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Statement of
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on

“Improvements and Challenges in the Afghan National Army Pharmaceutical Distribution Process”

Good morning Chairman Chaffetz, Ranking Member Tierney, and distinguished members of the Subcommittee. Thank you for the opportunity to appear before you today to discuss our audit of the Afghan National Army (ANA) pharmaceutical distribution process.[1] Following three decades of war, the health care system in Afghanistan did not meet any internationally recognized standard. In order for the Afghan National Security Force (ANSF) to become fully independent and effective in conducting combat operations, it was recognized that the health care delivery system would need to be capable of providing essential field-level combat casualty care, evacuation of casualties, restorative surgery and rehabilitation, and long-term care for disabled personnel.

Since 2008, the Department of Defense Inspector General (DoD IG) has provided ongoing oversight of the U.S. Military and Coalition efforts to develop the Afghan military health care system, which includes the Dawood National Military Hospital (NMH),[2] completing eight oversight projects including five assessments, one audit, and two criminal investigations. In addition, there is an ongoing assessment of U.S. Military, Coalition, and ANA efforts to improve the management of healthcare services provided at the NMH.

[1] Report No. DODIG-2012-083, "Additional Guidance and Training Needed to Improve Afghan National Army Pharmaceutical Distribution," May 7, 2012.

[2] The NMH complex includes among other things; the hospital, built in the early 1970s by the Soviet Union; an out-patient clinic; the Armed Forces Academy of Medical Sciences; and a recently constructed medical warehouse. The NMH is under the command of the ANA Surgeon General, is managed by the ANA Hospital Commander, and staffed by ANA medical personnel.

Our audit of the ANA pharmaceutical distribution system was initiated after a February 2011 assessment by the DoD IG performed at the NMH which identified pharmaceutical accountability concerns. The overall objective of the audit was to determine whether the ANSF pharmaceutical distribution process was effective. During the audit we evaluated ANA's processes for procuring, delivering, and taking inventory of a wide variety of pharmaceuticals. We conducted site visits at six ANA locations including the National Supply Depot (NSD) in Kabul, NMH, Mazar-e Sharif Regional Military Hospital and its Forward Supply Depot, and the Kandahar Regional Military Hospital and its Forward Supply Depot.

Overall, we found that the pharmaceutical distribution process had improved since the previous assessment. However, the procurement, delivery, and inventory control processes for pharmaceuticals at ANA medical facilities and depots could be improved. Until these improvements are realized, the ANA will be unable to develop reliable pharmaceutical requirements. In addition, the pharmaceutical distribution process is at risk of mismanagement, theft, and waste of U.S.-funded pharmaceuticals. These challenges could also hamper the transition of the distribution process to full ANA control.

Early Improvements Identified

Since our February 2011 assessment, we noted improvements in the pharmaceutical distribution processes. For example, we reported that ANA officials conducted their first

procurement of pharmaceuticals and medical supplies. Specifically, ANA officials selected vendors and awarded a $4.7 million contract in September 2011. During the procurement process ANA officials developed and validated pharmaceutical requirements, developed the contract terms and conditions, and obtained vendor qualifications.

We also reported that ANA officials at the NSD demonstrated their ability to receive, account for, and prepare Afghan-procured pharmaceuticals to be issued to the forward supply depots and the NMH. For example, ANA officials inspected and verified the quantity, type, and quality of the pharmaceuticals. ANA officials also demonstrated their ability to complete the proper forms to record the movement of pharmaceuticals in and out of the depot and recorded the increases and decreases to stocks on hand. Further, ANA officials were able to properly account for pharmaceuticals at the NSD. For example, we selected 22 of 170 pharmaceuticals items to verify inventory accountability and found no discrepancies. We also observed various access controls implemented such as a locked, temperature controlled room.

Additional Challenges Must be Overcome

While our report highlights some improvements, we also found that the new distribution process had not been fully implemented at the forward supply depots and medical facilities. For example, there were deficiencies in the procurement process, such as ANA officials being unable to provide documentation verifying whether vendors were

evaluated based on their ability to meet contract requirements. Those deficiencies were highlighted when none of the 11 vendors were able to deliver all of the pharmaceuticals in accordance with contract requirements. Subsequently, ANA officials issued a contract modification allowing vendors more flexibility to meet contract requirements.

We also found deficiencies in the delivery and inventory control processes. Of the six supply depots and medical facilities reviewed, four did not properly account for pharmaceuticals. For example, 24 of the 32 line items we selected at Kandahar and Mazar-e Sharif medical facilities had discrepancies. At the Kandahar medical facility, discrepancies ranged from 20,772 fewer units of Amoxicillin on the floor than on record and 328 fewer vials of morphine. We were unable to fully complete inventory testing at two other locations because of the inability of ANA officials to provide consistent and reliable inventory data. For example, we could not verify the accuracy of on hand inventory at the NMH because the dispensing documentation was not reconciled to the stock accounting record. However, for the items we selected to verify whether the NMH property record was complete and accurate, 6 of 14 had discrepancies ranging from 6 to over 200 units.

Two of the six supply depots and medical facilities did not have adequate inventory access controls in place for controlled pharmaceuticals, which are more susceptible to abuse and theft. For example, ANA officials at the Kandahar Regional Hospital left controlled pharmaceuticals, such as morphine, unattended and unsecured and did not

properly secure the entry door where those pharmaceuticals were stored. Further, we found at both the NMH and the Kandahar Regional Hospital that controlled pharmaceuticals were not separately secured from uncontrolled pharmaceuticals.

We also found that none of the six supply depots and medical facilities properly used or completed all forms, and in some cases, used other processes, such as spreadsheets and tally charts. Yet, the consistent and proper use of forms is imperative to obtaining accurate and reliable data. For example, inconsistent and unreliable pharmaceutical usage data increases the risk of procuring improper quantities of pharmaceuticals. By procuring improper quantities of pharmaceuticals, the ANA could waste U.S. funds, procuring unnecessary or insufficient amounts of pharmaceuticals needed for patient care. We concluded that ANA officials need to develop additional guidance for medical facility personnel on how to collect and report pharmaceutical usage. Once developed and fully implemented, this guidance should increase assurance that accurate and reliable usage data is provided on a reoccurring basis to consistently generate pharmaceutical requirements for procurement.

With the new pharmaceutical distribution process still early in its implementation, we also concluded that ANA officials required a communication strategy and additional training at the forward supply depots and medical facilities. During our interviews, officials at the forward supply depots and medical facilities were unable to demonstrate the same level of understanding as ANA officials at the NSD. For example, ANA

officials at Mazar-e Sharif and Kandahar were unaware of the new process. Until ANA officials are fully trained on the proper use of forms and gain buy-in from the Afghans on the new distribution process, inventory discrepancies will likely continue and opportunities for theft of materials will remain a serious problem within the Afghan military health care system.

We recommended that the U.S. Combined Security Transition Command-Afghanistan (CSTC-A) assist ANA officials in developing a communication strategy and training program to effectively implement the new process and obtain Afghan buy-in at the forward supply depots and regional medical facilities. In addition, we recommended that CSTC-A assist ANA officials in providing training and developing guidance on the new distribution process.

Improvements Continue to be Made

During the course of our audit, we notified CSTC-A of some of our preliminary concerns for each of the locations visited. Both CSTC-A and ANA officials provided actions taken or planned to address those concerns. For example, at the NMH, we provided CSTC-A officials with our concerns about inadequate storage space and staffing of pharmacy positions. In response, ANA officials stated that they moved consumables to a separate location to allow for more storage space to further improve pharmaceutical accountability. In addition, CSTC-A officials stated that they were in the process of resolving the pharmacy staffing concerns with senior ANA officials.

At the regional locations, we provided CSTC-A officials with our concerns about physical access controls, communication and training on use of forms, and controls over expired pharmaceuticals.[3] ANA officials in Kandahar stated that they planned to obtain a locked cabinet for controlled substances, conduct training to ensure pharmaceuticals are secured, and separate and use expired pharmaceuticals only when necessary. CSTC-A officials also agreed to provide additional training emphasizing the proper use of forms. In addition, CSTC-A officials stated that they encouraged ANA medical facilities personnel to secure pharmaceuticals and noted improvements during their routine observations. Finally, CSTC-A officials stated they planned to assist ANA officials in developing a policy on use of near or recently expired medications.

As recently as June 2012, CSTC-A in coordination with ANA officials took corrective action to close some of our recommendations. For example, CSTC-A officials provided modified training modules that include the proper use of forms and issued additional guidance to ANA hospitals. Other documentation included the new NMH standard operating procedures and revisions to existing guidance on the use of expired pharmaceuticals.

During the last week of June 2012, a DoD IG team inspected the NMH to review the status of U.S., Coalition, and ANA efforts to improve the management and healthcare

[3] In addition to our preliminary concerns, we also highlighted best practices when identified at each location. Best practices not previously mentioned include Mazar-e Sharif forward supply depot officials providing medical instrument cases to medical facilities and local ANA units picking up pharmaceuticals to reduce the risk of damage during transport.

services provided at the facility, including the medical logistics processes and accountability and control of medical supplies. In its preliminary observations, the team noted that progress had been made at NMH since the February 2011 inspection by the DoD IG. They noted improved medical logistics system performance, improved accountability for medical supplies, and a fully operational NMH medical warehouse. However, there are still challenges that need to be addressed. For example, the pharmacy department continues to experience personnel shortages that may hinder the ability of the NMH pharmacy to perform sufficient quality control measures. Further, the security and accountability of controlled pharmaceutical substances in the bulk storage area and medication in the pharmacy dispensary were still insufficient.

Conclusion

While there has been progress in the pharmaceutical distribution process, until ANA officials and CSTC-A make additional improvements, the ANA will be unable to develop reliable pharmaceutical requirements. Further, the pharmaceutical distribution process is at risk of mismanagement, theft, and waste of U.S.-funded pharmaceuticals. These challenges could delay the transition of the distribution process to full ANA control. DoD IG will continue to provide oversight of the U.S. Military and Coalition efforts to support the Afghan health care system.

This concludes my statement today and I would be happy to take any questions the Committee may have for me.