

Rational Medicine Use in Afghanistan: Report on Initial Activities, December 9-20, 2008

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About SPS

The Strengthening Pharmaceutical Systems (SPS) Program strives to build capacity within developing countries 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.

Abstract

As access to medicines is increasing, it is vitally important to ensure that the available medicines are used appropriately. However, irrational use is a widespread global problem. The USAID-supported Strengthening Pharmaceutical Systems (SPS) Program of MSH has initiated collaboration with the Ministry of Public Health (MoPH) of Afghanistan to improve the use of medicines in the country. As a startup activity in the process, SPS technical staff from Washington and Kabul offices conducted a rapid appraisal of the current situation in December 2008 and drew short and longer-term plans for appropriate actions with MoPH collaboration. This report documents the activities conducted during the December visit, findings of the rapid appraisal, and the suggested action plans.

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Key Words

Rational Medicine Use, Antimicrobial Resistance, Drug and Therapeutics Committee, antimicrobial use indicators, training, standard treatment guidelines

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CONTENTS

Acronyms	v
Background	1
Purpose of Trip	2
Scope of Work	2
Activities	4
Collaborators and Partners	8
Next Steps	9
Immediate Follow-up Activities	9
Recommendations	9
Agreement or Understandings with Counterparts.....	10
Annex 1. RFCC.....	11
Annex 2. Stakeholder Meetings.....	14
Annex 3. Attendees for the RMU and Coordinated Procurement Presentations.....	16
Annex 4. Proposed 1- and 3-year plans	18
Annex 5. Catalog of RMU-Related Documents	21
Annex 6. Rational Medicine Use Rapid Appraisal.....	49

ACRONYMS

ADR	Adverse Drug Reaction
AIDS	Acquired Immunodeficiency Syndrome
AMR	Antimicrobial Resistance
API	Avicenna Pharmaceutical Institute
BASICS	Basic Support for Institutionalizing Child Survival
BHC	Basic Health Center
BPHS	Basic Package of Health Services
CBHC	Community Based Health Care
CHC	Comprehensive Health Center
DEWS	Disease Early Warning System
DH	District Hospitals
DMIS	Drug Management Information System
DTC	Drug and Therapeutics Committee
EC	European Commission
EDL	Essential Drugs List
EML	Essential Medicines List
EPHS	Essential Package of Hospital Services
FFSDP	Fully Functional Service Delivery Point
GoA	Government of Afghanistan
GDPA	General Directorate of Pharmaceutical Affairs
HIV	Human Immunodeficiency Virus
IDC	International Donor Community
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illness
INN	International Non-proprietary Name
JICA	Japan International Cooperation Agency
LDL	Licensed Drug List
MCH	Maternal Child Health
M&E	Monitoring and Evaluation
MDR-TB	Multi-Drug Resistant Tuberculosis
MoPH	Ministry of Public Health
MSH	Management Sciences for Health
NDTC	National Drug and Therapeutics Committee
NGO	Non-government Organization
OB	Obstetrics
OTC	Over the Counter
PHD	Provincial Health Department
QA	Quality Assurance
REACH	Rural Expansion of Afghanistan Community-based Health Care
RMU	Rational Medicine Use
RPM Plus	Rational Pharmaceutical Management Plus Program
SCA	Swedish Committee for Afghanistan

SOP	Standard Operating Procedures
SPS	Strengthening Pharmaceutical Services
STG	Standard Treatment Guidelines
STI	Sexually Transmitted Infections
Tech-Serve	Technical Support to the Central and Provincial Ministry of Public Health
TB	Tuberculosis
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

BACKGROUND

Background:

Afghanistan has been a country in conflict for most of the past 30 years. As a result, healthcare services have suffered dramatically and the country has some of the worst health indicators in the world. With the deterioration of the health infrastructure, irrational medicine use has become a significant issue that contributes to poor health outcomes and increasing costs. The Ministry of Public Health (MoPH) and the U.S. Agency for International Development (USAID) supported Rural Expansion of Afghanistan Community-based Health Care (REACH) and Tech-Serve programs have made significant improvements in healthcare services as evidenced by the implementation of the Basic Package of Health Services¹, Essential Package of Hospital Services², and other health improvement programs from 2003 to 2008.

Comprehensive assessments of the pharmaceutical sector in Afghanistan have been infrequent and specific assessments of medicine use are rare. The Swedish Committee for Afghanistan (SCA) conducted a medicine use study using health facility indicators in the SCA region that showed an overuse of antimicrobials coupled with an irrational practice of dispensing half treatment courses.³ An assessment by the WHO in 2002 concluded that irrational use was common in Afghanistan including the overuse of antimicrobials and injections. The assessment also noted that consumers cannot always afford complete courses of therapy and that medicines (generics) are perceived to be of low quality leading the prescription of high doses and multiple products in the same therapeutic category.⁴ The 2008 European Commission (EC) assessment, although lacking in objective evidence, concluded there was much anecdotal evidence from various sources that suggests a tendency among Afghan doctors to over-prescribe medicines generally and antibiotics in particular, and that combinations of medicines are prescribed without due consideration of possible side effects. Patients often ask pharmacists to prescribe medicines even though a large proportion of private pharmacies do not have a qualified pharmacist on staff. In addition to the problem of over-prescribing by qualified practitioners, there is a serious problem with diagnosis and prescription by unqualified people posing as doctors in private clinics and working in private pharmacies as well as by street vendors.⁵

Upon the request of the Mission, in February 2008 Anthony Savelli and Mark Morris of the USAID-supported Strengthening Pharmaceutical Systems (SPS) Program of Management Sciences for Health (MSH) visited Kabul to develop a scope of work, initial work plan and budget to improve the use of medicines by healthcare providers and patients and build the capacity of the MoPH to manage pharmaceuticals and related services. Technical areas include quality assurance of pharmaceutical products, establishment of a coordinated pharmaceutical

¹ Ministry of Public Health, Islamic Republic of Afghanistan, 2005 *A Basic Package of Health Services*

² Ministry of Public Health, Islamic Republic of Afghanistan. 2005 *The Essential Package of Hospital Services for Afghanistan*

³ Mansoor, B, Najib, Mohd 2003. *Baseline Drug Indicator Study, A comparative Cross-Sectional Study in SCA Health Facilities in Afghanistan, Part II Results and Next Steps*. Swedish Committee for Afghanistan

⁴ World Health Organization, 2002. *Pharmaceutical Situation in Afghanistan, Preliminary Assessment*

⁵ European Commission, 2008. *Afghanistan Pharmaceutical Sector Identification Mission Report, Interventions Scenarios for the EC –Draft*

procurement and distribution system within the MoPH, and design of a system for the procurement of pharmaceuticals using USAID funds to succeed the system currently managed by Tech-Serve. Staff recruitment was recently finalized and all SPS staff is in place. One of the key intervention areas of importance in the SPS Afghanistan work plan is Rational Medicine Use (RMU). Dr. Mohan Joshi and Mr. Terry Green are SPS internal experts in the area of Rational Medicine Use. They have assisted several MSH RPM Plus (now SPS) supported countries with the development and establishment of RMU programs inclusive of the establishment of National Drug and Therapeutics Committees, Drug and Therapeutics Committees (DTCs) at various levels, and the development of activities to address the issues associated with RMU and the containment of antimicrobial resistance (AMR) in the broader context. These two technical staff traveled to Kabul from 9 to 20 December 2008 to work with the technical staff of SPS/Afghanistan and to assist MoPH in carrying out RMU activities in a systematic and organized manner.

Purpose of Trip

The purpose of Kabul visit for Dr. Joshi and Mr. Green were to:

- Orient the staff of SPS and MoPH/Directorate of Pharmaceutical Affairs on DTCs and RMU
- Assist the SPS and MoPH team with the identification of RMU activities, materials, and actors within the pharmaceutical sector in Afghanistan
- Begin the process of developing operational/implementation plans to address the issues associated with RMU.

Scope of Work

The scope of work for Dr. Joshi and Mr. Green were:

- Conduct arrival and departure briefings with USAID as required;
- Attend a Security Briefing with the Tech Serve Head of Security as soon as possible after arrival;
- Introduce the concept of DTCs to local staff of SPS, the staff of MoPH/Directorate of Pharmaceutical Affairs, and the relevant stakeholders to obtain consensus on this intervention;
- Locate and catalog existing documents (policies, standards, & training materials) related to RMU and identify actors (within and outside of the MoPH) responsible for activities influencing the use of medicines;
- Based upon initial information gathering and gap identification, technically assist the staff of SPS Afghanistan and the MoPH/Directorate of Pharmaceutical Affairs with the development a plan for the review and adaptation of existing SPS DTC/RMU materials to suit the context of Afghanistan incorporating facts and materials available in the country.
- Provide technical assistance (TA) to the staff of SPS Afghanistan and the MoPH/Directorate of Pharmaceutical Affairs with the development of 1 & 3 year overall operational/implementation plan that will include among other things plans for training courses/schedules, development of the TOR and work plan for the National DTC, and implementation of indicator based studies in several Kabul hospitals using methods developed by the International Network for Rational Use of Drugs (INRUD) and WHO

for OPD settings and by SPS for in-patient settings.

See Annex 1 for the approved RFCC.

ACTIVITIES

Introduce the concept of DTCs to local staff of SPS, the staff of MoPH/Directorate of Pharmaceutical Affairs, and the relevant stakeholders to obtain consensus on this intervention

The local SPS staff was introduced to the concepts of RMU starting on December 13th and this continued daily through December 18th. RMU concepts and potential strategies were discussed with many different stakeholders. See Annex 2 for a list of stakeholders met during this visit to Afghanistan.

There was a general consensus that the proposed RMU interventions discussed were relevant for the situation in Afghanistan. The development of DTC at the central level and eventually at the hospital level was considered by most stakeholders as an important strategy to improve the use and management of medicines, especially antimicrobials. The development and dissemination of standard treatment guidelines (STGs) is also considered to be a high priority intervention in Afghanistan. As expected, meetings with academic institutions resulted in a preference for RMU training and capacity building of their own institutions.

We conducted two meetings with key MoPH stakeholders, on December 14th and on the 17th. A presentation was prepared and delivered on the 17th to a large group of MoPH stakeholders. See Annex 3 for the list of attendees and Annex 4 for specific interventions discussed and the suggested timeframe for implementation. MoPH was generally in favor of the activities proposed and had some additional suggestions and recommendations including the following by Dr. Faizullah Kakar, the Deputy Minister of Health:

- Work closely with personnel at Avicenna Pharmaceutical Institute (API) to increase their capacity to address the issues of irrational medicine use
- Include the National Drug and Therapeutics Committee in the current structure at MoPH, e.g. API or National Medicine Board
- Provide training to pharmacy personnel in Afghanistan to ensure that medicines are used appropriately - training of pharmacists is a key issue in Afghanistan
- Increase capacity of laboratories and the Food and Drug Agency
- Improve surveillance of AMR – use Disease Early Warning System (DEWS) that is already in place

The first three items will be included in the implementation of RMU activities as recommended by Dr. Kakar.

Locate and catalog existing documents (policies, standards, & training materials) related to RMU and identify actors (within and outside of the MoPH) responsible for activities influencing the use of medicines.

Key RMU-related documents were reviewed, cataloged, and a summary key points provided for each document. There were no documents that addressed RMU directly or in

any depth, but many that had indirect and pertinent information concerning the issues of RMU. This activity was conducted prior to travel and while in Kabul, December 10-13. See Annex 5 for the catalog of key documents and a summary of the review.

Using this document review and key informant interviews, an RMU rapid appraisal was undertaken while in Kabul. The results of this rapid appraisal show that there is very little objective information available in Afghanistan regarding RMU. There is ample information that the MoPH is slowly improving health services, but there is not much available on addressing RMU issues at any level of health care. See Annex 6 for results of the rapid appraisal.

Based on the rapid appraisal, the following conclusions can be drawn:

- MOPH regulations, policies, procedures, strategies all address healthcare delivery and indirectly the provision of RMU, but it is unclear how effective these are and to what degree health providers know about these or actually follow them.
- API has a mandate to oversee and coordinate RMU activities including drug information, poison information, ensure the quality of medicines, licensing and approval of all imported medicines, licensing and registration of pharmacies, training of pharmacist, monitor adverse drug reactions (ADR) and coordinating RMU efforts. Currently, there is limited development of these mandates and activities.
- Essential Medicines List and procedures for maintaining the list have been developed as a valuable tool to control the use of medicines in the public sector. Dissemination has occurred throughout the public healthcare system. The EML restricts drugs to different levels of the healthcare system and was last updated in December 2007.
- RMU pre-service training is under reform at the Kabul University School of Pharmacy and a new curriculum will be available in 2009. RMU training is provided in a very limited scope at the medical school.
- RMU training is provided by Health Services Support Project (HSSP) on a regular basis to selected health facilities. This important training program introduces RMU concepts, sick newborn management, Integrated Management of Childhood Illness (IMCI) standards, drug supply management and other RMU topics on a regular basis.
- There is widespread concern regarding the quality of medicines available in Afghanistan, including issues relating to substandard drugs, counterfeit drugs, and smuggled drugs/medical supplies. Many documents and key informants state that this is a significant problem and it has an adverse affect on prescribing behavior. A recent study of drug quality found that public sector drugs are of acceptable quality while private sector drugs were of equivocal quality and this needs more

study.

- Treatment standards for providing healthcare services are available for only a limited number of diseases and medical conditions. There are no comprehensive, nation-wide STGs.
- Studies of the pharmaceutical sector are limited and do not reveal much objective information about RMU. The SCA medicine use study of 2003 showed that there was overprescribing and underprescribing of antimicrobials, knowledge of medicines by patients was poor, and labeling of medicines almost non-existent. The most recent EU assessment conducted in 2008 provided information on the poor quality of drugs and the irrational prescribing of antimicrobials.

The RMU plans should build on the following *enabling factors* that were identified during this rapid appraisal period:

- Strong support for RMU by MoPH and other stakeholders
- National Medicines Policy emphasizes RMU
- Clinical standards recommended in EPHS
- Strong Donor Support for health and pharmaceutical sectors
- API of MOPH has provided some RMU trainings
- HSSP currently providing RMU training
- Some standards currently exist
- RMU Interventions, including NDTC recommended by WHO
- Four health professionals recently underwent DTC training
- Many policies already developed relating to the pharmaceutical sector

Similarly, the RMU planning will need to pay attention to find ways to reduce the following constraints that currently exist:

- Insufficient coordination by donors and MoPH
- Lack of sufficient awareness about RMU concepts, including DTCs
- Inadequate technical expertise, equipment, supplies, and pharmaceuticals in many hospitals
- Lack of drug information resources and expertise
- Lack of standard treatment guidelines for most conditions
- Inadequate pharmaceutical governance
- Lack of supervision and follow-up on trainings
- Inadequate implementation and enforcement of existing policies and regulations

As a part of the startup process, the SPS team met with several stakeholders relevant to RMU in Afghanistan. Those visited included officials at World Health Organization (WHO), European Commission (EC), World Bank (WB), HSSP, and Kabul University. The SPS team also visited the honorable Deputy Minister for Academic Affairs Prof. M. Osman Babury. All the stakeholders that the SPS team visited showed support for RMU activities in Afghanistan, including DTCs and STGs. The names of the stakeholders visited and the meeting schedules appear in Annex 2.

Based upon initial information gathering and gap identification, technically assist the staff of SPS Afghanistan and the MoPH/Directorate of Pharmaceutical Affairs with the development a plan for the review and adaptation of existing SPS DTC/RMU training materials to suit the context of Afghanistan incorporating facts and materials available in country.

Discussions were held on the development and implementation of a National DTC and hospital DTCs and a plan was formulated. In order the fully implement DTCs in Afghanistan, a 6-day DTC training course will be developed and conducted for National DTC (NDTC) members, API staff, HSSP staff, local Kabul hospitals, and other key Afghan professionals in July 2009. The total number of participants will be limited to 35-40. The training materials will be revised based on the current literature review, rapid appraisal, and the results of the Rational Medicine Use study that is planned for March 2009. Final revisions of the training materials will be completed in April 2009.

Provide TA to the staff of SPS Afghanistan and the MoPH/Directorate of Pharmaceutical Affairs with the development of 1 & 3 year overall operational/implementation plan that will include among other things plans for training courses/schedules, development of the TOR and work plan for the National DTC, and implementation of indicator based studies in several Kabul hospitals using methods developed by the International Network for Rational Use of Drugs (INRUD) and WHO for OPD settings and by SPS for in-patient settings.

A plan was developed and presented to MOPH at a meeting on December 17. See Annex 6 for summary of the RMU plan. Initial activities include:

- Review of HSSP Rational Medicine Use training materials (Jan-February 2009)
- Rational Medicine Use study (March 2009)
- DTC Training (July 2009)
- STG implementation Workshop (July 2009)

There was a general consensus of support and approval from MoPH for the proposed activities and plans.

Debrief USAID

A debriefing of USAID officials took place on December 17 and included:

Dr. Randolph Augustin, MD, MPH, MA
Health, Population, Nutrition Officer
Office of Social Sector Development (OSSD)
USAID/Kabul

Dr. Mohammad Shapor Ikram, MD, EMBA H/GM
Program Management Specialist Health
Office of Social Sector Development (OSSD)
USAID/Kabul

The debriefing included the activities completed from December 9 to 17 and included:

- Stakeholders meetings (Annex 2)
- Rational medicine use presentation to MoPH (Annex 3 and 4)
- Overall plan of activities (Annex 4)
- Afghanistan RMU literature review (Annex 5)

Document provided to USAID:

- RMU presentation made to MoPH. The presentation slides provided a review of the worldwide situation of irrational medicine use and suggestions regarding potential SPS activities that could help address irrational medicine use in Afghanistan.

Collaborators and Partners

Ministry of Public Health, Pharmaceutical Affairs

- Dr. Alhaj Jamahir Anwari, Director General of Pharmacy Affairs
- Dr. Quriashi, Director of Procurement and Registration, Directorate of Pharmacy Affairs
- Dr. Aisha Noorzai, Director of Avicenna Pharmaceutical Institute, MoPH
- Dr. Fahima Habib, Senior Officer, Essential Drug Department

Health Services Support Project (HSSP)

- Dr. Hamid Shinwari, NGO Capacity Building Manager

European Union (European Commission), Afghanistan

- Sarah Bernhardt, Task Manager, Health and Disability Sector

The World Bank, Afghanistan

- Mohammad Tawab Hashemi, Extended Term Consultant, South Asia Region

World Health Organization, Afghanistan

- Dr. Ahmed Abd El Rahman, Medical Officer

University of Kabul

- Pohanwal Mohammad Nassim Sediqi, Director of Faculty of Pharmacy
- Assoc. Prof. Aqa Mohammad Jakfar, Head of the Pharmaceutical Department
- Assoc. Prof. Haji Mohammad Naimi, lecturer of Faculty of Pharmacy
- Dr. Mohammad Rafi Rahmani, Lecturer of Faculty of Medicine

NEXT STEPS

Immediate Follow-up Activities

SPS will:

- Begin review of HSSP rational medicine use training materials and activities. HSSP has provided their curriculum to SPS and we will offer comments and input to their RMU training program.
- Initiate technical assistance to MoPH for the establishment of a national level Drug and Therapeutics Committee. Actual implementation will take place in February and March after approvals have been obtained from MOPH.
- Develop a detailed plan for a drug use study covering both in- and out-patient settings. This study will cover various components including health facility indicators, antimicrobial hospital indicators, prescribing studies, ABC/VEN analysis, and medicine availability analysis.

Recommendations

Key MoPH officials are highly interested in and committed to promoting rational medicines use in Afghanistan. The Ministry is interested in collaborating with SPS to achieve this goal. It is therefore recommended that USAID and SPS continue and expand the recently initiated technical assistance to MoPH and other stakeholders for designing and implementing interventions that contribute to RMU.

Several other donors and programs are active in the country to support its pharmaceutical sector, which has thus far primarily concentrated in increasing access. In this context SPS can play a highly complementary role to help increase appropriate use of the available medicines. In terms of SPS collaboration for RMU work, the primary stakeholder is MoPH, but attention will have to be paid to keep adequate partnership with all other relevant stakeholders including HSSP, European Commission, World Bank, World Health Organization, and Kabul University (Faculty of Medicine and Pharmacy).

The key initial activities identified are DTC and STG, but opportunities exist to support several other areas such as rational medicine use training, drug information, pharmacovigilance, and the containment of AMR. In the longer run, there may be need and opportunity to revise the National Medicines Policy, Essential Medicines List, and Formulary.

It will be important to ensure adequate coordination between the RMU activities and other initiatives that SPS has recently initiated pertaining to drug quality and coordinated pharmaceutical procurement. Additionally, the RMU initiative should collaborate with and learn from experiences of other on-going MSH projects such as Tech-Serve, BASICS, and TB CAP.

Agreement or Understandings with Counterparts

SPS will review HSSP RMU training materials with the goal of assessing strengths and weaknesses in content and delivery style. SPS will provide comment and input for strengthening the rational medicine use training program that is currently being provided to USAID-supported health facilities.

ANNEX 1. RFCC

Request for Country Clearance

TO: Randolph Augustin/USAID Afghanistan
Shapor Ikram/USAID Afghanistan

FROM: Management Sciences for Health (MSH) Strengthening Pharmaceutical Systems (SPS) Program (GHN-A-00-07-00002-00)

SUBJECT: Request for Country Clearance for travel for Mohan Joshi and Terry Green to Afghanistan for the period December 9 through December 20, 2008.

COPY: Anthony Boni/USAID/GH/HIDN/HS, CTO for SPS
Veerle Coignez/USAID/GH/HIDN/HS, Pharmaceutical Management Advisor
Douglas Keene, Director, MSH/SPS
Maria Miralles, Deputy Director, MSH/SPS
Mark Morris, Country Program Manager, MSH/SPS
Mohan Joshi, AMR Program Manager, MSH/SPS
Terry Green, Senior Program Associate, MSH/SPS
Dr. Mubarak Shah Mubarak, Tech-Serve Chief of Party
Steve Morgan, Tech Serve Finance and Operations Director, MSH/CLM
Fabiola Odio, Administrative Coordinator, MSH/SPS

1. The SPS program wishes to request country clearance for the proposed travel to Kabul, Afghanistan for Mohan Joshi and Terry Green on or around December 9 – December 20, 2008. Mr. Joshi is the AMR Program Manager for MSH/SPS and Mr. Green is a Senior Program Associate for MSH/SPS. This has been concurred by Anthony Boni/CTO SPS.

2. Background:

Upon the request of the Mission, in February 2008 Anthony Savelli and Mark Morris of the Strengthening Pharmaceutical Systems (SPS) Program visited Kabul to develop a Scope of Work, initial work plan and budget to improve the use of medicines by healthcare providers and patients and build the capacity of the MoPH to manage pharmaceuticals and related services. Technical areas include quality assurance of pharmaceutical products, establishment of a coordinated pharmaceutical procurement and distribution system within the MoPH, and design of a system for the procurement of pharmaceuticals using USAID funds to succeed the system currently managed by Tech Serve. Currently staff recruitment was finalized and all SPS staff are in place. One of the key intervention areas of importance in the SPS Afghanistan work plan is Rational Medicine Use (RMU). Both Mr. Joshi and Mr. Green are MSH SPS internal experts in the area of Rational Medicine Use. They have assisted countless MSH RPM Plus (now SPS) supported countries with the development and establishment of RMU programs inclusive of the establishment of National Drug and Therapeutics Committees, Drug and

Therapeutics Committees at various levels, and the development of activities to address the issues associated with RMU in the broader context. SPS' approach to improving the use of medicines will be through establishment of a National Drug and Therapeutics Committee, initially at the central MoPH level with the goal to develop a plan for eventual roll out to the provincial level when appropriate.

3. The purpose of this visit is to 1) Orient the staff of SPS and MoPH/Directorate of Pharmaceutical Affairs on DTCs and RMU, 2) Assist the SPS and MoPH team with the identification of RMU activities, materials, and actors within the pharmaceutical sector in Afghanistan, and 3) begin the process of developing operational/implementation plans to address the issues associated with RMU.

4. Scope of Work:

Mohan Joshi and Terry Green will:

- Conduct arrival and departure briefings with USAID as required;
- Attend a Security Briefing with the Tech Serve Head of Security as soon as possible after arrival;
- Introduce the concept of DTCs to local staff of SPS, the staff of MoPH/Directorate of Pharmaceutical Affairs, and the relevant stakeholders to obtain consensus on this intervention;
- Locate and catalog existing documents (policies, standards, & training materials) related to RMU and identify actors (within and outside of the MoPH) responsible for activities influencing the use of medicines;
- Based upon initial information gathering and gap identification, technically assist the staff of SPS Afghanistan and the MoPH/Directorate of Pharmaceutical Affairs with the development a plan for the review and adaptation of existing SPS DTC/RMU materials for suit the context of Afghanistan incorporating facts and materials available in country.
- Provide TA to the staff of SPS Afghanistan and the MoPH/Directorate of Pharmaceutical Affairs with the development of 1 & 3 year overall operational/implementation plan that will include among other things plans for training courses/schedules, development of the TOR and work plan for the National DTC, and implementation of indicator based studies in several Kabul hospitals using methods developed by the International Network for Rational Use of Drugs (INRUD) and WHO for OPD settings and by SPS for in-patient settings.

5. Anticipated Contacts:

- USAID/Kabul
- Ministry of Public Health
- Tech-Serve staff
- SPS Afghanistan staff

- HSSP staff
- Compri-A staff
- WHO
- World Bank
- EU

6. Logistics:

- Mohan Joshi and Terry Green will be traveling from Washington, DC and will arrive on or around December 9th and depart on or around December 20th, 2008. Accommodations will be at MSH Guest House in Kabul.
- Transportation will be provided by MSH vehicles in Kabul.
- No Mission assistance is required.

7. Funding: All costs for this visit will be funded using SPS funds.

Action: Please inform the SPS Program whether country clearance is granted for the activity to take place as proposed. Please reply via e-mail to the attention of Tony Boni, USAID/G/PHN/HN/HPSR, e-mail: aboni@usaid.gov, tel. (202) 712 4789, fax (202) 216 3702. Please send carbon copies to Veerle Coignez at vcoignez@usaid.gov, Douglas Keene at dkeene@msh.org, Maria Miralles at mmiralles@msh.org, Mark Morris at mmorris@msh.org, Mohan Joshi at mjoshi@msh.org, Terry Green at tgreen@msh.org, Dr. Mubarak Shah Mubarak at mmubarak@msh.org, Steve Morgan at smorgan@msh.org, Fabiola Odio at fodio@msh.org

Thank you for Mission cooperation.

ANNEX 2. STAKEHOLDER MEETINGS

December 13

Tech-Serve

Dr. Steven L. Solter
Technical Director

Sunday, Dec 14

MOPH, Pharmaceutical Affairs Meeting

Dr. Alhaj Jamahnal Anwari, Director General of Pharmacy Affairs
Aisha Noorzai, General Director of Avicenna Pharmaceutical Institute
Dr. Fahima Habib, Senior Officer, Essential Drug Department
Zakia Adel, Manager of National Medicine Registry
Dr. Abdul Hafiz Qurishi, Director of Procurement and Registration, Pharmacy Affairs
Mohammad Zekria Fathazada, Manger of inspection Program

Pharmacy Enterprises

Dr. Kasim Naemie, Director of Pharmacy Enterprises

BASICS

Dr. Hedayatullah Stanckzai
Team Leader, USAID/BASICS/Afghanistan

TB CAP Country Team Leader/Afghanistan

Dr. Mohammad Khalkerah Rashidi

HSSP

Hamid Shinwari, MD
NGO Capacity Building Manager

Monday, Dec 15

Indira Gandhi Hospital

Dr. Khalil, Deputy Director of Hospital
Dr. Sediq Faizi, Children Specialist
Mohammed Salim, OPD pharmacist

Kabul University (Faculty of Pharmacy)

Prof. Pohanwal Mohammad Nassim Sediqi, Dean of the Faculty of Pharmacy
Aqa Mohammad Jakfar, Assoc. Prof. and Head of the Pharmaceutics Department of the
Faculty of Pharmacy and President of Pharmacy Association

Haji Mohammad Naimi, Assoc. Prof. in Microbiology, Faculty of Pharmacy

Tuesday, December 16

Kabul University (Faculty of Medicine)

Professor Dr. Mohammad Rafi Rahmani
Pharmacologist and Lecturer, Kabul Medical University

European Commission

Sarah Bernhardt
Task Manager Health and Disability Sector

WHO

Dr. Ahmed Abd El Rahman
Medical Officer

Wednesday, December 17

MoPH

See Annex 3 for attendees

USAID

Dr. Mohammad Shapor Ikram
Program Management Specialist Health

Dr. Randolph Augustin
Health, Population, Nutrition Officer

Thursday, December 18

World Bank

Mohammad Tawab Hashemi
Extended Term Consultant
South Asia Region

Ministry of Higher Education

M. Osman Babury
Deputy Minister for Higher Education

**ANNEX 3. ATTENDEES FOR THE RMU AND COORDINATED
PROCUREMENT PRESENTATIONS
MINISTRY OF PUBLIC HEALTH
DECEMBER 17, 2008**

Dr, Sadrudding Sahar	Deputy Health Minister
Dr, Faizullah Kakar	Deputy Health Minister
Dr, Nadera Hayat Burhani	Deputy Health Minister
Ph, Aisha Noorzia	Pharmaceutical Director of MoPH
Dr, Ghulam Sarwar Homayee	Head of Reform and RB department
Dr, Mohd Kazem Naimi	Head of Pharmaceutical interprise
Dr, Hayatullah Nawabi	Admin D.P of MoPH
Salim Jawid	Food and drug quality control
Amena Rustaqi	Drug Quality Control
Kamela Sultani	Director of Food and Quality Control Department
Zakia Adil	N.M.A
Ph, Fahima Habibi	ESD Officer
Anthony Savelli	Principle Program Associate
Dr.Mohammad Zafar Omari	Country Team Leader
Wahidullah Karwar	Quality Assurance Advisor
Abdul Zahir Siddiqui	Rational Drug Use Advisor
Noorullah Bawar	Administrative Assistant
Abdul Tawab Khitab	Procurement Advisor
Noura Naalaoui	Consultant
Mohan Joshi	Consultant
Terry Green	Consultant
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Rational Medicine Use in Afghanistan: Report on Initial Activities, December 9-20, 2008

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Sayd Reza Shah Masoomi	Deputy Director of Pharmaceutical Affairs
Abdul Hafiz Qurishi	General Manager of Procurement & Registration
Dastagir Fazilat	Finance Director
Ph, Ahmad Farid	Technical Manager of Medical Equipment Department at MoPH

ANNEX 4. PROPOSED 1- AND 3-YEAR PLANS

Establish Drug and Therapeutics Committees at the National Level, Hospitals, and Health Centers

- Establish a *multi-disciplinary* National DTC (NDTC) within the Pharmaceutical Affairs Unit of MOPH with a clear TOR (Feb/Mar 2009)
- Equip the NDTC with key drug information resources (Apr/May 2009)
- Conduct drug use studies such as ABC/VEN analysis, indicator studies, and prescribing practices in a sample of health facilities in both the public and private sectors (Mar to May 2009)
- Organize a national DTC course with leadership of NDTC and technical support from SPS (July 2009)
 - Objectives: disseminate findings of drug use study; capacitate the NDTC; train selected staff from health facilities who could be potential DTC members
- Establish DTCs at pilot hospitals and provide them with key drug information resources (Sep/Oct 2009)
- Supervise, monitor and provide follow-up technical assistance to the DTCs in these hospitals (on-going from Nov 2009)
- Conduct a follow-up workshop for those DTC members that show results in order to:
 - give them a chance to share the achievements, experiences and lessons learned
 - train them as DTC trainers through a short TOT package (July 2010)
- Conduct further trainings utilizing the TOT-exposed staff as lead facilitators, and roll-out establishment of DTCs in other parts of the country (second half of 2010)

Collaborate with HSSP to Improve RMU Training Programs

- Collaborate with HSSP to revise their RMU training curriculum (Jan-July 2009)
- Strengthen the RMU training capacity of HSSP through a TOT exposure to its training staff (July 2009)

- Support in the supervision and follow-up of HSSP's TOT participants (on-going from Aug 2009)

Develop and Implement Standard Treatment Guidelines

- identify all the relevant stakeholders (Mar/Apr 2009)
- Map what already exists through specific disease programs and through different NGO activities (Mar-May 2009)
- Set up an STG Committee under NDTC leadership and convene a national stakeholder workshop to agree on the scope, content and format of the STG (July 2009)
- Develop a draft ,and revise based on wide consultation with external reviewers (Mar 2010)
- Field test and finalize the document and print (May/Jun 2010)
- Official launch, distribution, and initial training of the STG (July 2010)
- Supervision and monitoring of the use of the guidelines (including STG Compliance study) (on-going from Aug 2010)
- STG utilization feedback meeting and reinforcement training (Mar 2011)

Initiate RMU Training Programs

- Develop training materials on dispensing, counseling, communication skills, and outpatient pharmacy management (Aug-Oct 2009) and provide training to pharmacists (provincial Government Drug Stores) (Nov 2009)
- Compile, and review various sets of pharmaceutical training materials used by the MoPH and NGOs, and work with the MoPH to produce a single MoPH-approved set (Dec 2009-July 2010)

Longer Term Plans

- Revise EML to match with the newly developed national STG (tentative target – second half of 2010)
- Provide technical assistance to the Kabul University to incorporate rational medicines use and AMR related topics in the pharmacy curriculum, which is currently undergoing revision (tentative timeline – 2009)

- Initiate advocacy and actions to contain antimicrobial resistance (AMR) (tentative target – second half of 2010/first half of 2011)
- Initiate public education on rational medicines use, responsible self-medication, and AMR (tentative target – second half of 2010/first half of 2011)
- Revise the National Medicines Policy (tentative target – 2011)
- Update national formulary (tentative target – 2011)
- Training on drug information (tentative target – 2011)
- Update the STG (tentative target – 2012)

ANNEX 5. CATALOG OF RMU-RELATED DOCUMENTS

Catalog of Afghanistan RMU-related Documents December 20, 2008

Summary of Document Review

There is much written about the healthcare system in Afghanistan. The MOPH has produced a large number of policies, procedures, guidelines and laws. NGO's have produced much information on their particular healthcare programs. Pharmaceutical assessment have been done but on a very limited basis. Specific information on rational medicine use is very limited. There is much anecdotal information and key informants have provided details about the common practices of over and under prescribing of antimicrobials, the use of medications without prescriptions, low quality medicines (and counterfeit) available in the private sector and other irrational medicine use issues

The following documents have been reviewed to document facts on the use of medicine and the prevalence of irrational use. Key findings and a brief summary are provided for each. A overall summary is provided below.

- There have been a lot of positive outcomes from investments in the Afghanistan MoPH over the past 5 years. These include
 - Development of numerous guidelines, strategies, policies and procedures for the pharmaceutical sector
 - National Medicines Policy
 - Pharmaceutical Laws
 - Pharmaceutical regulations that license pharmacists, pharmacies and drugs
 - Drug Donation Guidelines
 - Drug Procurement Guidelines
 - National Health Policy, 2005-2009
 - Health and Nutrition Sector Strategy 2008-2013
 - Development of an official package of basic health services and framework for the delivery health services. This framework in contained in 2 documents revised in 2005:
 - Basic Package of Health Services (BPHS)
 - The Essential Package of Hospital Services for Afghanistan (EPHS)
 - Development and dissemination of the national Essential Medicine List. This important document provides guidance on a limited list of medicines that can be used in the public sector.

- API has been given a mandate to manage the use of drugs in the country. This organization is important because it provides the following activities in the area of RMU
 - Regulatory approval of medicines (through the National Medicine Agency)
 - Medicine information
 - Quality Control (through National Quality Control Laboratory)
 - Rational Use of medicine
 - Medicinal research
 - Education and Training (working with Faculty of Pharmacy)

These activities have limited functionally due to a low capacity and lack of funding and staffing for this organization.

- Even though policies, procedures, guidelines and laws have been enacted, it is difficult to tell how effective these have been for patient care or their influence on RMU or if they are followed. Because policies and guidelines are available there is the potential for controlling how medicines can be used if they are enforced.
- Systematic assessments of the pharmaceutical sector are infrequent.
 - Assessments of drug use are rare (1 study in 2003). This SCA study showed that there was over prescribing of antimicrobials in healthcare facilities and the prescribing of half treatment courses and antimicrobials was a common practice.
 - EC assessment found that the Afghanistan pharmaceutical sector is complex and chaotic. There is widespread smuggling of medicines into the country. 80% of drugs available in the private sector may be smuggled. Drugs are available in drug stores, grocery stores, wholesalers, street sellers.
 - EC assessment was emphatic that there are serious concerns about rational medicine use. Although objective evidence is limited, there is ample antidotal evidence of overprescribing of antimicrobials. Patients ask pharmacist to prescribe medicine and this is readily done. The quality of many drugs available in the country are questionable
 - Afghanistan Private Pharmacy Survey found that poor quality drugs were being imported from Pakistan. Quality issues are highly prevalent. Most all prescription drugs can be obtained without a prescription. Survey shows that only 14% of dispensers are qualified pharmacists.
 - The MOPH study of drug quality in 2007 found that there was acceptable quality in drug provided in the public sector. Private pharmacy drugs had some quality issues, but this sector was not studied in significant amounts to draw conclusions
- There is a well recognized lack of standards for clinical patient care and management of hospitals. Standards of care (and treatment) do exist for some diseases and medical conditions and include:
 - IMCI

- TB
- Malaria
- MCH
- Infection Control

- Factors contributing to irrational use
 - Weak pharmaceutical management infrastructure
 - Weak pharmaceutical regulatory authority
 - Poor quality and counterfeit drugs in the private sector
 - Low level of education of primary health care providers
 - Lack of in-service and pre-service education on RMU
 - Inadequate staffing
 - Security problems in many health centers and hospitals
 - Lack of standards for RMU
 - Low priority (but getting higher with MOH)

- In developing plans for addressing irrational use, one should consider
 - Drug use assessment to establish baseline and identify specific problems with drug use
 - A multi-factorial approach
 - Strengthen Regulatory structure (Drug quality, drug registration, licensing, pharmacovigilance)
 - Pharmaceutical management:
 - DTC for management of medicines
 - Training for health professionals
 - Training for the public
 - Introduction of standards
 - Primary health drug use standards (in addition to IMCI)
 - Hospital STGs
 - Audit and feedback activities
 - National Formulary

Catalog of Documents Pertaining to RMU

Document	Author	Key Findings and Conclusions
Core Healthcare Documents		
A Basic Package of Health Services for Afghanistan, 2005	MOPH	<p>This document provides comprehensive information on services that will be provided at different levels of primary health care system in Afghanistan. The Basic Package of Health Services (BPHS) serves as the official package of basic health services for primary health. Medical services, diagnostic services, staffing, equipment and essential drugs are all described for different levels of health care. The document serves as a framework for future Afghanistan health care activities. Seven elements of the BPHS include:</p> <ul style="list-style-type: none"> • Maternal and New Born Health • Child Health and Immunizations • Public Nutrition • Communicable disease treatment and control • Mental Health • Disability Services • Regular supply of essential drugs
The Essential Package of Hospital Services for Afghanistan, 2005	MOPH	<p>The Essential Package of Hospital Services (EPHS) describes official services that are provided at hospitals in Afghanistan. All levels of hospitals (district, provincial, and referral) are described in this document. Outlines six areas where standards need to be developed in the future.</p> <p>Areas of concern for hospitals include:</p> <ul style="list-style-type: none"> • Lack of standards for clinical patient care and management of hospitals • Lack of equitable access to hospital services • Concentration of financial resources and health workers at hospitals • Lack of hospital management skills • Lack of necessary staff, equipment, supplies, and pharmaceuticals in many hospitals • Referral system does not work

Rational Medicine Use in Afghanistan: Report on Initial Activities, December 9-20, 2008

National Essential Drugs List, Dec 2007	MOPH	<p>This document lists all of the revised essential medicines for use in the public sector. Document provides information on the following:</p> <ul style="list-style-type: none"> • Committee members • Review process, procedures and forms for adding new drugs to the EDL • References identified for reviewing new drugs for the EDL: WHO Model List, BPHS/EPHS documents, treatment guidelines, product information (package insert), British National Formulary (BNF), Martindale • Classification of drugs (WHO) • Detailed instruction for using EDL • Levels of care that essential medicines are available
National Licensed Drug List	MOPH	<p>List of essential medicines and all drugs licensed for import, use and sale in the country. Includes OTC medicines and includes EDL medicines. This medicine list is consistent with the EDL, BPHS, EPHS. This list has the same transparent review process that is used for the EDL.</p>
National Drug Policy and Drug Law	<p>MOPH</p> <p>Graham Dukes</p>	<p>National Drug Policy and Drug Law produced – 2003 -See below</p> <p>Laws are established to ensure that all medicines and certain other medical products essential to health care are suitable for their purpose, are safe, and of good quality, they are both assessable and affordable to the entire population and that they are rationally used</p> <p>Laws include:</p> <ul style="list-style-type: none"> • Product licenses • Licensing of wholesalers and retail outlets • Licensing and grading of pharmacies • Manufacturing • Illegal Possession of medicines • Scheduling and Classification of Medicines • Rational Medicines use, principles • Advertising and Promotion • ADR • National Poison Information Center • Regulations on the promotion and advertising of medicines

<p>National Medicines Policy of the Islamic Transitional Administration of Afghanistan, 2003</p>	<p>MOPH</p>	<p>This document does not constitute law or set down firm rules. The purpose of the document is to set goals. Provisions of the NMP include:</p> <ul style="list-style-type: none"> • Makes reference to obtaining medicines with efficacy, safety, and quality. • Supply and control medicines – task of manufacture, importing, and distribution is the responsibility of the private sector. During this time of emergency the MOPH will take necessary steps to ensure the availability of medicines. MOPH will be responsible for licensing and inspection of drugs, manufacturers and importers. • Proper and Appropriate use – Prescribers, pharmacist, patients all bear the responsibility for ensuring medicines are used in a manner consistent with current knowledge and opinion and which is appropriate to the individual needs. • Reference is made to the need for a drug information center to ensure the provision of reliable and impartial drug information. To support drug information services, there will be a national formulary and register of adverse drug reactions (ADRs) • Advertising and promotion is allowed for certain medicines with government control of what is actually said • EML is enacted and OTC (list of free sale medicines) drugs are described as drugs that the public can obtain without a prescription • Accessibility - private sector is best suited to providing medicines in Afghanistan and will be encouraged to so. Government will be the provider in special circumstances such as this state of emergency and to rural areas where private sector is not involved • Monitoring and evaluation will be undertaken by the pharmaceutical affairs department • Lowering of financial barriers - the purchase of low price drugs (including generics) where possible to control the overall cost of medicines

Rational Medicine Use in Afghanistan: Report on Initial Activities, December 9-20, 2008

National Health Policy 2005-2009	MOPH	<p>The national Health policy objective for 2005-2009 is to reduce the high levels of mortality and morbidity by:</p> <ul style="list-style-type: none"> • Improving access to quality emergency and routine reproductive and child health services • Increasing coverage and quality of services to prevent and treat communicable diseases and malnutrition among children and adults • Strengthening institutional development and management at the central and provincial levels to ensure the effective and cost-efficient delivery of quality health services • Further developing the capacity of health personnel to manage and better deliver quality health services including services for diagnosis and treatment of mental health disorders <p>Expected outcomes for health care in Afghanistan during this time period:</p> <ul style="list-style-type: none"> • Maternal mortality ration reduced from 1600 to 1300 • Infant mortality rate reduced from 165 to 115 • Under-five mortality rate reduced from 230-180 • Prevalence of acute malnutrition among under-five years of age lowered from 7% to less than 5% • Control and surveillance system for infectious diseases established • Integrated mental health support and care services developed at all levels of the health system
Draft Health and Nutrition Sector Strategy 2008-2013	MOPH	<p>Strategy is outlined and targets for improvement provided for 2008-2013. Major components of the strategy include:</p> <p>Reducing morbidity and mortality</p> <ul style="list-style-type: none"> • Implement the Basic Package of Health Services (BPHS) • Implement the Essential Package of Hospital Services (EPHS) • Improve the quality of maternal and reproductive HCSs • Improve the quality of child health initiatives • Strengthen the delivery of cost effective integrated Communicable Disease Control (CDC) Programs • Establish prevention and promotion programs • Promote greater community participation

		<ul style="list-style-type: none"> • Improve coordination of HCSs • Strengthen the coverage of quality support programs • Reduce prevalence of malnutrition and increase access to micronutrients. <p>Institutional development</p> <ul style="list-style-type: none"> • Promote institutional and management development at all levels • Strengthen health planning, monitoring and evaluation (M&E) at all levels • Develop Health Care Financing (HCF) and national health accounts • Strengthen HR Development (HRD), especially of female staff • Strengthen provincial level management and coordination • Continue to implement Priority Reform and Restructuring (PRR) • Establish quality assurance (QA) • Develop and enforce public and private sector regulations and laws
Regulations on the Advertising and Promotion of Medicines		<p>Very general regulation affecting promotion of medicines. Regulations stipulates that no advertisement for any medicine, whether intended for health professionals or the public, may be disseminated in any manner until the contents have been submitted to the National Medicines Agency and approved by it. The conditions of approval will be notified to the Inspectorate of Medicines.</p> <p>Promotion of medicines to healthcare professionals must include the package insert (the approved literature for the medicine).</p>
Regulations on the Licensing and Classification of Medicines and Designed Medical Products	MOPH	<p>Brief regulations that cover the licensing of medicines that are imported into the country. Any firm, institution or individual desiring to import or market a medicine or designated medical product by way of trade shall submit to the Department of Pharmaceutical Affairs an application for a Product License. Usual standards apply - efficacy, safety, quality, licensed in another country. All products imported into Afghanistan must have a license.</p>
Regulations on Pharmacies, 2003	MOPH	<p>MOPH regulations for hospital and retail pharmacies. There are basically 4 types of pharmacies</p> <ul style="list-style-type: none"> • Hospital pharmacy – licensed to handle inpatients drugs and a small supply of outpatient drugs upon patient discharge • Retail, Grade 1 – staffed by university trained pharmacist – all licensed drugs are available • Retail, Grade 2 – Staffed by diploma trained pharmacist – limited set of drugs available at this

		<p>pharmacy</p> <ul style="list-style-type: none"> • Retail, Grade 3 - rural pharmacies only – no pharmacist available – full range of medicines are available in order to provide access to medicines in the rural areas of the country <p>Regulations include:</p> <ul style="list-style-type: none"> • Duties of pharmacy owners • Duties of pharmacy managers • Licensing, administration and inspection of pharmacies • Financing and supply
<p>Country Cooperation Strategy 2006-2009</p>	<p>WHO</p>	<p>This document describes the WHO Strategy for 2005-2009. Strategy includes:</p> <ul style="list-style-type: none"> • Overall Health Sector Policy and Sector Management • Health System Development including Health Care Financing, Human Resource Development and District Health Systems. • Control of Communicable Diseases • Reproductive and Child Health • Health Education, Prevention and Promotion. • Mental Health • Emergency Preparedness and Response <p>The WHO strategy also discusses priority health issues in Afghanistan:</p> <ul style="list-style-type: none"> • Malaria, tuberculosis and HIV/AIDS: these three major communicable diseases pose a serious threat to health and economic development and have a disproportionate impact on the lives of the poor • Cancer, cardiovascular diseases and diabetes: there is a growing epidemic of these diseases of the poor and transitional economies • Tobacco: a major killer in all societies and rapidly growing problem in developing countries • Maternal health: the most marked difference in health outcomes between developed and developing countries show up in maternal mortality data and it is difficult to reduce maternal mortality with out a well functioning health system • Food safety: a growing public health concern with potentially serious economic consequences • Mental health: five of the ten leading causes of disability are mental health problems. Major depression is the fifth contributor to the global burden of disease and may be second by 2020

		<ul style="list-style-type: none"> • Safe blood: both a potential source of infection and major component of treatment. Crucial in the fight against hepatitis and HIV/AIDS; • Health systems: development of effective and sustainable health systems underpins all the other priorities. Demand is substantial from member states for support and advice on health sector reform; • Investing in change in WHO: a prerequisite for WHO to become a more efficient and productive organization and one capable of response with in an increasingly complex environment. • The development of new skills, systems and process is central to the effective management of WHO's core functions.
Policies, Procedures, and Guidelines		
National EPI Policy, Afghanistan, February 2004	MOH, Directorate General of Health Care and Promotion, National EPI Office	<p>Comprehensive policy (123 pages) for immunization including preparing for immunizations clinics, cold chain, social mobilization, campaigns, safety of injections, M&E, surveillance, managing adverse events, safety of injections and disposal, outbreak response.</p> <p>Immunizations are given as fixed, outreach, pulse immunizations/mobile. This document outlines specific immunization guidelines including:</p> <ul style="list-style-type: none"> • Standard child immunization schedule (DPT x 3 doses, OPV x 4 doses, measles x 2 doses, BCG at birth) • Standard TT immunization Schedule for adults (target – women of child bearing age) (TT X 5 doses) • Cold chain procedures • Vitamin A administration guidelines • Standards for preparation, reconstitution and administration of all vaccines
Principles and Mandates of the Avicenna Pharmaceutical Institute		<p>This MoPH, Pharmaceutical Affairs, organization has a very important mandate that is pertinent to medicine use and RMU. Activities include:</p> <ul style="list-style-type: none"> • Regulatory approval of medicines (through the National Medicine Agency) • Medicine information • Quality Control (through National Quality Control Laboratory) • National Poisons Information Center • Rational Use of medicine • Medicinal research • Education and Training (working with Faculty of Pharmacy) <p>There is no elaboration on how these activities will be carried out and no evidence provided that they are</p>

Rational Medicine Use in Afghanistan: Report on Initial Activities, December 9-20, 2008

		really fulfilled
Hospital Standards for Accreditation	MOPH	<p>These comprehensive documents are provided in 14 separate manuals that describe standards to meet hospital accreditation standards. The organization and the descriptions of the standards are similar to Joint Commission accreditation standards in the U.S. Contents of the manual:</p> <ul style="list-style-type: none"> • Governance • Pediatrics • Surgical Care • Surgical Emergencies • Anesthesia • OR • Surgical Emergencies • Anesthesia • OB • Infection Prevention • Laboratory • Blood Bank • Hospital Pharmacy • Facilities • HR <p>Treatment guidelines available in the manuals include: OB – preeclampsia and eclampsia complications and their treatment, Pediatrics - initial treatment of meningitis, sepsis, measles, typhoid fever, malaria</p>
National Malaria Strategic Plan	MOPH	History, Epidemiology, drug resistance, prevalence data throughout the country treatment strategies/protocol and Strategic Plan. STG for treatment of Malaria is provided
Afghanistan National Strategic Framework for HIV/AIDs	MOPH	History, Epidemiology, prevalence and strategic plans. Surveillance, VCT, IEC preventions are the major activities in the strategic plan. Framework states there is no treatment available in Afghanistan. Antiretroviral drugs are listed on the EML and the LDL
Guidelines for Tuberculosis Control Programs in	MOPH	History, epidemiology, policy, diagnosis, bacteriology. STG for TB management and treatment is provided.

Afghanistan, Oct 2005		
Procedure Manual for Infection Prevention and Control in Hospital Health Centers, 2005	MOPH, General Directorate of Curative Diagnostic Services	Procedures and guidelines for infection control in hospitals and health centers. Includes detailed procedures for infection control: <ul style="list-style-type: none"> • Infection Prevention and Control Program • Patient Care • Department/Unit/Ward • Environmental Care <p>Surgical Prophylaxis procedure is described (Cefazolin 30 minutes before procedure, for appendectomy use cefoxitin or cefotetan, for MRSA use vancomycin). 3rd and 4th generation cephalosporins shall not be used</p>
Drug Donation Guidelines April 2003	MOPH, HealthCare and Promotion Department	Detailed guidelines are provided for drug donations in Afghanistan. Key points include: <ul style="list-style-type: none"> • Drugs must be on the EML • Presentation, strength, formulation must be similar to those drugs commonly used in Afghanistan • WHO Certification Scheme on the quality of pharmaceuticals moving in international commerce should be used • Shelf life - must be greater than 1 year remaining • Language – understandable in Afghanistan • EML department must be notified
Development of Clinical Standards improvement in Anesthesia, General Surgery, and Emergency Care	REACH	Clinical standards developed for anesthesia, general surgery, emergency services. These standards do not include medicine use.
Pharmaceutical Sector Assessments and Studies		
Communication for Behavior Change: Expanding Access to	Compri-A	Capacity building and assessment of private health care organizations and professional associations: Includes the Association of Private Hospitals and the Pharmacists' Association.

Rational Medicine Use in Afghanistan: Report on Initial Activities, December 9-20, 2008

<p>Private Sector Health Products and Services in Afghanistan (COMPRI-A) Institutional Capacity Assessment – Private Hospital and Pharmaceutical Associations within Afghanistan February 19 – March 3, 2008: Trip Report</p>		<p>Action plans were developed by both professional associations for future professional activities.</p>
<p>Baseline Drug Indicator Study, Final draft 9 April 2003 A comparative Cross-sectional Study in SCA Health Facilities in Afghanistan Part II: Study Results and Next Steps</p>	<p>Swedish Committee for Afghanistan</p>	<p>Comprehensive drug use study of SCA health facilities in 2003. Study included WHO health facility indicators and others.</p> <p>Positive Findings include:</p> <ul style="list-style-type: none"> ● % Injections -5.7% ● % of drug that are on the EDL – 89% ● Availability of key drugs – 83% <p>Negative Findings</p> <ul style="list-style-type: none"> ● % Antibiotics - 50% ● Ave duration of antibiotic course - 4.7 days ● % adequately labeled – 1.1% ● Patient’s knowledge of correct dosage 63.4% <p>Other indicator results</p> <ul style="list-style-type: none"> ● Ave consultation time – 4.8 min ● Ave dispensing times – 149 sec ● % of drugs dispensed – 79%

		<p>Other important findings</p> <ul style="list-style-type: none"> • Antibiotic were given to patients for 4 days or less in 1/3 of all prescriptions (and nearly ½ of all prescriptions for antibiotics in some health facilities). • The prescription ½ courses of antibiotics is common - patients must come back for the second half and most did not. 50% of patients receiving antibiotics is considered to be a significant contribution of irrational medicines use in these SCA clinics <p>Based on results and discussion a mixed managerial/educational approach was chosen to address irrational drug use especially antimicrobial prescribing. A taskforce was set up to introduce interventions. One suggestion was to develop a standard curriculum for RMU and provide this training throughout SCA clinics.</p> <p>This study also suggested that sociological/anthropological research e done to explore determinants of drug use in Afghan society</p>
<p>Afghanistan National Health Resources Assessment, 2002</p>	<p>MOPH MSH</p>	<p>Comprehensive assessment of health resources in Afghanistan. Main conclusions from this assessment include:</p> <ul style="list-style-type: none"> • There is great inequity in the distribution of facilities and services throughout the country between provinces, and between districts in the same province. Further analysis may allow correcting for geographic features that interfere with access (e.g. rivers and mountain ranges), as well for facility catchment areas that cover population clusters in neighboring districts. • Most facilities seem to be close to roads, which may enhance referral and access for population-dense areas, but may also create problems of access for population in more remote areas. The MoPH is convinced that equitable distribution of health resources and ensuring equal access to basic health services for all Afghans are prerequisites for lasting peace. The mobilization of the resources necessary to offer reasonable access to health services to all Afghans is a priority for the MoPH. Presently a target of 1 health facility per 30,000 people has been established. This is a first step; the ultimate goal will be 1 facility per 10,000 people. Several donor agencies have expressed interest in (re)constructing facilities. • Any newly implemented facilities should target the underserved areas and districts. Even where health facilities exist, they often lack basic utilities. All facilities should have access to safe water

sources, which is not the case today. Also, they are not necessarily equipped and staffed to offer the BPHS. This may partly explain the low referral rates found in the assessment. For example, only half of district hospitals have a functioning laboratory; this interferes with the management of TB and complicated malaria. When cross-tabulating specific services with the availability of critical equipment needed to deliver the services, it dramatically diminishes the adequate availability for all the services of the BPHS.

- MoPH's priorities will be to collaborate with its partners to ensure that all existing and newly planned health facilities will offer the necessary services to take care of the most vulnerable groups (women and children) and are appropriately equipped and staffed.
- Specific services dealing with pregnancy and delivery urgently need to be upgraded where they exist and implemented where they are lacking. The extremely high maternal mortality rate illustrates a silent emergency, which the MoPH wants to deal with immediately. Essential obstetric care should be available throughout the system, and emergency obstetric care must be made available at all referral facilities. A plan has been drafted for emergency obstetric care and will be implemented aggressively. It involves the training of midwives and auxiliary midwives in several locations throughout the country.
- Diminishing the high infant and child mortality rate in Afghanistan is another priority of the MoPH. This assessment clearly shows that many first-line facilities do not offer the complete basic package for child health (immunization, child nutrition, and childhood diseases). The implementation of the BPHS will ensure the necessary equipment and supplies, as well the necessary capacity building, where needed.
- Reasonable access to the most basic health services cannot be ensured through facility-based care only. The CBHC providers surveyed claimed to be providing a surprising number of MCH services. This may indicate a resource that is ill used at the moment. For example, combining facility-based with community-based numbers, it seems that female providers, including those trained at only a basic level, are the main group of health workers called to assist deliveries in the home. Offering improved obstetric care only at facilities will probably have a slow or minor effect, unless the link with those health workers who assist with most home deliveries is made.

		<ul style="list-style-type: none"> • The gender ratio between male and female health providers needs to be addressed as soon as possible. The MoH promotes the training of additional female health workers of all levels, ut particularly of clinical mid-level health workers like nurses and auxiliary midwives that will staff BPHS facilities and provide MCH services. • Efficient collaboration between public, private, and NGO sectors will be easier to achieve at the provincial or sub provincial level. For pharmaceutical distribution systems in particular, the MoPH plans to explore the possibility of using private distribution systems where they exist and to ensure the quality of products through the implementation of a national drug policy, which is under development.
Afghanistan National Hospital Survey, 2002	MOPH MSH	<p>Main lessons learned from this comprehensive survey</p> <ul style="list-style-type: none"> • Afghanistan has a relatively low number of hospitals and hospital beds compared with other countries with a comparable level of income. The ratio of 1 bed for 1,000 people, recommended by WHO, is not reached in any province • The distribution of hospital facilities and services is uneven with large parts of the population unable to access referral facilities • The physical condition of facilities is acceptable, but they often lack adequate supply of water and electricity. • Hospitals are under-equipped and their equipment is not adequately maintained. • Access to technical units (medical imaging, laboratory, surgery) is limited to few facilities • Facilities are under-used, with average occupancy rates below 50%. Emergencies and outpatient units are more used by the population than inpatient units • Hospitals are generally over-staffed, particularly in the large urban areas, but too few facilities have an adequate number of female staff to provide acceptable services to the whole population they are supposed to serve. • Among services proposed to patients, delivery care and emergency obstetric care are particularly poor. Very few facilities can supply C-sections in safe conditions. • Some provinces have little or no access to a hospital in good condition. In spite of the heavy investment efforts supported by the international community, discrepancies between provinces tend
Afghanistan Private Pharmacies Survey,	MSH Europe	Comprehensive survey of private pharmacies throughout Afghanistan. Survey of private pharmacies used questionnaires. Finding include the following:

Rational Medicine Use in Afghanistan: Report on Initial Activities, December 9-20, 2008

2004		<ul style="list-style-type: none"> • Public expenditure for Health \$11 per capita • \$140 million per year Pharmacy market (almost all private) • Avicenna Pharmaceutical manufactures a few products, otherwise everything is imported • Pakistan is primary supplier of drugs • Poor quality drugs from Pakistan is common. Quality issues are highly prevalent • Nobody knows about the EML • Most all prescription drugs can be obtained without a prescription • RDU is not really addressed in AF. Faculty of medicine may not be interested in STGs. Faculty of pharmacy is very interested in RDU • Survey showed only 14% of dispensers are qualified pharmacists • Large number of wholesalers and importers • Drugs are very expensive and are readily available • Quality of drugs is a significant issue for retailers and patients
Fully Functional Service Delivery Point in Afghanistan: A Baseline Evaluation, October 2005	Zohal, Laumonier-Ickx	<p>The present report is based on the results of the FFSDP baseline evaluation conducted between February 2005 and July 2005 in 180 REACH-supported health facilities (Rounds 1 and 2 NGO grantees) operating in 11 REACH-supported provinces. Results show low scores for meeting many of the standards of quality included in the FFSDP: nothing is in place, forms are in place but not in use and/or planned activities are not being performed. Most standards get a positive score when forms and procedures are in place and used and when activities are planned and performed as planned.</p> <p>Very low compliance with QA indicators. Clinical guidelines (defined in this report)) and available in <1% of facilities. Guidelines include:</p> <ul style="list-style-type: none"> • Maternal and Child Health • Immunizations • Public Nutrition • Communicable diseases (TB&Malaria) • Essential Drugs
Pharmaceutical situation in Afghanistan,	WHO	<p>WHO Report on the current situation and recommendations for improving supply and use of drugs. Some of the recommendations:</p> <ul style="list-style-type: none"> • Create a Department of Pharmaceutical Affairs

<p>Preliminary Assessment</p> <p>Mission Report 14-23 January 2002</p>		<ul style="list-style-type: none"> • Move all pharmaceutical Services to the site of the API manufacturing plant • Develop a National Drug Policy • Review and update pharmaceutical Legislation • Adopt guidelines for drug donations and ensure interagency coordination • Create new Central Medical stores and combine the two MOPH warehouses into a single one • Update the National Essentials drugs list and create a NDTC committee • Training of health professionals in rational drug use • Create national level Drug and therapeutics committee <p>This assessment and recommendations strongly urge more training in RMU at all levels of care. Training in RMU should concentrate on clinical diagnosis, appropriate treatment, of a limited range of priority diseases, proper referral mechanism and appropriate dispensing practices</p> <p>Training manuals are needed for prescribing</p> <p>Existing materials from various NGOs/UN Agencies should form the basis of agreed national guidelines</p>
<p>Afghanistan Pharmaceutical Sector Identification Mission Report: Intervention Scenarios for EC November 2007 – January 2008</p>	<p>EC</p>	<p>Extensive report on the pharmaceutical sector situation and accompanying recommendations for addressing problems. This assessment reviewed the Afghanistan health literature and used key informant interviews to obtain information. Main conclusions:</p> <ul style="list-style-type: none"> • An uninformed observer upon seeing the Afghanistan pharmaceutical market situation can rightly say that this is a situation completely out of control in all respects – Afghanistan has a serious public health and trade problem concerning medicines • Positive aspects of Afghanistan pharmaceutical sector development. Since 2002 there have been a number of positive sector developments, particularly concerning the introduction of the donor funded BPHS/EPHS system that is providing essential drug coverage to the population in need and the putting in place of basic policy and regulatory systems and structures; • Weaknesses in the provision of essential medicines through the BPHS/EPHS scheme. It is not clear what level of coverage the BPHS/EPHS system is supposed to achieve in terms of supplying essential medicines to the population in need (at least 70% of essential medicines are provided through the private sector in spite of the BPHS/EPHS system). The BPHS/EPHS system has made

several achievements since it was established in 2003, but the system is highly complex and suffers from incoordination between the Government of Afghanistan (GoA) Ministry of Public Health (MoPH) and the International Donor Community (IDC) that funds it.

- Ongoing conflict between ‘Command Economy’ and ‘Market-based Economy’ systems operating in the Afghanistan health sector. The Afghanistan MoPH continues to operate a ‘command economy’ system, a residue of the Socialist period, particularly through its API, which causes conflict with ‘market economy’ based systems being introduced by the IDC;
- Absence of sector coordination between the International Donor Community (IDC), the MoPH and other relevant sector stakeholders. There is almost a complete absence of sector coordination.
- One global standard exists for pharmaceutical regulation and pharmaceutical policy should be evidence-based – Afghanistan is far from meeting international pharmaceutical regulatory and policy standards and practices.
- Afghanistan is a receptacle for sub standard, counterfeit, adulterated and diverted medicines.
- Afghanistan’s adverse economic and geopolitical situation makes it a strong target for pharmaceutical crime that seriously undermines health care provision. Failing sector management facilities and infrastructure. The quality control laboratory is operating in a dilapidated condition, is not internationally accredited and operates without any international formal cooperation. The MoPH pharmaceutical policy and regulatory function is working in temporary buildings. Aside from good policy reasons, the very poor physical infrastructure situation in itself is enough to suggest that investment is required to create a GoA Drug Regulatory Agency.
- Afghanistan faces a ‘Pharmageddon’ scenario. Irrespective of the clear inadequacies that exist in the pharmaceutical policy and regulation system in Afghanistan particularly with respect to a lack of enforcement, what both the GoA and the IDC operating in Afghanistan do not yet realize is that there is an increasing global threat from pharmaceutical crime and lack of supervision of medicines production and distribution at all stages of the supply chain in all countries of the world.
- There is an urgent need for formal regional cooperation in pharmaceutical regulation and dealing

		<p>with pharmaceutical crime.</p> <p>Major healthcare issues in Afghanistan:</p> <ul style="list-style-type: none"> • Afghanistan pharmaceutical sector is highly complex and chaotic (for several reasons this is more so than the situation that exists in most countries in the world). • Sector data provided is often conflicting in terms of both reports and analysis which has required the need to conduct more in depth research in some areas. The pharmaceutical sector is understudied. Donors do not coordinate concerning the identification, classification and provision of key sector documents • There are many weaknesses in the Afghanistan pharmaceutical sector that have not previously been well described or summarized, for example issues concerning the increasing global threat of pharmaceutical crime; • There has been a need to conduct some basic research into the pharmaceutical sectors in immediately neighboring countries so as to gain a better understanding of how the regional pharmaceutical market operates which has a direct impact on the Afghanistan situation; • The report authors felt it was necessary to provide a thorough and well constructed analysis of the Afghanistan pharmaceutical sector before making recommendations for sector interventions.
<p>Understanding Markets in Afghanistan: A study of Markets for pharmaceuticals 2007</p>	<p>Afghanistan Research and Evaluation Unit</p>	<p>The purpose of this study was to investigate the real structures of markets in Afghanistan. Researchers attempted to gain an insight into the experiences of Afghan businessmen in the private pharmaceuticals market; how numerous the players were; where the greatest margins were made; what connections there were between market players; and what if any barriers were faced by new entrants. Semi-structured interviews were conducted with importers, wholesalers, large and small retailers, certain groups of customers, international agencies and relevant government bodies.</p> <p>Research was conducted in Kabul; Mazar-i-Sharif and Heiratan; Herat, Islam Qala and Turghundi; Zaranj; Quetta; Kandahar; Peshawar; and Jalalabad from April to May 2005.</p>

		<p>Key findings in this study:</p> <ul style="list-style-type: none">• There has been a dramatic increase in the quantity of both donated and privately imported medicines entering Afghanistan since 2002.• The private sector accounts for between 70 and 80 percent of total pharmaceuticals consumption and the market may be worth up to US\$200m per year.• Medicines for use in public health facilities are determined by the National Essential Drugs List. Privately imported medicines are also nominally limited by the Ministry of Public Health list of medicines licensed for use in Afghanistan. Were all importers to bring medicines into the country formally, only drugs from this list would be available on the market.• However, there is widespread smuggling of medicines into Afghanistan. The proportion of smuggled drugs may be as high as 80 percent of medicines sold in the private sector• The pharmaceuticals market is much more chaotic than the other markets studied in AREU’s political economy research stream.• Pharmaceuticals are brought into Afghanistan from many different sources, and there is a bewildering array of products on sale.• The number of players is larger at every point in the supply chain than in other markets studied. There are more importers, more wholesalers, many more pharmacies, many grocery stores that sell pharmaceuticals and street vendors of medicines, as well as purveyors of traditional medicine.• There are serious concerns over the rational use of drugs in Afghanistan, and anecdotal evidence from various sources suggests a tendency among doctors to over-prescribe medicines generally and antibiotics in particular, and that combinations of medicines are prescribed without due consideration of possible side effects. Patients often ask pharmacists to prescribe medicines even though a large proportion of private pharmacies do not have a qualified pharmacist on staff. Exacerbating all these factors is the presence on the market of low quality and counterfeit medicines containing insufficient or no active ingredients
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| | | <ul style="list-style-type: none">• Inspection, sampling and testing facilities are inadequate to secure basic standards of medicines on the market. It makes sense to concentrate efforts on inspection and testing at the point of wholesale and retail, given the scale of smuggling. However, the lack of testing facilities at border points, and resultant long delays in clearing imports, pending sample results from Kabul, is a serious disincentive for importers to bring their imports through official channels. The feasibility of installing testing facilities at borders or of a mobile laboratory could be considered.• Pricing of pharmaceuticals also reflects the lack of control or regulation of this market. In Afghanistan, profit margins at the point of import, wholesale and retail are technically capped by the government at between 8–15 percent. But almost all players admitted that this was not followed in practice. However, many medicines on the market are cheap, but of low quality, as market players opt for cheap products to meet the demand of poor Afghan customers.• There is room in the market for domestic production or compounding of pharmaceuticals from imported raw materials to partially substitute imports and to boost Afghan manufacturing and economic growth.• There are a number of small scale 100 percent Afghan-owned pharmaceuticals manufacturers and two foreign direct investors that have begun production of medicines. Access to land, basic infrastructure and credit is key to allowing Afghan manufacturers to break free of the small scale turnover that often makes them uncompetitive. For foreign investors, further streamlining of bureaucratic procedures for gaining permissions to begin production are vital if foreign investors are not to be frightened away by the prospect of long delays.• Simple measures such as publishing more widely the list of permitted medicines and obliging retailers to display this in a prominent place on their premises might be a useful tool. Lists of common counterfeits and banned medicines could also be displayed.• Continued support for the training of pharmacists in the Faculty of Pharmaceutical Sciences in Kabul University would help to secure the supply of qualified staff both for pharmacies and for regulatory authorities. |
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Rational Medicine Use in Afghanistan: Report on Initial Activities, December 9-20, 2008

		<ul style="list-style-type: none"> • Licensing procedures should be fair and transparent, and licensing authorities should be independent and demonstrably free from any influence by the private sector. Streamlining of the process for licensing importers could provide an incentive for importers to enter the official economy and would eliminate room for corruption, favoritism and bribe taking. • There are already some public education campaigns on pharmaceuticals use, including posters explaining the appearance and function of different medicines on display at clinics and other public health centers. More comprehensive public health campaigns are needed, possibly using different media such as radio and television.
<p>Drug Quality Assessment Study, Afghanistan, 2007</p>	<p>MOPH</p>	<p>This large scale study of drug quality was supported by Johns Hopkins University and the Indian Institute of Health Management Research. A total of 1008 drug samples were tested, 40 percent were drawn from Comprehensive Health Centers (CHCs), 26 percent from District Hospitals (DHs), 25 percent from Basic Health Centers (BHCs) and 10 percent from private pharmacies.</p> <p>Results show the following:</p> <ul style="list-style-type: none"> • None of the samples were found to be substandard by both laboratories • 4 percent of the samples were found to be substandard by one of the two laboratories • Among samples from BPHS facilities, four percent were found to be substandard. • Among samples drawn from DHs, six percent were found to be substandard while four percent of samples from CHCs two percent of samples from BHCs were found to be substandard • Among samples from private pharmacies, three percent were found to be substandard. • Among drugs classified as substandard, 18 failed tests for dissolution, and 23 had amounts of the active drug which were less than what was stated on the label. Although the substandard drugs failed the standards specified by the pharmacopeia used, the variation from the acceptable range was in general, not great. <p>The study concluded that Afghanistan does not face a large problem of substandard drugs at the present time. Implementers of the Basic Package of Health Services are providing drugs that are largely of standard quality to patients. The small sample size from the private sector precludes one from drawing sweeping conclusions about the extent of substandard drugs in the for-profit private pharmaceutical market.</p>
<p>Miscellaneous RMU-related Documents</p>		

Infection Prevention Program, Final Report, 2006	REACH	Report of activities in hospitals with the REACH infection prevention program. Progress and future plans are described. National policies and procedures were developed in 2005 and implementation activities in 13 hospitals are described.
Quality Assurance Process	HSSP	<p>Performance improvement model introduced at the October 2008 RDU roundtable. Incorporates currently available standards into a performance improvement (PI) mode. Key points include:</p> <ul style="list-style-type: none"> • Central Quality Assurance Committee established • Utilizes self internal standards • Peer assessments/Benchmarks • Supportive supervision (on request) • External assessments • Client involvement and community participation • Standards actually developed include pharmacy (stock), dehydration, umbilicus infections), “MDS” <p>This PI model utilizes IMCI, TB, Malaria, MCH standards of care. IMCI and TB achievements and gaps are described.</p> <p>Conclusions: Standards for clinical areas are available and need to be monitored carefully. Constraints to process: Security, needs close monitoring and supervision, need new technical areas standards, staff turnover, proper interventions, NGOs/HD need to lead the process</p>
Pharmaceutical Management and Financial Challenges for USAID PPG Grant Program	Tech-Serve Paul Ickx	<p>Review of the drug management cycle and where Tech-Serve contributes to improving healthcare services.</p> <p>Selection: Uses EML and searches for the least expensive drugs. No STG available to guide selection (except for IMCI and TB standards).</p> <p>Procurement: Consumption methods do not seem to work, so Tech-Serve has adopted an adjusted consumption methodology using WHO estimates of drug use for a population of 30,000 in emergency situations.</p> <p>Distribution: Central warehousing is done by Tech-Serve and distribution to the health facilities by NGOs</p> <p>Use: No direct activities for RMU. HSSP to provide RMU training to NGOs</p>
Implementation of Clinical Standards	Pashtoonyar	Report on the implementation of emergency and surgical standards for hospitals in Afghanistan. The results of this study showed 53%-74% compliance with the established standards. The actual standards

Rational Medicine Use in Afghanistan: Report on Initial Activities, December 9-20, 2008

Practice and Conference Preparation		used are not in the report.
Evaluation of Quality of Care	REACH	Evaluation instrument developed to assess quality of care being given in health facilities. Includes clinical practice and organization of care. There is no reference to quality of medicines.

Other RMU-related references to be located, reviewed and cataloged

Title of document	Location/Comments
Community Health Worker Training Manual	MOPH
CHW supervisory check list	MOPH
Afghanistan National Strategic Framework for HIV/ AIDS	MOPH
Harm Reduction Strategy for IDU (Injecting Drug Use) and HIV/AIDS Prevention in Afghanistan	MOPH
National Guideline for Voluntary HIV/AIDS Counseling and Testing	MOPH
Hospital Policy for Afghanistan's Health System	MOPH
National Health Communication (IEC-BCC) Policy and Strategy	MOPH
National Infection Prevention and Control Policy	MOPH
National Malaria Strategic Plan 2006 – 2010	MOPH
Malaria Handbook for Doctors and Technicians	MOPH
Malaria Treatment Protocol	MOPH
CHW Malaria Handbook	MOPH
Malaria Handbook for Technicians	MOPH
Curriculum for Community Midwifery Education	MOPH
Midwifery Curriculum	MOPH
National Reproductive Health Strategy	MOPH
National Policy on Reproductive Health	MOPH
National Standards for Reproductive Health Services: Intra Partum and Emergency Obstetric Care Standards	MOPH
National Standards for Reproductive Health Services: Newborn Care Services	MOPH

Rational Medicine Use in Afghanistan: Report on Initial Activities, December 9-20, 2008

National Standards for Reproductive Health Services: Postpartum Care Services	MOPH
National Standards for Reproductive Health Services: Antenatal Care Services	MOPH
National Standards for Reproductive Health Services: Family Planning for Birth Spacing	MOPH
Maternal Health Services in Afghanistan: Maternal Health Services in Afghanistan and Who Should Provide These Services	MOPH
Guideline to improve the quality of care for TB patients in treatment	MOPH
Guidelines for TB Control Program in Afghanistan	MOPH
Regulation Of Import And Wholesaling Of Medicines & Designated Medical Products	MOPH
Policy Outline: Cost Containment And Price Control For Pharmaceuticals	MOPH
Regulation on Manufacturing Of Medicines And Designated Medical Products	MOPH
Regulation on the Licensing And Classification Of Medicines And Designated Medical Products	MOPH
National QA standards for Health Posts	MOPH
National Strategy for Healthy School Initiative	MOPH
National Policy for Healthy School Initiative	MOPH

ANNEX 6. RATIONAL MEDICINE USE RAPID APPRAISAL

SPS/Afghanistan
Rapid Appraisal tool for Rational Medicine Use

Pharmaceutic al Management Category	Structure- related questions (Yes/No)	Process-related questions	Outcome-related questions
(A) Selection	<p>(i) Do <i>Standard treatment guidelines</i> (STG) exist?</p> <p><i>These exist for some individual diseases and medical conditions. There are no comprehensive national level guidelines</i></p>	<p>1. For which diseases do STGs exist?</p> <p><i>Malaria, TB, eclampsia, pediatrics inpatients -meningitis/sepsis, typhoid fever, IMCI</i></p> <p>2. What was the process of their development?</p> <p><i>For TB, the process was developed by committee that involved WHO, Japan International Cooperation Agency (JICA) and National Tuberculosis Program (NTP) and approved by MoPH.</i></p> <p>3. How often revised? When last revised?</p> <p><i>Last revised 2005 (TB), 2006 (Malaria), 2006 (inpatient pediatrics), 2003 (IMCI)</i></p> <p>4. Do STGs exist for different levels of health care practice?</p> <p><i>IMCI – Primary health limited pediatric inpatient and eclampsia – Hospitals</i></p>	<ul style="list-style-type: none"> Any survey data on the extent of availability of STGs in health facilities? <p><i>No</i></p>

		<p>5. Are prescribers trained on the use of and adherence to the STGs? If yes, training given to what kind of prescribers and how regularly?</p> <p><i>IMCI – training course is available and has been used at many health facilities to train staff</i></p> <p>6. Are medical students trained on the importance of STGs?</p> <p><i>No</i></p> <p>7. Is there a mechanism to monitor adherence to STGs</p> <p><i>HSSP QI program includes activities to monitor the use of standards</i></p> <p>8. For those medical conditions for which standards exist, are they readily available in the health facilities?</p> <p><i>There are some guidelines available for malaria, TB, influenza, ARI (70 % available in health facilities)</i></p>	
	<p>(ii) Is there an <i>Essential Drugs List</i> (EDL)?</p> <p>YES</p>	<p>1. What is the process of selecting medicines for the EDL?</p> <p><i>Multidisciplinary committee reviews requests including the evidence, comparative efficacy, and cost. There does not appear to be in-depth review of the evidence as sources of information are limited</i></p> <p>2. How often revised? When last revised?</p> <p><i>Revised every 2-3 years. Last revised December 2007</i></p>	<ul style="list-style-type: none"> • Any data on the extent of availability of EDL medicines in health facilities <p><i>A single report showed that 83% of key medicines were available in a sample of SCA health</i></p>

		<p>3. Are the drugs included in the EDL consistent with those in the STG?</p> <p><i>Yes</i></p> <p>4. Are health care providers trained on the concept of EDLs?</p> <p><i>Yes, workshops have been conducted for physician, pharmacists and private sector practitioners</i></p> <p>5. Is there a national formulary that provides prescribing information on each drug in the EDL</p> <p><i>Yes, but there is a lack of consistency with EDL</i></p> <p>6. Is there an active national committee responsible for managing the process of maintaining an EDL?</p> <p><i>Yes, National Essential Drugs List Committee at the GDPA, MoPH. EDL/LDL database is functioning in MoPH and there is procedure for inclusion/deletion of items in EDL/LDL.</i></p> <p>7. What is the total number of products on the EDL?</p> <p><i>Approximately 458 (includes specific medicines and different dosage forms)</i></p> <p>8. What is the total number of antimicrobials on the EDL?</p>	<p><i>facilities.</i></p>
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		<p>55 antimicrobials (includes medicines and different dosage forms (does not include antiretrovirals and anti-TB medicines)</p> <p>9. Are INN used for products on the list?</p> <p>Yes</p> <p>10. Are EDL drugs restricted to different levels of the Healthcare system?</p> <p>Yes (health posts, basic health centers, comprehensive health centers district hospital, provincial hospitals, referral hospitals)</p> <p>11. Is the EDL available in all health facilities</p> <p>Not in all health facilities, but exist in all NGOs, Provincial Health Departments (PHD) and is available at MoPH website. SCA study showed that 93% of SCA clinics has a copy of the EDL</p>	
<p>(B) Procurement And Availability</p>	<p>(i) What quality assurance mechanisms are in place to ensure the quality of medicines marketed in the country?</p>	<p>1. What mechanisms are in place, in the public sector and in the private sector to ensure the quality of medicines marked in the country?</p> <ol style="list-style-type: none"> a. Prequalification of suppliers b. Monitoring of product quality including laboratory testing c. Supplier performance monitoring & evaluation <p>a- for the prequalification of suppliers especially for all importers - during the registration of the company, all documents of the company especially the complete documents of Good Manufacturing Practices (GMP), ISO, license of the company</p>	<ul style="list-style-type: none"> ● Any data on the proportion of inspected medicines that was substandard? <p>Data is available, but was not specifically identified during this rapid appraisal</p> <ul style="list-style-type: none"> ● Any documented report of counterfeit antimicrobials?

		<p><i>are obtained and reviewed</i></p> <p><i>b- For each shipment of drugs in the country, department of pharmacy collects a sample according to the rule regulation and sends to MoPH quality control laboratory. After the results of quality control lab are confirmed, the shipment is cleared from customs.</i></p> <p><i>c- For the performance of suppliers, the procurement and registration department of pharmacy uses check lists.</i></p> <p>2. What is the level of enforcement of these mechanisms/ regulations?</p> <p><i>All pharmaceutical companies and local manufacturers have been registered in Afghanistan; the Director General of Pharmacy Affair approves the registration. You can find reliable documents and file for each company or local manufacturer in the registration department.</i></p> <p>3. Does a national drug quality control lab exist in the country?</p> <p><i>Yes, but not with a reasonable capacity.</i></p> <p>4. How are donated drugs processed? What mechanisms are in place to ensure that these drugs have the same level of quality as other procured medicines?</p> <p><i>MOPH Policy exists that regulates donations. Must be on EDL, must comply with quality standards in both donor countries and Afghanistan, The WHO Certification Scheme on the quality of pharmaceutical products moving in International Commerce should be used.</i></p> <p><i>Drug donation guideline exists in MoPH, but are not enforced</i></p>	<p><i>There are many antidotal reports and the EC assessment expresses much concern about counterfeit products. During our visit to MOPH, we were shown some examples of counterfeit products</i></p>
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		<p><i>properly.</i></p> <p>5. Are there any data on the proportion of inspected medicines that was substandard in the past two years?</p> <p><i>Yes, the data is available with quality control laboratory of MoPH. This data could not be obtained during this visit.</i></p>	
	<p>(ii) Is there a <i>policy guiding the utilization of EDL</i> for procurement of medicines?</p> <p><i>Yes</i></p>	<p>1. What policy is in place for the public sector?</p> <p><i>The EDL list all of the drugs that can be imported for the public Sector</i></p> <p>2. What policy (if any) is in place for the private sector?</p> <p><i>The National Licensed Drug List (LDL) contains all the chemical therapeutic substances allowable in Afghanistan.</i></p>	<ul style="list-style-type: none"> • Any data on the level of adherence to the policy? <p><i>No specific data was available</i></p>
	<p>(iii) What is the general <i>availability of medicines</i> at public health hospitals and clinics</p>	<p>1. What do studies show of the availability of medicines at the hospital and primary care clinic level?</p> <p><i>SCA study in 2003 showed that 83% of key medicines were available in SCA clinics (58 clinics, range 80-89%). Some other reports provide data but they may be unreliable, for example availability or stock out of drugs reported at the day of visit, not in a specific period, for instance not assessed for 365 days.</i></p>	
<p>(C) Use</p>	<p>(i) Is there provision of <i>in-service training/</i></p>	<p>1. What activities have been carried out in the medical, nursing, and pharmacy sectors?</p> <p><i>Limited number and scope of training programs.</i></p>	

	<p><i>continuing education to prescribers</i> on the importance of appropriate use of medicines? Yes</p>	<p>2. Document each activity with subject matter, time devoted to the subject, follow-up activities</p> <p><i>HSSP has provided in-service training at selected health facilities. Their training programs include a lecture and Q&A/discussion format. Subject matter includes RMU concepts and practices, sick newborn standards, management of drug supply, IMCI guidelines.</i></p>	
	<p>(ii) Are topics on appropriate medicine use, antimicrobial use & containment of AMR included in <i>undergraduate & postgraduate curricula</i> (medical, pharmacy, nursing)?</p>	<p>1. Which university curricula do and which don't? What are the hours of exposure identified in the curricula that include these topics?</p> <p><i>The Kabul medical institute has a basic curriculum addressing rational medicine use (not comprehensive) and the faculty of pharmacy wants to include RMU for next year. The RMU curriculum is currently under development.</i></p> <p>2. What are the main subjects that offer RMU training (e.g., Antimicrobial use, treatment of TB,)</p> <p><i>The main subject are rational use of medicine, rational distribution, managerial and educational process for promoting RUM</i></p> <p>3. Does the university curricula also include infection prevention and control?</p> <p><i>NO. but in the new curriculum of the pharmacy, which is under process, will include this subject</i></p>	

	<p>(iii) Are there public education campaigns on rational medicine use, antimicrobial use, AMR, treatment of common diseases?</p> <p>NO</p>	<p>1. What kind of campaigns, and how frequent?</p> <p><i>There have not been any significant campaigns; most of irrational drug use problems belong to the health services providers. There is a general consensus that the first action needed to improve the health system should be directed at public sector then choose interventions in regards to rational use of medicines for the patient community. There have been some education programs by NGOs in limited health facilities.</i></p> <p>2. Who provide these education campaigns?</p> <p><i>Local NGOs. At national level, API will manage and lead these campaigns in the future.</i></p> <p>3. Are there education campaigns relating to prevention of infection (eg, hand hygiene, food hygiene, vector control, immunization)?</p> <p><i>These have not been visible.</i></p> <p>4. Are there education campaigns relating to appropriate use of antimicrobials and sensitization of AMR issues?</p> <p><i>No</i></p> <p>5. Are school children provided education on healthcare issues?</p> <p><i>No</i></p>	<ul style="list-style-type: none"> • Any data on the use of medicines by the public (including level of appropriateness of use)? <p><i>SCA study show that there is a low percentage of patients who understand how to use their medicines</i></p> <ul style="list-style-type: none"> • Any data on the impact of these measures? <p><i>No</i></p>
	<p>(iv) Do prescribers and dispensers</p>	<p>1. What policies/recommendations are in place?</p> <p><i>Policies are not in place to address this issue.</i></p>	

	<p><i>provide education directly to patients on the appropriate use of medicines</i></p> <p><i>Yes, probably at a very minimal level</i></p>	<p>2. What information/counseling is generally given? <i>Dose, route of administration, and time of administration</i></p> <p>3. Is there a mechanism to monitor patient compliance</p> <p><i>There is poor communication between prescribers, dispensers and patients. Patients are not contributing in the treatment plan; no attention has been paid in this regard.</i></p>	
	<p><i>(v) Does a system or mechanism exist for post-marketing surveillance of medicines available in the country?</i></p> <p><i>No</i></p>	<p>1. Does an ADR monitoring system exist?</p> <p><i>MoPH, Pharmaceutical Affairs has a provision for monitoring of ADRs. There is no evidence that this is actually done.</i></p> <p>2. Do hospitals have mechanisms to monitor or prevent medication errors?</p> <p><i>No, they are not familiar with this type of monitoring</i></p>	<p>Any studies or surveys documenting the impact of such programs?</p> <p><i>No</i></p>
	<p><i>(v) Have there been any studies on prescribing and dispensing medicines</i></p> <p><i>Yes</i></p>	<p>1. Document the results of any studies conducted on drug use</p> <p><i>SCA study on prescribing indicators. This study showed the overuse of antimicrobials, prescribing of half treatments for infectious diseases, inadequate labeling of prescriptions and inadequate patient knowledge about drug dosage.</i></p> <p>2. Obtain information on the following drug use indicators if available, quantitative/and or qualitative</p> <ol style="list-style-type: none"> a. Average number of drugs per encounter b. % of drugs prescribed as generic c. % of antimicrobials prescribed per encounter 	

		<p>d. Percentage of encounters with an injection prescribed e. % of drugs prescribed from EDL f. Average Consultation time g. Average Dispensing time h. % of drugs dispensed i. % of drugs adequately labeled j. % knowledge of correct use k. Availability of a copy of the EML l. Availability of Key Drugs m. Availability of STGs n. Availability of protocols for use of prophylactic antimicrobials o. % of patients that follow standard treatment guidelines</p> <p><i>SCA study in 2003 provided the following drug use study results:</i></p> <ul style="list-style-type: none"> • <i>Average # of drugs per encounter - 1.93</i> • <i>% # drugs prescribed by generic name – 83%</i> • <i>% # of encounters with at least one antibiotic prescribed- 50%</i> • <i>% of encounters that had an injection prescribed – 5.5%</i> • <i>% drugs prescribed from Essential drug list – 89%</i> • <i>Average duration of antibiotic course- 4.7 days</i> • <i>Average consultation time-4.8 min</i> • <i>Average dispensing time-149secs</i> • <i>% of drugs dispensed-79%</i> • <i>% of drugs adequately labeled- 1%</i> • <i>% of patients with knowledge of correct dosage-63%</i> • <i>Availability of a copy of essential drug list or formulary- 93%</i> • <i>Availability of key drugs-83%</i> 	
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	<p>(vi) Is there a national Drug Information Center</p> <p>Yes</p>	<p>1. Where is the DIC located?</p> <p><i>There is a drug information center at API in MoPH</i></p> <p>2. What kinds of activities are they involved with?</p> <p><i>This drug information center cannot be considered to be active at this time.</i></p> <p>3. What references are available?</p> <p><i>The DIC does not have references to perform their duties.</i></p> <p>4. Is the DIC utilized in evaluating drugs for the EDL and STGs</p> <p><i>No</i></p>	
<p>(D) Management Support</p>	<p>(i) Is there a national body/committee to coordinate issues relating to medicines use?</p>	<p>1. What are the responsibilities of this body/ committee?</p> <p><i>Yes, API in the MOPH has a mandate to coordinate and manage medicine information, quality control, RMU, medicinal research, education and training.</i></p> <p>2. What activities has it carried out so far?</p> <p><i>This organization has not been very active in carrying out its mandate. There is not much to report on specific activities they have undertaken.</i></p>	<ul style="list-style-type: none"> • Any funding allocated by the government for Rational Medicines Use (RMU) activities? <p><i>There are government agencies that are responsible for RMU. API has the responsibility for ensuring RMU, but has little capacity (or funding) to actually carry out this function.</i></p> <ul style="list-style-type: none"> • Any data on the impact of activities carried out by

Rational Medicine Use in Afghanistan: Report on Initial Activities, December 9-20, 2008

			<p>this body/ committee?</p> <p><i>No</i></p>
<p>(ii) Do hospitals have a <i>Drug & Therapeutics Committee</i> (DTC) (If possible find out what proportion of tertiary & secondary hospitals have DTCs)</p> <p><i>No</i></p>	<p>1. What strategies and activities has the Committee used (if any) relating to</p> <ol style="list-style-type: none"> Selection/formulary management of medicines for use in hospital Prescriber and patient education on medicines use Medicines use evaluation program Control of promotion of medicines in the hospital by the drug industry <p><i>There are no DTCs in hospitals in Afghanistan.</i></p> <p>2. Any other activities relating to medicines use?</p> <p><i>May be equivalent committees that exist in some hospitals, but they are not standardized. DTC is a new name (and function) for hospitals.</i></p>	<p>• Any data on the impact of DTC activities?</p> <p><i>No</i></p>	
<p>(iii) Do hospitals <i>audit prescribing and dispensing practices</i> and utilize peer group or external standard comparison to provide</p>	<p>1. What strategies are used to audit prescribing?</p> <p><i>No strategies available in this regard.</i></p> <p>2. Are STG utilized, either local or international?</p> <p><i>There are no comprehensive STG in the county. There are a limited number of individual guidelines covering a single disease or medical condition.</i></p> <p>3. Are there vertical program STGs, e.g., TB, MCH available and</p>	<p>• Any data on the results of these studies</p> <p><i>None readily available</i></p>	

	feedback <i>No</i>	used <i>Yes, TB, IMCI, MCH guidelines exist.</i>	
	(iv) Is a system in place to generate and disseminate drug management information? <i>Yes</i>	1. Does information relating to drug selection, availability, use, and antimicrobial resistance flow between relevant stakeholders in a timely and effective manner? <i>The MoPH Drug Management Information System (D MIS) exists, but is not shared directly with other stakeholders.</i>	<ul style="list-style-type: none"> Any evidence to show improved drug management and drug use decisions based on timely and coordinated information flow? <p><i>Evidence is not available</i></p>
(E) Policy and Legal Framework	(i) Is there a <i>national policy for medicine Use</i> ? <i>Yes</i>	<p>1. What processes are adopted to oversee enforcement of this regulation?</p> <p><i>There is no enforcement of regulation at the national level of GDPA, NGOs do enforce by supervision</i></p> <p>2. What specific policies exist that would control the prescribing and use of medicines?</p> <p><i>Most of the policy maker and health providers do not know about NDP, the NDP has been not publicized and distributed. The NDP has very general policies concerning medicine use. The NDP is considered to be a guideline and there is nothing in the NDP that would be enforceable.</i></p>	<ul style="list-style-type: none"> Any data on the level of enforcement of this policy? <p><i>No</i></p>
	(ii) Is there an effective pharmaceutical registration	<p>1. What regulations are in place?</p> <p><i>Health constitution, drug law, regulation for private pharmacies, regulation for importation and production of medicines.</i></p>	<ul style="list-style-type: none"> Any data on the level of implementation of the regulation?

	<p>system</p> <p>NO</p>	<p>2. Are mechanisms in place to monitor implementation of these regulations?</p> <p><i>The GDPA and the Directorate of Legislation are responsible, but are not considered to be a good mechanism.</i></p> <p>3. Are there low quality, ineffective, counterfeit, drugs available in Afghanistan</p> <p><i>Afghanistan has a licensing system for all pharmaceutical products. All products, manufacturers, and importers must be registered. Low quality, ineffective and counterfeit drugs are available in Afghanistan despite this system.</i></p>	<p><i>None available</i></p> <ul style="list-style-type: none"> • Any data on the impact of these regulations? <p><i>None Available</i></p>
	<p>(iii) Are there any <i>policies to regulate the promotional activities</i> of pharmaceutical companies?</p> <p>Yes</p>	<p>1. What policies are in place?</p> <p><i>National Medicine Policy</i> <i>MOPH regulations on the advertising and promotion of medicines</i></p> <p>2. Any data on regulatory activities concerning pharmaceutical promotion</p> <p>No</p> <p>3. How active is the pharmaceutical industry in Afghanistan?</p> <p><i>Minimally, there are only four manufactures active in the country.</i></p>	<ul style="list-style-type: none"> • Any data on the level of implementation of the policies? <p><i>None available</i></p> <ul style="list-style-type: none"> • Any data on impact of the policies? <p><i>None available</i></p>

	<p>(iv) Is there an effective drug regulatory authority in the country</p> <p>No</p>	<p>1. Do mechanisms exist for the licensing, inspection and control of pharmaceutical personnel, manufacturers, distributors/importers, pharmacies</p> <p><i>There is no specific department designated as the drug regulatory agency, but these activities are accomplished by registration and procurement department, inspection department and others.</i></p> <p>2. Is there a regulation that limiting antimicrobials and other “prescription” drugs to a prescription only status?</p> <p><i>The national LDL has provision for obtaining certain drugs, OTCs, which can be obtained without a prescription. All other drugs are considered to be prescription only. IMCI and TB guidelines limit medicines to prescription.</i></p> <p>3. Do consumers have illegal access to prescription only drugs?</p> <p><i>Yes, from private pharmacies you can obtain any drug that you are able to buy.</i></p> <p>4. Is there a system for collection of data regarding the efficacy, quality and safety of marketed products (Post marketing surveillance)</p> <p><i>No, most of the responsible individuals do not know about the definition of efficacy, safety and quality.</i></p> <p>5. Are the sufficient procedures and controls so that pharmaceuticals meet international standards of quality, safety, and efficacy</p>	<ul style="list-style-type: none"> • What is the level of implementation of these policies? <p><i>Data is not available to substantiate the level of implementation.</i></p> <ul style="list-style-type: none"> • Any data on impact of these policies? <p>No</p>
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