SIGAR

Special Inspector General for Afghanistan Reconstruction

OFFICE OF SPECIAL PROJECTS

REVIEW OF THE COLLECTION AND PROCEDURES FOR SCREENING THE BLOOD OF AFGHANISTAN NATIONAL ARMY PERSONNEL

MARCH 2018

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1550 Crystal Drive, 9th Floor
Arlington, Virginia 22202

Mailing 2530 Crystal Drive
Arlington, Virginia 22202-3940

Tel 703 545 6000

www.sigar.mil

SIGAR | Office of the Special Inspector General for Afghanistan Reconstruction

March 15, 2018

The Honorable Jim Mattis
Secretary of Defense

General Joseph L. Votel
Commander, U.S. Central Command

General John W. Nicholson, Jr.
Commander, U.S. Forces–Afghanistan and
Commander, Resolute Support

Major General Robin L. Fontes
Commander, Combined Security Transition Command–Afghanistan

In March 2016, SIGAR received information expressing concerns that blood types collected from Afghan National Army (ANA) recruits were not being recorded correctly in the Afghan Human Resource Information System (AHRIMS), the Afghan National Defense Forces personnel database that includes personally identifiable information, including medical data, on soldiers and civil workers. The information we received raised suspicions that the service provider used by the ANA to collect and test blood from soldiers, as required by Afghan policy, was charging the recruits to collect their blood but not conducting valid blood type testing or recording accurate blood types in AHRIMS. The source also expressed concern that ANA soldier blood type records in AHRIMS may be inaccurate because it appeared that a suspiciously large number of soldiers were reported to have the same blood type.

We initiated this review based on that information and found that the ANA stopped collecting or verifying blood types from new recruits in January 2017 because it lacked the supplies and equipment to conduct blood tests. As a result, we found that between January and July 2017 approximately 15,400 new ANA recruits did not have their blood type tested or verified before entering the ANA ranks, and the blood type of at least 9 percent of the total ANA force currently remains unconfirmed. We also found that 45 percent of all active Ministry of Defense personnel, including active ANA soldiers, did not have their blood type recorded in AHRIMS as of July 2017. Furthermore, according to DOD officials we spoke with, the ANA does not have an official system of record that tracks the medical data of new recruits. As a result, the Afghan government does not know which soldiers have been blood-typed or screened for infectious diseases. This information is critically important because successful blood transfusions for wounded soldiers require that donated blood be the appropriate type and free from infectious diseases. Lastly, we found that the ANA's overall medical record keeping is unreliable and often inaccurate, and the use of AHRIMS—an established system capable of serving as a centralized, automated repository for medical information—or other electronic systems to track blood type and assist in ANA trauma care presents logistical challenges due to issues with ANA literacy and technical skills related to using computer systems, internet access, and institutional knowledge.

Developing a credible and accessible system of record to ensure that soldiers' blood types are accurately recorded, to help ensure that the proper type of blood is administered to a wounded soldier is an important component to the health of soldiers and the sustainability of the ANA. Therefore, we suggest that CSTC-A develop a plan to improve the ANA's medical accessions process—a process intended to detect any medical issues that might prevent a recruit from serving successfully—including (1) assisting the ANA in conducting and/or validating blood testing; (2) requiring the use of AHRIMS, or other suitable systems, to record blood type and other medical data; and, (3) training ANA personnel on the use of AHRIMS, or other suitable electronic system of record, to collect this data and expanding the usability of AHRIMS throughout Afghanistan. We also suggest that CSTC-A work with the ANA's Medical Command to develop a process aimed at testing for, and correcting, errors in soldiers' medical records as reported in AHRIMS and soldiers' identification cards.

We provided a draft of this report to DOD for comment on January 26, 2018. We received written comments from CSTC-A on March 2, 2018. In its comments, CSTC-A concurred with SIGAR's suggestions to strengthen the ANA's medical accession process and assist the ANA in collecting and recording soldiers' blood type to maintain more accurate records. CSTC-A pointed out that the ANA will transition away from AHRIMS, but acknowledged the importance of maintaining accurate records regardless of the system used. CSTC-A stated that the ANA is required to record a soldier's blood type [when collected], and it will ensure that "blood type is documented in the [new] system of record for maintaining ANA solider personnel information." CSTC-A also stated that it will "continue to provide training, assistance, and advising for ANA medical testing processes utilizing common standards established by the World Health Organization and Centers for Disease Control and Prevention," and support the ANA's medical procurement process "to ensure required equipment and supplies are on hand and operational." Furthermore, CSTC-A stated it is "standard protocol to test blood before any transfusion, regardless of any previous recorded blood type test, and a soldier's blood type, as recorded in their file, does not affect the direct administering a transfusion, or classifying a person's blood for donation." However, we understand that in emergency situations, blood tests on blood donors may be performed retrospectively. Given the increased potential for the spread of infection and communicable disease in combat situations, it is imperative that CSTC-A work with the ANA to ensure that blood types are recorded correctly on soldiers' medical records and identification cards. CSTC-A's written comments are reproduced in appendix I.SIGAR incorporated technical changes into its report as appropriate to reflect the ANA's upcoming transition from AHRIMS to the Afghan Personnel Pay System.

We conducted this special project in Washington, D.C. and Kabul, Afghanistan from January 2017 to December 2017, in accordance with SIGAR's quality control standards. These standards require that we carry out work with integrity, objectivity, and independence, and provide information that is factually accurate and reliable. SIGAR performed this special project under the authority of Public Law No. 110-181, as amended, and the Inspector General Act of 1978, as amended. Should you or your staff have any questions about this project please contact Mr. Matthew Dove, Director of Special Projects, at (703) 545-6051 or matthew.d.dove.civ@mail.mil.

Sincerely,

John F. Sopko
Special Inspector General
for Afghanistan Reconstruction

In trauma cases, including trauma arising from combat operations, uncontrolled hemorrhage is the leading cause of preventable death, and resuscitative therapy, such as blood transfusion, is a critical component for survival.[1] According to U.S. Army Medicine publication, *Emergency War Surgery*, in cases of massive blood loss, such as in combat operations, there is no substitute for the transfusion of blood. Thus, blood products are an essential resource for military readiness and the prevention of loss of life on the battlefield.[2] The U.S. Army reports that approximately 25 percent of persons requiring medical evacuation as a result of combat injury will require blood products for survival, and five to eight percent of those evacuated will lose large volumes of blood during initial care and require a "massive transfusion" of blood over the course of 24 hours.[3]

Blood transfusions require knowledge of both donor and recipient blood type, either A, B, AB, or O.[4] Patients who need blood transfusions must receive blood that matches their own blood type otherwise the patient may be at risk of severe allergic reaction that may be life-threatening. Blood transfusions also require that donor blood be free from infectious diseases in order to prevent the spread of disease to the recipient. Blood collection and testing serves multiple purposes, including providing adequate blood reserves for wounded soldiers and preventing the spread of infectious disease. The risk of transmitting a blood-borne disease in operational conditions is much higher than in the civilian environment given the prevalence of blood loss and injury during combat operations, and the difficulty associated with collecting and testing blood from donors in such an environment.

The Combined Security Transition Command-Afghanistan (CSTC-A) is responsible for training, advising, and assisting the Afghan National Army (ANA) in combat medical care, ground medical evacuation, and medical logistics. CSTC-A's Essential Function (EF) office 5.2 (EF 5.2) advisors assist the ANA with procuring medical equipment and supplies for testing blood through the Afghan Ministry of Defense (MOD) medical logistics system.[5] For example, in fiscal year 2017, CSTC-A expected to procure approximately $23.5 million in medical equipment for the Afghan National Defense and Security Forces (ANDSF).[6] The Defense Logistics Agency (DLA) also reported that it worked with CSTC-A to provide $142 million worth of pharmaceuticals and medical/surgical materiel, laboratory reagents, vaccines, and first aid kits to the ANA through the DOD's foreign military sales process.

In March 2016, SIGAR received information from a U.S. Forces-Afghanistan program manager expressing concerns that blood types collected from ANA recruits were not being recorded correctly in the Afghan Human

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[1] Carl. W. Goforth et al., "Fresh Whole Blood Transfusion: Military and Civilian Implications," *Critical Care Nursing* no. *36*; https://www.ncbi.nlm.nih.gov/pubmed/27252101.

[2] Blood products refer to the range of blood components that can be transfused to control hemorrhage and/or replace lost blood in critically wounded individuals. According to the American Red Cross, blood products include whole blood, red blood cells, plasma, platelets, and white blood cells.

[3] "Chapter 33: Battlefield Transfusions," *Emergency War Surgery*; *Emergency War Surgery was published by the Borden Institute, U.S. Army Medical Department Center and School on Fort Sam Houston, Texas and the Office of the Surgeon General, U.S. Army in 2013, p. 467-470.* http://www.cs.amedd.army.mil/FileDownloadpublic.aspx?docid=189c4a13-522f-4d91-9236-a109d7b5ee4d.

[4] According to the American Red Cross, there are four major blood groups determined by the presence or absence of two antigens – A and B – on the surface of red blood cells. Antigens are substances that can trigger an immune response if they are foreign to the body. In total, there are eight different common blood types A+, A-, B+, B-, O+, O-, AB+, AB-. See http://www.redcrossblood.org/learn-about-blood/blood-types.html.

[5] CSTC-A is organized into eight Essential Functions that are arranged to provide the framework and guidelines to achieve Afghan sustainability. Each EF is comprised of components. EF-5 is responsible for ANA sustainment, including supply and maintenance. Under EF-5, EF 5.2 is responsible for training, advising, and assisting the Afghan National Defense Forces on point of injury care, ground medical evacuation, medical logistics, equipment maintenance, medical support planning, and medical staffing. Additionally, EF 5.2 advisors are responsible for ministry level advising aimed at developing a comprehensive National Healthcare System.

[6] EF 5.2 assists the ANA on the procurement of medical supplies, including assisting with identifying equipment requirements, building procurement packages, contracting for the equipment, and ensuring the receipt of equipment at medical facilities through the foreign military sales system or through the North Atlantic Treaty Organization (NATO). After the U.S. transitioned security responsibilities to the ANDSF in January 2015, each medical unit within the ANA became responsible for identifying annual requirements for medical supplies including the blood testing kits, and sending these requirements through the MOD medical logistics system. According to CSTC-A, this equipment was procured through the NATO's Support and Procurement Agency.

Resource Information System (AHRIMS), the Afghan National Defense and Security Forces personnel database that includes personally identifiable information, such as medical data, on soldiers and civilian workers from the ANA and Afghan National Police for attendance and payroll purposes.[7] The information we received raised suspicions that the service provider used by the ANA to collect and test blood from soldiers, as required by Afghan policy, was charging the recruits to test their blood, but not doing a valid blood typing or recording accurate blood types in AHRIMS. The source also expressed concern that ANA soldier blood type records in AHRIMS may be inaccurate because it appeared that a suspiciously large number of soldiers were reported to have the same blood type.

In response to that complaint, we conducted this review to determine the processes by which the ANA collects and records the blood types of its soldiers in AHRIMS, the extent to which blood type data stored in AHRIMS appears to be accurate, and the effect of any gaps in the collection or recording of blood type on the ANA's ability to conduct its mission. To accomplish our objectives, we reviewed studies conducted on the efficacy and safety of the Afghanistan blood supply system, as well as standard medical procedures for supplying and transfusing blood during combat operations. We obtained and analyzed blood type data recorded in AHRIMS to determine the range of blood types recorded and the percentage of soldiers' blood types unaccounted for in the system. We interviewed officials from DOD, DLA, CSTC-A, the training, advising, and assisting mission, and the Afghan MOD. We also interviewed officials from the U.S. Armed Services Blood Program, the Office of the Surgeon General, U.S. Medical Command, Deployment Health Branch, and the former Command Surgeon within EF 5.2 to determine how ANA blood is collected and blood type is tested during the medical accessions process—a process intended to detect any medical issues that might prevent a recruit from serving successfully— to support military medical readiness. We conducted our work in Washington, D.C. and Kabul, Afghanistan from January 2017 through December 2017, in accordance with SIGAR's quality control standards. These standards require that we carry out work with integrity, objectivity, and independence, and provide information that is factually accurate and reliable.

MEDICAL ACCESSIONS AND BLOOD TYPE COLLECTION

Part of the recruitment process for ANA soldiers includes a medical evaluation intended to detect any medical issues that might prevent a new recruit from serving successfully, and to ensure recruits are physically fit for the rigors of military training and occupational requirements. This process, known as the medical accessions process, includes requirements for several blood tests designed to identify blood type and infectious disease status, which typically includes screening for hepatitis B and C, venereal diseases, and HIV. Immunizations are also provided to new recruits during this process to prevent the spread of common diseases, such as meningitis, measles, and hepatitis. The results of the blood tests, and medical evaluations, are recorded in the recruit's hard copy (paper) file and stored on hand-written logs at designated locations. If computer access and trained personnel are available, blood type may also be inputted into AHRIMS, the ANA's personnel database. Photo 1 shows an ANA soldier getting blood drawn.

Photo 1 –Blood Sample Drawn from ANA Soldier

Source: Photo provided by the Office of Secretary of Defense

[7] AHRIMS contains, among other things, attendance rates and a variety of personally identifiable information on soldiers, including education level, training, and medical status. The ANDSF is transitioning from AHRIMS to the Afghan Personnel Pay System to provide better accountability of force strength, improve record keeping, and reduce problems associated with unverified and absent personnel. The transition is expected to take 12 months.

All military and civilian MOD personnel are required to have their blood collected to determine blood type and screen personnel for infectious diseases before they report for duty. For new recruits in and around Kabul, the Afghan National Army Recruiting Command (ANAREC)—the ANA's command for staffing the army—is responsible for collecting information on blood type, as well as for providing a physical examination, to determine medical suitability. For personnel outside the Kabul area, information on blood type, and other medical evaluations, may be completed outside of ANAREC at other health facilities. In those cases, ANAREC provides a medical form to recruits to be filled out and stamped by an attending physician at a local hospital. Completed and stamped forms documenting the results of blood tests are required for new recruits to be issued an identification card, and blood type is recorded on MOD ID cards.

THE PROCESS USED BY ANAREC TO COLLECT AND TEST BLOOD SINCE AT LEAST JANUARY 2017 DOES NOT ENSURE ACCURATE COLLECTION OR RECORDING OF TEST RESULTS

In March 2016, CSTC-A turned over the ANA recruitment mission to ANAREC. However, according to an advisor working with ANA personnel at ANAREC, when CSTC-A turned over the recruitment mission, ANAREC did not have the necessary supplies and equipment to test new recruits for blood type and infectious diseases.[8] The advisor stated that the ANA's Medical Command (MEDCOM), which oversees ANAREC, assumed responsibility for this task, but MEDCOM stopped drawing blood from recruits shortly after assuming this responsibility because it ran out of medical supplies. According to the CSTC-A Command Surgeon and the ANAREC advisor, because ANAREC did not have the necessary supplies and equipment to collect blood, it required that new recruits go to a local physician to have their blood tested and pay for the blood tests (without reimbursement from ANAREC) and have the attending physician stamp an official ANA medical form to verify the accuracy and completion of the blood tests. This resulted in a scenario wherein ANAREC was entirely reliant on unaffiliated doctors to perform this critical, required service, and the command had no assurance that the tests were actually conducted or accurate.

Failure of the ANA to perform or validate routine blood testing of new recruits is not a new issue. In 2012, an article published in *BioMed Central Infectious Diseases* reported that ANA recruitment centers were not routinely performing screening on new recruits, and blood tests for infectious diseases were not being conducted.[9] Researchers reported that the ANA relies primarily on personal hygiene and vaccination at enlistment, instead of preventive medicine programming, such screening for infectious diseases to ensure that its recruits are medically fit for duty.[10] While health education plays an important role in reducing the spread of infectious diseases, military personnel are at risk of contracting infectious diseases due to interactions with soldiers wounded in combat and bacteria arising from infections.[11]

During the course of our review, we received additional information from an ANAREC advisor, confirming initial concerns, that physicians may be stamping medical forms without actually collecting and testing blood samples, or without conducting any medical examinations. According to CSTC-A EF-5 and an ANAREC advisor, neither ANAREC nor MEDCOM has tested blood from new ANA recruits since at least January 2017. Our analysis of available documentation found that between January and July 2017, 15,400 new recruits did not have their blood tested or results validated by ANAREC before entering the ANA ranks, and as a result, the blood type of at least 9 percent of the total ANA force remains unconfirmed.[12]

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[8] CSTC-A employs contractors to help oversee these processes when the security situation allows.
[9] Catherine Todd et al., "Cross-sectional Assessment of Prevalence and Correlates of Blood-Borne and Sexually-Transmitted Infections among Afghan National Army Recruits," *BioMed Central Infectious Diseases* no. 12 (196) [2012]; http://www.biomedcentral.com/1471-2334/12/196.
[10] *Id.*
[11] Zheng Jie Marc Ho et al., "Emerging and Re-emerging Infectious Diseases: Challenges and Opportunities for Militaries," *Military Medical Research* no. 1 (21) [2014]; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4341224/.
[12] As of August 2017, the reported size of the ANA was 174, 450.

According to the ANAREC advisor, ANAREC's medical department has made repeated requests to MEDCOM for blood typing equipment, but these requests have been rejected because ANA officials overseeing medical logistics requests claimed that there was no dedicated budget to fund such equipment. A CSTC-A EF5.2 official reported that CSTC-A was unable to validate whether or not ANAREC medical personnel submitted official requests for resupplying equipment for blood typing because that is an internal Afghan government process. The official reported that CSTC-A EF 5.2 advisors are aware of challenges in the ANA medical logistics system and are currently providing training and assistance on logistics processes to improve compliance with supply chain procedures.

POOR RECORD KEEPING MAY HAVE RESULTED IN ANA SOLDIERS RECEIVING THE WRONG TYPE OF BLOOD DURING TRAUMA CARE

A U.S. Air Force public health officer that we met with, formerly assigned to CSTC-A EF 5.2, reported that the overall medical record keeping within the ANA is unreliable, and the quality of record-keeping and processes for medically screening soldiers occurring at ANA medical accessions facilities in Afghanistan varies greatly from site to site due to differences in equipment and capacity.[13] He also told us that the ANA does not have an official system of record to track the medical data of new recruits, including blood type, and, as a result, it cannot reliably determine which soldiers have been blood-typed or screened for infectious diseases.

According to a 2015 *New York Times* article, the blood type that Afghan soldiers have listed on their identification cards to assist medics is often incorrect."[14] The public health officer we spoke with told us that, in part because of the widespread illiteracy in the ANA, recorded medical information is likely inaccurate. He stated that based on his experience in Afghanistan, ANA soldiers often have no medical documentation associated with their name (apart from the paper record housed at designated ANA facilities) and there is no way to quickly identify their blood type, disease status, or immunization history when they arrive for trauma care. He said that ANA soldiers wounded on the battlefield are often given "combat names," because there is no official way to link an injured solider with his real identity or medical records. Even if blood type is recorded on a soldier's ID card is correct, this information becomes useless if the soldier loses his card or does not have it in their possession during combat operations. According to a CSTC-A EF-5.2 official we spoke with, the value of having an official system of record, such as AHRIMS, is to allow the ANA to record and store blood type and other medical data so that management can effectively make critical care decisions. This is especially important given the continual increases in ANA combat causalities.[15]

Further complicating matters, ANA units commonly employ what is known as a walking blood bank and draw blood from healthy personnel as needed. A walking blood bank is particularly important when frozen blood and its components are otherwise unavailable to support massive blood loss, such as in combat situations. According to the United Kingdom's Blood Care Foundation,[16] walking blood banks are comprised of a voluntary group of people who are prepared to be called on to donate blood to meet a particular emergency.[17] In emergency situations, when there is no time to perform any prospective diagnostics, such as rapid testing for blood type or disease status, blood donors are selected from a walking blood bank on the basis of an epidemiological interview and medical examination. The use of a walking blood bank makes the efficacy of the

[13] When we met with the public health officer, he was stationed in the Office of the Surgeon General, as Acting Chief of U.S. Medical Command's Deployment Health Branch Public Health Division.
[14] Joseph Goldstein, "Afghan Security Forces Struggle Just to Maintain Stalemate," *The New York Times,* July 22, 2015.
[15] Afghan Security Force casualties have "steadily increased" since January 2015, with 2,531 service members killed in action between January 1, and May 8, 2017 alone. See SIGAR, *Quarterly Report to the United States Congress*, July 30, 2017, p. 100. As of October 2017, DOD has classified the number of Afghan combat casualties.
[16] The Blood Care Foundation is a charitable, non-profit organization registered in the United Kingdom in 1991. The Foundation operates a blood care program, which is designed to provide screened blood, in an emergency, to its members in any part of the world (*see,* http://www.bloodcare.org.uk/index.html).
[17] According to the United Kingdom's Blood Care Foundation, each volunteer participating in a walking blood bank has to be interviewed to screen out those whose medical history or life style would make them unsuitable to act as donors. Those who pass the interview have a number of tests performed to ascertain their blood group and antibody status. These tests include those for HIV 1 and 2, hepatitis B and C, syphilis and any other disease, such as malaria, which might be endemic in that particular country.

ANA medical accession process and record-keeping extremely important as the potential for the spread of infectious disease and death is especially high given the use of this practice.

According to a former CSTC-A Command Surgeon we met with, Afghan soldiers want to know that their military will take care of them if they are injured, and contracting new diseases during their service time would hurt both combat and recruitment efforts. She also stated that if a solider contracts a disease then he will likely be unemployable, and this may also have an impact on whether he is socially accepted by his tribe and family. The U.S. Air Force public health officer we spoke with told us that because the ANA has not been collecting and testing blood, or routinely retesting soldiers for infectious diseases, the ANA has been over--vaccinating soldiers to ensure that infectious diseases and blood borne pathogens are kept away from the ANA blood supply. He stated that the excess use of vaccinations wastes the limited vaccine resources available to ANA.

An advisor assisting ANA personnel at ANAREC told us that he was aware that ANA soldiers have been killed from receiving the wrong type of blood when injured in combat. However, neither he nor CSTC-A was able to provide the number of soldiers killed as a result of receiving the wrong type of blood.

APPROXIMATELY 45 PERCENT OF MOD PERSONNEL DO NOT HAVE THEIR BLOOD TYPE RECORDED IN AHRIMS

AHRIMS has the capability to serve as a centralized, automated repository for ANA blood type data, but the ANA is not required to input blood type into AHRIMS during the medical accessions process and the data stored in the system is incomplete and reportedly unreliable. While blood type is not required to be entered into AHRIMS, the system has a "blood type" field, and the information may be recorded in the system if the AHRIMS operator chooses to upload the information during the recruitment process.

We asked CTSC-A to provide us with AHRIMS data including the number of entries in AHRIMS associated with each blood type for ANA personnel and those entries that have been left empty or unpopulated. Based on the AHRIMS data provided by CSTC-A, 77,178 (45 percent) of the 171,510 active MOD records in AHRIMS do not have their blood type recorded in the system as of August 2017.[18] See table 1 for the total number of active MOD personnel who have their blood type recorded in AHRIMS and the number of personnel that do not have their blood type recorded.

Table 1 - Total Active MOD Records with and without Blood Type Recorded in AHRIMS as of July 2017

Blood Type	# Personnel	Percent Total
A +	25,696	
A -	1,819	
O +	26,458	
O -	2,169	
AB +	8,620	
AB -	1,903	
B +	26,063	
B -	1,634	
Total	**94,362**	**55%**
Left Empty/Not Populated	77,148	**45%**
Total Active MOD Records	**171,510**	

Source: SIGAR analysis of AHRIMS data.

Of those blood types recorded in AHRIMS for current MOD personnel, we found that blood group frequencies reported are similar to the overall blood group frequencies reported for a sample population in Kabul, Afghanistan in 2014. According to a study published by *Transfusion and Apheresis Science* in May 2014, which looked at a retrospective sample of 250 patients blood types at the Kabul Military Hospital, the frequency of blood types for those sampled was spread almost evenly across three blood types—O, A, and B—

[18] Active records are those currently linked to the MOD position list, or "tashkil."

with a small percentage reporting to have type AB blood.[19] We found that the blood types recorded in AHRIMS follow a similar pattern and appear representative of the blood types reported in the 2014 study.[20] See table 2 for a distribution of blood types identified by the research sample, and as reported in AHRIMS by the MOD.

Table 2 –Blood Type Reported Frequencies (%) in Kabul vs. Blood Type Reported for MOD personnel in AHRIMS

Blood Type (both positive and negative)	Study Sample	MOD – AHRIMS
O	34.8	30.1
A	25.6	28.9
B	29.2	29.1
AB	10.4	11.9

Source: *Transfusion and Apheresis Science*, Vol 50 (2):307-308; AHRIMS data as of July 2017.

Despite the similar distribution of blood types to the general population recorded in AHRIMS, CSTC-A questioned the validity of the AHRIMS blood type data and reported that ANA personnel statistics are not accurate or comprehensive. A U.S. Air Force public health official we met with also expressed doubts about the accuracy of data in AHRIMS given the ANA's high illiteracy rate. The accuracy of data in AHRIMS is not a new issue, as we have previously found that AHRIMS contains missing, inaccurate, and outdated personnel records that have not been fully corrected or removed from the system leaving limited assurance that personnel and payroll data recorded are accurate.[21] Furthermore, when asked whether ensuring blood type was recorded in AHRIMS would help to address some of the concerns related to poor recording keeping, the public health official we met with stated that even if AHRIMS were to serve as a national database for ANA medical information, the lack of internet access, computer equipment, and the institutional knowledge and skills to use such a system, and the fact that AHRIMS was not designed in the local language, make using AHRIMS to track blood type and assist in trauma care impractical. CSTC-A reported that there are no current plans to require that blood type be inputted into AHRIMS.

CONCLUSION

In January 2017, the ANA stopped collecting and testing blood, or validating test results, from new recruits, and between January and July 2017 approximately 15,400 new ANA recruits did not have their blood tested before entering the ANA ranks. This is equivalent to approximately 9 percent of the total ANA force. Knowing blood types and screening for infectious disease is critical to the sustainability of the ANA, as receiving blood that has not been correctly typed or screened may be life-threatening. However, the ANA does not have a complete and accurate system to track the medical data of new recruits, and, as a result, does not know which soldiers have been blood-typed or screened for infectious diseases. This puts both soldiers and military readiness at risk. In addition, the ANA's unreliable and inaccurate medical record keeping makes using AHRIMS, an established system capable of serving as a centralized, automated repository for medical information, or other electronic systems, difficult due to the challenges associated with ANA literacy and technical skills related to using computer systems, internet access, and institutional knowledge.0

Developing a credible and accessible system to ensure that soldiers are free from infectious diseases and can provide blood to wounded soldiers is an important component to the health of soldiers and the sustainability of the ANA. Therefore, we suggest that CSTC-A develop a plan to improve the ANA's medical accessions process,

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[19] C. Garcia-Hejl et al, "Blood Group Antigens Frequencies in Kabul, Afghanistan," *Transfusion and Apheresis Science*, no.50 (2) [2014]. https://www.ncbi.nlm.nih.gov/pubmed/24492066.

[20] CSTC-A also told us that blood type fields are not populated with a default value.

[21] We previously reported on the accuracy of the data recorded in AHRIMS, and found that missing, inaccurate, and outdated personnel records have not been fully corrected or removed from the system leaving limited assurance that personnel and payroll data recorded are accurate. See SIGAR, *Afghan National Police: More than $300 Million in Annual, U.S.-funded Salary Payments Is Based on Partially Verified or Reconciled Data*, SIGAR 15-26-AR, January 7, 2015; and SIGAR, *Afghan National Army: Millions of Dollars at Risk Due to Minimal Oversight of Personnel and Payroll Data*, SIGAR 15-54-AR, April 23, 2015.

including (1) assisting the ANA in conducting blood and/or validating blood testing; (2) requiring the use of AHRIMS, or other suitable systems, to record blood type and other medical data; and, (3) training ANA personnel on the use of AHRIMS, or other suitable systems, to collect this data and expanding the usability of AHRIMS throughout Afghanistan. We also suggest that CSTC-A work with ANA MEDCOM to develop a process aimed at testing for, and correcting, errors in soldiers' medical records as reported in AHRIMS and soldiers identification cards.

AGENCY COMMENTS

We provided a draft of this report to DOD for comment on January 26, 2018. We received written comments from CSTC-A on March 2, 2018. In its comments, CSTC-A concurred with SIGAR's suggestions to strengthen the ANA's medical accession process and assist the ANA in collecting and recording soldiers' blood type to maintain more accurate records. CSTC-A pointed out that the ANA will transition away from AHRIMS, but acknowledged the importance of maintaining accurate records regardless of the system used. CSTC-A stated that the ANA is required to record a soldier's blood type [when collected], and it will ensure that "blood type is documented in the [new] system of record for maintaining ANA solider personnel information." CSTC-A also stated that it will "continue to provide training, assistance, and advising for ANA medical testing processes utilizing common standards established by the World Health Organization and Centers for Disease Control and Prevention," and support the ANA's medical procurement process "to ensure required equipment and supplies are on hand and operational." Furthermore, CSTC-A stated it is "standard protocol to test blood before any transfusion, regardless of any previous recorded blood type test, and a soldier's blood type, as recorded in their file, does not affect the direct administering a transfusion, or classifying a person's blood for donation." However, we understand that in emergency situations, blood tests on blood donors may be performed retrospectively. Given the increased potential for the spread of infection and communicable disease in combat situations, it is imperative that CSTC-A work with the ANA to ensure that blood types are recorded correctly on soldiers' medical records and identification cards. CSTC-A's written comments are reproduced in appendix I.SIGAR incorporated technical changes into its report as appropriate to reflect the ANA's upcoming transition from AHRIMS to the Afghan Personnel Pay System.

NON SENSITIVE INFORMATION RELEASABLE TO THE PUBLIC

DEPUTY CHIEF OF STAFF SECURITY ASSISTANCE
COMBINED SECURITY TRANSITION COMMAND – AFGHANISTAN
KABUL, AFGHANISTAN
APO AE 09356

DCOS SA/CSTC-A

25 February 2018

MEMORANDUM THRU

United States Forces – Afghanistan, Audit Cell, APO AE 09356
United States Central Command (CCIG), MacDill AFB, FL 33621

FOR Special Inspector General for Afghanistan Reconstruction, 2530 Crystal Drive, Arlington, VA 22202-3940

SUBJECT: SIGAR SP-161 Draft Report for Comment "Review of the collection and procedures of Blood Testing for Afghanistan's National Army" (SIGAR 18-XX-SP)

1. Below is the CSTC-A response to SIGAR SP-161, Audit Draft Report for Comment "Review of the collection and procedures of Blood Testing for Afghanistan's National Army" (SIGAR 18-X-SP). This response highlights some of the suggestions identified. CSTC-A also realizes the suggestions are based on dated information and the does not account for the transition away from AHRIMS. We understand the intent is to maintain accurate records, regardless of the system of record.

2. **DCOS SA/CSTC-A Management Response –**

Developing a credible and accessible system of record to ensure that soldiers are free from infectious diseases and can provide blood to wounded soldiers is an important component to the health of soldiers and the sustainability of the ANA. Therefore, we suggest that CSTC-A develop a plan to improve the ANA's medical accessions process, including a. CSTC-A develop a plan to improve the ANA's medical accessions process, including

(1) assisting the ANA in collecting blood and/or validating blood testing;

(2) requiring the use of AHRIMS to record blood type and other medical data; and,

(3) training ANA personnel on the use of AHRIMS to collect this data and expanding the usability of AHRIMS throughout Afghanistan.

(1) CSTC-A concurs with SIGAR's suggestions (with the appropriate system of record for files) and will continue to TAA the ANA medical testing processes utilizing common standards established by the World Health Organization and Centers for Disease Control and Prevention for blood type (ABO group) and Rh type (positive or negative). It is standard protocol to test blood before any transfusion, regardless of any previous recorded blood type test. After ensuring blood type, and blood compatibility, type-specific plasma is administered. A Soldier's blood type, as recorded in their file, does not affect the direct administering a transfusion, or classifying a person's blood for donation. Testing to ensure compatibility is necessary prior to transfusions using type-specific plasma.

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(2) Blood type will be documented in the system of record for maintaining ANA Solider personnel information. Recording a Soldier's blood type continues to be required.

3. CSTC-A continues to support the ANA to ensure required equipment and supplies are on hand and operational. The procurement process, including medical equipment, continues to develop as processes and procedures improve. CSTC-A supports, through TAA, continued improvements in procurement and sustainment.

4. CSTC-A is committed to supporting our Afghan partners through training, advising, and assisting the ANDSF in their efforts to provide the best medical care possible to maintain the health of their personnel. The point of contact for this memorandum is Mr. Jeffrey Zielinski at DSN 318-449-9935 or via email at jeffrey.m.zielinski2.civ@mail.mil.

KELLY.ANDREW.DONALD.JR.1025510875
ANDREW KELLY

COL (OF-5), US Army
Chief of Staff, CSTC-A

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Public Affairs Officer

- Phone: 703-545-5974
- Email: sigar.pentagon.ccr.mbx.public-affairs@mail.mil
- Mail: SIGAR Public Affairs
  2530 Crystal Drive
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