

SIGAR

**Special Inspector General for
Afghanistan Reconstruction**

OFFICE OF SPECIAL PROJECTS

HEALTH FACILITIES IN AFGHANISTAN: OBSERVATIONS FROM SITE VISITS AT 269 CLINICS AND HOSPITALS



March 2020

SIGAR 20-28-SP



SIGAR

Office of the Special Inspector General
for Afghanistan Reconstruction

March 18, 2020

The Honorable Mark Green
Administrator, U.S. Agency for International Development

Ms. Karen Freeman
Assistant to the Administrator, Office of Afghanistan and Pakistan Affairs, USAID

Mr. Peter Natiello
USAID Mission Director for Afghanistan

Dear Administrator Green, Ms. Freeman, and Mr. Natiello:

This is a summary report of our findings from site visits at 269 health facilities across ten provinces in Afghanistan. The purpose of our work, which resulted in ten reports issued from October 2015 to April 2019 was to determine the extent to which these facilities were open and operational, and to assess their current condition. Before the U.S. military intervention in 2001, several decades of conflict severely degraded Afghanistan's health system. After the fall of the Taliban in 2001, USAID and other donors worked with the Ministry of Public Health (MOPH) to build or renovate hundreds of health facilities, train health professionals, and establish the criteria with which to equip and operate health facilities nationwide. As of 2019, USAID spent approximately 1.3 billion to build, support, train, and sustain the Afghan health system. Since 2008, USAID and its partners executed three on-budget programs to support facilities in 13 provinces: Partnership contracts for Health (PCH), System Enhancement for Health Action in Transition (SEHAT), and Sehatmandi. Together these programs in coordination with the World Bank and other donors have sustained and funded the Afghan Health system in both rural and urban settings.

From July 2015 through October 2018, we visited 269 health facilities in 10 provinces to confirm their operational status and to assess their condition. SIGAR issued 10 reports and 2 alert letters addressing the condition of these facilities. We found that although most facilities were operational and, except for one instance, included an operational pharmacy, two facilities were in potentially hazardous condition due to possible seismic activity and an explosion. Finally, at another facility, staff were not present because a staff member had been killed offsite earlier in the day. The facility was closed as a result. During our site visits we observed that many facilities had other deficiencies including a lack of access to utilities such as electricity or water; wall or ceiling defects; incinerators in poor condition, or a lack of resources.

This report summarizes our findings from site visits across ten provinces in Afghanistan. We provided a draft of this review to USAID for comment on February 28, 2020. USAID provided comments on March 13, 2020. In its comments, USAID stated that "SIGAR corroborated the progress that has been made to expand the presence of female health workers in facilities and highlighted infrastructure challenges" and that, "USAID will share the final report with the MOPH and World Bank." USAID's comments are reproduced in appendix I.



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We conducted our work in ten provinces throughout Afghanistan, and in Washington, D.C under the authority of Public Law No. 110-181, as amended, and the Inspector General Act of 1978, as amended; and in accordance with the Council of Inspectors General on Integrity and Efficiency (CIGIE) *Quality Standards for Inspection and Evaluation*. Should you or your staff have any questions about this project, please contact Mr. Benjamin Piccolo, Director of Special Projects, at (703) 545-2192.

Sincerely,

John F. Sopko
Special Inspector General
for Afghanistan Reconstruction

The World Health Organization (WHO) characterizes “the highest attainable standard of health” as a fundamental right and critical to peace and security. The WHO also recognizes that better health is not only central to well-being, but also an important contributor to economic progress, productivity, and development. By 2002 after decades of civil unrest and war, Afghanistan’s health sector was severely degraded and Afghanistan suffered from among the worst health standards in the world. Specifically, Afghanistan was plagued with the world’s highest maternal mortality rate, high infant and child mortality rates, low life expectancy, and limited access to healthcare.

To address these and other health deficiencies, the United States and its partners have made significant investments in Afghanistan’s health sector. As of January 11, 2020, the U.S. Agency for International Development (USAID) reported that it disbursed more than \$1.3 billion to improve access to and the quality of healthcare services, and bolster the management capacity of Afghanistan’s health system. USAID’s programs have concentrated on supporting the delivery of health services across 13 provinces in Afghanistan; the construction or rehabilitation of hundreds of health facilities ranging from rural health clinics to large urban hospitals;¹ and off-budget and issue-specific programs targeting health challenges such as nutrition, tuberculosis, or polio.²

USAID has claimed that the Afghan health sector is an area in which USAID programs made significant progress. For example, in USAID’s 2014 fact sheet on health care in Afghanistan, USAID cited 53 and 62 percent decreases in infant and child mortality respectively, and increased access to health services for Afghan citizens, as evidence of overall progress in the sector. Nevertheless, numerous obstacles challenge Afghanistan’s health sector. They include inadequate staffing, poor working conditions, insecurity, unreliable data, and allegations of corruption within the Ministry of Public Health (MOPH). These challenges have received attention from the highest levels of the Afghan government. In 2014, then Afghan Minister of Public Health, Dr. Ferozuddin Feroz, requested that Afghanistan’s Independent Joint Anti-Corruption Monitoring and Evaluation Committee (MEC), conduct an independent report on vulnerabilities or corruption. This assessment found instances of absenteeism, bribery, and embezzlement of public property.

SIGAR conducted limited inspections of health facilities across ten Afghan provinces supported by Partnership Contracts for Health (PCH) and its follow-on programs: the World Bank-managed System Enhancement for Health Action in Transition (SEHAT) and Sehatmandi.³

We conducted our work in Afghanistan, and in Washington, D.C. under the authority of Public Law No. 110-181, as amended, and the Inspector General Act of 1978, as Amended; and in accordance with the Council of Inspectors General in Integrity and Efficiency (CIGIE) *Quality Standards for Inspection and Evaluation*.

BACKGROUND

The Afghan Ministry of Public Health (MoPH) is responsible for administering Afghanistan’s public healthcare system, which, with USAID support, operates facilities at the community, district, and provincial/national levels. Since 2008 USAID has supported these health facilities through three separate programs. USAID’s \$259.6 million Partnership Contracts for Health (PCH) program operated from July 2008 through June 2015 and supported the MoPH in its delivery of health services to Afghans in 13 provinces. In addition to the PCH

¹ For example, through the Schools and Clinics Construction and Rehabilitation Program (SACCARP) USAID constructed or renovated more than 670 health facilities. Of these, 220 were new facilities (42 comprehensive health centers and 178 basic health clinics).

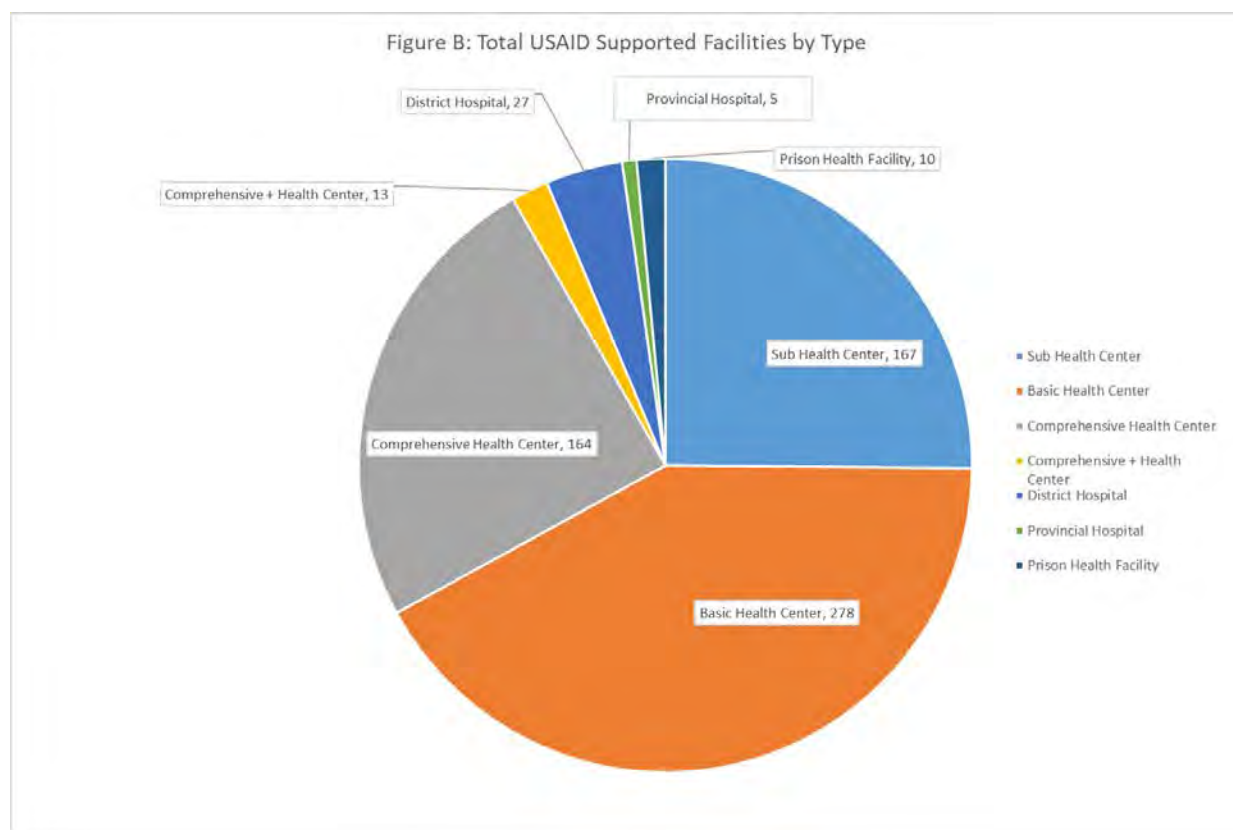
² Examples of issue specific programming include but are not limited to Challenge TB, Helping Mothers and Children Thrive (HEMAYAT), and the Initiative for Hygiene, Sanitation, and Nutrition (IHSAN).

³ PCH ended on June 30, 2015. SEHAT ended in June 2018. Sehatmandi began in July 2018 and is anticipated to end in June 2021. While the PCH program ended in June 2015, USAID continued to support health facility operation through the World Bank-managed System Enhancement for Health Action in Transition (SEHAT) program and now through the World Bank-Managed Sehatmandi.

program, USAID supported the World Bank administered System Enhancement for Health Action in Transition (SEHAT) program, from February 2013 until it ended in June 2018. As of 2018 USAID contributed approximately \$218.7 Million to the SEHAT program through a Public International Organization (PIO) grant to the World Bank Administered Afghanistan Reconstruction Trust Fund (ARTF).⁴ Since the conclusion of SEHAT, the World Bank has initiated a follow-on, Sehatmandi program that USAID intends to continue to support. These projects were intended to expand the scope, quality, and coverage of health services provided to the Afghan Public by the MoPH.

At the community level, MoPH provides services at health posts, sub-health centers (SC), and basic health centers (BHC). Health posts support small rural communities, and provide a link to the nearest health facility, while SHC are small facilities that increase access to health services in remote areas and are intended to cover a population of 3,000 – 7000 people. BHCs supervise activities of health posts and cover a population of less than 30,000 people. District-level services are provided through comprehensive health centers (CHC), and/or small district hospitals (CHC+), and district hospitals (DH). CHCs cover 30,000-60,000 people and assist BHCs with complications and laboratory services, while DHs cover a population of 100,000-300,000 people. At the provincial and national levels, services are provided at provincial, regional, national, and specialty hospitals. Figure 1 shows a breakdown of USAID supported health facilities by type.

Figure 1 - USAID-Supported Health Facilities by Type



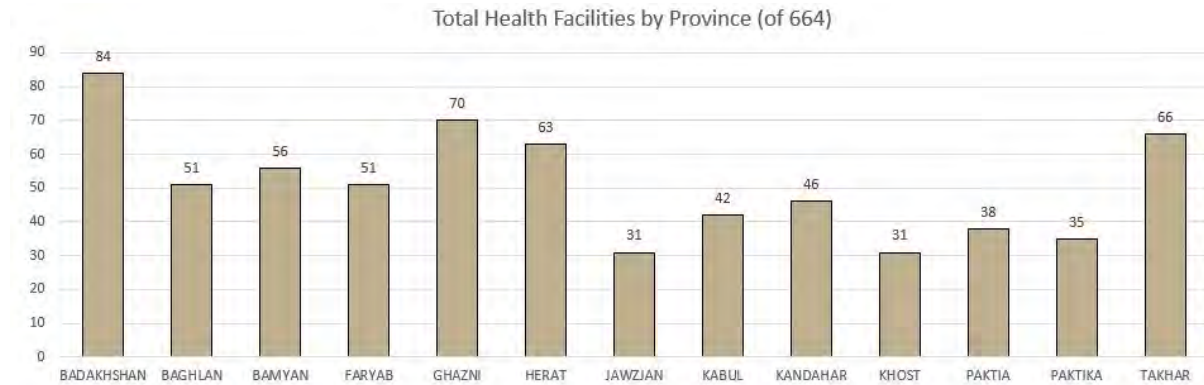
Source: SIGAR analysis of USAID-provided data

USAID supported 664 health facilities in 13 provinces, with Badakhshan province receiving support at the greatest number of health facilities (84 health facilities), followed by Ghazni province (70 health facilities) and

⁴ USAID, Implementation Letter Number 43-01: the Ministry of Public Health System Enhancement for Health Action in Transition (SEHAT) Program: USAID agreement to support SEHAT, January 15, 2014.

Takhar province (66 health facilities) respectively. Figure 2 provides a breakdown of USAID-supported health facilities by province.

Figure 2 - USAID-Supported Health Facilities by Province



Source: SIGAR analysis of USAID-provided data

A component of the PCH program was the use of detailed geospatial location information—in the form of global positioning system (GPS) coordinates—to verify that health facilities constructed under the program were in locations to provide the intended population with needed health services. As we have reported in the past, accurate location-specific information, including geospatial coordinates, is also critical to provide effective oversight and support data systems.

In recent months, the World Bank has proposed economic initiatives if a peace agreement is reached. These economic initiatives, if approved and funded by the donor community may involve construction or rehabilitation of health facilities throughout Afghanistan.

SIGAR’s Reports on USAID-Supported Health Facilities in Afghanistan

As part of our examination of the Afghan health sector, and to assess the condition and extent to which USAID-supported health facilities were maintained and utilized, we visited 269 health facilities from July 2015 to October 2018 and issued 10 reports and two safety related alert letters.⁵ Figure 3 provides a breakdown by province of the 269 health facilities we visited.

⁵ This is the eleventh and final report in a series that discusses our findings from site visits at USAID-supported health facilities across Afghanistan (see, SIGAR, *USAID Supported Health Facilities in Faryab Province, Afghanistan: Observations From 17 Site Visits*, SIGAR-19-20-SP, February 22, 2019; SIGAR, *USAID Supported Health Facilities in Kandahar Province, Afghanistan: Observations from 9 Site Visits*, SIGAR 18-55-SP, June 7, 2018; SIGAR, *USAID Supported Health Facilities in Khost Province, Afghanistan: Observations from 20 Site Visits*, SIGAR 18-13-SP, November 27, 2017; SIGAR, *USAID Supported Health Facilities in Takhar Province: Observations from Site Visits to 35 Locations*, SIGAR 17-51-SP, July 6, 2017; SIGAR, *Review: USAID Supported Health Facilities in Ghazni Province Observations from Site Visits to 30 Locations*, SIGAR 17-34-SP, March 30, 2017; SIGAR, *Review Letter: USAID-Supported Health Facilities in Baghlan*, SIGAR 17-18-SP, December 12, 2016; SIGAR, *Review Letter: USAID-Supported Health Facilities in Badakhshan*, SIGAR-16-40-SP, June 30, 2016; SIGAR, *Review Letter: USAID-Supported Health Facilities in Kabul*, SIGAR 16-09-SP, January 5, 2016; SIGAR, *Alert Letter: USAID-Supported Health Facilities in Herat*, SIGAR 16-01-SP, October 20, 2015; SIGAR, *USAID Supported Health Facilities in Bamyan Province, Afghanistan: Observations from 44 Site Visits*, SIGAR 19-34-SP, April 19, 2019).

Figure 3 - SIGAR Site Visits across 10 Afghan Provinces.

Province	Number of Reported SIGAR Inspections	Timeline of SIGAR Inspections
Herat	23	Jul-Aug 2015
Kabul	32	Jul – Nov 2015
Badakhshan	29	Nov – Dec 2015
Baghlan	30	Oct – Dec 2015
Ghazni	30	Apr – May 2016
Takhar	35	Apr – May 2016
Khost	20	Mar – May 2017
Kandahar	9	Jul 2017
Faryab	17	Jul – Aug 2017
Bamyan	44	Sept – Oct 2018
Total	269	

Source: Analysis of prior SIGAR work

At each SIGAR site inspection, the team took time-, date-, and location-stamped photographs.⁶ Where possible, the following activities were also completed during the course of each site inspection:

- An overall assessment of the facility (outside and inside), recording, among other information, the geospatial coordinates of the facility, whether the facility was open and operational, and whether the facility had reliable access to electricity and water, and an on-site pharmacy;
- An interview with a facility staff member; and,
- An interview with a member of the community served by the health facility.

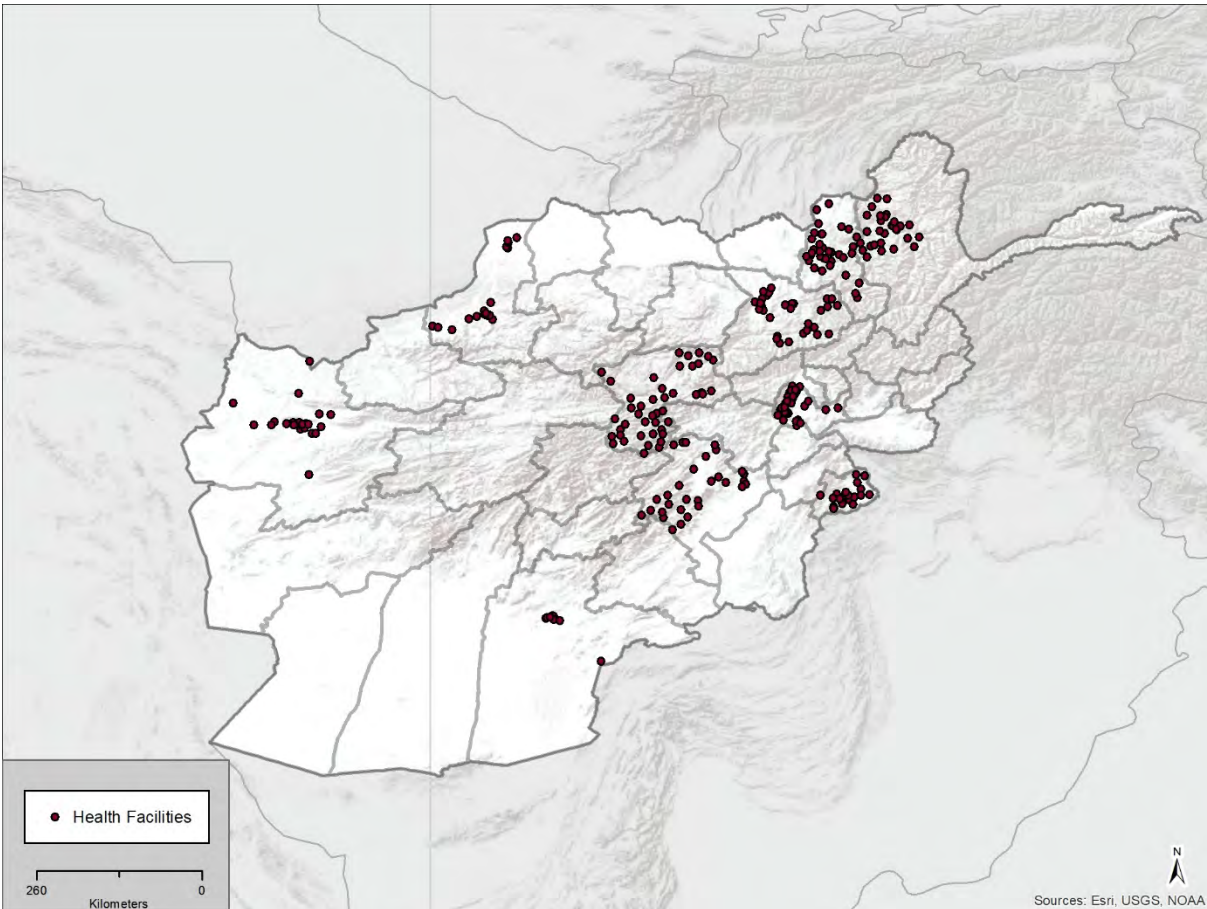
Our site visits were generally limited to 1 – 3 hours, and were limited in scope to minimize the impact on facility operations. The site inspections did not include comprehensive engineering evaluations of structures, complete testing of system (electrical or water) quality, or an evaluation of the quality of care being provided.

From July 2015 through October 2018 we conducted site visits at 269 USAID-supported health facilities across 10 provinces. We found that all 269 facilities were open and in use at the time of our site visits, with all but

⁶ Nearly all photographs contained time, date, and location stamps; however, at some locations, there were individual photographs that did not contain geospatial stamping.

one possessing pharmacies in use.⁷ At many of these facilities, however, we observed structural damage, health or safety concerns, unused or damaged equipment, and other deficiencies. In two instances, these concerns warranted alert letters warning of potential harm to occupants of the health facilities.⁸ Figure 4 shows the general location of the health facilities we visited across Afghanistan.

Figure 4 - Location of Health Facilities Visited Across Ten Provinces in Afghanistan



Source: SIGAR analysis

The USAID-supported health facilities we visited comprised three Provincial Hospitals, 11 District Hospitals, and approximately 250 sub, basic, and comprehensive health centers. Figure 5 shows the breakdown of the health facilities we visited by type.

⁷ Note: one facility was closed due to the death of a medical worker during the day our inspectors arrived. Because of these extraneous circumstances, we did not code this facility to be permanently non-operational.

⁸ See SIGAR 17-59-SP, *Alert Letter: Structural Damage at Health Facility 2132*, August 1, 2017; and SIGAR 16-19-SP, *Alert Letter: Structural Damage at Health Facility 1987*, March 1, 2016.

Figure 5 - SIGAR Site Visits Facility Type

Facility Type	Site Visits	Percent of Site Visits
Sub Health Center	55	20.45%
Basic Health Center	109	40.52%
Comprehensive Health Center	79	29.37%
Comprehensive Health Center +	6	2.23%
District Hospital	11	4.09%
Provincial Hospital	3	1.12%
Prison Health facility	6	2.23%
Total:	269	100%

Source: SIGAR analysis of USAID-provided data

NOTE: percentages rounded.

CONDITIONS REPORTED AND OBSERVED AT 269 HEALTH FACILITIES ACROSS 10 PROVINCES IN AFGHANISTAN

During our site visits we noted structural and operational issues such as structural damage, and lack of consistent access to electricity and drinking water. Some of these deficiencies could potentially affect safety and may negatively impact the provision of health services. Of these, all but one were observed to possess a pharmacy in use. Although these facilities were open, many lacked consistent electricity, access to drinking water, or were observed to have other challenges present which may warrant attention. Additionally, we observed that many facilities rely on incinerators to dispose of medical wastes and that in some cases, these incinerators were potentially hazardous to staff or patients due to their location and poor condition.

Structural Deficiencies at Several Health Facilities Including Damaged Walls and Roofs, Mold, Leaks, and Deteriorating Foundations, Could Present Safety Hazards

Although most facilities were operational and, except for one instance, included an operational pharmacy; we observed structural deficiencies at several facilities, including some deficiencies that may put the safety of occupants at risk. Specifically, we observed that of the 269 facilities, 99 (37 percent) had damaged walls, 37 facilities (14 percent) had damaged roofs, and 79 (29 percent) showed signs of mold or leaks. We also observed damaged or missing windows at 31 facilities (12 percent) and damaged or removed doors at 44 facilities (16 percent). Finally, we observed 18 facilities (7 percent) with signs of settlement or deterioration of the building's foundation. At two facilities, damage to the primary building presented operational and safety hazards that resulted in the writing of alert letters alerting USAID to the safety matters that warranted timely action by the agency. Photo 1 shows damage from an explosion at Facility 2132 in Khost. Photo 2 shows foundation and wall damage at facility 1987 in Badakhshan province.

Photo 1 - Damage from an explosion at Facility 2132 in Khost



Source: SIGAR, April 2017

Photo 2 - Foundation Damage at Facility 1987 in Badakhshan



Source: SIGAR, November 2015

Approximately Half of the Facilities Lacked Reliable Electricity

Although all of the facilities we visited were observed to be in use, we observed that many facilities lacked or had inconsistent access to basic utilities which may be impacting health service delivery at these locations. Specifically, we found that 42 of 269 facilities – or about 16 percent - lacked electricity. Similarly, 129 facilities – or 48 percent – reported inadequate or inconsistent power and other concerns. While in many cases these concerns did not inhibit facility staff from providing services, it may impact the quality of services provided. For example, staff members at one facility reported that its staff had to rely on using flashlights while assisting patients during emergencies at night. Staff at a separate facility with a broken generator reported bringing a battery from home to assist in health service delivery at night. Additionally, several facilities relied on refrigerators to store vaccines; a prolonged absence of electricity is likely to render vaccines and other medications requiring refrigeration unusable.

Photo 3 - A damaged light switch at facility 2157 in Kandahar.



Source: SIGAR, July 2017

Photo 4 - Exposed outlet at Facility 1959 in Khost.



Source: SIGAR, April 2017

Many Facilities Lacked Adequate Access to Clean Drinking Water

We observed that 55 of 269 facilities lacked water at the facility grounds. Water concerns such as access, quantity, or damaged equipment were also observed or reported at 95 facilities. For example, In lieu of wells or city provided water, 12 facilities reported carrying water from distant sources and ten reported using water from rivers and streams. In other cases, staff at facilities expressed concern that their water source was inadequate, unclean, or unsafe.

Photo 5 - Missing hand pump at facility 2131 in Khost



Source: SIGAR, March 2017

Photo 6 - Functioning hand pump at facility 1617 in Takhar



Source: SIGAR, April 2016

Incinerators at 50 facilities were in poor condition or poorly positioned.

We also observed that although many of the inspected facilities possessed medical waste incinerators that conformed to best practices, several were noted to be poorly situated or in poor condition.⁹ Specifically, we observed 50 incinerators with damaged or missing chimneys, corroded metal, or broken concrete. In addition we observed 77 poorly sited incinerators with obstructed chimney or easy public access. Below are two examples of problematic medical waste disposal incinerators that we observed at facility 2565 in Khost and at Facility 496 in Bamyan.

Incinerators that are in poor condition or are poorly situated pose a risk to the staff or visitors to health facilities. In some cases, incinerators may need to be replaced or relocated to ensure that staff are not exposed to toxic fumes or protruding metal.

⁹ Best practices include recommendations for chimney height, location, and other safeguards to protect users and community members outlined in Stuart Batterman, "Findings of an Assessment of Small-scale Incinerators for Health-Care Waste", World Health Organization, 2004 and "Safe Management of Wastes from Health-Care Activities, Second Edition". World Health Organization, 2014.

Photo 7 - Damaged incinerator in the parking lot of facility 2565 in Khost



Source: SIGAR, April 2017

Photo 8 - Unmarked, un-cordoned substandard incinerator at facility 496 in Bamyan.



Source: SIGAR, October 2018

Although we observed female staff members at nearly all health facilities during our site visits, less than half of facilities reported having enough female staff.

During our site visits we observed whether staff, including female staff, were present in accordance with the Basic Package of Health Services (BPHS) requirements at various facility types.¹⁰ Although the majority of clinic patients are women and children Afghanistan faces a shortage of female staff workers. USAID and other partners have expressed the hope that by addressing this shortage of trained staff, women’s health issues may be improved.

According to a USAID fact sheet regarding maternal health, less than 25 percent of Afghan health facilities had female staff present in 2002 and that as of 2015 this improved to 85 percent. Further, in June of 2019 USAID reported that 95 percent of all health facilities had at least one female health service provider. Although USAID reports that nearly all facilities have female health staff, this does not imply that USAID believes there is no need for further growth and development of the female health worker cadre. As of 2016, the Afghan Government reported that women comprise roughly 20 percent of all health sector employees and USAID and members of the international community have acknowledged that there are shortages of trained female health workers, a limitation that could negatively impact women’s’ health in Afghanistan. As such, components of SEHAT, PCH, and other previous and ongoing off-budget USAID projects include the training and support of female doctors, midwives, and nurses.

Our site visits largely corroborated USAID’s assessments of female health worker employment progress. Specifically, at 239 health facilities (89 percent) we observed female staff in compliance with BPHS requirements.¹¹ At many of the remaining facilities no female staff were observed during the time of our visit, but staff members who were present reported that female staff members were employed at the facility but were not currently at the facility. At nine facilities (about 3 percent) no female staff were observed, and staff

¹⁰ The MOPH ratified the BPHS in March 2003, and revised it in 2005 and again in 2010 to ensure that all primary health care facilities deliver a standardized package of basic services.

¹¹ BPHS advises a 1:1 ratio of male to female staff members but accepts that a 1:1 ratio may not be feasible at all facilities. Instead, for certain facility types, BPHS determined a minimum female staff requirement. For example regarding Basic Health Centers (BHC) BPHS states, “A male/female ratio of 1/1 is recommended, and at least one female should be part of the BHC staff” And that, “the minimal staffing requirements for a BHC are a nurse, midwife, and two vaccinators.” Similarly, according to the BPHS, “the staff of a Comprehensive Health Clinic (CHC) will be larger than that of a BHC, it will include both male and female doctors, male and female nurses, midwives, and [various] technicians.”

members who were present indicated that no female staff members were employed. Of these nine facilities, four were prison health clinics while the remaining five were BHCs, CHCs, or SCs.

Although a majority of facilities employed female staff, only 112 of 269 facilities (42 percent) reported that there were enough female medical staff that worked at their health centers or hospitals to meet the needs of their community. These figures largely align with USAID assessments that although progress has been made to ensure that nearly all health facilities have female staff, there remains a capacity gap of female medical workers in the Afghan health system.

CONCLUSION

Since 2002 USAID disbursed \$1.3 billion to increase access to and improve the quality of health care in Afghanistan's health system. Since 2008, more than \$475 million was spent to sustain 664 health facilities across 13 Afghan provinces. USAID and its partners have consistently highlighted Afghanistan's progress in the health sector and several key health indicators show considerable improvement. However, the condition of health facilities, unreliable data, and other factors may hinder progress in building a self-sustaining health sector.

We conducted site visits from July 2015 to October 2018 at 269 facilities across ten USAID-supported provinces. We found that the facilities we visited were operational and that most were in generally usable condition, possessed pharmacies, and had female staff members. Finally, many facilities lacked electricity or water, showed damage or lack of maintenance, had damaged or substandard medical waste incinerators, or reported shortages of female staff.

The World Bank has proposed economic initiatives if a peace agreement is reached. These economic initiatives, if approved and funded by the donor community may involve construction or rehabilitation of health facilities. If a peace agreement is reached and the World Bank begins supporting infrastructure projects, a mechanism will be needed to ensure that MOPH has the capacity to maintain, staff, and sustain these and any additional health facilities.




USAID | **AFGHANISTAN**
FROM THE AMERICAN PEOPLE

MEMORANDUM

March 13, 2020

TO: John F. Sopko, Special Inspector General for Afghanistan Reconstruction (SIGAR)

FROM: Jeffery P. Cohen, Acting Mission Director 

SUBJECT: Mission Response to Draft SIGAR Special Project Report titled: "Health Facilities in Afghanistan: Observations from site visits at 269 clinics and hospitals" (SIGAR-20-XX-SP)

REF: SIGAR Transmittal Email dated February 28, 2020

USAID would like to thank SIGAR for the opportunity to comment on the draft "Health Facilities in Afghanistan: Observations from site visits at 269 clinics and hospitals" report.

SIGAR corroborated the progress that has been made to expand the presence of female health workers in facilities and highlighted infrastructure challenges. The SIGAR special project report is consistent with the ten reports provided previously and reflects the conditions of facilities during site visits between 2015-2018.

USAID continues to work closely with the Ministry of Public Health (MoPH) to improve the quality of health services. For each of the previous reports that are the subject of this capping draft report, USAID informed the MoPH, requesting them to take appropriate action to address the issues identified by SIGAR. USAID will share the final report with the MoPH and World Bank, as the Afghanistan Reconstruction Trust Fund supports public health facilities.

cc: Elizabeth A. Chambers, Controller, USAID/Afghanistan
U.S. Embassy/Kabul
OAPA Audit
Derek Sedlacek, Health & Nutrition Director, USAID/Afghanistan

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under project code SP-216.

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The mission of the Special Inspector General for Afghanistan Reconstruction (SIGAR) is to enhance oversight of programs for the reconstruction of Afghanistan by conducting independent and objective audits, inspections, and investigations on the use of taxpayer dollars and related funds. SIGAR works to provide accurate and balanced information, evaluations, analysis, and recommendations to help the U.S. Congress, U.S. agencies, and other decision-makers to make informed oversight, policy, and funding decisions to:

- improve effectiveness of the overall reconstruction strategy and its component programs;
- improve management and accountability over funds administered by U.S. and Afghan agencies and their contractors;
- improve contracting and contract management processes;
- prevent fraud, waste, and abuse; and
- Advance U.S. interests in reconstructing Afghanistan.

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