

# **Report of the Nigeria Procurement and Supply Management**

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## ***Stakeholders' Meeting on Global Fund (Malaria) Grants to Nigeria***

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Catherine Adegoke  
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*September 2007*

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## **About RPM Plus**

RPM Plus works in more than 20 developing countries to provide technical assistance to strengthen pharmaceutical drug and health commodity management systems. The program offers technical guidance and assists in strategy development and program implementation both in improving the availability of health commodities—pharmaceuticals, vaccines, supplies, and basic medical equipment—of assured quality for maternal and child health, HIV/AIDS, infectious diseases, and family planning and in promoting the appropriate use of health commodities in the public and private sectors.

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## ACRONYMS

ACT	artemisinin-based combination therapy
BCC	behavior change communication
CCM	country coordinating mechanisms
CHAN	Christian Health Association of Nigeria
CHAN MediPharm	CHAN MediPharmaceuticals
CMS	Central Medical Stores
DPS	Directorate of Pharmaceutical Services
FCT	Federal Capital Territory
FDS	Food and Drug Services (of the Federal MoH)
GFATM	Global Funds to Fight AIDS, Tuberculosis and Malaria
IDA	International Dispensary Association
IEC	information, education, and communication
ITN	insecticide-treated net
LFA	local funding agent
LGA	local government area
LLIN	long-lasting insecticidal net
M&E	monitoring and evaluation
MAC	Malaria Action Coalition
MOU	Memorandum of Understanding
MSH	Management Sciences for Health
NAFDAC	National Agency for Food and Drug Administration and Control
NGO	nongovernmental organization
NMCP	National Malaria Control Program
NPI	National Program on Immunization
NPO/MAL	National Program Officer (Malaria)
PR	principal recipient
PSM	procurement and supply management
RBM	Roll Back Malaria (initiative)
RPM Plus	Rational Pharmaceutical Plus (Program)
SFH	Society for Family Health
SON	Standards Organization of Nigeria
SP	sulfadoxine-pyrimethamine
SR	subrecipient

STG	standard treatment guidelines
TA	technical assistance
TOR	terms of reference
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization
YGC	Yakubu Gowon Center

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The Nigeria Procurement and Supply Management Stakeholders' Meeting, "To Develop a Participation and Monitoring Framework for the Implementation of the PSM Component of the Global Fund (Malaria) Grants to Nigeria" was held February 5–7, 2007, in Abuja, Nigeria. It was organized and conducted by the Rational Pharmaceutical Management (RPM) Plus Program of Management Sciences for Health in collaboration with the Procurement and Supply Management Stakeholders in Nigeria.

The procurement and supply management meeting was carried out using funds provided by the U.S. Agency for International Development Mission to RPM Plus through the Malaria Action Coalition.

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- Dr. T. O. Sofola, Coordinator of the National Malaria Control Program, Federal Ministry of Health, Nigeria
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- Dr. B. S. Fatunmbi, National Professional Officer for Malaria Control, World Health Organization
- Dr. E. I. Gemade, Principal Officer, Health, United Nations Children's Fund
- Mrs. G. O. Abumere, Deputy Director, Federal Ministry of Health, Food and Drug Services Focal Officer, National Malaria Control Program
- Mrs. O. Otsemobor, Monitoring and Evaluation Focal Person, National Malaria Control Program, Federal Ministry of Health
- Staff of the Federal Ministry of Health Roll Back Malaria Secretariat
- Staff of the Yakubu Gowon Centre
- Staff of the federal Central Medical Stores, Lagos
- Agencies in attendance, represented by—
  - National Agency for Food and Drug Administration and Control—Mrs. R. Momodu
  - Society for Family Health—Dr. U. Gilpin, Mr. W. Adedeji, and Dr. E. Nwokolo
  - International Dispensary Association—Mr. Bart Vander Grinten
  - Community Participation for Social (Sector) Services—Dr. Muzan Siddiq and Mr. Duza Baba

- United Nations Children's Fund—Mr. A. Osuji
- CHAN MediPharmaceuticals—Mr. M. Omotosho and Mr. T. Tarhembah
- State (Roll Back Malaria) Program Managers—Bayelsa, Borno, Ebonyi, Ekiti, Federal Capital Territory, and Sokoto
- State Directors of Pharmaceutical Services—Bayelsa, Borno, Ebonyi, Ekiti, Federal Capital Territory, and Sokoto

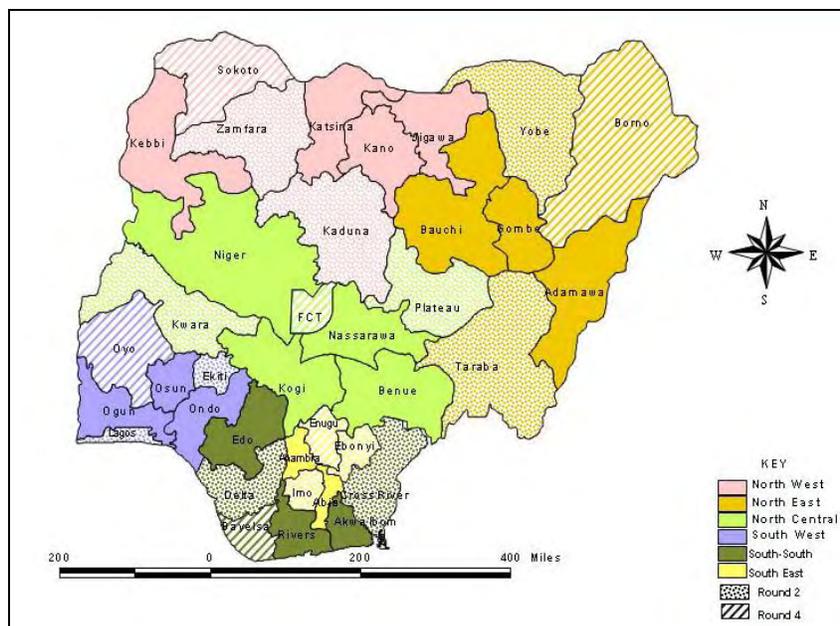
Finally, the authors thank all the Management Sciences for Health/Nigeria office staff and all others who contributed to the organization and coordination of the meeting.

## EXECUTIVE SUMMARY

The Federal Republic of Nigeria has received two Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) malaria grants that cover 18 of the 36 states and the Federal Capital Territory (FCT) (Figure 1). The principal recipient (PR) for both rounds is the Yakubu Gowon Center (YGC), and the subrecipient (SR) is the National Malaria Control Program (NMCP) of the Federal Ministry of Health (FMOH). In the recent past, Nigeria has had to respond to queries by GFATM to prevent the country from being issued a “No Go” verdict for Phase 2 of both its GFATM malaria grants. The threat to the grants was consequent to the slow start up, poor burn rate, and low achievement of targets. The situation was caused by several factors, among which were the poor understanding of GFATM processes and the lack of clarity of roles and responsibilities of key actors including the PR, SR, implementers and other partners. Furthermore, there was inadequate coordination among partners in the areas of program management, procurement and supply management (PSM), and monitoring and evaluation (M&E) as well as chronic health systems challenges such as in human resources and logistics.

In anticipation of further GFATM challenges to grant implementation, Nigeria requested technical assistance (TA) from the Malaria Action Coalition (MAC) to address implementation bottlenecks. The Nigeria team envisioned a two-phase approach. Phase 1 would involve all partners working together over a two-week period with the PR, the SR, and other partners to address the overarching organizational concerns of (1) management and coordination, (2) monitoring and evaluation (M&E), and (3) PSM. Phase 2 would then follow up on MAC partner-specific issues to be arranged as convenient. ACCESS would provide TA in capacity building planning in MIP, RPM Plus would help develop action planning for PSM down to the local government area (LGA) and facility levels, and WHO would follow up on M&E strengthening and coordination.

Following the MAC Phase 1 TA, Nigeria reported to GFATM on implemented actions to rectify identified issues and challenges, and provided details of ongoing actions and immediate plans for other requisite actions.



**Figure 1. Map of Nigeria Highlighting GFATM-Supported States<sup>1</sup>**

Nigeria has now received provisional approval to continue program implementation of Phase 2 of the grant. Strengthening the PSM component, within the purview of RPM Plus Program support, had been earmarked under the Phase 2 TA, and was adopted at the PSM stakeholders meeting as one of the strategies.

The three-day PSM stakeholders meeting was held in Abuja, Nigeria, February 5–7, 2007. More than 41 participants attended, including 14 from the national level (MoH), 17 from national and international agencies, and 11 from 6 states representing the six geopolitical zones of Nigeria. The meeting, which included plenary presentations, discussions, and group work, was arranged and facilitated by the Management Sciences for Health (MSH) RPM Plus Program.

To assist Nigeria in demonstrating timely coordination and results, RPM Plus support was geared to develop a participatory and monitoring framework for PSM. Thus the meeting was aimed at clearly defining the roles of different partners, developing a distribution model to rectify the current vague distribution and supply system for antimalarial medicines and commodities at all levels, and finalizing the draft memorandum of understanding (MOU) to be signed by the GFATM grant SRs (at the state level).

The PSM stakeholders' meeting was structured to deliver significant outputs, which are summarized as follows—

- Identification of key stakeholders concerned with malaria PSM, particularly those that can contribute to distributing antimalarials efficiently

<sup>1</sup> North Central states includes FCT.

- Development of a draft to define specific roles for PRs, SRs, states, local government areas (LGAs), health facilities, and communities in malaria medicine distribution
- Identification of the distribution channels for malaria medicines and commodities—a distribution flowchart was revised and amended for the public sector. Then the private sector distribution was considered.
- Assembly of policies related to the selection, procurement, distribution, and use of antimalarials at the federal, state, and LGA levels
- Definition of roles of the Roll Back Malaria (RBM) partners' in monitoring the malaria PSM
- Review of the draft of a comprehensive MOU with particular reference to GFATM medicines and commodities (PR and SR with partners, state participants, and legal and financial experts)
- Assembly and review of PSM tools—for implementation and monitoring

A previous NMCP commitment, however, shortened the PSM stakeholders meeting from the planned four days to three days. In addition, one of the meeting's major objectives—assigning lead status to a PR—was not accomplished because the reforms on the major stakeholders for the Phase 2 GFATM grant to Nigeria had not been concluded prior to the meeting.

PSM meeting recommendations were multidimensional and addressed the following issues—

- The need to accurately capture antimalarial medicine and commodity use, consumption data, supervision, monitoring and evaluation (M&E), feedback, and the institutionalization of statutory meetings
- The call for regular funding and strengthening logistics and infrastructure for medicine storage, distribution, inventory management, and M&E, especially in the public health sector
- The need for effective collaboration at all levels between PRs, SRs, sub-SRs, the federal and state MoHs, parastatals, and agencies and line governments at all levels (i.e., other government entities that have roles to play in the functioning of a ministry), partners, national and international agencies, and the private sector
- The need for capacity building for PSM and M&E for all levels of implementers

The immediate next steps from the PSM stakeholders' meeting was documenting and disseminating the meeting report to national authorities and partners; collecting and collating the completed capability matrixes, for which the template was distributed to key PSM stakeholders at the meeting; and finalizing all PSM tools for dissemination; and pilot testing by the end of February 2007.

In conclusion—keeping in view the new arrangements for Phase 2 of the implementation of the GFATM grant in Nigeria to include additional PRs and SRs—it is important to quickly apply the outputs of this meeting towards improving the quality of the implementation processes and data management. Carefully managing the private sector's new roles will help actualize the PSM program targets, given the immense potentials of the private sector for adding value to quality and delivery.

The integration of M&E for malaria PSM into existing federal MoH structures will ensure efficiency and sustainability of adopted processes. The support (improvement of funding, logistics, and infrastructure) from the highest levels of government, and partners, especially to the public sector, is vital to achieve the targets of the RBM Initiative.

# INTRODUCTION

## Background

MSH/RPM Plus Program has received funds from USAID to develop strategies to implement malaria policies and to provide technical assistance in pharmaceutical management issues for malaria. RPM Plus is one of the technical partners in the USAID MAC, a partnership of four technical partners. The other partners are WHO, working primarily through its Africa Regional Office; the U.S. Centers for Disease Control; the Access to Clinical and Community Maternal, Neonatal, and Women's Health Program of JHPIEGO. RPM Plus has been working to improve pharmaceutical management for malaria in African countries by identifying and addressing the causes of poor access, ineffective supply, and inappropriate use of antimalarials.

Nigeria has received two GFATM malaria grants that cover 18 of its 36 states and the Federal Capital Territory (Figure 1). The PR for both rounds is the Yakubu Gowon Center, and the SR is the National Malaria Control Program, Federal Ministry of Health. Round 2 was entitled "Scaling Up Roll Back Malaria in 12 States in Nigeria" and started on November 1, 2004. The Round 4 grant was called "Improving Malaria Case Management through Promotion and Distribution of Pre-Packaged Artemisinin-Based Combination Therapy (ACT) and Training of Health Service Providers," and its start date was January 1, 2005.

In the recent past, Nigeria has had to respond to queries by GFATM to prevent the country from being issued a "No Go" verdict for Phase 2 of both its' GFATM malaria grants. Anticipating further GFATM challenges to grant implementation, the Federal Republic of Nigeria requested technical assistance from MAC to address the bottlenecks.

In response, MAC partners proposed and implemented an initial joint two-week trip to Nigeria (TA Phase 1) to be followed shortly thereafter by a two- to three-week trip (TA Phase 2). Together, MAC partners assessed the GFATM malaria grant status and provided TA aimed at resolving the bottlenecks impeding grant implementation. The details of the initial trip can be found in *Report on Technical Assistance on Implementation Bottlenecks for the Global Fund Malaria Grants in Nigeria: Phase 1 Activities*, September–October 2006.

Following the MAC Phase 1 TA, Nigeria has successfully reported to the GFATM on implemented actions to address and rectify the identified issues and challenges and has provided details of ongoing actions and immediate plans for other requisite actions.

Nigeria now has provisional approval to continue program implementation of Phase 2 of the grant—strengthening the system for better delivery of medicines and commodities. The strengthening of the PSM component, within the purview of RPM Plus support, had been earmarked under Phase 2 support, and was adopted at the PSM stakeholders meeting as a key strategy.

## **Objectives of the Stakeholders' Meeting**

The meeting's goal was to strengthen the PSM component of this program, and the major objectives were to—

- Produce a framework to actively engage RBM partners in the procurement, distribution, rational use, and tracking of antimalarial medicines and commodities, with all the stakeholders having clearly specified and agreed-upon roles
- Comprehensively address distribution and inventory management issues of antimalarial medicines and commodities
- Address salient issues to strengthen the monitoring and feedback systems for malaria PSM concurrently with the distribution plan for medicines and commodities

## **Expected Outcomes of the Stakeholders' Meeting**

The following outcomes were expected from the three-day meeting—

- Identification of key stakeholders concerned with malaria PSM, and those that can help distribute antimalarials efficiently
- Development of a draft document that would specify roles for PRs, SRs, RBM partners, states, LGAs, facilities, and communities in malaria pharmaceutical distribution
- Development of a draft framework matrix for malaria PSM stakeholders
- Determination of the terms of reference (TOR) for the Malaria PSM Technical Committee and a proposal for the constitution of the committee
- Identification of distribution channels of malaria medicines and commodities (a distribution flowchart was revised and amended)
- Assembly of policies related to the distribution and use of antimalarials at the federal, state, and LGA levels
- Definition of the roles of RBM partners in monitoring the malaria PSM processes
- Review of the draft of a comprehensive MOU with particular reference to GFATM pharmaceuticals and commodities (by the PR/SR with RBM partners, state participants, and legal and financial experts)

## METHODOLOGY

The three-day meeting, held in Abuja, February 5–7, 2007, was designed to be serialized. The first part (a one-day meeting) would develop a participatory framework for PSM in Nigeria and involve primarily the stakeholders from the national level as well as partners and agencies. (See Annex 1 for a complete list of the participants.) The second part (a two-day meeting) would combine the stakeholders represented on day 1 and participants from the state level, that is, two participants each from six states selected from each of the six geopolitical zones in Nigeria (an expected total of 12 participants from the state level). Each state sent one state RBM Manager and one state pharmacist in charge of antimalarial medicines and commodities as participant-designates. The states sampled for the meeting were—

- Bayelsa (south-south)
- Borno (northeast)
- Ebonyi (southeast)
- Ekiti (southwest)
- Federal Capital Territory (north central)
- Sokoto (northwest)

The meeting was designed to be highly interactive, with targeted plenary presentations that disseminated the current status of issues to be discussed or worked on, combined with presentations of draft documents to be reviewed and adopted, such as the MOU and the distribution model for antimalarials.

By design, the stakeholders' meeting sessions consisted of a combination of the following methods—

- Presentations (plenary)
- Discussions (plenary)
- Group work, followed by plenary presentations and discussions
- Resolutions and commitments
- Meeting evaluation

The meetings were conducted in English, and all materials were prepackaged for the participants. Meeting materials were developed, assembled, or distributed by the RPM Plus consultants facilitating the PSM stakeholders' meeting along with the major stakeholders (Annex 2).



## PROCEEDINGS OF THE NIGERIA PSM MALARIA STAKEHOLDERS' MEETING

This section presents a day-by-day summary of the sessions, the presenters, and when applicable, the highlights from the stakeholders' meeting. (Refer also to "Methodology" above and Annex 2.)

### **Day 1—February 5, 2007**

#### ***Session 1. Objectives of the PSM Stakeholders' Meeting***

**Presenter:** Dr. Catherine Adegoke, MSH/RPM Plus

##### ***Presentation Highlights***

Dr. Adegoke described the background for the PSM meeting (i.e., the Phase 2 TA initiated to Nigeria to help resolve the bottlenecks on implementing the GFATM grants for malaria).

#### ***Session 2. Situation of Malaria PSM in Nigeria***

**Presenter:** Dr. Catherine Adegoke, MSH/RPM Plus

Session 2 was an overview of procurement, supply, and distribution of antimalarials in general and the implementation of the GFATM Rounds 2 and 4 grants in particular. The new ACT policy was highlighted.

##### ***Presentation Highlights***

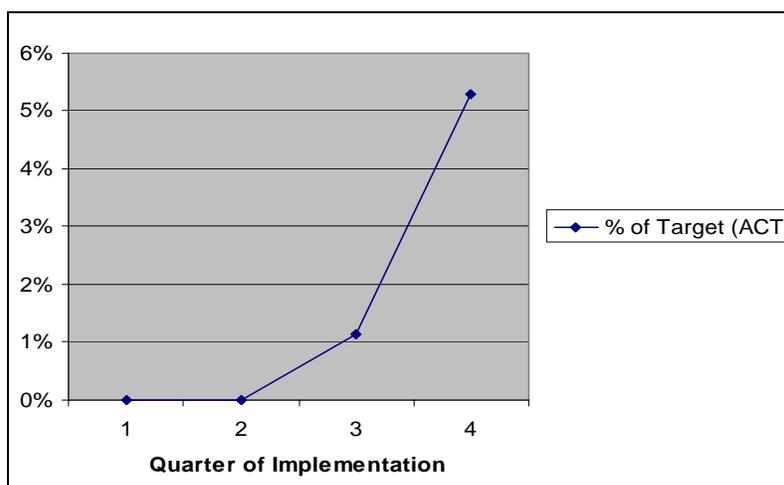
- Presentation of the new antimalarial medicine policy framework
- Outline of the processes and importance of pharmaceutical management practices
- Review of the general situation regarding pharmaceutical management for malaria in Nigeria
- Review of the situation of the implementation of the PSM component of the Nigeria GFATM Grants, Rounds 2 and 4
- Presentation of the recommendations made by the PSM group of the (September and October 2006) MAC TA on the GFATM implementation bottlenecks

### **Session 3. Presentation of the Reviewed Nigeria Malaria Workplan for PSM for GFATM Rounds 2 and 4 Grants**

**Presenter:** Dr. Baba Sheshi, YGC—PR

#### ***Presentation Highlights***

- Introduction to GFATM Grants (Rounds 2 and 4) procurement, distribution (of Coartem, SP, and long-lasting insecticidal nets [LLINs]), and implementation processes for the projected targets (figure 2)
- Round 2 and Round 4 grant implementation results
- Review of grant implementation over both the short and long term
- Current implementation arrangements: PSM



**Figure 2. GFATM Grant Round 4 Percentage of People on ACT (Target)**

Dr. Sheshi presented the following comparison of the old and new implementation arrangements.

The old implementation arrangement entailed the following—

- The initial push of Coartem down the supply chain was based on population projections and estimates, as detailed morbidity data was scarce.
- Using a one-off delivery whereby imported supplies were all unloaded at one place, with minimal emphasis placed on establishing an effective distribution system.
  - Existing reordering and stock inventory forms were not used

- Outlining of inventory procedures was poor (e.g., clear definitions were lacking of minimum stocks at the different levels)
- A preset and predictable delivery schedule was lacking
- Vaguely defined commodity flow management created bottlenecks in the reporting system.

The new implementation arrangement entails the following—

- The new implementation arrangement provides for additional PR/SRs with specific capacity and experience in commodity logistic supply, particularly with the rollout of Coartem to the private sector. The mode of operation and TOR of the additional PR/SRs are yet to be developed by the country coordinating mechanism (CCM), however.
- Commodity deployment is done in a scheduled manner.
- A mechanism was developed for distribution of comprehensive delivery packages (inventory forms, stocks, and data capture tools).
- Inventory forms were developed and used to determine needs.
- Simple guidelines for commodity inventory management (i.e., operational manuals) were developed.
- To ensure monitoring, the roles and responsibilities of stakeholders are described in proposed TOR.
- Rollout of Coartem is done through alternative distribution channels (e.g., role model mothers, faith-based organizations, and the Association of General Medical Practitioners).

#### ***Session 4. Plenary Discussions***

Facilitator: Dr. O. Sofola, NMCP

The plenary discussions in Session 4 identified stakeholders concerned with antimalarials' procurement, supply, distribution, and use.

#### **Day 2—February 6, 2007**

#### ***Session 1. Objectives of the PSM Stakeholders' Workshop (Recap)***

**Presenter:** Dr. Catherine Adegoke, MSH/RPM Plus

Session 1 gave a summary of the purpose and objectives of the PSM stakeholders' meeting with the format adopted for their achievement.

## ***Session 2. Feedback from the States***

**Facilitator:** Dr. O. Sofola, NMCP

### ***Presentation Highlights***

Session 2 was dedicated to reports from the six states concerning their current capacity to absorb available ACTs and SP. A list of documents for states to present at the meeting had been included in the letters of invitation and included the following—

- Receipts records (with dates and quantities) of antimalarial goods and commodities (ACTs, SP, insecticide-treated nets [ITNs], LLINS)
- Distribution records (with dates and quantities) of antimalarial goods and commodities (ACTs, SP, ITNs, LLINS) to state and LGA facilities
- Consumption reports (per month) of ACTs and SP in state and LGA facilities
- Stock-out reports in state Central Medical Stores (CMS) as well as in state and LGA facilities (if any)
- Resupply reports of ACTs and SP to the state after each episode of stock-out (if any)
- Immediate needs for implementing the program, including PSM tools

The original plan had been to help the states combine their reports into a uniform format after the meeting on the second day to harmonize their presentations. At the plenary session of Day 2, however, the consensus was to use the feedback from the states as the starting point for the day's deliberations. Therefore, the data from states did not flow in a logical sequence—these data have been omitted from this report, but the examples of Sokoto are included as Table 1. Highlighted below are areas of needs and challenges in implementing the program in the different states. The comments from states are summarized here.

Bayelsa (south-south)

- Monitoring is poor because of the terrain; getting to some sites is difficult.
- Medicines are poorly utilized—primarily government hospitals in the urban areas are patronized; however, mobile clinics have been successful.
- Health-seeking behavior is still very poor. Patients prefer the traditional healers such as Mama Ijaws.

- Bayelsa discovered that ACTs were being distributed indiscriminately during activities of the National Program on Immunization (NPI).
- The collection of the use data is inadequate because malaria focal officers often complain of lacking funds to fuel the bikes provided for this purpose.

Borno (northeast)

- The state is experiencing stock-outs.
- Borno uses the WHO monitoring and evaluation meeting as a platform to collect data from the LGAs. Not all LGA RBM focal persons participate in this meeting, however, so the data being collected still has gaps.

Ebonyi (southeast)

- Quarterly meetings are held to discuss implementation issues and the status of stock.
- No stock-outs have been reported so far.
- The health staff who distributed the LLINs are requesting remuneration as applicable in the onchocerciasis program.
- Support from the LGAs is low.
- The M&E component needs to be strengthened.
- Pregnant women complain of the lack of water to take the SP.
- Allowance is being requested for the malaria focal person at the LGA.
- Periodic advocacy visits were solicited. The visit by Federal MoH and other partners led to the release of funds, which were used to purchase a laptop and a vehicle.
- The relationship between the RBM Manager and the Director of Pharmaceutical services needs to be harmonized.

Ekiti (southwest)

- Patronage of patients to the hospital has increased because the medicines are free.
- A budget for monitoring is lacking at all levels—state, LGA, and facility.
- The RBM Manager has had to use personal funds to convene meetings and collect data.
- Meetings are held every month to obtain use data from LGAs, which are compiled from facility generated data.

Federal Capital Territory (north-central)

- The RBM commodity use report has not yet been received.
- Funds are inadequate to carry out program logistics.
- LGA feedback is weak.
- Area councils lack commitment.
- Quarterly meetings are held with managers of area councils.
- YGC and FCT normally sponsor supervisory visits.

Sokoto (north-west)

- The working relationship between the RBM and the Director of Pharmaceutical Services is excellent.
- Sokoto has recorded an increase in the hospital patronage due to the availability of these medicines.
- The state has experienced stock-outs of SP.
- The state was not supplied with ITNs.
- All arms of the enforcement agencies are fully involved in preventing medicines leakage.
- Lack of funds to support the program has made logistics difficult.
- Monitoring is sporadic.

The challenges and needs at the state level can be summarized as follows—

- Regulations and structures are inadequate.
- Public sector staff has little or no training in program management.
- Government funding is absent or irregular and insufficient.
- Medicine distribution at the state and LGA levels is fragmented.
- Capacity building on inventory management is urgently needed at all levels.
- Logistics, including transport, is inadequate.
- All states need to make service providers, state and LGA authorities, and the general population aware of and have them advocate for malaria issues at appropriate levels.
- The availability of antimalarial medicines and commodities must be sustained.
- Stock monitoring and record keeping are inappropriate—and the commitment to data collection and collation is insufficient.

- Proper monitoring of processes at LGA and facilities needs to be addressed.
- The states use differing modes of reporting to agencies.
- Feedback is inadequate and improvised.
- Resources from government and partners need to be coordinated.

**Table 1. Use of ACTs in Sokoto State LGAs (March 2006 to January 2007)**

<b>LGA</b>	<b>Total Quantity Received (Starting March 2006)</b>	<b>Quantity in Stock (as of January 2007)</b>	<b>Percentage Utilization</b>
Binji	3,900	434	88.9
Bodinga	3,900	546	86.0
Dange-Shuni	6,000	2,086	65.2
Gada	6,930	0	100.0
Goronyo	3,900	2,766	29.1
Gudu	3,900	1,739	55.4
Gwadabawa	3,900	0	100.0
Illela	6,000	90	98.5
Isa	6,000	3,271	45.5
Kebbe	4,740	0	100.0
Kware	3,900	1,183	69.7
Rabah	6,000	1,303	78.3
Sabon Birni	3,900	2,678	31.3
Shagari	3,900	0	100.0
Silame	3,900	0	100.0
Sokoto N	8,100	0	100.0
Sokoto S	13,500	0	100.0
Tambuwal	6,000	1,657	72.4
Tangaza	6,000	3,918	34.7
Tureta	3,900	0	100.0
Uduth	31,350	24,210	22.8
Wamakko	4,680	0	100.0
Wurno	6,000	2,506	58.2
Yabo	6,000	1,377	77.1

### **Session 3. Presentation of the Reviewed Nigeria Malaria Workplan for PSM for GFATM Rounds 2 and 4 Grants**

**Presenter: Dr. Baba Sheshi, YGC—PR**

This session, a recap of Day 1, Session 3, was provided for the benefit of the participants from the states.

### **Session 4. Identification of Stakeholders Concerned with Procurement, Supply, Distribution, and Use of Antimalarials**

**Facilitator—Dr. E. I. Gemade, United Nations Children's Fund (UNICEF)**

This session's goal was to identify the distribution channels for PSM of malaria medicines and commodities (in line with new work plan).

### **Session 5. Proposal for Monitoring the Procurement and Supply Chain Management of Antimalarial Medicines**

**Presenters—Dr. Bayo Fatunmbi, WHO National Program Officer (Malaria) (NPO/MAL), and Mrs. Otsemobor, M&E, NMCP**

This session served to highlight the basic issues in M&E for malaria PSM in general and in relation to the GFATM grant in particular.

#### ***Presentation Highlights***

- Definition of some M&E concepts such as monitoring, evaluation, M&E tools, indicators, antimalarial medicines, procurement, and supply chain management
- Description of institutional arrangements for procurement and supply chain management (current situation and expectations)
- Discussion of the monitoring framework—inputs, processes, and outputs
- Discussion of the evaluation framework—outcomes and impact
- Description of procurement and supply chain management M&E tools, such as the following—
  - Reordering and stock inventory forms
  - Checklists
    - Stock levels

- Inventory procedures
- Delivery schedule
- Supervisory
- Malaria data capturing formats
- Definition of core indicators for routine reporting
- Discussion of medium-term outcome and impact reporting
- Delineation of programmatic indicators by service delivery area
- Discussion of the need to reach consensus on indicators
- Analysis of the way forward; states will need to—
  - Develop a supervisory and M&E plan
  - Define detailed activities, specifying who, when, and how
  - Budget for PSM M&E (5–10 percent of total budget)
  - Update all PSM and M&E tools
  - Produce the tools
  - Ensure supportive supervision at all levels
  - Coordinate with relevant agencies and bodies with comparative advantages
  - Improve data management and use at all levels
  - Ensure dissemination and feedback at all levels
- Conclusions
  - M&E helps to justify absorptive capacity and continued funding, enhance transparency, ensure accountability
  - M&E leads to timely and accurate reports and results dissemination

***Session 6. Plenary Discussion: Definition of Roles of RBM Partners in Monitoring the Malaria PSM Processes***

**Facilitator**—Mrs. Otsemobor, M&E, NMCP

**Day 3—February 7, 2007**

***Session 1. Group Work***

For a summary of the topics assigned for the four-and-a-half-hour group work sessions, please refer to the “Methodology” section above or to Annex 2.

## **Session 2. Plenary Presentation**

**Presenter**—Mr. Bart Vander Grinten, International Dispensary Association (IDA)

### ***Presentation Highlights***

- Introduction to IDA—a leading not-for-profit supplier of affordable health care
  - More than 700 customers and distributions to over 100 countries worldwide
  - Over 3,000 products in product range—750 pharmaceutical products available
  - Full-service package—from supplier selection to the end of the cycle with delivery
  - Product range—medicines, medical supplies, emergency health kits
- Strategic focus—available, quality assurance, affordability, customer service
  - List of partners—United Nations Development Programme, Médecins Sans Frontières, WHO, MSH, Clinton HIV/AIDS Initiative
  - PSM in-country (Nigeria)—HIV/AIDS pharmaceutical system (32,000 HIV/AIDS patients being treated with drugs supplied by IDA)
- Functioning of the PSM component—framework
- Capacity building activities—examples from the Netherlands, South Africa, and Nigeria
- IDA contact in Nigeria

## **Session 3. Group Work Presentation**

**Facilitator**—Mrs. Otsemobor, M&E, NMCP

Within each working group, there were three subgroups charged with the responsibility for particular reviews, compilations or completion. In this session, a member of the six subgroups made presentations to the rest of the participants, for further reviews and endorsement of the final documents to be delivered as outputs from the stakeholders' meeting. Groups 1 and 2, and their subgroups A, B, and C, were asked to present the results of their discussions to the rest of the participants.

## **Session 4. Challenges, Recommendations, and Next Steps**

**Facilitators**—Dr. B. Fatunmbi, WHO NPO/MAL, and Dr. Catherine Adegoke, RPM Plus

The results of this session are presented in the “Conclusions” section of this report. During this session, a meeting evaluation was conducted (Annex 3).

## CURRENT PSM ISSUES AND RESOLUTIONS (FROM WORKSHOP DISCUSSIONS)

Many issues were discussed during and after workshop presentations. These issues and their resolutions at plenary are presented in Tables 2 and 3.

**Table 2. Issues Raised in the State Presentations**

Topic	Query or Issue	Plenary Resolution
Financing and fund management	Funds for logistics are lacking.	Advocacy to the government will be carried out to solicit support. UNICEF has logistics data and can help in this regard.
Budgeting and financing	How can budgeting problems be prevented?  RMMs are asking for remuneration.	Budgeting must be precise and realistic—a detailed plan of action is needed.  Caregivers could give a token to the RMM for transport to facilities to pick up the medicines.
Advocacy	Advocacy visits are few and far between for some states.	More advocacy visits will be made to other states to garner support for the program.
Inventory management	Who receives the antimalarial medicines on delivery at the state level?  RBM managers are in custody of the medicines in some states.  How does one stop leakages of the medicines and commodities?  There is sometimes disparity in the amount of RBM commodities received. (Note: Definition of stock supply discrepancies—when excess or shortage of stock is supplied in relation to amount declared in the documentation)  Prescription forms are in inadequate supply.	The PR should supply the medicines to the designated pharmacists.  The pharmacist in the program should be in charge of storage.  Proper documentation and prompt reporting with the PSM tools are essential.  Pharmacies must keep proper records.  Discrepancy forms should be used when commodities received differ from the declared amount supplied.  A needs assessment will be carried out, so that correct amount is obtained from the supplier.
Access to medicines	Pharmacists and pharmacy technicians close shop at 4:00 p.m. and are not available to dispense the medicines to patients at odd hours.	An RMM should be used to get the medicines to the patient. If remuneration is required, the community should mobilize funds to pay for it.

Topic	Query or Issue	Plenary Resolution
Medicine prescription and dispensing	Clarity is lacking about who can dispense the medicines.	This issue is to be addressed in the MOU, to obtain the commitment of the states. Flexibility must be used in implementing the policy (e.g., nurses can dispense the medicines if the pharmacists or pharmacy technicians are not available).
Data management	<p>How should medicine use be tracked? How does one track use data from home-based treatment, faith-based organizations, and RMMs? How does one prevent abuse?</p> <p>Retrieving information from tertiary institutions in the state has been difficult because medicines are supplied to them directly by the PR.</p> <p>Feedback on data is poor.</p> <p>The collection of data has been difficult.</p>	<p>Training and training tools should be supplied to encourage and improve data keeping.</p> <p>Abuse can also be prevented by keeping good data, followed by verification.</p> <p>Their medicines will be distributed via the state CMS from now on.</p> <p>They should report directly to the State Directorate of Pharmaceutical Services (DPS).</p> <p>Feedback mechanisms will be improved along the line up to the state RBM/DPS, Federal MoH/NMCP, and the PR with current arrangements.</p> <p>Managers of the RBM should have monthly—<i>not</i> quarterly—meetings so that data are collected.</p>
Information management	There is an acute paucity of information on current issues.	Meetings must be held with stakeholders and information must be shared.
Training at community level	Opinion leaders, vendors, RMMs, and other voluntary groups should be trained.	Refresher courses should be given, and other groups already involved in the village health care should be integrated.

**Table 3. General Implementation Issues**

Topic	Query or Issue	Plenary Resolution
Artemisinin monotherapy	Why are artemisinin monotherapies still in the market despite the ACT policy?	NAFDAC has directed that already registered monotherapies be relabeled to reflect that they are “not to be used singly but in combination,” or in the alternative, such products could be repackaged locally until the license expires. All existing orally administered artemisinin monotherapies shall not be renewed at the end of the life span of the certificate.
Procurement	How does one curtail late procurement in Phase 2 of the grant because this affected the program in Phase 1?	Late procurement and clearance at the ports occurred as a result of the delay in obtaining the waiver to clear. This issue has been taken care of by the Ministry of Finance. The port is clearing the ACTs and commodities faster now.
Budgeting	Funds supplied are not adequate to perform the designated activities.	In Phase 2, detailed costs are being taken into consideration, including all activities up to the end user.
Fund flow	Sometimes the funds sent are delayed or stuck at the state MoH.	Processes for fund flow must be streamlined for efficiency.
Federal CMS	Is there an enabling law to permit staff of the federal CMS to be at the ports?  Medicines and commodities are being kept in the CMS for long periods without any distribution.	International agencies are tasked to procure the medicines and other commodities, to ensure delivery to the states, and to provide seamless distribution. The federal CMS, however, will be involved in taking inventory of the items, which may be a physical or virtual oversight.  All supplies must be accompanied by distribution lists at the federal, state, and LGA.
Quantification at the federal level	How does one determine the right amount to supply to the facility?	This determination should be made using the use data. More important, accurate quantification means getting the medicines and commodities to the places where they are needed. Studies on health-seeking behavior have revealed that more children are being treated in private clinics.
Quantification of need at the facility level	How do facilities and states calculate what they need from the PR or SR?	States should share information on how they use consumption data to estimate future need.
Partners assistance for PSM logistics	This need must be anchored.	UNICEF can provide assistance because they have the cognate experience and resources.
Workplan of Phase 2 of the GFATM grant	Phase 1 overlaps Phase 2. GFATM will backdate the start date of Phase 2 when funds are released.	The Phase 2 workplan has identified the gaps in phase and will be structured to fill the gaps and improve target accomplishment.

<b>Topic</b>	<b>Query or Issue</b>	<b>Plenary Resolution</b>
Data management	<p>There is a disparity between consumption and distribution data.</p> <p>Why are consumption data not put into Excel form so the data can be processed more easily for use?</p> <p>Inadequate reporting may be due to difficult terrain and lack of logistics.</p>	<p>States should meet with federal MoH to harmonize these data.</p> <p>Officers must train themselves without waiting for government, even though the federal MoH plans to conduct training for all malaria control program officers on health management information system.</p> <p>The LGA malaria focal person should find a feasible means of collecting the data and sending them on to the state level.</p>
PSM tools	<p>Producing and using the tools seems cumbersome. Why has GFATM not provided the tools?</p> <p>Is it possible to capture the information in one form? Currently, some facilities use forms and some use registers.</p>	<p>Each country will have to develop its own tools and orient the users so that the M&amp;E will improve.</p> <p>The levels of health facility may be a strong factor in determining which type of system to use.</p>
Prescription forms	<p>How else can information be captured if one does not have prescription forms?</p>	<p>The prescription forms are to be used until the summary forms are launched. The doctors in facilities can prescribe normally, and then the staff of the pharmacy can record prescriptions in the dedicated notebooks.</p>

## **OUTPUTS FROM THE NIGERIA PSM (MALARIA) STAKEHOLDERS' MEETING**

The stakeholders' meeting effectively summarized and delineated the roles and responsibilities of the stakeholders, provided a list of the national policies that govern those roles and responsibilities, and distributed three documents (Annex 4) that further clarify the roles.

### **Roles and Responsibilities of Stakeholders**

Immediately below are lists of responsibilities for PSM of antimalarial medicines and commodities. Following the lists, Table 4 presents an expanded description of those roles, and Table 5 provides a template to help stakeholders understand and define their roles. Figure 4 provides a visual aid for understanding the roles and interconnections, and Table 6 outlines the distribution channels. Table 7 reviews the stakeholder roles for distribution, and Table 8 identifies the possible roles and responsibilities of organizations and agencies.

PRs—

- Procure medicines and commodities
- Oversee deliveries to all 18 state capitals
- Are responsible for final data management and reporting to GFATM
- Are responsible at the national level, along with the national authorities and the SR, for storage and inventory control of medicines and commodities
- Receive funds and disburse to SRs
- Hold oversight responsibility of SR activities on PSM
- Ensure timely disbursement of funds to SR for PSM activities
- Disburse funds for the training personnel

SRs—

- Develop delivery schedules
- Oversee and coordinate delivery from the states to the LGAs and health facilities
- Collect and collate commodity use and consumption use data
- Monitor commodity distribution
- Train personnel

States (sub-SRs)—

- Work closely with the SR; work under the SR
- Engage the actual delivery of commodities to the LGAs and the health facilities
- Supervise the distribution of commodities from the LGA to health facilities or end users
- Collate and transfer or submit commodity use data to the SR
- Ensure capacity building training of implementers

LGAs—

- Store and deliver the medicines and commodities
- Collect data for the health facilities that can be provided to the state

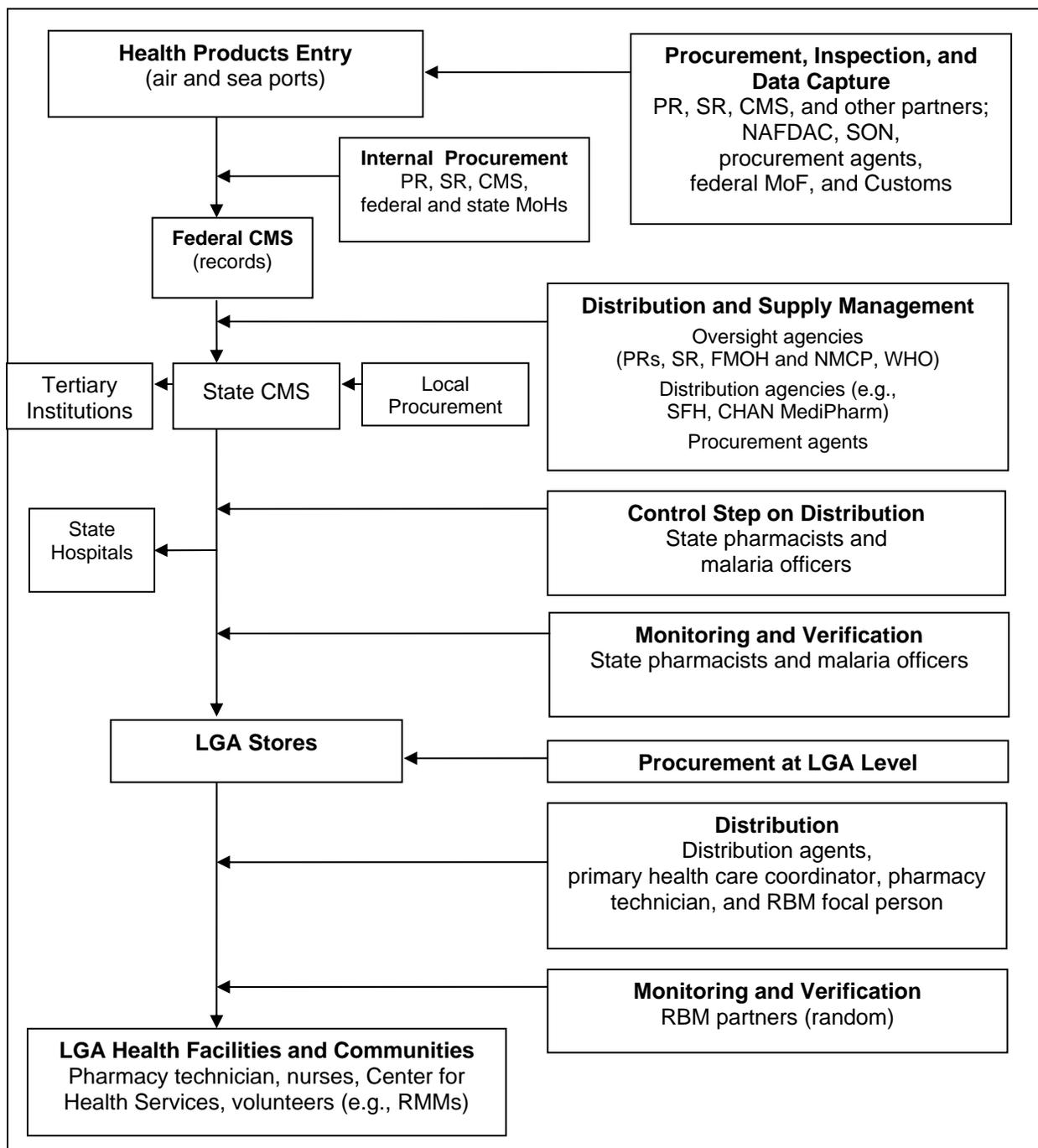
Health facilities—

- Ensure rational medicines use
- Capture commodity consumption data

**Table 4. PSM Roles and the Organizations and Agencies Involved**

<b>Activity and Activity Components</b>	<b>Organizations and Agencies</b>
<b>Phasing out old medicines</b>	
—	NMCP, Food and Drug Services (FDS), NAFDAC, WHO, Population Services International, states and LGAs, National Transitional Working Committee
<b>Procurement</b>	
Quantification	Federal MoH, state MoH (NMCP), WHO, UNICEF, FDS, PRs
Financial mobilization	Federal MoH, PRs, SRs, RBM partners (WHO, UNICEF, USAID, corporate bodies)
	Organized private sector
Tender	PR, federal MoH, procurement agents (e.g., Crown Agents, IDA)
Procurement	PR, Society for Family Health (SFH), federal MoH, state MoH, UNICEF, procurement agents (e.g., Crown Agents, IDA)
Clearing	PR, clearing agencies, NAFDAC, Standards Organization of Nigeria (SON), federal Ministry of Finance (MoF)
Quality issues	Federal MoH, NAFDAC, WHO, UNICEF, SFH, Pharmaceutical Society of Nigeria
<b>Distribution</b>	
Documentation	Federal MoH (NMCP), PRs, clearing agencies, procurement and distribution agencies (e.g., IDA, Christian Health Association of Nigeria, CHAN MediPharm), Customs
Storage	CMS and state CMS, NMCP, PRs, procurement agents (e.g., SFH, CHAN MediPharm)
Distribution planning (macro and micro)	NMCP, CMS, PR, MSH, WHO, UNICEF, state CMS, clearing and logistics agents (e.g., SFH, CHAN MediPharm)
Transport logistics	PRs, federal MoH, state MoH, LGAs, distribution agents (e.g., CHAN MediPharm, Virgin Atlantic)
Delivery scheduling	NMCP, PR, CMS, federal MoH and state MoH, LGAs, WHO, UNICEF, clearing and distribution agents (e.g., SFH, CHAN MediPharm)
<b>Inventory management</b>	
Coordination	PRs, SRs, NMCP, state MoH, LGAs, CMS and state CMS, SFH
Training	WHO, MSH, NMCP, PRs, federal MoH and state MoH, SFH, IDA





Note: Reviewed channels of distribution for antimalarial medicines and commodities—developed for the public sector.

**Figure 3. Distribution of Antimalarial Medicines and Commodities**

The guiding principles for the Medicine Distribution Model, (which had been developed during the Phase 1 of the GF MAC TA and was reviewed at the workshop) urges the creation of a system that—

- Draws from existing capacities in the public and private sector (especially from within the RBM partnership)
- Conforms with relevant government policies, without creating additional bureaucratic bottlenecks
- Provides clear guidelines on the obligations and roles of each player (PR, SR, CMS, and technical partners) and gives clear pathways for support supervision, active feedback, and an audit trail

**Table 6. Distribution Channels for Medicines and Commodities—Private Sector Issues**

Issues	Considerations	Plenary Resolution
Roles and coordination of public–private sector partnership	Is the private sector being strengthened with the funds, to the disadvantage of the public sector?	Private sector collaboration is intended to strengthen the distribution and supply chain.  It will also enhance use of medicines and commodities because a higher percentage of the population visits private health facilities.
Distribution	Who or what constitutes the private sector?	In terms of distribution, the Association of General Practitioners, community pharmacists, RMM, and faith-based organizations are considered to be the “private sector.” National Coalition of NGOs working on Malaria) will monitor and evaluate their activities.
Distribution and supply chain management under the private sector	Private central stores are to be run parallel to government central stores. How can professionalism be ensured?	The TOR will be spelled out.

*Note:* The flowchart for the distribution pipeline will be developed after the resolution of new PRs and SRs in the Implementation of the GFATM (malaria) grant for Nigeria.

**Table 7. Review of Stakeholder Roles in Distribution of Medicines and Commodities**

Note: This table covers the specific roles of stakeholders in antimalarial medicine clearing, storage, and distribution—as developed for implementation.

Agency or Organization	Documentation	Clearing	Storage	Distribution Planning	Transport Logistics	Delivery Scheduling	Inventory Management
PRs	✓	✓	✓	✓	✓	✓	✓
SRs			✓	✓	✓	✓	✓
Federal MoH, NMCP	✓	✓		✓	✓	✓	✓
Procurement agents (e.g., Crown Agents, IDA, CHAN Mediharm)	✓						
Clearing agents	✓	✓					
Federal MoF		✓					
NAFDAC		✓	✓				
Customs	✓	✓					
Distribution agencies and organizations (e.g., SFH, CHAN MediPharm)	✓		✓	✓	✓	✓	✓
Logistic partners (e.g., Virgin Atlantic)				✓	✓	✓	
Federal CMS	✓		✓	✓	✓	✓	✓
State MoH				✓	✓		
State CMS			✓	✓	✓	✓	
UNICEF				✓		✓	
WHO				✓		✓	✓
LGAs			✓	✓	✓	✓	✓
Health facilities			✓			✓	✓
Community agencies (e.g., Community Participation for Social [Sector] Services, UNICEF)						✓	✓

**Table 8. Roles and Responsibilities of Organizations and Agencies in PSM M&E**

Organization or Agency	Roles and Responsibilities	Remarks
<b>CCM</b>	<ul style="list-style-type: none"> <li>• Oversight for all GFATM grants</li> <li>• Advocacy (e.g., issues with Customs or clearance with federal MoF)</li> </ul>	M&E committee
<b>PRs</b> (YGC and others)	<ul style="list-style-type: none"> <li>• Management</li> <li>• Processing and release of funds to SRs</li> <li>• Data collation from states (through SRs)</li> <li>• Verification of data</li> <li>• Documentation</li> <li>• Feedback to relevant levels</li> </ul>	<ul style="list-style-type: none"> <li>• Verification done by local funding agent, CCM</li> <li>• Data to be sent to NMCP first</li> <li>• PR to translate data into report for local funding agent</li> <li>• Quarterly reports</li> </ul>
<b>SR</b>	<ul style="list-style-type: none"> <li>• Collaboration with PR to review activities</li> <li>• Monitoring of data from states, LGAs, and facilities</li> <li>• Supervision of roles and activities; training on PSM and M&amp;E</li> <li>• Production of tools</li> <li>• Planning and dissemination of reports</li> <li>• Advocacy to all levels for medicine and other RBM commodity procurement, distribution, and maintenance.</li> <li>• Feedback to relevant levels</li> </ul>	<ul style="list-style-type: none"> <li>• States to maintain adequate stock of tools</li> <li>• SR to ensure adequate quantities of tools</li> <li>• Monthly reports</li> <li>• SR to serve as custodian of data</li> </ul>
<b>Sub-SR</b>	<ul style="list-style-type: none"> <li>• Collection of data from health facilities through LGAs; analysis and transmission to the states and then to the national level</li> <li>• Training of implementers at designated levels</li> <li>• Field supervision of implementers at least once every quarter</li> <li>• Collaboration with other departments on logistics and other topics</li> <li>• Feedback to relevant levels</li> </ul>	<ul style="list-style-type: none"> <li>• Data to be sent by 14th day of the following month</li> <li>• Will take advantage of other programs for the visits</li> <li>• Pharmacovigilance issues included</li> </ul>
<b>Community</b> (e.g., opinion leaders, RMMs, vendors' groups, other volunteer groups)	<ul style="list-style-type: none"> <li>• Mobilization of support for the program and commodities</li> <li>• Actively engaging community resources in monitoring of PSM</li> </ul>	Will revive, empower, support, and train community-based groups to support the programs in the various states
<b>RBM partners</b>	Provision of technical support in planning, field supervision, advocacy, funding, and training for PSM	Coordination needed

## **National Policies Governing Stakeholder Responsibilities**

The following documents delineate the national policies related to PSM of antimalarial medicines and commodities at the federal, state, and LGA levels.

### National Drug Policy<sup>2</sup>

Section 6.1.	Selection of Drugs
Section 6.2.	Procurement of Drugs
Section 6.5.	Drug Storage
Section 6.6.	Drug Distribution
Section 6.7.	Rational Drug Use
Section 6.8.	Donated Drugs
Section 6.11.	Inspection of Drugs
Section 6.12.	Importation and Exportation of Drugs
Section 6.13.	Registration of Drugs
Section 6.14.	Patents
Section 6.15.	Quality Assurance
Section 6.16.	Prescribing and Dispensing Drugs
Section 6.17.	Pharmacovigilance
Section 6.18.	Drug Information and Promotion
Section 6.19.	Drug Financing and Affordability
Section 6.22.	Human Resources Development
Section 6.23.	International Cooperation
Section 6.25.	Monitoring and Evaluation

### National Antimalarial Treatment Policy<sup>3</sup>

Section 1	Introduction
Section 1.1.	Policy Strategy
Section 3	Essential Antimalarial Drugs
Section 3.2.	Criteria for Selection of Antimalarial Medicines
Section 3.3.	List of Essential Antimalarial Medicines
Section 3.4.	Updating the List of Antimalarial Medicines
Section 4	Rational Use of Antimalarials
Section 4.1.	Disease Management at the home
Section 4.2.	Disease Management in Health Facilities: Level I, II, and III
Section 4.3.	Referral
Section 4.4.	Chemoprophylaxis
Section 4.5.	Pregnancy
Section 6.	Management of Antimalarial Medicine Supply
Section 6.1.	Procurement
Section 6.2.	Packaging

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<sup>2</sup> Federal Ministry of Health, World Health Organization, Department for International Development [UK], the European Union. 2005. *National Drug Policy*.

<sup>3</sup> Federal Ministry of Health. National Malaria Control Program. 2005. *National Antimalarial Treatment Policy*

Section 6.3.	Storage
Section 6.4.	Distribution
Section 6.5.	Cost

### **Other Relevant Documents from the Stakeholders' Meeting**

Annex 4 contains a final draft of the MOU. Annex 5 contains the PSM Capability Matrix. Annex 6 contains the Tools for PSM Malaria Implementation, Data Capture, and M&E.



## CONCLUSIONS

Table 9 summarizes the challenges and recommendations defined during the stakeholders' meeting. The responses shown came from a questionnaire handed out at the meeting.

**Table 9. Identified Challenges and Recommendations to the Management of Antimalarial Medicines and Commodities**

Issue	Identified Challenges	Recommendations	RESPONSIBILITY
Planning and coordination	Communication between the PR and SR seems to have been largely a one- way street.	Proper systems should be put in place to ensure coordination between the PR and the SR.	PR, SR
	Logistics are poorly coordinated because of uncertain lead times.	Allocation of funds should be adequate and timely.	PR, SRs, sub-SRs
	Planning is poor, and the use of estimates to forecast results in ambitious targets.	Data should be assembled to provide evidence-based quantification, targets, and planning at all levels.	CCM, PR, SR, RBM partners
Quantification	Quantification targets are unrealistic, and procedures are poor.	Quantification procedures training and implementation should be improved.	SR, RBM partners
	Data capture for consumption is inadequate.	Specific data capture forms should be designed.	PR, SR, RBM partners
Financing	Reductions have been made to budget proposals.	Budgets should conform with proposals.	PR, SR
	Getting appropriate, timely, and adequate allocation of funds is difficult.	The PR should allocate adequate, timely funds to the SRs.	PR
Procurement	The PR should ascertain the procurement of quality goods.	Competitive bidding should be used for procurement agencies; oversight of procurement processes should assure quality.	PR, SR, RBM partners
	Nonprofessionals are handling procurement.	These responsibilities should be assigned to professionals—to organizations or agencies with cognate experience.	PR,SR
	Incompetent, fraudulent procurement agencies have been selected.	Only capable procurement companies or agencies should be selected.	PR

<b>Issue</b>	<b>Identified Challenges</b>	<b>Recommendations</b>	<b>RESPONSIBILITY</b>
		CCM and RBM partners should have an oversight in the selection of competent procurement agencies in a transparent manner.	CCM, RBM partners
	The environment is not conducive to importation and clearing, leading to multiple delays.	Advocacy to the federal government for a conducive environment (e.g., on duty waivers, "Form M," and other forms) should improve the environment.	CCM, federal government
Behavior change communication (BCC) and information, education, and communication (IEC)	Few IEC materials are available; awareness is below expectations.	More IEC materials should be printed. BCC should be made more vibrant.	SR, PR
Pharmaceutical management	Capacity is lacking at all levels.	Regular and relevant training activities should be conducted.	Federal MoH, RBM partners
Logistics	States and LGAs do not have funds and logistics for pharmaceutical storage and distribution.	Beneficiaries should be trained and adequately funded to appropriately store and distribute ACTs, SP, and LLINs.	PR, SR, Federal MoH, State MoH, LGAs
Distribution	Documentation of distribution is sparse.	Distribution should be made with proper forms provided by the SRs.	PR, SR, RBM partners
	Pharmacists and pharmacy technicians are not involved in distribution.	These professionals should be required to handle medicines at all levels.	SR, Sub-SRs
	Effective collaboration between the public and private sector is lacking.	The PR should exercise greater care in choosing SRs to reflect comparative advantages.	PR
	How can high mark-up fees on ACTs by commercial outlets be prevented?	The PR and SR should monitor distribution and the marketing plan.	PR, SR
	The pharmaceutical distribution system in Nigeria is chaotic.	Stakeholders should coordinate and empower the system to move closer to the ideal.	Federal MoH, FDS, Pharmacists' Council of Nigeria, NAFDAC, RBM partners
	Distribution at the states is hampered by the lack of funds for various activities.	Adequate funding should be budgeted and provided.	
Advocacy visits should be made to state governments to support distribution.			PR, SR, RBM partners

*Conclusions*

<b>Issue</b>	<b>Identified Challenges</b>	<b>Recommendations</b>	<b>RESPONSIBILITY</b>
	Distribution plans do not address the needs of the target population.	Distribution practices and partnerships should be made competent.	PR, SR, federal MoH, state MoH
	According to the National Drug Policy (section 6.6), donated medicines are to pass through the federal CMS.	The federal CMS should be strengthened to upgrade its systems and processes.	PR, SR, federal MoH, FDS, federal CMS
	The distribution plan for medicines kept at CMS is usually delayed, leading to expiry of the medicines in storage.	Distribution lists should always follow the storage of goods, to avoid the practice of dumping.	PR, SR, federal MoH, FDS, federal CMS, RBM partners
Delivery of ACTs and SP	For medicine receipt, there are communication gaps between the RBM Managers and the state pharmacists.	Partnership and better information flow is needed.	SR, state MoHs
Storage and warehousing	Antimalarial medicines are kept outside of the main pharmaceutical stores.	The storage of all antimalarial medicines and commodities at the states should be in the state CMS.	PR, SR, state MoHs
	Security of commodities, especially ACTs, is a concern.	Orientation on Good Storage Practices should be provided.	PR, SR, health facilities (federal, state, LGAs)
		Prescriptions should be matched with treatment courses.	
	According to the National Drug Policy (section 6.5), stock security, quality, and maximum shelf life should be ensured.	The federal and state CMS should oversee pharmaceutical storage.	PR, SR, federal MoH, FDS, federal CMS
	Government storage facilities are not functional.	A mix of public and private storage facilities and procedures should be used.	CCM, PR
Government storage facilities should be upgraded.			
Inventory control	Ensuring that dispensed medicines are used—and not sold to commercial outlets—is a concern.	Restrictions should be imposed on sale quantities.	State MoHs, LGAs
		Inventory control should be strict and transparent.	
	Inventory control is inadequate and laborious.	Computerization is at appropriate levels.	MoH
		User-friendly tools are needed at all levels.	

<b>Issue</b>	<b>Identified Challenges</b>	<b>Recommendations</b>	<b>RESPONSIBILITY</b>
	Coartem has leaked into the private sector.	Better inventory management and control is needed. An MOU should be sent to all beneficiary states. More stringent measures for culprits should be imposed.	NMCP, sub-SRs, NAFDAC, police
Documentation and record keeping	The general attitude toward record keeping is negative.	All classes and levels of implementers should receive training in data management.	PR, SR, sub-SRs
	Ordering, tendering, shipping, and delivery of goods are not documented.	Checklists and document storage files should be designed to meet the need.	PR, procurement agents
Coordination of information	Captured data is not coordinated.	An adequate system for information flow should be ensured, and feedback should be established across all levels of implementers.	PR, SR, state, LGAs
Phasing out of old medicines	Interest is minimal, and action has not been demonstrated for this activity.	An aggressive campaign is needed to address this issue.	Federal MoH, PRs, FDS, NAFDAC
Standard treatment guidelines (STGs)	Dissemination of STGs to would-be users is poor.	The distribution network and procedures should be reviewed.	Federal MoH
Prescription forms	The supply of prescription forms is inadequate.	The number of forms supplied should tally with the treatment doses supplied.	PR, SR
Rational use of ACTs	Laboratory diagnoses are not usually carried out for malaria.	Rapid diagnostic tests (for adults) should be incorporated for rational use of ACTs.	SR
	Experience on the use of ACTs is lacking at the facility level.	Staff should be exposed to STGs, the principles of rational use, and the specific use of ACTs.	NMCP, federal MoH, state and LGA MoHs
Monitoring and supervision	Vehicles are needed.	Appropriate transport should be provided to supervisors.	PR, SR, federal MoH
	The activity of internal monitoring is omitted from the plans.	A multi-professional team should be raised for internal monitoring and auditing.	State MoH
	Human resources are lacking at the LGA level.	Pharmacists should be deployed for states to oversee pharmaceutical management at LGAs.	State MoH, LGAs
	Funds for monitoring and supervision are lacking.	Adequate funding and logistics should be provided.	NMCP

*Conclusions*

<b>Issue</b>	<b>Identified Challenges</b>	<b>Recommendations</b>	<b>RESPONSIBILITY</b>
Tracking of commodities	M&E tools are needed for this activity.	Harmonized M&E tools should be provided.	PR, SR, state MoHs, RBM partners
M&E	A monitoring culture is lacking; logistic support is poor; and tools are uncoordinated and varying.	M&E should be institutionalized at all levels. A budget dedicated to M&E activities should be established. A link to existing M&E structures should be provided.	PR, SR, federal MoH, state MoHs, LGAs
	Evaluations are usually delayed until externally demanded.	Periodic evaluation should be institutionalized rather than ad hoc. Results should be disseminated so the need is appreciated.	CCM, PR, SR, federal MoH, state MoHs, LGAs
	Quarterly M&E is insufficient at all levels.	M&E should be done at least monthly with appropriate tools.	PR, SR, and RBM partners
Feedback	Feedback at all levels is poor.	Feedback should be institutionalized through existing structures (e.g., monthly Program Managers' and RMB Partners' Meetings, weekly departmental meetings, or quarterly review meetings).	CCM, PR, SR, federal MoH, state MoHs, LGAs

## **Recommendations from the PSM Stakeholders' Meeting (Plenary)**

In addition to recommendations made on the completed questionnaires (Table 9), participants attending the meeting made the following recommendations at the last plenary session—

- The federal MoH and RBM partners are to ensure that advocacy visits are made to all the stakeholders.
- M&E for PSM is to be strengthened and supported adequately.
- The SR is to review and adopt processes for the efficient flow of funds to the state and LGA levels, especially for routine activities.
- Feedback is a very important component of implementation and must be institutionalized and streamlined.
- There must be statutory monthly and quarterly meetings at the state and national levels, respectively.
- Monthly reports from all levels are to be uniform and standardized.
- Realistic data planning should be made integral in RBM processes with the current Nigeria census figures.
- There is still need for a high-level review of all the issues of malaria PSM.
- The federal and state CMS are to be strengthened for improved performance of their roles.
- Capacity building for implementation of PSM (procurement, distribution, inventory management, and M&E) should be undertaken immediately at all levels.
- TORs and guidelines for private sector involvement in malaria PSM implementation should be developed as soon as possible.

## **Consensus from the PSM Stakeholders' Meeting**

To facilitate immediate activities and promote adherence to the various areas of agreements, it became necessary to capture these in concrete resolutions (see following), which will be binding on the stakeholders.

## Daily Utilization Forms

At the primary health care level, the head of facility collects and collates the completed forms and shares them with the pharmacy technician or officer-in-charge of the pharmacy, commodity store, or dispensary and personally makes a copy available to the RBM focal person

At other levels, the following occurs—

- The pharmacist, pharmacy technician, or officer-in-charge of the pharmacy, commodity store, or dispensary is to be responsible for completing the daily use forms and is to personally make copies available to the RBM focal person
- The RBM focal person at the LGA is to collect and collate data from the facilities and submit them to the state RBM manager—copying the state pharmacist.
- Pharmacists or pharmacy technicians should directly handle the medicines, and the RBM officers should take responsibility for their use.
- The state RBM Program Manager is to submit the documents to the federal level—specifically to the NMCP M&E focal person, who, after collating and analyzing the data, will in turn share with all other members of the group at national level, including SR(s), and will forward the data regularly to the PR, who will forward it to GFATM through the local funding agent.

## Prescription Forms and Daily Use Data

For prescription forms and daily use data, the meeting outcome was that—

- Specific antimalarial medicines (i.e., ACTs and SP) prescription forms shall no longer be used to capture data about their daily use or use of commodities. The forms, however, are still to be used until the new PSM summary forms are produced and disseminated to states.
- The medicines shall be prescribed on the normal (regular) hospital prescription form. Any antimalarial medicine (i.e., ACTs and SP) prescribed, however, must be captured on a form at the dispensary, pharmacy, or drug store.

## Next Steps

The immediate next steps identified from this meeting are the following—

- Document and disseminate immediately the report of the PSM workshop meetings with national authorities and RBM partners. The report will summarize key decisions, recommendations, consensus, and next steps. It will be prepared and disseminated to all stakeholders for necessary action. **(Responsibility: Workshop secretariat; Time frame: 1–2 weeks)**

- Collect the completed capability matrixes, the format of which was distributed to key PSM stakeholders (i.e., government, agencies, and private sector participants) at the PSM Stakeholders' Meeting. (**Responsibility: PR, SR, MAC, TA; Time frame: 2 weeks**)
- Assemble and fine-tune all PSM tools for dissemination in the immediate two weeks following the meeting. The amended PSM documents will later be finalized and printed. (**Responsibility: NMCP, FDS, PR; Time frame: 2 weeks**)
- Finalize the appropriate PSM tools, produce, and distribute for use at all levels. (**Responsibility: NMCP, FDS, PR; Time frame: 1 month**)
- Plan another stakeholders' meeting to review progress made after the implementation of recommendations, and decisions from this meeting. The next meeting should be convened by the end of the second quarter of 2007 (**Responsibility: PR; Time frame: 6 months**)

### **Other Short- and Medium-Term Follow-up Activities**

- Make and share a timetable on further meetings on PSM with participants (PR, NMCP).
- Obtain information on the implementation of the PSM of other GFATM programs (PR, NMCP).
- Obtain information on PSM of other countries or adaptation (PR, NMCP).
- Pretest PSM tools (PR, NMCP).
- Arrange a meeting of professionals in private organizations on all aspects of PSM (PR, SR).
- Delineate and publish exclusive roles for public and private sectors in malaria PSM (PR, NMCP, RBM partners).
- Provide training on inventory and stores management at all levels (PR, NMCP, federal MoH).
- Provide training at all levels on M&E (PR, NMCP, RBM partners).
- Institutionalize M&E activities with supervisory committees, release funds for the appropriate tools, disseminate the tools, and train staff on their use (PR, SR).
- Create and disseminate formats for programmatic reporting and provide training in their use (PR, NMCP, RBM partners).
- Use advocacy and conduct meetings to ensure continuous provision of funds for M&E activities (CCM, PR, NMCP, states, RBM partners).

- Monitor ACT use and ensure rational use at LGAs (SR, state MoHs, RBM partners).
- Provide vehicles for monitoring (PR, NMCP).
- Develop standard operating procedures for malaria PSM (SR, federal MoH, NMCP, FDS, state MoH, RBM partners).

## **Conclusions**

To assist Nigeria with timely coordination for implementing the GFATM grant Phase 2, RPM Plus support focused on developing a participatory and monitoring framework for PSM. Thus, the meeting aimed to clearly define different partners roles, to developing a distribution model to rectify the current vague distribution and supply system for antimalarial medicines and commodities to all levels, and to finalize the MOU draft to be signed by the sub-SRs of the grant.

Recommendations emanating from the PSM meeting were multidimensional and are captured earlier in the text of the report. Following are highlighted concerns—

- There is a strong need for the accurate capture of use and consumption data, supervision, feedback, and M&E, and instituting statutory meetings at all levels of implementation.
- The necessity for funds and logistic support for medicine storage, distribution, and M&E is an overarching program need and a weak link that must be strengthened to produce consistent and reliable delivery of expected program targets and outcomes.
- The need for effective collaboration at all levels—of PRs, SRs, sub-SRs, the federal and state MoHs, parastatals and agencies as well as line governments at all levels, RBM partners, and agencies—with private stakeholders has been showcased as the only way forward in the herculean tasks of implementing malaria PSM effectively and efficiently.
- Capacity building for PSM and M&E is an immediate next step in consolidating the gains of this workshop. Logistic and infrastructural strengthening is within the purview of the government and developmental agencies and should be integral to the assistance given to the country.

In view of the new arrangements for implementing Phase 2 of the GFATM malaria grant in Nigeria, (with implementation by additional PRs, and SRs) and the antimalarial program, in general, using the meeting outputs will jumpstart improving the quality of PSM processes and data management. The private sector's new role needs careful management to harness its immense potential for actualizing the program targets.

The integration of M&E into existing structures will lead to efficiency and sustainability. Support from the highest levels of government and from RBM partners is bedrock in the achievement of the laudable goals of the RBM Program in its crusade against a needlessly debilitating situation (to health and to the economy).

The regular funding and improvement of logistics and infrastructure, especially to the public sector, will produce benefits that will transcend this immediate program, because PSM is a consistent need throughout health program implementation and stands at the core of its success—always.

## ANNEX 1. LIST OF PARTICIPANTS

### Part 1. Participants' List: National

Name	Institution/Agency	Designation	Telephone Number	E-Mail Address
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**Part 2. Participants' List: Agencies**

<b>Name</b>	<b>Institution/Agency</b>	<b>Designation</b>	<b>Telephone Number</b>	<b>E-Mail Address</b>
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**Part 3. Participants' List: State Level**

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(participant absent)				
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## ANNEX 2. AGENDA FOR THE NIGERIA PSM (MALARIA) STAKEHOLDERS' MEETING

### Day One: Participants from National Level and Agencies

9:00 – 9:30 a.m.	Registration
9:30 – 9:45 a.m.	Opening Remarks <b>(PR [YGC], NMCP, FDS, and Agencies)</b>
9:45 – 10:30 a.m.	Current Situation of the Nigeria Malaria PSM with Emphasis on the Implementation of the ACT Policy <b>(Presentation by RPM Plus Consultant)</b>
10:30 – 10:45 a.m.	Objectives of the PSM Stakeholders' Workshop (For Day 1) <b>(MSH/RPM Plus)</b>
10:45 – 11:15 a.m.	Tea Break
11:15 a.m. – 12:30 p.m.	Presentation of the Reviewed Nigeria Malaria Workplan for PSM for the GFATM Rounds 2 and 4 Grants + Discussions <b>(Presentation by YGC/NMCP)</b>
12:30 – 2:00 p.m.	Identification of all stakeholders concerned with malaria procurement and supply management  Identification of key stakeholders with capacity to contribute to efficient distribution <b>(NMCP/YGC)</b>
2:00 – 3:00 p.m.	LUNCH
3:00 – 4:00 p.m.	Group Work 1 (Two working groups) <b>TOPIC: Suggestions for Quantification, Procurement, and Distribution in the Public Sector</b>
4:00 – 4:30 p.m.	General Discussions <b>(Facilitated by YGC/NMCP/FDS/WHO)</b>
4:30 – 5:00 p.m.	Tea Break/Closing

## **Day Two: Participants from Federal and State Levels (and Agencies)**

8:30 – 9:00 a.m.	Registration
9:00 – 9:15 a.m.	Opening Remarks <b>(YGC, NMCP, FDS, and Agencies)</b>
9:15 – 9:30 a.m.	Objectives of the PSM Stakeholders' Workshop (For Days 2 and 3) <b>(MSH/RPM Plus)</b>
9.30 – 11:30 a.m.	Current capacity of GFATM states and LGAs to absorb available ACTs and SP (based on current figures for distribution and consumption to date) and <i>(Processes, Challenges, Needs, and Recommendations)</i> <b>(Feedback from GFATM states Representatives)</b>
11:30 a.m. – 12.00 p.m.	Tea Break
12:00 – 1:00 p.m.	Presentation of the Reviewed Nigeria Malaria Workplan for PSM for the GFATM Rounds 2 and 4 Grants + Discussions <b>(YGC/NMCP)</b>
1:00 – 2:30 p.m.	Identification of the channels of distribution for PSM medicines and commodities (in line with workplan)
2:30 – 3:30 p.m.	LUNCH
3:30 – 4:30 p.m.	Identification of the channels of distribution for PSM medicines and commodities (in line with workplan)— <i>continued</i>
4:30 – 5:15 p.m.	Presentation of a general outline of the Nigeria proposal for monitoring malaria PSM processes (including set indicators) <b>(WHO/NMCP)</b>
5:15 – 6:00 p.m.	Definition of the roles of RBM partners in monitoring the malaria PSM processes <b>(Facilitated by NMCP/FDS/WHO/RPM Plus)</b>
6.00-6.15 p.m.	Tea Break/Administrative Issues/Closing

## Day Three: Participants from Federal and State Level (and Agencies)

9:00 – 9:30 a.m.	Registration/Distribution of Draft Documents
9:30 a.m. – 2.00 p.m. [11:00 – 11.30 a.m.]	<b><u>GROUP WORK</u></b> (Two working groups) Working Tea Break]
<b><u>GROUP WORK</u></b>	
<b><u>Group 1A:</u></b>	Review the draft of the specific roles for PR, SR, partners, state, LGA, facility, and communities in malaria medicine distribution.
<b><u>Group 1B:</u></b>	Review the draft of the comprehensive MOU with particular reference to GFATM medicines and commodities (PR/SR with partners, state participants, and legal and financial experts).
<b><u>Group 1C:</u></b>	<ul style="list-style-type: none"><li>○ Revise and complete the roles of all RBM partners in PSM monitoring.</li><li>○ Propose modalities for the processes of PSM monitoring.</li><li>○ Propose coordination mechanisms for the performance of PSM monitoring.</li></ul>
<b><u>Group 2A:</u></b>	Assemble the policies related to selection, procurement, distribution, and use of antimalarials at federal, state, and LGA levels.
<b><u>Group 2B:</u></b>	Review the draft of the comprehensive MOU with particular reference to GFATM medicines and commodities (PR/SR with partners, states, and legal and financial experts).
<b><u>Group 2C:</u></b>	Assemble, review, and elaborate the PSM tools already developed.
2:00 – 3:00 p.m.	LUNCH
3:00 – 3:15 p.m.	Presentation by IDA
3:00 – 4:30 p.m.	Group Work Presentations—(Two working groups)
4:30 – 5:30 p.m.	General Discussions—Challenges, Recommendations, and Next Steps <b>(Facilitated by NMCP/FDS/WHO/RPM Plus)</b>
5:30 – 5:45 p.m.	Evaluation of the meeting
5:45 – 6:00 p.m.	Submission of all documents
6:00 p.m.	<b>CLOSE OF MEETING</b> Tea Break



## ANNEX 3. WORKSHOP EVALUATION

Consolidated Evaluation of PSM Stakeholders; Meeting (Days 1–3)

### Quantitative Analysis

		Scores (1–5 Scale)					Total No. of Respondents	Average Score
		5	4	3	2	1		
1	How would you rate your overall satisfaction with the meeting?	10	10	3	—	—	23	<b>4.17</b>
2	How effective was the overall format of the sessions, case studies, exercises, and discussions?	5	13	5	—	—	23	<b>4.0</b>
3.	How would you rate the materials for this meeting (handouts, slides, and supplementary materials)?	11	8	3	1	—	23	<b>4.26</b>

## Qualitative Analysis

### How would you rate your overall satisfaction with the meeting?

- The meeting was well planned and organized, with relevant documents all provided
- Excellent meeting—a lot has been learnt
- The meeting has given very satisfactory information
- The meeting has been very educative—it has sensitized me and prepared me for the tasks ahead
- The meeting has further sensitized participants to a patriotic call to sanitize the health sector
- Technical Quality of Meeting is 100%. Logistics—100%; Time Keeping is 60%
- Great contributions from Partners; contributions from states was rather disappointing

### How effective was the overall format of the sessions, case studies, exercises, and discussions?

- All the sessions, especially the group work and discussions, have helped to produce good reports
- The sessions were effectively implemented and adequate technical support given
- The presentations were very topical
- The format brought out the best from the participants
- Very effective, interactive, and transparent participation
- The format of sessions gave room for cross fertilization of ideas and sharing of experiences
- Plenary sessions were precise, but group work and discussions were stretched longer than necessary
- Highly impressed with the group work and educative, elaborate discussions
- The meeting lacked warm-up exercises between sessions
- Participants too many for each group session

### How would you rate the materials for this course (handouts, slides, supplementary materials)

- Excellent—every document was ready at the end of the session
- All materials were relevant and enough to go round all the participant
- All issues were clearly presented in the materials
- The folders given to the states are a very good development

### How could this meeting be improved?

- It should be a residential meeting so people can work late
- The two days allocated to the meeting with states were not enough—at least 3–5 days needed. Agenda was ambitious for the time available
- Identify and reach out to all stakeholders that were not present
- Have a follow-up meeting soon
- Enlarging the number of participants—other states should be invited at another time
- Having more groups with fewer participants for effective participation
- Having a sub-stakeholders meeting at the end of the meeting to finalize various issues such as compilation, harmonization of comments, and MOU
- Earlier dispatch of invitation letters
- By sending the topics for group work ahead to all participants along with the invitation letter
- Provision of computers for group work on PSM Inventory Management
- The information from states was done differently and in an unorganized format—there should have been adequate briefing on how the reports would be presented. Kudos to Sokoto State for excellent and transparent reporting
- By involving senior policy makers from government, e.g., Permanent Secretaries
- IT should be improved

**Are there any additional topics you would like to see covered?**

- Policy Implementation Strategies
- Proper definition of the roles of the private sector
- Performance Assessment of State PSM
- Capacity Building in Inventory Management and Control
- Quantification

**Any other comments:**

- The PSM Stakeholders' Meeting was quite interactive, very practical, and provided opportunity for participation—I learned a lot of new things!!
- A very successful meeting—thank you for the efforts
- It is necessary to keep a list of all contacts—participants and involve them in future PSM meetings
- Some important stakeholders were absent, such as Crown Agents—why??
- Thanks to the organizers—the meeting has boosted the morale to work efficiently and to send data when needed
- Funds should be made available for the immediate replication of this type of meeting at the state and LGA levels
- Thanks to MSH rep for wonderful organization and coordination—Congratulations and more grease to your elbow
- There is need for the Public Health Department to integrate the skills of the pharmacists into GFATM implementation for effective PSM



**ANNEX 4. MEMORANDUM OF UNDERSTANDING—  
DOCUMENT REVIEWED AT THE PSM STAKEHOLDERS' MEETING**

**MEMORANDUM OF UNDERSTANDING**

**BETWEEN**

**FEDERAL MINISTRY OF HEALTH  
(National Malaria Control Programme)**

**AND**

**----- STATE MINISTRY OF HEALTH**

**FOR  
THE IMPLEMENTATION OF THE GLOBAL FUND MALARIA PROGRAMME IN  
NIGERIA**

**FOR**

**THE REDUCTION OF MORBIDITY AND MORTALITY DUE TO MALARIA  
INFECTION**

**JANUARY 2007**

**THIS MEMORANDUM OF UNDERSTANDING** made this ....day of ----- 2007

**BETWEEN**

The Federal Ministry of Health, whose address is at Federal Secretariat Complex, Shehu Shagari Way, Maitama Abuja (hereinafter referred to as “the Ministry” which expression shall where the context so admits include its successors-in-title and assigns) of the one part.

**AND**

The.....State Ministry of Health.....

**WHEREAS** Malaria is a major cause of morbidity and mortality particularly in children below the age of five years and pregnant women;

**WHEREAS** the Federal Government of Nigeria has adopted a new strategy for the control of the disease with the launching of the Roll Back Malaria Initiatives during the African Heads of Government Summit on Malaria in April, 2000.

**WHEREAS** the major interventions adopted for the control of the disease in Nigeria include ensuring that:

- (a) All individuals especially the vulnerable groups have access to appropriate treatment within 24 hours of onset of symptoms
- (b) The vulnerable groups (pregnant women and children) sleep under Insecticide Treated Nets/Long Lasting Insecticidal Nets
- (c) Pregnant women have access to two doses of Intermittent Preventive Treatment (IPT) during each pregnancy

**WHEREAS** the target of the Federal Government of Nigeria is to ensure that at least 80% of these interventions are accomplished by 2010. This plan is to be achieved through provision of anti-malaria commodities to public Health Institutions and not for Profit Health Organizations for the implementation of these interventions.

**WHEREAS** the Federal Government of Nigeria seeks to establish partnership with recognized and registered public health Institutions/Organizations in Nigeria whose mandate include complementing the effort of the Government in the reduction of morbidity and mortality due to malaria in the country.

**WHEREAS** this MOU shall be operational to the anti-malaria commodities supplied to the State.

**WHEREAS** .....State has agreed to partner with the Federal Government of Nigeria and the NMCP in the reduction of morbidity and mortality due to malaria in the country.

**NOW THEREFORE THE PARTIES HERETO HEREBY AGREE AS FOLLOWS:**

## **ARTICLE 1**

### **OBJECTIVE**

**1.1** Reduction of morbidity and mortality due to malaria in the country.

## ARTICLE 2

### RESPONSIBILITIES OF THE FEDERAL MINISTRY OF HEALTH

- 2.1 To provide appropriate anti-malaria medicines for the treatment of uncomplicated malaria in children less than five years of age and pregnant women.
- 2.2 To provide Insecticide Treated Nets (including re-treatment kits) /Long Lasting Insecticidal Nets for distribution to the vulnerable groups, i.e., children less than five years and pregnant women.
- 2.3 To provide Sulphadoxine-Pyrimethamine for Intermittent Preventive Treatment (IPT) for all pregnant women attending Antenatal clinics.
- 2.4 To provide technical and supportive supervision to the state for the implementation of malaria control activities.

## ARTICLE 3

### RESPONSIBILITIES OF .....STATE MINISTRY OF HEALTH

- 3.1 To work closely with the National Malaria Control Programme.
- 3.2 To provide technical and supportive supervision to all LGAs for the implementation of malaria control activities.
- 3.3 To facilitate the use of evidence to prepare relevant tools for documentation, inventory management, etc., that will ensure effective PSM activities.
- 3.4 To provide and maintain an updated list of all the health facilities including their categories (i.e., tertiary, secondary, primary, private and not-for-profit, etc.) operating under the umbrella of the state including their locations.
- 3.5 To make anti-malaria commodities available to target population at no cost (free).
- 3.6 To abide with the minimum skills criteria in the selection of the State Malaria Program Manager as stipulated by the National Malaria Control Programme while making efforts to reduce to the barest minimum the attrition of programme staff.
- 3.7 To support the supervision, monitoring, and evaluation of *catchments areas* and provide monthly reports to National Malaria and Vector Control Division.
- 3.8 To ensure that anti-malaria commodities are maintained at optimum shelf life and adequate storage conditions basic quality assurance processes should be maintained.

- 3.9** To task the State Director of Pharmaceutical Services and the State Malaria Programme Manager to notify the State Ministry of Health, onward to the National Malaria Control Programme should the need for recall or redistribution of anti-malaria medicines and commodities arise.
- 3.10** To ensure proper delivery scheduling of anti-malaria medicines and commodities to LGAs and facilities in the State are prepared and followed.
- 3.11** To keep and maintain proper inventory management of all antimalarial drugs and commodities as may be delivered to the State Central Medical Store.
- 3.12** To provide and maintain programme vehicles of all types and other equipment (computer, photocopier, generator) throughout the duration of the program while ensuring that they are under the custody of the State Programme Manager and used solely for programme activities.
- 3.13** To accommodate and provide oversight to other channels of Malaria Programme implementation within the states.
- 3.12** To provide monthly record of usage of the anti-malaria commodities to the NMCP.
- 3.13** To support awareness creation campaign on malaria control activities within the State.
- 3.14** To support the training and re-orientation of health workers in her facilities on the new National Anti-malaria Treatment Policy.
- 3.15** To organize monthly malaria programme meetings with LGA malaria focal persons participating and relevant programme managers such as Reproductive Health, NPI, IMCI, School Health, etc.

**ARTICLE 4  
EFFECTIVE DATE/DURATION**

- 4.** This MOU shall become effective upon signature and shall remain in force for a period of 3 years from the date of signing thereof.

**ARTICLE 5  
ASSIGNMENT**

- 5.** No party shall assign or transfer any rights or obligation due to him under this MOU or any part, share, or interest therein directly or indirectly or by power of Attorney to any person(s) or whatever without the prior written consent of the other party.

**ARTICLE 6  
AMENDMENT**

- 6.1 The parties shall give due consideration to any proposal for modification of any part of this Agreement.
- 6.2 Any amendment or modification of the terms and conditions of this MOU may only be made by written agreement between the parties.

**ARTICLE 7  
APPLICABLE LAW**

- 7. This MOU shall be governed and construed in accordance with the laws for the time being in the Federal Republic of Nigeria.

**ARTICLE 8  
FORCE MAJUERE**

- 8.1. For the purpose of this MOU, Force Majuere shall be construed as events beyond the control of either party to this MOU, including but not limited to ACTS of God, Flood, Fire, Industrial Unrest, Government Policy or any Order, Degree, Law or Regulation of any Government Agency which may impede or prevent the party's performance of this MOU.
- 8.2. The party claiming Force Majuere shall promptly advise the other party within fourteen (14) days of such Force Majuere.
- 8.3 In the event of the occurrence of Force Majuere as herein defined, the party's performance of this MOU shall be suspended until the removal of such Force Majuere and the time for performance extended for the corresponding period.
- 8.4 If however, such Force Majuere shall persist for a period exceeding three (3) weeks the parties shall consult with each other regarding the appropriate steps to be taken to achieve the purpose of this MOU.

**ARTICLE 9  
GOVERNING LANGUAGE**

- 9. The English Language shall govern and control any transactions of this MOU into any other languages.

**ARTICLE 10  
NOTICE**

**10.1.** Any correspondence required or permitted to be made under this MOU shall be in writing and shall be deemed sufficiently given when delivered to the other party at its address set forth below.

**10.2** Any Correspondence to the Federal Ministry of Health shall be to:

- (a) The Honourable Minister  
Federal Ministry of Health  
Federal Secretarial Complex  
Phase III  
Shehu Shagari Way  
Maitama Abuja

(b) Any Correspondence to the -----STATE MINISTRY OF HEALTH shall be to:

.....  
.....  
.....

Signed this \_\_\_\_\_ day of \_\_\_\_\_ 2007

\_\_\_\_\_  
**FOR THE FEDERAL MINISTRY  
OF HEALTH**

\_\_\_\_\_  
**EXECUTIVE STATE GOVERNOR  
FOR THE -----STATE  
MINISTRY OF HEALTH**

**ANNEX 5. PSM CAPABILITY MATRIX DOCUMENT REVIEWED AT THE PSM STAKEHOLDERS' MEETING**

<b>NAME OF INSTITUTION/AGENCY:</b>					
<b>ISSUE: PLANNING AND COORDINATION (for PSM)</b>					
<b>Key Activities</b>	<b>Comparative Advantage</b>	<b>Type of Role</b> Statutory/Legal, Coordination, Technical, Professional, Logistics, Technical Assistance <i>(State if fees are applicable)</i>	<b>Limitations</b>	<b>Immediate Needs</b> (Issue-Specific)	<b>Other Stakeholders</b>
1. Identifying stakeholders					
2. Determining their importance at the various stages, their roles and responsibilities, and how they should be engaged (stakeholder analysis)					
3. Identifying composition of transition committee or, if using an existing mechanism, determining which existing committee should carry out this process					
4. Establishing working groups or task forces and their respective membership within the committee					
5. Establishing TOR for working groups/task forces					

NAME OF INSTITUTION/AGENCY:					
ISSUE: FINANCING (for PSM)					
Key Activities	Comparative Advantage	Type of Role Statutory/Legal, Coordination, Technical, Professional, Logistics, Technical Assistance <i>(State if fees are applicable)</i>	Limitations	Immediate Needs (Issue-Specific)	Other Stakeholders
1. Development and review of budget					
2. Identification of resources					
3. Evaluation of current spending profile					
4. Development of strategy for accessing funds					
5. Review of proposals for GFATM or other funding agency					
6. Identification of commitments from departments within MoH and donors					
7. Evaluation of cost-sharing and exemption mechanisms and developing methods for improving equity					
8. Development and review of financial accountability mechanism					

NAME OF INSTITUTION/AGENCY:					
ISSUE: REVISION OF PHARMACEUTICAL REGULATION					
Key Activities	Comparative Advantage	Type of Role Statutory/Legal, Coordination, Technical, Professional, Logistics, Technical Assistance <i>(State if fees are applicable)</i>	Limitations	Immediate Needs (Issue-Specific)	Other Stakeholders
1. Registration of new medicines					
2. Establishment of fast-track registration system as needed					
3. Evaluation of whether regulatory requirements may have a negative impact on implementation and establishment of mechanisms to alleviate this					
4. Evaluation and strengthening of regulatory enforcement capacity if needed					
5. Promulgation of regulations for appropriate importation, distribution, prescribing, and dispensing of ACTs and ensuring that they are consistent with the policy					

NAME OF INSTITUTION/AGENCY:					
ISSUE: ESSENTIAL MEDICINES LIST AND STANDARD TREATMENT GUIDELINES					
Key Activities	Comparative Advantage	Type of Role Statutory/Legal, Coordination, Technical, Professional, Logistics, Technical Assistance <i>(State if fees are applicable)</i>	Limitations	Immediate Needs (Issue-Specific)	Other Stakeholders
1. Determination of guidelines to be revised					
2. Determination of process for revision and groups to be involved					
3. Determination of whether new guidelines are to be published or existing ones are to be revised					
4. Publication of revised guidelines/essential medicines list and/or addendum					
5. Dissemination of new guidelines and essential medicines list					
6. Revision of pre-service and in-service training curricula to incorporate new guidelines					
7. Development/review of plan for training health workers and developing training materials, essential medicines list and STGs					
8. Organization of training after first procurement					

NAME OF INSTITUTION/AGENCY:					
ISSUE: BEHAVIOR CHANGE COMMUNICATION/INFORMATION, EDUCATION, AND COMMUNICATION					
Key Activities	Comparative Advantage	Type of Role Statutory/Legal, Coordination, Technical, Professional, Logistics, Technical Assistance <i>(State if fees are applicable)</i>	Limitations	Immediate Needs (Issue-Specific)	Other Stakeholders
1. Development and review of BCC strategies and coordination with IEC strategy					
2. Development and review of IEC strategies					
3. Development and review of plan for implementing the BBC strategies					

NAME OF INSTITUTION/AGENCY:					
ISSUE: PHASING OUT OLD MEDICINES					
Key Activities	Comparative Advantage	Type of Role Statutory/Legal, Coordination, Technical, Professional, Logistics, Technical Assistance <i>(State if fees are applicable)</i>	Limitations	Immediate Needs (Issue-Specific)	Other Stakeholders
1. Determining pipeline for the old medicine through central and peripheral level data collection					
2. Adjusting future procurements of the current medicine to make sure that large channels of old medicines do not accumulate when new medicines are procured					
3. Developing and reviewing plan for the phase-out of the current medicine from the health system as the new medicines become available					
4. Withdrawal of old medicine from peripheral areas following the phase-out plan when policy change occurs					

<b>NAME OF INSTITUTION/AGENCY:</b>					
<b>ISSUE: QUANTIFICATION</b>					
<b>Key Activities</b>	<b>Comparative Advantage</b>	<b>Type of Role</b> Statutory/Legal, Coordination, Technical, Professional, Logistics, Technical Assistance <i>(State if fees are applicable)</i>	<b>Limitations</b>	<b>Immediate Needs</b> <i>(Issue-Specific)</i>	<b>Other Stakeholders</b>
1. Obtaining consumption data and morbidity from the field					
2. Using the data to calculate potential consumption for a phased or nationwide implementation, allowing for some buffer stock, and keeping in mind the short shelf life of ACTs					
3. Calculating the potential consumption of ACTs					
4. Ensuring that forecasts for parallel procurements efforts using other grants are coordinated					

NAME OF INSTITUTION/AGENCY:					
ISSUE: PROCUREMENT					
Key Activities	Comparative Advantage	Type of Role Statutory/Legal, Coordination, Technical, Professional, Logistics, Technical Assistance (State if fees are applicable)	Limitations	Immediate Needs (Issue-Specific)	Other Stakeholders
1. Ensuring that GFATM requirements are followed					
2. Developing a procurement plan for the ACTs					
3. Reviewing current procurement procedures including efficiency and transparency, identifying weaknesses, and developing mechanisms to address the weaknesses					
4. Identifying sources of technical assistance and obtaining the assistance as needed					
5. Processing procurement through WHO or UNICEF for artemether-lumefantrine					
6. Determining if there is a need for repackaging and a repackaging agent					
7. Developing tender documents and initiating and managing procurement					
8. Monitoring supplier performance					

<b>NAME OF INSTITUTION/AGENCY:</b>					
<b>ISSUE: DISTRIBUTION</b>					
<b>Key Activities</b>	<b>Comparative Advantage</b>	<b>Type of Role</b> Statutory/Legal, Coordination, Technical, Professional, Logistics, Technical Assistance <i>(State if fees are applicable)</i>	<b>Limitations</b>	<b>Immediate Needs</b> (Issue-Specific)	<b>Other Stakeholders</b>
1. Development and review of distribution plan					
2. Development and review of distribution systems to allow for coordination between the public and private sectors					
3. Development and review of strategies to avoid leakage to the private sector					
4. Development and review of storage capacity and conditions to meet Good Manufacturing Practices					
5. Development and review of human capacity for efficient implementation of distribution plan and supervision					
6. Development and review of transportation system					
7. Development and review of redistribution systems and systems to remove expired stocks					
8. Development and review of systems to monitor efficiency of redistribution systems and redistribution mechanism					

NAME OF INSTITUTION/AGENCY:					
ISSUE: RATIONAL USE					
Key Activities	Comparative Advantage	Type of Role Statutory/Legal, Coordination, Technical, Professional, Logistics, Technical Assistance <i>(State if fees are applicable)</i>	Limitations	Immediate Needs (Issue-Specific)	Other Stakeholders
1. Ensuring correct diagnosis					
2. Ensuring good prescription practice and compliance with STG/treatment policy					
3. Ensuring good dispensing practices					
4. Ensuring appropriate packaging and labeling of the prescribed medicine					
5. Ensuring patient counseling for compliance while taking the prescribed medicine					
6. Setting up and implementing pharmacovigilance system—developing of forms, making them available, ensuring the collection and processing of data					
7. Appropriate management of adverse reactions and reports of adverse reactions					

NAME OF INSTITUTION/AGENCY:					
ISSUE: INVENTORY MANAGEMENT					
Key Activities	Comparative Advantage	Type of Role Statutory/Legal, Coordination, Technical, Professional, Logistics, Technical Assistance <i>(State if fees are applicable)</i>	Limitations	Immediate Needs (Issue-Specific)	Other Stakeholders
1. Development and review of inventory management systems to improve the pharmaceutical management in the peripheral health facilities					
2. Development and review of security measures to prevent theft of stored products					
3. Development and review of systems to ensure management of the shelf life of products and development and review of systems for dealing with expired products					

NAME OF INSTITUTION/AGENCY:					
ISSUE: REVISION OF QUALITY ASSURANCE MECHANISMS					
Key Activities	Comparative Advantage	Type of Role Statutory/Legal, Coordination, Technical, Professional, Logistics, Technical Assistance <i>(State if fees are applicable)</i>	Limitations	Immediate Needs (Issue-Specific)	Other Stakeholders
1. Development and review of system for monitoring of adverse events					
2. Development and review of systems for quality assurance during pharmaceutical registration and procurement					
3. Development and review of systems for dealing with violations of pharmaceutical quality standards					
4. Establishment of mechanism to coordinate the various surveillance systems—adverse drug reaction, product quality, effectiveness, etc.					
5. Development and review of plans for post marketing product quality surveillance and ensuring that samples will be regularly tested by a qualified laboratory					

<b>NAME OF INSTITUTION/AGENCY:</b>					
<b>ISSUE: MONITORING AND EVALUATION</b>					
<b>Key Activities</b>	<b>Comparative Advantage</b>	<b>Type of Role</b> Statutory/Legal, Coordination, Technical, Professional, Logistics, Technical Assistance <i>(State if fees are applicable)</i>	<b>Limitations</b>	<b>Immediate Needs</b> (Issue-Specific)	<b>Other Stakeholders</b>
1. Developing and reviewing plans for post marketing product quality surveillance					
2. Defining program milestones (indicators)					
3. Identifying data needs					
4. Developing/adapting and implementing information systems					
5. Identifying and addressing human and information technology resource needs					



**ANNEX 6. TOOLS FOR PSM (MALARIA) IMPLEMENTATION, DATA CAPTURE, AND M&E**

**Federal Republic of Nigeria—Ministry of Health  
National Malaria Control Program**

**MALARIA MEDICINES AND COMMODITIES SUPPLY FORM**

Date \_\_\_\_\_

Reference No. \_\_\_\_\_

<b>RECEIVING INSTITUTION (Facility Name/LGA/STATE)</b>			
<b>SUPPLYING INSTITUTION</b>			
<b>ACT Yellow—Code 1— (5–14 kg)—(6 mos to 3 yrs)</b>	Quantity Supplied	BATCH NUMBER/S	EXPIRY DATE/S
<b>ACT Blue—Code 2— (15–24 kg)—(4–8 yrs)</b>	Quantity Supplied	BATCH NUMBER/S	EXPIRY DATE/S
<b>ACT Orange—Code 3— (25–34 kg)—(9–14 yrs)</b>	Quantity Supplied	BATCH NUMBER/S	EXPIRY DATE/S
<b>ACT Green—Code 4— (≥35 kg)—(&gt;14 yrs)</b>	Quantity Supplied	BATCH NUMBER/S	EXPIRY DATE/S
<b>SP (IPT)</b>	Quantity Supplied	BATCH NUMBER/S	EXPIRY DATE/S
<b>LLINs</b>	Quantity Supplied	BATCH NUMBER/S	EXPIRY DATE/S
<b>Others—(Insert Name)</b>	Quantity Supplied	BATCH NUMBER/S	EXPIRY DATE/S
<b>REMARKS: (Note here if EXPIRED, DAMAGED, BROKEN, or any other COMMENTS)</b>			
<b>NAME OF SUPPLIER AND SIGNATURE</b>			
<b>NAME OF RECEIVER AND SIGNATURE</b>			

Federal Republic of Nigeria—Ministry of Health  
National Malaria Control Program

DISPENSING/CONSUMPTION RECORDS OF ARTEMETHER-LUMEFANTRINE

Federal Republic of Nigeria—Ministry of Health				Artemether-lumefantrine (20 mg–120 mg/tablet) Doses				
Artemether-Lumefantrine Dispenser's Book (The total quantities of medicines dispensed are counted <b>per page</b> )				Artemether-lumefantrine (5–14 kg)	Artemether-lumefantrine (15–24 kg)	Artemether-lumefantrine (25–34 kg)	Artemether-Lumefantrine (>35 kg)	Comments
<b>Balance Previous Page</b> →								
Receipt Date	Reference Number	Quantities received						
<b>Total Stock Available</b> →								
S/N	Date	Patient Name	Hospital No./ Prescription No.	Quantities Dispensed				
Total Quantity Dispensed →								
Balance End of Page (Total stock available <b>less</b> quantity dispensed) →								



**Federal Republic of Nigeria—Ministry of Health  
National Malaria Control Program**

**DISPENSING/CONSUMPTION RECORDS OF SULPHADOXINE-PYRIMETHAMINE (IPT)**

Federal Republic of Nigeria—Ministry of Health				Sulfadoxine-Pyrimethamine (SP) DOSES			
SP (IPT) Dispenser's Book (The total quantities of medicines dispensed are counted <b>per page</b> ) LGA/State _____ Facility _____				Dose 1	Dose 2	Dose 3	Comments
<b>Balance previous page</b>							
Receipt Date	Reference Number	Quantities received					
<b>Total Stock Available</b>							
S/N	Date	Patient Name	Hospital No / Prescription No	Quantities Dispensed			
Total Quantity Dispensed							
Balance End of Page (Total stock available <b>less</b> quantity dispensed)							





**Federal Republic of Nigeria—Federal Ministry of Health  
National Malaria Control Program**

**MONTHLY SUMMARY REPORT OF TREATMENT AND PREVENTIVE SERVICES PROVIDED**

Health Facility: \_\_\_\_\_ LGA: \_\_\_\_\_ State: \_\_\_\_\_

Month/Quarter of Reporting: \_\_\_\_\_ Date: \_\_\_\_\_ Completed by: \_\_\_\_\_  
Designation: \_\_\_\_\_

Treatment and Preventive Services	Children 6 to 36 months		Children 4 to 8 years of age		Adolescents 9 to 14 years of age		Population above 14 years of age		Pregnant Women
	Male	Female	Male	Female	Male	Female	Male	Female	
<b>Diagnosis</b>									
Total fever cases									
Total uncomplicated malaria									
Total complicated malaria									
Total other									
<b>Laboratory Confirmed</b>									
Total microscopy tests									
Total rapid test									
<b>Treatment</b>									
Total ACT1									
Total ACT2									
Total ACT3									
Total ACT4									
Other									
<b>Intermittent Preventive Treatment</b>									
Total IPT1									
Total IPT2									
Total IPT3									
<b>ITN</b>									
Total ITN Distributed									
Total LLTN Distributed									
Other									







