INTEGRITY
WATCH
AFGHANISTAN

Afghanistan Readiness Against COVID-19

Survey Series: Round I

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Integrity Watch Afghanistan
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Kabul, Afghanistan
info@integritywatah.org
www.integritywatch.org

About Integrity Watch Afghanistan

Integrity Watch is an Afghan civil society organization committed to increase transparency, accountability, and integrity in Afghanistan. Integrity Watch was created in October 2005 and established itself as an independent civil society organization in 2006. It has approximately 95 staff members. The head office of Integrity Watch is in Kabul with provincial programmatic outreach in Balkh, Bamyan, Herat, Kabul, Kapisa, Kandahar, Nangarhar, Laghman, Kunar, Jawzjan, and Samangan province of Afghanistan.

Over the last decade, Integrity Watch's work has focused on three major elements: (1) Community Monitoring, (2) Research, and (3) Advocacy.

Ever since its establishment, Integrity Watch has tried to encourage active citizenship and community mobilization through its programs. Our community monitoring work has included development of community monitoring tools, mobilizing and training communities to monitor infrastructure projects, public services, courts, and extractives industries. So far, more than 1000 infrastructure projects, more than 3,400 open trials, more than 600 schools, more than 300 health centres, and around 12 different mining sites have been monitored by more than 1600 local monitors.

Our research work has focused on policy-oriented research, measuring trends, perceptions and experiences of corruption and covering a wide range of corruption related issues including security and justice sectors, extractive industries, budget and public finance management, and aid effectiveness. The objective is to develop new, ground-breaking empirical research in order to set the agenda, influence decision-makers, and bring to the public attention non-documented and non-explored issues. So far, we have published 42 research reports and 10 policy briefs on the mentioned topics, reaching out to millions of people through media and thousands of people directly receiving our reports.

The aim of our advocacy work has been to enhance Integrity Watch's pioneering role in advocating for knowledge-based decision-making and informed public debate on corruption and integrity issues. Our advocacy work includes facilitation of policy dialogue on issues related to integrity, transparency, and accountability. We have engaged in policy advocacy for issues that communities experience on a day-to-day basis while trying to hold the government and service providers accountable. Such issues include access to information, budget transparency and accountability, aid transparency and effectiveness, effective public services, and other topics related to anti-corruption.

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1. Executive Summary

The Corona Virus Disease 2019 (COVID-19) has had a tremendous human toll since the first case was reported in December 2019 in Wuhan, China. The disease spread to other countries within weeks, and the World Health Organization (WHO) declared the situation as a "Public Health Emergency of International Concern (PHEIC)" on January 30, 2020, followed by the declaration of a pandemic by the organization on March 11, 2020. Since the detection of the first COVID-19 case in February 2020 in Hirat province, the Ministry of Public Health (MoPH) of the government of the Islamic Republic of Afghanistan stepped up emergency response interventions in coordination with and through technical support from the WHO Afghanistan office.

The analysis presented in this report shows the performance of a sizable sample of public health facilities from 17 provinces of Afghanistan. The Integrity Watch Afghanistan is conducting a series of surveys of the target health facilities using an established mobile app that has been progressively refined since it was first introduced during the Baseline survey. The findings from the periodic surveys will be analyzed and presented through a series of reports to serve as an advocacy tool for further refinement of the government response to the COVID-19 epidemic. In this report, the analysis of the different variables is done in a comparative way between Baseline and Round-1 to show trends in COVID-19 services provided by public health facilities over the preceding several months.

The Round-1 data shows that the reported screening of clients for COVID-19 at the health facility entrance has been lower than the Baseline survey. During Baseline, 24 out of 32 provinces reported screening in 60% to 100% of instances, while in Round-1, 13 out of 17 provinces reported screening in 50% to 100% of instances. The second COVID-19 related activity performed by health facilities is the provision of awareness-raising about the disease. In Baseline, 24 out of 32 provinces indicated provision of awareness-raising in 90% to 100% of instances, while the Round-1 data shows huge improvement as all provinces (17) have reported screening in 80% to 100% of instances. The reported availability of COVID-19 test kits has increased 1.5 folds during Round-1 as compared to the Baseline. However, the availability of functional respiratory machines does not show any sensible improvement between Baseline and Round-1. The availability of other essential items required for the treatment of patients and staff protection have mostly remained unchanged between Baseline and Round-1 except for the availability of medical oxygen which shows reduction in Round-1. The possible reason for the lower oxygen availability can be the increase in number of patients in Intensive Care Units (ICUs) during Round-1

2. Methodology

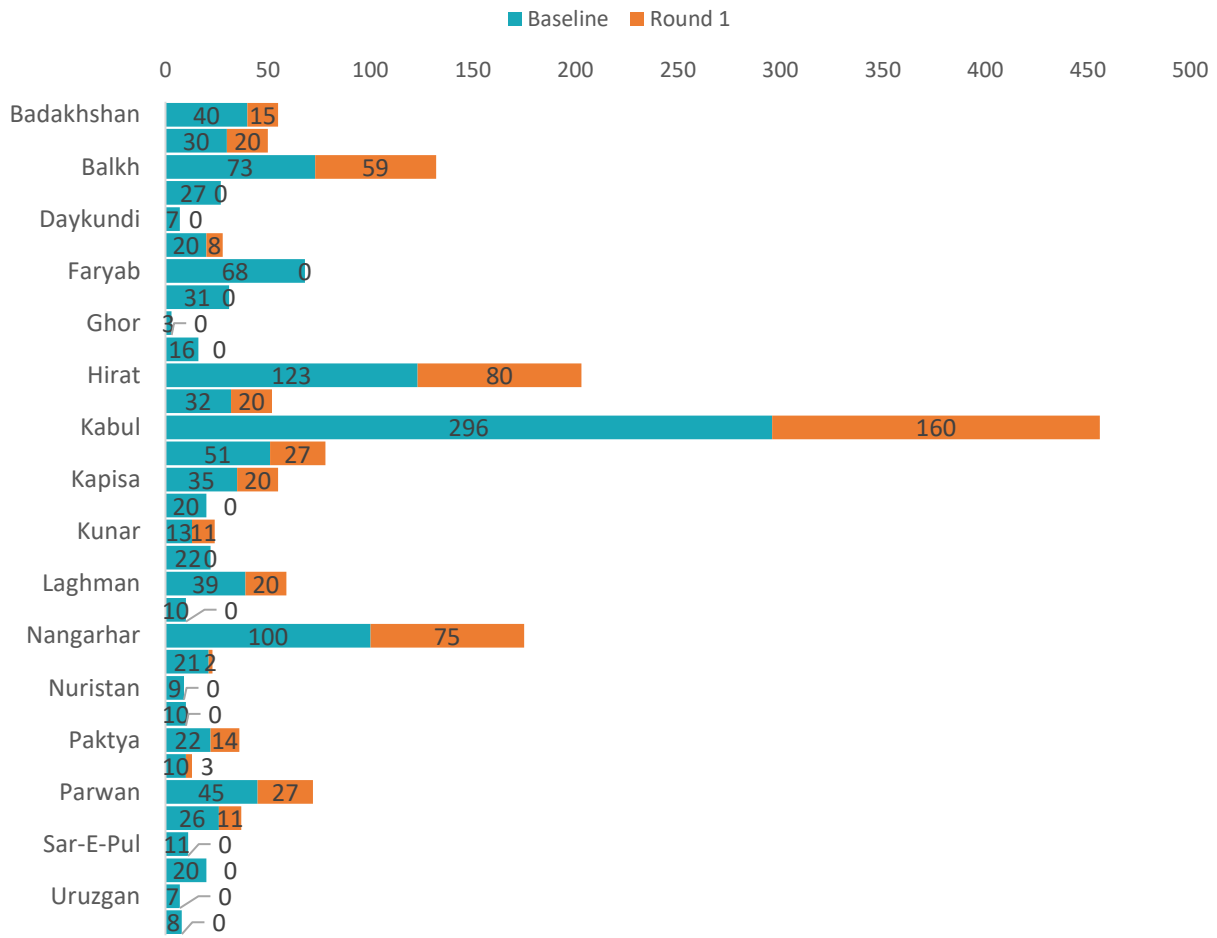
This periodic report covers the data from two periods – Baseline and Round-1. The Baseline data, as shown in Table 1, were collected during 2020 and 2021. Likewise, the Round-1 data is also for the 2020 and 2021 but it contains observations from the second-round visits. The Baseline data comes from 32 provinces (excluding Badghis and Maidan-Wardak), while the round-1 data covers 17 provinces as shown in Table 1.

Table 1: List of observations for different provinces

Province	Baseline (Round 0)			Round 1		
	2020	2021	Total	2020	2021	Total
Badakhshan	40	-	40	-	15	15
Baghlan	30	-	30	-	20	20
Balkh	73	-	73	17	42	59
Bamyan	27	-	27	-	-	-
Daykundi	7	-	7	-	-	-
Farah	20	-	20	8	-	8
Faryab	-	68	68	-	-	-
Ghazni	-	31	31	-	-	-
Ghor	3	-	3	-	-	-
Hilmand	16	-	16	-	-	-
Hirat	105	18	123	78	2	80
Jawzjan	32	-	32	20	-	20
Kabul	219	77	296	160	-	160
Kandahar	51	-	51	27	-	27
Kapisa	27	8	35	20	-	20
Khost	20	-	20	-	-	-
Kunar	12	1	13	-	11	11
Kunduz	22	-	22	-	-	-
Laghman	19	20	39	20	-	20
Logar	10	-	10	-	-	-
Nangarhar	99	1	100	72	3	75
Nimroz	21	-	21	2	-	2
Nuristan	-	9	9	-	-	-
Paktika	10	-	10	-	-	-
Paktya	22	-	22	14	-	14
Panjsher	5	5	10	3	-	3
Parwan	42	3	45	27	-	27
Samangan	26	-	26	11	-	11
Sar-E-Pul	-	11	11	-	-	-
Takhar	20	-	20	-	-	-
Uruzgan	-	7	7	-	-	-
Zabul	8	-	8	-	-	-
Grand Total	986	259	1245	479	93	572

The Figure 1 shows the distribution of observations over the two rounds for the different provinces.

Figure 1: Comparison of observations for Baseline and Round-1



During the Baseline round, each province in the lower quartile (below 25th percentile) has 10 or less observations; in the upper quartile (above 75th percentile) each has 40 or more observations; and in the remaining 50% (in the inter-quartile range) each has 11 to 39 observations. However, during the Round 1, each province in the lower quartile has 8 or less observations; in the upper quartile each has 59 or more observations; and the 50% in the middle two quartiles have 11 to 27 observations each.

The selection of indicators in the survey intended to examine the availability of services and facilities, and the management arrangements in health facilities. The following aspects of COVID-19 services were assessed during the surveys.

- Symptomatic screening for COVID-19 by health facilities
- Awareness-raising by health facilities about COVID-19
- Availability of test kits for COVID-19 diagnosis
- Availability of functional respiratory machines
- Availability of COVID-19 related essential pharmaceuticals in health facilities

The symptomatic screening of health facility visitors for COVID-19 is a critical activity in the detection of suspicious cases and to ensure the safety of other clients and health facility personnel. Awareness-raising provided to clients of public health facilities is among the priority preventative activities to promote healthy behaviors, and ultimately lower the transmission

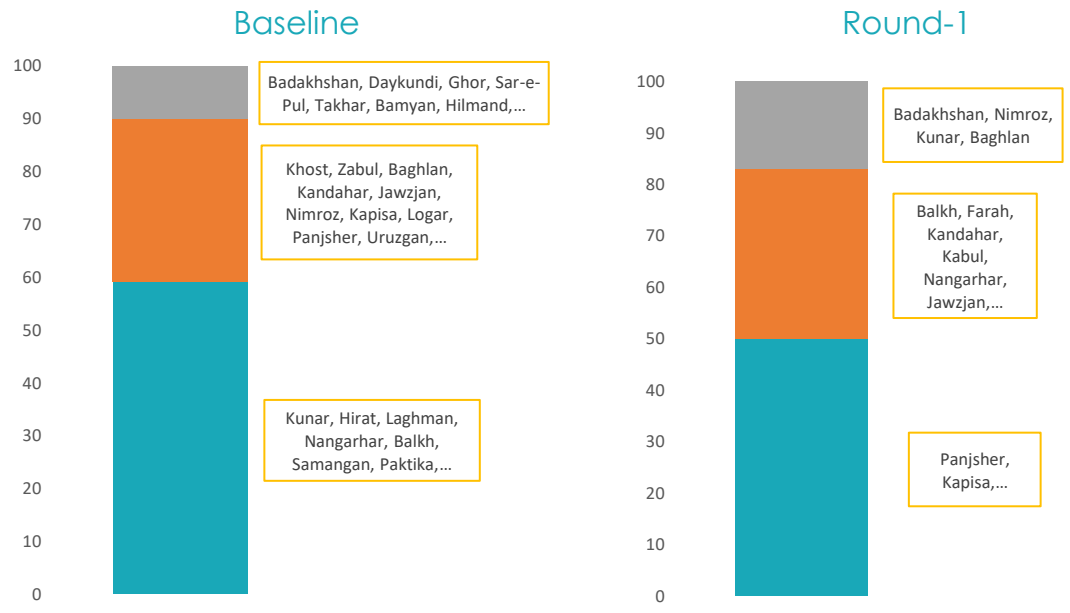
of corona virus among people. Moreover, respiratory support is pivotal in the treatment of severe COVID-19 cases. Combined with the uninterrupted supply of oxygen and suitable inpatient care, ventilators can prove a means of life and death in Intensive Care Units (ICUs). The uninterrupted supply and regular buffer stock of COVID-19 related pharmaceuticals and essential items is paramount in ensuring the capacity of health facilities to manage COVID-19 cases and to ensure staff safety.

3. Results and Findings

a. Screening for COVID-19 in the health facility

The left side section of Figure 2 on Baseline observations shows eight provinces at the upper end which reported screening for COVID-19 in more than 90% of cases on average, followed by 16 provinces in the middle portion reported screening from 59% - 90%, and the eight provinces at the lower end reported screening in less than 59% of cases. The data from the Round-1 on the right-side section of Figure 2 shows four provinces at the upper end reported screening for 84-100% cases, the middle nine provinces reported screening from 50%-82% of cases, and the lower-end four provinces reported screen in less than 50% of cases.

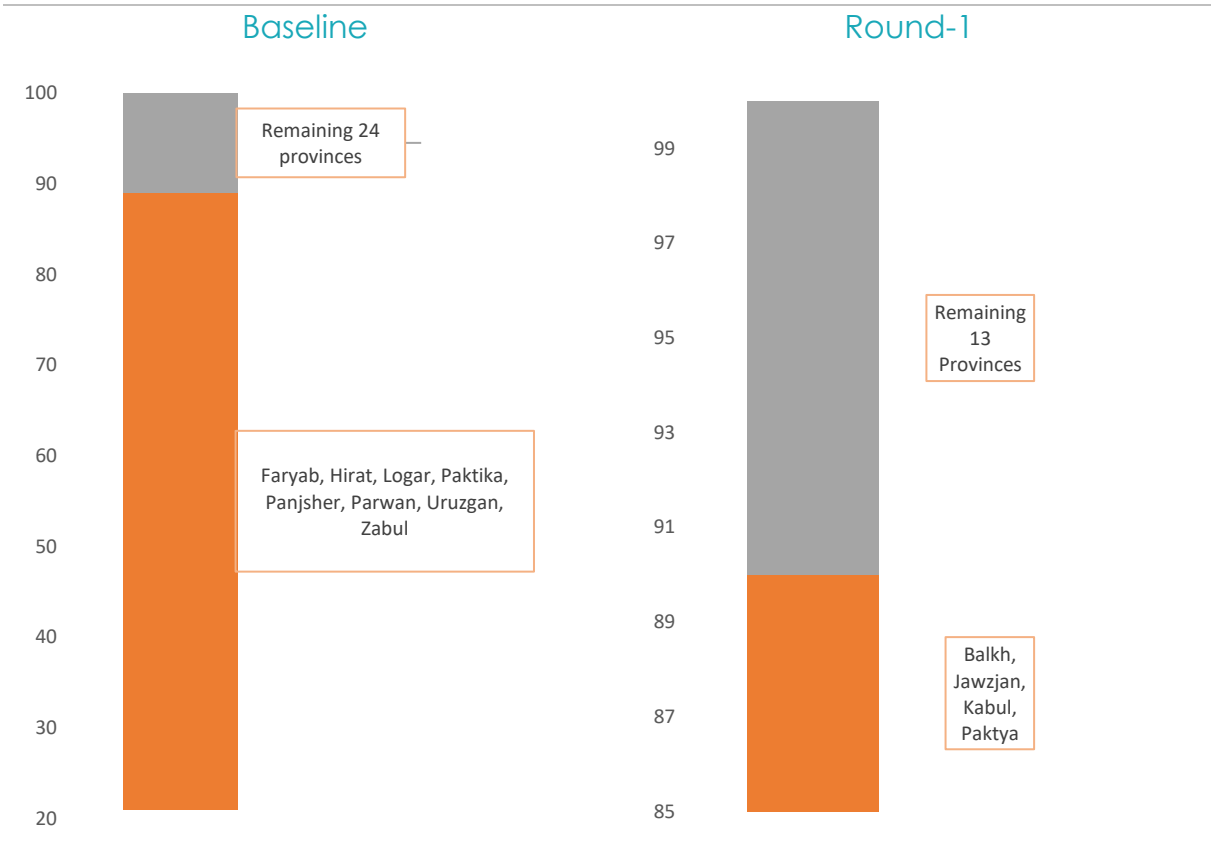
Figure 2: Screening for COVID-19



b. Awareness-raising about COVID-19

The charts in Figure 3 show the comparison between Baseline and Round-1 for the provision of awareness-raising sessions by health facilities regarding COVID-19. There is considerable increase in Round-1 as 13 out of 17 provinces reported awareness-raising sessions for 90%-100% of cases, while the remaining 4 provinces also reported good performance, ranging from 85%-90%. In contrast, the provinces surveyed in the Baseline reported performance of 90%-100% in 24 provinces, and 22%-89% in the remaining 8 provinces.

Figure 3: Provision of awareness about COVID-19



c. Availability of COVID-19 test kits

The numbers shown in Table 2 illustrate the improvement in availability of COVID-19 test kits in the provinces. In Round-1, provinces reported about 1.5 times more COVID-19 test kits even though the observations in Round-1 are less by half compared to the Baseline. This is an indication of swift change between the two rounds. However, some provinces have reported zero availability of COVID-19 test kits which need further investigation if this has been due to data collection error or if there could be issues with supply to these provinces.

Table 2: Availability of COVID-19 test kits

Province	Baseline	Round 1	Total
Badakhshan	93	136	229
Baghlan	268	2,113	2,381
Balkh	201	14,255	14,456
Bamyan	212	-	212
Daykundi	0	-	0
Farah	90	0	90
Faryab	600	-	600

Ghazni	1,199	-	1,199
Ghor	1,009	-	1,009
Hilmand	17	-	17
Hirat	61	260	321
Jawzjan	40	25	65
Kabul	2,288	341	2,629
Kandahar	563	1,274	1,837
Kapisa	415	0	415
Khost	199	-	199
Kunar	2	5	7
Kunduz	505	-	505
Laghman	1,084	0	1,084
Logar	0	-	0
Nangarhar	194	215	409
Nimroz	90	0	90
Nuristan	332	-	332
Paktika	2	-	2
Paktya	631	0	631
Panjsher	42	0	42
Parwan	153	0	153
Samangan	80	0	80
Sar-e-Pul	26	-	26
Takhar	0	-	0
Uruzgan	1,299	-	1,299
Zabul	61	-	61
Grand Total	11,756	18,624	30,380

d. Functional respiratory machines

The availability of respiratory machines is a vital component of the public health program to minimize mortality from COVID-19. However, there are different reports from the relevant agencies regarding the number and functionality of respiratory machines. Further, there is no unified understanding regarding what should be called a respiratory machine. The presents the status of availability of respiratory machines during Baseline and Round-1 surveys. The availability has not changed much except for couple of provinces which reported slight improvement and few others reported relatively lesser number during Round-1. However, this can be due to the selection of different health facilities for data collection in Round-1.

Table 3: Availability of functional respiratory machines

Province	Baseline	Round 1	Grand Total
Badakhshan	15	12	27
Baghlan	68	33	101
Balkh	3	44	47
Bamyan	26	-	26
Daykundi	6	-	6
Farah	5	1	6
Faryab	100	-	100
Ghazni	19	-	19
Ghor	20	-	20
Hilmand	6	-	6
Hirat	35	35	70
Jawzjan	6	18	24
Kabul	59	117	176
Kandahar	57	7	64
Kapisa	19	7	26
Khost	67	-	67
Kunar	4	6	10
Kunduz	26	-	26
Laghman	11	5	16
Logar	5	-	5
Nangarhar	41	16	57
Nimroz	6	4	10
Nuristan	18	-	18
Paktika	15	-	15
Paktya	6	14	20
Panjsher	4	0	4
Parwan	9	5	14
Samangan	4	2	6
Sar-e-Pul	30	-	30
Takhar	3	-	3
Uruzgan	28	-	28
Zabul	3	-	3
Grand Total	724	326	1,050

e.

f. Availability of COVID-19 essential items

The graphs presented in Figure 4 and Figure 5 illustrate the availability of essential pharmaceuticals and supplies used for prevention and treatment of COVID-19 in health facilities, especially in hospitals which specifically cater to COVID-19 positive patients. The two graphs (Figure 4 for Baseline, and Figure 5 for Round-1) show sufficient amounts of the 10 items for 15 days and one month period. However, these numbers are self-reported and does not seem plausible in view of the high reports of shortage of medical oxygen and other supplies during the past one year.

Figure 4: Baseline availability of essential pharmaceuticals and supplies for COVID-19

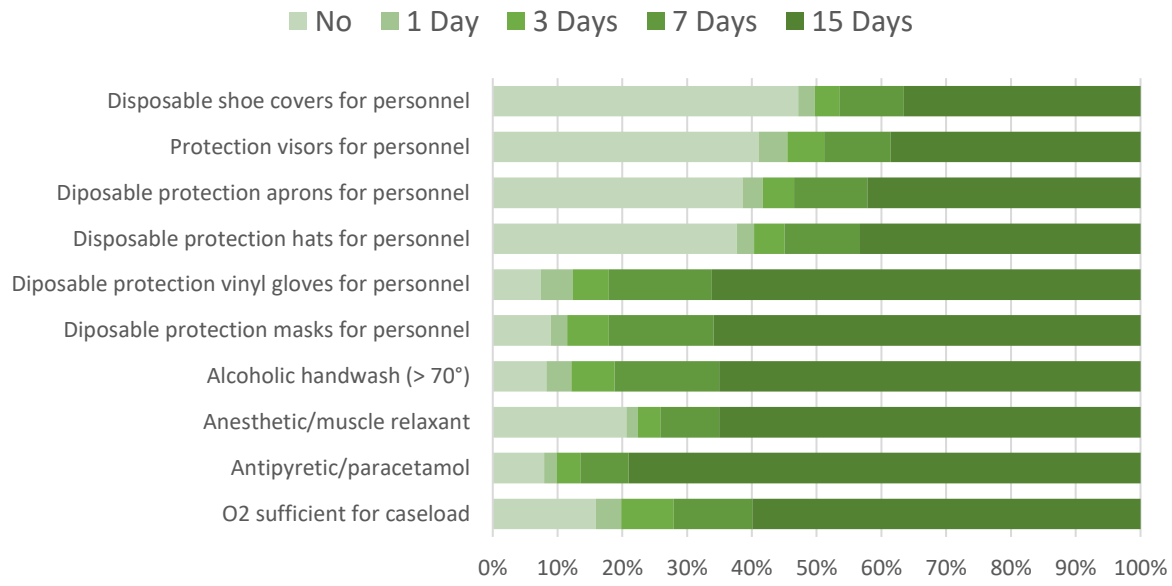
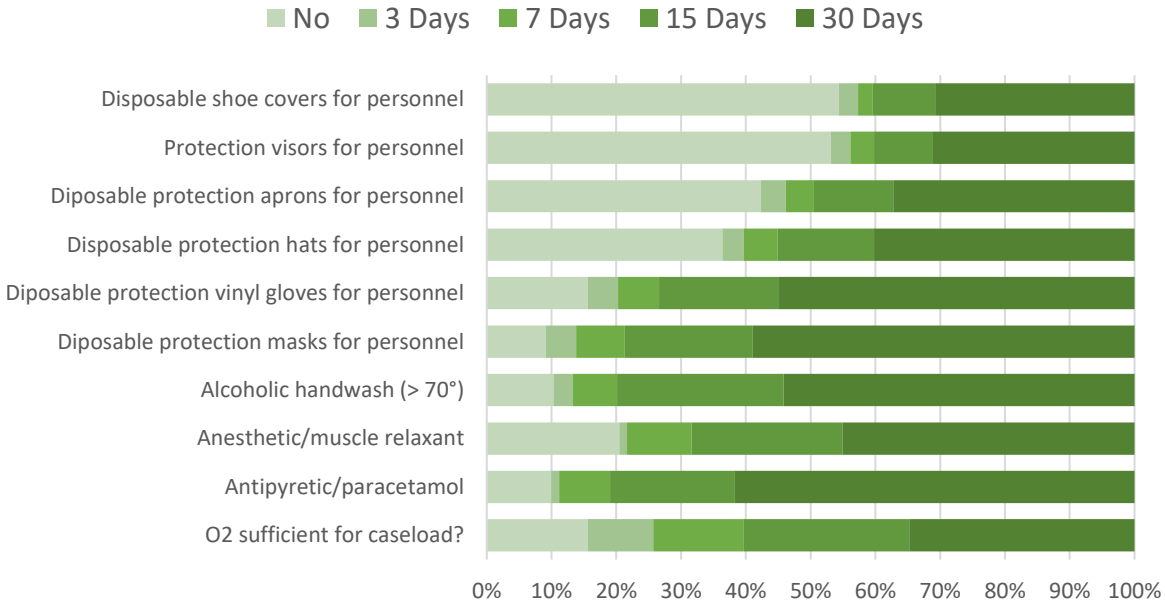


Figure 5: Round-1 availability of essential pharmaceuticals and supplies for COVID-19



4. Conclusions

The data covers a significant number of health facilities and can serve as a valuable resource for high-level decision making. The attention of health facilities to screening visitors for COVID-19 has not changed sensibly. The awareness raising regarding COVID-19 has improved significantly in health facilities. Health facilities are the main point for people to get reliable information about COVID-19 as recommended by the Ministry of Public Health (MoPH) and the World Health Organization (WHO). Similarly, the availability of COVID-19 test kits appears to be improved significantly. Quality and reliable testing facilities are among the top strategies for COVID-19 prevention and timely treatment. However, the definition of COVID-19 test kit can be different to different person. The COVID-19 test is either the rapid antigen test or the PCR test which are both meant for screening and diagnosis. The availability of functional respiratory machines also seems at satisfactory level. Again, the definition of respiratory machines should be clear to the surveyors and the availability should be confirmed through inspection rather than the self-reporting by the interviewee. Lastly, the availability of essential pharmaceutical items and supplies in health facilities, as reported in the surveys, seem at satisfactory level.

5. Recommendations

The results and findings of this report provide a valuable source for triangulation with other reports, such as the data collected by MoPH and WHO. The finding of this report can be used for advocacy and corrective action planning as well. In General, the data show satisfactory level of improvement in the Round-1 phase. However, the change in availability of different items cannot make a solid ground for making the conclusion as the health facilities included in one round are somewhat different in the next round.

The recommendations at the high level (to MoPH and implementing agencies) are to:

1. realistically ensure the availability of essential commodities, especially medical oxygen and other items used for personal protection of staff.

2. The recommendation for the data collection personnel and the Integrity Watch Afghanistan is to further refine the process through standardizing the definition of survey questions and the items being assessed. For instance, the interpretation of surveyors and the interviewee can be different about what is meant by COVID-19 test kit and respiratory machine. The knowledge of data collection personnel regarding the test kits and respiratory machines should be built so that they can confirm the availability of the self-reported items through observation.

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