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**ACCOUNTABILITY AND REFORM EFFORTS  
AT THE AFGHAN NATIONAL MILITARY  
HOSPITAL**

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HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT  
AND INVESTIGATIONS

OF THE

COMMITTEE ON ARMED SERVICES  
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

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# CONTENTS

## CHRONOLOGICAL LIST OF HEARINGS

2012

	Page
HEARING:	
Tuesday, July 10, 2012, Accountability and Reform Efforts at the Afghan National Military Hospital .....	1
APPENDIX:	
Tuesday, July 10, 2012 .....	27

### TUESDAY, JULY 10, 2012

#### ACCOUNTABILITY AND REFORM EFFORTS AT THE AFGHAN NATIONAL MILITARY HOSPITAL

##### STATEMENTS PRESENTED BY MEMBERS OF CONGRESS

Wittman, Hon. Rob, a Representative from Virginia, Chairman, Subcommittee on Oversight and Investigations .....	1
---	---

##### WITNESSES

Moorefield, Ambassador Kenneth P., Deputy Inspector General for Special Plans and Operations, U.S. Department of Defense .....	5
Sedney, David S., Deputy Assistant Secretary of Defense for Afghanistan, Pakistan, and Central Asia, U.S. Department of Defense .....	2

##### APPENDIX

PREPARED STATEMENTS:	
Moorefield, Ambassador Kenneth P. ....	38
Sedney, David S. ....	33
Wittman, Hon. Rob ....	31
DOCUMENTS SUBMITTED FOR THE RECORD:	
News article submitted by Ms. Speier .....	51
WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING:	
Ms. Speier .....	57
Mr. Young .....	57
QUESTIONS SUBMITTED BY MEMBERS POST HEARING:	
Mr. Cooper .....	61



## **ACCOUNTABILITY AND REFORM EFFORTS AT THE AFGHAN NATIONAL MILITARY HOSPITAL**

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HOUSE OF REPRESENTATIVES,  
COMMITTEE ON ARMED SERVICES,  
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,  
*Washington, DC, Tuesday, July 10, 2012.*

The subcommittee met, pursuant to call, at 3:04 p.m., in room 2118, Rayburn House Office Building, Hon. Rob Wittman (chairman of the subcommittee) presiding.

### **OPENING STATEMENT OF HON. ROB WITTMAN, A REPRESENTATIVE FROM VIRGINIA, CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS**

Mr. WITTMAN. Folks, welcome.

I want to call to order this Subcommittee on Oversight and Investigations of the House Armed Services Committee for today's hearing on Accountability and Reform Efforts at the Afghan National Military Hospital.

I would like to welcome our witnesses here today: Mr. David Sedney, Deputy Assistant Secretary of Defense for Afghanistan, Pakistan, and Central Asia; Ambassador Kenneth Moorefield, Deputy Inspector General for Special Plans and Operations; and Major General Dr. Douglas Robb, the Joint Staff Surgeon, Office of the Chairman of the Joint Chiefs.

Gentlemen, welcome today. We appreciate your taking your time to join us.

We are looking forward to your testimony today, and Ambassador Moorefield, in particular, I would like to thank you for the work you have done on monitoring these issues. I hope you will let your team know how much this committee appreciates their noteworthy dedication to this challenging mission.

Recently, I have traveled to Afghanistan and on a number of times over the past several years and have seen, particularly during my last trip in June, the great progress that has taken place since the surge has begun, a ways to go, but certainly significant progress to this point.

And the key to sustaining this progress is building a capable Afghan National Security Force and, of course, the support systems to maintain it, including a medical care system responsible for the health and well-being of those who have served and sacrificed. Taking care of these troops is absolutely critical to this mission and must be a continued area of focus as we move forward.

I am both disheartened and disgusted when I saw the pictures showing patient abuse and neglect at the military hospital, an institution where coalition forces serve as advisers and mentors. We

can and must do better to ensure that these troops receive adequate medical care. Anything less is detrimental to our mission and compromises our efforts to secure Afghanistan's future.

As I understand it, no one to date has been held criminally responsible for what happened. Moreover, there has been no accounting of the millions of dollars of funds and medical supplies that disappeared since these issues came to light. I hope you will provide us with explanations and detail the systemic reforms aimed at preventing this from happening again.

As an administrative note, I recognize that members of other subcommittees will join us today. Pursuant to the committee rules, I ask unanimous consent to allow their participation. And absent objection, I will recognize them after all O&I Subcommittee members have had an opportunity to question the witnesses.

Gentlemen, thank you again. We look forward to your testimony and taking our questions.

And with that, I will turn it over to our ranking member, Mr. Cooper.

[The prepared statement of Mr. Wittman can be found in the Appendix on page 31.]

Mr. COOPER. Thank you, Mr. Chairman.

I have no opening statement. I look forward to hearing the testimony of the witnesses.

Mr. WITTMAN. Thank you.

Mr. Sedney, we will begin with you.

**STATEMENT OF DAVID S. SEDNEY, DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR AFGHANISTAN, PAKISTAN, AND CENTRAL ASIA, U.S. DEPARTMENT OF DEFENSE**

Mr. SEDNEY. Thank you very much, Mr. Chairman and members of the subcommittee.

And I particularly thank you, Mr. Chairman, for your attention to this very important issue and for the continuing interest and effort that you have put into this area, which you have very aptly described the importance of.

I appreciate the opportunity to be before you and the members of the subcommittee to discuss Afghanistan and particularly the efforts towards accountability and reform at the Dawood National Military Hospital in Kabul, Afghanistan.

I want to start off by going back to basic principles here, which is why are we there? Why are we concerned about Afghanistan and the Afghan National Security Forces and, therefore, the hospital?

The United States, together with our coalition allies and our Afghan partners, is dedicated to our core objectives in Afghanistan of disrupting, dismantling, and defeating Al Qaeda and its extremist affiliates, to deny them safe haven from which they can launch attacks against the United States and our allies and partners, and to deny the Taliban the ability to overthrow the Afghan government and re-create such safe havens.

Thanks to more than 10 years of dedication and sacrifices by our forces, our coalition partners, and the Afghan people themselves, we have taken enormous strides towards achieving those objectives, particularly over the last 3 years.

A key objective, the key objective to achieving this strategy is the development of the Afghan National Security Forces into a sustainable and capable force. Their growth and confidence and demonstrated capability to provide suitable security against internal and external threats are essential for the responsible transition of security in Afghanistan to the Afghans themselves by the end of 2014, as agreed to by NATO [North Atlantic Treaty Organization] heads of state at Lisbon in 2010 and reinforced by NATO heads of state at Chicago last month.

To this end, with coalition support, the Afghan security forces have made great progress, both in terms of size and capability. Both the Afghan National Army and the Afghan National Police are on schedule to meet their surge end-strength goals of 352,000 by or before October of this year.

Their continued performance and ability has allowed them to move increasingly into the lead for operations, including in operations in recent days and weeks in countering major attacks in Kabul, in Kandahar, Helmand, and elsewhere. Currently, the Afghan security forces participate in over 90 percent of all coalition operations, and more than 50 percent of these partnered operations are led by the Afghan security forces.

In addition to the success of the Afghan security forces that I mentioned, I want to stress to the committee the importance of two signal achievements that have sent an important signal to the Taliban, the Afghan people, and to countries in the region.

The first is the strategic partnership agreement that President Karzai and President Obama signed in May that shows the United States and Afghanistan are committed to a mutually beneficial relationship beyond 2014.

Second, as I mentioned before, the Chicago summit was a great success and demonstrated the continued dedication of over 50 NATO and other partner nations to supporting security and stability in Afghanistan. They reaffirmed their commitment to the Lisbon timeline but, very importantly, agreed to continue their commitment after 2014.

Despite these achievements, there are still many areas that need improvement. Many, many areas. Particularly, in the Afghan security forces, it is important to have improvements for them to be the independent force that they need to be in 2014 to protect Afghan security.

One of the key areas, as you have said, Mr. Chairman, is the development of a medical system capable of sustaining the health and well-being of the Afghan security forces. The allegation raised in the past years, particularly in 2010, of mismanagement at the Dawood National Military Hospital highlighted gross deficiencies in the system and the critical need for serious reforms.

Coalition medical mentors and advisers reported inexcusable mismanagement and, at times, neglect in the operation and provision of basic medical care, resulting in substandard patient care, disturbing sanitation conditions, poor facilities management, and a dysfunctional medical logistical system.

These concerns were elevated to senior leaders in the NATO Training Mission–Afghanistan [NTM–A] and to its commander at that time, Lieutenant General William Caldwell.

Recognizing the enormity of the situation, General Caldwell took action. He requested the involvement of the Department of Defense Inspector General [IG] Office of Special Plans and Operations to assess the nationwide medical logistics system in Afghanistan.

With regard to the substandard patient care concerns, Lieutenant General Caldwell's staff alerted the IG and his staff to those concerns, and the IG expanded the scope of its oversight activities to include reports on this matter.

Thanks to the response and effort in reforming the healthcare and medical systems, we are now helping to turn around what had been a broken system, introducing accountability, standards, and stewardship at all levels.

The senior leadership of ISAF [International Security Assistance Force] NTM-A and the medical advisory group recognized the critical importance of enabling a system that could provide adequate healthcare to the Afghan security forces now and for a transition to take place in 2014. Improvements in the accountability of the changes in and improvements in the hospital leadership and staff, the general sanitation standards, the standard of patient care, and the logistics systems are underway.

Following the removal of General Ahmad Zia Yaftali from his position as hospital commander, new leadership established more stringent planning and oversight to advance the professional conduct and accountability of the medical staff, with special attention towards combating staff absenteeism.

By last summer, NTM-A mentors reported that a new hospital commander, chief of surgery, and chief nurse routinely intervened in every case of possible neglect. And by August of last year, there were no known cases of neglect.

Follow-up inspections in 2011 showed marked improvement in cleanliness, dressing, and sterilization. The transfer of medical logistics from the Office of Surgeon General to the Logistics Command allowed the Ministry of Defense to enforce its own standard controls over receipt, storage, accountability, and distribution of pharmaceuticals and other supplies.

Newly implemented medical inventory and tracking systems at Dawood have introduced greater transparency and efficiency in the supply chain management. The Logistics Training Advisory Group and Medical Training Advisory Group conduct continuous battle-field circulations throughout the hospital to provide daily follow-up and ensure compliance.

These are just a few of the examples that I have been made aware of. If you have further questions regarding these recent improvements, we look forward to addressing them in Q&A.

NTM-A, the coalition forces, and the leadership, starting with General Allen, remain committed to continuing this progress and supporting our Afghan counterparts as they display increasing capability and growing responsibility and improvement. The conditions which existed before have changed. A lot more remains to be done, but we are committed to the sustained improvement necessary for Afghanistan to have that enduring capability that you described, Mr. Chairman.



Again, I would like to thank you and the members of the subcommittee for the opportunity to appear before you and look forward to your questions.

[The prepared statement of Mr. Sedney can be found in the Appendix on page 33.]

Mr. WITTMAN. Thank you, Mr. Sedney.

I appreciate your comments to begin with, but I would like to recognize Representative Mike Coffman from Colorado for his tireless advocacy to make sure that this issue with Dawood Hospital would be addressed. So, Mr. Coffman, I appreciate your efforts here.

And with that, Ambassador Moorefield, we will turn to you for your opening comments.

I want to remind, too, the witnesses that as much as we can, we like to try to stick to the 5-minute timeframe. Your comments will certainly be entered for the record in their full content.

**STATEMENT OF AMBASSADOR KENNETH P. MOOREFIELD,  
DEPUTY INSPECTOR GENERAL FOR SPECIAL PLANS AND  
OPERATIONS, U.S. DEPARTMENT OF DEFENSE**

Ambassador MOOREFIELD. Thank you, Mr. Chairman and Ranking Member Cooper and distinguished members of the committee and subcommittee.

Thank you for this opportunity today to discuss OIG oversight of the Department's efforts to develop the Afghan National Security Forces [ANSF] healthcare system and also the developments at the National Military Hospital.

The development of the Afghan National Security Forces has included, as Dr. Sedney said, building an effective healthcare system to support field-level combat casualty care, evacuation of wounded casualties, restorative surgery, and long-term care for disabled personnel.

Meeting this challenge has understandably proven difficult. When the ANSF medical care system development efforts began, the country's public healthcare system was rated among the worst in the world by international experts. The remnants of the Soviet era military medical facilities and services left by the Taliban had further deteriorated this limited capability.

But given the importance of the medical care issue, therefore, as it relates to the Afghan security forces, DOD IG [Department of Defense Inspector General] has undertaken a succession of oversight initiatives since 2008 and up to the present.

Our assessments in 2008 and 2009 determined that the complex set of issues related to medical stabilization and reconstruction challenges in Afghanistan called for a robust U.S. and international effort to develop and implement a multiyear planning strategy.

Many U.S. military medical mentoring teams at that time with whom our teams met were not appropriately staffed. The development of ANSF medical personnel was seriously hampered also by inadequate guidance to U.S. medical mentors, particularly regarding standards objectives.

Our 2009 assessment recommended that the U.S. Training and Advisory Command develop a clearly defined plan for building the

ANSF healthcare system in coordination with the relevant Afghan ministries and security forces. In 2010, at the request of the Commander, NTM-A CSTC-A [Combined Security Transition Command-Afghanistan], we assessed the Afghan army medical logistics system, which included the National Military Hospital.

We made recommendations for strengthening the system, including improved accountability and control of medical supplies. We also determined that ANSF healthcare system planning did not include a defined end-state goal, and the mentoring effort was impeded by only having half the authorized medical mentor personnel.

In February 2011, we conducted an inspection of just the National Military Hospital. This mission was precipitated by a report received by our IG who was on a tour of Afghanistan and in Kabul in November 2010.

During this mission, our team identified issues related to inadequate Afghan medical personnel staffing at the hospital, failure of the logistics system to reliably deliver pharmaceuticals to the hospital and the hospital to its patients, significant quantities of unused medical equipment and supplies, inadequate patient nutrition, and a lack of clearly defined medical standards, among other issues.

We subsequently carried out an audit of the pharmaceutical distribution system. The team found that although the process had made progress in the previous year, the delivery and inventory control processes for pharmaceuticals in particular at ANA [Afghan National Army] medical facilities and depots required further improvement.

Just 2 weeks ago, in this past June, a DOD IG team returned to the NMH [National Military Hospital] to review the status of efforts to improve its management, healthcare services, and logistical support. As is customary, our team outbriefed our military command and the National Military Hospital leadership and staff prior to its departure.

There were 15 U.S. military mentors present at the NMH during this inspection. The team noted that since our February 2011 inspection of the NMH, progress had been made in a number of areas. This is further detailed in my written testimony.

Key among these areas were no complaints or evidence of patient maltreatment; new processes and procedures to improve personnel accountability and patient care, including for nutrition; clearly defined medical standards; improvements in the medical logistics system; and improved leadership by the ANA medical command and at the NMH itself.

Also, ISAF, the International Security Assistance Force, and NTM-A have now published an ANSF healthcare development plan, identifying the readiness performance criteria for the NMH to be able to meet the NTM-A transition objective of Afghan assumption of lead responsibility for their functioning by the third quarter of 2013.

Our team observed substantial NMH progress towards achieving this objective. Once achieved, the NTM-A intends to continue to provide mentor monitoring of the NMH performance and the rest of the healthcare system through 2014.

There is still some NMH development challenges remaining. These include personnel shortages, specifically at the pharmacy and nursing departments, the transfer of ANA patients from coalition medical facilities to the NMH. NMH requires better coordination. Inventory control procedures have improved in the bulk storage area but need to be implemented in the dispensary, and the NMH staff needs additional training.

Finally, NTM-A is still working to identify the scope of its support for a post-2014 ANSF healthcare development mission intended to enable its enduring sustainability.

In closing, let me emphasize the DOD IG remains committed to providing oversight of U.S. and coalition efforts to develop further the Afghan military healthcare system, including at NMH. And we thank you for this opportunity to speak to you today, look forward to any questions you may have.

[The prepared statement of Ambassador Moorefield can be found in the Appendix on page 38.]

Mr. WITTMAN. Thank you, Ambassador Moorefield. We appreciate your opening testimony.

Major General Robb, I understand that you do not have opening testimony, but that you will be available to answer questions from committee members.

Thank you so much for joining us today.

With that, Mr. Sedney, I will begin with you. I want to focus on the former surgeon general there in Afghanistan, Ahmad Yaftali. And as you know, allegedly, he profited from missing medical supplies there at the hospital and failed to address some fairly serious neglect issues there at the hospital, in some cases leading to people dying at the hospital.

And based on that, my question is, is he still under investigation by our folks there in theater? Is he still wearing a uniform? And are U.S. or coalition force dollars still being expended to pay his salary?

Mr. SEDNEY. Mr. Chairman, we are very much aware of the serious allegations against General Yaftali, and there is currently an ongoing investigation. It is an Afghan investigation under Afghan law, carried out by Afghan authorities.

However, the U.S. Department of Defense, particularly through Task Force Shafafiyat (Transparency) at ISAF, are giving support to that investigation. We are conveying accurately to the Afghan authorities all the information that we have, working with them to develop additional information where it may be needed for the possible—or for any possible charges that may be brought.

Well, you are correct. No charges have been brought against General Yaftali or anyone or others involved in this. I can assure you that this is a very serious effort. It is supported and monitored at the top levels of our leadership structure in Afghanistan and here in Washington and that we believe that this investigation will result in—that it will result in a very close look at all the allegations.

We can't prejudge whether there will be charges, whether there will be convictions, and what the fate of any individual, including General Yaftali, will be. In fact, we have to be careful not to try

and make statements that will presuppose a particular outcome in the Afghan judicial system.

But as I said, I can assure you that the investigation is ongoing. It is serious and receiving a lot of assistance from the U.S. authorities.

Mr. WITTMAN. Just to reiterate the question, is he still wearing a military uniform, and are any U.S. or coalition funds being expended to pay his salary currently?

Mr. SEDNEY. General Yaftali was removed from the leadership of the hospital. To our knowledge, he does not have another position inside the Afghan forces.

Whether he is receiving his salary or not is a question that we will ask the Afghans, but we don't have any information to say that he is not. However, any disciplinary action that would be taken against him would come out of this ongoing investigation. So I am going to be careful not to say anything that will prejudge what that investigation might or might not result in.

Mr. WITTMAN. Thank you, Mr. Sedney.

Ambassador Moorefield, your June 2011 report outlined a number of significant shortcomings that continue to exist in areas of planning and execution of a medical logistics system there within the Afghan medical system. And you said there that the current system could not be maintained without continued U.S. and international support.

How long do you think this condition will continue to exist, and what other areas of medical care system pose similar challenges there in Afghanistan as we speak?

Ambassador MOOREFIELD. Okay. I think I got it this time.

Thank you, Mr. Chairman.

The planning that is currently going on, and this is according to our team's report—and they just came back a few days ago and spent extensive amount of time with the command—is that beginning at the end of 2013, after the third quarter of the calendar year, they are going to transition to lead responsibility to the Afghan medical personnel at all the hospitals and the depots with the intention of monitoring their performance through 2014.

And where intervention and support and additional mentoring is required, be able to provide that. But essentially, transfer the burden of that responsibility and, therefore, the need for them to take appropriate action on their own hook. So that is the intention through 2014.

Now I believe that the healthcare system has been identified as an ongoing responsibility, support responsibility of our command, along with several other key enabling function areas. I understand that even though we don't have the specifics of the plan, which I mention in my remarks and we hope to get soon—they are still working on it—but in any event, after 2014, we think the emphasis is going to be primarily on training and education. And this is where they seriously need additional assistance to help build a base, basically, for an enduring and sustainable Afghan military medical system.

And this could include a whole range of activities. There is medical training that is going on right now, but that base will be, we understand, expanded up to and include even fellowships and

residencies for doctors in specialty care areas that would be undertaken in the country.

Mr. WITTMAN. Thank you, Ambassador.

With that, we will go to our ranking member, Mr. Cooper.

Mr. COOPER. Thank you, Mr. Chairman.

I am worried that the interface between U.S. personnel and the Afghan so-called health system puts U.S. personnel in an impossible situation. Because to read one of the documents here, the MTAG [Medical Training Advisory Group] staff mentors and advises the Afghans, but they do not treat patients, prescribe, or otherwise administer vaccines or pharmaceuticals.

Their purpose is "to help the Afghans perform and to increase their capability, not by doing for them but rather by advising them and stepping back. They perform not as a clinician, not as a nurse, not as a technician, but as a trainer. When they come here, it is advising."

But this is an interface between the most advanced society on the planet and Fourth World medicine. How on earth do you advise when doctors and nurses so-called in Afghanistan don't show up, don't feel an ethical duty to treat the patient? Let them, in some cases, starve to death or steal their medicines or let bedsores kill them.

These are unspeakable conditions, but then this is a country without reliable power, without so many of the things that we take for granted in this country. How on earth could anybody advise in that situation? It is a guaranteed nightmare.

So I am not excusing any of the, by our standards, bad behavior in Afghanistan, but we can't change the whole country. And you wonder if we are fighting side by side with ANSF forces and our folks get first-rate, First World medicine, the most advanced battlefield medicine in the world, and some of these folks go to their so-called hospital, you would almost rather take a bullet than die of sepsis in one of these places.

But furthermore, in addition to putting U.S. personnel who are tasked with this impossible job of advising this hospital, I am worried that this puts you gentlemen in an impossible situation. Because you don't want to upset the Afghan relationship, and we know that it is a deeply corrupt country. We know that their culture in so many ways jars with ours.

And in terms of standards of care, to my knowledge, they haven't defined hospital services. So when we apply a Western lens to this, aren't we kind of fooling ourselves? And I am, again, not excusing any of the bad behavior over there, but how on earth do you drain this swamp?

We have no ability to compel the Afghan doctors to show up, to make them do right when they are there, to even sterilize their hands or instruments. So how do you administer care or how do you advise on administering care in that situation? This is the worst nightmare a health provider could ever possibly imagine to even be associated with that, without any control.

How do you fix it? All you do is get tainted by whatever you are associated with. So, again, I am not excusing any bad behavior. I wish they would do right. And when you wonder about if somebody

is being paid, the entire Afghan economy is subsisting off of the U.S. and Western taxpayers.

So whether it is directly or indirectly, unless it is their feeble internal production or the opium poppies, where else does their money come from unless it is from the West? This is why this is the second-poorest country in the world.

So I want to get to the bottom of this, and I am not making any apologies for General Yaftali, but for U.S. personnel to come in or alliance personnel to come in and try to fix this, how do you go about that without any control in a purely advisory capacity? What is the answer here, other than to put good U.S. personnel in an impossible situation?

I have 49 seconds left if anyone wants to respond to that.

Mr. SEDNEY. I will say a quick word, Representative Cooper. You have laid out the challenges. Those challenges existed when we went into Afghanistan 11 years ago. And as Ambassador Moorefield pointed out, Afghanistan had about the worst healthcare system in the world.

There has been a lot of progress. A week ago today, I was in Kabul. I met with a number of students from the American University of Afghanistan. They are well aware of the challenges that their country faces, and they are taking them on and moving forward.

Our advisers—and if we had time later, maybe General Robb can talk about the ethical quandaries that you mentioned. But the advice and assistance that we have been providing over the last 10 years is resulting in the kind of improvements that Ambassador Moorefield mentioned.

Is it a daunting challenge, as you have described it? Yes. Is it an impossible challenge? We don't believe so. Will it require continued effort even after 2014? Yes, and that is why we are committed and our NATO allies and partners are committed to continuing that effort.

But you have laid out very clearly the challenges. But I think the Afghan people working with us see a way forward despite those difficulties.

Mr. WITTMAN. Thank you, Mr. Cooper.

We are going to go now to Mr. Young.

Mr. YOUNG. Thank you, Mr. Chairman.

And I thank all our panelists for being here today. Thank you for your testimony.

Ambassador Moorefield, you had discussed at some length the adviser/mentor program, and you talked about that. I would like to dig a little deeper on that. Before I do, cite Lieutenant General Caldwell, who mentioned underresourcing and staffing as significant barriers to any further success we would see at the hospital there and, thus, I would say by extension barriers to achieving an independent force, as we look into the future.

Since Lieutenant General Caldwell made that statement, what improvements, if any, have we seen in an adviser/mentoring program trying to train more personnel in medicine? And is this adviser and mentor role, is it sustainable as we consider pulling forces out after 2014? With the understanding there will still be some support role for our forces, but will that in any way under-

mine our capability to strengthen the capabilities at this hospital and other medical facilities?

Ambassador MOOREFIELD. Thank you, Congressman Young.

The challenge is going to be ever-present for the immediate future as to whether or not they are going to be able to pick up the ball and run with it. I think that the command has a good game plan, and that is that they are not going to just give them the ball and walk away off the playing field.

They are going to be there to continue to monitor their performance and intervene as appropriate and necessary along the way. So there is a reasonable degree of confidence, and let me just talk about the National Military Hospital.

There are standards now. One of the big problems that we had identified in our work previously was in the absence of standards, it was very hard for our mentors to know what to do and for the hospital personnel either there or in the regional hospitals to know exactly what is it that we are trying to create here. What is the standard? What is the capability?

Considerable work has been invested in the last few years in developing Tier 1, Tier 2, and Tier 3 standards, and there is every expectation they will erase the Tier 1 standard, which is the objective by the third quarter of 2013. That standard has a whole series of requirements that are inspected on a quarterly basis now by our command and by the Afghan command. And they have made substantial progress.

Let me just quickly if I can say something about the regional hospitals. I realize the focus has, more often than not, been on NMH of late. But our work, which has included all of the hospital system in the Afghan security forces, including the ANP [Afghan National Police] hospital, has indicated the regional hospitals have actually—had actually made considerable progress that was not so visible because it is out there in the regional commands.

And indeed, I think have been very impressively moving forward, although even with greater speed and efficiency now that they have defined standards. The NMH was a lagging issue, and considerable progress has been made.

You mentioned, Congressman Cooper, that there were issues related to not showing up at work. That is absolutely the case. This is my own personal opinion, but I think leadership was a major factor. And now that the leadership has dramatically shifted in the right direction at the NMH, they are enforcing the standards of showing up for work and doing your job.

And those individuals—and there have been recent cases—who did not do their jobs have found themselves at the wrong end of administrative sanctions. So going back to your original question, I think there is a reasonable chance that if we continue there with them, shoulder to shoulder, so to speak, they will get to where they need to get to.

Mr. YOUNG. I have got 30 seconds left, Mr. Ambassador. But you indicated that there was progress, measurable progress based on the standards that have been set and the measurements as compared to those standards. Seeing as you have had access to these reports and what-not, could Congress get access to these progress, quarterly progress reports?

Mr. SEDNEY. I think that is certainly a very reasonable request, and we will get back to you on that with a definite answer.

Mr. YOUNG. Thank you.

Mr. WITTMAN. Thank you, Mr. Young. We appreciate it.

Mr. Sedney, if you could follow back up with that and let the committee know when and how those reports would be available, we would like to have them for the committee members.

Thank you.

[The information referred to can be found in the Appendix on page 57.]

Mr. WITTMAN. Thank you, Mr. Young. We will now go to Mr. Brooks.

Mr. BROOKS. Thank you, Mr. Chairman.

Just a quick background information. How much of the funding for the Afghan National Military Hospital comes from the United States? Do you have a judgment as to the percentage or the quantity, any of the three of you?

Mr. SEDNEY. What I can tell you, Representative Brooks, is we have spent about \$185 million over the past 9-plus years on the Afghan military medical system, and to the best of my knowledge, that has been virtually the only source of funding for it during that period of time.

There have been occasional efforts by other countries that have resulted in small amounts of—much smaller amounts of money. So I can't say with certainty that all of the support for the National Military Hospital come from the United States, but the vast majority of it has.

Mr. BROOKS. So that, I am sorry?

Mr. SEDNEY. That \$185 million is for the entire military medical system, of which the military hospital is only part of.

Ambassador MOOREFIELD. I would just add that, of course, there have been international donations, notably by Japan, in terms of equipment and supplies. In addition, the training and education has been very significantly impacted by coalition forces. And for example, next to the National Military Hospital is the medical university, and the program there has between 20 and 30 Canadian personnel that are responsible for training physician's assistants and medics and medical technicians.

That is true also up in the north, where the German command is located. So if you look at the overall effort, it is not just our funding. But I think specifically related to funding for equipment and supplies, that has been largely a U.S. contribution.

Mr. BROOKS. As America shifts more of the fight responsibility from American troops and allies to the Afghans, do you anticipate that the medical facility costs will go up?

Mr. SEDNEY. Trends right now are that the Afghan security forces are suffering casualties in their last 2 months at a somewhat increased level, at an increased level than we would expect. As they move more and more into the lead, there will be more Afghans who are wounded and require medical care in their facilities.

So, yes, we would expect those costs to go up and the need for care to increase.

Mr. BROOKS. Do you have a judgment as to how long it will be before the Afghan economy is strong enough to take over the re-



sponsibility of funding the cost of the Afghan National Military Hospital?

Mr. SEDNEY. For the Afghan security forces as a whole, the NATO heads of state meeting in Chicago last month committed that with \$500 million of Afghan government support for security forces, the international community would be contributing about \$3.6 billion, for a total of \$4.1 billion over the long term out through 2017 and beyond.

That was coupled with a commitment on the part of Afghanistan that Afghanistan expected to be able to fund its own security forces by 2024. So we look at continuing large international contributions, but at a declining rate with a goal of Afghanistan being able to support its entire security establishment, including the military medical establishment, by 2024.

Mr. BROOKS. So if my math is correct, roughly a dozen years from now is when the hope is that Afghanistan will be able to carry their own load?

Mr. SEDNEY. That is the goal that the international community is working with Afghanistan to support. In a meeting a couple of days ago in Tokyo on economic development assistance, the countries of the world agreed to continue funding for Afghan development and economic assistance that supplements that commitment to security assistance that was made in Chicago by the NATO countries and the partners.

So, yes, there will be a continuing very large need on the part of Afghanistan, but our allies have stepped forward to contribute even more. The relative weight of the United States contribution, if I can just give you some numbers, sir. In the current fiscal year, we will be spending about \$11.2 billion to support the Afghan security forces.

Our budget request for next year is \$5.75 billion, a very large reduction. For the longer term, we are looking at that \$4.1 billion, a larger portion of which, a significant portion of which has been committed to by other countries.

So, yes, it is a large amount of money. But it is going to be decreasingly a burden on U.S. taxpayers, more and more shared by other countries. And eventually, yes, Afghanistan is—Afghanistan's goal is to be able to support itself, but it is a long time away.

Mr. BROOKS. Thank you, Mr. Chairman.

Mr. WITTMAN. Thank you, Mr. Brooks. We appreciate your questions.

And we will move now to Mr. Coffman.

Mr. COFFMAN. Thank you, Mr. Chairman.

Ambassador, let me start with you. So in your investigation of the problems at the hospital, you concluded that there were a lack of standards that were set in place, and that was part of the problem? Am I correct in that?

Ambassador MOOREFIELD. Yes, Congressman. I would agree with you that that was a very significant part of the problem because I think even part of the ethical issue that our medical mentoring personnel were having had to do with not knowing exactly what it was their role was supposed to accomplish in terms of mentoring their personnel. So it was very hard to see where the line was in terms of what they should be helping them do to accomplish.

I think the introduction of standards is absolutely critical. It was something we identified at least 3 or 4 years ago. I think, as I recall, there was a visit by the Surgeons General of our Army, Air Force, Navy, and they also pointed out several years ago that without standards, how could you have a focused mentoring mission and how could you hope to possibly achieve an appropriate end-state objective?

Mr. COFFMAN. And that was a function of training? Isn't that a part, the establishment of standards is a part of the training mission?

Ambassador MOOREFIELD. It is part of the NTM-A CSTC-A responsibility. Is that—

Mr. COFFMAN. That is correct. And that was General Caldwell's responsibility, was it not?

Ambassador MOOREFIELD. Well, it was during the time that he was there. And of course, it was a responsibility that preceded him and succeeded him.

Mr. COFFMAN. And I think, in my view, he displayed a fundamental lack of leadership in the performance of those duties, and there will be a further investigation of this. I think a hearing in 2 weeks in the Oversight and Government Reform Subcommittee that will go into much greater depth.

And I have talked to some of his staff, or my office has talked to some of his staff. I have talked to one member of his staff directly, and my office has talked to another. And I think that the problem really rose to the top, in my view. And it is stunning that he is still serving today in the United States Army after all that has occurred here.

Let me say that I think that, Mr. Sedney, your description of events is fairly sanitized. Is it not true that there were Afghan security forces dying in the hospital from suffering malnutrition, suffering from untreated wounds because, in fact, their families couldn't come up with the necessary bribes for the hospital personnel?

Isn't that, in fact, true?

Mr. SEDNEY. Representative Coffman, as I said in my statement, there was a wide range of abuses and problems in the National Military Hospital for a number of times. As we increased the number of our advisers there and as those abuses were brought to our attention, we began to take action to try and address them. And that action has been difficult because of the level of medical care, as Representative Cooper pointed out there.

But also because of individual—because of problems with the way individuals were acting. Getting the change in the leadership in the hospital was essential and getting in place the standards that the ambassador mentioned. So where we are today is a great deal farther forward than we were 2 and 3 years ago when the conditions that you described existed.

I would say that the biggest problem that looking back at it is that when we began this effort, it was underfunded, under-resourced. And it was only after we increased our number of advisers in the post 2009 period that we were able to take the effective action that we have. So the situation today is so much better than it was during the period you are describing.

Mr. COFFMAN. Well, I should say how slow the command was to respond and how slow you were to respond to this issue as it filtered up in terms of talking to some of the people that were mentors on the ground. And at the point in time where they knew that there was a problem to the point in time that action was taken, there was a tremendous gap that doesn't, in my view, reflect a competence in leadership.

With that, Mr. Chairman, I will yield back. Hope that there will be a second round.

Mr. WITTMAN. Yes, Mr. Coffman, there will be. And I thank you for your questions.

And we will move on now to Mr. Conaway.

Mr. CONAWAY. Thank you, Mr. Chairman.

Gentlemen, thanks for being here.

Ambassador Moorefield, you used the phrase "intervene" a while ago in reference to what might be occurring in the future with things that would be going on there, either post 2014 or whatever. Does that represent a change in mission for our advisers that are there?

Because, previously, when Mr. Cooper read the mission statement for our folks, it was to watch what they are doing, advise, but we don't do any clinical work. We don't change dressings. We don't do the things that I know that our folks who watched these bad things go on, which they are itching to do. Is that a different word for them today than what would have been in place during the time in question?

Ambassador MOOREFIELD. Thank you, Congressman Conaway.

Our concept, our understanding of their concept of the command's goal here is to transition not just with respect to mentoring of the Afghan National Security Force's hospital system, but for the Afghan security forces as a whole, to their taking the lead.

And when I say "intervene," I meant that if they needed mentoring because it was clearly something their mission, their function, they were not fully prepared to carry out and it became evident, then we would intervene and provide that.

Mr. CONAWAY. So if somebody in an operating room were starting to bleed out and we had a surgeon there watching and can save their life, he would have the authority to step in and help save that life?

Ambassador MOOREFIELD. I do not believe that their current mission includes directly intervening.

Mr. CONAWAY. Okay. So the word "intervene" has a different definition?

Ambassador MOOREFIELD. Yes.

Mr. CONAWAY. Leon got a letter. Panetta got a letter from Jay, from Chafetz and the committee that Michael was referencing to. Dr. Kem directed, I think, a Colonel Mark Fassl to send you an email October 28, 2010. And then, apparently, there was a bit of a dustup in Kabul with Caldwell and others, and they attempted to retract that.

As Inspector General, does that give you a red flag that gives you a chance to wade in? Or given the fact that the three-star withdrew the request blocked you from being able to try to get at these issues

a little quicker than might have otherwise happened under the actual timeframe that actually happened.

In other words, how much time was lost by you getting your team in there to see for yourself what was going on?

Ambassador MOOREFIELD. Let me recall exactly what happened from our vantage point and my vantage point. Yes, I did receive an email from the CSTC-A IG, Colonel Fassl, whom I knew well, and had several phone conversations with him about the command's interest in having DOD IG provide a mission, an oversight mission.

And this was, as you said, towards the end of October. What I told him at the time is we were absolutely committed to supporting that, and we would begin preparing to do so right away, which we did, because they were talking about a mission. He was talking about a mission that would have a very short fuse, given the normal lead time that CENTCOM [U.S. Central Command] and the command requires.

So we were already well along when I finally received a letter, I think it was the 10th of November, from General Caldwell saying please come out and perform this logistical system oversight mission. So, in fact, I had a team on the ground the day after Thanksgiving, which, I have to say, given that I had to mobilize subject matter experts in addition to our own personnel was probably some sort of record response to any request we have ever received.

Mr. CONAWAY. How long did it take you to get the work done? When did they finish up the field work, so to speak?

Ambassador MOOREFIELD. On that particular mission, the report was issued in May or June of the following year.

Mr. CONAWAY. Again, we are operating through a lens of—

Ambassador MOOREFIELD. Yes, I was just going to say—excuse me for interrupting. But of course, they got a full outbriefing from our team before we left. So they knew what the issues were by the time our people left Afghanistan.

Mr. CONAWAY. And based on what you know, since then did they actually take action ahead of your report in May, or did they let the conditions continue to—

Ambassador MOOREFIELD. They took action in a number of respects, but I should point out that there were two follow-up missions that we implemented. One was that February following that mission that came back just before Christmas in December of 2010.

By February, we were on the ground inspecting the National Military Hospital in a very specific way.

Mr. CONAWAY. How is that different from what you did in November and December?

Ambassador MOOREFIELD. Well, what we did in November and December was a countrywide review of the entire logistical system and whether or not it had accountability and controls over U.S.-supplied equipment and pharmaceuticals.

Mr. CONAWAY. So patient mistreatment wasn't your focus until February?

Ambassador MOOREFIELD. It was not what was requested. And even though we took note of conditions, it wasn't until we got a specific report, in fact, our IG received a specific report in, I think, November of 2010 when he was on the ground in Kabul from the command, indicating that there were patient care issues at the hos-

pital that we deployed the team very soon thereafter. I think almost a week from the time we found out about this mission, we had a team on the ground there inspecting the hospital.

And then, in addition, we sent an audit team out to take a look at the pharmaceutical accountability and control countrywide and then specifically also at the NMH. So there were a succession of oversight missions that ensued during that period.

Mr. CONAWAY. I am over my time. But you said a team that went to look for the patient mistreatment was November 2010 or November 2011?

Ambassador MOOREFIELD. If you are referring to the National Military Hospital, that was February 2011.

Mr. CONAWAY. All right. That is the first time you had anybody looking at the patient mistreatment?

Ambassador MOOREFIELD. In detail, yes.

Mr. CONAWAY. Okay.

Thank you, Mr. Chairman.

Mr. WITTMAN. Thank you, Mr. Conaway.

We have been joined by Ms. Speier, who is a member of the full committee. And at this point, we will go to her, and then we will return to the subcommittee members for a second round of questioning.

Ms. Speier.

Ms. SPEIER. Thank you, Mr. Chairman and Ranking Member Cooper, for holding this important hearing.

I am deeply troubled by the reports that we have heard, and I think this hearing underscores a very important question, which is, is the Department of Defense living up to its responsibilities to root out waste and fraud of taxpayer dollars?

I would like to express disappointment, however, that Colonel Geller is not before the committee to discuss his concerns about the significant level of corruption in the Afghan military medical organization. If his allegations are true, we can only conclude that the Army was complicit in wasting millions of dollars and the horrendous neglect and abuse of patients that had a reasonable expectation of quality care.

It is clear that a follow-up hearing on this issue is needed, and it is my hope that Colonel Geller will be the first to testify so that the facilitators of wrongdoing can respond to his concerns.

With the chair and ranking member's permission, I would like to submit into the record a news article that lays out Colonel Geller's concerns.

Mr. WITTMAN. Without objection.

[The information referred to can be found in the Appendix on page 51.]

Ms. SPEIER. Most troubling to me, however, is Major General Gary Patton's alleged role in covering up this corruption. According to press reports, he urged the suppression of an investigation into this wrongdoing by urging Lieutenant General Caldwell to defer an investigation until after the 2010 congressional elections.

It also appears that when he learned that an external review was not supported by his commander, he backed off of his recommendation for an external investigation of the wrongdoing.

I have also learned that once the Pentagon Inspector General investigation was underway, Major General Patton may have attempted to obstruct the investigation by intimidating witnesses. Now those are very serious charges.

As the newly appointed head of the Sexual Assault Prevention and Response Office, or SAPRO, Major General Patton will have primary responsibility for cases that are not politically popular, particularly by his senior commanders. I worry that instead of enforcing justice, he will only enforce what advances his career, making his interests almost diametrically opposed to getting justice for victims.

These allegations imply that he has used his leadership to create a chilling effect against reporting wrongdoing, instead of facilitating the command environment necessary to maintain zero tolerance for these abuses.

If any of these allegations are true, I have very serious concerns about Major General Patton's capacity to be an effective advocate for victims of rape in the military. I believe that it is this committee's duty to investigate the veracity of these claims and to take up the question of whether Major General Patton is the appropriate choice to head SAPRO.

I look forward to working with my colleagues on this issue, and I yield back.

Mr. WITTMAN. Thank you, Ms. Speier.

We are going to begin a second round of questioning. And with that, I am going to go to Mr. Coffman.

Mr. COFFMAN. Thank you, Mr. Chairman.

What is stunning in this whole situation is the fact that we have U.S. taxpayer dollars flowing into Afghanistan, obviously, in addition to the contributions of our allies. But predominantly, U.S. tax dollars are funding much of the Afghan security forces, certainly to include the Afghan medical component of that. And that we have all these dollars flowing in, but yet a real lack of oversight over them.

And as we draw down, obviously, we are going to have fewer, a lighter footprint there. And so, I am very concerned that, first of all, obviously, we haven't dealt with the situation that has occurred, I think. But we will in time, hopefully, whether both with General Yaftali on the Afghan side and General Caldwell on our side.

But also I think the fact that we are going to have a lighter footprint, one of the concerns expressed was that we didn't have enough personnel to monitor the situation. And now how are we going to monitor it in the future?

How are we going to make sure that we deal with this culture of corruption in terms of how U.S. tax dollars are handled prospectively? And I am real concerned about that.

Mr. Sedney, why don't you try and address that?

Mr. SEDNEY. Thank you, Congressman.

You have raised some very important questions. I do want to just comment for the record that because there is an ongoing investigation regarding the individuals that were mentioned earlier that we are not allowed to comment on that. We, of course, have heard allegations, but once this ongoing investigation is completed, then we

will be able to respond to some of the allegations and various stories that appear to have been in the press.

The questions about the ability to account for U.S. taxpayers' dollars, to account for whether we have achieved the goals that we have set, as you mentioned, Representative Coffman, is very important.

Certainly up until 2008, our advising effort in Afghanistan was underresourced and underfunded. This was recognized by this administration, and the surge into Afghanistan included a surge in advisers, mentors, and trainers, both from the United States and from our allies, that enabled us in a host of areas, including in the national military area, to put in place high-quality mentors who had the ability to take a look behind the scenes what was happening.

That is why we were able to discover the problems that you have laid out and why we were able to work with the Afghans to put in place systems that they just didn't have before for monitoring. In Ambassador Moorefield's testimony, he lays out some of the improvements that have begun to be made.

Those improvements are ongoing. One of the major tasks that we have right now out in the field is to help the Afghans build those systems, work those systems, including the investigatory efforts that are going on that I mentioned earlier, and then to monitor to see if they are working.

And then, this is where the intervention comes in, sir, we have to try and intervene on a policy way to try and get the policies and procedures that the Afghans are using up to the level so that we can get the level of certainty that we need.

Mr. COFFMAN. Are we serious about this now? Because, obviously, we weren't serious about this in the past. But all of a sudden, now we are serious about the—

Mr. SEDNEY. I would say that certainly since we have put more resources into this, we are very serious. It has not just the attention of the highest levels. It has the attention of the Department, but also of our leaders in the field.

Mr. COFFMAN. Why weren't we serious in the past?

Mr. SEDNEY. I don't say it wasn't serious. I say it was underfunded and underresourced before 2008.

Mr. COFFMAN. You don't think there was a lack of leadership there?

Mr. SEDNEY. I think before 2008, we just didn't have—before 2008, we just didn't have the resources to follow through with doing it.

Mr. COFFMAN. You don't think it was lack of leadership? That the fact that the leadership couldn't even tell that there was a, couldn't even say, "Hey, I don't have enough resources here. Because we don't have the resources here, we have got some problems with corruption."

Or do you think the leadership just wasn't even paying attention because how could you miss something so big?

Mr. SEDNEY. I think that the leadership on the ground before 2008, going back to 2004, 2005, 2006, and 2007, recognized that there were problems that they weren't able to address because they didn't have the resources and made the request for additional re-

sources in terms of mentors and oversight ability. But we were not—we, the United States, were not in a position to provide the level of resources——

Mr. COFFMAN. So what we did instead of that was we just allowed corruption to occur. We didn't care about accounting for U.S. taxpayer dollars. I guess that was okay then because we didn't have enough people there, and we just didn't know what was going on. Is that what you are trying to say?

Mr. SEDNEY. No. I am saying that the people who were there, who tried very hard to do sometimes the jobs of two, three, four, and five people, were overwhelmed by the level—by the amount of the challenges and the amount of effort that they have in that period of 2004, 2005, 2006, 2007, and 2008.

The situation, as Representative Cooper described it, it was very accurate in terms of the challenges that were faced. And so, we had a lot of good people doing their very best, but they were overwhelmed by the magnitude of the problems.

Mr. COFFMAN. I think we disagree with this, and I think the truth will come out.

Mr. Chairman, I yield back.

Mr. WITTMAN. Thank you, Mr. Coffman.

And we are going to go now to Mr. Cooper.

Mr. COOPER. Thank you, Mr. Chairman.

I am a little worried that with all this talk of standards for the Afghan healthcare system and monitoring and resources and all that good stuff, that sounds like we are talking about it in a nice, air-conditioned hearing room in Washington. And I am no expert on Afghanistan, but the reality on the ground, when they have intermittent hot water, intermittent electricity, all kinds of personnel and quality problems that we can't even imagine, that without enforcement, without some ability for U.S. personnel to step in and, as my colleague Mr. Conaway was saying, stop somebody from bleeding to death because the bribe wasn't big enough to save the life.

Or to give a starving man a candy bar that might tide him over until the next day until the family can come up with the bribe money or whatever other nightmarish scenario is out there that without enforcement, we are still putting good U.S. personnel in an impossible situation.

Like why do that? Because even being associated with this mess can ruin a career. And standards sound fine, and they sound good for us, but that just assumes that there is going to be some sort of accountability or enforcement or people want to do right.

We are worried here about green on blue violence. Well, this is green on green violence, and it seems to be, sadly, a part of the culture. Well, maybe that is why they are the second-poorest country in the world.

So I worry about good, clean U.S. personnel like it is the worst assignment in the world. So whoever is associated with it must have drawn the short straw to get this. I always thought that the Aleutian Islands was the worst posting you could get. This has got to be the worst of the worst.

So I am not making excuses for any of this bad behavior, but to apply Western standards to this is like completely unrealistic. If



our guys are just tasked with the job of standing there and looking at evil, looking at Afghan people destroying the lives of their own Afghan military, and presumably with Western aid or even minimal local resources they could have done something about that, at least let their own family members nurse the poor invalid.

So standards, monitoring ain't going to do it. It is going to take some sort of ability to intervene or enforce or do something. Otherwise, we are putting our folks in a bad place.

Would anyone like to comment on that?

General ROBB. Yes, sir. The feedback we are getting from the surgeon over there for the National Training Mission-Afghanistan, as was also evidenced by the IG report, is subsequent to three major events that occurred in the fall of 2010. One was increased mentors on the ground. And the early fall, mid fall was, of course, when they transferred the medical logistics from the National Military Hospital system to the ANSF Logistical Command.

And then, but more importantly, late fall/early winter was the subsequent relief of about 25 senior medical leaders. And I think that was the key to include, as you know, their surgeon general and also dual-hatted as the hospital commander.

So fast forward 1 year plus about 6 months later, you get a report, again as recent as June 2012, that addresses many of those issues, sir, that rightly we have concerns and you have concerns. So the key that has happened, and again in direct discussions with the leadership on the ground, the mentors, is that the approach that they have taken is you have heard that they have standards now.

In other words, we are not using Mayo Clinic standards. We are using the standards that are appropriate for the level of care that would be delivered in Afghanistan. We are using what we call the Tier 1 or the cure standards. So now they have a definitive end-state of which they know that they must accomplish.

And so, what the new leadership, again expressly through the leadership of the new hospital commander there, he personally takes interest in any cases of abuse, of which there have been none reported, you know, in the recent 6 months. And the way they did that was because of a leadership change.

So what our mentors did was when they saw during last year, as they were cultivating a culture of accountability in the new leadership, they got those to chief nurse, the chief of surgery, and the hospital commander also demanded to be involved in those cases of suspected either undertreatment or maltreatment. And so, they were involved.

And so, that is why you see now, with accountability through their leadership, there is no shortage of people that want to do good things in Afghanistan, and I have experienced that. You know, they are underresourced, okay, and they may be undereducated, but there is no shortage of, again, good people with the desire to do the right thing over there.

And I have been impressed with the Afghan, again, medical professionals. That doesn't mean there weren't bad actors over there, but I have met many of them that are good.

So I am encouraged, sir, again. And it is going to take time. And that leadership, that culture change began, again, with what I

would call weeding out of the 25 poor leaders and have been replaced with leaders that our mentors now and our medical leadership over the training mission believe they have the right stuff to help turn the tide there not only in the National Military Hospital, but also within the whole Afghan healthcare system.

As was mentioned before by my colleagues here, there are a lot of success stories out there. I mean, when you look at Kandahar, you look at Herat, Mazar-e-Sharif, Gardez, these are the regional hospitals that we share with the Ministry of Public Health. And they are, again, by Afghan capability, standards, training, and by the resourcing, they are doing an incredible job.

And quite frankly, I am proud of them. I am proud of them, again considering where they have started. Four decades of really neglect because they weren't allowed to, again, train to what was appropriate for Afghan standards because of four decades of war and, again, back and forth with the different folks that have occupied their country.

So I am encouraged by the direction that has taken place in this last year.

Thank you very much.

Mr. WITTMAN. Thank you, Mr. Cooper.

We are going to go to Mr. Conaway.

Mr. CONAWAY. Just real quickly, this may sound pretty frivolous, but in terms of where they are right now, do they—Mr. Sedney or General Robb, do our advisers run customer satisfaction surveys of folks coming out of the hospital to see if there are lingering or ongoing issues that aren't obvious, or do you actually use that tool? Or does it make sense to use that tool in that society?

General ROBB. Sir, I will have to get back to you on that. I am not sure. I know that we have validation teams that are going through now to match against the standards. And then Ambassador Moorefield may have more detail on that.

Ambassador MOOREFIELD. Yes, thank you.

They do. They do run customer surveys. And our team, while they were there, by the way, inspecting the hospital, spoke with many patients. They have a bill of rights. It was not well understood and shared with the patients previously.

It is now explained to them when they enter the hospital. And when we discussed what their rights were with the patients, they knew what their fundamental rights were, to get three square meals a day, to have a doctor see them every day and a nurse every 8 hours. So I would say that there is certainly an enhanced consciousness about the obligations of the hospital to the patients and the patients' understanding of those obligations.

Mr. CONAWAY. The customer satisfaction surveys that we run, are they controlled in a way that the folks who are being evaluated don't have the ability to skew the results?

Ambassador MOOREFIELD. As part of the standard that is applied now, they have to conduct regular customer satisfaction surveys and put it in writing.

Mr. CONAWAY. The Afghans do?

Ambassador MOOREFIELD. So we are not aware that they are anything but objective.

Mr. CONAWAY. Best you can tell.

Ambassador MOOREFIELD. But we will—we are going to continue to provide oversight. So that is one of the things we will be looking for.

Mr. CONAWAY. In the agreement that was made for the \$4.1 billion, Mr. Sedney, does it have enough teeth in it to allow the proper oversight of these functions as the dollars flow, continue to flow to the system during those timeframes?

Mr. SEDNEY. Yes. We have some very good accounting systems that we are putting in place. And the continuation of the funding obviously will be based on the Afghan military and police's performance. But they are going to be tested this year, as I have mentioned before.

Mr. CONAWAY. Thank you, Mr. Chairman.

Mr. WITTMAN. Thank you, Mr. Conaway.

We will now go to Ms. Speier.

Ms. SPEIER. Thank you, Mr. Chairman.

I just have one question for Major General Robb. You indicated that there is a change of leadership there, and over the last 6 months, things look like they are much better.

Who would someone report a problem to in the existing system if there was denial of care or denial of service? Who would they report that to, and how would they be informed of that as a patient?

[Pause.]

General ROBB. Yes, ma'am. As I stated before, the leadership—and again, as have been pointed out to us, specifically, the chief of surgery, the chief nurse, and also the hospital commander have taken this personally under their role to, again, address each one of these cases where folks feel that they were either underserved or not treated properly. The first directors of the hospital have also been instructed that if they discover something to pass that up again to the senior leadership for them to personally address that.

Ms. SPEIER. But if I am a patient there—

General ROBB. Yes.

Ms. SPEIER [continuing]. And I am seeking care and I am told, "Well, unless you give me \$10,000, I am not going to give you care," how would I know who to report that to? When they walk in, are they given some patient bill of rights to say at no point should you be subject to any kind of bribe? Healthcare here is provided without additional remuneration or—

General ROBB. Yes, ma'am. That is part of the bill of rights. That is what they are instructed on when they are actually admitted to the hospital.

Ms. SPEIER. Would you make a copy of that bill of rights available to the committee?

General ROBB. Yes, ma'am. Yes, ma'am.

Ms. SPEIER. Thank you. I yield back.

[The information referred to can be found in the Appendix on page 58.]

Mr. WITTMAN. Thank you, Ms. Speier.

We will now go to Mr. Coffman.

Mr. COFFMAN. Thank you, Mr. Chairman.

Let us talk about, going forward now, that here is my concern that not only going to be reducing our footprint, but as we get to 2014, to the end of 2014 when we are expected to give operational

control or switch operational control to Afghan security forces. And at that point in time, our expectation is that they will have the internal capability, logistically, administratively, to take U.S. military aid in whatever form, U.S. military medical aid and other forms, and to be able to disseminate it to their subordinate commands.

That actually increases the potential for corruption. So how are we going to be able to monitor that going forward?

Mr. SEDNEY. The procedures for monitoring—for the Afghans to be able to monitor, first of all, that they have to build up their own ability to have an inspector general capability, which NTM-A is working on to build, so that they can investigate problems and issues and come up with ways both to fix problems and also to recommend problems to the law enforcement bodies is a capability we are developing.

That capability is one that we are only more recently starting to work on because the original part of building the Afghan security forces was focused on the fighting forces. Building the supporting structure, such as you are describing, is what we are doing now.

We are going to have to examine that progress as we go along, and that will go into the determination of what kind and level of presence we need after 2014 either from the United States or from our coalition allies as we continue that train, advise, and assist mission after 2014.

But really, it is going to depend upon the performance of the Afghans themselves and the determination of the commander in the field as to what is necessary. It is a great question, and we don't really have the full answer yet, but we will be developing it over the next 12 to 24 months.

Mr. COFFMAN. Ambassador Moorefield, do you have anything?

Ambassador MOOREFIELD. Yes, sir. I think that one of the commitments that we have made in this post 2014 through 2024 era in terms of the continuing development of the Afghan National Security Forces is their logistical system. And essentially, aside from getting bullets and food and medical care to the troops in the field or the police forces wherever they may be deployed, there has been a very serious ongoing effort, and this will continue post 2014 to build up their logistical capability, to provide accountability and control for their resources because we will be providing fewer resources. They will be paying for more of the resources. So this isn't just about taking care of congressional and U.S. taxpayer and other coalition-supported resources.

So building those accountability and control mechanisms is a top priority. I would mention one of the reasons why I think I personally believe this is going to be an ongoing responsibility and challenge is building a logistical system is a lot more complex than turning out fighting forces or policemen on the beat.

And it is the case that we prioritize creating their—generating their security forces and only in the last few years have put our shoulder to the wheel on building up their logistical system. But it is complex challenges, and it is going to be an ongoing assistance effort.

Mr. COFFMAN. Well, thank you, Ambassador, Mr. Sedney, General. I hope we don't learn that the hard way, as we have obviously seemed to be learning things in Afghanistan up to this point.

Mr. Chairman, I yield back.

Mr. WITTMAN. Thank you, Mr. Coffman.

We will now go to Mr. Cooper.

Mr. COOPER. Thank you, Mr. Chairman.

I don't want to prolong this unduly, but it is my understanding that the life expectancy in Afghanistan is among the shortest in the world. And an adult male lives to maybe his late 40s, something like that?

So just allowing them to revert to the previous standard is half the life that a U.S. citizen would expect to live. I don't know what it would be if you were denied the state-of-the-art U.S. battlefield medicine. That would have to increase your chance of death from a bullet wound, from 1 percent to 50 percent, 70 percent, something like that.

So, again, in my opinion, it is very difficult for us to even understand a Fourth World medical system, and I hope we don't continue to put good U.S. folks in jeopardy by putting them in an impossible management situation.

Thank you, Mr. Chairman.

Mr. WITTMAN. Thank you, Mr. Cooper. We appreciate that.

Are there any other questions of the committee members?

Panelists, we thank you so much for joining us today. We appreciate you giving us your perspective on the challenges that we face there in Afghanistan. This is one of many, obviously, the medical system there itself and the efforts of providing care to the Afghans, as well as the issues of corruption there, things that are very much at the forefront of folks' minds here on the committee. So we appreciate you shedding some light on that.

We did have a few requests for some information. We would appreciate it if you would be timely in getting that back to the committee for our consideration.

And I want to remind committee members, too, if you have any additional questions, please let us submit those in writing to the panel members.

And if there is no further questions, we appreciate the panelists' time, and this hearing is adjourned.

[Whereupon, at 4:23 p.m., the subcommittee was adjourned.]



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# **A P P E N D I X**

JULY 10, 2012

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**PREPARED STATEMENTS SUBMITTED FOR THE RECORD**

JULY 10, 2012

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**Hearing: “Accountability and Reform Efforts at the Afghan  
National Military Hospital”**

**July 10, 2012**

**Chairman Wittman -- Opening Statement**

Welcome to today’s hearing on accountability and reform efforts at the Afghan National Military Hospital.

I’d like to welcome our witnesses:

- Mr. David Sedney, Deputy Assistant Secretary of Defense for Afghanistan, Pakistan and Central Asia; and
- Ambassador Kenneth Moorefield, Deputy Inspector General for Special Plans and Operations.

Thank you for your participation today and we look forward to hearing your testimony. Ambassador Moorefield, in particular, I would like to thank you for the work you’ve done on monitoring these issues. I hope you’ll let your team know how much this committee appreciates their noteworthy dedication to a challenging mission.

I have traveled to Afghanistan many times in the last few years and I have seen, particularly during my last trip this June, the great progress that has taken place since the surge began.

The key to sustaining this progress is building a capable Afghan National Security Force. And, of course, the support systems to maintain it, including a medical care system responsible for the health

and well-being of those who have served and sacrificed. Taking care of these troops is absolutely critical to this mission and must be a continued area of focus as we move forward.

I was both disheartened and disgusted when I saw the pictures showing patient abuse and neglect at the Military Hospital – an institution where coalition forces serve as advisers and mentors. We can and must do better to ensure that these troops receive adequate medical care. Anything less is detrimental to our mission and compromises our efforts to secure Afghanistan's future.

As I understand it, no one to date has been held criminally responsible for what happened. Moreover, there has been no accounting of the millions of dollars of funds and medical supplies that disappeared since these issues came to light. I hope you'll provide us with explanations and detail the systemic reforms aimed at preventing this from happening again.

As an administrative note, I recognize that members of other subcommittees will join us. Pursuant to committee rules, I ask unanimous consent to allow their participation and, absent objection, will recognize them after all O&I subcommittee members have had an opportunity to question the witnesses.

**NOT FOR DISTRIBUTION UNTIL RELEASED BY THE  
HOUSE ARMED SERVICES COMMITTEE**

**STATEMENT OF**  
**DAVID SEDNEY**  
**DEPUTY ASSISTANT SECRETARY OF DEFENSE**  
**AFGHANISTAN, PAKISTAN AND CENTRAL ASIA**  
**BEFORE THE**  
**UNITED STATES HOUSE OF REPRESENTATIVES**  
**COMMITTEE ON ARMED SERVICES**  
**SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS**  
**JULY 10, 2012**

Mr. Chairman, members of the Sub-Committee, thank you for the opportunity to update you on the ongoing efforts towards accountability and reform at Dawood National Military Hospital in Kabul, Afghanistan.

The United States, together with our Coalition Allies and Afghan partners, remains on track to accomplish our core objectives in Afghanistan: to disrupt, dismantle, and defeat al-Qaeda and its extremist affiliates and deny them safe haven from which they can launch attacks against the United States and to deny the Taliban the ability to overthrow the Afghan government. Thanks to the more than ten years of dedication and sacrifice of our forces, our Coalition partners, and the Afghan people themselves, we have taken enormous strides towards achieving those objectives, particularly over the last three years.

The key objective underpinning this strategy is the development of the Afghan National Security Forces (ANSF) into a sustainable and capable force. Their growth in confidence and demonstrated capability to provide suitable security against internal and external threats are essential for the responsible transition of nationwide security lead to the Afghans by the end of 2014. To this end, with Coalition support, the ANSF have made considerable progress in terms of both the size and capability of their force. Both the Afghan National Army and the Afghan National Police are on schedule to meet their surge-end strength goals by or before October. Their continued performance and proven ability has allowed them to move increasingly into the lead for operations. Currently, the ANSF participate in 90 percent of all Coalition operations, and more than 50 percent of partnered operations are ANSF-led.

In addition to the successes of the ANSF, we have seen two major achievements that send a strong signal to the Afghan people, the Taliban and the region. First, the Strategic Partnership Agreement (SPA) signed in May by President Obama and President Karzai shows the United States and Afghanistan are committed to a mutually beneficial relationship beyond 2014. Second, the Chicago Summit was a great success and demonstrated the continued dedication of over 50 NATO and other partner nations to supporting security and stability in Afghanistan. ISAF's members reaffirmed their commitment to the Lisbon timeline to complete transition by the end of 2014 and continue engagement in Afghanistan post-2014.

Despite these recent achievements, there are still areas needing improvement before the ANSF can be considered an independent force. One of those areas is the development of a medical system capable of sustaining the health and well-being of the ANSF. The allegations raised in 2010 of mismanagement at Dawood National Military Hospital highlighted the gross deficiencies in that system and the critical need for serious reforms.

Coalition medical mentors and advisors reported inexcusable mismanagement and, at times, neglect in the operation and provision of basic medical care, resulting in substandard patient care, disturbing sanitation conditions, poor facilities management, and a dysfunctional medical logistics system. These concerns were elevated to senior leaders in the NATO Training Mission-Afghanistan (NTM-A) and eventually directly to the Commander of NTM-A, Lieutenant General William Caldwell. Recognizing the enormity of the situation, Lieutenant General Caldwell took action. He requested the involvement of the Department of Defense Inspector General Office of Special Plans and Operations to assess the nation-wide medical logistics system in Afghanistan. With regard to the substandard patient care concerns, a member of Lieutenant General Caldwell's staff alerted the IG and his staff of the patient care concerns and the IG appropriately expanded the scope of its oversight activities to include reports on this important matter.

Thanks to the response and concerted effort devoted to reforming the healthcare and medical logistics systems at Dawood Hospital, we are now helping turn around what was once a broken system, introducing accountability, standards, and stewardship at all levels. In addition to the desire to eliminate unacceptable abuses, the senior leadership of ISAF, NTM-A and its medical advisory group recognized the critical importance of enabling a system that could effectively and transparently provide healthcare to the ANSF and achieve an end-state that will allow for transition to take place by 2014. Towards that end, it is my understanding that vast improvements have been made in the accountability of the hospital leadership and staff, the general sanitation of facilities, the standard of patient care, and the supporting logistics systems. The panel looks forward to addressing these improvements in the Q&A.

NTM-A and Coalition forces remain committed to continuing this progress and supporting their Afghan counterparts as they display increasing capability and a growing dedication to responsibility and self-improvement. These conditions, which create a sustained uplift in patient care, are key to the sustained improvement necessary for Afghanistan to have enduring capability past transition.

I would like to thank the House Armed Service Committee and this Sub-Committee for the opportunity to appear before you today. I look forward to your questions.





**David S. Sedney**

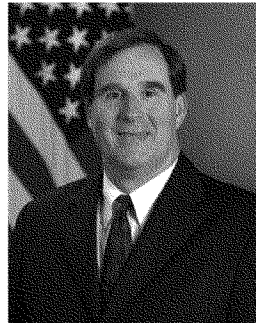
**Deputy Assistant Secretary of Defense for Afghanistan, Pakistan and Central Asia**



David Samuel Sedney is Deputy Assistant Secretary of Defense for Afghanistan, Pakistan and Central Asia in the Office of the Assistant Secretary of Defense for Asian and Pacific Security Affairs.

Mr. Sedney was Deputy Assistant Secretary of Defense for East Asia from 2007-2009. He served as Deputy Chief of Mission at the U.S. Embassy in Beijing from 2004-2007. Previously Mr. Sedney was Deputy Chief of Mission at the United States Embassy in Kabul, Afghanistan from 2003-2004, where he was Charge d'Affaires from August through November 2003.

Mr. Sedney was also Deputy Chief of Mission in Kabul in 2002, after the re-opening of the Embassy. Mr. Sedney was Director for Afghanistan at the National Security Council (2003), Senior Advisor in the State Department's Office of e-Diplomacy (2002), Senior Advisor to John Negroponte, United States Ambassador to the United Nations (2001-2002), Deputy Director of the State Department's Office of Chinese and Mongolian Affairs (1999-2001), and Special Assistant to Stephen Sestanovich, Ambassador-at-Large and Special Representative for the Newly Independent States (1997-1998).



Earlier, Mr. Sedney served as Deputy Chief of Mission at the United States Embassy in Baku, Azerbaijan (1995-1997), Political-Military Officer at the United States Embassy in Beijing, China (1991-1994) and Political Officer, Refugee Officer and Consular Officer at the United States Embassy in Bucharest, Romania (1985-1987). He was a Watch Officer at the State Department's Operations Center (1987-1988) and Duty Officer and Senior Duty Officer at the White House Situation Room (1988-1989).

Before joining the State Department, Mr. Sedney spent five years as a house-husband in Bern, Switzerland; Baton Rouge, Louisiana; and Williamstown, Massachusetts, raising three daughters. Mr. Sedney also taught courses at North Adams State College and Williams College. Earlier he worked for the United States Department of Labor's Wage and Hour Division after stints as a factory worker, truck driver and taxicab driver.

Mr. Sedney is a graduate of Princeton University and Suffolk University School of Law. He attended Louisiana State University's School of Law where he studied Law of the Sea and International Law. Mr. Sedney is a distinguished graduate of the National War College. He speaks Romanian, Mandarin Chinese and Azerbaijani. Mr. Sedney has received the Secretary of Defense Medal for Meritorious Civilian Service, the Department of State's Superior Honor Award six times, and Department of State's Meritorious Honor Award twice.



July 10, 2012

Expected Release  
3:00

Statement of  
Ambassador (Ret.) Kenneth P. Moorefield  
Deputy Inspector General for Special Plans and Operations  
Department of Defense Office of Inspector General

before the  
Subcommittee on Oversight and Investigations, House Armed  
Services Committee

on  
Accountability and Reform Efforts at the Afghan National  
Military Hospital

Chairman Wittman, Ranking Member Cooper, and distinguished members of the Subcommittee on Oversight and Investigations. Thank you for this opportunity to appear before you today to discuss past and ongoing Department of Defense (DoD) Office of Inspector General (DoD IG) oversight regarding U.S. military and Coalition efforts to develop the management, medical care services, and logistical capability and accountability of the Dawood National Military Hospital (NMH) in Kabul, Afghanistan.

#### **Health Care in Afghanistan**

Following three decades of war, the poorly developed health care system in Afghanistan had been further degraded and did not meet any internationally recognized health care standard. After the fall of the Taliban in 2001, U.S. and international coalition forces developed a plan for creating an Afghan National Security Force (ANSF), comprised of both military and police, intended to provide a supportive health care system capability.

For the ANSF to become fully independent and sustainably effective in conducting combat operations, it was recognized that this ANSF health care delivery system would need to be capable of providing essential field-level combat casualty care, evacuation of wounded and ill casualties, restorative surgery and rehabilitation, and long-term care for disabled personnel.

The military health care system in existence at the start of the U.S. / Coalition initiative consisted of remnants of the Russian-based system with multiple badly-supported clinics, four small hospitals spread across the country, and the 400-bed National Military Hospital (NMH), which is the largest hospital in Afghanistan, located in Kabul, and the only one providing specialty medical care.

Built in the early 1970s by the Soviet Union, the NMH resides on a medical campus that encompasses the hospital itself, an out-patient clinic, the Armed Forces Academy of Medical Sciences, a garrison support facility, and a logistics complex that includes a recently constructed medical warehouse. The NMH is under the command of the Afghan National Army (ANA) Surgeon General and is managed by an ANA Hospital Commander, and staffed by ANA medical personnel. Currently, approximately 260 patients, the majority of whom are soldiers and police personnel and their families, reside in the NMH.

### **Medical Training Advisory Group**

The International Security Assistance Force (ISAF) Medical Training Advisory Group (MTAG) was established to provide medical mentors who are assigned in every regional command and associated ANSF hospital in Afghanistan. These U.S. military mentors - doctors, nurses, administrators, logisticians, and technical personnel – advise and train Afghan healthcare personnel during the provision of care to the Afghan sick or wounded on the battlefield, in the operating room, the intensive care unit, and on the hospital wards, and at the supply depots. They also assist in the management of the health care system and its logistical support, the supplies for which are financed by U.S. Afghan Security Force Fund and also provided by international donor contributions. MTAG mentors operate in close partnership with their Afghan counterparts during the performance of their duties. There are fifteen MTAG mentors currently assigned to the NMH.

### **Completed DoD IG Oversight Projects**

The DoD IG has been engaged in providing ongoing oversight with respect to U.S. Military and Coalition efforts to develop the Afghan military health care system, including the NMH, since 2008, and has conducted multiple oversight missions focused on this issue.

#### **1st Oversight Project**

In April 2008, the DoD IG conducted its first assessment<sup>1</sup> of DoD efforts to develop the ANSF, which included the military health care system.

As a result of this assessment, we determined that the complexity of medical stabilization and reconstruction challenges in Afghanistan called for a robust U.S. interagency and international effort to assist deployed U.S. military medical personnel in developing and implementing a detailed, multi-year planning strategy. At that time, the U.S. Central Command, ISAF, and its Combined Security Transition Command – Afghanistan (CSTC-A), lacked the personnel and other

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<sup>1</sup>“Assessment of Arms, Ammunition, and Explosives Control and Accountability; Security Assistance; and Sustainment for the Afghan National Security Forces,” released October 24, 2008 (Report No. SPO-2009-001).

resource capability and expertise to expedite development of the ANSF health care system.

The report specifically noted that many U.S. military medical mentoring teams were not fully staffed, particularly those assigned to work with the Afghan police, and the development of ANSF medical personnel was seriously hampered, moreover, by inadequate U.S. military mentor headquarters guidance, and pre-deployment and in-country training. Further, we determined that the ANA Logistics Command was unable to support crucial ANA medical logistics requirements at NMH, as well as at the ANA Regional Hospitals.

The report concluded that the lack of progress in developing an effective Afghan military health care and logistical system would require prolonged combat casualty care assistance of ANSF personnel by the U.S. and other ISAF partner countries, and would delay development of an independent ANSF medical capability.

### **2nd Oversight Project**

In March 2009, we conducted a follow-up assessment<sup>2</sup> regarding ANSF medical system development.

During this assessment, we determined that CSTC-A lacked a clearly defined plan with an end state goal for the development of the ANSF health care system and that planning which had previously been conducted had not been fully coordinated with the Afghan Ministries of Defense and Interior, and incorporated into their planning and operations. As a result, U.S. military and ANSF resources were not being jointly focused, prioritized and executed in support of the development of a clearly defined and sustainable ANSF health care system, delaying progress in its accomplishment.

### **3rd Oversight Project**

During the past two years, DoD IG has conducted two criminal investigations related to the ANSF military health care system. The first was

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<sup>2</sup>“Assessment of U.S. and Coalition Efforts to Develop the Medical Sustainment Capability of the Afghan National Security Forces,” released March 31, 2010 (Report No. SPO-2010-001).

initiated based on allegations that a DoD contractor was not fulfilling its contractual obligations to safeguard U.S. purchased pharmaceutical supplies provided to the Government of Afghanistan. The investigation determined that the contract did not require the contractor to maintain inventory control and accountability of pharmaceutical products after they were turned over to the Government of the Independent Republic of Afghanistan (GIROA) and the ANA. After pharmaceutical or other items are transferred to GIROA control, DoD IG does not have investigative jurisdiction.

The second DoD IG investigation was initiated based on an allegation that U.S. supplied pharmaceuticals had been stolen from the ANSF military health care system. Interviews of the complainant, contractor personnel, as well as current and former U.S. Military personnel stationed in Afghanistan, determined that any theft of U.S. furnished pharmaceuticals would have occurred subsequent to the Government of Afghanistan accepting delivery of the pharmaceuticals. All relevant information was turned over to the anti-corruption Task Force Shafafiyat<sup>3</sup> within ISAF to be provided to the Afghan Minister of Defense and/or Justice and acted on, as appropriate.

#### **4th Oversight Project**

In November 2010, at the request of the Commander, NATO Training Mission – Afghanistan (NTM-A)/CSTC-A, a DoD IG team conducted an assessment<sup>4</sup> of the ANA medical logistics system, which included the NMH, and made recommendations for strengthening the system and improving its accountability and control of medical supplies purchased by DoD and distributed to the ANA medical system, including to the NMH.

Our assessment determined that NTM-A/CSTC-A and the ANA's Office of the Surgeon General did not have a coordinated plan to achieve a defined transition

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<sup>3</sup>Task Force Shafafiyat's mission is to plan and implement ISAF anti-corruption efforts, and integrate intelligence with planning, operations, engagement, and strategic communications. It integrates U.S. anticorruption activities with key partners in the international community and the Government of Afghanistan.

<sup>4</sup>“Assessment of the U.S. Department of Defense Efforts to Develop an Effective Medical Logistics System within the Afghan National Security Forces,” released June 14, 2011 (Report No. SPO-2011-007).

end state goal, and that accountability and controls over the receipt, storage, accountability and distribution of pharmaceuticals and other medical supplies were insufficient to prevent theft, misappropriation, unauthorized use, or improper distribution.

Furthermore, due to the lack of developed, implemented, and enforced Afghan health care standards and a related U.S./Coalition mentoring model, it was not possible to provide a properly resourced and focused medical mentoring capability. Consequently, development of a sustainable health care system was being impeded. The mentoring effort was also significantly hindered in its progress by having assigned only half of the authorized U.S. personnel believed necessary by the command to effectively carry out the mission to support the timely development of the ANSF medical system.

#### **5th Oversight Project**

In February 2011, in response to concerns identified in an inspection report issued by a joint team of the Inspectors General of the Afghan Ministry of Defense and CSTC-A, a DoD IG team conducted a "quick-look" assessment of the current status of healthcare, personnel, sanitation, supply and inventory issues at the NMH.

The team found that certain management, medical care and logistical challenges were prevalent. The NMH was understaffed and lacked sufficient numbers of ANA physicians, nurses, administrators and other staff. Additionally, there were staffing quality and attendance problems. In addition, though the Afghan Ministry of Defense had signed an order directing the transfer of MoD Medical Logistics, then under the ANA's Office of Surgeon General /Medical Command, to the separate ANA Logistics Command in order to gain better MoD management control, this had not yet occurred.

There also was evidence that medical logistics system delivery of medical supplies to the hospital's pharmacy, and from the pharmacy to the patients, was dysfunctional. Further, we found a number of orthopedic operating tables, valued at over \$400,000 each, the use of which appeared to be beyond the functional capability of the ANSF medical staff and which were still in their original packing crates.

Moreover, ANSF health care standards had not been defined. Therefore, it had not been feasible for the U.S. / Coalition to build an effectively focused medical mentoring model, one that was closely linked standards to the necessary supporting health care policy and planning objectives, or for the ANA medical

leadership to understand and integrate these quality standards into their health care system. Established medical standards and implementing policy were also necessary for the U.S. military and ANA to determine the resources required in order to accomplish development of the intended end-state transition capability of the ANA health care system.

#### **6th Oversight Project**

In response to the results of the February 2011 quick-look assessment, DoD IG conducted an audit<sup>5</sup> to determine whether the pharmaceutical distribution process within the ANA military health care system was sufficiently effective and secure.

The team found that although the ANA pharmaceutical distribution process had improved since the NMH inspection in February 2011, the delivery and inventory control processes for pharmaceuticals at medical facilities and depots required further work. Although Afghan Logistics Command officials did effectively receive, account for, and prepare pharmaceuticals for issuance to the forward supply depots and NMH, four of the six medical facilities reviewed either had no pharmaceutical accountability controls or failed to maintain the controls they had. Specific to NMH, the audit team could not verify the accuracy of the inventory on hand because the dispensing documentation was not reconciled to the stock accounting record. Further, none of the six medical facilities reviewed properly used or completed required Afghan Ministry of Defense supply forms.

In addition, Afghan Medical Command officials, in coordination with CSTC-A, had not developed procedures instructing medical facility personnel how to implement logistics guidance, and to collect and accurately report on pharmaceutical usage data. As a result, the ANA could not rely upon this data to develop sound pharmaceutical supply requirements, and there was an unacceptable risk of mismanagement, theft, and waste of U.S. funded pharmaceuticals.

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<sup>5</sup>“Additional Guidance and Training Needed to Improve Afghan National Army Pharmaceutical Distribution,” released May 7, 2012 (Report No. DODIG-2012-083).



### **7th Oversight Initiative**

In November 2011, the former DoD Inspector General, Mr. Gordon Heddell, visited Afghanistan and Kabul, at which time he conducted a walk-through of the NMH. He subsequently noted to the Commander, NTM-A/CSTC-A that although progress had been made at the NMH, there were still issues that needed to be addressed and that DoD IG intended to continue to maintain oversight of NMH.

### **Ongoing DoD IG Assessment**

During the last week of June 2012, a DoD IG team inspected NMH to review the status of U.S., Coalition and ANA efforts to improve the management and healthcare services provided at the facility, including the medical logistics processes and accountability and control of medical supplies, among other issues.

The team met with a wide range of responsible U.S. military and Ministry of Defense and ANA officials, commanders and staff. These included the U.S. military medical team assigned to the NMH and its ANA administrative and medical personnel, as well as patients in the hospital.

In its preliminary observations the team noted that progress had been made at NMH since the February 2011 inspection by DoD IG in a number of key areas, including:

- Significant progress in the joint effort between ISAF and the Afghan Ministries to develop and implement an overarching ANSF healthcare system plan.
- Medical standards clearly defined as goals for the ANSF medical care system, including NMH, giving focus and direction to joint development efforts.
- No complaints or evidence of patient maltreatment.
- Nutritionist oversight capability established.
- Improved cleanliness, sanitary conditions and general appearance.
- New processes and procedures to improve personnel accountability and patient care.
- Improved medical logistics system performance, including accountability for medical supplies; fully operational NMH medical warehouse.

- Focused medical advisor training added to pre-deployment Program of Instruction for medical mentors.
- New management of the ANA Medical Command and NMH providing effective leadership.

However, there are still challenges that need to be addressed.

Although there have been improvements in overall staffing levels at the NMH, the pharmacy and nursing departments continue to experience personnel shortages. These shortages may hinder the ability of the NMH pharmacy to perform quality control measures and the hospital to continue to improve delivery of safe and effective patient care.


The NMH also lacked administrative procedures to transfer equipment from clinical areas that had more than a sufficient supply to areas in need of the same medical equipment. In addition, there was limited medical equipment repair capability at the NMH.


Furthermore, the security of controlled pharmaceutical substances in the bulk storage area and the accountability of medication in the pharmacy dispensary were insufficient.

Finally, we found that the plan for the medical mentoring mission beyond NMH's scheduled date in 2013 was unclear and needed to be refined and communicated to medical mentors and ANSF medical system staff.

### **Conclusion**

There has been notable progress in the development of the ANSF health care system, starting from a very low level of capability and resourcing, but the capacity building process is incomplete and significant challenges remain. The DoD IG will continue to provide oversight of U.S. Military and Coalition efforts to support continued improvements in the health care system.

Biographies




### Ambassador Kenneth P. Moorefield

#### Deputy Inspector General for Special Plans & Operations


Before joining the Office of the Inspector General, Ambassador Moorefield served as senior State Department representative on the Iraq/Afghanistan Transition Planning Group, from December 2005 to June 2007.

Kenneth P. Moorefield was sworn in as Ambassador to the Republic of Gabon and the Democratic Republic of Sao Tome and Principe on April 2, 2002.

Prior to this appointment, Ambassador Moorefield had over 30 years of experience in the U.S. foreign, military, and civil services. During his overseas career with the Departments of State and Commerce, he has held political, economic, consular, and commercial officer positions at our Embassies in Vietnam, Peru, Venezuela, the United Kingdom, the U.S. Mission to the European Union, and France.

Ambassador Moorefield graduated from the Senior Seminar (1995) and the United States Military Academy at West Point (1965) and took graduate studies at the Georgetown University School of Foreign Service (1972). He has received various military and Foreign Service decorations including the Silver Star, Purple Heart, State Department Superior Honor Award, and two Presidential Meritorious Honor Awards.

He was born in Temple, Texas.





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**DOCUMENTS SUBMITTED FOR THE RECORD**

JULY 10, 2012

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## Top General Accused of Blocking Corruption Probe to Help Obama

- By Spencer Ackerman and Noah ShachtmanEmail Author
- June 20, 2012 |
- 12:35 pm |
- Categories: Af/Pak,Army and Marines, Info War, Paper Pushers, Beltway Bandits, Politicians
- 



Lt. Gen. William B. Caldwell IV speaks to troops in Afghanistan. Photo: DoD

One of the US Army's rising stars stands accused of obstructing an inquiry into widespread corruption and mismanagement of the Afghan forces he mentored. And if the charges are accurate, they could end the career of one of the military's top officers.

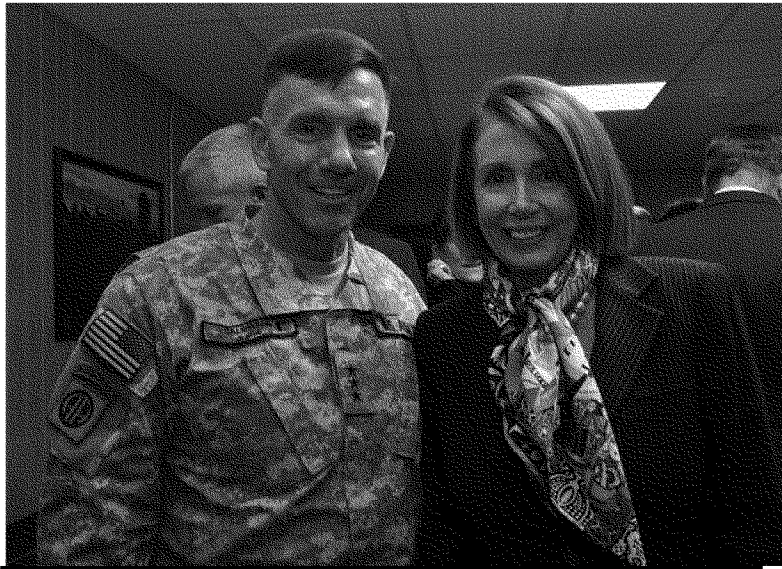
Lt. Gen. William Caldwell IV, until last year the US officer in charge of training Afghan security forces, allegedly blocked a Defense Department inspector general investigation into a pattern of misconduct exhibited by the Afghan National Army's medical division. Aided by his senior staff, Caldwell prevented that inquiry to spare his command embarrassment ahead of US national elections.

"How could we think to invite the DOD IG [the Pentagon inspector general] in during an election cycle?" Caldwell allegedly upbraided subordinate officers who favored an outside inquiry in fall 2010. Caldwell, supposedly in an "emotional" state, yelled, "You should know better!"

The accusations are laid out in a letter sent to Defense Secretary Leon Panetta by Rep. Jason Chaffetz(pdf), who calls the incident an apparent "cover up." The *Wall Street Journal* first reported the letter's contents.

President Obama "calls me Bill," Caldwell allegedly bragged, according to the letter. The general supposedly didn't want to spoil that first-name relationship with a messy inquiry into corruption and wrongdoing at Afghan hospitals.

Since then, Caldwell has assumed command of US Army North in Texas, following a series of plum assignments. The son of a prominent Army general himself, his career trajectory has resembled that of another prestigious, esteemed general — David Petraeus. Caldwell commanded an airborne division at war (the 82nd; Petraeus ran the 101st); then took a senior appointment to Iraq as chief spokesman there; ran the Army's big-think Combined Arms Center at Fort Leavenworth (as Petraeus did before him); and then took a crucial job in Afghanistan running the training of Afghan forces (eventually under the command of Petraeus, who did the same job in Iraq). With a massive budget, Caldwell's training efforts were considered the key to extricating the US military from combat in Afghanistan, a critical objective for Obama. Caldwell once told confidantes he considered himself fit to run the entire Afghanistan war.



Lt. Gen. William Caldwell briefs House Minority Leader Nancy Pelosi in Afghanistan, 2011. Photo: Flickr/Office of Nancy Pelosi

Many of the allegations against Caldwell come from Air Force Col. Schuyler Geller, who served as Caldwell's command surgeon when Caldwell ran the NATO Training Mission-Afghanistan (NTM-A). A memo from Geller recounting Afghan corruption and Caldwell's reaction, dated 2011, was acquired by Danger Room under the condition we not publish it. He outlines "a significant level of corruption" by the Afghan military medical organization, which he helped mentor. That corruption, he charges, was "known to be present by NTM-A's Senior Army leadership."

"Scores of millions" of dollars in U.S. taxpayer aid to the Afghan Army medical corps disappeared from the official balance sheets, Geller charges, and into what looked to Geller like a criminal enterprise for selling pharmaceuticals



meant for Afghan troops. Despite nearly \$180 million in U.S. taxpayer money since 2008 for the Afghan medics, Afghan troops far from Kabul have reported a lack of medical support and supplies. "It was clear that financial management at the [Afghan National Army] surgeon general's office was known by NTM-A Programs leadership in March of 2010," Geller writes.

But it wasn't just financial irregularities and pill-selling. Physicians, including surgeons, went into the Afghan military based on political connections, since they could earn "five to eight times" in uniform what they could working for the Afghan public-health system. The result was "suspicious of fuel diversion" at the main Kabul military hospital, where Geller says "patients [were] horrendously neglected and abused." A medical colonel once had a student nurse beaten for requesting the colonel not be verbally abusive, going so far as to pull out his pistol and chamber a round — all in a dining hall.

Geller and his colleagues, all colonels and captains, took their concerns to Caldwell and his staff in the fall of 2010. They sought a top-to-bottom inquiry into the Afghan army medical organization from the Defense Department's inspector general. Initially, Caldwell's chief civilian deputy approved the request, calling it a "no-brainer." Then, allegedly, Caldwell thought otherwise.

Caldwell "directed a retraction of the request," Geller said. One of Caldwell's top officers, Maj. Gen. Gary Patton, had "concerns about the Congressional election next week," and suggested punting on the inspector general request until after the vote. "Three attorneys in the room" told Patton they "recommended against anything in writing to the effect that the decision was timed to the elections."

Caldwell personally reprimanded Geller and his colleagues, allegedly yelling "you should have known better" than to pass the inquiry recommendation to the inspector general, putting Caldwell in the awkward position of retracting it after it came to the inspector general's attention. According to Geller, Caldwell limited the scope of the request for an outside inspector-general inquiry to "pharmaceuticals, medical logistics and mentoring," instead of the "more comprehensive" inquiry Geller wanted.

Geller left Afghanistan in February 2011. "[T]o date no improvement has occurred" in the Afghan army medical corps' hiring practices, he writes in his memo. Caldwell runs U.S. Army North — the same unit commanded 35 years ago by his father. Last week, Patton, a two-star general, became the incoming leader of the Pentagon's sexual-assault prevention and response team.

Caldwell has previously faced accusations that he manipulated politicians and public opinion to make his command look better. The specifics of those allegations turned out to be less than met the eye — and Danger Room defended the general at time. But that doesn't necessarily mean Caldwell was squeaky clean. If what Geller is saying is true, then some of the corruption of the Afghan army medical corps rubbed off on Caldwell. It could well make him unfit for command. Generals have seen their careers ended for much, much less.

Caldwell is entitled to the same presumption of innocence as any American citizen, and the accusations against him are not proof. (He did not respond to requests to comment for this article.) Chaffetz is seeking a deeper Pentagon investigation of Caldwell, and demanding that Panetta dig into this "apparent attempt by senior U.S. military officials to delay the exposure of — or cover up — these atrocities for political reasons." At the Pentagon on Tuesday, spokesman George Little told Danger Room he was "unaware" that the accusations against Caldwell "were known prior to his most recent assignment." He didn't specify how this might impact Caldwell's until-now skyrocketing career.



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**WITNESS RESPONSES TO QUESTIONS ASKED DURING  
THE HEARING**

JULY 10, 2012

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#### **RESPONSE TO QUESTION SUBMITTED BY MR. YOUNG**

Mr. SEDNEY. Response to Information Request for Quarterly Assessment Reports of Dawood by NTM-A/CSTC-A Validation Team for NTM-A/CSTC-A Surgeon's Office (CJSURG) assessing all ANA hospitals on a quarterly basis, using their Healthcare Standards tool.

Quarterly Assessment Summary: The Afghan National Military Hospital (NMH) is evaluated utilizing a healthcare standards tool to validate Capability Milestones (CM). The goal is for the NMH to operate autonomously. The NMH displayed significant improvement and received a CM1B rating during its May 2012 assessment, up from a CM2A rating, received during the February 2012 Quarterly Assessment.

The NMH demonstrated best practices (CM1A) for Blood Bank, Central Sterile Service Department (CSSD), Dental, Human Resources, Intensive Care Unit (ICU), Internal Medicine, Laboratory, Leadership Council, Medical Logistics (MEDLOG), Nursing, Operating Theater, Outpatient Clinic, Patient Administration, Pharmacy, and Surgery. The Biomedical Repair, Facilities Management, Infection Prevention, Radiology, and Ultrasound departments earned CM1B ratings.

The remaining departments are at a CM2A rating, which NATO Training Mission-Afghanistan (NTMA-A) expects will improve with enhanced mentoring, training, well-written standard operating procedures (SOPs), and improved organizational structure. Emergency and Anesthesia have been identified as functional areas requiring improved leadership. The Emergency Department also requires improved written SOPs, improved equipment/supply organization, more attention to cleanliness, renovation, and space expansion. The Anesthesia Department requires greater supervision and oversight, equipment management, and clerical documentation.

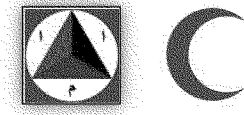
The ANA Medical Command (MEDCOM) has established an Afghan validation team that allows for direct reporting of hospital elements and practices to the ANA Surgeon General. Through the ANA MEDCOM validation team, the NMH should realize significant gains in its health system. This process will be completely led by ANA leadership. [See page 12.]

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#### **RESPONSE TO QUESTION SUBMITTED BY MS. SPEIER**

General ROBB. [The chart provided can be found on the following page.] [See page 23.]

## Medical Rights of ANA Officers, Soldiers and Bridmals



As an Officer, Bridmal or Soldier, if you are sick or wounded you are entitled to the following from the ANA:

*Proper, professional treatment of your wounds or sickness*



**and FREE MEDICINE**

to be seen by a nurse at least once every 6 hours. The nurse should explain your medicines to you.



to be seen by a doctor at least once every 24 hours.



Your doctor should explain to you your illness and his/her plan for your treatment  
clean sheets and clean floors



clean bandages, changed at least every 24 hours.



Edible food, including fruit and vegetables.

These are your rights. If you are not getting them, you or your family member must contact your unit RCA, IG, or Legal officer or call \_\_\_\_\_.

This notice must be posted where it can be seen in every room of every hospital, clinic and pharmacy and in every ANA unit's orderly room.

By Order of the Minister of Defense

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**QUESTIONS SUBMITTED BY MEMBERS POST HEARING**

JULY 10, 2012

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### QUESTIONS SUBMITTED BY MR. COOPER

Mr. COOPER. Please describe in detail the “vast improvements” made in the accountability of hospital leadership and staff, general sanitation of facilities, the standard of patient care, and the supporting logistics systems.

Mr. SEDNEY. Afghanistan's National Military Hospital (NMH) has made improvements in the accountability and responsibility of its leadership. Demand for training and education at the hospital has also increased. The combination of these changes will result in improved and sustained patient care.

Improvements in NMH leadership and staff accountability, general sanitation standards, standard of patient care, and logistics systems are underway. Following the removal of General Ahmed Zia Yafthali as hospital commander, new leadership established more stringent planning and oversight to advance the professional conduct and accountability of the Afghan National Army (ANA) medical staff, with special attention towards combating staff absenteeism. Major General (MG) Wardak, ANA Surgeon General, established rules, regulations, and policies that Brigadier General (BG) Sherzai, the NMH Hospital Commander, actively enforces. Since MG Wardak's appointment in February 2012, twice-daily attendance verification for all ANA NMH staff members has decreased absenteeism. Absence, depending on frequency and length, has resulted in pay deduction, transfers, or termination. Attendance verification is ANA-led and sustainable.

Accountability for the general cleanliness of and sanitation for the NMH is a routine discussion topic with the Hospital Leadership Council (HLC). Hospital administration, facilities management, and nursing staff personnel monitor each floor for cleanliness. Having facilities sanitation and cleanliness as a routine HLC agenda item brings heightened awareness to all NMH leaders, as well as to the hospital commander. In 2011, the NATO Training Mission-Afghanistan (NTM-A) Medical Training Advisory Group (MTAG) mentors reported that the new hospital commander, chief of surgery, and chief nurse intervened in every case of alleged patient neglect; by August 2011, there were no substantiated cases of patient neglect. An ANA Nutrition Task Force was created, which implemented processes and monitoring systems to improve patient nutrition. MTAG mentors currently supply liquid supplements from the United States, but are working to develop an Afghan-led solution that is sustainable after 2014. The transfer of medical logistics from the ANA Surgeon General to the ANA Logistics Command (LOGCOM) allowed the Ministry of Defense to enforce standard controls over receipt, storage, accountability, and distribution of pharmaceuticals and other supplies. Newly implemented ANA medical inventory and tracking systems have brought greater transparency and efficiency to the supply chain management.

Mr. COOPER. What remains to be done with improving accountability in the Afghan National Military Hospital?

Mr. SEDNEY. Overall, accountability in the Afghan National Military Hospital (NMH) has improved greatly. Continued NATO Training Mission-Afghanistan (NTM-A) mentorship will sustain the improvements in accountability.

MG Wardak, ANA Surgeon General, established rules, regulations, and policies that BG Sherzai, NMH Hospital Commander, actively enforces. Since MG Wardak's appointment in February, twice-daily attendance verification for all Afghan National Army (ANA) NMH staff members has decreased absenteeism. Absence, depending on frequency and amount of time, has resulted in pay deduction, transfers, or termination. Attendance verification is ANA-led and sustainable. Personnel accountability is further tracked through a Surgeon General-chaired meeting, held twice each week, where the hospital commanders provide daily reports on personnel accountability.

MG Wardak has placed logistics, supply, and equipment accountability as a top priority. He has fined the Director of the Outpatient Clinic for allowing pharmaceuticals to expire and has warned BG Sherzai not to allow this waste to occur anywhere in the NMH. Logistical practices have been implemented to ensure that pharmaceuticals are rotated and not filled with items near expiration. The logistics system continues to advance with greater scrutiny on administrative oversight, personnel training, and maintenance of authorized pharmaceuticals. Accountability is

further tracked through a Surgeon General-chaired weekly meeting that includes the ANA Logistics Command (LOGCOM) Commander, who provides an account on medical logistics.

NTM-A Medical Training Advisory Group (MTAG) mentors will continue to advise ANSF medical leadership on the importance of continued enforcement of personnel and logistics accountability, as well as the importance of developing clear and concise standard operating procedures (SOPs). Moreover, ANSF-developed training programs need to be standardized and verified by Ministry of Defense (MoD), Ministry of Interior (MoI), Ministry of Public Health (MoPH), and NTM-A Medical Validation teams.

Mr. COOPER. Will the U.S. Medical Training Advisory Group continue after the transition in Afghanistan? In what way?

Mr. SEDNEY. We are currently assessing all of our post-2014 train, advise, and assist missions. Even though the Afghan National Security Forces (ANSF) Health Care System is well on the way to autonomous operations, we currently envision that the role of the Medical Training Advisory Group (MTAG) will continue, in a limited role, after 2014 by:

- Assisting the ANSF Health Care System leadership to conduct self-assessment of internal processes to identify areas of improvement via surveys, data analysis, and evidence-based best practices. Following validation of Regional Military Hospital (RMH) Herat, Afghan National Army Medical Command (ANA MEDCOM) and MTAG mentors will develop and implement a survey process that continues to improve the ANSF health care delivery;
- Encouraging ANA MEDCOM in the continued evolution and quality management of health care in Afghanistan to meet the changing challenges, needs, and wants of the ANSF;
- Mentoring greater cooperative health care efforts amongst the Ministry of Defense, Ministry of the Interior, and Ministry of Public Health.

Mr. COOPER. Is the Afghan government committed to improving the ANSF healthcare system? If so, how and what actions have they taken and demonstrated to show this to the U.S. government?

Mr. SEDNEY. The Afghan government has taken actions to improve the healthcare system in the areas of fighting corruption and in collaboration, capability, and accountability.

Corruption—Since January 2012, under the direction of President Karzai, Afghanistan's High Office for Oversight and Anti-Corruption (HOOAC) assessed crimes committed at National Military Hospital (NMH) by both staff members and the former Surgeon General (Yaftali). As of July 2012, the HOOAC's efforts had led to seven potential cases for investigation and prosecution. Three cases were referred to the Ministry of Defense (MoD) Legal Department for investigation and prosecution. Two of these cases were referred to military courts. The four remaining cases (including the case against Yaftali) have yet to be referred by the HOOAC.

Collaboration—In July 2012, Afghan National Security Forces (ANSF) hosted a two-day Healthcare Shura attended by medical leaders from the Afghan National Army (ANA), including the ANA Surgeon General, Minister of Defense (Health Affairs), and NMH and Regional Hospital Commanders; the Afghan National Police (ANP), including the ANP Surgeon General and Hospital Commanders; and the Ministry of Public Health (MoPH). U.S. Department of Defense Inspector General representatives also attended this event.

The participants in the Shura discussed the current state of the ANSF healthcare system, the impact and challenges the ANSF faces as Coalition forces complete transition in 2014, and actions required to mitigate the impact of transition while enhancing Afghan stewardship of the ANSF healthcare system. A constant theme emphasized by ISAF leaders was that the responsible Afghan government entities must develop their own plan for taking ownership of ANSF healthcare, and that coordination and cooperation across the MoD, the MoPH, and the Ministry of Interior is critical throughout this process.

Capability—The NMH demonstrated progress ahead of expectations in meeting quality performance criteria for the first tier capability of the ANSF Healthcare Standards, a key indicator of the NMH's readiness to transition. Furthermore, an Afghan-led team (ANA Medical Command) validated this effort with NATO Training Mission-Afghanistan (NTM-A) oversight.

Accountability—Under the command of MG Wardak, the NMH has implemented improved procedures to ensure its medical personnel act in a professional and ethical manner and work their assigned hours. This accountability is monitored at the command level, with NTM-A mentor oversight, and verified in the Capability Milestone validation process. NTM-A plans to continue its oversight of NMH progress

and the continued development of the Afghan healthcare system, which will be a key focus of the 2013 assessment process.

Mr. COOPER. Does the U.S. government now have a way to account for pharmaceuticals supplied to the Afghan government?

Mr. SEDNEY. Newly implemented medical inventory and tracking systems have introduced greater transparency and efficiency into pharmaceutical supply chain management.

The transfer of medical logistics from the Surgeon General to the Afghan National Army's Logistics Command (ANA LOGCOM) allowed the Ministry of Defense (MoD) to enforce standard controls over receipt, storage, accountability, and distribution of pharmaceuticals and other supplies. These controls are embodied in Decree 4.0, described below.

Decree 4.0 addresses logistics within the Afghan National Army system and specifically delineates logistics processing. The guidance states:

All incoming supplies, including pharmaceuticals, are accounted for via MoD Form 8. This form is the receipt document for orders. A delegation of three members representing the ANA LOGCOM, Medical Command (MEDCOM), and Acquisition, Technology, and Logistics (ATL) initiates an MoD Form 8. The form details the number of supplies ordered, who shipped the supplies, and identifies any systemic deficiencies. A copy of the MoD Form 8 is sent to the following:

- Materials Management Division. A copy of the MoD Form 8 is sent to the Minister of Finance and the Coalition comptroller, who validate receipts, orders, and funding allocated.
- Warehouse Manager. The Manager creates an MoD Form 1 to annotate that purchased materials have been added to the warehouse inventory.

The processes above are monitored by Coalition mentors resident in the Medical Training Advisory Groups (MTAGs). The Coalition Comptroller validates receipts, orders, and funding for pharmaceuticals and other supplies. The MTAGs verify if hospitals have the pharmaceuticals and other supplies on hand, while Coalition logistics mentors verify the medical inventory in the warehouses.

Mr. COOPER. What remains to be done with improving accountability in the Afghan National Military Hospital?

Ambassador MOOREFIELD. The ANA Medical Command (MEDCOM) is now under the command of Major General Mussa Warkak who has established responsible expectations for the conduct and performance of ANA medical personnel. Specifically, the National Military Hospital (NMH) has implemented procedures to ensure their personnel act in a professional and ethical manner and work their assigned hours. These procedures are positively impacting on NMH personnel accountable performance.

Additionally, MEDCOM and NMH are taking action based on recommendations made in the DOD IG report "Additional Guidance and Training Needed to Improve Afghan National Army Pharmaceutical Distribution" Report No. DODIG-2012-083, published May 7, 2012. This report recommended that the ANA and MEDCOM develop a training program and implementation guidance specific to the pharmaceutical distribution process and the proper use of the Ministry of Defense (MoD) Decree 4.0 logistics forms to properly receive, account for, and distribute pharmaceuticals. Additionally, it was recommended that MEDCOM undertake the same initiatives for non-Ministry of Defense forms addressed in Decree 4.0 that are used to collect and report pharmaceutical usage data. Pharmaceutical usage data is necessary to properly identify pharmaceutical resupply requirements for procurement. Furthermore, continued refinement and use of pharmaceutical usage data will help to prevent mismanagement, theft and waste of U.S. funded pharmaceuticals.

Continued oversight by NMH, MEDCOM, ANA GS Inspectors General, as well as NTM-A and the DOD IG, is required to ensure that effective internal control procedures are in place and implemented to ensure the accountability of commands and their personnel with respect to medical supplies. Additionally, a collaborative relationship and effective communication between ANA Logistics Command and MEDCOM is critical to ensuring continued improvement of pharmaceuticals accountability and control throughout ANA, MEDCOM and at NMH specifically.

Mr. COOPER. Will the U.S. Medical Training Advisory Group continue after the transition in Afghanistan? In what way?

Ambassador MOOREFIELD. Based on our discussions with NTM-A leadership and our assessment of the National Military Hospital (conducted from 28 June-5 July), we understand that both NTM-A and ANA medical leadership believe it is important to continue the medical advisory mission beyond 2014. Accordingly, we will request a plan which describes the medical advisory effort beyond the transition to Afghan-lead of the National Military Hospital, which is estimated for the 3rd quarter of Calendar Year 2013, and then in the post-2014 transition era.

Mr. COOPER. Is the Afghan government committed to improving the ANSF healthcare system? If so, how and what actions have they taken and demonstrated to show this to the U.S. government?

Ambassador MOOREFIELD. We have observed and reported on progress in the capability and performance of the ANSF healthcare system over time and believe this is an indication of the Ministry of Defense and ANA General Staff's commitment to continued reform and improvements. Specifically, ISAF continues to mentor the MoD/ANA and MoI/ANP to work together to further develop and improve the ANSF healthcare system. ISAF's efforts to improve ANSF healthcare also includes a collaborate effort with both the Ministry of Public Health (MoPH) and Ministry of Education (MoE). For example, in July 2012, ISAF together with the ANSF hosted a 2 day ANSF Healthcare Shura attended by medical leaders from the ANA (including ANA Surgeon General, MoD Health Affairs and NMH and Regional Hospital Commanders), ANP (ANP Surgeon General and ANP Hospital Commanders) and MoPH. DOD IG representatives attended this event.

The purpose of the Shura was to discuss the current state of the ANSF healthcare system, the impact and challenges the ANSF faces as Coalition forces transition in 2014 and to initiate action to mitigate the impact of transition while enhancing Afghan stewardship of the ANSF healthcare system. A constant theme emphasized by ISAF leaders was that the responsible Afghan government entities must develop their own plan for taking ownership of ANSF healthcare from Coalition Forces and that coordination and cooperation across MoD/MoI/MoPH is critical throughout this process.

We have observed additional indicators of Afghanistan's commitment to improving their healthcare system at NMH during our recent assessment. Specifically, NMH demonstrated progress in meeting the performance criteria to qualify for the first tier capability of the ANSF Healthcare Standards, a key indicator of their readiness to transition. Furthermore, it was an Afghan-led team who worked shoulder-to-shoulder with NTM-A's validation team in determining this level of effort.

We plan to continue our oversight of the NMH and the continued development of the Afghan healthcare system will be a focus of a future assessment planned for 2013.

Mr. COOPER. Does the U.S. government now have a way to account for pharmaceuticals supplied to the Afghan government?

Ambassador MOOREFIELD. Under the new Afghan pharmaceutical distribution system developed by CSTC-A, U.S. officials provide funding and Afghan Acquisition, Technology and Logistics (AT&L) officials procure pharmaceuticals. The pharmaceuticals ordered should be based on requirements identified by Afghan Medical Command officials. The USG have both the CSTC-A Medical Training Advisory Group and Logistics Training Advisory Group providing guidance to these Afghan entities. During our audit, CSTC-A personnel were able to obtain and provide documentation of the items Afghan AT&L officials procured as well as documentation with the total funds spent to acquire the items. According to CSTC-A personnel, the USG is still responsible for managing vaccines for the Afghans separately from other pharmaceuticals because they require cold storage and transportation costs are higher and easily diverted.

Mr. COOPER. Please describe in detail who the DOD IG team met with during the recent visit to Afghanistan.

Ambassador MOOREFIELD.

ISAF

Grp Cpt Steven Kilbey, UK, Deputy ISAF Surgeon

IJC

BG Norvell Van Coots, Surgeon General for USFOR-A, Medical Advisor to COMIJC

NTM-A/CSTC-A

LTG Dan Bolger, USA, Commander NTM-A/CSTC-A

Cdre Mike Farrage, UK, Chief of Staff, NTM-A/CSTC-A

COL Kenneth Deal, USA, DCG-OPS, NTM-A/CSTC-A

COL Debra Daniels, USA, Director Content Management/Audit Oversight NTM-A/CSTC-A

CAPT John Lamberton, USN, Chief of Staff CJSURG, NTM-A/CSTC-A

CAPT Fernando Moreno, USN, Deputy Command Surgeon, NTM-A/CSTC-A

CAPT Donald Worm, USN, Team Lead for Validation, NTM-A/CSTC-A

CDR Kathryn Mangion, USN, ANA Command Surgeon/Medical Command (MEDCOM) Advisor, NTM-A/CSTC-A

CDR Joe Taylor, USN, MTAG Team Lead, NTM-A/CSTC-A

CDR Ethan Josiah, USN, MTAG Deputy Team Lead, NTM-A/CSTC-A

CDR Melissa Smith, USN, MTAG Nurse Advisor, NTM-A/CSTC-A

LCDR Steven Bailey, USN, MTAG Hospital Administrator Advisor, NTM-A/CSTC-A  
 LCDR Kelly, USN, MTAG Pharmacy Advisor, NTM-A/CSTC-A  
 Capt Sarah Byron-Smith, USAF, MTAG MEDLOG Advisor, NTM-A/CSTC-A  
 MSgt Troy Inabinet, USAF, MTAG Physical Therapy Advisor, NTM-A/CSTC-A  
 Ibanez Cocrates, MTAG Radiology Advisor, NTM-A/CSTC-A  
 HM2 Joanna Castro, USN, MTAG Dental Advisor, NTM-A/CSTC-A  
 LT David Varney, USN, MTAG Facilities/Administrator Advisor, NTM-A/CSTC-A  
 Dr. Susanna Cooper, MTAG Physician Advisor, NTM-A/CSTC-A  
 LCDR Gail Alexander, USN, MTAG Nurse Advisor, NTM-A/CSTC-A  
 Capt Kimberly Price, USAF, MTAG Nurse Advisor, NTM-A/CSTC-A  
 SSG Michael Lonak, USAF, MTAG Medical Logistics Advisor, NTM-A/CSTC-A  
 HM1 Alvaro Benitez, USN, MTAG Bio-Medical Repair Advisor, NTM-A/CSTC-A

#### ANA Medical Command

MG Mussa Wardak, ANA Surgeon General  
 ANA National Military Hospital (NMH)  
 BG Nazir Shirzai, ANA, NMH Commander  
 COL Jurhat, ANA, Chief of Administration  
 COL Hasan, ANA, Chief Pharmacist  
 COL Noorzai, ANA, Chief of the Medical Staff  
 COL Rahmani, ANA, Director of Medical Logistics  
 LtCol Latif, ANA, Chief Nurse  
 MAJ Ahmar, ANA, Plans Officer  
 MAJ Zia, ANA, Chief Quartermaster Pharmacy  
 MAJ Khalil, ANA, NMH Warehouse Manager  
 Lt Behroz, ANA, NMH Pharmacy Dispensary  
 Various Charge Nurses, Physicians and Patients at the NMH

Mr. COOPER. Describe the joint effort between ISAF and the Afghan government to develop and implement an overarching ANSF healthcare system plan.

Ambassador MOOREFIELD. ISAF released the ANSF Healthcare System Development Support Plan to the COMISAF OPLAN 38302 in December 2011. This plan identifies the focus areas for the plan which are defined as follows:

a) ANSF Medical System Organization—The organization of the ANS medical system will be optimized in terms of core processes, sustainable Tashkil<sup>1</sup>, clear and reliable command and control (C2), and capability laydown, thereby ensuring maximal efficiency of health care delivery.

b) Personnel—Effective operation of an ANSF-developed, requirements-driven, personnel management system that continuously adapts to meet the changing needs of the Afghan Health system and results in optimal staffing, with appropriate geographic distribution.

c) Education and Training—A standards-based, ethics driven system of education and training that produces professional and competent healthcare providers, administrators, and technicians that is responsive to enterprise requirements, adaptive to emerging demands, and sustainable.

d) Evacuation—An efficient, sustainable ANSF ground casualty evacuation capability, tailored to geographical region, with developing en route care capability.

e) Quality Management—An enduring culture of quality will exist within the ANSF health systems, manifest by continuously improving metrics of clinical outcomes, independently fostered by ANSF quality management experts and programs. Ideally, the ANSF culture of quality will spur development of and be supported by a culture of quality within the broader government health systems within Afghanistan, as reflected in national quality and credentialing standards.

f) Logistics—A requirements-driven and accountable requisition, receipt, reconciliation and distribution (R3D) process, embedded within the MoD and MoI logistics systems and aligned to ANSF clinical needs.

The vision driving the planning efforts, and the Afghan Healthcare System development effort overall is “quality warrior care, from point of injury through a professional, ethical, effective and efficient medical system, to recovery and discharge, for the nation’s defenders.”

The ANSF Healthcare System Development Support Plan will be one of the foci of a DODIG Special Plans and Operations (SPO)-led assessment planned for March 2013.

Mr. COOPER. Describe the new medical logistics plan for accountability for medical supplies.

<sup>1</sup>The Tashkil describes the authorized strength and structure of an ANSF organization.

Ambassador MOOREFIELD. In 2011, we observed a restructuring of ANSF medical logistics whereby the functions of requisition, acquisition, storage, transfer and disposition of medical logistics were transferred from the ANA Surgeon's General office to the MoD/GS G4 and the ANA Logistic Command. This action brought MEDCOM into compliance with MoD Decree 4.0 and was intended to improve and promote accountability and responsibility for medical supplies.

We saw several examples of improvements in the medical logistics system during our recent visit to NMH. Specifically we observed that the medical logistics staff participated in training to ensure they were complying with directives in MoD Decree 4.0. Additionally, they provided training to other NMH staff who also are required to utilize the MoD logistic forms. Furthermore, we observed that U.S. mentors assisted NMH medical logistics staff in developing an automated system which helped the Afghans to properly account for medical supplies and pharmaceuticals in their warehouse. Although recently implemented and only 20 percent complete, the Afghans were excited and proud to display this new technology and their intent to complete the data entry allowing them to completely automate inventory control measures for their medical supply inventory.

Mr. COOPER. Describe the personnel shortages of the NMH in more detail.

Ambassador MOOREFIELD. During our recent NMH assessment, we observed personnel shortages in the pharmacy and on the patient care wards.

The Pharmacy at NMH is authorized five pharmacists according to the 1391 Tashkil and they have five pharmacists onboard. However, we observed that the pharmacy was extremely busy due to the high patient volume. NMH is a facility with an average daily census of 260 patients and has a bed capacity for 410 patients. We believe they could use 1-2 additional clinical pharmacists who would be dedicated to dispensing pharmaceuticals to patients and providing pharmacy oversight of the inpatient wards.

Additionally, we noted that several of the busiest inpatient wards experienced nursing personnel shortages. Specifically, the Orthopedic Ward (mostly war-related injuries) had 45 patients and only 6 nurses assigned filling 13 positions that were authorized on the NMH 1391 Tashkil. However, at the time of our inspection visit, there were 126 Nursing positions at NMH with 97 filled and 28 vacant for a fill rate of 77.6%, a significant improvement in staffing compared to our assessment in 2010 in which we noted a nursing fill rate of 51.5%. Nonetheless, the nursing staff shortages that still exist are in key medical support areas which may affect the quality of care and safety of patients.

Mr. COOPER. Describe the problems regarding security of controlled pharmaceutical substances in more detail.

Ambassador MOOREFIELD. DODIG conducted an audit of the ANA's pharmaceutical distribution, which was published on May 7, 2012. One of the discrepancies noted at NMH during this audit was that controlled pharmaceuticals were not secured separately from uncontrolled pharmaceuticals. NMH took corrective action based on the report's findings and removed the controlled pharmaceuticals from the open shelves in their pharmacy stock room where they were stored with uncontrolled pharmaceuticals. Additionally, NMH obtained a storage locker where they placed all the controlled pharmaceuticals and locked the container per their regulations.

However, during our visit in July 2012, we noted that this storage locker, although an improvement of the previous method of storing controlled substances, was not properly secured to the floor to ensure that it could not be easily removed. Our understanding is that NMH is already working on fixing this problem based on the recommendations we made during our out-brief to the command in July.

Mr. COOPER. Describe the problems regarding equipment transfer and repair in more detail.

Ambassador MOOREFIELD. During our July 2012 visit we noted that some wards needed additional medical equipment such as patient monitors and IV pumps. We observed that some wards had equipment that was not used 100% of the time, and other wards did not have access to a particular piece of equipment when it was periodically needed. It was explained to us that accountability of medical equipment is taken very seriously among the Afghans and wards are possessive of maintaining control over the equipment they have assigned to them on their Tashkil. Consequently, the wards do not easily share medical equipment that may be needed for patient care on other wards. We will recommend in our report that NMH reassess the accuracy of the amount and distribution of medical equipment listed on the Tashkil and develop policy/procedure which enable loaning of medical equipment among the different patient wards. We also made this recommendation to the Hospital Commander, ANA Surgeon General and Assistant Minister for Health Affairs.

Additionally, we noted that NMH continues to have challenges with the maintenance and repair of their medical equipment. This was due, in part, to a lack of qualified medical equipment repair technicians. NTM-A initiated a contract to support NMH with medical equipment repair in 2011 due to a lack of qualified ANA medical equipment repair technicians. However the Afghan company under contract did not perform the work that was required. Due to the contractor's non-compliance, work on this contract was discontinued in July 2012.

In 2011, the ANA Armed Forces Academy of Medical Sciences (AFAMS) developed a 12 month curriculum, with U.S. and Coalition support, to train ANA soldiers as bio-medical equipment repair technicians. The first set of students have completed the didactic portion of the training and are now involved in the 2nd phase of the training where they participate in hands-on training maintaining and repairing equipment at ANA medical facilities. 10 of the 21 ANA soldiers who completed the first phase of training were assigned to work at NMH in June 2012.

Mr. COOPER. Describe your concerns regarding the plan for medical monitoring beyond 2013 in more detail.

Ambassador MOOREFIELD. ISAF released the "ANSF Healthcare System Development Support Plan" in response to the COMISAF OPLAN 38302 in December 2011. Accordingly, NTM-A has developed a coordinated plan to guide the efforts of medical mentors/advisors as they work with their ANSF partners to transition to Afghan-led healthcare facilities. The objective for transition is as follows: "An interdependent, professionally-led ANSF Health Function which generates and sustains sufficient police and army medical personnel, infrastructure, services and logistics capabilities, with accountable and effective health system that support the ANSF".

We have reviewed ISAF's plan and NTM-A's supporting plan, which includes objectives and milestones for the development of the Afghan healthcare system for 2012, 2013 and 2014. ANA hospitals, under the mentorship of U.S. and Coalition forces, are beginning to achieve success in demonstrating their readiness to transition.

According to an NTM-A assessment conducted in June 2012, NMH received an overall rating which indicated that they are capable of executing functions with coalition oversight only. Furthermore, the NTM-A plan identified the third quarter of Calendar Year 2013 as the window for the transition of NMH to an "Afghan-led" hospital.

Given the successes of NMH in working towards transition, we have asked NTM-A/CSTC-A to define a plan for the medical mentoring mission beyond the transition to NMH-lead to ensure the continued success of NMH and the ANSF Healthcare system, in general.

