1	3.7	4.0	3.8	3.1	3.9	3.1	4.0	4.0	3.0	3.3	3.5
Know how much I will be paid at the end of month	3.0	3.0	3.8	3.0	3.9	3.1	3.9	4.0	3.7	2.8	3.8	3.2	4.0	4.0	2.9	3.2	3.5
Know what is expected of me	3.2	3.1	4	3.0	4.0	3.1	4.0	4.0	3.9	3.1	3.9	3.3	4.0	4.0	3.0	3.3	3.6
Understand daily duties in job	3.1	3.4	4	3.1	4.0	3.2	3.9	4.0	3.8	3.3	4.0	3.4	4.0	4.0	2.9	3.7	3.6

Weighted average indicating dissatisfaction.

Indicator	Antani (Infectious Disease)	Attaturk	Dasht-e-Barchi	Ehayaye Mojadad	Esteqlal	Ibne Sina Emergency	Ibne Sina Sadri	Indira Gandhi	Jamhoriat	Malalai	Mental Hospital	Noor Eye	Rabia Balkhi	Stomatology	Tuberculosis	Wazir Akbar Khan	16 National hospitals
Have good working relationships with colleagues	3.1	3.4	3.9	3.5	4.0	3.3	3.9	4.0	3.7	3.4	3.8	3.4	4.0	3.8	3.5	3.5	3.6

	Weighted average indicating dissatisfaction.

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