

Afghanistan Technical Report: Post Tech-Serve Options Analysis December 2009

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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

Options for continuing the provision of a dependable supply system following the end of Tech-Serve in 2011 are explored, including the potential for using the Central Medical Stores. Broader issues related to the development of drug policy, regulation and law are also considered, as well as problems associated with procurement outside of USAID-supported NGOs. The appropriateness of current levels of funding for essential medicines is discussed. Recommendations are made as appropriate.

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Key Words

Afghanistan, CIDA, Tech-Serve, Ministry of Public Health (MOPH), Basic Package of Health Services (BPHS), Coordinated Procurement and Distribution Service (CPDS), Private Sector.

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Acronyms

API	Avicenna Pharmaceutical Industry
BDN	Bakhtar Development Network
BPHS	Basic Package of Health Services
CIDA	Canadian International Development Agency
CMS	Central Medical Stores
CPDS	Coordinated Procurement and Distribution System
DFID	UK Department for International Development
DMU	Drug Management Unit
EU	European Union
EC	European Commission
EPHS	Essential Package of Health Services
GDA	General Directorate of Administrative Affairs
GDPA	General Department for Pharmaceutical Affairs
GH/OHA	Global Health/Office of HIV/AIDS
HPIC	Health Partners International of Canada
IDPIG	International Drug Price Indicator Guide
IGPE	Identified Governmental Pharmaceutical Entity
JICA	Japan International Cooperation Agency
JSI	John Snow, Inc.
LOE	Level of Effort
LSAT	Logistics System Assessment Tool
MOPH	Ministry of Public Health
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
OOP	Out Of Pocket
PE	Pharmaceutical Enterprise
PEPFAR	President's Emergency Plan for AIDS Relief
PPD	Pharmaceutical Planning Department
RFP	Request for Proposal
SCMS	Supply Chain Management System
SOW	Scope of Work
SPS	Strengthening Pharmaceutical Systems
TS	Tech-Serve
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USG	United States Government
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

With the USAID-funded Tech-Serve program due to conclude by September 2011, USAID wished to explore options for ensuring the continued provision of a reliable medicines supply service after that date. USAID was initially interested in examining the option of using the Ministry of Public Health (MOPH) Central Medical Stores (CMS) to provide this service and this option was investigated along with other options dependent on using non-government organizations, both commercial and non-profit.

A rapid assessment was undertaken of the CMS using a tool designed for this purpose and it was found that the CMS fell significantly short of minimum standards required of a public health distribution operation. The scale of CMS operations was also found to be substantially smaller than those of programs such as Tech-Serve. For these reasons, it was concluded that the CMS would not be a viable option for USAID following the planned end of Tech-Serve in 2011 and that alternative solutions would need to be evaluated.

However, planned support to the CMS from the Canadian International Development Agency (CIDA), which is due to begin in 2010, is expected to improve the standard of operations at the CMS over the course of the CIDA-funded program. Depending on the results from this program it may be possible to reconsider the transfer of USAID storage and distribution functions at a later date.

There does appear to be potential for the MOPH to develop as to undertake procurement planning and quantification. Recommendations are made on this.

Two premises underpin all options discussed, namely that (1) USAID funding for procurement supply operations would need to continue and (2) an international contractor would need to have continued involvement in core procurement activities.

Two broad options are presented for consideration. The first retains the full integrity of the procurement, storage and distribution operations either by extending the Tech-Serve contract or by replacing Tech-Serve with a new contract. The second anticipates separating procurement from storage and distribution with separate mechanisms for managing each. In both broad options, the possibility of establishing contracts involving an international contractor partnering with an Afghan organization is discussed. The idea is that, over time, operations would be gradually transferred to the Afghan partner with a view to the international partner withdrawing by the end of the contract. This has a number of attractions, not least of which is the potential for supporting long-term sustainability and reducing operating costs for USAID.

Discussions were also held with NGOs receiving funding from the European Union (EU) and World Bank (WB). Relying largely on the national market for their supply, they experience similar procurement problems, especially in relation to quality. There is a general interest in exploring the feasibility of entering into a pooled procurement arrangement. The possibility of SPS providing technical assistance to investigate this is discussed.

Finally, funding levels for essential medicines are discussed. Data in this area is sparse, especially in the private sector. Such data that does exist, however, is suggestive of the public experiencing access problems at least partly due to underfunding for the public sector. Recommendations are made to study this issue further with a view to providing government and donors with better information on which to base pharmaceutical funding decisions.

INTRODUCTION

Background and Objectives

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 (SOW), 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. One of the key activities of importance in the SPS Afghanistan work plan is SPS' assistance with the designing of the system that will be utilized for procurement of USAID pharmaceuticals after the conclusion of the Tech-Serve Project.

The Tech-Serve Project is currently purchasing pharmaceuticals for USAID-supported NGO grantees implementing the Basic Package of Health Services (BPHS) and Essential Package of Health Services (EPHS). The Tech-Serve system for procurement and distribution is centralized. Procurements come from two main supplies (The International Dispensary Associate and Mission Pharma) and are managed by Tech-Serve staff in Kabul, with some support from MSH/Washington. Products are stored in warehouses maintained by Tech-Serve in Kabul. Grantees submit orders to Tech-Serve and are responsible for product pick-up at the warehouse. The system works well but the lead time for procurements is fairly long. With Tech-Serve ending in mid 2010 with the possibility for an extension, a new mechanism for USAID procurements must be chosen and implemented without interruption of supplies to grantees. SPS continues to monitor Tech-Serve's end date, as well as any potential extensions as well as procured the services of Mr. Clark and Mr. Barraclough to conduct a comprehensive options analysis as a means by which to identify appropriate options for USAID procurements and assist with the development of an effective transitional plan for implementation at a later point in time.

Purpose of Trip

In conducting a supply system options analysis, MSH/SPS aims to identify and evaluate feasible alternative solutions to the problem of assuring the supply of essential medicines and supplies to USAID-funded health programs and the general health service both in the short term, immediately following the closure of the Tech-Serve program, and the longer term.

The primary objectives of the mission will be to:

- Assess the current situation at the National, Provincial, and, to the extent possible, village levels with regard to effectiveness, efficiency and sustainability of the public health supply system
- Identify the problems in the supply system that impact on the efficiency, effectiveness and quality of the service provided
- Identify and evaluate feasible options for establishing a dependable supply system for serving the public health system

- Analyze each option and prepare the major inputs government and donors will need for the appraisal and eventual implementation of the preferred option
- Provide USAID and the Afghan government with recommendations and/or strategies for assuring the supply of essential commodities in the medium-to-long term

Mr. Malcolm Clark and Dr. Andrew Barraclough visited Afghanistan from November 22 to December 10, 2009.

Annexes E and F contain the SOW for the trip and a list of people met.

MOPH POLICY AND SUPPLY OPERATIONS, CURRENT STATUS

Policy Governing Pharmaceutical Procurement and Supply

A sine qua non for transferring important supply services, such as those provided by Tech-Serve to the MOPH, is that the public supply system is governed by a clear and widely accepted overall pharmaceutical policy. Although Afghanistan has developed policy in some important areas, including essential medicines and donations, there is no clear policy to direct pharmaceutical procurement and supply management activities in the public sector.

At present responsibility for public sector pharmaceutical management activities are split between direct (in-house) MOPH operations and external operators. Currently, the bulk of the public sector pharmaceutical supply is undertaken outside direct MOPH operations by external operators (mainly NGOs) following donor funded and regulated supply streams. The available data is confused and unclear, but indicates MOPH direct operations might account for around 10% of the public sector essential medicine supply with the remainder split roughly equally between the three main funding streams of EU, WB and USAID. A summary table follows.

The MOPH in-house activities are fragmented among different streams. The two main streams are divided between different departments of the MOPH: the General Directorate of Pharmaceutical Affairs (GDPA) and the General Directorate of Administrative Affairs (GDAA). Broadly, the GDPA is responsible for policy, planning, training, and regulation while the GDAA is responsible for procurement and storage and distribution through the Central Medical Stores. Additionally, there is; the Department of Pharmaceutical Enterprises which appears to procure and store medicines entirely independently, and distribute them to 'government' pharmacies (usually at hospital sites); a pharmaceutical 'manufacturing' unit in an exceedingly dilapidated condition at the Avicenna Pharmaceuticals Industry (API) site, and doing little more than bottle filling.

The MOPH-GDPA has a vision of integrating all pharmaceutical management into a single department, the GDPA. A multi-member Task Force, supported by the principal donors for pharmaceuticals and with technical assistance from SPS, has been formed to prepare the studies and recommendations needed by the MOPH to decide where best to locate pharmaceutical management and supply functions within the Ministry and to implement a Coordinated Procurement and Distribution System (CPDS). The work of this CPDS Task Force is in its very early stages and, given its controversial nature, is likely to take some time to reach a consensus on the way forward.

More broadly, this may also be a propitious time to revisit the policy, legal and regulatory work for pharmaceuticals within MOPH that was started with USAID support in 2003.

In 2003, with expert consultancy support provided by USAID, it was possible to draw up a National Drug Policy and a Drug Law based on the consensus built up during a USAID-sponsored Drug Policy Workshop. The Workshop also provided an opportunity to draw up and obtain consensus on the essential elements of the other essential regulations, namely:

Public Sector Essential Medicines Funding and Supply Management: Stakeholders and Roles

	GoA, MOPH									
	GDPA	GDA A	P.E.	Manufacturing Avecinna	EU	JICA	UNFPA	USAID	WB	CIDA
Selection	GDPA	GDPA	P.E.	GDA A/P.E			UNFPA	Committee: NGOs, MOPH		
Product Quality	GDPA	None specified	None specified	None specified	None specified		UNFPA	USA FDA, Stringent regulatory authority	None specified	
Quantification	GDPA	GDA A - mainly budgetary restriction		P.E.	Individual NGOs		UNFPA	Tech-Serve using data from NGOs	Individual NGOs	
Procurement		GDA A local market	PE	P.E.	Individual NGOs mainly local market		UNFPA	Tech-Serve using accredited supply houses	Individual NGOs mainly local market	
Delivery		Local vendor to CMS	Local vendor to PE	To P.E.	Local vendor to NGO		UNFPA to CMS	Secure supply chain. Products collected by supported NGOs		
Storage		CMS	PE	P.E.	NGOs	CMS	CMS	Tech-Serve	NGOs	
Distribution		Kabul Hospitals and Provinces, CMS trucks	Provinces - by collection	Govn pharmacies and Provinces by collection	NGOs	Kabul Hospitals and Provinces, CMS trucks	Kabul Hospitals and Provinces, CMS trucks	Products collected by supported NGOs, then distributed by individual NGOs. Also Kabul Hospital	NGOs	
					Multiple vertical operations			Multiple vertical operations	Multiple vertical operations	
NGOs					13			30	16	
Provinces		34	34		10			13	11	
Commodity Funding US \$ p.a.¹	None	maybe 1 million	around \$ 1 million	unknown but probably negligible	uncertain maybe \$ 5 million	unknown	reported \$100,000	\$7 to 8 million including all program products	uncertain maybe \$ 5 million	New program maybe \$ 3 million p.a.
Approximate indication of public sector commodity volume²		6%	6%		29%		1%	29%	29%	

¹ Sources: Gross estimates provided by Techserve; HealthNet TPO; Swedish Committee for Afghanistan; BDN

² Source: Gross estimate provided by Director of Procurement, GDA A, MOPH

- Regulation and registration
- Retail pharmacy
- Manufacturing
- Importation and wholesaling
- Advertising and promotion
- Traditional and complementary medicines

Thought was also given to the revitalization of the API.

A brief outline plan was developed in relation to drug pricing and cost containment, although it was recognized that, at that time, implementation would be impractical.

A draft timetable was drawn up at the conclusion of the consultancy, providing a guideline for future developments.

In the present context where there are discussions with regard to the future development of a public health supplies system and the potential to involve the private sector in that system, as well as there being donor support planned to the CMS and the on-going CPDS work, now may be a propitious time to assess the status of these issues and the progress made on implementing the 2003 work plan. Such an assessment would enable the MOPH and its donor partners to:

- determine the importance of the various policy, legal and regulatory issues in relation to short and longer term objectives
- reprioritize MOPH and/or donor support activities to ensure a sharp focus on core areas of concern
- broaden the SOW of the CPDS as deemed necessary

Central Medical Stores

The current infrastructure, management and control systems, and logistics operations are at a very low level. Using a tool developed to have wide application of pharmaceutical logistics activities with standards recognized across a broad range of players and donor agencies, a rapid assessment conducted by SPS staff in preparation for this TDY illustrates this well³. The

³ Standards applied by the logistics assessment are drawn from a range of guidelines and standards, including:

1. WHO GDP and Good Storage Practice guidelines:

WORLD HEALTH ORGANIZATION, GOOD DISTRIBUTION PRACTICES (GDP) FOR PHARMACEUTICAL PRODUCTS. Working document QAS/04.068/Rev.2

2003. Guide to Good Storage Practices for Pharmaceuticals. Annex 9 to the WHO Expert Committee on Specifications for Pharmaceutical Preparations: Thirty-seventh Report. WHO Technical Report Series 908. Geneva: WHO

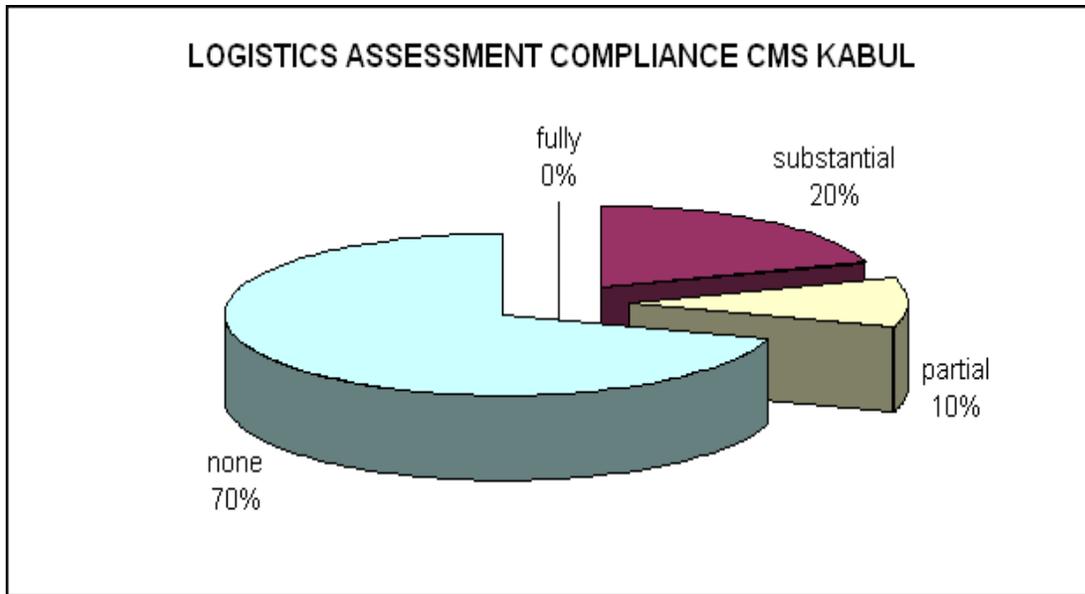
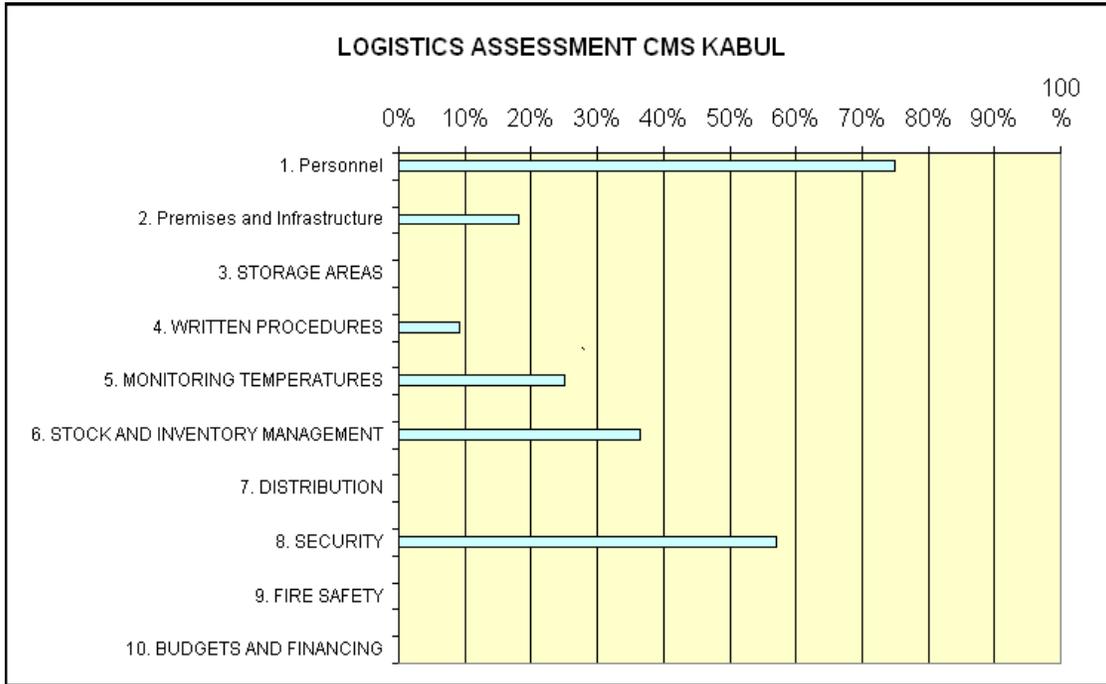
2. UK Government GDP Guidelines

The UK Medicines and Health products Regulatory Authority (MHRA) publishes a range of documents providing guidance on storage and distribution of pharmaceuticals. These can be found on the MHRA web site, which also provides a link to EU GDP guidelines:

<http://www.mhra.gov.uk/Howweregulate/Medicines/Inspectionandstandards/GoodDistributionPractice/index.htm>

3. EU Guidelines: Guidelines on Good Distribution Practice of Medicinal Products for Human Use (94/C 63/03), prepared in accordance with Article 10 of Council Directive 92/25/EEC of 31 March 1992 on the wholesale distribution of medicinal products for human use.

following graphics summarizes the findings of this rapid assessment. Annex B contains a copy of the tool.



4. John Snow: DELIVER: Logistics System Assessment Tool (LSAT)

5. PHD, South Africa: Unpublished Warehouse Assessment Tool

6. Logistics Training International, Leicestershire, UK: Auditing Logistics. The Audit Workbook (1994)

The scale of pharmaceutical supply operations at the CMS is very small compared to the current Tech-Serve service. Although only crude data are available, it appears that, excluding vertical program supplies, the MOPH spends less than \$1 million a year on pharmaceuticals for the population of the whole country (28.4 million) that pass through the CMS, around \$0.03 per capita. This compares to an estimated \$5m supplied by Tech-Serve to an estimated population of 8 million, around \$0.65 per capita, again excluding vertical program supplies.

In order for the CMS to be a viable option for absorbing Tech-Serve responsibilities, it would not only be necessary to significantly upgrade infrastructure, staffing and systems, but it would also have to be scaled up to handle volumes several magnitudes larger than they are used to managing.

Experience from other countries strongly suggests that it would require substantial capital investments as well as extensive management support and technical assistance over many years to have the potential of bringing the CMS to a point where they could confidently be expected to absorb Tech-Serve operations and provide the service that USAID-supported NGOs require. Experience elsewhere, in much less challenging environments, further suggests that \$10s millions and a timeframe of 7 to 10 years are required⁴ and with no guarantee of success if the policy and legal frameworks are not supportive of a serious reforming-strengthening effort; investments such as this are therefore inherently high risk undertakings.

Moreover, successful programs of CMS strengthening depend upon more than infrastructure and technical assistance. Successful strengthening programs elsewhere have also required reform of the status of the CMS vis-à-vis the MOPH with a significant level of autonomy being granted with regards to its day to day operations, management procedures, information systems, and human resource management. Such reform is not yet on the agenda for discussion in Afghanistan, even within the CPDS framework.

To complicate matters further, the status of the CMS within the MOPH structure is an area of some controversy, with the GDPA arguing through CPDS, perhaps correctly, that the rightful home of the CMS and associated operations should be the GDPA rather than the GDAA where it currently rests. While the CPDS process will provide a formal and structured forum for this issue to be discussed, it is unlikely to be resolved quickly. Final decisions on all these matters will need to be taken at a senior Ministerial level, and possibly inter-Ministry level

Under such circumstances, it is felt that there would be considerable risk attached to any investments made in the CMS, and USAID would be best advised to look to other options for securing the longer term supply service needs of NGOs currently supported by Tech-Serve.

⁴ In Tanzania, for example, Danida and the World Bank commenced support to the newly created Medical Stores Department in 1994. This support covered expatriate management for almost 10 years, investment in warehouse construction and rehabilitation, the purchase of a transport fleet of 13 ton distribution vehicles and trailers, MIS systems, and stock. It is estimated that \$70 to \$80 million were invested over a 10 year period. Comparable programs have been implemented in Uganda, Zambia and Kenya with mixed results.

For all of these reasons, the CMS option for managing post-Tech-Serve operations within the foreseeable future can be ruled out. There is, however, one caveat to this general conclusion.

Proposed Canadian Support to the CMS

The Canadian International Development Agency (CIDA) is reported to be planning a program to finance essential medicines through the MOPH. This includes CDN \$25 million for medicines and supplies, and a program to strengthen the CMS. Details of this program are still under development, but it is expected to begin in the first quarter of 2010. The CMS strengthening component is projected to include the following activities:

- Review and validate priority needs in Year 1
- Conduct environmental assessment study by end of Year 2
- Develop and implement SOPs in Year 2
- Provide basic warehouse and office equipment beginning in Year 2
- Train CMS staff beginning in Year 2
- Provision of CDN\$10,000 annually to support CMS staff salaries beginning in Year 2
- Channel Health Partners International of Canada (HPIC) donations effectively through CMS beginning in Year 3

We would recommend that USAID periodically review the progress of the strengthening work at CMS through SPS with a view to reviewing the status of the CMS towards the end of the CIDA program. Should significant progress have been made during that time, then it may be possible to review the recommendation of not transferring at least some operations to the CMS. Should this program of support produce good results, then it may become possible to justify some degree of USAID investment into the CMS in order to continue with the work started by CIDA. At this point it may become possible to transfer some USAID operations to the CMS.

SPS-Tech-Serve could provide constructive support to the proposed CIDA funded program by offering to provide on-the-job exposure to the warehousing and distribution operations to selected CMS staff. While it is acknowledged that Tech-Serve has made such offers in the past that have not been taken up by the MOPH, perhaps the momentum that will be generated by the CIDA program may lead to the opportunity being taken up more readily. Such training-skills development opportunities would complement the proposed skills transfer in relation to quantification and procurement planning, which is described in the next section.

OPTIONS ANALYSIS

Premises Underpinning All Options

Regardless of how USAID-supported pharmaceutical supply services are managed and operated in the future, any such service will of necessity have the following features:

- USAID funding for procurement, storage and distribution continues for the foreseeable future whether through Tech-Serve or some other mechanism.
- USAID international contractor will continue to have a core role in procurement

Annex A provides a tabular summary of the principle options with a general indication of the LOE anticipated to be required for investigation, and implementation

What Can Be Transitioned to MOPH/GDPA?

Policy Development

In spite of the need to look outside the MOPH-CMS for supply solutions for the foreseeable future, support to the MOPH in the area of drug management should not be neglected. In particular, the CPDS process promises to be an important initiative that could result in setting out a long-term strategic plan for the public pharmaceutical sector.

With encouragement and support it is possible that the scope of work for the CPDS could be broadened, perhaps to encompass the whole pharmaceutical sector, both public and private (commercial and not-for-profit). This could become an important strategic document providing a focus for guiding and coordinating work in the sector for years to come. Whether the terms of reference of the CPDS are broadened or remain focused on the public sector, USAID support to the process is considered important and should continue.

The request by Deputy Minister Kakar for SPS to attend the planned January retreat to present its thoughts on strategic options open to the MOPH for the future development of the public health supply system, drawing on lessons from around the world, may also represent an important opportunity to identify important policy issues and help to broaden thinking about alternatives and options for future public sector supply activities.

Quantification and Procurement Planning

More pragmatically, there are discrete areas where strengthening should be provided to the GDPA immediately. These will be consistent with both the CPDS process as well as USAID's desire to support the MOPH. In this regard, a plan to gradually develop their quantification and procurement planning skills within MOPH and to involve them in Tech-Serve quantification and planning would be appropriate.

This could move forward through a phased process beginning with formal training in quantification and procurement planning. Exposing GDPA planning staff to actual Tech-Serve planning and quantification activities would deepen their understanding and skills. Depending on how well this process proceeds, a combination of formal and on-the-job training could, over time, prepare the GDPA planning department to assuming greater responsibility for quantification and planning. This would involve the following range of activities:

- Receiving reports
- Undertaking quantification
- Preparing procurement quantities
- Selection of drugs to be procured; essentially maintaining the Tech-Serve medicine list, but perhaps with modifications over time

Depending on progress, it may be possible to transfer responsibility for these activities to GDPA within two to three years, perhaps by the end of Tech-Serve, should the program be extended to September 2011. However, this assumes that the CPDS process resolves the issue of where responsibility for quantification will reside in the long term, either GDAA or GDPA, within a reasonably short period of time.

Tech-Serve

Tech-Serve is currently providing an important and responsive service to NGOs providing health services to 8 to 10 million people in 13 provinces. It is possible that this mandate could be broadened in the future in line with USG strategic plans for extending support to the health sector in additional, insurgent threatened provinces. It is clearly vital that nothing disrupts this service once Tech-Serve comes to an end.

In order to ensure the continued provision of essential medicines to USAID-supported NGOs, options other than the CMS need to be considered. With regards to this, the discussions to extend Tech-Serve through to September 2011, which are at an advanced stage, are considered to be a vital and entirely appropriate means of securing the supply service to the NGOs in the short term.

The options analysis that follows is focused first of all on finding a means of ensuring that a secure supply service continues beyond 2011, but will also consider ways in which the provision of that service could be broadened to NGOs receiving financial support from other donors, most notably the EC and World Bank. Thinking more radically and for the much longer term, it is conceivable that the Tech-Serve/post-Tech-Serve operation could become the basis for a reformed, private sector-based MOPH supply system. The outcome of the CIDA-CMS program as well as the work of the CPDS will have a direct bearing on this. This will also be considered.

End of Project Stock

USAID has expressed a desire for there to be 12 to 18 months of stock on hand at the end of Tech-Serve in order to ensure continuity of supply. It is unclear if there is sufficient budget provision has been made to cover this. In order to aid end-of-project planning, it will be

important that USAID issues clear instructions to Tech-Serve on this issue so that a budget provision can be made.

Post-Tech-Serve Options for Ensuring Continued Supply of Essential Medicines to USAID-Supported Provinces

Option A: Maintaining Full Integrity of Procurement, Storage & Distribution Operations

Option A1: Continue Tech-Serve

As USAID funding needs to continue into the foreseeable future, extending Tech-Serve offers a readymade solution. The benefits of this option are:

- Proven mechanism
- Infrastructure, management and reporting systems are already in place
- Known contractor with a successful track record and extensive experience of the country
- Familiar with USAID requirements, rules and regulations governing procurement with USG funds
- Majority of operational staff are Afghan with a maturing skill set, which provides the potential basis for future transfer to a fully Afghan owned and managed supply operation

Against this option, however, are the following factors:

- Limited scope within the Tech-Serve project for building in-country capacity, although Tech-Serve's relationship with sister projects, such as SPS, fills this gap to some extent
- Risk of entrenchment, the longer it runs, making it more difficult to transition to new arrangements
- Likely to be more expensive than a purely national operation

Option A2: New contract to replace Tech-Serve with similar range of responsibilities, but linked with substantive national partner who would assume full operational responsibility by the end of the project

This option has its eye firmly focused on Afghanization of the supply service through transitioning responsibility for all operations to the national partner over the course of the project. Although it is expected that the prime contractor would be a US-based organization, awarding of the contract would be predicated on the prime contractor having a mature and viable Afghan partner with demonstrable potential to manage all procurement and supply operations by the end of the contract.

Potential partners for such a contract might include existing pharmaceutical distributors; pharmaceutical manufacturers; NGOs; and other commercial supply companies. Capacity to extend distribution capacity to other parts of the country would be considered an important attribute of the Afghan partner as this would (a) better serve existing Tech-Serve clients, (b) open

up potential for providing service to other clients, and (c) help lay the groundwork for the development of a truly national distribution system in the longer term.

Due to the complexities and requirements of procuring pharmaceuticals with USAID funding, as well as the need to ensure continued adherence to Good Procurement Practice, it is anticipated that the international partner would have a continued role in procurement. To begin with, this may be continued responsibility for all procurement activities. Over time, however, this could be reduced to a role of establishing framework contracts with USAID-approved suppliers, reviewing and approving orders, and approving USAID payments to suppliers.

The benefits of this option include

- Revitalization of the current Tech-Serve operation, bringing in new blood and fresh approaches
- Moves towards a national solution, albeit one still supported by USAID funding
- An Afghan solution lowers costs to USAID and opens the door/helps promote future sustainability
- Ensures the continued integrity of procurement operations
- It may be easier for other donors, such as the EC and World Bank, to work with an Afghan entity for procurement purposes than a US-based contractor

Drawbacks of this approach include:

- Initial investigations suggest that potential partners with capacity, experience and interest do exist in the private sector. However, visits to the Kabul store of one of the larger, commercial distributors revealed that capital investments may be required in storage space to enable them to scale up further. This serves to underline that actual capacity within the private sector (commercial and non-commercial) would have to be ascertained independently before the viability of this approach could be proven and any partnerships could be contemplated. Further work should therefore be conducted to determine the extent of actual capacity and interest in both the commercial and not-for-profit NGO sectors and determine the costs and benefits of such an approach. Annex C provides further information on this distributor.
- Donor support for capital investments, either through making capital available and/or through the payment of charges levied to recover the investments, may be required if serious private sector partners are to be attracted and retained
- Removing the US-based contractor from day-to-day operations potentially runs the risk of compromising service quality
- There may be some risk of higher stock losses
- Duty and tax-free status, as well as import and customs clearance operations may become more complicated
- The long term interest of the Afghan partner may be lost should USAID funding be reduced or withdrawn in the years to come

Option B: Separate Procurement and Storage/Distribution Functions

General Points

Procurement

USAID regulations relating to procurement and associated USA government Federal Acquisition Regulations⁵ place various requirements and restrictions on the procurement of pharmaceuticals funded by USAID.

Whilst the regulations are complex and subject to change, especially in relation to the detailed operational practice required to obtain waivers to various clauses, in essence they render it unlikely that there can ever be full transfer of procurement and procurement related financial activity to a recipient country, Governmental Procurement operation. Some involvement of a Cooperating Agency, Contractor or other mechanism is always likely to be required to manage the procurement regulation waiver requirements for essential medicines, and ensure compliance on financial routings.

This is not to say that recipient country Governmental Procurement operations cannot be actively involved in, and have large degrees of control of the procurement process, but a recognition that certain boundaries exist is required in considering the overall procurement processes and the feasibility of alternative mechanisms.

Storage and Distribution

The USAID and associated USA government regulations relating to the accounting, reporting, auditing, and control of medicines procured with USAID funding also place certain restrictions and requirements on the storage and distribution process.

Once again the USG regulations and auditing requirements are complex, but in essence require an operation that meets Good Distribution Practice standards⁶, including excellent stock accounting systems. It should be recognized that many Governmental medical logistics operations in developing countries fail to operate at such levels, and this once again can effectively restrict the degree of operational transfers which can occur within Governmental logistic systems when USAID funded commodities are involved.

⁵ For example, FAR 312.5.3.c PHARMACEUTICALS

⁶ For example, OFFICE OF INSPECTOR GENERAL: WORLDWIDE AUDIT OF USAID'S PROCUREMENT AND DISTRIBUTION OF COMMODITIES FOR THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF: AUDIT REPORT NO. 9-000-09-011-P : August 13, 2009 http://pdf.usaid.gov/pdf_docs/PDACO880.pdf

Recommendation 1: *We recommend that USAID's Office of HIV/AIDS Director send a written request to the Department of State's Office of the U.S. Global AIDS Coordinator, asking that office to issue clear and explicit guidance to all missions with PEPFAR activities to ensure that (a) standards for warehousing commodities are distributed to all warehousing facilities, and (b) implementation of the standards is reviewed and monitored regularly.*

GH/OHA agrees with both the above recommendations and will request that the Office of the U.S. Global AIDS Coordinator send out guidance to all PEPFAR country teams, partners and Ministry of Health counterparts, regarding standards and best practices for warehousing of commodities, and standards for managing expired commodities. This guidance will be taken from WHO guidelines and SCMS standard operating procedures which represent internationally recognized best practice. GH/OHA will send the request to the PEPFAR Coordinator, along with the standard operating procedures, by July 17, 2009.

B1: Procurement

Option P1: Appoint an international procurement agent

Rationale: USAID procurement regulations for the acquisition of pharmaceuticals have a significant degree of donor specific requirements which require specific skill levels and substantial experience to operate effectively. The transfer of skills relating to donor specific requirements to Governmental entities, especially at a time requiring rapid generalized pharmaceutical skills development, may be of limited value, and not entirely appropriate.

By retaining an agency to undertake part of the procurement process (essentially the buying and authorization functions), full compliance with USAID regulations can be assured, and an opportunity provided for Afghanistan to acquire and undertake pharmaceutical and procurement planning, management and control skills.

In essence, this mechanism provides a time window for the development of pharmaceutical planning functions within an Afghan Government appointed entity without the burden (at this stage) of that entity having to deal with complex and donor specific procurement regulations. It allows for the process of control of pharmaceutical operations to be started within an Afghan entity, and for those planning and control operations to have entirely general applicability to all pharmaceutical activities, regardless of funding source.

An Afghan government entity, such as the Pharmaceutical Planning Department (PPD) within the Ministry of Public Health, for example, could conceivably have (eventual) control on the selection of medicines to be supplied; quantification; quantity adjustments within budgets; order quantities; and specification of delivery time requirements.

Bluntly the entity could specify: what, how much, and when, commodities are to be supplied. It provides orders directly to the Procurement Agent who is then responsible to buy and deliver the products.

Such control and the range of operations undertaken could be phased-in over time. Perhaps starting by building on the existing product selection committee operations; then through initially observed/joint quantifications with Tech-Serve, gradually transferring to supported entity quantifications, and finally independent entity quantifications, and then on to the other pharmaceutical planning functions in a similar fashion.

The existing SPS mechanism could be used to provide the necessary technical support for the development of the identified government entity, such as PPD. The final identification of the entity will be decided at Ministerial level. Advice received from CPDS will be important in this regard.

An initial estimate of a timescale might be for the governmental entity (albeit with continuing appropriate technical support) to be in a position to undertake the pharmaceutical planning

process and start placing orders on a Procurement Agent by mid 2011. However, achievement of this will depend on progress on a number of fronts over the coming 12 to 18 months.

For the Procurement Agent:

- Options include, established contracting/cooperating/associated partner mechanisms such as: MSH, SCMS-PEPFAR, JSI;
- Other commercial entity

Whatever type of entity was eventually appointed, it would be selected on basis of an RFP or tender.

Option P2: USAID (through contracted agency) establishes framework contracts with approved pharmaceutical suppliers

This provides for a development from either the A2 or P1 Option.

Once the Afghan partner or Identified Governmental Pharmaceutical Entity (IGPE) is able to undertake the pharmaceutical planning processes, and has gained experience of working with an International Medicines Procurement Agency it can start to become more involved in the procurement process.

There will still be donor specific requirements which are best addressed by established USAID agencies, partly because of the skill and experience levels required, and also partly because they are donor specific so do not have general applicability to medicines procurement. Essentially it will be only be those procurement operations which have generalized applicability, regardless of funding stream, which will be developed.

But, it should be possible for the Afghan private sector partner or IGPE to gain experience and eventual control on managing international supplier relations and performance.

In essence, instead of the Afghan partner or IGPE undertaking pharmaceutical planning and then placing orders on an International Procurement Agency, it will be able to place directly on suppliers.

The suppliers to be used will be pre-determined, and the procurement operation established under framework contracts with those suppliers, managed by a USAID contractor/cooperating partner.

A typical flow pattern would be:

- USAID contractor/cooperating partner (e.g. Tech-Serve, MSH, JSI, etc.) establishes framework contracts with approved suppliers
- Private Sector Partner or MOPH procurement unit invites quotes from approved suppliers
- Private Sector Partner or MOPH places orders
- USAID contractor reviews and approves orders, and authorizes USAID payment

Assumptions:

- Afghan partner can be identified and contracted (A2) and/or
- MOPH determines which department has responsibility for procurement
- Appointed department is competent to perform assigned responsibilities

B2: Storage and distribution

Option S1: Continue with Tech-Serve or a Tech-Serve like mechanism as outlined in the options described above, but restricted to storage and distribution only (procurement to be undertaken by a USAID contractor).

Rationale: As described in the ‘Current Status’ section, above, it is likely to be a substantial period of time before the Governmental medical logistics operation could be expected to handle the volume of throughputs currently being undertaken by Tech-Serve.

Further, USAID regulations require substantial auditing and accounting functions which it is likely to take even longer to develop, and which are probably not required (to the same extent) by other funding streams.

Tech-Serve or a Tech-Serve-like mechanism would ensure full compliance with USAID regulations and ensure continuity of operation.

Option S2: Contract to pharmaceutical distributor or other supply chain company

Rationale: Whilst the existing value of commodities routed through Tech-Serve is believed to be around five times larger than the current Governmental medical logistics operations, it is probably not larger than the private/commercial pharmaceutical sector operations. It is believed that a significant proportion of the EU and WB funding for commodities is obtained from the local market⁷, and this coupled with Out Of Pocket (OOP) buying suggests the possibility of private/commercial sector pharmaceutical operators on a par with the Tech-Serve volumes.

Additionally, it is believed that there may be private distribution/logistics operations, in both the NGO and commercial sector, which may be able to handle the envisioned future USAID-funded commodity volumes as long as the investments are made that will be required to do this.

- Pros:
 - Lower cost to USAID through use of national operators
 - Movement towards national sustainability
 - Opens potential for extending distribution-storage network to other parts of the country, either through central organization’s own infrastructure or via zonal partners, e.g. pharmaceutical distributors in zonal centers such as Mazar-i-Sharif, Jalalabad, Herat and Kandahar

⁷ Reported during interviews with HealthNet TPO, Swedish Committee for Afghanistan, and BDN

- Potential for more readily scaling up operations as required (note: extending distribution capacity will become more critical as funding for essential medicines increases)
- Cons
 - Operators with requisite expertise, experience and interest may not exist. Further study will be needed to ascertain this.
 - Removing the US-based contractor from day-to-day operations potentially runs the risk of compromising service quality
 - The long term interest of the Afghan operator may be lost should USAID funding be reduced or withdrawn in the years to come

Option S3: Central Medical Stores (CMS)

- Major Assumption: reformed and vastly improved CMS with adequate infrastructure, management and control systems, as well as the requisite level of autonomy, etc. functioning with volumes at least comparable to current Tech-Serve operation

Rationale: Centralized logistics operation provides for greater degrees of coordination, especially when there are diverse funding and supply streams, and can bring economies of scale.

- Pros
 - Integration of medical logistics service into government structures
 - Long term sustainability may be more readily achieved
 - Lower costs for USAID and longer term potential to withdraw funding support completely for logistics operation
- Cons
 - Very high levels of investment are required over many years
 - High risk of poor performance leading to collapse of, or otherwise compromised service levels, and major commodity losses
 - Within the Afghan context, security of stock carried by government vehicles is more difficult to assure than when private carriers are used

Generally speaking, this is only ever likely to be an option in the very long term (7 years plus), mainly because of the huge infrastructure expansion and system development that will be required (at least 5 times current capacity), not to mention the probable need for legal and regulatory changes to provide the essential framework for an expanded and strengthened CMS. Nevertheless, the situation at CMS should be monitored and reviewed over time in light of the proposed CIDA program of support to CMS.

OPTIMIZING CURRENT AND FUTURE FINANCING FOR ESSENTIAL MEDICINES

EC and World Bank Funded NGOs

Discussions with the larger NGOs working in the health sector suggests that there is considerable expenditure on essential medicines and supplies by NGOs providing BPHS services with support from the EC and World Bank. HealthNet TPO, for example, estimated their annual expenditure to be \$1.25 million.

At the same time, they experience considerable difficulties in procuring their essential supplies. Procuring internationally is administratively demanding, costly in terms of transportation and importation procedures, and, most importantly for them, suffers from very long lead times of about nine months. Procuring locally overcomes many of these problems through being able to have day-to-day contact with suppliers. However, it is very difficult to assure the quality of products bought on the local market. A 2005 DFID-funded study, for example, reported that smuggling could account for as much as 80% of drugs sold on the private market, which contributed to a problem of low quality and counterfeit drugs being sold⁸.

Ideally, the NGOs would like to develop a system that combines the responsiveness and flexibility of local procurement with the quality assurance of buying internationally. In relation to this, there has been periodic interest expressed in some kind of pooling arrangement among a number of NGOs, but they have been unsure how to assess the feasibility of this and develop the idea into practical options for moving forward.

Pooling demand may well be attractive enough to commercial importers-distributors to realistically establish a prime vendor-type relationship or a rate contract arrangement with one or more importers-distributors in Afghanistan. It is not possible to say this would work with any degree of certainty at the present, but the NGOs would be interested in receiving Technical Assistance to help them evaluate the feasibility of various options. There may well be a role for Tech-Serve in such a system either as a source of emergency supplies or, conceivably, as the prime vendor.

As well as being potentially invaluable for the NGOs being supported by the EC and World Bank, it could also assist with overcoming supply problems associated with other funding sources, most notably the Global Fund. Moreover, successfully developing a local, private sector-based procurement system would generally strengthen the pharmaceutical distribution infrastructure of the country, not least in the private market. This would open up new opportunities that the public sector could potentially take advantage of in the future as it strives to build a national supply system.

⁸ UNDERSTANDING MARKETS IN AFGHANISTAN: A Study of the Market for Pharmaceuticals
Anna Paterson and Asif Karimi, December 2005; Afghanistan Research and Evaluation Unit. Funding for this research was provided by the UK Department for International Development (DFID)

It is recommended that SPS explore these issues more systematically than has been possible hitherto by conducting an options analysis/feasibility study for pooling procurement-supply among interested NGOs receiving support from the EC and World Bank.

Rationale: Developing a more integrated supply system between major NGOs dependent on non-USAID funding streams would not only assist those NGOs in addressing a major problem they face in providing services, but would also support the development of a generalized medical logistics operation for BPHS and, at a later date, the broader public health system. It also has the potential to raise the reliability and quality assurance of medicines currently being provided through different supply routes.

Sustainability of Funding Levels: Is Enough Being Spent on Essential Medicines in BPHS?

How much should a country spend on pharmaceuticals? Experts have tried to indicate the possible effects on access of different levels of spending on pharmaceutical. For example⁹,

- Less than \$5 per capita per year is unlikely to provide a regular supply of drugs to the entire population.
- An expenditure of \$5 to \$10 per capita should supply a large part of the population.
- With an expenditure of \$10 to \$50 per capita, the needs of the entire population should be satisfied.

These figures are based on national averages and allow for a considerable degree of unevenness in access to drugs.

More recently, the latest WHO World Medicines Situation (2004) indicates that low income countries spend about \$4.4 per capita per year, \$1.1 of which is in the public sector. See Table 1 below.

⁹ For example, Dumoulin, Kaddar, and Velásquez, WHO SEARO Working Group on Drug Financing, Health Economics and Drugs, DAP Series No. 8, Yogyakarta, November 1997.
<http://apps.who.int/medicinedocs/en/d/Js2239e/7.1.html>

Table 1: Private and government per capita expenditure on pharmaceuticals, 1990-2000
(US\$ at exchange rate)

Income clusters	1990			2000		
	Private	Govt.	Total	Private	Govt.	Total
WHO Member States	28	21	49	45	29	74
High-income	130	110	240	229	167	396
Middle-income	13	5	18	22	8	30
Low-income	2.6	1	3.6	3.2	1.1	4.4

Source: Table 5.4, *World Medicines Situation*, WHO, 2004
<http://apps.who.int/medicinedocs/en/d/Js6160e/7.html#Js6160e.7>

Comparable figures for Afghanistan are hard to pin down with any degree of accuracy. However, from the information available it would appear that BPHS pharmaceutical expenditure is around \$0.65 per capita per year. In earlier times, WHO recommended a minimum of \$2 per capita for the public sector. While this is no longer in wide use, it perhaps gives some indication that expenditures through BPHS are somewhat below what they need to be to ensure secure access.

There is very little data for private expenditures, although a quick check of prices at one wholesaler indicates that prices in that sector are high by international standards, which may be an indication that many members of the public will have difficulty accessing drugs from the private market. See Table 2 below.

Table 2: Comparison of Afghanpharm prices with the International Drug Price Indicator Guide (IDPIG)

Generic Description	IDPIG	Afghanpharm				% of IDPIG
		Brand	Pack Size	Price (\$)	Price/Tab-Cap	
Azithromycin caps 250mg	0.2417	Azomycin	6	22.34	3.72	1540%
Nifedepine caps 10mg	0.0122	Cardiopine	20	5.86	0.29	2402%
Doxycycline caps 100mg	0.009	Duradox	1000	408.72	0.41	4541%
Erythromycin Tabs 500mg	0.0461	Eromycin	500	115.8	0.23	502%
Amoxicillin Tabs 500mg	0.027	Julphamox	1000	408.72	0.41	1514%
Enalapril Tabs 20mg	0.0081	Narapril	28	26.98	0.96	11896%
Metronidazole Tabs 500mg	0.008	Negazole	500	102.18	0.20	2555%
Omeprazole Caps 20mg	0.0594	Risek	28	65.8	2.35	3956%
Furosemide Tabs 40mg	0.0037	Salurin	20	7.08	0.35	9568%
Atenolol Tabs 100mg	0.0101	Tensotin	30	14.71	0.49	4855%

The 2005 DFID study of the pharmaceutical market estimated the annual value of the private market to be about \$200 million, amounting to 70% to 80% of the total value of pharmaceuticals available to the population in Afghanistan. This suggests a per capita expenditure of between \$6 and \$7. The large number of unregistered importers-distributors, together with smuggling, makes it difficult to know the actual size of the private market with any degree of certainty.

Moreover, given high prices in the private sector, it is also difficult to know what this means for assuring access to essential medicines in Afghanistan. High levels of poverty and insecurity, however, mean that there is at least the possibility that the majority of the population do not have assured access. Tech-Serve monitoring of stock availability during 2009 indicates an average of 15% out of stock at any one time, which supports the contention that there may be some gaps in financing, although the out of stocks may well be the result of a number of factors, including poor inventory management and ordering.

Nevertheless, the issue is sufficiently important to justify further work to understand better the financial drivers of access in Afghanistan, the relative importance of the public and private sectors and, through that, to advise better on appropriate funding levels for pharmaceuticals made available through the MOPH and, more especially, BPHS. This would provide important data on spending and financing needs that would permit government, donors and NGOs to better estimate actual needs in order to meet a desired level of pharmaceutical access.

NEXT STEPS

Final Debriefing to USAID

A debriefing was presented to USAID on December 9th. Annex D provides a copy of the PowerPoint presentation used at this meeting.

Recommendations

1. Policy, Regulation and Legal Framework

- SPS to continue supporting CPDS process
- Investigate the possibility and appropriateness of broadening the Terms of Reference of the CPDS to include looking at both the commercial and not-for-profit private sector.
- Assess the interest of the MOPH in developing a strategic plan for the pharmaceutical sector. Should there be such an interest, determine the most appropriate mechanism for conducting the necessary work. This may include conducted as part of CPDS, but could also require stand alone studies to complement the work of CPDS.
- Review status of work and recommendations of 2003 Drug Law and Regulation workshop and USAID supported work in this area
- SPS to attend MOPH retreat in January 2010 in order to present strategic options for the development of a secure supply system to serve the national health service.

2. Strengthening the MOPH and CMS

- Support CIDA support to CMS through providing exposure to Tech-Serve operations to CMS staff
- Monitor progress of CIDA work with CMS and provide support as appropriate
- Begin the transfer of responsibility for quantification and procurement planning from Tech-Serve to the MOPH

3. End of Tech-Serve Project Stock

- USAID should issue clear instructions regarding planning for end of project stock for Tech-Serve so that appropriate budget provisions can be made.

4. Post Tech-Serve Options analysis

- USAID will, of necessity, require time to consider the pros and cons of each option. While it would be inappropriate to firmly recommend one option over another, the options that envisage a process of Afghanization through a strategic partnership between an international and Afghan organization have much to recommend them.

5. Private Sector Capacity

- Assess the actual interest and capacity of the private sector (commercial and non-commercial) to play a role in supplying essential medicines and supplies to the public health system.
 - Determine the implications of private sector involvement for government, donors and NGO providers of health services
6. Pooling procurement and supply – EC and World Bank supported NGOs
- Conduct a feasibility study of pooling procurement and/or storage-distribution services among NGOs receiving BPHS funding from the EC and World Bank
 - Determine the potential and feasibility of involving Tech-Serve in this.
7. Expenditure on pharmaceuticals
- Review public and private expenditures on pharmaceuticals with a view to determining if current levels of public expenditure, including as part of BPHS, are appropriate to ensure full access to essential medicines for the broad public

Important Upcoming Activities or Benchmarks in Program

The MOPH has a retreat planned for January, 2010 to discuss strategic issues related to delivering health care in Afghanistan. SPS has been invited to participate in order to give a presentation on strategic options available to the MOPH for building a national supply system for the health service.

ANNEX A: TABLE OUTLINING OPTIONS AND INDICATIVE LOE FOR IMPLEMENTATION

				Time	Person Days	Entity Responsible	Key Decisions
Option A	Full Procurement and Supply Service						
	1	Continue with Tech-Serve	Formulation of future operating targets, volumes, and outline commodity budgets	Jun-10	40	TS DMU/SPS	USAID wish to explore this route
			Discussions with Tech-Serve DMU on technical approach to be used to meet target requirements	Sep-10	20	TS DMU/SPS	
			Formulation of extension contract conditions and operating parameters	Nov-10		USAID	
			Draw up RFP	Jan-11		USAID	USAID commit to follow this route
			Award contracts for Tech-Serve DMU for new operating period	Apr-11		USAID	
	2	Transition to Afghan partner	Detailed investigation/Study to see range and quality of potential NGO and commercial sector partners available	Mar-10	80	TS DMU/SPS	USAID agree to investigation
			Agree feasibility of using this route with all relevant partners	Jul-10	10	TS DMU/SPS	USAID agree to follow this route
			Draw up RFP, contract conditions, performance monitoring parameters, etc.	Oct-10	40	TS DMU/SPS	
			Issue and assess RFP responses	Nov-10	20	TS DMU/SPS	
			Award contracts for Tech-Serve DMU and identified partner and	Mar-11		USAID or Tech-Serve as sub-contract	USAID agrees awards

Option B	Split Procurement and Supply						
	1	International Procurement Agent	Agree feasibility of using this route with all relevant partners	Jun-10	10	TS DMU/SPS	USAID to agree to follow this route
			Draw up RFP, contract conditions, performance monitoring parameters, etc.	Oct-10	40	TS DMU/SPS	
			Issue and assess RFP responses	Nov-10	20	SPS/USAID	
			Award contracts for Procurement Functions	Mar-11		USAID or Tech-Serve as sub-contract	USAID agree awards
	2	USAID contracted agency to arrange framework contracts					
			partner -Identify prime procurement partner - MOPH/NGO/other body				
			Commence intense support to MOPH/other body for selection, quantifications, and supply management	Feb-10	200	TS DMU/SPS	MOPH which department will undertake medicines procurement/s supply management
			Agree feasibility of using this route with all relevant partners	Jun-10	10	TS DMU/SPS	USAID to agree to support this route
			Issue tenders for framework contracts	Jan-11	20	TS DMU/SPS	
			Make awards for framework contracts	Mar-11	20	TS DMU/SPS	
			Monitor NGO order placement and supplier performance	Dec-11	40	TS DMU/SPS	
	3	Storage and Distribution					
		Continue with Tech-Serve	As A1 above				

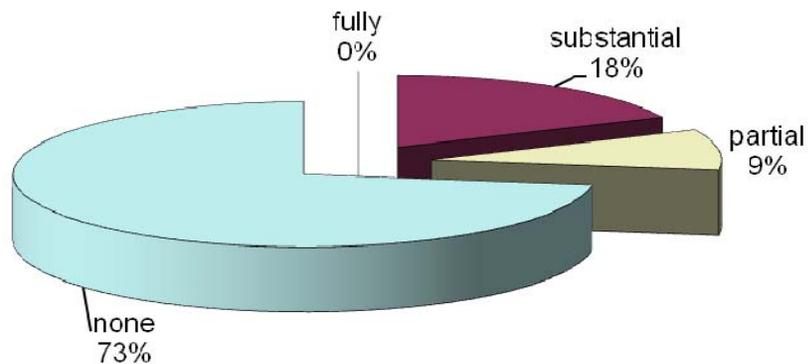
		Contract with a pharmaceutical distributor	Survey market, establish range of possible companies/organizations available	Mar-10	40	TS DMU/SPS	USAID wish to explore this route
			Draw up ToRs/RFP for possible service	Aug-10	40	TS DMU/SPS	USAID agree to follow this route
			Trial one Province/Zone				
			Issue RFP	Jan-11	20	TS DMU/SPS	
			Award contract for storage and distribution for one province	Apr-11	10	TS DMU/SPS	USAID agree to contract
			Monitor contract performance	Sep-11	30	TS DMU/SPS	
			Roll out other Provinces	Nov-11	30	TS DMU/SPS	

ANNEX B: RAPID ASSESSMENT LOGISTICS TOOL

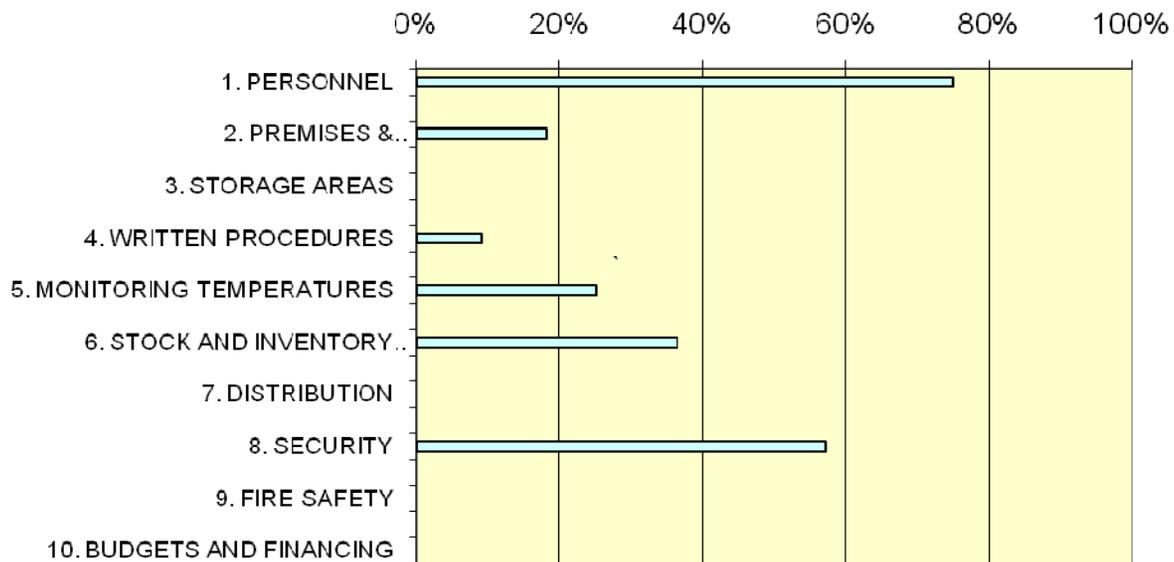
MSH/SPS Logistics Agency Assessment Tool

	Afghanistan, MoPH, Pharmaceutical Operations							
	Kabul, Central Medical Stores							
	Min Score	Actual Score	Max Score	Percentage	Compliance			
					fully	substantial	partial	none
1. PERSONNEL	19	18	24	75%		S		N
2. PREMISES & INFRASTRUCTURE	53	12	66	18%				N
3. STORAGE AREAS	14	-	18	0%				N
4. WRITTEN PROCEDURES	26	3	33	9%				N
5. MONITORING TEMPERATURES	19	6	24	25%				N
6. STOCK AND INVENTORY MANAGEMENT	79	36	99	36%			P	
7. DISTRIBUTION	-	-	-	0%				N
8. SECURITY	34	24	42	57%		S		
9. FIRE SAFETY	14	-	18	0%				N
10. BUDGETS AND FINANCING	2	-	3	0%				N
ASSESSMENT TOTAL SCORE	262	99	327	30%	0	2	1	8
<i>checksum</i>	<i>0</i>	<i>0</i>	<i>0</i>		0%	18%	9%	73%

LOGISTICS ASSESSMENT COMPLIANCE CMS Kabul



LOGISTICS ASSESSMENT CMS KABUL AFGHANISTAN



ANNEX C: AFGHANPHARM VISITS

- Met with Habibullah Emal, Kabul Office Manager, December 1st, 2009
- Holding company with exclusive rights to market products manufactured by Julpharm/Gulf Pharmaceuticals from UAE.
- Headquartered in Dubai with office also in Tajikistan
- Head office and central warehouse for Afghanistan in Herat
- Market for 11 multinationals
- Supply every province with sales-marketing-warehousing in 25
- Claim to have supply relationships with MOPH, WHO and some international NGOs
- Main business is with private sector, but also said to be selling to the MOPH, Afghan Ministry of Defense, US Army (\$800,000 of business), WHO, NGOs, other UN agencies
- Prices high compared to IDPIG (see table)

Generic Description	IDPIG	Afghanpharm				% of IDPIG
		Brand	Pack Size	Price (\$)	Price/Tab-Cap	
Azithromycin caps 250mg	0.2417	Azomycin	6	22.34	3.72	1540%
Nifedepine caps 10mg	0.0122	Cardiopine	20	5.86	0.29	2402%
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Furosemide Tabs 40mg	0.0037	Salurin	20	7.08	0.35	9568%
Atenolol Tabs 100mg	0.0101	Tensotin	30	14.71	0.49	4855%

- Annual turnover is \$15m to \$18m
- 249 staff, including 68 doctors and pharmacists
- Sales teams make more than 2,500 calls to doctors a month and 2,800 to pharmacies
- Main stock is held in Herat (5,920 square meters), but hold stock in 25 provinces
- Kabul main store: presentation at office reported 2,630 square meters. However, visit to store on December 6th revealed a store of no more than 600 square meters. Further investigations indicated that the 2,630 square meters was largely made up of shop space. This situation illustrates the need to not take claims at face value.
- Distribution capacity: 24 vehicles and 78 staff
- Stock range of 400+ pharmaceutical products; 2,300 products in all, including med-surgical items
- Are constructing a production facility in Herat that is due to start manufacturing by the end of 2010. Building is completed; needs fitting out. Intend to seek USFDA approval (note: Julpharm factory in Dubai has USFDA approval from March 2005)

- 3 “coordination offices”: Herat, Mazar-i-Sharif, Kabul
- Fully computerized IT/MIS (not seen)
- Have operated in Afghanistan for 12 years, started by serving 4 provinces

ANNEX D: USAID DEBRIEFING PRESENTATION

Post Techserve DMU Essential Medicines Provision Options Analysis

Malcolm Clark & Andy Barraclough
December 2009



Premises Underpinning All Options

- USAID funding for procurement, storage and distribution of essential medicines continues for the foreseeable future whether through Techserve or some other mechanism.
- A USAID international contractor will continue to have a role in medicines procurement (to comply with FAR and USAID financial regulations)

2

Options Study - Data Collection

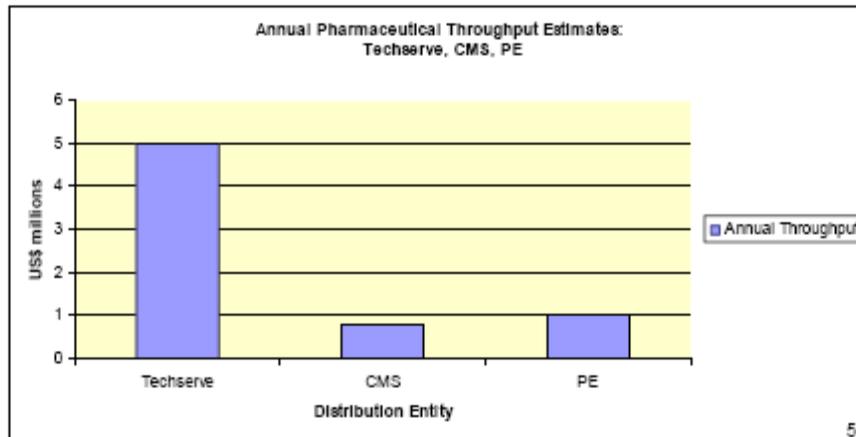
- Existing reports and documentation
- Visits to public and private sector operators and operations:
 - MoPH;
 - Techserve DMU;
 - UN agencies;
 - NGOs – USAID, EC and WB funded;
 - Commercial Sector Pharmaceuticals;
 - Commercial Sector logistics.

3

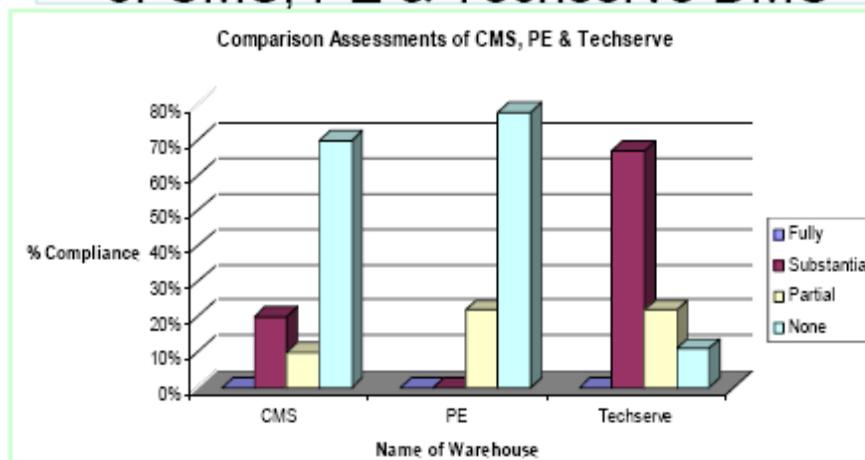
Current Situation Analysis From:

- MSH developed Medical Logistics Operations Rapid Assessment Tool
- Comparisons of Techserve DMU; MOPH operated, Central Medical Stores and Pharmaceutical Enterprises Stores
- Discussions with active NGOs
- Initial indications from commercial sector 4

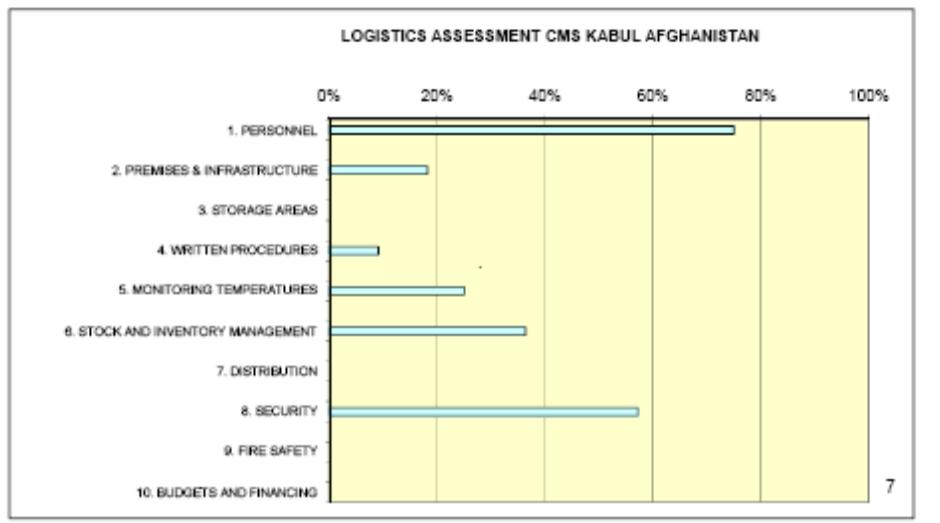
Monetary Value of Drug Throughput of CMS, PE and Techserve DMU



Logistics Assessment Comparison of CMS, PE & Techserve DMU



Logistics Assessment CMS



Basic Policy Option - MOPH Procurement & Supply

- CPDS Process: Policy on procurement and supply under discussion and controversial (GDPA vs GDAA); likely to take time to finalize
- CMS and PE Operational standards & level of control very low
- Scale of operations small compared to Techserve DMU

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SPS
Strengthening
Pharmaceutical
Systems

Logistics/Warehouse - CMS/PE

- This option can be ruled out for the foreseeable future (3 to 5 years)

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Systems

Proposed CIDA Support to CMS

- Project proposal CDN\$25m for essential drugs & supplies over 5 years, beginning 2010
- Strengthening to CMS (\$ unknown)
 - Review and validate priority needs in Year 1
 - Conduct environmental assessment study by end of Year 2
 - Develop and implement SOPs in Year 2
 - Provide basic warehouse and office equipment beginning in Year 2
 - Train CMS staff beginning in Year 2
 - Channel HPIC donations effectively through CMS beginning in Year 3
 - Provision of CDN\$10,000 annually to support CMS staff salaries beginning in Year 2

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Systems

CMS – Longer Term

- Review impact of CIDA support towards end of project (3 to 4 years time)
- Reassess potential for involvement in USAID funded supply operations at that time

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Strengthening
Pharmaceutical
Systems

Basic Policy Option Involvement MOPH/GDPA

- Support to MoPH
- Policy Development
 - CPDS process
 - Private sector inclusion ?
 - Strategic/Master Plan for Pharmaceutical Sector
- Skills & Responsibility Transfer
 - Quantification & Procurement Planning

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Quantification & Procurement Planning

- Assumes CPDS process agrees to transfer responsibility from GDAA to GDPA
- Phased process of transferring responsibility from USAID contractor to GDPA Planning Department (by end of 2011?)
- Formal and on-the-job training
- Includes the following activities:
 - Receiving reports
 - Undertaking quantification
 - Preparing procurement quantities
 - Selection of drugs to be procured; essentially maintaining the Techserve medicine list, but perhaps with modifications over time

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Major Options Considerations

- A. Full Operation, Procurement and Supply Service
 - Continue with Techserve DMU
 - Operation with Afghan partner
- B. Splitting Procurement and Supply Functions
 - With greater flexibility for transferring some functions to MOPH over time

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Option A: Full Operation, Vertical, Procurement & Supply Service

Option A1: Continue Techserve DMU

- Pros:
 - Proven mechanism
 - Infrastructure, management and reporting systems are already in place
 - Known contractor with track record and extensive experience of the country
 - Familiar with USAID requirements, rules and regulations governing procurement with USG funds
 - Majority of operational staff are Afghan with a maturing skill sets, which provides the potential basis for future transfer to a fully Afghan owned and managed supply operation
- Cons:
 - Limited scope within the Techserve DMU project for building in-country capacity, although Techserve's DMU relationship with sister projects, such as SPS, fills this gap to some extent
 - Risk of entrenchment the longer it runs, making it more difficult to transition to new arrangements
 - Likely to be more expensive than a purely national operation

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Option A: Full Operation, Vertical, Procurement & Supply Service

- **Option A2: New Contract**
- New USAID contract replaces Techserve DMU
- Similar range of responsibilities to Techserve DMU
- Linked with substantive national partner who would assume full operational responsibility by the end of the project

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Option A2: Full Operation, Vertical, Procurement & Supply Service

- Pros:
 - Revitalization of the current Techserve DMU operation, bringing in new blood and fresh approaches
 - Moves towards a national solution, albeit one still supported by USAID funding
 - An Afghan solution lowers eventual costs to USAID and promotes future sustainability
 - Ensures the continued integrity of procurement operations
 - It may be easier for other donors, such as the EC and World Bank, to work with an Afghan entity for procurement purposes than a US-based contractor

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Option A2: Full Operation, Vertical, Procurement & Supply Service

- Cons:
 - While potential partners do exist, further study should be conducted to determine extent of actual capacity and interest
 - Removing the US-based contractor from day-to-day operations potentially runs the risk of compromising service quality
 - There may be some risk of higher stock losses
 - Duty and tax-free status, as well as import and customs clearance operations may become more complicated
 - The long term interest of the Afghan partner may be lost should USAID funding be reduced or withdrawn in the years to come

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Options B: Splitting Procurement & Supply Functions

- USG FAR make it difficult to transfer full responsibility for procurement to a non-US, established contractor
- A Cooperating Agency, Contractor or other mechanism is likely to be required to:
 - manage product FAR waiver requirements
 - ensure product quality
 - ensure documented/auditable procurement integrity & financial management compliance

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Option B: Procurement Options (1)

- **Option B1:** Appoint an international Procurement Agent
 - established USAID partner mechanisms such as: MSH, SCMS-PEPFAR, etc.;
 - Selected through an RFP
 - Other commercial entity
- **Pros:**
 - Ensures compliance with USG regulations
 - Confidence in service
 - Provides opportunity to develop planning skills in GDPA and/or private Afghan partner (Option A2)

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Option B2: Procurement Options

- **Option B2:** USAID contracted agency establishes framework contracts with approved, international pharmaceutical suppliers
 - USAID contractor/cooperating partner (e.g. Techserve DMU, MSH, SCMS, etc.) establishes framework contracts with approved suppliers
 - Afghan Private Sector Partner or MOPH procurement unit, invites quotes (only) from approved suppliers
 - Afghan Private Sector Partner or MOPH places orders directly with approved suppliers
 - USAID contractor reviews and approves and authorizes orders and makes USAID funded payment¹

Option B: Storage & Distribution

- Option S1: Continue with Techserve DMU
 - Similar rationale to A1

Option B: Storage & Distribution

- Option S2: **Contract to pharmaceutical distributor** - or other supply chain/logistics company/organization
- Pros:
 - Probable lower cost to USAID through use of national operators
 - Movement towards National sustainability
 - Opens potential for extending distribution-storage network to other parts of the country
 - Potential for more readily scaling up operations (note: extending distribution capacity will become more critical as funding for essential medicines increases)

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Option B: Storage & Distribution S2

- Option S2 (continued)
- Cons:
 - While potential partners do exist (e.g. commercial pharmaceutical distributor), further study should be conducted to determine extent of actual capacity and interest
 - Removing the US-based contractor from day-to-day operations potentially runs the risk of compromising service quality
 - The long term interest of the Afghan operator may be lost should USAID funding be reduced or withdrawn in the years to come

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Option B: Storage & Distribution S3

- Option S3: CMS (or PE)
- **Major Assumptions:**
 - reformed and vastly improved CMS with adequate infrastructure, management and control systems, etc.
 - functioning with volumes at least comparable to current Techserve operation
- Not considered a short term option
- Perhaps review possibility in 3 to 5 years

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Option B: Storage & Distribution S3

- Option S3 continued
- Pros
 - Integration of medical logistics service into government structures
 - Long term sustainability
 - Lower costs for USAID and longer term potential to withdraw funding support completely for logistics operation
- Cons
 - High risk of poor performance leading to collapse of, or otherwise compromised service levels, and major commodity losses
 - Within the Afghan context, security of stock carried by government vehicles is more difficult to assure than when private carriers are used

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Leveraging USAID funding stream advantages

- One effect of the USAID funding stream and FARs for essential medicines supply, is to create a requirement for significant in-country stock holdings
- These stocks can provide the security of supply needed to develop transfers of authority to MOPH and operational integrations of logistics functions beyond the USAID funding stream

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EC & World Bank NGOs (1)

- Considerable spending on meds & supplies (e.g. HealthNet: \$1.25m per year)
- Experiencing procurement difficulties
 - International: slow, burdensome and costly
 - Local: quality problems, unreliable service
- Would like a system combining quality assurance of international procurement with flexibility & responsiveness of local procurement

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EC & World Bank NGOs (2)

- There is interest in pooling procurement among some NGOs
- They are unsure how to assess feasibility and plan way forward
- Potential options include:
 - Prime vendor
 - Framework/Rate Contracts
 - Techserve DMU (either as principal or emergency supplier)
- SPS could provide TA to conduct options analysis/feasibility study

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EC & World Bank NGOs (3)

- Potential Benefits:
 - Advantageous to NGOs supported by the EC and World Bank
 - Assists with overcoming supply problems associated with other funding sources, e.g. Global Fund
 - Strengthens the in-country private pharmaceutical sector
 - A strengthened private market could open up future opportunities for the public sector

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ANNEX E: SCOPE OF WORK

- 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
- Conduct a structured and rapid assessment of the public and private health supply systems, including NGO and private sector, in the context of the broader pharmaceutical sector. The assessment should cover:
 - An assessment of the overall pharmaceutical and medical supply needs at the National, Provincial and village levels. This will include an assessment of the current financial allocation and its capacity to support a well functioning system
 - Policy and legislation covering the pharmaceutical sector in general and the supply system in particular
 - Financing of pharmaceuticals and medical supplies
 - The current status of drugs procurement, storage, distribution systems
 - The current status of human resources and management responsible for supply services
 - Quality assurance for pharmaceuticals and medical supplies used in the public and private sectors
 - Capacity and interest of the private sector, including NGOs and international contractors operating both within and outside the health sector, in providing a supply

To the extent possible, this assessment will be conducted using existing reports, studies and assessments. Additional data should be collected as possible within existing time and security constraints to complete the rapid assessment.

- On the basis of the rapid assessment, evaluate the immediate and longer term public health supply needs of Afghanistan and identify alternatives for addressing these needs. The assessment will examine all dimensions of the supply system from procurement, to quality assurance, to storage and distribution, and to linkage with demand and financing among others.
- Analyze the feasibility and implications of each alternative and provide the financial and service-level analysis that will guide the selection from among the different alternatives. In evaluating options the need for making legal changes, changing government policy and/or regulations, should be taken into consideration when assessing their feasibility. The role of each level of government (National, Provincial, District) and of donors in the provision the recommended system should be determined.
- Prepare an initial budget costing for the recommended option with detailed costing for the initial phase of the implementation plan for the various proposed activities. Potential

obstacles to successful implementation should be identified and strategies for overcoming them proposed.

- Taking the difficult national and geographical context fully into account, the feasibility of the recommended option must be demonstrated through the willingness and ability of the Afghan government, with donor support, to sustain the proposed solution, operationally and financially, over the medium-to-longer term.
- Identify key outputs and indicators for monitoring the implementation of the proposed supply system

ANNEX F: COLLABORATORS AND PARTNERS

- Dr. Faizulla Kakar, Deputy Minister for Technical Affairs, MOPH
- Dr. Abdul Khalil Khakrad, Administrative and Planning Manager, GDPA, MOPH
- Director of Pharmaceutical Planning, PPD, MOPH
- Director General of Pharmaceutical Affairs, MOPH
- Dr. Hayabulla Nawabi, Director of Procurement, General Directorate of Medical Drugs and Equipment, GDAA, MOPH
- Dr. Asif Safer, MOPH consultant attached to CMS
- Mr. Mizra Mohammed Ayubi, Deputy Director, Pharmaceutical Enterprise, MOPH
- Dr Said Jawid Atef, Drug Administrator & Medical Supply Director, Afghanpharma Holding Group
- Mr. Habibullah Emal, Kabul Manager, Afghanpharma Holding Group
- Dr. Mohammed Naseem, Public Health Director, HealthNet TPO
- Dr. Ahmed Khalid Fahim, Deputy Director of Operations, Swedish Committee for Afghanistan
- Dr. Juma Khan Nasir Khairzada, Director, BDN and Chairman of CPDS
- Mr. N. A. Rengarajan, Station Manager, AFEX Logistics
- Dr. Paul Ickx, Tech-Serve
- Dr. Steve Solter, Tech-Serve
- Dr. Abdullah, Director, Tech-Serve
- Steve Morgan, Operations Director, Tech-Serve