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PERFORMANCE EVALUATION

STRENGTHENING PHARMACEUTICAL SYSTEMS (SPS)



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ACRONYMS

AMR	Anti-Microbial Resistance
ANDS	Afghanistan National Development Strategy
ANPA	Afghanistan Nationwide Pharmacists Association
ANMSO	Afghan National Medicines Services Organization
API	Avicenna Pharmacy Institute
BPHS	Basic Package of Health Services
CHC	Community health clinic
CHW	Community health worker
CMS	Central Medical Store
COP	Chief of Party
CPDS	Coordinated Procurement and Distribution System
CSC	Commodity Security Committee
DCOP	Deputy Chief of Party
DEC	Development Experience Clearinghouse
DEWS	Disease Early Warning System
DTC	Drug and Therapeutics Committee
EML	Essential Medicines List
EPHS	Essential Package of Health Services
FY	Fiscal Year
GCMU	Grants and Contracts Management Unit
GDCM	General Directorate of Curative Medicine
GDHR	General Directorate of Human Resources
GDPA	General Directorate of Pharmaceutical Affairs
GIHS	Ghazanfar Institute of Health Sciences
GoIRA	Government of Islamic Republic of Afghanistan
HLIED	Health Legislation Implementation Ensuring Directorate
HMIS	Health Management Information System
IHSSSP	Integrated Health Services and Systems Strengthening Project
IR	Intermediate Results
LML	Legal Medicine List
MDS	Medicine and Drug Safety
MoD	Ministry of Defense
MoF	Ministry of Finance
MoPH	Ministry of Public Health
MSH	Management Sciences for Health
NDTC	National Drug and Therapeutics Committee
NGO	Non-Governmental Organization
NMFB	National Medicines and Food Board
NMP	National Medicine Policy
OSSD	Office of Social Sector Development
PCH	Partnership Contracts for Health
PDQ	Procurement, Distribution and Quantification

PE	Pharmaceutical Enterprise
PIRS	Performance Indicator Reference Sheet
PLIS	Pharmaceutical Logistic Information System
PMIS	Pharmaceutical Management Information System
PMP	Performance Monitoring Plan
PPHO	Provincial Public Health Offices
PRIS	Pharmaceutical Registration Information System
PSM	Procurement and Supply Management
QA	Quality Assurance
QC	Quality Control
RMU	Rational Medicine Use
SCD	Supply Chain Development
SCO	Supply Chain Operations
SEHAT	System Enhancement for Health Action in Transition
SOW	Statement of Work
SPS	Strengthening Pharmaceutical Systems
STG	Standard Treatment Guideline
USAID	United States Agency for International Development

I. EXECUTIVE SUMMARY

1. PROJECT BACKGROUND

A strong pharmaceutical sector is essential for Afghanistan considering the current status of population health and the burden of disease. Afghanistan continues to face high infant and child mortality, primarily due to treatable conditions such as upper respiratory infections and diarrheal diseases. The burden of non-communicable diseases (NCDs) is also growing, with Afghanistan ranking the worst in premature mortality due to heart disease, depression, and diabetes, in comparison to competitor countries.

The pharmaceutical sector in Afghanistan consists of a largely donor-dependent public sector and an unregulated private sector. Management Systems for Health (MSH)—through its Strengthening Pharmaceutical Systems (SPS) Program— has been providing technical assistance and support to the Ministry of Public Health (MoPH) to improve the pharmaceutical system since 2008. In August 2011, USAID awarded an Associate Award to MSH under the SPS Program to build capacity to effectively manage all aspects of pharmaceutical systems and services. On August 27, 2015, the current iteration of the SPS program will come to an end, and USAID is planning for a follow-on project to begin shortly thereafter. USAID will contribute on-budget support to the World Bank’s System Enhancement for Health Action in Transition (SEHAT) Program.

The purpose of this evaluation is to assess the effectiveness of the SPS program in improving and strengthening various strategic components of the pharmaceutical sector in Afghanistan, including regulatory and quality assurance systems, supply chain management, pharmaceutical management information systems (PMIS), human resource capacity, the delivery of pharmaceutical services, and the rational use of medicines.

The findings and recommendations of this final performance evaluation of SPS will be utilized by USAID as input into the design of the SPS follow-on project. USAID will also use the results of this evaluation to determine resource allocation decisions and to make recommendations to the MoPH and other donors and stakeholders regarding the future development of pharmaceutical supply and distribution systems in Afghanistan.

2. EVALUATION QUESTIONS, DESIGN, METHODS AND LIMITATIONS

The evaluation approach and methodology consisted of both qualitative and quantitative methods. Qualitative methods included primary data collection, a document review, and key informant interviews and focus groups with key stakeholders. We also visited a sample of BPHS/EPHS¹ health facilities and private pharmacies to conduct exit surveys with patients.

¹ Basic Package of Health Services/Essential Package of Hospital Services

We conducted secondary data analysis of our site visits and surveys. Finally, we developed a tool to analyze the Performance Monitoring Plan (PMP) data provided by the MSH SPS Monitoring and Evaluation (M&E) team, as well as quarterly and annual reports developed by the SPS team for USAID.

A simple random sample, stratified by SPS-support status (SPS-supported vs. not-SPS supported), was used to select 38% of public health facility (BPHS/EPHS) pharmacies in Kabul, Herat, Badakhshan, and Kandahar provinces (Figure 2). In order to conduct site visits and patient exit surveys, we used a convenience sampling approach for private pharmacies based on proximity to the health facility being visited. The team would first visit the health facility selected in the sample and then visit one or two private pharmacies in close proximity. Due to security and travel restrictions in several provinces, particularly Herat, we were only able to implement our survey in four of the eight selected health facilities.

3. FINDINGS AND CONCLUSIONS

Through various activities in a largely fragmented pharmaceutical sector, the SPS program has strengthened the capacity of the MoPH, NGOs contracted by the MoPH to provide health services (called PCH-NGOs), and other organizations, particularly the General Directorate of Pharmaceutical Affairs (GDPA). Improvement has been seen in policy development, inventory and stock management, and procurement at the central-level. However, SPS activities have not sufficiently improved policy implementation and coordination, especially at the provincial and local levels, in the regulation, quality, and rational use of medicines, and in evidence-based decision-making. *Most importantly, we found that while SPS is a nationally-recognized program with excellent leadership, the program design is not community-centered, and thus has had a minimal impact on access to and the use of quality pharmaceutical products and services at the local level.*

1. The SPS program has strengthened the MoPH, particularly GDPA, through improved policy development (e.g. National Medicines Policy) and decision-making at the national-level. However, the implementation of policies in both the public and private sector is lacking (e.g. pharmacy inspections, unlicensed pharmacies), especially at the provincial and local levels.
2. The procurement and supply chain management undertaken by SPS have ensured availability of high quality medicines at the facilities managed by the PCH-NGOs. This however has not resulted in capacity building of MoPH and the PCH-NGOs in undertaking procurement, which would be a mandate for these entities under the proposed SEHAT project. There has been no progress in the activity of establishing the quality control lab, which is critical for pharmaceutical quality assurance.
3. SPS lacks a clear exit strategy. It is involved in a range of program activities with various organizations, including the National Medicines and Food Board (NMFB). It has weak coordination with MoPH/GDPA, which has threatened MoPH/GDPA

ownership of pharmaceutical affairs, and consequently, the accountability and sustainability of the SPS activities.

4. The Essential Medicines List (EML) across all levels of care is outdated, and, along with the Standard Treatment Guidelines, is not available at nearly all SPS supported health facilities.
5. SPS supply does not align with the EML or with procurement patterns based on aggregate quantification of health facilities supported by the PCH-NGOs. Therefore, many facilities encounter shortages of essential medicines prescribed to their patients.
6. According to various key informants, there are more than 30 private pharmacy schools and 12,000 private pharmacies in the country; yet, the private sector is excluded from current SPS capacity-building activities, such as curriculum revisions and seminars/workshops on rational drug use.
7. In the community, medicines are delivered to patients from across all levels of care (from hospitals and comprehensive health centers that have a pharmacies onsite to basic health centers and health posts that do not have pharmacies) and primarily prescribed by community health workers (CHWs), nurses, and other prescribers, not by pharmacists. Yet, the SPS program targets only pharmacies and pharmacists.
8. PMIS/PLIS² data collection and reporting does not align with the existing Health Management Information System (HMIS), and does not incorporate a quality improvement framework, thus limiting evidence-based decision-making. Furthermore, current SPS PMIS/PLIS training activities are focused at the central level of the PCH-NGOs, with limited coordination with the health facilities. This potentially limits monitoring and evaluation capacity at the local level.
9. SPS project management performance data collection and reporting lacks coordination, report validation, PCH-NGO oversight, and is limited to a select number of health facilities. Thus, it inadequately supports effective M&E, especially at the facility-level.
10. There is notable variation at the provincial level in key indicators, such as product availability, labeling of dispensed medicines, and pharmacy staffing patterns. One explanation might be that PCH-NGO practices, and/or the implementation of SPS activities at supported health facilities, affect the quality of pharmaceutical services.

² Pharmaceutical Management Information System/ Pharmaceutical Logistics Information System

11. The evaluation team has identified numerous knowledge gaps that need to be addressed in areas such as local prescribing patterns, alignment of program activities with priority needs at the community-level, and improvement of the delivery and use of medicines and pharmaceutical services.

Following were the lessons learned from the SPS program implementation till date:

- It is important to consider the capacity of field staff across all levels of care, including CHWs, who are more likely than a pharmacist to deliver medicines to the community.
- Regular revision and dissemination of STGs and EMLs is critical for improving prescription and procurement, and for use of essential medicines.
- Communities matter and SPS program activities have not been effectively translated at the implementation level to enhance the delivery of quality pharmaceutical services.
- The private sector, particularly private pharmacies, provides medicines to the vast majority of the population, including those that utilize public health facilities, and should not be excluded from SPS programming efforts.
- Affordability of medicines is not addressed by SPS program and may influence access to essential medicines in various population segments, which is the cornerstone of the SPS program.
- PCH-NGOs supporting the SPS program have various strengths and weakness, and their different abilities to deliver medicine may impact the

4. RECOMMENDATIONS

Based on the purpose, findings, and conclusions of this performance evaluation, the following recommendations are offered, which correspond to the conclusions. We provided the following recommendations based on priority. In summary, in the follow-on project design, the current mandate of SPS to provide technical support to MoPH in improving the pharmaceutical regulatory and quality assurance systems should continue, but should focus more on implementation capacity, such as inspection capabilities of GDPA at national and provincial levels.

High Priority

1. In the follow-on project, USAID should provide the necessary financial and technical resources to enable the MoPH to establish standardized procurement guidelines and develop the MoPH's capacity for undertaking high-quality procurement.
 - a. Specifically, we recommend that the MoPH (not PCH-NGOs, as currently envisaged) take the responsibility for procurement under SEHAT in order to ensure cost-effective procurement of quality medicines that rely on facility-based quantification.
2. In the follow-on project, USAID should prioritize and provide technical and financial resources to assist the MoPH/HMIS in establishing a Quality Improvement Strategy to inform and develop a comprehensive PMIS/PLIS that is designed to align with the existing HMIS, with data collection and reporting done at the local level.

3. In the follow-on project, USAID should expand the SPS mandate, and provide the necessary resources to incorporate capacity-building efforts in rational medicines use and medicines safety to field staff across all levels of care, specifically CHW, nurses, and other prescribers, who are more likely than a pharmacist to deliver medicines to the community. It is especially important to target women CHWs and nurses, considering our finding that a disproportionate number of women patients seek treatment at public health facilities.
4. USAID should develop a clear exit strategy for SPS in the next ten months of programming. It should establish an administrative and management structure to undertake activities planned in the National Medicine Policy (in the follow-on project) that delineate the role of GDPA leadership in the NMFB transition into the FDA in order to ensure ownership, accountability, and long-term sustainability of the SPS activities.
5. Specifically, outline a timeline of processes and activities for transition of NMFB to FDA and clearly defined role of GDPA, focusing on regulatory oversight at central and provincial levels. USAID should provide the financial and technical resources to conduct community-based assessments on prescribing practices, STG compliance, and the use of medicines at the household-level. These assessments would inform program activities, including SPS drug supply, with patterns of medicines use in the community. Specific recommendations for initial studies are outlined in the report.
6. In the next ten-months of programming, USAID should provide SPS with external support in order to develop a PMP dashboard for effective monitoring and evaluation at the management- and facility-levels for all SPS-supported health facilities.

Moderate Priority

7. Within the next ten months of programming, SPS should revise the national EML for primary care levels (e.g., CHC, BHC, HP) to reflect current treatment patterns, especially for the NCDs (heart disease and diabetes) and for mental health issues, which are increasingly prevalent in the population. In addition, in coordination with PCH-NGOs and the MoPH/GDPA, SPS should ensure Standard Treatment Guidelines (STGs) are available at all health facilities and all staff are informed and trained on their purposes.
8. In the next 10-months of programming, USAID should provide the necessary resources to enable SPS to facilitate the expansion of partnerships with private academic institutions providing pharmaceutical education in Afghanistan, and to establish linkages with internationally recognized pharmacy schools.
 - a. SPS should also work with the Afghanistan National Pharmacist Association (ANPA) to incorporate pharmacy staff from private pharmacies into their training activities.

9. In the follow-on project, USAID should allocate the necessary resources to ensure that SPS medicine supplies are aligned with a revised EML and with local prescribing patterns. Procurement should rely on facility-based quantification in order to prevent stock-outs of essential medicines prescribed to patients.

II. INTRODUCTION

1. PROJECT BACKGROUND

CONTEXT

While Afghanistan has achieved significant progress in the health sector since 2002, including improvement on population health indicators, the country continues to face major development challenges, due in part to the ongoing conflict. These development challenges necessitate a sustained, proactive partnership between the international community and the Government of the Islamic Republic of Afghanistan (GIRoA). The U.S. Government's health and development programs in Afghanistan directly support the goal of achieving national health targets, as outlined in the Afghanistan National Health and Nutrition Sector Strategy and the Afghanistan National Development Strategy (ANDS), which is based on the Millennium Development Goals (MDGs).

The Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) are the cornerstone of the strategy for the Ministry of Public Health (MoPH) and all international donors, including USAID. USAID's technical support to the BPHS / EPHS focuses on six primary objectives:

1. Strengthening the leadership and management capabilities of the central MoPH to support the delivery of BPHS and EPHS services in 13 provinces, primarily through non-governmental organization (NGO) service providers;
2. Enhancing staff capacity of the 17 partner Provincial Public Health Offices (PPHO) of the MoPH to support the delivery of the BPHS and EPHS;
3. Strengthening the MoPH's disease surveillance systems, such as the Disease Early Warning System and the Acute Flaccid Paralysis surveillance system;
4. Improving health data collection, analysis, and management at all levels of care and in facilities and communities where services are delivered;
5. Strengthening hospital financial and procurement accountability and responsibility; and,
6. Strengthening pharmaceutical management systems and staff capacity.

In 2014, 547 health facilities and more than 6,000 health posts provided basic primary health care services to more than half of the Afghan population.

The pharmaceutical sector in Afghanistan, both the public and private, is largely unregulated, with very limited information on pharmaceutical utilization, expenditures, and quality, nationally and sub-nationally. Pharmaceutical product availability in the public sector is highly dependent on international donors, including USAID, with a largely uncoordinated supply chain. The policy and regulatory framework for the pharmaceutical sector is outdated and/or poorly-enforced, leading to unknown quality assurance of pharmaceutical products and services.

STRENGTHENING PHARMACEUTICAL SYSTEMS (SPS) PROGRAM OVERVIEW

In 2008, USAID/Afghanistan invited MSH—through its SPS Program—to provide technical assistance and support to the MoPH to improve the pharmaceutical system. Since then, SPS has worked closely with the MoPH to achieve the following objectives:

1. Improve the use of medicines;
2. Build MoPH’s capacity to manage pharmaceutical services;
3. Build the capacity of the MoPH to ensure the quality of pharmaceutical products; and,
4. Establish a coordinated procurement and distribution system.

In August 2011, USAID awarded an Associate Award to MSH under the SPS Program. The SPS Afghanistan Associate Award is a four-year, \$24.5-million project that strives to build capacity to effectively manage all aspects of pharmaceutical systems and services. The current SPS program focuses on improving governance in the pharmaceutical sector, strengthening pharmaceutical management systems and financing mechanisms, containing antimicrobial resistance, and enhancing access to and appropriate use of medicines. The current SPS program is being implemented in 13 provinces and supports 629 BPHS/EPHS facilities in these provinces (Table 1).

While the SPS program was originally designed to align with the USAID/Afghanistan Mission Assistance Objective for improved health of the population, the mission’s results framework recently underwent revisions to align it with the USAID/Afghanistan Strategy for Transformation (2015-2024). Under the updated results framework, the goal of USAID assistance is “Afghan-led sustainable development.” Thus, in order to achieve this goal, USAID expects to meet the Intermediate Result (IR): “Health Outcomes Improved,” and the Sub-IRs: “Afghan Ownership to Ensure an Effective Health Response Strengthened” and “Use of Quality Health Services Increased.” The activities implemented under the current SPS program should directly contribute to the IR as well as both Sub-IRs.

This new framework for improving the health of the population of Afghanistan is particularly important considering the World Bank’s Afghanistan Reconstruction Trust Fund (ARTF). Beginning in June 2014, the U.S. Government’s support for the public health sector will be channeled through the ARTF, and its Integrated Health Services & Systems Strengthening Project (IHSSSP). USAID will contribute on-budget support to the World Bank’s System Enhancement for Health Action in Transition (SEHAT) Program. IHSSSP will also have an off-budget component to complement the work being done through SEHAT. IHSSSP (including both its on- and off-budget components) is a \$477 million, five-year project.

The IHSSSP addresses these technical areas: 1) Effective utilization of BPHS and other health services; 2) Strengthened private sector health services and products; and, 3) Improved GIRoA stewardship of the health system and promotion of healthy behaviors. At the core of IHSSSP is the development hypothesis that strengthening Afghan ownership to ensure an effective health response and increasing the use of quality health services will lead to improved health outcomes.

Table 1: Coverage of health facilities by SPS in the 13 provinces

FACILITY TYPE	NUMBER
Provincial Hospital (H2)	5
District Hospital (H3)	27
Comprehensive Health Center (CHC)	170
Basic Health Center (BHC)	275
Sub Health Center (SHC)	141
Others	11
TOTAL	629

Source: HMIS data, as on March 2014

2. EVALUATION PURPOSE

The SPS program is being implemented by MSH at the national level. USAID/Afghanistan’s Office of Social Sector Development (OSSD) manages the SPS program, which has been active since 2008 and has yet to undergo an external performance evaluation. The current four-year iteration of the SPS program began in August 2011. The purpose of this performance evaluation is to assess the effectiveness of the SPS program in improving and strengthening various strategic components of the pharmaceutical sector in Afghanistan.

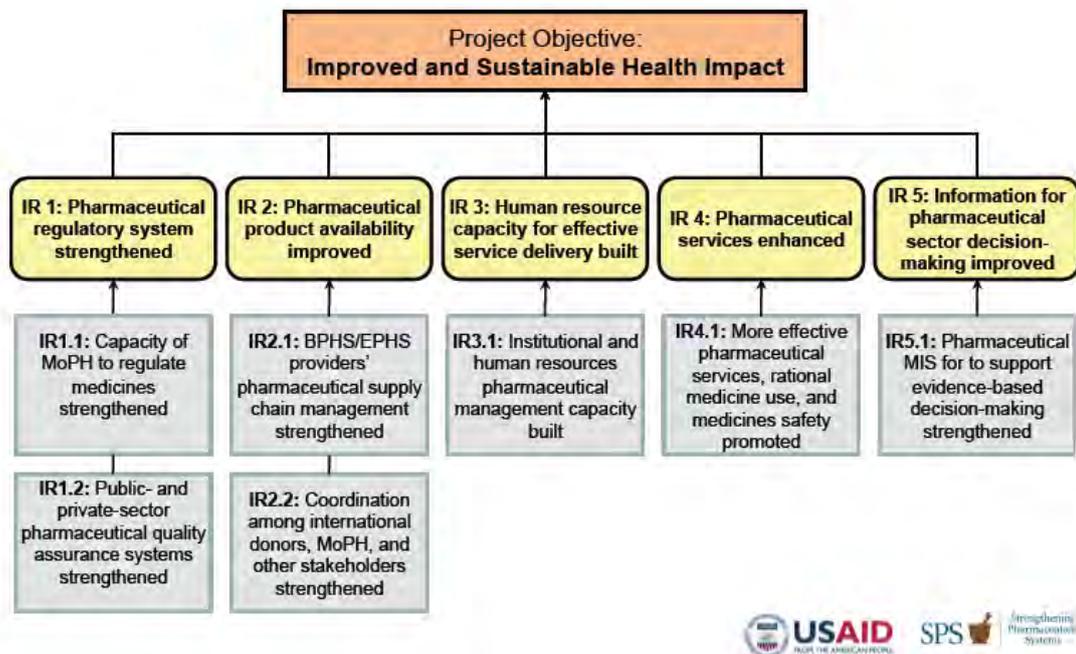
On August 27, 2015, the current iteration of the SPS program will come to an end; USAID is planning a follow-on project to begin shortly thereafter. Therefore, the findings and recommendations of this final performance evaluation of SPS will be utilized by USAID as input into the design of the SPS follow-on project. USAID will also use the

results of this evaluation to determine resource allocation decisions and the recommendations it will make to the MoPH and other donors and stakeholders regarding the future development of the pharmaceutical supply and distribution systems in Afghanistan.

The intended audience for the evaluation recommendations is USAID decision-makers in the OSSD-Health Office and the Office of Project and Program Development (OPPD), as well as USAID/Afghanistan senior leadership. In addition, the evaluation’s recommendations will be shared with USAID/Washington, stakeholders within the MoPH, including senior leadership, and staff at the implementing partner MSH. In particular, USAID expects the evaluation to identify lessons learned through implementing the SPS program and to recommend program components and or activities that merit discontinuation, continuation, or expansion, as well as actionable recommendations for future stakeholders.

The USAID/SPS Results Framework that includes the Objectives and Intermediate Results (IR), outlined in **Figure 1**, guided the performance evaluation of the SPS program. To determine if the SPS program activities were effective in improving these technical objectives, and in order to address the evaluation questions, we used both qualitative and quantitative data collection and analysis strategies that targeted various stakeholders.

Figure 1: SPS Objectives and Intermediate Results Framework (2011-2015)



3. EVALUATION QUESTIONS

Our findings and recommendations are based on the following evaluation questions (Annex I-Evaluation SOW), which aim to determine whether and how the SPS program performed in meeting its stated objectives:

1. To what extent has the SPS program strengthened the pharmaceutical regulatory and quality assurance system in Afghanistan?
2. How has the SPS program addressed the capacity of GDPA (General Directorate of Pharmaceutical Affairs) at national and subnational levels?
3. How has the SPS program improved pharmaceutical supply chain management in Afghanistan to ensure product availability?
4. As a result of the SPS program, what gaps in the MoPH and NGO pharmaceutical systems human resources capacity have been addressed? What gaps still exist and how could these gaps be addressed in the future?
5. To what extent has the SPS program strengthened pharmaceutical services and improved rational medicine use and medicines safety?
6. How has the SPS implementation of PMIS (Pharmaceutical Management Information Systems) improved evidence-based decision-making in the pharmaceutical sector in Afghanistan?
7. Do any policies, laws, regulations, and standard operating procedures need to be developed and institutionalized in order to have an effective coordination of the pharmaceutical procurement and distribution system in the country?
8. In light of evaluation findings, what lessons learned can be identified that apply to future pharmaceutical system programs under SEHAT (with particular emphasis on monitoring of pharmaceutical quality) or future off-budget projects?
9. How has the SPS program addressed gender equity issues, particularly in the provision of pharmaceutical services and the rational use of medicines?

4. METHODS AND LIMITATIONS

METHODOLOGY

Our evaluation approach and methodology consisted of both qualitative and quantitative methods. Our qualitative methods included primary data collection and a review of relevant documents, key informant interviews, and focus group discussions with key stakeholders. We also conducted site visits to a sample of BPHS/EPHS health facilities and private pharmacies, and administered exit surveys to patients. Lastly, we developed a

tool to analyze the data derived from the Performance Monitoring Plan (PMP) provided by the MSH SPS Monitoring and Evaluation (M&E) team, as well as quarterly and annual reports developed by the SPS team for USAID. Our Evaluation Methodology is explained in more detail in Annex II-Work Plan.

Table 2: List of health facilities visited

Date	HF ID	Province	District	Facility Name	Facility Type	Implementer	PCH/Non PCH
25-Aug	27	Kabul	Charasiab	Charasiab	DH (H3)	BRAC	PCH
26-Aug	108	Kabul	Kabul	Deh Dana Clinic	CHC	MoPH	MoPH
27-Aug	113	Kabul	Kabul	Bibi Maharo Clinic	CHC	MoPH	MoPH
27-Aug	151	Kabul	Kabul	Jamal Mena Clinic	CHC	MoPH	MoPH
27-Aug	153	Kabul	Kabul	Bahzad Clinic	CHC	MoPH	MoPH
28-Aug	154	Kabul	Kabul	Prozha-e-Jadid Panjsad Family Clinic	CHC	MoPH	MoPH
28-Aug	166	Kabul	Kabul	Qalai Zaman Khan Clinic	CHC	MoPH	MoPH
28-Aug	170	Kabul	Kabul	Dasht-e- Barchi Hospital	DH (H3)	MoPH	MoPH
28-Aug	1673	Kabul	Kabul	Gul khana Clinic	CHC	MoPH	MoPH
30-Aug	2957	Kabul	Kabul	Maidan-e-Hawahi	CHC	MoPH	MoPH
30-Aug	1668	Kabul	Kabul	Khoshhal Khan Mina Part B Clinic	CHC	MDM French	Other
30-Aug	37	Kabul	Khakijabar	Khakijabar	CHC	BRAC	PCH
31-Aug	3	Kabul	Mirbachakut	Mirbachakut	CHC	BRAC	PCH
31-Aug	14	Kabul	Paghman	12-Emam	CHC	BDN	PCH
31-Aug	1671	Kabul	Paghman	Khaldari	CHC	BRAC	PCH
1-Sep	1672	Kabul		Bar Arghandi	CHC	BRAC	PCH
2-Sep	665	Herat	Adraskan	Adraskan	CHC	Ibn Sina	PCH
2-Sep	670	Herat	Chesht sherif	Chesht	CHC	Ibn Sina	PCH
2-Sep	626	Herat	city	Baba-e- Barq	CHC	BDN	PCH
3-Sep	632	Herat	city	Now Abad	CHC	BDN	PCH

3-Sep	639	Herat	Enjil	Injil	CHC	BDN	PCH
3-Sep	667	Herat	Farsi	Farsi	CHC	Ibn Sina	PCH
3-Sep	658	Herat	Gulran	Gulran	DH (H3)	Ibn Sina	PCH
4-Sep	1737	Herat	Karukh	Karukh	CHC	BDN	PCH
4-Sep	648	Herat	Guzara	Gozara Hospital	DH (H3)	DAC	Other
4-Sep	630	Hiram	Hirat	600 beds Hospital	RH / NH (H1)	MoPH	MoPH
4-Sep	2366	Herat	Hirat	MCH-FP Clinic	CHC	MSI	Other
5-Sep	643	Herat	Injil	Imam Shash Noor Clinic	CHC	AIL	Other
5-Sep	666	Herat	Obeh	Obe CHC+	CHC	DAC	Other
10-Sep	401	Badakhshan	AROG	Shatak Clinic	CHC	CAF	PCH
10-Sep	406	Badakhshan	Darayem	Shahre e Safa Clinic	CHC	CAF	PCH
10-Sep	410	Badakhshan	Jurm	Jurm	CHC	SHDP	PCH
11-Sep	424	Badakhshan	Yaftal Pyeen	Naland Clinic	CHC	CAF	PCH

SAMPLING OF FACILITIES

We limited our sample to four provinces (Kabul, Herat, Badakhshan, and Kandahar) from the 13 SPS-supported provinces, due to security concerns as well as logistical constraints. We also restricted our sample to CHCs (community health centers) and district/provincial hospitals, since they are the only type of facilities that have on-site pharmacies and are potentially supported by the SPS program. **Figure 2** depicts our sampling frame for eligible health facilities based on SPS-supported status. SPS-supported health facilities are limited to the 59 health facilities located within these four provinces that are supported by PCH-NGOs.

We used a simple random sample stratified by SPS status to select 38% of all health facilities to visit and in which to conduct exit surveys of patients. We used a convenience sampling approach for private pharmacies based on proximity to the health facility being visited. In summary, our team first visited the health facility selected in the sample and then visited one or two private pharmacies within close proximity. Due to security and travel restrictions in Herat, we were only able to implement our survey in four of the eight selected health facilities. **Table 1** outlines the distribution of the health facilities included in our final sample, as well as private pharmacies overall and by SPS status.

The data and analyses derived from this evaluation approach can be aggregated and/or disaggregated at the provincial-, NGO- and facility/pharmacy-level, but most of our analysis will be presented at the national- and provincial-level. However, we have included the raw data in the Annex V- SPS Evaluation Survey Data as a resource.

Figure 2: Sampling Frame

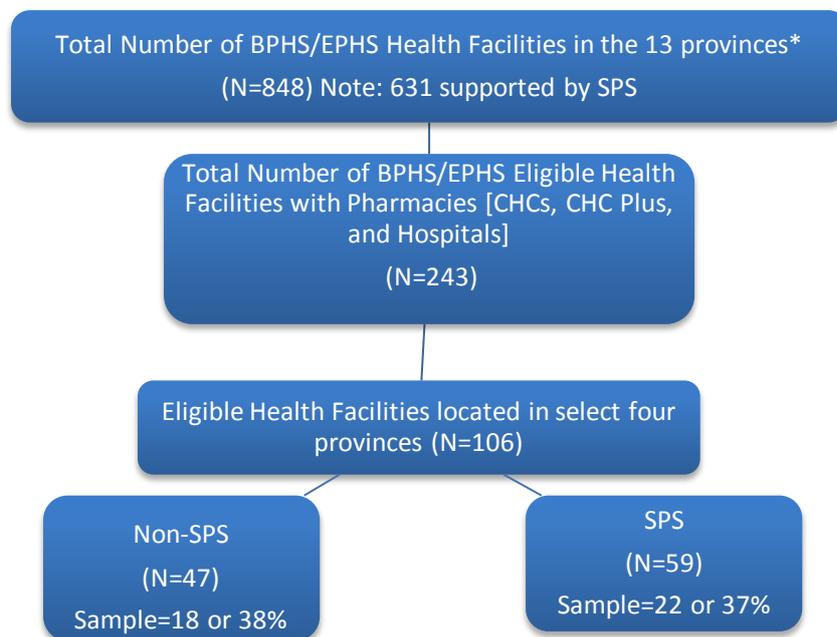


Table 3: Distribution of Sampled Health Facilities by SPS Status and Province

<u>Province</u>	<u>SPS</u>		<u>Non-SPS</u>		<u>Total Health Facilities</u>	<u>Total Private Pharmacies</u>
	Eligible	Final Sample	Eligible	Final Sample		
Herat	21	4 (from 8)	9	4 (from 5)	8	15
Badakhshan	18	3	1	1	4	9
Kabul	13	6	35	10	16	16
Kandahar	7	4 (from 5)	3	2	6	2
Total	59	17	47	17	34	42

LIMITATIONS / CHALLENGES / RISKS

1. While the team attempted to interview and/or visit all selected stakeholders, security and logistical constraints necessitated the exclusion of some site visits (five in Herat, and one from Kandahar). In addition, in Kandahar, only a few private pharmacies were surveyed due to security concerns for the evaluation team. Please refer to **Table 1** above, which depicts the distribution of our sample.

2. Absence of baseline data for many of the PMP indicators limited our analysis for several of the Technical Objectives.
3. While we report differences between provinces, and compare SPS-supported facilities with those that are not supported by SPS, our sample size (N=34 for health facilities and N=42 for private pharmacies) limits the statistical significance of our findings. Despite this, the patterns we identified were often reinforced through our interviews and discussions with key informants, NGO partners, and/or other stakeholders. Therefore, we are confident that the findings and conclusions derived from our data analysis of the patient exit surveys and site visits are reliable.

III. FINDINGS

This section outlines key findings derived from our document review, key informant interviews, data analysis and field visits. We present the findings in the order of the evaluation questions. In summary, the evaluation team found that the SPS program, through its various activities in a largely fragmented pharmaceutical sector, has strengthened the capacity of the MoPH, PCH-NGOs, and other organizations, particularly the GPDA, in policy development, inventory and stock management, and procurement. However, SPS activities do not have not sufficiently improved coordination within the pharmaceutical sector regarding the regulation, quality, and rational use of medicines, nor have they improved evidence-based decision-making. *We found that while SPS is a nationally-recognized program, it has had minimal impact on health outcomes at the local level.*

EVALUATION QUESTION 1:

To what extent has the SPS program strengthened the pharmaceutical regulatory and quality assurance system in Afghanistan?

The SPS program is currently the only intervention in Afghanistan focused on strengthening pharmaceutical systems, including the regulatory and quality assurance systems. As stated by the deputy minister for Department of Technical Affairs and Planning, the SPS program has helped in mainstreaming pharmaceutical issues within the broader public health agenda. Through its various activities, the SPS program has brought the quality assurance of pharmaceuticals, both in the public and private sectors, to the forefront, and the MoPH has made it a priority moving ahead into SEHAT.

These findings reflect *key achievements* derived from our key informant interviews and our document review:

- SPS has strengthened the technical and human resource capacity of GPDA, enabling it to better manage pharmaceutical issues in Afghanistan, primarily in

policy development, strategic planning, and technical training through seminars and workshops.

- SPS has built the capacity of the National Medicines and Food Board (NMFB) through technical support by placing a consultant on the Medicine and Food Committees to manage their day-to-day activities, and by providing and logistical support (e.g., by arranging regular meetings of the NMFB).
- SPS has been instrumental in the development of the National Medicine Policy (NMP) and the Standard Treatment Guidelines (STG).
- SPS has provided support to the General Directorate of Curative Medicine (GDCM) in establishing the National Drug and Therapeutics Committee (NDTC) and the Drug and Therapeutic Committee (DTC) in 12 hospitals across Afghanistan.
- Approximately 30 key activities have been implemented to-date by SPS in order to achieve the stated objective of strengthening the pharmaceutical regulatory and quality assurance system (Annex XI- Summary of SPS Activities).

Despite these achievements, findings derived from our analysis of the PMP data and site visits indicate the following *gaps/challenges*:

- SPS has yet to achieve the targets outlined for Technical Objective 1 (Pharmaceutical regulatory system strengthened), and specifically corresponding to the PMP indicators presented in **Table 2**.
- Limited coordination *within* the public sector (MoPH/GDPA) and between the MoPH and private sector contribute to unregulated and poorly-monitored pharmaceutical regulatory and quality assurance systems.
- Development of regulatory guidelines and enforcement of existing guidelines and requirements is lacking in both the public and private sectors.

Figure 3: Signboard of a Registered Pharmacy in Kabul (Sept. 2014)



Approximately 62% [range 33% in Herat to 81% in Kabul] of private pharmacies included in our sample were registered by MoPH.

Table 4: Assessment of the Select PMP Indicators for Pharmaceutical Regulatory System Strengthened

PMP Indicator	LOP Target	LOP Actual (as of
1. Number of pharmaceutical sector laws or policy documents developed or updated.	2	0
2. Number of pharmaceutical standard operating procedures and Terms of Reference developed or updated.	4	0
3. Number of pharmaceutical standard regulatory guidelines developed or updated	4	0
4. Percent of available drugs in the market that are registered drug products	68	14
5. Percent of available registered drugs in the market matching LDL (Licensed Drug List).	38	4
6. Number of Private retail pharmacy outlets that MOPH inspected last quarter.	89	37
7. Percent of inspected private retail pharmacy outlet, disaggregated by site type, that meet minimum requirements according to MoPH standards.	NA	NA
8. Number and percent of pharmacies that comply with waste management requirements, as determined by MoPH	82	8.5
9. Percent of drug samples from retail pharmacy that meet quality standards for physical inspection and labeling.	116	12

EVALUATION QUESTION 2:

How has the SPS program addressed the capacity of GDPA (General Directorate of Pharmaceutical Affairs) at national and subnational levels?

The GDPA is housed in the Ministry of Finance (MoF) and reports to the Deputy Minister of Technical Affairs and Planning under the MoPH. The directorate’s mandate is to develop and implement policies and regulatory mechanisms for pharmaceutical services in the country and for undertaking quality assurance of products procured in Afghanistan. Specifically, GDPA is responsible for licensing, registration, Post-Marketing Surveillance (PMS), Rational Medicine Use (RMU), Adverse Drug Reactions (ADR), and Medicine Safety in the public and private sectors.

The following are a summary of findings that reflect *key achievements* derived from our key informant interviews and document review:

- **SPS has markedly improved the policy and decision-making capacity of the GDPA at the national level.** Prior to the SPS program, GDPA had no capacity or authority as a policymaker or regulatory agency, but these capacities have been strengthened. The following is a list of policies/guidelines and systems developed as a result of the SPS program:
 - Standard Treatment Guidelines (STG), Licensed Drug List (LDL) and National Medicine Policy (NMP)
 - Pharmaceutical Logistic Information System (PLIS)/ Pharmaceutical Management Information System (PMIS)
 - Coordinated Procurement and Distribution System (CPDS)

Despite these important achievements, the following *gaps/challenges* were identified:

- **GDPA has limited regulatory authority sub nationally, at the local and provincial levels.**
 - There is significant fragmentation within the MoPH/GDPA regarding policy and regulatory responsibilities for pharmaceutical services at the provincial level. For example, provincial public health departments have pharmacy officers who are responsible for inspections of the pharmacies at BPHS/EPHS health facilities (both public and private) in the provinces, but there is no coordination between these inspectors and the GDPA regarding compliance with regulations not monitored by GPDA.
- Alongside the GDPA, SPS has many independent partnerships with various organizations within the MoPH (e.g. HMIS, CMS, Office of Procurement, and Office of Private Sector Coordination) and outside the MoPH (e.g., including Afghan National Medicines Services Organization (ANMSO), the Ghazanfar Institute of Health Sciences, the NMFB, and Afghanistan Nationwide Pharmacists Association) resulting in an unintended fragmented approach.
- The GDPA lacks rules, regulations, and law enforcement at both the national and subnational levels.
- There have been delays in receiving technical support from SPS due to the required routing of all technical issues through MSH USA headquarters.

EVALUATION QUESTION 3:

How has the SPS program improved pharmaceutical supply chain management in Afghanistan to ensure product availability?

As per the program mandate, SPS has been procuring and supplying drugs listed in the BPHS Essential Medicine List (EML) to 629 health facilities managed by PCH-NGOs in 13 provinces of Afghanistan (See **Table 3**). Through technical, financial, and logistical support and effective coordination between the Coordinated Procurement Distribution Systems (CPDS), GDPA, PCH-NGOs, and the PLIS coordinator, this has been the most

effective component of the SPS program. The procurement and supply chain management in these provinces has been exemplary, as evidenced by the establishment of the CPDS and more than 50 key activities implemented by SPS (Annex XI-Summary of SPS activities) in order to accomplish Technical Objective 2.

Table 5: SPS Health Facility Coverage

SPS Coverage of Health Facilities in the 13 Provinces by Type of Health Facility	Number of HFs
Basic Health Center (BHC)	275
Comprehensive Health Center (CHC)	170
District Hospital (DH)	27
Provincial Hospital (PH)	5
Sub Health Center (SHC)	141
Other	11
Total	629

*“The community trusts the white tablets from IDA (SPS supply) more than any other medicine supply in the private market”
Dr. Ahmad Jawed, IMC (PCH-NGO)*

The following are a summary of findings that reflect *key achievements* derived from our key informant interviews with PCH-NGOs:

- Through the CPDS and its various training seminars/workshops and tools, the SPS program has improved the coordination of supplies, inventory management, and recording-keeping between the PCH-NGOs and their health Facilities.
 - SPS helped develop a format and tools to ensure transfer of medicines with short expiry between the BPHS and EPHS facilities.
- The SPS program has established a standardized supply chain management (SCM) and procurement system, leading to drastic reduction in incidences of stock-out and over-stocking over the past two years.

Findings derived from our analyses of the PMP data and site visits, indicate the following *key achievements*:

- SPS procurement and SCM guidelines are of high quality:
 - On average, less than one percent of medicines in-stock at health facilities and private pharmacies were expired. There was no difference between SPS-supported and non-SPS-supported health facilities and private pharmacies. Please see Annex for aggregate and disaggregated data.

Table 6: Assessment of Select PMP Indicators for Pharmaceutical Product Availability

PMP Indicator	LOP Target		LOP Actual (as of PY3Q4) per PMP data	
	HF's	WH	HF's	WH
1. Percent of unexpired indicator drugs available in selected public storage and health facilities.	90	90	92	94
2. Percent of stock records that correspond with physical count in PCH facilities and warehouses	90	95	64	93
3. Average percent of time out of stock for tracer drugs in the last 6 months in PCH facilities and warehouses	10	2	4	3
4. Weighted average percentage of inventory variation for tracers drugs in PCH facilities	5	1	6	0.7
5. Number of supportive monitoring visits to PCH HF's and warehouses by SPS	833	135	343	47

- SPS program activities have met or exceeded targets in ensuring product availability, stock, and inventory management at SPS-supported health facilities and warehouses, as outlined in Technical Objective 2 (pharmaceutical product availability improved) and specifically corresponding to PMP indicators 1 through 5 (depicted in **Table 4**).

Despite these achievements, our interviews with PCH-NGOs identified the following *gaps /challenges* in the supply chain, which adversely affected product availability:

- Stock-out of essential medicines is a facility-specific problem within and between PCH-NGOs
 - Quantification is currently undertaken as an aggregate of all PCH-NGO health facilities, which does not ensure procurement requirements for individual health facilities.
 - The SPS supply does not align with the BPHS/EPHS at any given level of care (e.g. the community health center EML does not align with the SPS supply for supported facilities).
 - Some medicines prescribed locally by medical doctors at the health facilities are not available in the SPS supply, which is based on outdated EMLs and STGs.
- There is inadequate cold-chain support for specific medicines.
- PLIS does not align with the MOPH HMIS.

Findings derived from our analyses of the PMP data and the site visits/survey indicate the following *gaps/challenges* in ensuring product availability:

Table 7: Assessment of Select PMP Indicators for Pharmaceutical Product Availability Improved

PMP Indicator	LOP Target	LOP Actual (as of PY3Q4) per PMP data
6. Percent of PCH HF managers who know the standard formula for determining order quantities for Co-trimoxazole.	80	92
7. Number of procurement plans shared between CPDS stakeholders	10	0
8. Number of CPDS participants trained on Pharmaceutical Logistics Information System reporting format	330	70
9. Percent sites with under 15% product expiry or wastage in last quarter.	80	0
10. Percent of BPHS contractors that submitted comprehensive stock status reports last quarter.	80	0

- SPS has not yet met targets in coordination and information sharing of procurement plans between CPDS members, PLIS training targets, and reporting of stock status targets. These activities are monitored through the PMP indicators 6-10 (**Table 5**) for Technical Objective 2 and outlined below:
- According to our site visit analysis, in both types of health facilities (SPS- and non-SPS-supported) and private pharmacies, only 45% of indicator medicines were available, with a limited difference between SPS and non-SPS supported health facilities (**Table 6**).
 - There was geographic variation in product availability within Kandahar province. Largely, supported by the Afghan Health and Development Services PCH-NGO, Kandahar performed better than any other province across all types of health facilities. Please refer to **Table 1** for the sample size.
 - Herat province was the lowest performing and is largely supported by the Bakhtar Development Network BDN PCH-NGO.
- While there was limited difference between SPS and non-SPS facilities in aggregate product availability, the types of medicines out-of-stock varied between SPS and non-SPS facilities, as depicted in **Table 7**.
- In summary, our site visits indicated product-specific stock-outs and variation between SPS- and non-SPS-supported health facilities:

- SPS-supported facilities were less likely to have stock-outs for several anti-infective medicines (e.g., Amoxicillin, Rifampin, and Ampicillin), labor induction/pregnancy termination medicine (Oxytocin), oral contraceptives (Ethinyl/Estradiol), and antifungal medicines (Mebendazole).
- Several medicines, specifically Ciprofloxacin (anti-infective agents) and Glibenclamide (indicated for diabetes), were included in the SPS EML and excluded from the BPHS EML, but were not available at nearly all SPS and non-SPS health facilities.

Table 8: Percent of Indicator Medicines (Mean %) Available

	Health Facilities			Private Pharmacies	Overall
	Overall	SPS	Non-SPS		
Kabul	41	42	40	45	43
Herat	24	15	33	51	41
Badakhshan	45	44	47	47	46
Kandahar	57	60	50	57	57
Overall	40	40	40	48	45

Table 9: Distribution of Stock-Outs by Type of Health Facility (Aug-Sept 2014)

Indicator Medicines	Health Facilities (N=34)			Private Pharmacies (N=42)	SPS EML (0=No; 1=Yes)	BPHS EML (0=No; 1=Yes)
	Overall	SPS	Non SPS			
1. Amoxicillin 500mg	10	2	8	21	1	1
2. Hydrochlorothiazide 25mg	31	15	16	39	1	1
3. Ciprofloxacin 500mg	30	16	14	1	1	0
4. Atenolol 25mg	33	17	16	26	0	0
5. Paracetamol 100mg	7	1	6	28	1	1
6. Azithromycin 250mg	32	17	15	18	0	0
7. Artesunate 50mg	22	11	11	40	1	1
8. Glibenclamide 5mg	32	18	14	21	1	0
9. Rifampin/INH 150/75	5	1	4	41	1	1
10. Ampicillin 500mg vial	11	1	10	22	1	1
11. Oxytocin 1ml ampoules	9	1	8	22	1	1
12. Ethinyl Estradiol/ Norgesterol	8	1	7	30	1	1
13. Mebendazole 100mg	11	3	8	12	1	1
14. Metronidazole 400mg	28	15	13	2	0	1
15. ORS packets	3	0	3	10	1	1

EVALUATION QUESTION 4:

As a result of the SPS program, what gaps in MoPH and NGO pharmaceutical systems human resources capacity have been addressed? What gaps still exist and how could these gaps be addressed in the future?

The SPS project has addressed the management and technical capacity of the GDPA, NMFB, and the PCH-NGOs at the central level. Capacity has been built through various approaches, including:

- Continuous technical support to the GDPA staff through placement of SPS consultants at GDPA;
- Technical support to NMFB by placing two consultants – one each on the Medicine Board and the Food Board;
- Training of the pharmacists at the PCH-NGOs on RMU (Rational Medicine Use), ADR (Adverse Drug Reactions), and MS (Medicines Safety); and,
- Training the National Drug and Therapeutics Committee (NDTC) and Drug Therapeutics Committees (DTCs) on managing pharmacovigilance issues at the hospitals, along with the development of drug formularies.

The following are a summary of findings that reflect *key achievements* derived from our key informant interviews:

- Management and technical capacity of the GDPA to manage, coordinate, and provide technical oversight on pharmaceutical issues at the *central* level has improved under the SPS program.
- The operationalization of the NMFB was solely a result of SPS's continuous logistical and technical support, including placing two consultants at NMFB.
- All PCH-NGOs stated that the trainings of pharmacists on RMU, ADR and MS have supported the delivery of quality healthcare services at their facilities.
- The capacity building of NTDC and DTC members has helped DTCs streamline and manage Pharmacovigilance activities, and oversee the implementation of STGs at respective hospitals.
- Overall, the SPS program has trained more than 1,300 participants (LOP target is 1,550) in pharmaceutical management principles (PMP indicator for Technical Objective 3 *building human resource capacity for effective service delivery*).

Despite these achievements, our analysis of the PMP data and key informant interviews with PCH-NGOs, GIHS, Kabul University, and the Afghanistan Nationwide Pharmacists

Association, indicate the following *challenges/gaps* in building human resource capacity for effective service delivery (Technical Objective 4):

- Pharmacist and pharmacy technician shortage is a major problem that affects the successful implementation of various SPS activities at the central and local levels.
 - For example, CHWs, nurses, and physicians often prescribe and/or deliver the medicines at pharmacies located in CHC health facilities, as well as BHC and hospitals. These staffs are not trained in RDU, MS, or ADR.
 - The number of pharmacies (many un-licensed) in the country far exceeds the number of pharmacists – there are more than 16,000 pharmacies and no more than 2,000 registered pharmacists.
 - Despite this, SPS training and seminar participants focus on management and pharmacy staff of SPS-supported PCH-NGOs and health facilities.
- There is inefficient and inadequate curriculum revision to address pharmaceutical management issues such as RDU and MS for Kabul University and Ghazanfar Institute of Health Sciences.
 - SPS support in curriculum revision is limited to several modules at Kabul University and GIHS, and is insufficient given SPS program objectives and the growing availability of private pharmacy schools in the country.
 - Private colleges of pharmacy (more than 30 schools) account for a disproportionately large and growing share of pharmacy students and graduates in the country.
- Despite the dominant role of the private sector in both the procurement and distribution of medicines to the population, SPS trainings/seminars and initiatives do not cover the capacity building of the private sector, including private pharmacies and wholesalers.
- The GDPA indicated that SPS consultants provide GDPA staff with only two-three days/week of onsite technical support, and more onsite support is necessary to ensure efficiency in improved capacity.
- Our site visit data identified different pharmacy staffing patterns between SPS-supported health facilities and non-SPS-supported facilities. SPS-supported health facilities had fewer pharmacists or pharmacy technicians than non-SPS supported facilities (**Figure 4** and **Figure 5**)
 - This pattern may be related to both the differences in availability of pharmacists and technicians between provinces, or differences in benefits offered in SPS-supported health facilities in comparison to non-SPS-supported facilities.

Figure 4: Pharmacy Staffing Patterns Overall and by Province for SPS-Supported Facilities

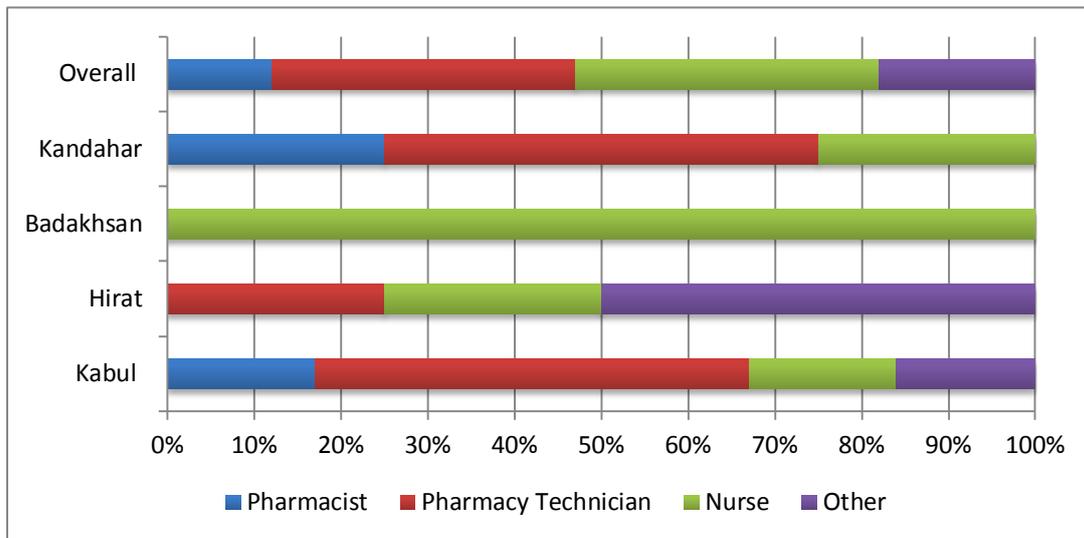
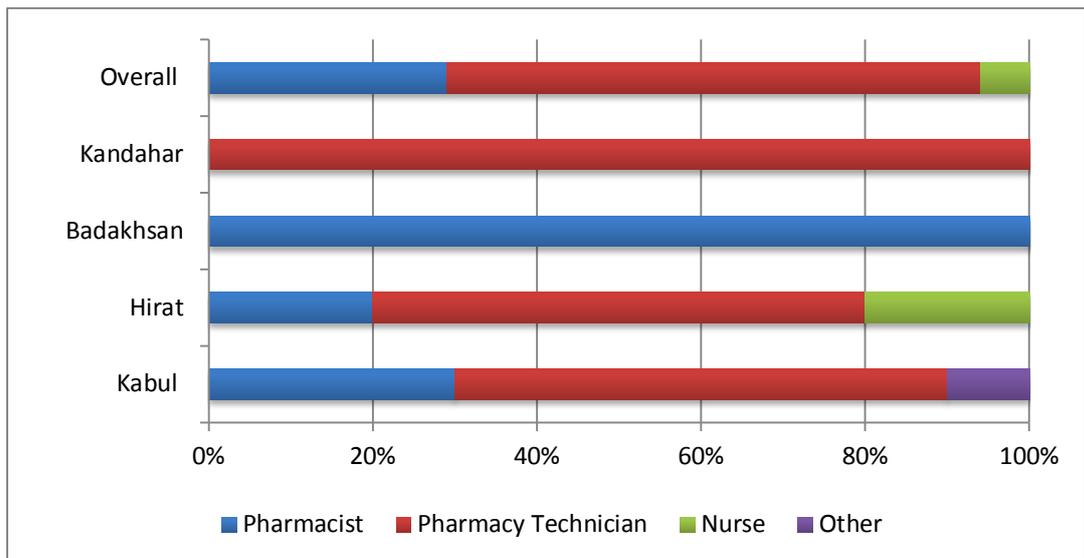


Figure 5: Pharmacy Staffing Patterns Overall and by Province for Non-SPS-Supported Facilities



EVALUATION QUESTION 5:

To what extent has the SPS program strengthened pharmaceutical services, improved rational medicine use and medicines safety?

According to the PCH-NGOs, the SPS program has been somewhat effective in strengthening the following components of pharmaceutical services – Rational Medicine Use (RMU), Anti-Microbial Resistance (AMR) and Medicine Safety (MS) – in the PCH-NGO health facilities in the 13 provinces it covers. This has been achieved by: 1) Adopting MSH and WHO guidelines for RMU, AMR and MS; 2) Adopting and

contextualizing necessary data collection tools; 3) Training appropriate staff at the PCH-NGO health facilities on RMU, AMR, MS and inventory management; and 4) Monitoring the performance of most facilities on these issues.

The following are a summary of findings reflecting *key achievements* derived from our document review and key informant interviews:

- Data collection and monitoring tool development:
 - SPS developed and disseminated MSH tools to collect data on RMU, AMR, MS, and inventory management (IMAT tool).
 - Barring the health facilities in high security risk provinces, particularly Kandahar and Paktika, facilities regularly reported and submitted data using the RMU and IMAT tools.
- Key staff at all the ten PCH-NGOs was trained on RMU, AMR, MS, and inventory management; this master training was further cascaded by the NGOs to the *pharmacy* staff in all the health facilities in respective provinces.
- SPS provided technical assistance to General Directorate of Curative Medicine (GDCM) in establishing the National Drug and Therapeutic Committee (NDTC) and DTCs in 12 hospitals across the country, further strengthening the compliance to STGs, RMU, AMR, and MS initiatives in these hospitals.
- Several SPS-supported health facilities have reported a reduction in antibiotics usage.
 - Afghan Health and Development Services (AHDS), a PCH-NGO managing 42 health facilities in Kandahar province, has reported reduction in antibiotic usage from 57% to 34% in six months (report annexed) with SPS support.
 - International Medical Corps, UK (IMC) is a PCH-NGO managing 35 health facilities in Paktika province. With SPS support, IMC has managed to bring down the antibiotic usage from 77% to 65% (Annex VIII-Summary of Key Informant Interviews).
- The SPS program raised public awareness on rational and safe use of medicines through messaging in media outlets (TV, radio, and posters). According to an SPS survey, 72% of the respondents correctly recalled the radio spot message, while 88% correctly recalled the TV spot message.³

³ According to a survey conducted under the 'Evaluation of Message #1 of the Rational Medicine Use Communication Initiative, SPS/Afghanistan, July 2012'.

- SPS program activities exceeded target for only one out of the five PMP indicators corresponding to Technical Objective 4, outlined in **Table 8**.
 - More than 87 percent of sites with DTCs have implemented pharmaceutical services improvement activities.
 - Less than half of patients at PHCs are prescribed antibiotics.
- SPS-supported facilities performed better than non-SPS-supported facilities in *labeling medications* (noting directions for use by patient on medication packaging); however, there were notable variations at the provincial level within SPS-supported facilities, as depicted in **Table 9**.

Table 10: Assessment of Select PMP Indicators for Enhancing Pharmaceutical Services

PMP	LOP Target	LOP Actual (as of PY3Q4)
1. Percent of sites with DTCs that have implemented pharmaceutical services improvement activities	90	87
2. Percent of patients in primary care facilities receiving antibiotics	40	46
3. Percent of prescriptions complying with STGS	85	55
4. Percent of health facilities with approved set of STGs	80	10
5. Number of hospital DTCs with medication safety action plans	5	0

- Nearly 2/3 of patients filling medicines at both non-SPS and SPS-supported-facilities knew how to take their medications, with notable variation between health facilities and private pharmacies (**Table 10**).

Table 11: Average Percent of Medicines Dispense Adequately Labeled

	Health Facilities			Private Pharmacies	Overall
	Overall	SPS	Non-SPS		
Kabul	45	68	26	34	40
Herat	43	34	56	70	61
Badakhshan	78	84	60	77	77
Kandahar	100	100	100	100	100
Overall	62	73	48	62	62

- Surprisingly, Kabul province had both the lowest percent of dispensed medicines adequately labeled and patients knowing how to take their medicines in non-SPS facilities and private pharmacies, while SPS-supported facilities appear to perform better for these measures.

Despite these achievements, our analysis of key informant interviews, PMP data, and our site visits/patient exit surveys identified the following *gaps/challenges* in enhancing the delivery of pharmaceutical services:

- The SPS program has not met targets in three out of the five PMP indicators:
 - Less than 12 percent of sites had approved STGs available.
 - Only 55 percent of prescriptions comply with STGs in SPS-supported sites.
 - There are currently no hospitals (Target 5) implementing medicine safety action plans.

Table 12: Percent of Patients Who Know How to Take Medications

	Health Facilities			Private Pharmacies	Overall
	Overall	SPS	Non-SPS		
Kabul	61	64	58	37	50
Herat	47	34	68	62	57
Badakhshan	74	77	67	88	83
Kandahar	86	92	76	100	89
Overall	66	68	64	64	65

Table 13: Average Percent of Medicines Prescribed That Were Dispensed

	Health Facilities			Private Pharmacies	Overall
	Overall	SPS	Non-SPS		
Kabul	85	87	84	69	78
Herat	71	77	61	23	41
Badakhshan	76	74	83	24	47
Kandahar	95	94	97	59	85
Overall	83	84	82	42	64

- We found no difference between SPS and non-SPS supported health facilities in the percent of medicines prescribed that were dispensed (**Table 11**).
 - According to our patient exit survey, both types of facilities dispensed approximately 80% of the medicines prescribed.
 - However, patients going to private pharmacies filled less than half (~42%) of their prescribed medicines.

- EMLs were not available in more than half of health facilities, regardless of SPS-support.
- STGs were not available in nearly all health facilities, regardless of SPS-support. Our site visits found that only one SPS-supported facility, in Herat, and one non-SPS supported facility, in Kandahar, had STGs on site.

EVALUATION QUESTION 6:

How has the SPS implementation of PMIS (Pharmaceutical Management Information Systems) improved evidence-based decision-making in the pharmaceutical sector in Afghanistan?

This crucial area, involving important components – Pharmaceutical Management Information System (PMIS) and Pharmaceutical Logistic Information System (PLIS) – has not seen significant progress under the SPS program, and is currently in pilot stage.

- Over the last three years, SPS has supported various partners in the pharmaceutical sector to assess their existing PMIS, analyze gaps, and develop a system that meets stakeholder needs, including harmonizing and coordinating donor activities and reporting.
- SPS plans to incorporate different functional components, such as tendering and procurement planning, inventory management, medicine consumption, and patient data, in the proposed comprehensive PMIS. The plan is to integrate data collection, processing, and presentation of information in a way that helps staff at all levels of the country’s health system make evidence-based decisions.

The following are a summary of findings reflecting *key achievements* derived from our PMP data analysis, document review, and key informant interviews:

- Prior to the SPS program, there was no monitoring of PCH-NGOs; the SPS program has record-keeping, documentation, and reporting capacities of PCH-NGOs.
 - SPS support led to improved ownership and close monitoring of these activities by GDPA.
- SPS strengthened PMIS through the following:
 - Registration of pharmaceutical companies;
 - Registration of pharmaceutical products;
 - PMP indicator on the *number of medicine items submitted for registration computerized for* Technical Objective 5 indicates that SPS achieved 7,880 from the LOP target of 7,100.
 - Initiation of the registration of drugs imported by the private sector.

- Quarterly meetings conducted by CPDS with GDPA and PCH-NGOS improved coordination and information sharing for effective planning and implementation for high risk provinces with limited success, such as Paktika and Kandahar.

The following are a summary of findings reflecting *gaps/challenges* derived from our analysis of the PMP data, document review, and key informant interviews:

- SPS lacks a comprehensive, reliable, and dynamic dashboard to assess and track progress on various performance indicators in aggregate and at the facility-level. The evaluation team reconciled SPS quarterly and annual PMP reports and performance indicator reference sheets (PIRS) and developed an excel file in order to facilitate the evaluation of the PMP (see Annex for PMP data analysis).
 - PIRS reference sheets and the SPS quarterly PMP reports are not standardized, have missing baseline and actual values, and therefore are very difficult to evaluate.
 - There is weak oversight and review of data entered into PRIS; the evaluation team identified several data calculation and discrepancy issues.
- The IMAT and RMU data collection and monitoring tools are outdated, with selection criteria for indicator medicines unclear.
 - The RMU data tool omits information on compliance with antibiotic STGs and focuses on the number and percent of antibiotics prescribed.
 - The selection criteria for 30 products from the 158 supplied by the SPS are not clear in the IMAT tool.
- According to an assessment of quarterly reports received by SPS, several health facilities in high-risk provinces like Paktika, Kandahar, and others did not submit reports – sometimes for a year – and the security situation prevented SPS from visiting these facilities.
 - These ‘non-reporting’ health facilities are not provided with any checklists/templates to collect this information locally on a regular basis and submit it to their NGO headquarters and subsequently to SPS.

EVALUATION QUESTION 7:

Do any policies, laws, regulations, and standard operating procedures need to be developed and institutionalized in order to have an effective coordination of the pharmaceutical procurement and distribution system in the country?

The SPS program should focus on coordinating the following activities through the MoPH, SEHAT, PCH-NGOs and other relevant stakeholders, in order to further improve the coordination of the pharmaceutical procurement and distribution systems moving forward:

- Policy and Planning
 - A standardized procurement policy and relevant guidelines for MoPH need to be established and institutionalized. These should incorporate all the best practices from various donors currently implementing individual procurement systems.
 - A comprehensive policy to promote and regulate local manufacturing of pharmaceuticals and health commodities needs to be developed.
 - A policy on pharmaceutical human resources (HR) is necessary, aligned with MoPH and GIRoA HR policies, to reduce the high HR turnover, which adversely affects the service delivery and its quality.

- Rules and Regulations

As per SEHAT, the following three priority areas have been identified for strengthening regulatory mechanisms in both the public and private sectors:

 - Upgrading Quality Control Lab (QC lab);
 - Post-Market Surveillance; and
 - Enhanced Inspection Capability at the national and provincial levels of MoPH/GDPA.

- Guidelines and Standard Operating Procedures (SOPs)
 - A web-based data warehouse system, wherever technology infrastructure permits, should be developed to support the development, institutionalization, and alignment of PMIS and PLIS.
 - USAID/SPS can provide technical support to SEHAT in establishing an effective procurement system based on its excellent procurement track record under the SPS program.
 - The procurement capacity of the MoPH/GDPA should be strengthened in terms of processes, HR capacity, and oversight.

- Coordination
 - Standard documents like STGs, EMLs, and LMLs should be available at all the health facilities, and doctors, nurses, and pharmacists should be trained on their purpose and use.
 - Systematic coordination (e.g., regular and documented quarterly meetings) should be established between all the stakeholders involved in the provision of pharmaceutical services in Afghanistan. This should include the MoPH entities (the GDPA, NMFB, GCMU, GDCM, CPDS, MoPH Procurement department, Pharmacy Enterprise, Office of Private Sector Coordination), academic institutions (GIHS and University of Kabul), ANPA, ANSMO, and PCH-NGOs.

EVALUATION QUESTION 8:

In light of evaluation findings, what lessons learned can be identified that apply to future pharmaceutical system programs under SEHAT (with particular emphasis on monitoring of pharmaceutical quality) or future off-budget projects?

Assuming the SEHAT project will be implemented in *all* of the health facilities; experience from the SPS project would be very helpful in ensuring effective and efficient pharmaceutical services in the country. The following are several lessons learned from our evaluation of the SPS program:

- Regulation and Quality Assurance:
 - A QC lab should be established at the central and regional levels on a priority basis in order to ensure the procurement of quality medicines.
 - This is important under SEHAT because PCH-NGOs are responsible for individual procurement.
- Supply Chain Management and Procurement:
 - Technical assistance should be provided to PCH-NGOs and their health facilities in procurement through a centralized pooled procurement system.
 - Adequate systems for oversight, monitoring, and evaluation of supply chain activities (inventory management, storage, distribution), at all levels, need to be institutionalized.
- Enhancing the Quality of Pharmaceutical Services and Rational Medicine Use:
 - Issues related to RMU (AMR, ADR, and MS) need to be mainstreamed and implemented across all the health facilities, with systematic training of all the relevant staff at all levels, including CHWs, nurses, and prescribers.
 - Academic partnerships (e.g. with the University of Kabul and GIHS) need to be strengthened and expanded to ensure that all the technical issues related to the effective implementation of pharmaceutical services are incorporated in the curriculum.
 - Regular revision of the STGs, EMLs, and LMLs is critical for both prescribing and procurement.
- Ensuring MoPH/GDPA ownership of NMFB and its active role in managing its day-to-day affairs, gradually transitioning the responsibility from the SPS program:
 - There should be active involvement of the Office of the Private Sector Coordination of the MoPH to ensure regular coordination with ANPA and ANSMO.

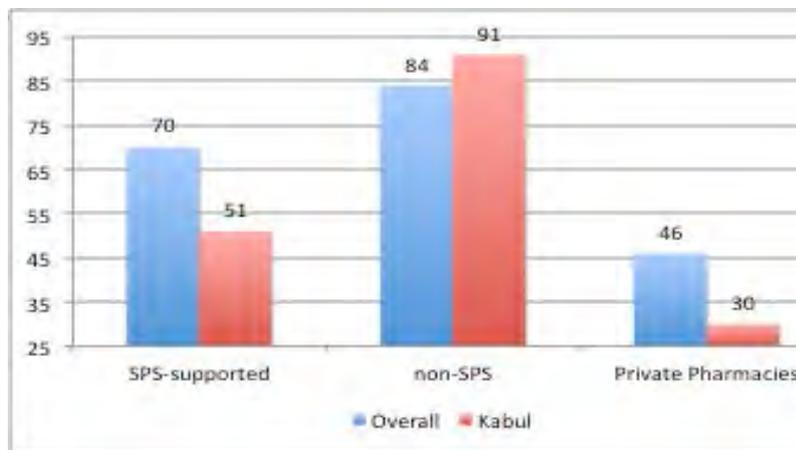
EVALUATION QUESTION 9:

How has the SPS program addressed gender equity issues, particularly in the provision of pharmaceutical services and the rational use of medicines?

There has not been a specific focus on gender equity in the SPS program, although efforts were made to build the capacity of the female staff within the program.

- Only 18 percent of total number of participants (~1,300) for SPS training activities were women.
- While MoPH has a policy on gender equity, it is only followed by a few PCH-NGOs (BRAC, Agha Khan Development Network, and Care of Afghan Families) when possible.
- Moving ahead, the SPS program should ensure that the PCH-NGOs and all the entities involved in the program have a clearly defined gender equity policy and guidelines, even if all the components of such a policy cannot be implemented immediately.
- Training and hiring women at health facilities should be a focus for SPS-supported health facilities, considering our findings from the patient exit survey, depicted in **Figure 6**.

Figure 6: Percent of Patients Visiting Health Facilities who are Women (Aug.-Sept. 2014)



- More than 70% of patients are women in SPS-supported facilities compared to more than 80% in non-SPS facilities. This gap is substantially larger in Kabul province.

IV. CONCLUSIONS

This section summarizes our conclusions drawn from the findings of this performance evaluation of the SPS program:

1. The SPS program has strengthened the MoPH, particularly GDPA, through improved policy development (e.g. National Medicines Policy) and decision-making at the national-level. However, the implementation of policies in both the public and private sector is lacking (e.g. pharmacy inspections, unlicensed pharmacies), especially at the provincial and local levels.
2. The procurement and supply chain management undertaken by SPS have ensured availability of high quality medicines at the facilities managed by the PCH-NGOs. This however has not resulted in capacity building of MoPH and the PCH-NGOs in undertaking procurement, which would be a mandate for these entities under the proposed SEHAT project. There has been no progress in the activity of establishing the quality control lab, which again is critical for pharmaceutical quality assurance.
3. SPS lacks a clear exit strategy. It is involved in a range of program activities with various organizations, including the National Medicines and Food Board (NMFB). It has weak coordination with MoPH/GDPA, which has threatened MoPH/GDPA ownership of pharmaceutical affairs, and consequently, the accountability and sustainability of the SPS activities.
4. The Essential Medicines List (EML) across all levels of care is outdated, and, along with the Standard Treatment Guidelines, is not available at nearly all SPS supported health facilities.
5. SPS supply does not align with the EML or with procurement patterns based on aggregate quantification of health facilities supported by the PCH-NGOs. Therefore, many facilities encounter shortages of essential medicines prescribed to their patients.
6. According to various key informants, there are more than 30 private pharmacy schools and 12,000 private pharmacies in the country; yet, the private sector is excluded from current SPS capacity-building activities, such as curriculum revisions and seminars/workshops on rational drug use.
7. In the community, medicines are delivered to patients from across all levels of care (from hospitals and comprehensive health centers that have a pharmacies onsite to basic health centers and health posts that do not have pharmacies) and prescribed primarily by community health workers (CHWs), nurses, and other prescribers, not by pharmacists. Yet, the SPS program targets only pharmacies and pharmacists. It is especially important to target CHWs and nurses who are women because a disproportionate number of female patients seek treatment at these health facilities.

8. PMIS/PLIS⁴ data collection and reporting does not align with the existing Health Management Information System (HMIS), and does not incorporate a quality improvement framework, thus limiting evidence-based decision-making. Furthermore, current SPS PMIS/PLIS training activities are focused at the central level of the PCH-NGOs, with limited coordination with the health facilities. This potentially limits monitoring and evaluation capacity at the local level.
9. SPS project management performance data collection and reporting lacks coordination, report validation, PCH-NGO oversight, and is limited to a select number of health facilities. Thus, it inadequately supports effective M&E, especially at the facility-level.
10. The SPS program does not address the affordability of medicine, a cornerstone of MSH. This affects access to essential medicines in various communities, especially considering the problem of stock-outs at health facilities and the cost of medicines at private pharmacies.
11. There is notable variation at the provincial level in key indicators, such as product availability, labeling of dispensed medicines, and pharmacy staffing patterns. One explanation might be that PCH-NGO practices, and/or the implementation of SPS activities at supported health facilities, affect the quality of pharmaceutical services.
12. The evaluation team has identified numerous knowledge gaps that need to be addressed, such as local prescribing patterns, in order to align program activities with priority needs at the community-level, and to improve the delivery and use of medicines and pharmaceutical services.

⁴ Pharmaceutical Management Information System/ Pharmaceutical Logistics Information System

V. RECOMMENDATIONS

Based on the purpose, findings, and conclusions of this SPS performance evaluation, the following recommendations are offered to USAID in the design and implementation of the SPS program moving forward.

High Priority

1. In the follow-on project, USAID should provide the necessary financial and technical resources to enable the MoPH to establish standardized procurement guidelines and develop the MoPH's capacity for undertaking high-quality procurement.
 - Specifically, we recommend that the MoPH (not PCH-NGOs, as currently envisaged) take the responsibility for procurement under SEHAT in order to ensure cost-effective procurement of quality medicines that rely on facility-based quantification.
2. In the follow-on project, USAID should prioritize and provide technical and financial resources to assist the MoPH/HMIS in establishing a Quality Improvement strategy to inform and develop a comprehensive PMIS/PLIS that is designed to align with the existing HMIS, with data collection and reporting done at the local level.
3. USAID should develop a clear exit strategy for SPS in the next ten months of programming. It should establish an administrative and management structure to undertake activities planned in the National Medicine Policy (in the follow-on project) that delineate the role of GDPA leadership in the NMFB transition into the FDA in order to ensure ownership, accountability, and long-term sustainability of the SPS activities.
 - Specifically, outline a timeline of processes and activities for transition of NMFB to FDA and clearly defined role of GDPA, focusing on regulatory oversight at central and provincial levels
4. USAID should provide SPS with external support in order to develop a PMP dashboard for effective monitoring and evaluation at the management- and facility-levels for all SPS-supported health facilities.
 - In the follow-on project, PMP indicators should be revised to reflect updated STGs and revised EMLs.
 - SPS should work with PCH-NGOs and MoPH in identifying staff at health facilities that should be trained in in PMP data collection, recording, and reporting.
 - USAID should provide external support to SPS in the development and validation of a comprehensive PMP dashboard within a quality improvement framework.
 - USAID should expand the M&E capacity of SPS by providing the financial and technical resources that are necessary to improve its current PMP and expand its data collection to all SPS-supported health

facilities. The evaluation team has developed a pilot master datasheet for guidance (annexed to this report).

5. In the follow-on project, USAID should expand the SPS mandate, and provide the necessary resources, to incorporate capacity-building efforts in rational medicines use and medicines safety to field staff across all levels of care, specifically CHW, nurses, and prescribers, who are more likely than a pharmacist to deliver medicines to the community. It is especially important to target female CHWs and nurses, considering our finding that a disproportionate number of women patients seek treatment at public health facilities.
6. USAID should provide the financial and technical resources to conduct community-based assessments on prescribing practices, STG compliance, and the use of medicines at the household-level. These assessments would inform program activities, including SPS drug supply, with patterns of medicines use in the community. Specific recommendations for initial studies are outlined in the report.
 - Facility-based studies to evaluate local prescribing patterns, and to determine and characterize the extent of prescriber compliance with STGs. This study will also inform the SPS medicines supply and the revision of the EMLs to align with facility-level prescribing, which will directly influence procurement and product availability.
 - A household consumption study to determine the types of medicines commonly used, by whom, and where they are purchased. This study would identify local treatment preferences and use; whether and how patients in specific communities use the BPHS health facilities; and the role of the private pharmacy. It may also improve awareness of unknown medication practices that are potentially harmful and unsafe.
 - An evaluation to study the private pharmacy market, and assess the quality of medicines available in the private sector.
 - A drug utilization study using existing procurement data to examine regional and facility-level utilization patterns.

Moderate Priority

7. In the next 10-months of programming, USAID should provide the necessary resources to enable SPS to facilitate the expansion of partnerships with private academic institutions providing pharmaceutical education in Afghanistan, and to establish linkages with internationally recognized pharmacy schools.
 - SPS should also work with the Afghanistan National Pharmacist Association (ANPA) to incorporate pharmacy staff from private pharmacies into their training activities.

8. Within the next ten months of programming, SPS should revise the national EML for primary care levels (e.g., CHC, BHC, HP) to reflect current treatment patterns, especially for the NCDs (heart disease and diabetes) and for mental health issues, which are increasingly prevalent in the population. In addition, in coordination with PCH-NGOs and the MoPH/GDPA, SPS should ensure Standard Treatment Guidelines (STGs) are available at all health facilities and all staff are informed and trained on their purposes.
9. In the follow-on project, USAID should allocate the necessary resources to ensure that SPS medicine supplies are aligned with a revised EML and with local prescribing patterns. Procurement should rely on facility-based quantification in order to prevent stock-outs of essential medicines prescribed to patients.

LESSONS LEARNED

- It is important to consider the capacity of field staff across all levels of care, including CHWs, who are more likely than a pharmacist to deliver medicines to the community.
- Regular revision and dissemination of STGs and EMLs is critical for improving prescription and procurement, and for use of essential medicines.
- Communities matter and SPS program activities have not been effectively translated at the implementation level to enhance the delivery of quality pharmaceutical services.
- The private sector, particularly private pharmacies, provides medicines to the vast majority of the population, including those that utilize public health facilities, and should not be excluded from SPS programming efforts.
- Affordability of medicines is not addressed by SPS program and may influence access to essential medicines in various population segments, which is the cornerstone of the SPS program.
- PCH-NGOs supporting the SPS program have various strengths and weakness, and their different abilities to deliver medicine may impact the coordinated functioning of SPS program implementation at their supported health facilities.

SWOT (Strengths Weaknesses Opportunities Threats) Analysis

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> ▪ Strong technical support from MSH SPS ▪ Technically strong local team ▪ Established coordination with the PCH-NGOs ▪ Well-coordinated procurement and supply management systems ▪ Active involvement of the academic institutions ▪ Fundamentals of appropriate pharmaceutical systems in place ▪ MoPH inclination to expand the system of DTCs across all facilities ▪ Committed continued support by USAID ▪ Synergy of public health activities under SEHAT 	<ul style="list-style-type: none"> ▪ Focus on too many activities simultaneously with limited resources ▪ Delays in providing timely technical support to MoPH due to the MSH HQ loop of feedback ▪ Inadequate involvement of the private pharmacy sector ▪ Revision of STGs not undertaken regularly ▪ Comprehensive management dashboard (fragmented PMP datasheet) not available for effective decision-making ▪ Lack of a clear exit strategy resulting in inability to adequately build the capacity of MoPH and sustainability.
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> ▪ Lack of linkages between the provincial pharmacy inspectors and GDPA. ▪ Inadequate monitoring and evaluation of HFs in high security risk provinces leading to weak and incomplete program performance monitoring. ▪ Lack of provision for regular update of the STGs, EMLs and LMLs ▪ Limited availability of STGs and updated EMLs at the HFs ▪ The PMP datasheet is not robust enough to provide all the necessary information for management action. ▪ Ownership and inclination of MoPH to focus on pharmaceutical issues ▪ Private sector organized under the umbrella of ANSMO. ▪ PCH-NGOs interested in continuing with SPS protocol of centralized procurement and coordinated supply chain 	<ul style="list-style-type: none"> ▪ Fragile political situation and ever present security risk ▪ Inability to access some health facilities due to security risks ▪ Provision of independent procurement responsibilities to NGOs under SEHAT, doing away with pooled procurement ▪ High turnover of human resources at all levels ▪ Supply chain efficiency dependent on timely receipt of products from Pakistan (Karachi port), prone to unanticipated delays. ▪ Fragmented decentralized pharmaceutical sector.

ANNEX I: SCOPE OF WORK

**OFFICE OF SOCIAL SECTOR DEVELOPMENT (OSSD) /
OFFICE OF PROGRAM AND PROJECT DEVELOPMENT (OPPD)**

STATEMENT OF WORK: PERFORMANCE EVALUATION

STRENGTHENING PHARMACEUTICAL SYSTEMS (SPS)

**LEADER WITH ASSOCIATES COOPERATIVE AGREEMENT NUMBER: 306-A-00-11-00532-00 WITH
MANAGEMENT SCIENCES FOR HEALTH (MSH),
UNDER LEADER AWARD NUMBER: GHN-A-00-07-00002-00**

I. INTRODUCTION

The U.S. Agency for International Development (USAID) Evaluation Policy (2011) encourages independent external evaluation to increase accountability, to inform stakeholders who develop programs and strategies, and to refine designs and introduce improvements into future efforts and investments. In keeping with these aims, USAID/Afghanistan requests technical assistance to conduct an independent external formative performance evaluation of the Strengthening Pharmaceutical Systems Program (SPS), implemented by Management Sciences for Health (MSH) at the national level. The SPS program is managed by USAID/Afghanistan's Office of Social Sector Development (OSSD). The evaluation will focus on assessing the SPS program from its beginning in August 2011 to the present in achieving its goal and objectives. SPS is a four-year project; the end date is August 27, 2015. The findings of the performance evaluation will be used by USAID to design a follow-on project. Further, the evaluation will focus on answering the evaluation questions listed under Section V. The **Program Goal** of SPS is improved and sustainable health impact.

II. BACKGROUND AND CONTEXT

Over the past twelve years, Afghanistan achieved significant progress in the health sector; however, the country continues to face major development challenges. These development challenges, particularly in the health sector, necessitate a sustained, proactive partnership between the international community and the Government of the Islamic Republic of Afghanistan (GIRoA). U.S. Government (USG) health programs in Afghanistan directly support the joint USG and GIRoA goal of achieving national health targets as outlined in the Afghanistan National Health and Nutrition Sector Strategy, Afghanistan National Development Strategy (ANDS), and National Priority Program No. 5. The Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) are the cornerstone of the strategy for the Ministry of Public Health (MoPH) and all donors. USAID technical support to the BPHS/EPHS includes: 1) strengthening the leadership and management capabilities of the central MoPH to support the delivery of BPHS and EPHS services in 13 provinces, primarily through non-governmental organization (NGO) service providers; 2) enhancing staff capacity of the 17 partner Provincial Public Health Offices (PPHO) of MoPH to support delivery of the BPHS and EPHS; 3) strengthening the MoPH's disease surveillance systems, such as the Disease Early Warning System (DEWS) and the Acute Flaccid Paralysis surveillance system; 4) improving health data collection, analysis, and management at all tiers of the system, and in facilities and communities where services

are delivered; 5) strengthening hospital financial and procurement accountability and responsibility; and 6) strengthening pharmaceutical management systems and staff capacity. Work is also being done through BPHS in the areas of tuberculosis response, polio eradication, and routine immunization. In the past year, 547 health facilities and more than 6,000 health posts provided basic primary health care to over half of the Afghan population.

USAID also supports the procurement and delivery of essential drugs and contraceptives to public health facilities in 13 provinces –valued at \$4.8 million in 2013. USAID has also helped strengthen the essential drug and contraceptive regulatory capacity of the MoPH. For example, USAID supported the National Medicine and Food Board to draft a three-year strategic plan and a one-year action plan that outline concrete activities to ensure quality of food and medicines in Afghanistan as well as the drafting of the National Pharmaceutical Human Resources Strategic Framework. These efforts will enable the MoPH to better plan their workforce needs in regard to pharmaceuticals and to ensure that staff are strategically placed.

USAID also promotes private sector support for the achievement of public health objectives. In 2013, social marketing efforts resulted in the sale of over 11.3 million condoms, and oral and injectable contraceptive products. However, the program has reached only 51% of its 2013 Couple Years of Protection target due to stock-outs of family planning products caused by unexpected delays in shipping and poor procurement planning. Efforts to rectify this situation are ongoing, including creating more realistic procurement plans based on regular past sales patterns and the unpredictability of shipping through Pakistan.

In addition, USAID supports a large communications campaign which aims to increase demand for these products as well as training for pharmacists, shopkeepers and community members in product usage. In 2013, a total of 673 pharmacists, 19 shopkeepers and 73 NGO staff received training in Family Planning (FP). Over 557 community Shura members participated in health meetings on these topics, while over 1,695 TV and 2,421 radio spots collectively reached an estimated 12 million viewers and listeners. By March 2013, 1,871 Community Health Workers, community health supervisors, midwives, nurses and doctors attended NGO-provided training on skills and knowledge which included provision of FP counseling.

In 2008, USAID/Afghanistan invited MSH—through its SPS Program—to provide technical assistance and support to the MoPH to improve the pharmaceutical system. Since then, SPS has worked closely with the MoPH to (1) improve the use of medicines, (2) build MoPH's capacity to manage pharmaceutical services, (3) build the capacity of the MoPH to ensure the quality of pharmaceutical products, and (4) establish a coordinated procurement and distribution system.

Through SPS in Afghanistan, USAID works closely with the Afghan Ministry of Public Health (MoPH) to improve the rational use of medicine, build the capacity of MoPH to manage pharmaceutical services, strengthen the capacity of the MoPH to ensure the quality of pharmaceutical products entering and used within the country, establish a coordinated procurement and distribution system, and design a system for USAID procurement of pharmaceuticals. Through SPS, USAID brings essential medicine distribution together with strong technical assistance in pharmaceutical management to build on the work initiated under other projects. SPS works with the MoPH General Directorate of Pharmaceutical Affairs and the National Drug and Therapeutic Committee (NDTC) to improve the selection,

procurement, distribution, and rational use of drugs. Drug and Therapeutics Committees have also been established in 8 national, provincial and district hospitals, and will be scaled up to additional hospitals over the next four years. SPS is working with the Kabul University Faculty of Pharmacy to strengthen the curriculum to include the rational use of medicines and anti-microbial resistance and with the MoPH to develop and operationalize the use of Standard Treatment Guidelines in BPHS health facilities across Afghanistan.

In August 2011, USAID awarded an Associate Award to MSH under the SPS Program. The SPS Afghanistan Associate Award is a four-year, \$24.5-million project which strives to build capacity to effectively manage all aspects of pharmaceutical systems and services. SPS focuses on improving governance in the pharmaceutical sector, strengthening pharmaceutical management systems and financing mechanisms, containing antimicrobial resistance, and enhancing access to and appropriate use of medicines.

SPS was originally designed to align with USAID/Afghanistan’s Mission Assistance Objective 2: Improved health of the population. However, the Mission’s results framework recently underwent revisions to align with the USAID/Afghanistan Strategy for Transformation (2015-2024). Under the Mission’s new Results Framework the goal of USAID assistance is “Afghan-led Sustainable Development”. In order to achieve this goal USAID expects to meet the Intermediate Result (IR), “Health Outcomes Improved”, and the Sub-IRs, “Afghan Ownership to Ensure an Effective Health Response Strengthened” and “Use of Quality Health Services Increased.” The activities implemented under the SPS program directly contribute to the IR as well as both Sub-IRS. The health portion of the Mission’s Results Framework is represented graphically below.



Beginning in June 2014, USG support for the public health sector will be channeled through the World Bank’s Afghanistan Reconstruction Trust Fund (ARTF). Through ARTF and its Integrated Health Services & Systems Strengthening Project (IHSSSP), USAID will contribute USG on-budget support to the World Bank’s System Enhancement for Health Action in Transition (SEHAT) Program. IHSSSP will also have an off-budget component to complement the work being done through SEHAT. IHSSSP (including both on- and off-budget components) is a \$477 million, five-year project. The project addresses four technical areas: effective utilization of BPHS and other health services, strengthened private sector health services and products, improved GIRoA stewardship of the health system and

promotion of healthy behaviors. At the core of IHSSSP is the **development hypothesis** that strengthening Afghan ownership to ensure an effective health response and increasing use of quality health services will lead to improved health outcomes. SPS is one of several off-budget components that make up IHSSSP.

III. PROJECT GOALS AND OBJECTIVES

The SPS 2013 Annual Report states the Technical Objectives of the program:

Technical Objectives:

- 1) Strengthen medicines regulatory capacity;
- 2) Improve supply chain management and commodity security to assure product availability;
- 3) Build human resource capacity for effective service delivery;
- 4) Enhance pharmaceutical services to achieve desired health outcomes; and
- 5) Address information for decision-making challenges in the pharmaceutical sector.

The intended intermediate results (IRs) and activities of the project are:

- **IR 1.1: Ministry of Public Health (MoPH) capacity to regulate medicines strengthened.**
- **IR 1.2: Public and private sector quality assurance systems strengthened.**
- **IR 2.1: Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) providers' pharmaceutical supply chain management strengthened.**
 - **Intervention 2.1.1:** Provide technical assistance to ensure an uninterrupted supply of essential medicines and health commodities to BPHS and EPHS providers;
 - **Intervention 2.1.2:** Provide technical assistance to build the institutional capacity of Partnership Contracts for Health (PCH) NGOs for assuming critical functions in procurement and distribution.
- **IR 2.2: Coordination among the international donor community, the MoPH and other relevant stakeholders strengthened.**
 - **Intervention 2.2.1:** Facilitate activities to develop and sustain good governance by strengthening the coordination and capacity of Coordinated Procurement and Distribution System (CPDS) stakeholders;
 - **Intervention 2.2.2:** Provide technical assistance to harmonize pharmaceutical supply management among stakeholders and build MoPH capacity toward the maintenance of a sustainable procurement and distribution system;
 - **Intervention 2.2.3:** Provide technical assistance to develop a Pharmaceutical Logistics Information System (PLIS) and build stakeholder capacity to use the information in planning and decision-making;
 - **Intervention 2.2.4:** Provide technical assistance to selected MoPH officials and BPHS/EPHS implementers on the use of PLIS data for quantification and redistribution.

- **IR 3.1: Institutional and human resource pharmaceutical management capacity built.**
 - **Intervention 3.1.1:** Build MoPH capacity to plan pharmaceutical human resources;
 - **Intervention 3.1.2:** Assist MoPH with pharmaceutical sector capacity development;
 - **Intervention 3.1.3:** Provide technical assistance for development, implementation, and improvement of pharmaceutical management training and training materials.

- **IR 4.1: Provide assistance to promote more effective pharmaceutical services, rational medicine use, and medicines safety.**
 - **Intervention 4.1.1:** Support the development of standard treatment guidelines;
 - **Intervention 4.1.2:** Support Essential Drug List/License Drug List revision process;
 - **Intervention 4.1.3:** Provide targeted technical assistance to BPHS implementers;
 - **Intervention 4.1.4:** Support the stock management practices of the Pharmaceutical Enterprise;
 - **Intervention 4.1.5:** Provide support to the Afghanistan Nationwide Pharmacists Association;
 - **Intervention 4.1.6:** Disseminate public health messages on correct use of medicines through mass media;
 - **Intervention 4.1.7:** Support the appropriate functioning of national, regional, provincial, and institutional Drug and Therapeutics Committees (DTCs) to oversee the implementation of rational use strategies and interventions;
 - **Intervention 4.1.8:** Support the development of feasible monitoring program for medicines safety in at least two hospitals to demonstrate the public health value of Pharmacovigilance in Afghanistan.

- **IR 5.1: Pharmaceutical management information systems to support evidence-based decision-making strengthened.**
 - **Intervention 5.1.1:** Support the development of a comprehensive computerized Pharmaceutical Management Information System (PMIS).

IV. PURPOSE AND USE OF THIS EVALUATION

The Strengthening Pharmaceutical Systems program has been active since 2008 and to date the program has not undergone an external performance evaluation. The evaluation will assess SPS performance from August 2011, when the current four-year iteration of the project began. On August 27, 2015, the current iteration of the SPS program will come to an end and USAID is planning for a follow-on project to begin shortly thereafter. The findings and recommendations of the formative performance evaluation of SPS will be utilized by USAID as input into the design of the SPS follow-on project; the design process will begin at the earliest in July 2014. USAID will also use the results of this evaluation to determine resource allocation decisions and the recommendations it will make to the MoPH, other donors and

stakeholders regarding the future development of pharmaceutical supply and distribution systems in Afghanistan.

The intended audience for the evaluation recommendations is USAID decision-makers in OSSD-Health and the Office of Project and Program Development (OPPD) as well as USAID/Afghanistan Senior Leadership. In addition, the evaluation recommendations will be shared with USAID/Washington, stakeholders within the MoPH including MoPH Senior Leadership, and staff at the implementing partner MSH.

In particular, USAID expects that the evaluation will identify lessons learned through implementation of the SPS program and will recommend program components and or activities that merit discontinuation, continuation, or expansion as well as actionable recommendations for the future for stakeholders.

V. EVALUATION QUESTIONS

1. To what extent has the SPS program strengthened the pharmaceutical regulatory and quality assurance system in Afghanistan?
2. How has the SPS program addressed the capacity of GDPA (General Directorate of Pharmaceutical Affairs) at national and subnational levels?
3. How has the SPS program improved pharmaceutical supply chain management in Afghanistan to ensure product availability?
4. As a result of the SPS program, what gaps in MoPH and NGO pharmaceutical systems human resources capacity have been addressed? What gaps still exist and how could these gaps be addressed in the future?
5. To what extent has the SPS program strengthened pharmaceutical services, improved rational medicine use and medicines safety?
6. How has the SPS implementation of PMIS (Pharmaceutical Management Information Systems) improved evidence-based decision-making in the pharmaceutical sector in Afghanistan?
7. Do any policies, laws, regulations, and standard operating procedures need to be developed and institutionalized in order to have an effective coordination of the pharmaceutical procurement and distribution system in the country?
8. In light of evaluation findings, what lessons learned can be identified that apply to future pharmaceutical system programs under SEHAT (with particular emphasis on monitoring of pharmaceutical quality) or future off-budget projects?
9. How has the SPS program addressed gender equity issues, particularly in the provision of pharmaceutical services and the rational use of medicines?

VI. EVALUATION METHODS

The evaluation methodology should comply with the USAID Evaluation Policy, be outlined as part of the draft work plan per Section IX below, and be attached to the final evaluation report. Methodology strengths and weaknesses should be identified as well as measures taken to address those weaknesses. Any limitations in carrying out the methodology should be explained. All data collected and presented in the evaluation report must be disaggregated by gender and geography when possible.

The evaluation team will be responsible for developing an evaluation strategy and methodology that includes a mix of qualitative and quantitative data collection and analysis approaches. The evaluation team will propose the analytic design/technical approach, analysis plan and any necessary data collection methods in addition to those listed below. The evaluation team will have available for their analysis a variety of program implementation documents and reports. Further, the evaluation team will design, pilot, and implement the most appropriate evaluation tools as possible taking limitations in the Afghanistan environment – for example, limitations on travel due to security concerns – into

account. The team must also provide USAID with the opportunity to review evaluation tools prior to piloting or final implementation.

The evaluation approach should be participatory in design and implementation, and should include but is not limited to key informant interviews, focus group discussions, semi-structured questionnaires and/or surveys, desk analysis of existing data, and site visits/observation.

- **Desk review:** Program documents, i.e. contracts or cooperative agreements, Mission and Project Performance Management Plans (PMPs), implementing partner reports, quarterly/annual reports, training materials and registers, and other documents mentioned in Section VII.
- **Key Informant Interviews/Focus Group Discussions:** Key individuals and groups will be interviewed to collect qualitative information on the evaluation questions. The interviews will be with USAID/Afghanistan project staff, relevant MoPH staff (General Directorate of Pharmaceutical Affairs, GCMU staff, senior MoPH management staff) MSH/SPS senior management and staff, health facility and PCH NGO staff, Afghanistan Nationwide Pharmacists Association members, DTC members, other project beneficiaries, and relevant stakeholders (e.g. donors) at central, provincial, district and community levels.
- **Data analysis of available relevant datasets:** SPS data is collected separately from the MoPH, and is not a direct part of the Health Management Information System (HMIS); however, any existing or possible linkages will be examined by the evaluation team.
- **Visits to BPHS/EPHS Implementers and PCH-NGOs.** Given the reach of SPS, the evaluation team will select a sample of supported health facilities and PCH-NGOs, with consideration of key variables such as geography, and will report on limitations of this method. The evaluation team will develop the sampling frame.

The evaluation team is required to meet with an appropriate sample of all stakeholders identified. In its work plan, the evaluation team will develop and present to USAID a clear methodology of the sampling approach prior to implementation to ensure an adequate cross-section of qualitative and quantitative data collected for later analysis in the final report. The design and methodology will be finalized after the team has an opportunity to gather detailed information and discuss final issues with USAID.

Due to the constantly changing security situation in Afghanistan, close coordination with USAID/Afghanistan will be necessary to ensure that the evaluation team selects methods, a sampling approach, and site visits suitable given the security environment. If security precludes application of certain evaluation methodologies, the USAID implementing partner that hired the evaluation team will inform USAID's Evaluation Officer and Health Team.

VII. EXISTING PERFORMANCE INFORMATION SOURCES

The evaluation team will be expected to meet with USAID/Afghanistan Health and M&E staff; the MoPH at senior levels and SPS senior management and mid-level staff; - if the security situation permits. The evaluation team will review the following broad range of background and program documents including, but not limited to:

- a) Program Descriptions and Modifications
- b) Work Plans
- c) Quarterly Reports
- d) Annual Reports
- e) Other partner monitoring reports
- f) PMP and other M&E documents
- g) Project performance data
- h) Project-generated assessments, including the Procurement and Distribution Options Analysis for SPS.
- i) Relevant external evaluations from other sources (e.g., other donors)
- j) GIROA performance data (if available)

VIII. EVALUATION TEAM COMPOSITION

The evaluation team shall be a five person team consisting of three independent public health experts; one team member will also be an ex-pat evaluation expert. The team leader should be an ex-pat pharmaceutical services specialist with considerable experience working with and/or evaluating pharmaceutical systems in developing countries and will serve as the primary team lead. The evaluation specialist will report to the team leader and should have experience managing evaluation teams in developing countries, writing evaluation reports in English and coordinating with USAID. A statement of potential bias or conflict of interest (or lack thereof) is required of each team member.

The evaluation team leader should be an ex-pat senior public health expert who is a specialist in pharmaceutical services and supply chain management. S/he should have the following additional qualifications:

1. Strong skills in program implementation, monitoring and evaluation of disease pharmaceutical systems (preferably more than 7 years) in developing country contexts;
2. Strong management skills and experience leading teams, preferably evaluation teams;
3. Experience analyzing and presenting evaluation data, experience as a lead author on evaluation reports is preferred;
4. Knowledge of the Afghan health sector or significant regional experience (7 or more years).

The evaluation specialist should be an ex-pat with preferably 7 or more years of evaluation or research experience in developing countries. Experience leading evaluation teams in a developing country context and serving as lead author on evaluation reports in English is required. Experience evaluating public health programs preferred. In addition s/he should have:

1. Experience in evaluation team management including coordination of meetings, field visits, periodic reporting, planning travel and other logistics, and professional analytical evaluation reports – note that the USAID implementing partner for the evaluation will take the responsibility for managing the evaluation travel and other logistics needs in support of the evaluation team;
2. Significant knowledge of evaluation design and methods and/or applied research.
3. Strong English writing skills.

A third member of the team should be an ex-pat or Afghan senior/mid-level public health expert with experience in pharmaceutical services and/or logistics and supply chain management. S/he should have the following additional qualifications:

1. Strong skills in program implementation, monitoring and evaluation of disease pharmaceutical systems (preferably more than 5 years) in developing country contexts;
2. Experience analyzing and presenting evaluation data, experience as an author on evaluation reports is preferred;
3. Knowledge of the Afghan health sector or significant regional experience (5 or more years).

The two Afghan evaluation specialists should have experience working in the public health sector. Experience working in pharmaceutical services or supply chain management is strongly preferred. In addition:

1. Strong skills in monitoring and evaluation are preferred.
2. Knowledge of terminology related to pharmaceutical systems in English, Dari and Pashto is strongly preferred.
3. Strong skills in spoken and written English as well as Dari and Pashto are required.

IX. EVALUATION SCHEDULE

The estimated time period for undertaking this evaluation is 45 working days, from July 1, 2014 – August 22, 2014. The ideal arrival time in Afghanistan will be finalized between USAID and the organization conducting the evaluation.

The evaluation team is required to work six days a week. The team is required to travel to selected provinces in each region where program activities are being implemented. At least 50% of the consultants' time will be spent outside Kabul to conduct interviews with municipal officials, project staff, government officials, and the public. The evaluation team will prepare an exit briefing and presentation of the findings, which it will deliver to USAID staff before the consultants depart Afghanistan. Also, the evaluation team will submit a draft report **24 hours in advance of the exit briefing** for review and comments by USAID. Comments from USAID will be incorporated before the submission of the final draft. The target date for completion of the final evaluation report is July 22, 2014. Receipt of the final evaluation report by August will allow USAID to incorporate the evaluation findings and recommendations into the project design for the follow-on project to SPS that will begin in September 2015.

Level of Effort (LOE) in Days:

Activity	LOE for Ex-pat Team Leader/Health Specialist	LOE for Ex-pat Evaluation Specialist	LOE for Ex-pat or Local Health Specialist	LOE for CCN#1	LOE for CCN#2
Document review, work plan development, draft questions, data collection and analysis plan, proposed list of interviewees, finalized questions based on qualitative approach	4	4	4	5	5
Travel to/from Afghanistan	4	4	4 if expat or 0 if local	0	0
In-briefing with USAID	1	1	1	1	1
Interviews/focus groups/surveys (based on 8 regions for sample)	23	23	23	25	25
Mid-Term briefing with USAID	1	1	1	1	1
Data analysis, translation, preliminary report, and final presentation preparation	5	5	5	2	2
Draft final report preparation	4	4	4	1	1
Final exit presentation to USAID (with PowerPoint presentation and draft evaluation report)	1	1	1	1	1
Final evaluation report+ one page briefer preparation	2	2	2	0	0
Total	45	45	45 or 41	36	36

X. USAID MANAGEMENT

The evaluation team will officially report to SUPPORT II, managed by Checchi and Company Consulting, Inc. SUPPORT II is responsible for all direct coordination with the USAID/Afghanistan OPPD, through the Contract Officer's Representative for SUPPORT II. From a technical management perspective, the evaluation team will work closely with the member(s) of USAID's Health Team in OSSD, assigned to manage and oversee assistance for SPS. In order to maintain objectivity, all final decisions about the evaluation will be made by OPPD's M&E Unit.

XI. REPORTING REQUIREMENTS AND DELIVERABLES

a. DESCRIPTION AND TIMELINE OF DELIVERABLES

- In-briefing:** Within 48 hours of arrival in Kabul, the evaluation team, will have an in-brief meeting with USAID/Afghanistan's OPPD M&E Unit and Office of Social Sector Development (OSSD) for introductions, presentation of the team's understanding of the assignment, initial assumptions, review of the evaluation questions, public perception survey instrument (if required) discussion of initial work plan, and/or adjustment of the SOW if necessary.
- Evaluation Work Plan:** The evaluation team shall provide a detailed initial work plan to OPPD's M&E Unit and the OSSD Health Team and a revised

work plan three days after the in-briefing. USAID will share the revised work plan with GIRoA for comment, as needed, and will revise accordingly. The initial work plan will include (a) the overall evaluation design, including the proposed methodology, data collection and analysis plan, and data collection instruments; (b) a list of the team members indicating their primary contact details while in-country, including the e-mail address and mobile phone number for the team leader; and (c) the team's proposed schedule for the evaluation. The revised work plan shall include the list of potential interviewees, sites to be visited, and evaluation tools.

- 3. Mid-term Briefing and Interim Meetings:** Schedule a mid-term briefing with USAID to review the status of the evaluation's progress, particular emphasis will be on addressing the evaluation's questions and a brief update on potential challenges and emerging opportunities. The team will also provide the Contracting Officer's Representatives for SUPPORT II and SPS with periodic written briefings and feedback on the team's findings. Additionally, a weekly 30 minute phone call with OPPD's M&E Unit and the OSSD/Health Team Leader (or designee) will provide updates on field progress and any problems encountered.
- 4. PowerPoint and Final Exit Presentation:** will include a summary of key findings and key conclusions as these relate to the evaluation's questions and recommendations to USAID. The presentation will be scheduled as agreed upon during the in-briefing, and five days prior to the evaluation team's departure from Kabul. A copy of the PowerPoint file will be provided to the OPPD M&E Unit prior to the final exit presentation.
- 5. First Draft of Report, PowerPoint and Final Exit Debriefing:** Shall be consistent with the guidance provided in Section XII below. Length of the report: not to exceed 50 pages, exclusive of Annexes in English, using Times New Roman 12 point font, 1.15 lines spacing, consistent with USAID branding policy. The report will address each of the issues and questions identified in the SPS Evaluation SOW and any other factors the team considers to have a bearing on the objectives of the evaluation. Any such factors can be included in the report only after consultation with USAID.

The draft evaluation report will be submitted by the evaluation team leader to OPPD's M&E Unit for review and comments by USAID. USAID's M&E Unit and OSSD Health Team will have ten calendar days in which to review and comment and OPPD's M&E Unit shall submit all comments to the evaluation team leader.

- 6. Final Evaluation Report** will incorporate final comments provided by the M&E Unit. USAID comments are due within ten days after the receipt of the initial final draft. The final report should be submitted to the OPPD M&E Unit within three days of receipt of comments by the evaluation team leader. All project data and records will be submitted in full and shall be in electronic form in easily accessible and readable format; organized and fully document for use by those not fully familiar with the project or evaluation; and owned by USAID and made available to the public barring rare exceptions.

7. **A One-page Briefer** on key qualitative and quantitative findings and conclusions relative to the evaluation questions to be given to the appropriate municipal government, provincial government, and/or GIRA representative(s), so that they have the opportunity to review evaluation findings and share them with the larger community. Each briefer shall be translated in Dari and/or Pashto. Each briefer will be reviewed by the OPPD M&E Unit and OSSD Health Team prior to distribution.

A. FINAL REPORT CONTENT

The evaluation report shall include the following:

1. **Title Page**
2. **Table of Contents (including Table of Figures and Table of Charts, if needed)**
3. **List of Acronyms**
4. **Acknowledgements or Preface (optional)**
5. **Executive Summary (3-5 pages)**
6. **Introductory Chapter**
 - a. A description of the project evaluated, including goals and objectives.
 - b. Brief statement on purpose of the evaluation, including a list of the main evaluation questions.
 - c. Brief statement on the methods used in the evaluation such as desk/document review, interviews, site visits, surveys, etc.
 - d. Explanation of any limitations of the evaluation—especially with respect to the methodology (e.g., selection bias, recall bias, unobservable differences between comparator groups, etc.)—and how these limitations affect the findings.
7. **Findings:** This section should include findings focusing on each of the evaluation questions.
8. **Conclusions:** This section should include value statements drawn from the data gathered during the evaluation process. It should also reference how any limitations affect the conclusions.
9. **Recommendations:** Based on the conclusions, this section must include actionable statements that can be implemented into the existing program or included into future program design. Recommendations are only valid when they specify who does what, and relate to activities over which the USAID

program has control. For example, recommendations describing government action is not valid, as USAID has no direct control over government actions. Alternatively, the recommendation may state how USAID resources may be leveraged to initiate change in government behavior and activities. It should also include recommended future objectives and types of specific activities based on lessons learned.

10. Annex: The Annexes to the final evaluation report should be submitted as separate documents—with appropriate labels in the document file name (e.g., Annex 1 – Evaluation SOW), and headers within the document itself—and may be aggregated in a single zipped folder.

- a. Evaluation Statement of Work
- b. Places visited; list of organizations and people interviewed, including contact details.
- c. Evaluation design and methodology.
- d. Copies of all tools such as survey instruments, questionnaires, discussions guides, checklists.
- e. Bibliography of critical background documents.
- f. Meeting notes of all key meetings with stakeholders.
- g. “Statement of Differences”
- h. Evaluation Team CVs

B. REPORTING GUIDELINES

- The evaluation report should represent a thoughtful, well-researched and well-organized effort to objectively evaluate what worked in the project over the given time period, what did not, and why.
- Evaluation reports shall address all evaluation questions included in the statement of work.
- The evaluation report should include the statement of work as an annex. All modifications to the statement of work, whether in technical requirements, evaluation questions, evaluation team composition, methodology, or timeline need to be agreed upon in writing by the OPPD M&E unit.
- Evaluation methodology shall be explained in detail and all tools used in conducting the evaluation such as questionnaires, checklists and discussion guides will be included in an annex in the final report.

- Evaluation findings will assess outcomes and impact on males and females, and data will be disaggregated by gender, age group, and geographic area wherever feasible.
- Limitations to the evaluation shall be disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence, and data and not based on anecdotes, hearsay or the compilation of people's opinions.
- Findings should be specific, concise and supported by strong quantitative and/or qualitative evidence.
- Sources of information, including any peer-reviewed or grey literature, will be properly identified and listed in an annex.
- Recommendations will be supported by a specific set of findings. They will also be action-oriented, practical, and specific, with defined responsible parties for each action.

ANNEX II: WORKPLAN

WORKPLAN

PERFORMANCE EVALUATION

OF

**STRENGTHENING PHARMACEUTICAL SYSTEMS (SPS)
PROGRAM**

**LEADER WITH ASSOCIATES COOPERATIVE AGREEMENT NUMBER: 306-A-00-11-00532-00 WITH MANAGEMENT SCIENCES FOR HEALTH (MSH),
UNDER LEADER AWARD NUMBER: GHN-A-00-07-00002-00**

Submitted on:

August 16, 2014

1. Purpose of the Performance Evaluation

Strengthening Pharmaceutical Systems (SPS) program is implemented by Management Sciences for Health (MSH) at the national level. USAID/Afghanistan's Office of Social Sector Development (OSSD) manages the SPS program which has been active since 2008 and has yet to undergo an external performance evaluation. The current 4-year iteration of the SPS program began in August 2011. The purpose of this evaluation is to assess the effectiveness of the SPS program in improving and strengthening various strategic components of the pharmaceutical sector in Afghanistan. On August 27, 2015, the current iteration of the SPS program will come to an end and USAID is planning for a follow-on project to begin shortly thereafter. Therefore, the findings and recommendations of this final performance evaluation of SPS will be utilized by USAID as input into the design of the SPS follow-on project. USAID will also use the results of this evaluation to determine resource allocation decisions and the recommendations it will make to the Ministry of Public Health (MoPH), other donors and stakeholders regarding the future development of pharmaceutical supply and distribution systems in Afghanistan.

The intended audience for the evaluation recommendations is USAID decision-makers in the OSSD-Health and the Office of Project and Program Development (OPPD) as well as USAID/Afghanistan Senior Leadership. In addition, the evaluation recommendations will be shared with USAID/Washington, stakeholders within the MoPH including senior leadership, and staff at the implementing partner MSH.

In particular, USAID expects that the evaluation will identify lessons learned through implementation of the SPS program and will recommend program components and or activities that merit discontinuation, continuation, or expansion as well as actionable recommendations for the future for stakeholders.

2. Proposed Methodology:

Our findings and recommendations will be based on the following evaluation questions that will determine whether and how the SPS the program performed in meeting its stated objectives.

2.1 Evaluation Questions

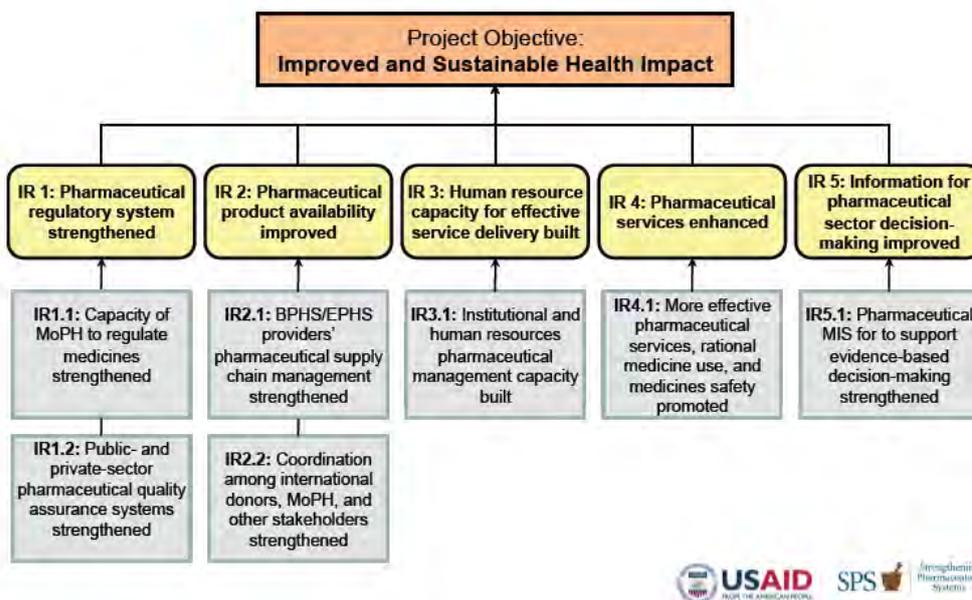
1. To what extent has the SPS program strengthened the pharmaceutical regulatory and quality assurance system in Afghanistan?
2. How has the SPS program addressed the capacity of GDPA (General Directorate of Pharmaceutical Affairs) at national and subnational levels?
3. How has the SPS program improved pharmaceutical supply chain management in Afghanistan to ensure product availability?
4. As a result of the SPS program, what gaps in MoPH and NGO pharmaceutical systems human resources capacity have been addressed? What gaps still exist and how could these gaps be addressed in the future?
5. To what extent has the SPS program strengthened pharmaceutical services, improved rational medicine use and medicines safety?

6. How has the SPS implementation of PMIS (Pharmaceutical Management Information Systems) improved evidence-based decision-making in the pharmaceutical sector in Afghanistan?
7. Do any policies, laws, regulations, and standard operating procedures need to be developed and institutionalized in order to have an effective coordination of the pharmaceutical procurement and distribution system in the country?
8. In light of evaluation findings, what lessons learned can be identified that apply to future pharmaceutical system programs under SEHAT (with particular emphasis on monitoring of pharmaceutical quality) or future off-budget projects?
9. How has the SPS program addressed gender equity issues, particularly in the provision of pharmaceutical services and the rational use of medicines?

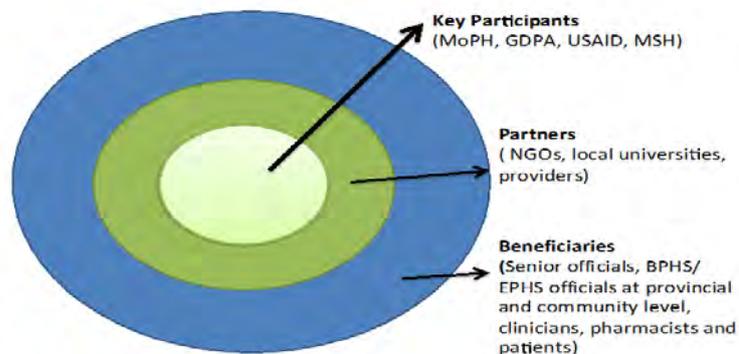
2.2 Approach

2.3 Framework

This performance evaluation will be guided by the USAID/SPS AA Results Framework that includes the Objectives and Intermediate Results (IR) outlined in the figure below. To determine if SPS program activities were effective in improving these technical objectives, we will use an evaluation approach that is participatory in design and includes both qualitative and quantitative data collection and analysis strategies that target various stakeholders. We may also utilize other tools such as SWOT analyses to inform our evaluation.



2.4 Stakeholder Mapping



2.5 Methods of Data Collection and Analysis

Methods	Data Sources	Sampling Approach	Data Analysis Methods
1. Document Review	<ol style="list-style-type: none"> SPS program documents (e.g. program description, situational analysis, PMPs, Annual/Quarterly Reports) Training Material and manuals (e.g. STGs, EDLs/LDL PharmD curricula) Relevant external reports/articles on the health and pharmaceutical sector in Afghanistan (e.g. National Medicines Policy) 	<ul style="list-style-type: none"> NA 	<ul style="list-style-type: none"> Content analysis with a focus on relevant evaluation questions
2. Key Informant Interviews/ Focus Groups with all key stakeholders	<ol style="list-style-type: none"> MSH/SPS, USAID staff MoPH and GDPA <ol style="list-style-type: none"> CMS TAB CPDS NMFD GCMU STGs/DTC committee Kabul University BPHS/HF NGOs Nationwide Pharmacist Association members <p>*at national, provincial and community-levels.</p>	<ul style="list-style-type: none"> Purposive (for pre-specified informed persons) Census of PCH-NGOs (all PCH NGO SPS coordinators will be interviewed) 	<ul style="list-style-type: none"> Content analysis of primary data (qualitative information) collected during interviews/discussions based on the evaluation questions. Case studies
3. Secondary Data Analysis of Existing data sets	<ol style="list-style-type: none"> PMPs PRIS HMIS (if possible) 	<ul style="list-style-type: none"> NA 	<ul style="list-style-type: none"> Descriptive statistics at the national, provincial, community and facility level
d. Site visits/ observations	<ol style="list-style-type: none"> Survey Instrument Direct Observation checklists notes 	<ul style="list-style-type: none"> Sampling frame (all SPS and non-SPS supported HF and pharmacies that are available in the 13 served provinces) Simple random sample Of 5% of sites (HF and pharmacies) with at least 2 PH and DH. Replacement may be necessary due to security and transportation limitations. A convenience sample of 5 HP will also be included. 	<ul style="list-style-type: none"> Content analysis of observations and descriptive statistics of survey data at the national, provincial and facility level Comparisons will be made within and between provinces at the aggregate and disaggregated levels.

Evaluation Questions, Corresponding Methods, and Data Sources

	Data Collection Methods (1-Document Review; 2-KI/FG; 3-Analysis of Existing Data; 4-Field Visit/Survey)	Data Sources/Target Key Informants	Level of Data Collection
Evaluation Question (s)			
1. To what extent has the SPS program strengthened the pharmaceutical regulatory and quality assurance system in Afghanistan?	1, 2, 3	<ul style="list-style-type: none"> - GDPA, MoPH - NMFB - Avicenna Pharmaceutical Institute (API) 	Central
2. How has the SPS program addressed the capacity of GDPA (General Directorate of Pharmaceutical Affairs) at national and subnational levels?	1, 2, 3	<ul style="list-style-type: none"> - GDPA - PCH-NGOs 	Central, Provincial, and NGOs
3. How has the SPS program improved pharmaceutical supply chain management in Afghanistan to ensure product availability?	1, 2, 3, 4	<ul style="list-style-type: none"> - GDPA - Coordination and Procurement Distribution System (CPDS) - Advisory Committee for System Strengthening (ACSS) - BPHS and EPHS HF (to be sampled) - PLIS Coordinator 	Central, Provincial, and NGOs, facility level
4. As a result of the SPS program, what gaps in MoPH and NGO pharmaceutical systems human resources capacity have been addressed? What gaps still exist and how could these gaps be addressed in the future?	1, 2, 3	<ul style="list-style-type: none"> - Kabul University School of Pharmacy (Dean and Curriculum Director) - GIHS - PCH-NGOs - Nationwide Pharmacists Association (ANPA) 	Central, Provincial, and NGOs
5. To what extent has the SPS program strengthened pharmaceutical services, improved rational medicine use and medicines safety?	1, 2, 3, 4	<ul style="list-style-type: none"> - GDPA - ANPA - DTC committees (National and Hospital) - HF (BPHS and EPHS) and Pharmacies 	National, local/facility-level
6. How has the SPS implementation of PMIS (Pharmaceutical Management Information Systems) improved evidence-based decision-making in the pharmaceutical sector in Afghanistan?	1, 2, 3	<ul style="list-style-type: none"> - MoPH/GDPA - HMIS - M&E Director 	National
7. Do any policies, laws, regulations, and/or standard operating procedures need to be developed and institutionalized in order to have an effective coordination of the pharmaceutical procurement and distribution system in the country?	1, 2, 3	<ul style="list-style-type: none"> - GPDA - MoPH/Procurement Department - GCMU - MSH - PCH-NGOs - ACSS 	National, Provincial, and NGOs
8. In light of evaluation findings, what lessons learned can be identified that apply to future pharmaceutical system programs under SEHAT (with particular emphasis on monitoring of pharmaceutical quality) or future off-budget projects?	1, 2, 3, 4	<ul style="list-style-type: none"> - GPDA - NMFB - MSH/USAID 	National
9. Overall, how has SPS the program performed in meeting its stated objectives?	1, 2, 3, 4	<ul style="list-style-type: none"> - ALL 	National, Provincial, and NGOs
10. How has the SPS program addressed gender equity issues, particularly in the provision of pharmaceutical services and the rational use of medicines?	1, 2, 3, 4	<ul style="list-style-type: none"> - ALL 	National, Provincial, and NGOs

2.2.5 Total Number of Facilities included in our proposed sample for site visits

Type of Facility	Total No. of Facilities	No. in Sample
BHC	278	14
HSC	144	7
CHC	164	8
CHC+	13	1
DH	27	2
PH	5	2
Total (in 13 USAID/SPS provinces)	631	34

2.2.7 Sampling Approach and Methods of Data Collection for Site Visits and Surveys

For the *BP/EPHS public sector facilities* located in the 13 SPS supported provinces, we will use a simple random sample process to select 5% of all health facilities (See Table 2.2.5 above) in order to conduct site visits/surveys. However, we would include 2 PH and 2 DH as well as 5 HPs. For the private pharmacies, we will also use a simple random sample to select 30 private pharmacies from a complete list of private pharmacies, which will be provided by MSH. From the randomly selected sample of HF and pharmacies we will exclude sites based on feasibility of implementation due to security and travel constraints. For example, we anticipate 50% of HF and private pharmacies from our sample to be excluded. Consequently, we estimate that we will be conducting field visits for site observations at 15-17 HF and surveys at 15 private pharmacies.

2.2.7 Summary of Objectives

The data and analyses derived from this evaluation approach would provide aggregated and/or disaggregated (at the provincial, NGO and facility / pharmacy level) data will also provide information that will identify:

1. The differential performance of completed SPS program activities and interventions at the provincial, NGO and facility level.
 - a. What are the characteristics (e.g. location, Type of PCH NGO, private vs. public) of a better performing province, HF or NGO)?
 - b. Whether and how the level of care through BP/EPHS (e.g. BHC, CHC, SC) influences performance.
2. The factors underlying the successful completion/implementation of SPS activities.
3. How the SPS program has influenced the role of the pharmaceutical sector at the national and subnational levels.
4. New programs/activities that need to be incorporated in the design of the SPS program moving forward, what existing programs should be discontinued, expanded or scaled-down.

Ultimately, this performance evaluation will determine whether the SPS program is on track in strengthening the pharmaceutical sector in Afghanistan, and where SPS programs and objectives can be adjusted to more strategically respond to opportunities that will have a greater impact on the health of the population.

Anticipated Challenges / Risks

1. While attempts to interview and / or visit all selected stakeholders will be made, due to the unstable security situation in Afghanistan, security may necessitate the exclusion of some site visits.
2. Absence of baseline data for some of the indicators may limit the analyses.

Specific Activities and Timeline

Time Period	Specific Activities	Milestones
08/12-08/21	<ol style="list-style-type: none"> 1. Document review and compilation 2. Develop work plan 3. Meet with MSH/USAID <ol style="list-style-type: none"> a. Identify potential interviewees b. Select survey instrument / observation tool c. Obtain list of SPS and non-SPS supported pharmacies and HF nationally and at the provincial level d. Secure access to existing datasets (e.g. PMP) 4. Develop proposed interview 	<ol style="list-style-type: none"> 1. Work plan approved 2. Interview Questions approved by MSH/USAID 3. Key informant interviews/focus scheduled for subsequent 2-3 weeks. 4. Select survey items for HF/pharmacy survey. 5. Select observation instrument 6. Existing datasets available for secondary analysis
08/22-08/29	<ol style="list-style-type: none"> 1. Conduct Initial Interviews and FG at select provinces (TBD) 2. Conduct Initial field visits/surveys at select (sample) pharmacy/HF facilities 3. Begin descriptive data analyses of existing datasets. 4. Prepare for USAID mid-term briefing. 	<ol style="list-style-type: none"> 1. Complete half of scheduled field visits/Interviews. 2. Mid-term briefing with USAID
08/30-09/08	<ol style="list-style-type: none"> 1. Begin content analysis of Interviews/FH discussions. 2. Begin descriptive analyses of survey/direct observation. 3. Prepare summary report on findings from analyses of existing data sets. 4. Conduct KI Interviews and FGs for remaining key informants. 5. Conduct Field visits/surveys at remaining facilities. 	<ol style="list-style-type: none"> 1. Completed analyses of existing data. 2. Preliminary analyses of interviews/FG and surveys. 3. Near completion of interviews/FGs and surveys/site visits.
09/09-09/16	<ol style="list-style-type: none"> 1. Prepare preliminary report. 2. Prepare for final exit presentation. 	<ol style="list-style-type: none"> 1. Review preliminary findings with MSH/USAID.
09/16-09/20	<ol style="list-style-type: none"> 1. Prepare Exit Power Point Presentation. 2. Prepare draft of final report 	<ol style="list-style-type: none"> 2. Complete final Exit presentation and draft of final report.
09/21-09/28 -	<ol style="list-style-type: none"> 1. Incorporate final comments provided by the M&E USAID team. 	<ol style="list-style-type: none"> 1. Submit final evaluation report and one-page brief.

EVALUATION TEAM

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ANNEX III: BIBLIOGRAPHY OF DOCUMENTS REVIEWED

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ANNEX IV: SCHEDULE OF MEETINGS

No	Date	Organization	Name	Title	Phone	Email
1	17-Aug-2014	MSH	Dr. Zafar Omari and staff	SPS Chief of Party, SPS Program Managers and SPS Technical Advisers.	93(0)700169632	<i>momari@msg.org</i>
2	20-Aug-2014	MoPH/GDPA	Dr. Abdul Aziz Quraishi	Director, GDPA		
3	23-Aug-2014	MoPH/Procurement Directorate	Mr. Suleiman Saleh	Director, Procurement	(77)581-7425	<i>Suleiman252003@yahoo.com</i>
4	23-Aug-2014	GIHS	Drs Kemia Azizi	Director	799217595	<i>Drskymia_azizi@yahoo.com</i>
5	24-Aug-2014	MoPH/Office of Private Sector Coordination (OPSC)	Dr. Sayed Saadat	Private Sector Advisor, MoPH	(70)003-3671	<i>mssaadat@yahoo.com</i>
6	25-Aug-2014	Central Medical Stores	Dr. Abdul Wahab Wahidi	Director	(79)655-7525	<i>wahidi.arian@yahoo.com</i>
7	25-Aug-2014	ANMSO (Afghanistan National Medical Services Organization)	Abdul Khaliq Zazai	Director	0788405340	<i>Anmso786@gmail.com</i>
8	26-Aug-2014	GDPA/Pharmacy Enterprise	Dr. Farid Alokozai	General Manager for production of Pharmacy Enterprises	+93(0)799211424	<i>Not available</i>
9	26-Aug-2014	CPDS Team	CPDS coordinator Dr. Ajmal Yadgari, and team members	Technical Leaders (TLs), Technical Focal Points (TFPs) and some active members of CPDS committees / GDPA	93(0)799304633	<i>cpds.moph@gmail.com</i>
10	26-Aug-2014	ANPA	Prof. Aqha Muhammad Zhakfar	President/Dean	93(0)799 133 811	<i>AQ.zhakfar@gmail.com</i>

11	26-Aug-2014	Kabul University (Faculty of Pharmacy)	Professor M. Nasim Sidiqi and Zhakfar	Deputy Dean	93(0)799104877	<i>moseddiqui@yahoo.com</i>
12	26-Aug-2014	MoPH HMIS	Dr. Sayed Yaqoob Azimi	MoPH HMIS Director	93(0)93792595861	<i>drazimi56@googlemail.com</i>
13	27-Aug-2014	NMFB (National Medicine and Food Board)	Naimatullah Mawrozian Sayed Naeem Khalid	Medicines and Food Affairs, Technical Advisors	799104877 700028924	moseddiqui@yahoo.com aq.zhakfar@gmail.com
14	31-Aug-2014	BRAC	Dr. Mohammad Shafiul Islam,	Program Manager		
15	4-Sept-2014	SPS Warehouse visit	Abdullah Masood	Supply Chain Operations Manager		
16	4-Sept-2014	Stomatology Hospital	Dr. Bahram Sadat	Chair, DTC	93(70)025-0687	
17	7-Sept-2014	MoPH/NDTC	Dr. Qamaruddin Haffiz	Chair, NDTC	93(70)0211-470	<i>Moph.gdcm@yahoo.com</i>
18	7-Sept-2014	MoPH/Department of Technical Affairs and Planning	Dr. Ahmad Jan Naeem	Deputy Minister		
19	14-Sep-2014	Aga Khan Foundation, Afghanistan-AKDN	Dr. Shafiq Mirzazada	Provincial Coordinator	93(0)793-203-04	<i>shafiq.mirzazada@akdn.org</i>
20	15-Sep-2014	Agency for Assistance and Development of Afghanistan AADA	Dr. Yasamin Yousofzai	Director	93(0)700-012-25	<i>yyousofzai@aada.org.af</i>
21	15-Sep-2014	HealthNet TPO-HNTPO	Dr. Abdul Ghan	Provincial Manager	93(0)789-880-497	<i>ghani@healthnetpoaf.org</i>
22	16-Sep-2014	Bakhtar Development Network-BDN	Dr. Zabihullah Najib	Contact Person	93(0)700-257-131	<i>zabih.najib.bdn@gmail.com</i>
23	17-Sep-2014	Afghan Health and Development Services-AHDS	Dr. Najib Aria	Provincial Manager	93(0)700-231-115	<i>ariazab@gmail.com</i>

24	17-Sep-2014	International Medical Corps-UK-IMC	Dr. Ahmad Jawed	Provincial Manager	93(0)786-432-429	<i>ajawed@internationalmedicalcorpors.org</i>
25	18-Sep-2014	Sanayee Development-SDO	Dr. Jamshid Oma	Director	93(0)700-258-961	<i>health.sdo@gmail.com</i>
26	21-Sep-2014	Solidarity for Afghan Families -SAF	Dr. Jumakhan Nasir Khairzada	Program Director	93(0)707-778-873	<i>program_director@saf.org</i>

ANNEX V: SPS PMP

OBJECTIVES AND INDICATORS	Project Baseline		PY2								Annual PY2		PY3								Annual PY3		PY4				Annual PY4		LOP					
	Date	Value	Q1		Q2		Q3		Q4		T	A	Q1		Q2		Q3		Q4		T	A	Q1		Q2		T	A	T	A				
			T	A	T	A	T	A	T	A			T	A	T	A	T	A	T	A														
Objective 1: Pharmaceutical regulatory system strengthened																																		
<i>Sub-Objective 1.1: MoPH capacity to regulate medicines strengthened</i>																																		
1.1a: Number of pharmaceutical sector laws or policy documents developed or updated	Sep-11	0	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	2	0
1.1b: Number of pharmaceutical standard operating procedures and terms of reference developed (or updated)	Sep-11	0	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	4	0
1.1b1: Number of pharmaceutical regulatory guidelines developed (or updated)	Feb-13	0	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	4	0	
1.1c: Percent of available drugs in the market that are registered drug products	Feb-13	57	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	29	68	14
1.1d: Percent of available registered drugs in the market is matching LDL Proxy: % of products in PRIS that are in LDL	Feb-13	32	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	8	38	4	
1.1e: Number of private retail pharmacy outlets that MoPH inspected last quarter (disaggregated by site structure type/province)	Feb-13	74	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	74	89	37	
1.1f: Percent of inspected private retail pharmacy outlets (disaggregated by site type) that meet minimum requirements according to MoPH standards Proxy: % of retail outlets in RO database that meet all requirements	Feb-13	0	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0		
<i>Sub-Objective 1.2: Public and private sector quality assurance systems strengthened</i>																																		

ANNEX VI: SURVEY INSTRUMENTS

General information: Public health facility pharmacy/dispensary

Facility _____ Date _____
Region _____ Investigator _____

1) Does the law require a pharmacist to be present during hours of operation of public/government pharmacies/drug outlets?

Yes No

2) Is a pharmacist present at the time of the visit?

Yes No

Assessment

1 complies with the law (items 1 and 2 are both Yes)

2 does not comply with the law (item 1 Yes and item 2 No)

3 no requirement for pharmacist presence (item 1 No)

3) Who is dispensing during the time of visit? (Check all that apply)

Pharmacist (1=Yes; 0=No) Pharmacy aide/ health assistant (1=Yes; 0=No)

Nurse (1=Yes; 0=No) Untrained staff (1=Yes; 0=No)

Survey form 2: Public health facility pharmacy/dispensary patient care exit interview

Public Health
Facility
Pharmacy

Indicators: Average number of medicines per prescription
 % medicines dispensed or administered
 % medicines adequately labeled

% patients who know how to take medicines
 Average cost of medicines
 Geographical accessibility of facilities

Facility # _____
(1-30)

Facility _____ **Date** _____
Region _____ **Investigator** _____

Patient sex M/F [A]	Age 1) less than 5 y. 2) older children 3) adults 4) older than 60 [B]	Number of medicines prescribed [C]	Number of medicines dispensed or administered [D]	Number of medicines adequately labeled [E]	Patient knows how to take medicines Yes=1, No=0 [F]	Price patient paid for purchased medicines [G]	How long did it take the patient to get to the health facility today? 1. <30min; 2. 31min-1h; 3. > 1h [H]	How much did it cost him/her to come here? [I]
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								

Patient sex M/F [A]	Age 1) less than 5 y. 2) older children 3) adults 4) more than 60 [B]	Number of medicines prescribed [C]	Number of medicines dispensed or administered [D]	Number of medicines adequately labeled [E]	Patient knows how to take medicines Yes=1, No=0 [F]	Amount patient paid for purchased medicines [G]	How long did it take the patient to get to the health facility today? 1. <30min; 2. 31min-1h; 3. > 1h [H]	How much did it cost him/her to come here [I]
[A ¹] = Sum cases	[B ¹]=Sum of 1= [B ²]=Sum of 2= [B ³]=Sum of 3= [B ⁴]=Sum of 4=	[C ¹] = Sum of C =	[D ¹] = Sum of D =	[E ¹] = Sum of E =	[F ¹] = Sum of F =	[G ¹] = Sum of G =	[H ¹]=Sum of 1= [H ²]=Sum of 2= [H ³]=Sum of 3=	[I ¹] = Sum of I = [I ²] = Average transport cost = I ¹ ÷ total responses = [I ³] = Average transport cost to minimum daily salary = [I ²] ÷ [J]
[A ²]=Sum females= [A ³] = % females = A ² ÷ A ¹ x 100 =		[C ²] = Average number of medicines = C ¹ ÷ A ¹ =	[D ²] = % dispensed = D ¹ ÷ C ¹ x 100 =	[E ²] = % adequately labeled = E ¹ ÷ D ¹ x 100 =	[F ²] = % know how to take medicines = F ¹ ÷ A ¹ x 100 =	[G ²] = Average cost = G ÷ total patient =		
[J] = Lowest daily government salary (divide weekly salary by 7 or monthly salary by 30) =								

Notes:

[A&B] Interview 30 patients leaving the dispensing area/pharmacy. Obtain the sex and age of the patient, not those of the person obtaining the medicine. Use the number of patients/cases able to respond to corresponding questions as denominators for (G, H, I, J)

- [A] Record the number of cases [A1] and the number of females [A2]. Calculate the percentage of females by dividing the total number of females [A2] by the total number of cases [A1] and multiplying by 100.
- [B] Record the age of the patient. Indicate 1) less or equal to 5 years of age, 2) for older children, 3) for adults & 4) if equal or more then 60. Sum the total of patients in each category [B1-4].
- [C] Record the number of medicines prescribed for each patient. Combination medicines in one dosage form count as one medicine. Sum the number of medicines prescribed for all patients [C1]. Calculate average number of medicines prescribed [C2] by dividing number of medicines prescribed [C1] by number of cases [A1].
- [D] Record the number of medicines dispensed or administered to each patient. Sum the total number [D1]. Calculate the percentage of medicines dispensed [D2] by dividing the number of medicines given to all patients [D1] by the total number of medicines prescribed [C1] and multiplying by 100.
- [E] Record the number of medicines labeled with at least the name of the medicine and how to take it*. Count only medicines meeting both criteria. Sum the total [E1]. Calculate the percentage of medicines adequately labeled [E2] by dividing the total number of adequately labeled medicines [E1] by the total number of medicines dispensed [D1] and multiplying by 100.
- [F] Determine if patient (or an adult accompanying a pediatric patient) knows how to take all medicines dispensed (patient knows dosage and duration of all dispensed medicines*). Mark "1" only if patient can correctly state how ALL medicines should be taken and "0" otherwise. Sum the total [F1]. Calculate the percentage of patients who know how to take all medicines [F2] by dividing the total number who know how to take all medicines [F1] by the total number interviewed [A1] and multiplying by 100.

* Criteria for [E] and [F] can be adjusted as relevant to the surveyed population.

- [G] Record the amount each patient paid out-of-pocket for all medicines received at the facility. Check with a receipt if possible. Sum the total amount [G1]. Calculate the average medicines cost by dividing the amounts paid for medicines [G1] by the total number interviewed able to respond.
- [H] Record the time it took the patient to get to the facility. Indicate the codes 1-3. Sum the total of patients in each category [1-3].
- [I] Note travel cost in local currency. Sum the total amount [I1]. Calculate the average transport cost [I2] by dividing the amounts paid for transport [J1] by the total number of interviewed persons able to respond. To calculate the = Average transport cost to minimum daily salary [I3], divide the average transport cost by the minimum daily salary [J]

Survey form 3: Public health facility: Essential medicine information

Public Health
Facility

Facility # _____
(1-30)

**Indicators: Availability of Standard Treatment Guidelines (STG)
Availability of Essential Medicines List (EML)**

Facility _____ **Date** _____
Region _____ **Investigator** _____

Standard Treatment Guidelines (STG) available	Yes=1, No=0
STG for pneumonia (as part of combined STG publication or disease-specific STG)	
STG for _____ (as part of combined STG publication or disease-specific STG document)	
[A¹] =Both STGs are present =	
Essential Medicines List (EML) updated within last 5 years available	Yes=1, No=0
National EML	
Provincial/District EML	
Facility-specific EML	
Other EML (describe):	
[B¹] =At least one current EML is present =	
<p><i>Notes:</i></p> <p>[A] Identify the second required STG at the national level and pre-print on the form. This should be for an important disease in the region, e.g. malaria in endemic areas or hypertension. Check to see if there is a copy of each of the STGs either as part of a combined STG publication or a disease-specific STG document. Record “1” if the facility is able to present a copy of the document and “0” if the facility is unable to present the document. If both STGs are present record “1” in [A¹] otherwise record “0”.</p> <p>[B] Record “1” next to each type of EML updated within the last 5 years that is physically present in the facility. If the facility is unable to present the document or if the EML presented has not been updated in the last 5 years, record “0”. If any current EML is available, mark “1” in [B¹], otherwise record “0”.</p>	

General Information: Private pharmacy/drug outlet

Facility _____
Region _____

Date _____
Investigator _____

1. Does the law require a pharmacist to be present during hours of operation of private pharmacies/drug outlets?

Yes No

2. Is a pharmacist present at the time of the visit?

Yes No

Assessment

- 1 complies with the law (items 1 and 2 are both Yes)
- 2 does not comply with the law (item 1 Yes and item 2 No)
- 3 no requirement for pharmacist presence (item 1 No)

3. Who is dispensing during the time of visit? (Check all that apply)

Pharmacist (1=Yes; 0=No) Pharmacy aide/ health assistant (1=Yes; 0=No)
 Nurse (1=Yes; 0=No) Untrained staff (1=Yes; 0=No)

Survey form 1: Private pharmacy/drug outlet

Private Facility # _____ (1-30)

Indicator: % key medicines available
 % medicines expired

Facility _____ **Date** _____
Region _____ **Investigator** _____

Key medicines to treat common conditions	In stock Yes=1, No=0	Expired medicines on shelves
[A]	[B]	[C]
1. Amoxicillin 500mg tablets		
2. Hydrochlorothiazide 25mg tablets		
3. Ciprofloxacin 500mg tablets		
4. Atenolol 25mg tablets		
5. Paracetamol 100mg tablets		
6. Azithromycin 250mg tablets		
7. Artesunate 50mg tablets		
8. Glibenclamide 5mg tablets		
9. Rifampin with INH 150/75 tablets		
10. Ampicillin vial 500mg per vial		
11. Oxytocin Inj 1ml ampoules		
12. Ethinyl Estradiol and Norgesterol (pack)		
13. Mebendazole 100mg		
14. Metronidazole 400mg		
15. ORS (Oral Rehydration Solution) packets		
	[B¹] = Sum of B =	[C¹] = Sum of C =
	[B²] = % in stock = B¹ ÷ 15 x 100 =	[C²] = % expired = C¹ ÷ B¹ x 100 =

Notes:

[A] The same lists of 15 key medicines used for Survey Form 1 should be pre-printed on the survey forms.

[B] Mark “1” if any quantity of any dosage form of the medicine is available in the pharmacy on the day of the visit. Mark “0” if the medicine is not physically available. Add the total at the bottom [B¹]. Calculate the percentage in stock [B²] by dividing the total in stock [B¹] by 15 and multiplying both by 100.

[C] For all medicines in stock, check if any of the stock is expired. If any amount of a medicine has an expiry problem, mark “1” for yes. Do not count expired medicines stored in a separate area for destruction. Add the total at the bottom [C¹ & F¹]. Calculate the percentage expired [C²] by dividing the total expired [C¹] by the total number of medicines in stock [B¹] and multiplying by 100.

Survey form 2: Private pharmacy/drug outlet - Exit interview

Private Pharmacy # _____

Indicators Average number of medicines purchased % medicines adequately labeled % patients know how to take medicines
 % prescription medicines bought without prescription Average cost of medicines Geographical accessibility of facilities

Facility Date
 Region Investigator

Patient sex M/F F=1, M=0 [A]	Age 1) Less than 5 yrs. 2) 5 – 14 years 3) 15 – 59 years 4) older than 60 [B]	Number of medicines purchased [C]	Number of prescription medicines [D]	Number of prescription medicines purchased with no prescription [E]	Number of medicines adequately labeled [F]	Patient knows how to take medicines Yes=1, No=0 [G]	Price patient paid for purchased medicines [H]	How long did it take to get to the health facility today? 1) < 30min; 2) 31min-1h; 3) > 1h [I]	How much did it cost him/her to come here? [J]
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									
15.									

Notes:

Interview 30 patients leaving the dispensing area/pharmacy (only patients older than 16 years). Ask if the interviewed is looking for medicines for his use or for another person. If he/she is looking medicines for another person ask for whom, trying to identify the king of link and if the interviewed person is the caregiver and helps the other with medication. If (1) the interviewer is the patient itself of (2) The interviewer is the caregiver, tell he/she briefly the purpose of the interview, needed time to complete it (3-5 minutes) what will be required from him/her (look into the prescription, look the medicines and ask some questions). If the interviewed agrees, follow with the interview. In any case, be kind, respectful and thanks.

Obtain the sex and age of the patient, not those of the person obtaining the medicine. Use the number of patients/cases able to respond to corresponding questions as denominators for (G, H, I)

- [A] R e c o r d the number of cases [A¹] and the number of females [A²]. Calculate the percentage of females by dividing the total number of females [A²] by the total number of cases [A¹] and multiplying by 100.
- [B] Record the age of the patient. Indicate 1) less or equal to 5 years of age, 2) for older children, 3) for adults & 4) if more than 60. Sum the total of patients in each category [B¹⁻⁴].
- [C] Record the number of medicines purchased by each customer. Combination medicines in one dosage form count as one medicine. Sum the total number [C¹]. Calculate average number of medicines purchased [C²] by dividing number of medicines purchased [C¹] by number of customers [A¹].
- [D] R e c o r d the number of prescription medicines purchased. Note: these are mainly antibiotics, antihypertensive, anti-diabetics, asthma and other medicines that should only be bought with prescription.
- [E] Record the number prescription medicines (antibiotics, antihypertensive, medicines for diabetes, asthma, etc.) bought without prescription. Sum the number of prescription medicines bought without prescription [E1]. Calculate % of prescription medicines bought without prescription [E2] by dividing total number of prescription medicine bought without prescription [E1] by total number of medicines purchased [D1] and multiplying by 100.
- [F] Record the number of medicines labeled with at least the name of the medicine and how to take it. Count only medicines meeting both criteria. Sum the total [E1]. Calculate the percentage of medicines adequately labeled [F2] by dividing the total number of adequately labeled medicines [F1] by the total number of medicines purchased [C1] and multiplying by 100.
- [G] D e t e r m i n e if the customer who has purchased the medicines (or an adult accompanying a pediatric patient) knows how to take all medicines dispensed. Mark “1” only if customer can correctly state how ALL medicines should be taken and “0” otherwise. Sum the total [G1]. Calculate the percentage of customers who know how to take all medicines [G2] by dividing the total number who know how to take all medicines [G1] by the total number interviewed [A1] and multiplying by 100.
- [H] R e c o r d the amount each patient paid out-of-pocket for all medicines received at the facility. Check with a receipt if possible. Sum the total amount [H1]. Calculate the average medicines cost by dividing the amounts paid for medicines [H1] by the total number interviewed able to respond.
- [I] Record the time it took to the patient to get to the facility. Indicate the codes 1-3. Sum the total of patients in each category [I1-3].
- [J] Note travel cost in local currency. Sum the total amount [J1]. Calculate the average transport cost [J2] by dividing the amounts paid for transport [J1] by the total number interviewed persons able to respond. To calculate the average transport cost to minimum daily salary [J3], divide the average transport cost by the minimum daily salary [H]

ANNEX VII: INTERVIEW QUESTIONS

LEVEL	ILLUSTRATIVE QUESTIONS
ALL	<ol style="list-style-type: none"> 1. In which office / department do you work? How much time have you spent in your current position? 2. State purpose of the SPS evaluation, use of the report, and clarify the role of the interviewee. 3. How has the pharmaceutical sector changed over the last five years in the country? How do you think it will change in the future? 4. What is the role of your department / office in the public pharmaceutical sector under the MoPH? What will it be in the future? 5. What specific SPS programs or activities worked well? Which aspects of the program can be improved? 6. Has the SPS program led to an improvement in the data collection, record keeping, reporting, supervision and monitoring systems? If not, why? 7. Which SPS programs were the most challenging to implement? Why?
KEY PARTICIPANTS MSH-SPS, USAID, GDPA, MoPH	<ol style="list-style-type: none"> 2. What pharmaceutical systems (e.g., policy, regulation, strategy, management, HR, coordination, Pharmacovigilance, RMU, ADR, MS, SCM, and PMIS) did the SPS program improve? 3. Which SPS programs have been very effective? Why have they been effective? Ask for examples. 4. What has not worked well under the SPS program? Why? 5. Which pharmaceutical sector issues did the SPS program not address? 6. Moving forward, what can and should SPS specifically do to strengthen the pharmaceutical sector and the MoPH? 7. What is the current role of SPS consultants? What should it be in the future (day-to-day involvement or few days a week)? Are there any drawbacks in the SPS consultants stationed at GDPA / MoPH? 8. Are gender issues (in hiring, training, service provision and equitable access to services) addressed in your activities? Has the SPS program provided support in this area?
IMPLEMENTING PARTNER Provinces, PCH-NGOs, CPDS, GCMU, GDHR	<ol style="list-style-type: none"> 9. What changes (in strategy, management, HR, coordination, Pharmacovigilance, RMU, ADR, MS, SCM, and PMIS) have you seen since the SPS program began in 2008? 10. What capacity building (formal training, on-job training) measures were implemented under the SPS program? How did it help improve performance? Give examples. 11. What kind of Monitoring and Evaluation is done under the SPS program? (Is the monitored entity aware of the activities being monitored by SPS? Is there a formal reporting and feedback system between the entity and SPS?) How effective is it? How can it be done better? How is success defined? 12. Has the SPS program addressed gender issues (from the supply and demand sides) in your activities?

ANNEX VIII: SUMMARY OF KEY INFORMANT INTERVIEWS

Evaluation question 1: To what extent has the SPS program strengthened the pharmaceutical regulatory and quality assurance system in Afghanistan?

- Capacity to develop and execute policies and regulatory mechanisms built
- Policy development: Standard Treatment Guidelines (STGs) and National Medicine Policy (NMP) developed
- Move towards more regulatory and quality assurance systems seen
- SPS assistance has helped initiate the process of regulation of drugs being imported in the country
- SPS has provided technical and financial support to NMFB; initially, the work was through GDPA because the NMFB was not organized and structured; SPS provided the necessary support to strengthen NMFB
- SPS has helped develop a strategic plan (2013 – 2016) for NMFB that stresses 1) strengthening regulation; 2) capacity building; 3) financial support; and 4) sustainability.

Evaluation question 2: How has the SPS program addressed the capacity of GDPA (General Directorate of Pharmaceutical Affairs) at the national and subnational levels?

- There has been improvement at the national level, but the GDPA has no mandate at the subnational and SDP levels.
- The National Health and Nutrition Policy and the National Medicine Policy (NMP) have noted that the GDPA should be mandated with medicine regulatory capacity.
- Earlier GDPA had no capacity or powers as a policy maker, but now it is playing that role. Regulatory capacity has been built slowly over a period of time
- GDPA is responsible for licensing, registration, post marketing surveillance (PMS), Rational Medicine Use (RMU), Adverse Drug Reactions (ADR), and Medicine Safety.
- SPS has improved management capacity at GDPA, which now has the ability to identify problems and develop solutions. The GDPA now has the capacity to lead on technical issues and chair technical committees, with evident expansion in the range of communication.
- Good coordination has been established between the GDPA and academia.

Evaluation question 3: How has the SPS program improved pharmaceutical supply chain management in Afghanistan to ensure product availability?

- SPS support has helped streamline the supply chain management with PCH-NGOs.
- Product distribution plan was finalized by SPS-MSH in coordination with the NGO, in accordance with the following:
 1. Consumption report (based on the HMIS factor) is received from each NGO
 2. The SPS quantification officer verifies the report and stock balance
 3. The request received from the NGO is verified and sent back to the NGO
 4. The NGO submits the request to GCMU
 5. GCMU reviews and verifies the request and sends it to SPS

6. SPS-MSH sends the approval to the warehouse; the NGO is also informed
7. The goods to be distributed are moved to the distribution area in the warehouse
8. NGOs come to the warehouse and receive the goods

Evaluation question 4: As a result of the SPS program, what gaps in MoPH and NGO pharmaceutical systems human resources capacity have been addressed? What gaps still exist and how could these gaps be addressed in the future?

- Gaps in human resources (HR) have been identified but cannot be filled due to lack of consensus between the MoPH and MoF.
- High turnover of Human Resources (HR) is an issue across the public health system and seriously affects the pharmaceutical systems – SPS needs to support GDPA and MoPH in establishing adequate policies and processes to counter this high turnover.
- Availability of pharmacist at all the health facilities, especially in the high risk areas, is an issue. SPS needs to support GDPA and MoPH in undertaking trainings to ensure task-shifting in eligible and available staffing at the health facilities.
- There has been training and capacity building of medical staff at the hospitals with DTCs on Pharmacovigilance issues.
- The capacity building support from SPS is currently for 2 – 3 days per week, and it needs to be throughout the week, with some SPS staff being placed at the GDPA.
- All of the GDPA staff have bachelor's degrees, and there is a need to provide them with access to higher qualifications in their fields for better technical performance.

Evaluation question 5: To what extent has the SPS program strengthened pharmaceutical services, improved rational medicine use and medicines safety?

- SPS's work with Kabul University and GIHS in developing curriculum on RMU and ADR has been fruitful.
- There is a need to sensitize the medical fraternity on RMU, AMR, and medicine safety through regular workshops to ensure their buy-in.
- National formulary had expired, but with SPS – GDPA coordinated efforts it has been revised.
- A National Drug and Therapeutics Committee (NDTC) was formed and bi-monthly meetings have been planned; the frequency of meetings with the chairperson and the team have been on a monthly basis. 12 DTCs have been supported by the SPS program in 12 hospitals; six of these hospitals are in Kabul and six are in the provinces.
- SPS has provided good coordination and logistics support to GDCM (General Directorate of Curative Medicine), which is responsible for oversight of DTCs through NTDC. The SPS's review of TORs for NTDC and DTCs and its feedback helped strengthen and operationalize the system of NTDC – DTCs.
- RMU and ADR have been established and regularly monitored at facilities with DTCs.
- SPS has helped establish and coordinate record-keeping and reporting from the DTCs to NTDC.

Evaluation question 6: How has the SPS implementation of PMIS (Pharmaceutical Management Information Systems) improved evidence-based decision-making in the pharmaceutical sector in Afghanistan?

- PLIS / PMIS are still in the pilot stage.
- Previously, there was no monitoring of PCH – NGOs, but under the SPS support program there is some improvement in this area. The monitoring and evaluation of the NGOs by the MoPH M&E Department has improved.
- The gaps in the registration system have been identified due to initial activities on PMIS.
- Quarterly meetings conducted by CPDS with GDPA and NGOs helped improve coordination between the NGOs and GDPA, with regular sharing of information for effective planning and implementation.
- PMIS was strengthened through SPS support; earlier, there was no proper data support. The focus of PMIS is on:
 - Registration of pharmaceutical companies
 - Registration of pharmaceutical products
 - Drug importation by the private sector
- Work on creating a database of drugs is being undertaken with SPS support.
- Better coordination between HMIS, PLIS, and PMIS needs to be established.

Evaluation question 7: Do any policies, laws, regulations, and standard operating procedures need to be developed and institutionalized in order to have an effective coordination of the pharmaceutical procurement and distribution system in the country?

- The GDPA needs specialized QC and regulatory management capacity.
- A Quality Control laboratory system and inspection responsibility needs to be established.
- NMFB will be the future FDA for Afghanistan. The current structural and operational status of NMFB needs a lot of improvement, and SPS should provide stronger logistical and financial support in ensuring a strong and sustainable NMFB.
- Coordination is needed with entities like FoPL, GIHS, and ANPA, with whom SPS is working independently. There is only one representative from GDPA involved in these initiatives. The GDPA should be assigned lead role in these activities
- Registration and licensing programs could be further improved.
- Capacity building through SPS could be further improved.
- Pharmacy officers in the provinces report to the Provincial Health Department, not GDPA. These officers are responsible for monitoring BPHS and EPHS facilities.
- MoPH needs to have a standard procurement procedure for all the entities procuring drugs in Afghanistan; this work is in progress.
- NMP has been approved by MoPH, but a regulatory system needs to be put in place.
- There is a need for establishing regulatory systems and mechanisms for narcotics and imported medicines.
- Differences within the MoPH regarding policy and regulatory responsibilities for pharmaceutical services needs to be eliminated. Cohesion and coordination needs to be established.

- The strategy for ensuring the quality of products being imported into Afghanistan is weak, with only 6 people responsible for monitoring the private pharmacies across the country.
- MoPH needs implementation support for establishing PMIS.
- Additional policy documents and regulatory mechanisms need to be developed; a list of 13 such documents has been identified by SPS.
- Standardization in the private pharmaceutical sector is needed.
- SPS to support GDPA in the implementation of some components of NMP.
- The SPS project will end in 2015, so the ensuing project should not take too long.
- The following areas of support have been identified by SPS moving forward:
 - Industrial pharmacy
 - Herbal medicine
 - Cosmetic products
 - Pharmacy college curriculum
 - Association of pharmacy council
 - Pre-qualification of products
 - Licensing renewal
 - Quality dispensing by chemists
- The clinical guidance department should have been included in the development of STGs.
- DTC should have been established at the Wazir Khan Hospital (210 beds) in Kabul.
- Despite budget constraints, which prevented the expansion of DTCs to all provinces, SPS could have arranged for ‘study tours’ for administrative and technical staff of other hospitals in the country to the facilities with DTC in order to understand the functioning, relevance, and impact of DTCs.

Evaluation question 8: In light of evaluation findings, what lessons learned could be identified that applies to future pharmaceutical system programs under SEHAT (with particular emphasis on monitoring of pharmaceutical quality) or future off-budget projects?

- The following three specific activity areas / objectives need to be a part of SEHAT:
 - Inspection
 - Post Marketing Surveillance (PMS)
 - Quality Control (QC)
- Since July, there has been no procurement because this responsibility is to be transferred to the NGOs under SEHAT. There is a large concern about quality and risk of stock-outs in the interim.
- DTCs should be expanded to all of the provinces.
- More technical support is needed from SPS.
- GDCM should be given a more active role in the SPS project.
- Trainings on inventory management, storage, and distribution to hospital staff and pharmacists across the country, needs to be provided.
- Moving forward there should be more focus on implementation than policy.

- Advisors / consultants providing support to various divisions of MoPH should provide support on-site, i.e., should be stationed at the respective division rather than at the SPS office.
- The current warehouse of SPS is on rented property, which is an unnecessary expense. In order to ensure sustainability, SPS should help develop the MoPH Central Medical Store (CMS) and designate it as the central warehouse.
- Currently, the decision-making at SPS is centralized (from Washington DC, MSH office), which causes delays and hampers initiative. Decentralization is needed.
- Support is needed from SPS and other partners to establish and operationalize FDA (currently NMFB).
- A stringent but ‘conducive for business’ regulatory framework for the private pharmaceutical sector should be developed.
- Strengthen capacity building in a practical manner. That is,
 - Capacity building should correlate with requirements and infrastructure availability
 - Capacity building should extend beyond trainings and courses; a task-shifting approach should be deployed wherever necessary as temporary measures.
- The monitoring and evaluation (M&E) systems – strategy, protocols, and tools – should be strengthened
- The NGOs don’t have the facilities to transport the goods while maintaining a cold chain. This is a concern that should be addressed.
- And most important, the SPS program should have a clear and well-defined phase-out (exit) strategy.

Evaluation question 9: How has the SPS program addressed gender equity issues, particularly in the provision of pharmaceutical services and the rational use of medicines?

- Currently, there are 40 women working at GDPA but none at the higher management level.
- There was no specific emphasis on ensuring gender equity in the SPS program, but the government has mandated specific gender equity strategies. For example, if 2 candidates (one male and a female) are shortlisted for a position in the public sector and both have equal capabilities and skills then the woman is to be given preference in the hiring process.
- The SPS program has a sizeable number of female staff, but none in management positions.
- During Taliban rule, women were not allowed to work, which led to many deserving female candidates losing out on experience, and thus not able to compete for current management positions.
- Three staff from SPS / MSH (a couple from the provinces) have been sent for higher education to Europe as a part of capacity building.
- The gender balance was weak at NMFB, with two women on the Medicine Committee and one on the Food Committee.

- There is no specific thrust on gender equity in the NTDC, but wherever possible women are involved in the DTC as members.
- The GDCM department, per government policy, tries to recruit women wherever possible.

ANNEX IX: SUMMARY OF NGO INTERVIEWS

Evaluation question 1: To what extent has the SPS program strengthened the pharmaceutical regulatory and quality assurance system in Afghanistan?

- The SPS program has helped strengthen pharmaceutical management.
- DTCs have helped percolate the STGs to the HFs's strategies, thus ensuring effective and quality healthcare service delivery.
- Stress on RMU and AMR has led to improved quality of care at the HFs.

Evaluation question 2: How has the SPS program addressed the capacity of GDPA (General Directorate of Pharmaceutical Affairs) at national and subnational levels?

- The NGOs had no specific inputs for this question, as they had no interaction with GDPA.

Evaluation question 3: How has the SPS program improved pharmaceutical supply chain management in Afghanistan to ensure product availability?

- The SPS program has helped strengthen coordination of supply between the PCH-NGOs and their health facilities (HFs).
- A total of 131 drugs are supplied under SPS. The types of drugs supplied to the facilities depend on the type of the facility.
- Time is saved due to a good procurement process by SPS.
- Standardized supply chain management (SCM) system and processes have been established. This has resulted in a drastic reduction in incidences of stock-out and over-stocking over the past 2 years.
- SPS has led to an improvement in the logistic management system – inventory management, record keeping, documentation and reporting.
- SPS helped develop a format and tools to ensure the transfer of medicines with short expiry between the BPHS and EPHS facilities.
- SPS helped improve management systems in the NGOs by helping them streamline the supply chain system.
- Sensitization on the IMAT tool has been helpful as well.
- The supply of medicine has been very effective under the SPS project:
 - The procurement has been good quality
 - Medicine supply has been regular and timely
 - The supply has been as requested
 - Effective follow-up of stock management and drug consumption, especially based on the HMIS factor calculation
- SPS has indeed led to an improvement in the documentation and reporting of supply chain activities.

- Medicine supply by SPS on a quarterly basis has been very helpful, as the capacity of warehouses in the provinces is not huge. Storing more than a quarter's stock can be a problem.

Evaluation question 4: As a result of the SPS program, what gaps in MoPH and NGO pharmaceutical systems human resources capacity have been addressed? What gaps still exist and how could these gaps be addressed in the future?

- The capacity building of pharmacists (ToT at NGO headquarter level) on IMAT, RMU, AMR and MDS has been helpful and productive. It has helped cascade these initiatives to the HF level and helped improve the quality of pharmaceutical services provided by the NGOs, resulting in better access to quality drugs for the population.
- MDS training was conducted for pharmacists at HFs, and this was done in collaboration with CPDS- DIC.
- There is a high HR turnover in Paktika and Kandahar, as these are high security risk areas.
- There is dearth of pharmacists at the BPHS HFs, and there is no standard for who is responsible for managing and distributing drugs at these HFs. Assigning these tasks to the nurses increases their already large workload.

Evaluation question 5: To what extent has the SPS program strengthened pharmaceutical services, improved rational medicine use and medicines safety?

- Elements of pharmacovigilance like RMU (Rational Medicine Usage), AMR (Adverse Medicine Reaction), and MDS (Managing Drug Safety) have been initiated, leading to significant improvement in quality service delivery at the HF level.
- DTC implementation has been very positive. Through their reviews, DTCs have identified gaps in RMU, AMR and MDS at the hospitals, and necessary actions were initiated, improving pharmaceutical and clinical service delivery management at the hospitals.
- RMU training has been very effective in reducing antibiotic use; it was reduced from 57% to 34% in 6 months at AHDS facilities and from 77% to 65% at IMC facilities.
- Procurement has been the most effective of the interventions under the SPS program; it has taken a large burden off of the NGOs.

Evaluation question 6: How has the SPS implementation of PMIS (Pharmaceutical Management Information Systems) improved evidence-based decision-making in the pharmaceutical sector in Afghanistan?

- The program has also bolstered the record keeping and reporting; consumption reports are received by PCH-NGOs from each of their facilities on a monthly basis; these reports are then compiled, verified, and reviewed and sent to SPS on a quarterly basis; SPS reviews and verifies the reports and makes quarterly supplies available based on the reports.
- Each PCH-NGO has an internal monitoring system, but it is not effective in some high-risk and remote areas.

- SPS M&E: Ideally SPS should visit every PCH-NGO once or twice a quarter, visit the PCH-NGO provincial headquarter, then the facilities selected based on criteria developed by SPS. This activity has been undertaken by SPS in provinces that are less risky in terms of security, but SPS has not been able to implement this effectively in high-risk areas like Paktika and Kandahar.
- GCMU (Grants and Contract Management Unit) M&E: HR, Finance, and M&E teams from GCMU usually visit each PCH-NGO on a quarterly basis, but as with SPS, these visits are not regular in the high-risk areas.
- PPHD (Provincial Public Health Department) M&E: a PPHD team from each province usually undertakes joint monitoring on a monthly basis with the respective PCH-NGO.
- The feedback from all the above visits are discussed during the quarterly PPHD meetings in each province, and a monthly / quarterly action plan is developed.
- Prompt communication systems regarding medicine supply have been established, enabling prompt decision-making.
- SPS has strengthened documentation of supply chain and timely reporting from the HFs and has improved overall supervision and monitoring.
- Strengthening the documentation capacity of the NGOs has had a spillover effect on other healthcare service delivery activities.

Evaluation question 7: Do any policies, laws, regulations, and standard operating procedures need to be developed and institutionalized in order to have an effective coordination of the pharmaceutical procurement and distribution system in the country?

- Coordination between different entities – other PCH-NGOs and MoPH departments – has been established under SPS, but these need to be strengthened through regular information sharing.
- SPS has led to some improvement in the supervision and monitoring of pharmaceutical affairs, but further strengthening is required in this area.
- PLIS needs to be established and aligned with the MoPH HMIS.
- There has been shortage of supply of some products from SPS leading to a stock-out of these products at the HFs. To mitigate such events, the NGOs should be given the freedom to procure from the market, while ensuring quality per SPS protocols.
- Quantification is a challenge because the aggregate of all PCH HFs is not an ideal representation of the requirements at an individual HF.
- BHCs require pharmacy technicians, if not pharmacists.
- Not all the medicines in the BPHS list are supplied by SPS.
- Some medicines, prescribed locally by medical doctors at the HFs, are not available in the SPS supply because it is based on EML and STGs, which have not been revised for a long time.
- Infrastructural support to maintain cold chain during transportation of some medicines needs to be provided.
- Refresher trainings should be included in the capacity building initiatives.
- The WHO indicator on antibiotic use of 23% or less should be revisited, as it may not be applicable in Afghanistan.

- Same shape and color of tablets for different formulations leads to problem in appropriate usage in the community, especially as the medicines are supplied in loose packets instead of blister packs. This is further complicated by the fact that adequately trained staffs are not available to properly guide the patients, many of whom are illiterate, on use of the medicines.
- Supervision and monitoring systems in Kandahar have not improved due to the security situation.
- There are always delays due to issues with custom clearance in Kandahar; some request that an official letter be provided to the NGOs stating the humanitarian nature of the procurement.
- Supervision and monitoring systems still remain weak in Paktika because it is a high-risk area with more than 300 miles of porous border with Pakistan.
- Due to security risks in these provinces, SPS has not visited for the past two years and no checklist / tool has been provided to IMC to undertake supervision, monitoring, and evaluation and report to SPS.
- GCMU visits once in six months, and these visits are not regular.

Evaluation question 8: In light of evaluation findings, what lessons learned can be identified that apply to future pharmaceutical system programs under SEHAT (with particular emphasis on monitoring of pharmaceutical quality) or future off-budget projects?

- The SPS program should continue under SEHAT
- System of medicine supply from the SPS warehouse: NGOs need to go and procure the medicine, which leads to delays sometimes. SPS should supply the medicines to the PCH-NGOs.
- There should be regular training of pharmacists at project and facility levels to counter the high HR turnover (up to 30%).
- Undertake supervision and monitoring more frequently.
- Additional reserve stock should be provided for some medicines during particular seasons, based on the historical consumption of those medicines.
- Individual procurement by NGOs under the SEHAT project is a threat to the quality of medicine to be procured, and may further complicate the pharmaceutical sector.
- Under SEHAT, SPS should continue procurement, as the products supplied by SPS are of good quality
- Central and regional laboratories for quality control (QC) need to be established, and SPS can provide technical and financial support.
- SPS should also focus on developing curriculum on quality assurance / quality control (QA / QC).
- GDPA should be supported by SPS to take more active responsibility of pharmaceutical affairs.
- One good aspect of SEHAT is that the NGO can procure medicines that are not in the STGs / EML / LML / formulary, based on the need in the HF. This convenience is not available with SPS and should be incorporated in the future.

- The EML has been revised but not regularly (last in 2008), so a system of annual revision of EML / LML needs to be put in place.
- There is inadequate warehouse space at the province level.
- EML, LML, and EPHS drug formulary were developed in 2005 and need revisions with a provincial focus; specialists at HF's prescribe drugs that are new and not included in the older guidelines.
- SPS should assist the provinces in building and establishing properly managed warehouses.
- A system of cold chain needs to be established at the provincial level to ensure the efficacy of the medicines to be used per guidelines.

Evaluation question 9: How has the SPS program addressed gender equity issues, particularly in the provision of pharmaceutical services and the rational use of medicines?

- Only a few NGOs (BRAC, AKDN, and CAF) have an internal gender policy that focuses on equity, while the rest are in the process of developing such a policy.
- MoPH has a well-laid out policy on gender equity.
- The national salary is generally higher for women than men.
- The NGOs said they encourage female candidates to apply to positions, but women with requisite skills are poor in the health sector.
- There are certain constraints faced by NGOs, always on a limited budget, in hiring women. The need to provide maternity leave, child-care, along with restrictions on travel and working hours affects their ability to hire women.
- The situation is worse in high-risk provinces like Paktika and Kandahar because there are few girls' schools in these provinces. There is a serious lack of educated women to fill higher positions.

ANNEX X: DESCRIPTION OF HEALTH FACILITIES SAMPLED

Facility ID	Facility Name	Type of Facility	Province	District	PCH STATUS	PCH NAME
711	Rawani Clinic	Comprehensive Health Center (CHC)	Kandahar	Kandahar	PCH	AHDS
2157	Loya wala Clinic	Comprehensive Health Center (CHC)	Kandahar	Kandahar	PCH	AHDS
626	Baba-e-Barq Clinic	Comprehensive Health Center (CHC)	Hirat	Heart	PCH	BDN
632	Now Abad Clinic	Comprehensive Health Center (CHC)	Hirat	Heart	PCH	BDN
639	Injil Clinic	Comprehensive Health Center (CHC)	Hirat	Injeel	PCH	BDN
1737	Karukh Clinic	Comprehensive Health Center (CHC)	Hirat	Karokh	PCH	BDN
14	12 Emam Clinic	Comprehensive Health Center (CHC)	Kabul	Paghman	PCH	BDN
1167	Baharak Hospital	District Hospital (H3)	Badakhshan	Baharak	PCH	BRAC
27	Chahar Asyab Hospital	District Hospital (H3)	Kabul	ChaharAsyab	PCH	BRAC
37	Kahak Jabar Clinic	Comprehensive Health Center (CHC)	Kabul	Khak-e-Jabar	PCH	BRAC
3	Mir Bacha Kot CHC	Comprehensive Health Center (CHC)	Kabul	MirBachKot	PCH	BRAC
1671	Khaldari Clinic	Comprehensive Health Center (CHC)	Kabul	Paghman	PCH	BRAC
1672	Bar Arghandi Clinic	Comprehensive Health Center (CHC)	Kabul	Paghman	PCH	BRAC
406	Shahre e Safa Clinic	Comprehensive Health Center (CHC)	Badakhshan	Darayem	PCH	CAF
410	Jurm Clinic	Comprehensive Health Center (CHC)	Badakhshan	Jurm	PCH	CAF
424	Yawan Clinic	Comprehensive Health Center (CHC)	Badakhshan	Yaawan	PCH	CAF
665	Adraskan Clinic	Comprehensive Health Center (CHC)	Hirat	Adraskan	PCH	Ibn Sina
2186	MirZa Muhamad Khan Clinic	Comprehensive Health Center (CHC)	Kandahar	Kandahar	PCH	SHDP
1784	Alama Reshad Clinic	Comprehensive Health Center (CHC)	Kandahar	Kandahar	ANF	
630	600 beds Hospital	Regional/National hospital (H1)	Hirat	Heart	MoPH	
108	Deh Dana Clinic	Comprehensive Health Center (CHC)	Kabul	Kabul	MoPH	
113	Bibi Maharo Clinic	Comprehensive Health Center (CHC)	Kabul	Kabul	MoPH	
151	Jamal Mena Clinic	Comprehensive Health Center (CHC)	Kabul	Kabul	MoPH	
153	Bahzad Clinic	Comprehensive Health Center (CHC)	Kabul	Kabul	MoPH	
154	Prozha-e-Jadid Panjsad Family Clinic	Comprehensive Health Center (CHC)	Kabul	Kabul	MoPH	
166	Halo Kheil Clinic	Comprehensive Health Center (CHC)	Kabul	Kabul	MoPH	
170	Dasht-e- Barchi Hospital	District Hospital (H3)	Kabul	Kabul	MoPH	
1668	Khoshhal Khan Mina Part B Clinic	Comprehensive Health Center (CHC)	Kabul	Kabul	MoPH	
1673	Gul khana Clinic	Comprehensive Health Center (CHC)	Kabul	Kabul	MoPH	
2190	Central Poly Clinic	Comprehensive Health Center (CHC)	Kabul	Kabul	MoPH	
2957	Maidan-e-Hawahi	Comprehensive Health Center (CHC)	Kabul	Kabul	MoPH	
648	Gozara Hospital	District Hospital (H3)	Hirat	Guzarah	Other	
2366	MCH-FP Clinic	Comprehensive Health Center (CHC)	Hirat	Heart	Other	
1788	Mercy Malaysia Clinic	Comprehensive Health Center (CHC)	Kandahar	Kandahar	Other	

ANNEX XI: SPS KEY ACTIVITIES

RESULT AREA	ACTIVITIES	PRODUCT	STATUS	DATE
Objective 1: Pharmaceutical Regulatory System Strengthened	1a. Support the MoPH by developing and implementing strategies to establish a regulatory framework taking into account existing systems and resource constraints	Revision of NMFB TOR	1	AA Q1 (Sep- Dec 2011)
		Establishing NMFB sub- Committee	1	AA Q1 (Sep- Dec 2011)
		Developing TOR for Medicine & Food Committee	1	AA Q1 (Sep- Dec 2011)
		Conducting the NMFB re-launch meeting	1	AA Q1 (Sep- Dec 2011)
	1.a. Support the MoPH by developing and implementing strategies to establish a regulatory framework taking into account existing systems and resource constraints	Developed and finalized protocol and tool on GDPA Situation Analysis for the medicine registration and licensing	1	AA Q2 (Jan - Mar 2012)
		Conducted Situation Analysis of the medicine registration and licensing	1	AA Q2 (Jan - Mar 2012)
		The Situation Analysis of the medicine and registration system report prepared and a presentation developed for presenting the above report to the GDPA	1	AA Q2 (July - Sep 2012)
	1b. Support the MoPH to create and implement a plan for the development and update of required laws, regulations, and policies to support the regulatory system	Revised the National Medicine Policy (NMP) action plan for the remaining process	Unknown	Unknown

		Developed and finalized the goals, objectives, preambles and body of the National Medicine Policy (NMP)	1	AA Q2 (Jan - Mar 2012)
		Conducting NMP 1st Consultative Workshop	1	AA Q1 (Sep-Dec 2011)
		Developed and finalized the preliminary draft of NMP	1	AA Q2 (Jan - Mar 2012)
		Revised the preliminary draft of NMP	1	AA Q2 (Jan - Mar 2012)
		An update draft prepared by Consultant Dr. Graham Dukes		
	1c. Support the MoPH with the development and implementation of a comprehensive strategy and implementation plan to address medicines quality assurance and secure buy-in of stakeholders	Developed draft proposal for piloting the GPHF-Minilab component of Medicines Quality Assurance Strategy in Afghanistan	1	AA Q2 (Jan - Mar 2012)
IR1.1: Capacity of MoPH to regulate medicines strengthened	1.1a. Assist the NMFB in conducting a two-day re-launch meeting to communicate the NMFB revised terms of reference	Conducted a two-day relaunch meeting to communicate the NMFB revised TOR	1	AA Q1 (Sep-Dec 2011)
	1.1b. Assist the NMFB to establish its secretariat office and develop SOPs	Developed and finalized job descriptions of the NMFB secretariat staff	1	AA Q1 (Sep-Dec 2011)
		Secured approMFB for the establishment of the secretariat office	1	AA Q1 (Sep-Dec 2011)
		Announced 3 positions of the secretariat staff	1	AA Q1 (Sep-Dec 2011)
	Established budget for the secretariat office	1	AA Q1 (Sep-Dec 2011)	

	1.1c. Assist the NMFB to establish sub-groups (Committees and/or sub-committees) with clearly defined terms of reference	Approved the membership of medicine and food committee by MoPH/NMFD	1	AA Q1 (Sep-Dec 2011)
		Translated the Medicine Committee TORs to Dari	1	AA Q2 (Jan-Mar 2012)
IR1.2: Public and private sector Quality Assurance systems strengthened	1.2a. Assist the NMFB, GDPA, and FDQCL to establish a quality assurance technical committee for pharmaceutical products and develop its terms of reference	Developed and finalized TOR for medicine and food committee	1	AA Q4 (July - Sep 2012)
		Established Medicine and Food committee	1	AA Q4 (July - Sep 2012)
		Developed and finalized one year activity plan for food committee	1	AA PY2 Q1 (Oct - Dec 2012)
		The Medicine committee work plan was approved by MoPH	1	AA Q4 (July - Sep 2012)
	1.2b. Work with the medicines quality assurance committee to develop a comprehensive quality assurance strategy and a three-year road map for its implementation	Interviewed the medicines and food technical affairs advisors and administrative officer of NMFB secretariat positions	1	AA Q2 (Jan - Mar 2012)
		The secretariat office established	1	AA Q3 (April - Jun 2012)
		Hired 3 staff for the secretariat office	1	AA Q3 (April - Jun 2012)
		SOP (Standard Operating Procedures) developed	1	AA Q3 (April - Jun 2012)

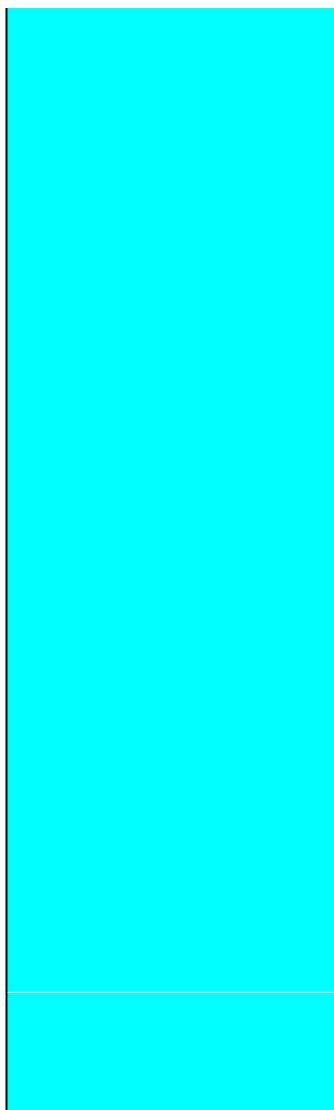
	1.2c. Assist the GDPA and FDQCL to assess the benefits and limitations of the GPHF-Minilab as a component of the national quality assurance program	Developed a draft proposal for piloting GPHF Minilab as one of the components of the Quality Assurance Strategy for Afghanistan	1	AA Q2(Jan - Mar 2012)
Objective 2: Pharmaceutical product availability improved	2a/b. Assist MoPH/GDPA conduct an assessment to collect data needed to evaluate the feasibility and appropriateness of arrange of options including - holding provincial buffer stock, local purchasing by provincial authorities and/or health facilities to supplement central supply and establishing systems to track stock in facilities and manage internal transfers between facilities	Reviewed the data collected from CPDS stakeholders to help make informed decision on developing strategies for strengthening procurement, distribution, storage, and inventory and promote rational use of medicine.	1	AA Q1 (Sep-Dec 2011)
		The bulk stock for PCH pharmaceuticals got shifted to new Qasaba warehouse	1	AA Q3 (April - Jun 2012)
		Decentralization of the PCH supply operations was deemed insufficient compared to the present set-up	Discontinued	AA Q3 (April - Jun 2012)

		Alternative routes avoiding transit to Pakistan explored	Discontinued	AA Q3 (April - Jun 2012)
IR2.1: BPHS and EPHS provider's pharmaceutical supply chain management strengthened	2.1a: In collaboration with Tech-Serve, develop a detailed plan for the integration of Tech-Serve drug management staff, infrastructure, and responsibilities into SPS	Tech Serve drug management staff, infrastructure, pharmaceutical stock, equipment and responsibilities were handed over to SPS	1	AA Q1 (Sep-Dec 2011)
	2.1b: Provide technical assistance to ensure an uninterrupted supply of essential medicines and health commodities to BPHS and EPHS providers/implementers, including the development of a quantification system to support procurement planning	Finalized the projection of pharmaceutical quantities needed for the USAID - supported facilities	1	AA Q1 (Sep-Dec 2011)
		Order request finalized	1	AA Q1 (Sep-Dec 2011)
		Reviewed , finalized and awarded four Tech Server task orders	1	AA Q3 (April - Jun 2012)

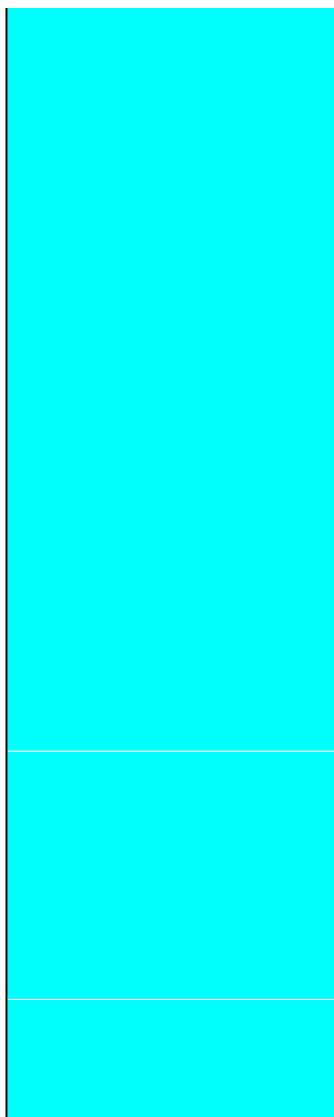
		Closely monitored the procurement pipeline of 42 items of Order # 9 that needed to be processed through Deliver/USAID	1	AA Q3 (April - Jun 2012)
		Obtained import license for Phenobarbital for order # 9 from MoPH	1	AA Q3 (April - Jun 2012)
		Supplied a total value of \$895,489 of essential medicines and contraceptives to be used by 10 PCH-NGOs in 13 USAID - funded provinces, Wazir Akbar Khan hospital and emergency situation of toxicity in Takhar province	1	AA Q3 (April - Jun 2012)
		Distributed essential medicines with a total value of \$49,127 to non- PCH health facilities for immediate use before they expire	1	AA Q3 (April - Jun 2012)
		Found and contracted a new warehouse for two years and shifted from old to the new warehouse	1	AA Q3 (April - Jun 2012)
	2.1c: Provide technical assistance for an operational plan to build the institutional capacity of the GDPA to assume responsibility for procurement, storage, and distribution	Reviewed, updated and finalized the first draft of functional GDPA analysis assessment report	1	AA Q3 (April - Jun 2012)
		Approval of the Functional Analysis assessment report and developing capacity building plan of GDPA staff	Unknown	AA Q4 (July - Sep 2012)
IR2.2: Coordination among the international donor community, the MoPH, and other relevant stakeholders strengthened	2.2a: Provide technical assistance to establish and implement a system of good governance to ensure transparency and efficiency in supply chain management and commodity security	Provided technical assistance to facilitate working relationship between key staff at the MoPH/GDPA with major stakeholders with the goal of building GDPA leadership, management, and technical capacity	Ongoing	AA Q1 (Sep- Dec 2011)

	Presented and included the CPDS in the MoPH action plan	1	AA Q2 (Jan-Mar 2012)	
	Inclusion of CPDS in to the National Medicine Policy/MoPH	1	AA Q2 (Jan-Mar 2012)	
	Presented the CPDS progress report to regular GDPA monthly coordination meeting	Ongoing	AA Q2 (Jan - Mar 2012)	
	CPDS Coordinator provided regular monthly updates to the MoPH deputy minister for administrative affairs	Ongoing	AA Q3 (April - Jun 2012)	
	2.2b: Provide technical assistance to the members of the CPDS committees and their sub-committees with the development and implementation of strategies and evidence-based technical interventions to assure pharmaceutical product quality and availability	Developed and implemented a comprehensive questionnaire for assessing the procurement and distribution procedures of GDPA/ MoPH	1	AA Q1 (Sep-Dec 2011)
		Finalized the Procurement and Quantification Assessment Report	1	AA Q3 (April - Jun 2012)
		Conducted baseline skills assessment for QUEM members for the main areas of drug quantification, English& Computer	1	AA Q3 (April - Jun 2012)

<p>2.2c: Support the MoPH with the development and implementation of a system to coordinate and standardize the collection, reporting, and analysis of essential data required to manage the procurement and supply of medicines and health commodities</p>	<p>Procurement, Distribution, and Quantification Report (PD&Q) Assessment Report translated and approved by MoPH</p>	1	<p>AA PY2 Q2(Jan- Mar 2013)</p>
	<p>DIC working group held 6 meeting sessions to review, edit and finalize pharmaceutical data collection format, user's manual, list of indicators, data flow chart</p>	1	<p>AAQ3 (April - Jun 2012</p>
	<p>DIC working group held 12 meeting sessions to finalize pharmaceutical data collection format, user's manual, list of 23 indicators</p>	1	<p>AA Q4 (July - Sep 2012)</p>
	<p>Conducted a 2 day workshop and introduced the data collection format to 9 BPHS/EPHS implementers</p>	1	<p>AA Q4 (July - Sep 2012)</p>
	<p>Analyze files test results and finalize the pharmaceutical data collection format and the user's manual accordingly (next step)</p>	Unknown	<p>AA Q4 (July - Sep 2012)</p>
	<p>Decide on Developing PLIS (MS ACCESS database) according to outcomes of the testing of the data collection format and indicators (next step)</p>	Unknown	<p>AA Q4 (July - Sep 2012)</p>



Plan for expansion of data collection to all BPHS/EPHS implementers	Unknown	AA Q4 (July - Sep 2012)
Developed action plan and TOR of PSD(Pharmaceutical Services Directory)	1	AA PY2 Q2(Jan - Mar 2013)
Prepared the list of stakeholders for data collection	1	AA PY2 Q2 (Jan - Mar 2013)
Developed and translated into Dari the data collection tools for PSD development	1	AA PY2 Q2 (Jan - Mar 2013)
Outline plan for technical sessions developed	1	AA PY2 Q2 (Jan - Mar 2013)
Roster plan for technical sessions for presenting organizations finalized	1	AA PY2 Q3 (Apr- Jun 2013)
Feedback sheet for technical sessions finalized	1	AA PY2 Q3 (Apr- Jun 2013)
Advocacy pager for the minimum standard requirements for quantification with CPDS members approved(nest step)	Unknown	AA Q4 (July - Sep 2012)
CPDS communication strategy developed	1	AA PY2Q2(Jan-Mar 2013)



Developed action plan for conducting National Management Commission (NMC) meeting	1	AA P2YQ2(Jan-Mar 2013)
Finalized CPDS committee action plan	1	AA P2Y2 Q3 (Apr- Jun 2013)
Developed and translated into Dari the CPDS semi - annual report	1	AA P2Y2 Q3 (April - Jun 2013)
Extracted, translated, and disseminated the Executive Summary for CPDS semi-annual report	1	AA P2Y2 Q3 (April - Jun 2013)
Drafted CPDS overview presentation	Unknown	AA P2Y2 Q3 (April- Jun 2013)
Drafted the quantification methods (part of the quantification guideline)	Unknown	AA PY2 Q2(Jan- Mar 2013)
Developed and translated into Dari the Minimum Requirement for Procurement and Distribution guideline	1	AA PY2 Q2(Jan - Mar 2013)
Disseminated the Dari version of procurement and distribution minimum requirements to CPDS stakeholders	1	AA PY2 Q3(April- Jun 2013)
Drafted pharmaceutical procurement guideline	Ongoing	AA PY3 Q1 (Oct - Dec 2013)

		Tested additional logistic indicators against the collected data from 8 tested BPHS/EPHS implementers	1	AA PY2 Q2 (Jan - Mar 2013)
		Drafted list of basic standards for supplier performance criteria	Ongoing	AA PY2 Q3 (Apr- Jun 2013)
		Presented the PLIS quarterly reporting from first phase testing summary page to mop	1	AA PY2 Q3(April- Jun 2013)
		Prepared for PLIS expansion	Ongoing	AA PY2 Q3(April- Jun 2013)
		Updated the PLIS quarterly reporting form and user manual in English and Dari for expansion phase	1	AA PY2 Q3 (Apr- Jun 2013)
		Drafted training plan and materials	Unknown	AA PY2 Q3(April- Jun 2013)
		Presented the PLIS reporting form at the PCH coordinating meeting	1	AA Q1 (Sep- Dec 2011)
	3a/b/c: Complete human resource assessment- based on the human resources assessment findings, quantifying and forecasting workforce needs in both private and public pharmaceutical sectors in the next three years, five years, and	Developed sampling protocol and assessment tools	1	AA Q1 (Sep- Dec 2011)

Objective 3: Human resource capacity for effective service delivery built	beyond five years	Developed training materials and conducted two day data collection training	1	AA Q1 (Sep-Dec 2011)
		Carried out data collection in four provinces (Herat, Balkh, Nangarhar, and Kabul)	1	AA Q1 (Sep-Dec 2011)
		Developed and finalized entry sheets through data pre-test and review	1	AA Q1 (Sep-Dec 2011)
		Finalized PHR/IST assessment report	1	AA PY3 Q1 (Oct - Dec 2013)
		Oriented the stakeholders of the MoPH capacity building committee on how to apply the competency framework to IST	1	AA PY3 Q1 (Oct - Dec 2013)
		Printed and disseminated 1500 copies of Competency Framework for Pharmaceutical Services	1	AA PY3 Q1 (Oct - Dec 2013)
	3.1a: Help build MoPH capacity to plan pharmaceutical sector human resources	Drafted MoPH/PHR operational plan	Ongoing	AA PY3 Q1 (Oct - Dec 2013)
	3.1b: Assist MoPH to improve pharmaceutical sector human resources management	will be contingent with the results of HR assessment	Unknown	AA PY2 Q3(April- Jun 2013)

	3.1c: Assist the MoPH with the development and implementation of a human resource strategy (competency development plan) to address deficiencies in pharmaceutical	Conducted a consultative workshop on the Draft National Pharmaceutical HR Strategic Framework	1	AA Q3 (Jan - Mar 2012)
		Prepared The Pharmaceutical HR Strategic Framework	1	AA PY3 Q1 (Oct - Dec 2013)
	3.1d: Provide technical assistance for development of pharmaceutical management training materials and implement training for pharmacy staff on the relevant aspects of pharmaceutical management	Trained 47 representatives of private sector pharmaceutical companies on stock management	1	AA PY2 Q2 (Jan - Mar 2013)
		Trained 13 supervisors of CAF NGO on Inventory Management Assessment Tools (IMAT)	1	AAPY2 Q2 (Jan - Mar 2013)
		Trained 5 pharmacists of Pharmacy Enterprise (PE) on using stock cards	1	AA PY2 Q2 (Jan - Mar 2013)
3.1e: Provide technical assistance to the pharmacy education institutions for the incorporation of modern pharmaceutical management concepts in their curricula	Conducted GIHS Pharmacy Department Workshop of Curriculum Revision	1	AA Q3 (April - Jan 2012)	
Objective 4: Pharmaceutical services	4a: Provide technical assistance and support to MoPH and standard treatment guidelines work groups to develop and roll	Finalized and translated the NSTG	1	AA PY2 Q3 (Apr- Jun

enhanced	out STGs to primary health facilities and hospitals			2013)
		Finalized and updated the EML/LML database	Ongoing	AA PY3 Q1 (Oct - Dec 2013)
	4b: Support development of adequate training materials for pharmaceutical services and outpatient pharmacy management	Conducted one round training course for 19 key staff of Bamyan provincial hospital for four days	1	AA Q1 (Sep-Dec 2011)
IR4.1: Institutional and human resource pharmaceutical management capacity built	4.1a: Improve the organizational capacity of GDPA, NGOs, and health facilities to support the provision of pharmaceutical services in the public and private sectors	Conducted three round Good Dispensing Practice Training in Kabul, Mazar and Herat for totally 77 pharmacists of Pharmaceutical Enterprises directorate of MoPH	1	AA Q1 (Sep-Dec 2011)
		Developed and transmitted TV spot through radio channels	1	AA Q1 (Sep-Dec 2011)
		Conducted the last round of the Good Dispensing Practice Training in Kabul for 25 pharmacists of Pharmacy Enterprises	1	AA Q2 (Jan-Mar 2012)
		Provided tools and technical assistance for a four day training on MDS and RMU in Badakhshan for 24 key staff	1	AA Q2 (Jan-Mar 2012)
		Visited 35 health facilities and six provincial stocks in seven provinces	1	AA Q2 (Jan-Mar 2012)

	Designed a stock card for use by the pharmaceutical enterprises	1	AA PY2 A1 (Oct - Dec 2012)	
	Applied The Rational Medicine Use (RMU) evaluation tool and the Supply Management Questionnaire	1	AA PY2 Q2 (Jan - Mar 2013)	
	Developed Inventory management and supply management action plan for each implementing NGO	1	AA PY2 Q2 (Jan - Mar 2013)	
	Conducted a one - day orientation workshop on the usage of RMU poster for 13 representatives of non- PCH-NGOs	1	AA PY2 Q2 (Jan - Mar 2013)	
	Completed the report on first health message evaluation and conducted a one day orientation workshop on inclusion/exclusion of drugs in EDL/ LDL	1	AA Q4 (July - Sep 2012)	
	4.1b: Support the appropriate functioning of national, regional, provincial, and institutional DTCs to oversee the implementation of rational use strategies and interventions	Offered support through Regular DTC follow - up and visits by SPS - GDPA team	1	AA Q4 (April - Jun12)
		Developed action plan to address the DTC problems in Baghlan and Takhar provinces through focused group discussions	1	AA Q4 (April - Jun 2012)
		Finalized and printed the first edition of Formulary list of three hospitals (Nangarhar, IG hospital & Stomatology hospital)	1	AA PY2 Q2 (Jan - Mar 2013)
		Finalized the English version of dental STG	1	AA PY2 Q2 (Jan - Mar 2013)
		Finalized list of contraindicated medicines	1	AA PY2 Q2 (Jan - Mar 2013)
		Prepared DTC visit reports	1	AA PY2 Q2 (Jan - Mar

				2013)	
		Finalized Medicine Distribution SOP for IGH	1	AA PY2 Q2 (Jan - Mar 2013)	
		Finalized and printed Noor eye hospital and Farkhar district hospitals formulary	1	AA PY2 Q2 (Jan - Mar 2013)	
		Finalized formulary list of Istiqlal hospital and Laghman provincial hospital	1	AA PY2 Q2 (Jan - Mar 2013)	
	4.1c: Assess the existing elements of the Afghanistan pharmacovigilance and adverse drug systems and support the development of a comprehensive approach		Hired pharmacovigilance technical officer	1	AA Q2 (Jan-Mar 2012)
			Translated 18 journal articles on drug safety into Dari	1	AA PY2 Q2 (Jan - Mar 2013)
		Finalized and translated the report on Medicine Safety situational assessment in six hospitals of Kabul	1	AA PY3 Q1 (Oct - Dec 2013)	
Objective 5: Information for pharmaceutical decision-making					

improved		Completed the drug importation data entry of private sector for the year 2012 (1391)	1	AA PY2 Q3 (Apr- Jun 2013)
	5a: Study the set of manual formats used at the facility level for both pharmaceutical commodity data recording, compiling and reporting, and assess if the current manual formats are sufficient to collect the required data	Completed the pharmaceutical manufacturing and importation companies data	1	AA PY2 Q3 (Apr- Jun 2013)
		Updated reference number of Afghanistan Essential Medicine List (LML) based on WHO EML reference number	1	AA PY3 Q1 (Oct - Dec 2013)
		Reviewed files of 8,562 products and applied standard labeling and coding	1	AA PY3 Q1 (Oct - Dec 2013)
	5b: Provide technical assistance to modify or design new manual formats if necessary and help develop instructions to use them if they do not exist	finalized the CPDS/DIC data collection format and the development of the user manual	Unknown	AA Q3 (April - Jun 2012)
IR5.1: Pharmaceutical management information systems to support evidence-based decision-making strengthened	5.1a: In collaboration with other relevant U.S. and Afghan government partners and counterparts involved in both supply chain and HMIS, support the development and implementation of a comprehensive PMIS for the recording, reporting, analysis, and presentation of patient-and product-related data to support decision-making	Developed PMIS strategy final draft	Ongoing	AA PY3 Q1 (Oct - Dec 2013)

	5.1b: Provide continued support to the paper-based and other existing forms of management information systems as required	Held meetings with the GDPA and MoPH/HMIS to get their input to draft PMIS strategy	Unknown	AA PY3 Q1 (Oct - Dec 2013)
	5.1c: Ensure collation of information related to medicine use outcomes (such as adherence indicators, adverse drug reactions) for pharmaceutical policy, medicine selection decisions, and treatment options	Finalized the survey implementation tools and report	Ongoing	AA PY2 Q2 (Jan - Mar 2013)
GENERAL SUPPORT				
	Procurement of Equipment for the MoPH and SPS	Completed the purchasing process of complete equipment list for MoPH/ GDPA and Faculty of Pharmacy - Kabul University	1	AA Q4 (July - Sep 2012)
		Done with inventorying the purchased items	Unknown	AA Q4 (July - Sep 2012)
	Work Plan Development	Developed and approved both M & E and Work plans for SPS	1	AA Q3 (April - Jan 2012)

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