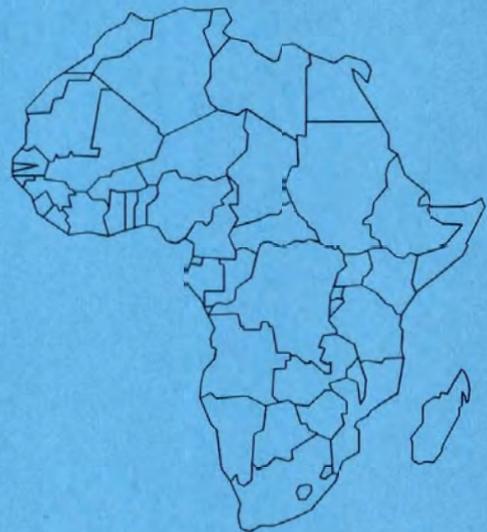


Consultative Meeting on Ensuring Availability and Appropriate Use of Essential Supplies for Child Health at Community Level in Africa

May 24, 2000



USAID
Bureau for Africa
Office of Sustainable Development



SARA Project
Academy for Educational Development
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SUMMARY: CONCLUSIONS/NEXT STEPS

On Friday May 25th, a consultative meeting, attended by 19 participants from the Africa and Global bureaus of USAID and relevant CAs, was held in the Academy for Educational Development's conference center from noon to 5pm. The two overall objectives were to:

1. To exchange experiences to date and learn lessons from different approaches to ensuring the availability and appropriate use of supplies at the community level, from both past and ongoing child health activities as well as family planning.
2. To recommend next steps for child health projects to improve availability and appropriate use of supplies at community level in Africa.

Conclusions

Participants shared a variety of lessons from social marketing, CBD, private sector, and other approaches (i.e., workplace distribution). Many important issues were discussed, including concern about overuse/misuse, drug resistance, the regulatory and policy environments, product quality, and segmentation of markets/suppliers to increase effective use of resources. (For the key points discussed see section II; for the detailed discussion, see section III.)

The major conclusions from the discussion were that:

- The only way to increase access to supplies to rural areas in the short-to-medium term is to find ways to **de-medicalize these products** by decreasing restrictions as to who can handle certain products.
- The only way to accomplish this is through developing and implementing **coordinated approaches involving all stakeholders**, starting with the strategy and planning phases, on a country level. This includes public, private, NGO sectors as well as donors.
- In addition to increasing access and supply, it is also necessary to **create demand through direct promotion and provide accurate usage information** to encourage the rural population to seek out and use these products appropriately. Social Marketing, CBD, NGOs, and the public and private sectors each has its own particular role to play—in an overall coordinated approach—in improving the image of these products as well as the image and knowledge of those who both buy and sell/distribute the products. (Resources spent on demand creation are wasted if customers cannot obtain the products, therefore, the prerequisite steps to assure commodity sufficiency and security at the national and the SDP levels on an on-going basis must be taken. In many countries, a high percentage of SDPs and the central warehouse are usually stocked out of even highest priority PH commodities.)

Next Steps

1. Consensus at USAID
 - Start with specific strategy meetings for Malaria, ORS, and Vitamin A.
 - Meet again, possibly in July, to determine if there's a general approach or whether the topics need to remain separate.
2. Meet with WHO/Geneva, WHO/AFRO, UNICEF to discuss how to approach
3. Hold country stakeholder meetings
 - Conduct operations research → results
 - Workshops/dissemination
 - Engage medical community
 - Determine costs
4. Strategy development approach
 - Partner with other partners
 - Who can procure supplies?
 - Private sector involvement
 - Develop marketing plan
 - Get private sector commitment
 - Involve all stakeholders (We need guidance for meeting)
 - Conduct operations research → situation analysis
 - Incentive
5. Determine logistics / management approaches
Leverage World Bank funds
6. Jumpstart the process with a task force
With key stakeholders (as Netmark did with an ITM stakeholder meeting in DC).

FLIP CHART NOTES¹

ISSUES

- Behavior change & “pull”
- Differentiation of products
 - Level of technology
 - Degree of services needed for support
- Target population
 - Coverage
 - Price/accessibility
- Multiplier:
 - Levels of supervision needed
 - Skills needed
 - Span of control
- CBD—mostly government/NGOs
 - Expensive
 - Medical barriers
- Does demand really “pull” product
- “Packaging”/positioning of drugs is important
- **Generation of appropriate demand**
- **Appropriate use is a big issue (e.g. anti-malarials)**
- **Potential of over-use/misuse of some products, e.g. antibiotics**

Marketer Consumer
Cost ----- > Benefit
Benefit ----- > Cost

- 1) **Pharmaceutical marketing**
- 2) **Consumer marketing**

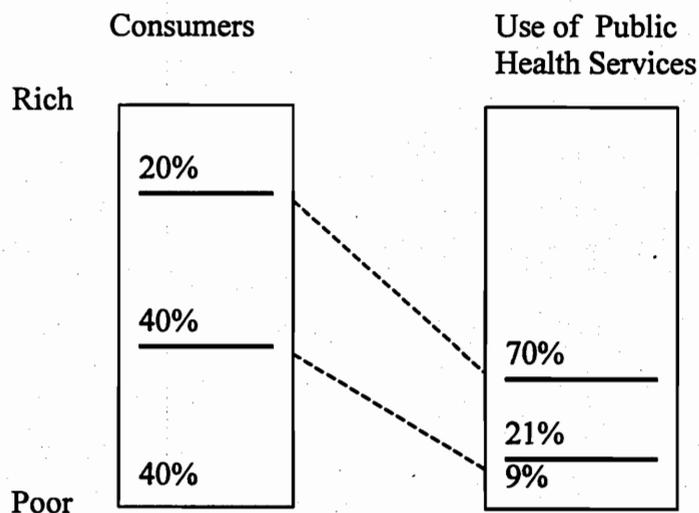
Mass consumer product	vs.	pharmaceutical/medical products
↑		↑
Social marketing success		? social marketing works less well

¹ These are the exact notes from the flip charts created during the meeting. Only minor changes, such as spelling out abbreviated words, were made.

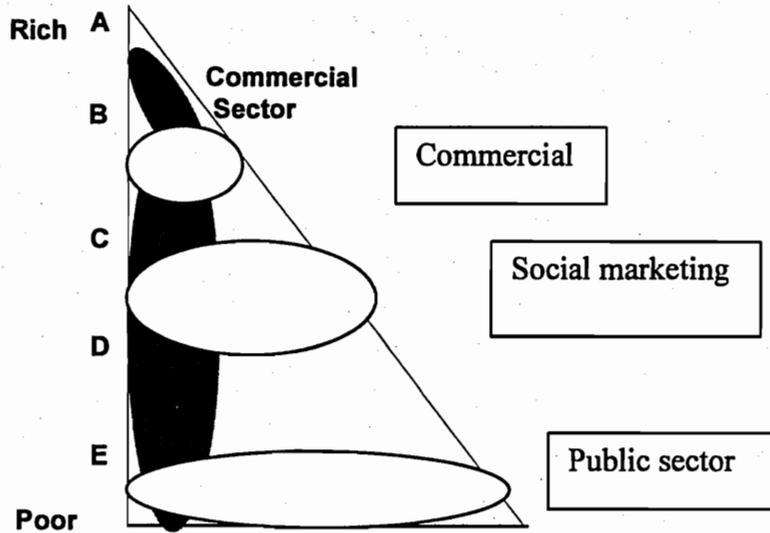
- Classifications of drugs
 - OTCs in Anglophone system
 - Francophone countries more restrictive – (turf issues)
 - **Regulatory & policy environment is key.**
 - a) Vitamin A & ORS
 - b) pre-referral drugs & their use
 - c) Injections and pills
 - **Quality of products needs to be dealt with**
- ⇒ Piloting as a way around medical barriers
- ⇒ Focus on de-medicalization

SOCIAL MARKETING IN RURAL AFRICA: SUCCESSES AND CONSTRAINTS

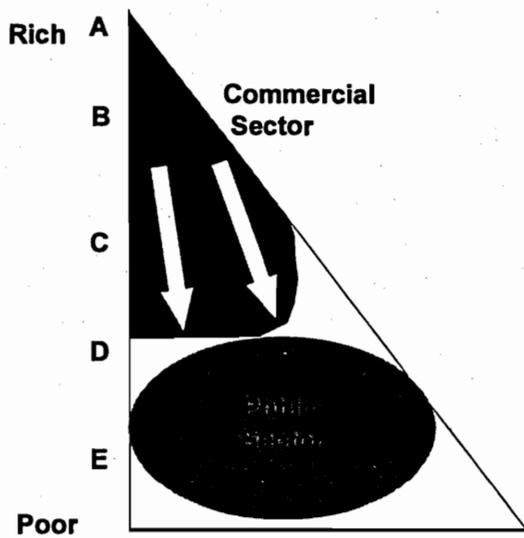
- Not a success in rural Africa—25% of sales in rural areas is the best being done
- Price issues, e.g. Ghana elasticities (contraceptives)
- Triage system in Haiti as instrument for getting products to “right” people
- Bolivia ORS: 97% of 2,400 pharmacies have ORS but no consumer marketing (tiendas)



Existing Situation - Poor Coverage



Expanding Coverage Through Partnerships



- Pharmaceutical companies don't know the mass market
- Social marketing has displaced the commercial sector - or not?
- Has it reached the poor?
- It costs to reach the poor

- In a district in Tanzania, PSI is social marketing nets via government centers in a poor, rural district to increase net use to 47%
- Often social marketing programs are mandated only to cover urban/peri-urban areas
- Social marketing (subsidized) sometimes uses non-branded products
(Problem of multiple definitions of Social Marketing)

CBD PROGRAMS

- Intensive needs for supervision, training, supplies
- NGO & donor resources & tools
- More successful in rural areas

- ⇒ CBD workers as social marketing outlets
- ⇒ Integrate CBD workers with District & other products

- Who will pay CBD costs (supervision, etc.)?
- \$ not available to take anything to scale (CBD or social marketing)
- Role of commercial sector needs to be addresses

WHAT IS THE MIX?

- Netmark objective: get AID out of business of commodities

- ⇒ Country coordination & planning, e.g. Zambia: PSI & WHO & UNICEF & AID & Netmark & MOH

- ⇒ Lower income people given vouchers to (subsidize) buying commercial product

- Workplace distribution (Ghana) experience
Bought from commercial companies Malawi

- Marketing of STD drugs (Uganda) being rolled out now to 11,000 pharmaceutical outlets (kit: 7 days of cypro are prescribed for males using syndromic approach.)
It took 3 years of policy dialogue to accomplish this.
But INRUD found compliance problems & some resistance signs in under 2 years of use of cypro.

- ⇒ Improve knowledge/practices of pharmacists & drug sellers

- Nepal experience: Female community health volunteers treat ARI with cotrimoxazole (using timers for diagnosis). This resulted in 30% more kids being treated. System is being rolled out.
- Community depots are contentious
- ⇒ Refugee settings have opportunities for impact (with little sustainability)
- Madagascar work with factories for family planning products (urban areas) peer CBD in workplace
- ⇒ Take product to potential consumers

VITAMIN A

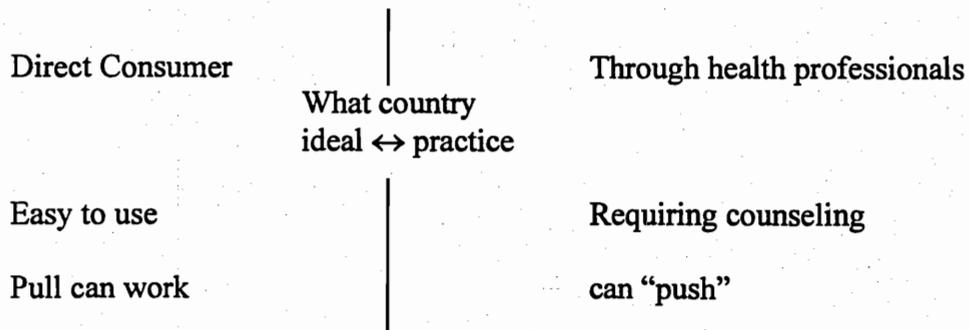
- Problems of toxicity in pregnancy & for young children
- ⇒ Multivitamins for the future (Vitamin A & Zinc for immunity)
- ⇒ Focus on diet
- ⇒ Focus on fortification of foods

SUGGESTED APPROACHES

- Experience with cooperative model group payment/contributions for purchase of kits, payment for health providers
- Community pharmacies buying from public and/or private sector
- “Tontines” and other local “insurance” schemes
- Issue of sustainability of contraceptives as cost recovery is at best partial
- Damage done by social marketing using low prices with no relation to market
- ⇒ Need rational pricing strategies for social marketing
- Subsidizing rural nets through urban sales is promising.
- Lesson from CBD has been behavior change outcome and women’s empowerment (not sustainable supply system)
- ⇒ For behavior change—objective
 - ⇒ CBD or other local workers
 - ⇒ Local groups
- ⇒ Base programs on analysis of barriers to use (Supplies? Empowerment? Behavior?)

- ? Different strategies at different stages
- ? Role of sustainability
- ? Building on economic factors (mutuelles)

FRAMEWORK



Behavior change products

ITNs – net & treatment

Antimalarials

Vitamin A

ORS

Cotrimoxazole/antibiotics

Anthelminths

Paracetamol

iodized salt

soap

birth kits

safe water - chlorine additive

iron iron folate

multivitamins

UGANDA (EXAMPLE)

Pharmaceuticals – Health Professionals

<p>(B)</p> <p>Cotrimoxazole (black market)</p> <p>Antimalarials (child)</p> <p>Pull</p>	<p>(C)</p> <p>Cotrimox./antibiotics Vitamin A capsules</p> <p>Preventative Antimalarials (women)</p> <p>Anthelminths (<5) Birth kit</p> <p>Iron/folate</p> <p>Push</p>
<p>(A)</p> <p>Paracetamol</p> <p>ORS</p> <p>Nets</p>	<p>(D)</p> <p>iodized salt</p> <p>multivitamin net treatment safe water chlorine soap (hands)</p>

Mass - Consumers

NEXT STEPS TO DE-MEDICALIZE PRODUCTS, ESPECIALLY IN QUADRANT C

1. Consensus USAID
2. WHO/Geneva, WHO/AFRO, UNICEF
3. Country stakeholder meeting
Conduct Operations Research → Results
Workshops/Dissemination
Engage Medical Community
Costs
4. Strategy Development Approach
 - Partner with other partners
Who can procure supplies?
 - Private Sector Involvement
Develop marketing plan
Get Private Sector Commitment
 - Stakeholder (We need guidance for meeting)OR → Situation Analysis
Incentive
5. Logistics / Management
USAID leverage World Bank \$
6. Consultative Meeting
ITMs (Stakeholder meeting in Wash)

MEETING NOTES²

INTRODUCTION

Hope Sukin: We really wanted to put together an informal meeting. We wanted to put together the lessons we have all learned. Everyone please introduce yourselves. (AFR/SD)

Steven Mobley: I am the Private Sector/Marketing advisor with Horizons. My role is to benchmark private sector initiatives which also involves social marketing and logistics issues. (HORIZONS/PATH)

Gary Steele: I have long had an interest in CBDs. Therefore, it is fitting be at a meeting discussing CBDs. (FPLM/JSI)

Linda Allain: I work with seven African countries and Haiti and have been with JSI for a couple of years. (FPLM)

David McGuire: In the past I worked on (SOMARC) contraceptive social marketing with public/private partnerships and subsidized products. Now, as project director for Network, we're creating commercially viable products, starting with bed nets, using donor resources. (NETMARK/AED)

Lonna Shafritz: I am a former market researcher for US consumer company. In international development arena, I focused on understanding consumer views on contraceptives and ORS. (SARA/AED)

William Warshauer: I work on social marketing with a range of products in Pakistan (resident for several years), and East and South Africa, particularly with bed nets and their treatment. (PSI)

Camille Saade: I work with the private sector at BASICS trying to engage the commercial sector in treatment or intervention. (BASICS/AED)

Mary Ettling: I work with USAID on malaria. (AFR/SD)

Caroline Blair: I was Deputy Manager for Contraceptive Social Marketing in Mali. (Currently with SARA/PRB).

Naomi Rutenberg: I work with the Pop Council analyzing studies on CBD family planning and with Horizons on issues of pediatric AIDS treatment. (Horizons/Pop Council)

Suzanne Prysor-Jones: I am the director of the SARA project, and worked previously for PRITECH, particularly focusing on child survival and ORS. (SARA/AED)

² These notes are not a verbatim transcription of the meeting, but are meant to capture the essence of the meeting's conversation. The main objective was to get an overall body of lessons learned and to determine next steps.

LESSONS LEARNED ON REACHING THE COMMUNITY

Hope: It is documented that 80 percent of child deaths from fever (assumed malaria) in Africa are happening in the communities, at home; rarely do they get to a facility or professional care giver. We can't ignore that most USAID programs are facility-based. If we want to reduce death, we have to get the products and services to the communities - fifteen kilometers from a facility is a long way away for a sick child. Getting services closer to the community is not going to happen, even in the next 5 years. We are working with BASICS and UNICEF on how to reach the communities. We have done a good job of getting commodity issues in the community on the agenda. Those of you working with community and contraceptive CBD workers—in family planning—you've been able to scale up and get products to communities. In child health, with efforts of Camille and David and PSI, we are getting there with bed nets. We are here to talk about experiences, especially those in Africa. What worked? What were the barriers? How can your lessons be applied to child health ?

Mary: There is a special problem in child health, especially as increased use of drugs has led to increased resistance to chloroquine and Fansidar. This has often hurt the problem rather than helped.

Hope: What lessons we can apply to child health commodities: bed nets, vitamin A, ORS?. The agenda is set up to first talk about experiences, lessons, and then their applications to child health, and by the end of the afternoon to get to specific next steps.

Mary: It's not just making things available, but also changing attitudes, and ensuring that commodities are properly used.

Hope: Issues include demand creation, behavior change, and scaling up. CBD programs have brought the community out but the geographic areas are limited.

Susan Bacheller: There are different barriers related to the availability and use of different types of products. Issues related pharmaceuticals (drugs) are different than other products, such as contraceptives. When a drug is not available, it cannot be assumed to be due to pure logistics or distribution problems. Irrational or overuse of drugs significantly affects availability. A lack of sufficient financial resources to procure necessary products is also an obstacle to product availability. The other important consideration is that health products have more than one use or indication, as compared to contraceptives that are only used for control of fertility. Therefore, in the case of drugs, attention must be given to appropriate use of these products.

Introduction of Michael Gabra & Susan Bacheller

William: Let's talk about PSI and work outside and inside of Africa. I'll begin by stating the obvious, social marketing is the same work as done commercial marketers: the need to create a consumer demand and behavior changes. The distribution of the commodity will happen if a demand is created, for example cigarettes. Condoms are easier than bed

nets and ORS, which need more instruction. There is a third group of products, which includes IUDs, pills and injections, all of which need service-provision and counseling. We have had the same experience using CBD as others here.

Gary: I am seeing a distinction of level of difficulty of product. From an observation viewpoint the multiplier effect is obvious but often overlooked. Supervisors of CBD agents need more training. How many people can an agent supervise? How many households can they reach? 10? 20? It depends on the country. CBD agents tend to have low literary levels so it is hard for them to keep records. A system of tick sheets was started so the supervisor would do the rest of the calculating. We're wanting to start with too wide a range of goods, a list of dos and don'ts. We should categorize by difficulty.

Steven: Interesting comments. One of the main things is to go to the community itself, which can identify what is needed, what the problems are, such as children are dying of diarrhea, etc. Agriculture has a great system of CBD through cooperative networks. I have a problem with "social" marketing pricing products out of the reach of underserved population, which should be the focus of their initiatives.

Hope: In terms of looking at social marketing, the behavior change element is what we want to change. With the product and product type, it is important to define them by level of technology and service needed with product. We also need to look at the target population, size, and affordability. Also the multiplier issues of supervisors' span of control, skills needed, and support needed.

Naomi: What is the role of CBD? It changes with time. Behavior change was important to expand access to contraception and increase CPR. There were a lot of programs that noted that CBD was an expensive way. In most CBD program studies - government or NGO - the problem was running into the medical establishment. Some of it was turf battles and some was real concern over medical supervision. Generally, pills were distributed by a lay person and injections referred to a medical professional. Referrals to medical professional were also given for Norplant, IUDs, etc.

Mary: It was asserted by persons that if you put demand first Chloroquine is the most ubiquitous; moms do look for anti-malarials, yet isn't it quite a blanket statement to say if there is a demand, the product will come? Question to all—how do we provide, at the household level, quick access to malaria drugs?. Is it with unit doses? Simplified doses? A push to have them take a complete cycle?

Lonna: Another point is proper use. Do they take the drug for the amount of time they are supposed to? There is a demand but is there proper use? There are many choices available, so we need to help them move toward the proper choices.

Susan: In the discussion of demand generation, we need to be sure that we promote appropriate demand. The private sector promotes anti-diarrheals; even when ORS is

appropriate it is not prescribed/given. At the lower community level, there is potential that they are using a drug for more than one thing. Antibiotics are used for many things.

Camille: I am a bit lost. Let me suggest one thing that is a basic thing in marketing.

Cost \leftrightarrow benefit

What is a cost for the marketer is a benefit for the consumer

What is a cost for the consumer (money, time, effort, thinking) is a benefit for marketer

Making product available, and correct use

We need to make a distinction between:

1. Pharmaceutical marketing (drugs)
2. Consumer marketing (mass produced, mass consumed)

Social marketing applies to the consumer market but not the pharmaceutical market. I don't know of any successes in the pharmaceutical market, but there are many failures.

Hope: Where do you put ORS and vitamin A?

Camille: ORS in the Francophone system is classified as a drug. In a few instances, there have been attempts to declassify it but there was strong resistance from the medical system. In the Anglophone system, it is an over-counter drug so it is sold in pharmacies. In Kenya, ORS is declassified. There is the regulatory component.

Michael: The regulation component is often ignored. It still remains on the essential drug list. The problem is that IMCI refers all drugs. IMCI trains personnel to use certain drugs. The pharmaceutical establishment will not easily allow non-clinical personnel to inject or give drugs, not at the community level. It is a policy issue.

Hope: On contraceptive side, we had this battle 10-15 years ago about not allowing it to go outside the medical establishment.

William: It is still going on, most recently in Zimbabwe.

Naomi: The injection is still an issue.

Caroline: Mali did manage to put it ORS into the system disguised as a market test. Without any promotion, sales went up. Official reasons given for reluctance to market ORS were that people might use it as an aphrodisiac, or that people would go into cardiac arrest from too much salt. As was the case with contraceptives years ago, we can move forward -on other issues – incrementally, despite resistance.

Mary: The quality of production is an issue. In anti-malarials, some are not effective due to poor quality.

Michael: These are key issues. It is good when the contents and source are known to be from a reputable company. However, chloroquine can be produced in any garage. In some places, ORS has caused cardiac arrest. It happened in some countries because the sodium content was wrong.

Hope: To recap the issues so far: appropriate use; regulatory environment; and policy. We should not let the policy side stop us. We need to hear people's experiences with contraceptives. Problems to get around are: technology - bed net dipping - and quality problems with bogus vitamin A and anti-malarials. A question to ask later about how we get it out there. Let's take social marketing first. Do you view this as a success? What are the issues that remain and major constraints that still have to be addressed?

Focus on Social Marketing

William: It absolutely has not been a success in terms of level of coverage. The best that we've done is that a quarter of sales in a country are in rural areas, with the exception of some focused areas. This is lousy in countries where 80% of the people live in rural areas. A quarter to rural areas is good by today's standards, but it is still not enough.

Linda: When contraceptives were free, it was easier. It was harder when the price went up. Who, where you getting before that you are not now?

Hope: Outside of Africa, is it any better in reaching rural areas?

Gary: Not in Haiti with contraceptives. Three categories of people for oral contraceptives: definitely no, possible, i.e., the clinic is open on Tuesday, and they only need to go over three hills ...

Hope: The missions, who report back to the Africa Bureau on performance, are high on contraceptives, but the major question is what percent is that really?

Mary: Tell me more about the lack of success with pharmaceuticals.

Camille: What coverage? Ninety-seven percent of pharmacies in Bolivia have ORS. In my view this is not a success. We did pharmaceutical marketing but not consumer marketing, as it is found nowhere outside of pharmacies. We are now striving to find a way to make it a consumer product. We are dealing with two pharmaceutical companies. They know distribution through pharmacies, but they don't know how to reach small stores where it is sold with soap and sugar—wholesalers don't know the system. There is no one solution, we should not deal only with social marketing, but should include NGOs, etc.

Steve said something about limitations because we put on a price. It is a factor, but to get a benefit you have to pay for it—to improve coverage. For example, in 1994, the EU did a survey on the use of public health facilities in Morocco. They divided the population into fifths from rich to poor. The richest 20% of the population used 70% of all public

health services, the next 40% of the population used 21% services, and the poorest 40% used 9%. (See first triangle graph Section II.) This is not unique to Morocco. The richest know what is there and how to take advantage of it. The poorest don't know or can't take advantage of it. What this is inviting us to do and it is what NETMARK is trying to do. The small commercial sector is living in easy urban sectors, with an indiscriminate public sector. We need to invite the commercial sector to move out to other areas which would force the public sector to move out also. A combination of subsidized, social marketing, public services, also NGOs is used to ensure as much coverage as possible. By charging nominal fees and encouraging the private sector, in theory, you free up resources for the lower income segment and the poorest. (See second triangle graph in Section II). This is in theory only; we are trying to prove it.

David: The rich use (free/low-cost) public health services, even though they can afford to pay. Also, social marketing is ineffective in reaching the rural poor. The public sector is displacing the commercial sector. I don't recall this and it really doesn't seem to follow. My premise was/is that cost recovery programs in an effort to be "sustainable" loose sight of the very reason they came into being in the first place, provide access to needed goods and services to the otherwise underserved population. If access is not afforded these underserved then all the social marketing effort succeeds in doing is displacing existing commercial systems by unfair donor subsidized competition.

William: That is an overstatement.

Hope: I want to move on to CBD, and other objectives. CBD appears to be more effective than social marketing in certain areas. One would assume that as with Coke, soap, contraceptives, you could find small stores to distribute certain products.

William: We need to focus on de-medicalization.

Caroline: In my experience in Mali, there was a separate program of CBD through NGOs. The CBD agent kept a fraction of the sales margin. A social marketing program can support CBD by creating brand awareness and a positive image for the product and for behaviors associated with it.

Mary: Is there unbranded social marketing? Is there a need for this?

Steven: There are two schools of Social Marketing. One involves a product or service and mimics commercial marketing in all aspects, including pricing, distribution, packaging, and advertising while the other is essentially social marketing communications and it involves the promotion of ideas, including generic product utilization such as condoms, pills, nets, etc.

Mary: Here, we define it as the picking of a particular product.

David: Part of the problem is there are so many definitions of social marketing. Here we're talking about the PSI style: take a product, brand it, and promote it.

Steven: There is very little incentive for commercial vendors to get out to rural areas in low resource settings. You can sponsor them for a time but as soon as you remove the subsidy they will cease the unprofitable activity. Many needed products can be sold at cost if excessive middlemen charges are not added on to the price. CBDs can provide access to otherwise hard to reach population groups and CBD agents can be incentivized to distribute certain products by allowing them to charge small amounts for them. Social marketers should identify existing networks within the community and try to build upon them. Traditional healers, for example have access to people in need of contraception. This activity can be sustained by the CBD agent identifying what is needed in the community and adding products that would both satisfy the CBD mandate and generate additional resources.

Steven: These are public sector policy issues, and need to follow a market planning process. Kotler had a diagram on this, which I modified to fit a social agenda. We are discussing these things and perhaps this diagram will tie everything together or at least present the planning process in a way that would prompt ones thinking and make sure nothing important was omitted. I have a copy I can show you.

Suzanne: It seems to me that CBDs are just new village health workers. What happened that we are still having this discussion? Partly it is because the national system doesn't have good coverage. Work done twenty years ago was not sustained. Places where we have had success are when there is a partnership between the CBDs and the health system. For example, in Haiti, a private drug company sold ORS in small stores. What happened to that? Because we seems go keep going through this but...

Michael: It's the same in Malawi with Fansidar. The CDC was involved and convinced the government to go outside the system and let it be sold over-the-counter everywhere like supermarkets. This happened in 1993, but it took two years of discussion. They had to store the product for almost a year until the government agreed to a change of policy.

Focus on CBD

Hope: If we go to CBD workers, are they different from village health workers? Are they government or from CAs trying to stay away from the government?

Naomi: CBDs are what survived of village health workers. They are resource-intensive on supervision and supplies. Village health workers were short on supplies; they never had any. However, that is good with CBD programs. Some are with the government, a lot are NGO-run. It is their focus on supervision and supplies, which gave them credibility. As to why it came about—women's empowerment, motivation, child survival, spacing births (too young, too late). Where there is a vertical structure, it is fairly resource intensive. Successful programs tend to be rural-based. With urban-based one the people have more choices.

Hope: With CBD, are there CAs focused on just working with CBDs? With one CA typically given the objective of CBD management, delivery, oversight?.

Naomi: It is linked to NGOs. Pathfinder is one with a large experience.

Barbara Seligman: It is often the way in which policy is addressed.

Naomi: There are pilot programs that have been going on for 20 years.

Barbara: Family planning associations always had volunteers whose role was redefined.

Suzanne: It is sad that we left village health workers. Now that we have the Bamako Initiative, we have more to go on. CBD came in vertically. The real gap is we don't know what the social marketers think. Something to work on inside the system?

Mary: Has anyone ever done this or looked at the experience of Alma Ata to answer these questions—how many tasks can they be given? Should they be paid or not? Is there a review, critique, or summary of the experience with PHC over the last 25 years since Alma Ata? One concerning the role, potential, factors that influence success, multiple tasks, etc. Questions for community workers?

Naomi: The lesson from family planning is integration.

Hope: Something else to move in this ... we always want it done yesterday. We need to be on some sort of accelerated track. Malaria contributed to 30% of child mortality. Most countries are changing their drug policy and we hope Africa gets the right drug. If it is not out there, it will have no impact. These discussions are not only what can we do but what can we do in a shorter time.

Mary: We only have a short time, but there are serious public policy and price issues. We know something about which antimalarial to push, but there are huge raging debates in the malaria world, and no prospect of affordability of drugs past SP. They cost 30 or 40 times as much. Who'll pay and how?

Suzanne: In Malawi, chloroquine was available everywhere. It was cheap and everyone used it, now there is resistance.

Michael: CBD has disconnected with the government. Francophone African CBDs are more and more about family planning, bringing supplies to the village point. Who can connect the CBDs to the district health center which has tons of supplies—ORS/Fansidar—and the CBDs can bring them to the villages? You have to think of the cost. It is costing a lot of money to run CBDs.

William: We see CBDs as another distributors. There is money at end of the cycle, and thus an incentive to re-supply. Social marketing hasn't used many CBD markets.

Susan: With commercially marketing drugs, you must be careful of overuse and resistance. Social marketing programs typically measure success by sales volume. Appropriate uses of products that are sold are not measured in social marketing programs.

William: It is important to go to scale. Really, only the government can do that with CBD and they have failed.

Camille: What about the commercial sector?

Commercial Sector

Steven: What about rural areas?

William: Aren't there profits in rural Africa?

David: To meet the demand out there, there isn't money to get the product out there in the quantities wanted, to take it to scale everywhere in Africa. The commercial sector isn't the answer, but it does have a role to play. The key is figuring out the mix. The bottom line is resources. It is tough to go to Congress here because it is losing battle. AID should get out of dealing with supplies and put it under the commercial sector. One of problems PSI faces is that they get whatever the product that AID orders and are stuck with it for five years. To the credit of social marketing, there has been lots of success, considering that the consumer is faced with packets of ORS that are too big and which make a liter of bad tasting liquid.

We are currently working with S.C. Johnson. They go and figure out what is the best product to meet consumer needs, and try to create the best possible bed net. We need to coordinate the generic market from their program with WHO, UNICEF, etc. Here we all are interested in how to use resources to create the best market and sustainability. There is no one with all the answers but we all must work together. In Zambia, we had a big meeting with all the players to see how to work together to address the problem. For example, PSI is concerned with selling bednets. UNICEF procures them and they want to be in refugee camps, very rural. If social marketing comes in, it kicks out the commercial sector, but we need the commercial sector. Maybe a better use of donor resources is to figure out at what price the product becomes unavailable to rural populations. Say that price is \$4, the maker price is \$7, and it costs UNICEF \$10 to get the product and distribute it. Maybe a better approach is for UNICEF not to distribute nets, but instead provides \$3 vouchers so people can go and buy it directly from the commercial vendor. To focus on CBD, social marketing, etc. alone is losing a battle.

Hope: What was this meeting? Did USAID call it?

David: National malaria control board has monthly meetings. Initially it was AID spearheaded, but now it is moving along independently.

Hope: For just \$8 person in America, we could address malaria and AIDS in Africa. We have done our job so well that if demand increases as suggested, we will need more of the product. At global, regional, and country levels it is easier to sell programs and we are doing more to bring other donors on board. If we can get the programs out there that others can see are working, other resources can be acquired

David: We need to beware of "flavor of the month" approach. Currently it is malaria, but eventually something will overshadow it for political and/or social reasons. We now have to put in a system that can outlast current donor popularity.

Hope: The biggest decision is what are those particular products, or behavior changes, that countries find relevant. Malaria is on the agenda because of Roll-Back Malaria. ORS is not there and Vitamin A is not of technical interest. There has to be more hype. I have more questions on level of interest, staff needs, and after the break it would be good if we could identify serious next steps on how to move ahead. We might want to take bed nets, Vitamin A, or ORS, which is the least controversial, but anti-malarials are very important.

Further Comments on CBD

Gary: You may have heard of the program in Ghana with workplace distribution. Supervisors were trained in the workplace of commercial enterprises. It had been assumed that plantations, factories, trucking, breweries were well served populations, but it was not true. Enterprises want better health among their employees such as fewer kids, less absenteeism. They started buying contraceptives from commercial vendors. I don't know if the program is still working.

Michael: Malawi tea plantations were given subsidized drugs from government-built clinics. It worked for a while.

Hope: What was the staffing and level of effort?

Naomi: There is a lot of focus in CBD on remuneration. But this is a small part of the expense, in the face of the costs of training, supervision, and logistic systems to get materials out to them. Those are often ignored but are significant.

Steven: I am reminded of the cooperative movement in South American agriculture. They managed to get seed, feed, fertilizer, and equipment. I believe it was OXFAM that donated some heavy farm equipment to the Agriculture Cooperative I was associated with in Guatemala in the late seventies. The cooperative rented out the equipment to those who could afford to pay and used the proceeds to support themselves and subsidize seed and fertilizer that everyone could benefit from. Has this ever been tried in CBDs?

Naomi: An example would be an approach like getting a mill for a village which participates in CBD. Most successful in Africa (except Zimbabwe which is very successful), but thought to be too expensive.

Rudolf Chandler: CBD's contribution to CYPs in Kenya decreased from 11% to 3% between 2 DHS. I think it was 1992 and 1997.

Caroline: In Mali, many clients of CBD workers get advice from them, but go buy contraceptives from elsewhere as they don't want their peer educators to know they are using it.

So working through peers can have results which are difficult to measure. This is particularly true when working with youth.

Barbara: CBDs are less and less in favor. Peer education is a favorite approach.

Naomi: Look also at the social marketing of STD drugs which has not been successful. Uganda is the exception where it is very good.

Rudolf: To treat male STIs —cypro 7 days. It took three years to get this through the government as a test program. This STI treatment, as allowed in most Anglophone countries, is sold in small drug shops. In a Francophone country this would be less possible.

Need for Expanding Drug Use vs. Complications

Michael: It was found that the drug was misused and there were signs of resistance. It is a dangerous trend. Some you can distribute with no problem and some...

Mary: There is a tension—without drug they will die but misuse leads to resistance.

Caroline: There are ethical issues. But people go in and get prescription drugs without prescriptions in pharmacies every day. In 9 years in Kenya I never needed a prescription. Education and training of people in pharmacies is needed to improve the way they do it. Few people go to pharmacies after seeing a doctor.

Mary: Tension.

Caroline: It is an issue of trade-offs: what trade-off a government or community is willing to accept. For example, it is possible that easier access to ORS could lead to one person having a heart attack, but many lives would also have been saved as a result?

Naomi: We started by saying that 80% of malarial death occurs at home. Do we know why? Access? Distance?

Mary: Some say there is a subset who will die, others doubt that. Some are doomed to die, some are mild. It is common in Africa to be taken to traditional healer for neurological disorders. Children have fevers all the time, so it is not realistic to go to the doctor every time a child has a fever. With no easy access to health care, they die too quickly.

Hope: I have got to go to another meeting, but one question to put out before I go. What are the advantages with some products of having counseling, where as, social marketing is seen as stepping back? What have we learned about these products that need one to one interaction versus social marketing?

Naomi: And some need one-to-one interaction and then easy access.

Suzanne: Hope left notes on lessons learned, the next step is recommendations. Let's try to highlight recommendations as they come out. Should we divide them by types of products?

Mary: Misuse, leading to bad consequences, is also an issue.

Other Experiences/Issues

Mary: Are there other experiences? We heard about in the workplace.

Susan: In Nepal, access issues were addressed through training Female Community Health Volunteers (FCHVs) to treat non-severe pneumonia with cotrimoxazole. Timers were provided so that workers could time breathing rates, and to identify non-severe pneumonia. Operations research was conducted to demonstrate that the FCHVs could effectively treat children, and helped to convince health authorities that this intervention could be safely implemented. Approximately 30% more kids were treated through this community-based approach, than would have been treated had the medication not been available and the FCHVs not trained in its appropriate use. It was a pilot activity that is now being expanded.

Mary: Is this the same as the one proposed by the TDR (WHO Spécial Program for Research and Training in Tropical Disease) committee?. Every one with fever gets chloroquine. How much better does it work if the health community agrees on what medicine it is? How does it work if they don't agree?

Gary: If we ignore sustainability, there are good opportunities in refugee camps.

Mary: This would provide an opportunity to educate national policy workers, but there is a difference between life in refugee camps versus normal life that can blow up in your face.

Lonna: There was a successful workplace program for contraceptives in a few companies in a few cities in Madagascar. They taped interviews with the factory managers and showed the tapes to others, who also became interested. It was an urban focus except for plantations. With CBD and peer counseling, the location is important. It should be in a known location, not out of the way. Since the workers came to work every day, it was convenient.

Vitamin A

Mary : Vitamin A, what are the issues on how to access it? It needs to be how often people need it.

Tim Quick: There are safety issues with regard to appropriate quantity and frequency of dosing of vitamin A, especially for young children and pregnant women. It is good that for preschool-age children vitamin A can be routinely given at approximately 6-month intervals, but these mega-doses should be directly administered within the context of the health system to avoid the risk of overdosing children or inadvertent administration to pregnant women.

Other micronutrients, such as iron, zinc and iodine, are needed on a more frequent basis, e.g. daily or weekly—not just for young children, but for older children and adults. Daily or weekly multi-vitamin/mineral supplements will have much greater potential for de-medicalization and promotion through commercial channels, but the efficacy and cost-effectiveness of these has not yet been established in developing countries.

Providing vitamin A supplements to preschool-age children can reduce measles' deaths by more than 50%, diarrheal deaths by about 40%, and significantly reduce malaria morbidity (mortality studies have not yet been conducted). Vitamin A is an essential nutrient and an important component of an Expanded Program for Immunity.

William: The possibility for de-medicalization of the different products has to be considered when looking at increasing access.

Tim: Other micronutrients are needed on a regular basis, such as iron, zinc, etc. Not just for young children but for older children and adults. More and improved supplements are needed to meet the needs of different groups.

Mary: With Vitamin A are there cases that need different sized doses?

Tim: Providing Vitamin A supplements can reduce measles' death by 50%, also with severe diarrhea and malaria. It is both a nutrient and important component of anti-mortality.

Financing Approaches/Sustainability

William: Steve mentioned cooperatives as important and valuable as part of creative payment schemes.

Mary: Are Bamako Initiative and cooperatives different?

Camille: In some countries, there exists the Pharmacie communautaire—a system of “tontine”. Whenever women have money, they put it in a basket, and at end of month, the lucky “winner” gets the money for a bed net, etc.

Suzanne: Even systems of community health insurance or “mutuelle” have improved the use of health services.

Michael: Another model is putting money in a pool to give to a health worker to buy a kit so it can be put in the village hospital. It is similar to the tontine system but it is focused on the kit. They are free to go where they want to buy it. There are some examples in Cameroon and Nigeria. Unlike with the public sector, the community gets to choose the drugs they want, but they have to stay within the formulary (official list).

Mary: To the contraceptive people, does it sound like child health is reinventing the wheel?

Naomi: No, because there are more issues of resistance to drugs than there are with contraceptives. Child health professionals have an important role in demand creation.

Mary: USAID plays a big role in procurement.

Naomi: But when AID pulls out, sustaining becomes issue.

Linda: It comes back to the cost of the product. In contraceptives, not even 1/10 of the cost is recovered. Can it become sustainable? It is not foreseeable now, even if other donors come in. The most successful model is with World Bank loans to buy drugs, and that is still subsidized.

David: We have done some potential damage in social marketing. Instead of doing research on pricing, we throw a low price on and create a subsidized product. While some subsidy is necessary, it may be too high and then expectations and habits about price have become established, which must be overcome when more realistic prices must be put into practice.

William: Price matters and ability to pay is lower among the poor.

David: Had there initially been more realistic pricing, there would be less backlash.

Mary: The approach was to create a culture of using a product—get consumers used to it and then deal with price.

William: Bed nets are more naturally appealing than contraceptives. The big challenge is retreatment. They are easy to sell but getting owners to retreat nets is more difficult.

Naomi: Behavior change was the bigger factor, with access as the next.

Lonna: Child health is not a private decision, it is done by groups. Demonstrations can be done in groups, where the group effect reinforces individual decision-making.

Naomi: Contraceptive use is also public because people notice when there are no more kids being born to a given woman.

Barbara: The fact that women were chosen according to social role to be CBDs was due to wanting to model behavior.

Mary: Let me summarize the last 15 minutes. We have issues of strategies and next steps, but with a long vision, issues of changing different strategies at different points in issue. Sustainability, its definition and role, and short term versus long term sustainability.

Naomi: The biggest lesson from family planning is to pinpoint which factors are more important: geography, economics, access, or behavior. These will guide which program interventions will be more helpful. Each will contribute some, but there is a difference between understanding the signs of a fever versus access to help.

Break

RECOMMENDATIONS/NEXT STEPS

Product Review/Categorization

Mary: I found the brainstorming and sharing of experiences very helpful. Now we should try to develop some concrete next steps. This is a very donor perspective meeting. We need to take advantage of the expertise here to know which direction to go in. Think of the time scale, regional approaches versus national, and what collaborations make most sense.

Holly Fluty-Dempsey: District level. Did you all make a master list of child health supplies?

Mary: We talked of ways to characterize them, pharmaceutical versus non, complex with counseling versus non.

Camille: List those which are direct to consumer versus through a medical professional. That helps determines strategy.

Steven: It depends upon the country, and the laws and policy in place.

Susan: What is in the law is not always enforced. The reality is you walk into a shop and ask for something by name and are sold it, or ask for a malaria product and are given what they want to sell you.

Mary: From an anti-malaria point of view it can't be through the medical establishment. It needs to be at the community level.

Lonna: It looks like a 2-dimension matrix, with axes of push/pull and consumer/pharmaceutical

Mary: Let us first list all the items and then put them on the matrix.
ORS, Vitamin A, Iodized salt, ITNs—bed nets & treatment, Soap, Anti-malarials, Birth kits (safe delivery), Safe water (chlorine additive), Anti-helminths, Iron, Iron folate, Multivitamins, Cotrimoxazole/antibiotics, paracetamol, behavior change materials.

Suzanne: They all have behavior change components, three sets of people need behavior change: consumers, providers, and ???

Lonna: And a fourth—policy makers

Camille: Let's pick one country so we can focus. How about Uganda?

Steven: Push or pull largely depends on whether the consumer knows if there is a problem or not? Pull would be when the problem is realized and the consumer accepts

that the provider has a solution to the problem, whereas Push involves a lot of training, convincing, and coaxing.

Mary: In Uganda, resistance to the first line drug is huge. It has not changed the drug commonly prescribed and officially recommended.

Camille: How known by the people is the drug?

Michael: Every mother knows. Mothers go and get chloroquine from the clinic. When it does not help, they get other treatments from traditional healers.

Steven: How much do people recognize malaria?

Mary: Mothers are very attuned to illness. Recognizing it as being malaria is more difficult. If there is a fever and vomiting, they see it as malaria. If the child has seizures, it is seen as spirit possession and the child is taken to a traditional healer. Anemia is very poorly recognized. It depends on the symptom presentation.

Lonna: Vitamin A?

Tim: Uganda is in the very early stages of developing and implementing a national vitamin A program. Zambia has been providing vitamin A capsules with polio vaccine at its National Immunization Days (NIDs) and, in February, they conducted the first Child Health Promotion Week to deliver the second vitamin A capsule six months after the NIDs the previous August. Also, Zambia is the first sub-Saharan country to implement a national sugar fortification program and they are presently exploring fortification of the maize meal ("mealie meal") with vitamin A, iron, and other micronutrients. We want to create a pull for these and other fortified foods, so that they are perceived by consumers as value-added foods so that pricing can allow the food industry to at least recover costs and possibly make some profit. In Guatemala, consumer demand for vitamin A-fortified sugar has become so strong that when the government suspended the law requiring fortification, the public outcry led to a quick reinstatement of the legislation.

Lonna: ORS?

Camille: We are promoting it.

Steven: It costs very little to produce.

Michael: You find it everywhere, but the price varies widely. You can easily find it in markets outside of pharmacies, but the quality is bad.

Mary: Local production, unsubsidized?

Michael: I don't know. Eighty to ninety percent of health workers give ORS with diarrhea. If moms go outside ...

Mary: Cotrimoxazole, antibiotics, but is ORS or any other product widely available?

Michael: Yes

Mary: Outside of pharmacies?

Michael: In the black market.

Holly: If you purchase via black market.

Mary: What is this matrix telling us?

Lonna: Where to put the focus—on supply or on education.

Michael: ORS, anti-malarials, etc. are very popular.

Mary: Next is anti-helminths (deworming drugs)

Michael: I'm thinking for children under 5, as it is different for school programs.

Mary: Paracetamol?

Camille: Very important, but subjective. The pharmacists feel obliged to give something

Mary: It is enabling rather than direct.

Camille: It eases pain.

Mary: Paracetamol encourages use of other products, by linking the person with the health system, but it won't reduce child mortality.

Lonna: Next is iodized salt.

Mary: Is this a child health issue?

William: Yes, it reduces mental birth defects and low birth weights.

Lonna: Pull?

?: Yes, for salt but not necessarily for iodized salt.

Tim: Most sub-Saharan African countries have significant iodine deficiency problems. There is a strong need for push with regard to iodized salt, to sensitize the consumers to the severe consequences of iodine deficiency and to create demand for iodized salt in spite of its higher cost relative to non-iodized salt.

William: There is not a huge consumer demand.

Lonna: Salt makes it a big pull, but iodized salt is not.

Camille: Next is soap.

Mary: Is there a pull for soap?

David: Not for the right reasons.

Camille: There is a pull for soap for dishes, laundry, but not for hand washing.

Mary: It is the same soap used for all? So is it a behavior change?

David: I was going to ask that about anti-malarials. You talk of treating kids, but pregnant women is in the push side.

Mary: Yes, Malawi put it on the common market

Camille: Birth kits. Holly you have a vested interest don't you?

Mary: Is this something given to a TBA or a mom?

Holly: TBA, it is a whole segment of debate on the role of the TBA in reducing maternal mortality.

Mary: It should be "push" in that it needn't be health worker dependent, give them to moms to be used by a TBA.

Steven: Are the kits standardized?

Holly: Yes

?: Are there pharmaceuticals in the kits?

Holly: No.

Mary: Chlorine in water?

William: Mass, but not a pull.

Camille: It is bleach, about 20 drops per liter.

Lonna: Iron and or iron folate also multivitamins?

Tim: Push, women ultimately have to take them at home.

Suzanne: They are not considered pharmaceuticals are they?

Tim: Yes.

Lonna: The only place they can get them is a health provider?

Tim: Through health centers or pharmacies.

Michael: More at pharmacies than kiosks.

Mary: Multivitamins, do they exist? Are they available?

Camille: There are tonic elixirs that are supposed to make you strong, but which really do nothing.

Lonna: So there are no real multivitamins being promoted?

Michael: Things are changing with HIV/AIDS. People are thinking of them again.

De-medicalization and Barriers

Mary: So all of these we want to move from push to pull so people want them?

Holly: What do we with this matrix now that we have made it?

Camille: We need the support of the health care profession for pharmaceutical products. We can't short cut them.

David: It is the incremental approach, long-term. It needs to be approached like it is in the US where they are looking ahead toward over-the-counter future. "Ask your doctor for...."

Camille: If we can look toward what is legally allowed and what the government might deregulate.

Caroline: This same problem was faced early on in family planning work.

Michael: We find that Zambia is not very regulated. Uganda is better at regulating. They are very strict on what is coming in. In Zambia, a national drug authority is just coming into existence. Would they allow us to? The solution for IMCI was that all those trained in IMCI can handle cotrimoxazole.

Holly: We are talking a lot about health professionals and know that people don't go to them. Need to look to others who influence: mothers, aunts.

Mary: We need to look at who is a health professional. What level of training? What are the things that we think could be de-medicalized?

Camille: What are the criteria for it?

Michael: Safety and registration of the product. The products should be divided by level of care.

Mary: What would we recommend or try to work to? Things like birth kits or vitamins could be de-medicalized.

Lonna: Or be moved down the chain.

Hope (returning from meeting): Have you talked about things related to contraceptive dosage and bad reactions?

Barbara: Not about it being terribly misused and misunderstood. In Egypt, there has been a big shift from orals to IUDs because misuse created lots of failure. In south Asia, where level of control is low, CBDs are giving depo-provera, and inserting IUDs. There is no example in French Africa of good pill distribution.

Lonna: A complicating factor as you move down the de-medicalization chain is costs of training and supply. More needs to be done to support to de-medicalized distributors and clients who get products from them. We are talking about things they just can't buy and take, but include a need for counseling.

William: What is good enough for these products?

Barbara: An example is family planning where low quality of care leads to people not wanting to use the product.

Mary: The main concern here is not a bad reaction to the drugs, but increasing drug resistance.

David: While working on contraceptives, it is the economics of it. It isn't the ethics, it is the pharmacies and doctors feeling threatened, so they resisted. We need to show them from the beginning that they are necessary. For example, in Senegal, we used pharmacies as wholesalers of condoms. While in India, when we went mass media with it, doctors didn't want to recommend something that was being mass marketed. Need to talk to the doctor organizations and pharmacy boards.

Michael: Depo-provera

William: Doctors have a vested interest in using other products than ORS, as they are more profitable.

Susan: Where prescribing drugs and selling them are not separated, this has to be taken into account.

Steven: What has USDA done? You need to package ORS in way to popularize it like Gatorade.

Hope: We need to make more available the information that people are spending a lot of their own money on healthcare, but not on the right products - or too late - so they have to spend more. We need to look at what the actual savings might be with programs. I recommend we go step by step with one product to develop an accelerated movement to get the product to the people. Even so, we need to have a USAID consensus on moving forward. Is there agreement that it makes sense to try to get these products closer to the people?

Mary: It is declared policy around the world to get it out there (i.e., improve access).

Tim: With Vitamin A, I am not sure what you mean in this context. If you mean getting a regular bi-yearly dose, in an ideal world they would see a healthcare worker regularly. In South Africa, they get it every three months and if the health workers sees that it is closer to the sixth month mark, then they give a double dose.

Hope: With Vitamin A you can achieve with just two doses a year, you do not use CBD agents or stores. It is more a campaign approach, such as NIDs.

William: Even though there has been success with Vitamin A campaigns, if it is de-medicalized it can be used in daily or weekly supplements.

Michael: For Vitamin A in Zambia there was a well-organized approach including dialogue with the government, and pharmaceutical approaches. It was on the radio every thirty minutes. The supplies were there. We were prepared so it was a success.

Mary: What about lower doses that people can manage themselves?

Michael: What was nice about the Zambia campaign was they knew what they wanted to achieve.

Hope: It's important to get WHO involved from beginning – both AFRO and Geneva; AFRO first.

William: Add UNICEF too?

Hope: Yes.

Mary: In terms of bed nets they have been a big procurer and distributor.

Hope: How do you engage ministries? Doctors?

Barbara: You can't antagonize doctors. The family planning approach was to do research, then expand the research. Show that women are not going to suffer because of quality.

Caroline: It's important to disseminate the research findings, and have the government participate on the research design team.

Barbara: A big concern is that they (doctors) don't support something that moves medicine out of their control.

Mary: Were governments presented with real costs of delivering contraceptives? Because with anti-malarials, cost is a real part.

Michael: There is a definite need for anti-malarials, Vitamin A, etc.

Hope: Does that put more of a burden on what we are doing? Is it a real ...

Susan: In Nepal it was divided between intervention v. non-intervention. Intervention—health worker were trained to recognize and give medicines. Non-intervention—it was recognized and referred on to a health worker. People are buying drugs. Seventy to eighty percent of household expenses are for health, but it is not good spending. They buy the wrong stuff, not enough, etc. Proper education of the person who they buy it from, etc. is very important. We need to measure if a complete course of medicine is sold.

Suzanne: As a package.

Michael: In Africa, some countries have old systems, a vertical approach. Some are moving from a vertical to an integrated approach, such as Zambia & Uganda. We need to bring everybody on board.

Mary: Different approaches are needed, depending on where things fall on the matrix in different countries.

Michael: In some places it is hard to get health workers to promote contraceptives.

Mary: How do we help people do the matrix analysis to decide what the approach should be?

Susan: If want to experiment with expanding access to community level, we need strong donor - strong World Bank - support, because the missions are not going to be buying supplies.

Mary: Where should USAID focus: production, distribution, logistic, or policy, or support CBD?

Hope: When typical technical people get together... first talks on malaria are with Ministry. You don't typically have initial discussions with technical people. In contraceptives, most missions have their own special program for getting them out. For anti-malarials, Vitamin A, etc., I hope we will not need special programs, but how do we get other people to the table, and not as an after thought.

David: Need to get private sector involved. Production is private. They have had it easy as they sit back and wait for order. AID needs to go to them and say you are not a passive supplier. Get them involved from start in developing a long-term strategy and marketing plan, so that when AID pulls out there is sustainability. Get them to commit resources. It gives a better chance of survival, but it also pulls in more resources.

William: Rural Africa is not who they want to market to.

Holly: But there's also urban poor.

David: The private sector is realizing that developed markets are saturated. They need to go to Brazil, China, India, Africa. With S.C. Johnson, Africans don't need Drano, Ziploc, or Windex, so they are figuring out what they do need.

Camille: Segmentation is key to an evolving sustainability in the long-term. We're not going to cover the poor rural African in year 2, 5, 15, but we have a long term vision. Say this is what commercial sector can do to influence public view and use; this is what government should do; NGOs, etc. Involve stakeholders in grand marketing plan.

Lonna: In order to market the plan to stakeholders, it's necessary to let them know what benefit they get from it. For example, WHO wants to achieve their goals and need to get to rural people to do it. The private sector needs to have explained how they can benefit. We need to find what motivates each type of stakeholder.

Hope: Is it baseline information or situation analysis that would guide ministries to do it?

William: They are so risk adverse. We need to show them that they will do no harm.

Lonna: We can show them information from other countries.

Mary: How can we answer concerns? Have a list of answers to their standard questions pulled from our experience of the last 20 years.

Michael: Convince them that 60-70% of Africa buy drugs through World Bank. With no logistics, plans to distribute, market, etc. there are stockpiles at the Ministry and nothing with people. USAID can help with that. Invest 5-10% in logistics.

Suzanne: Suggest process tools for systematic discussion when stakeholders meet.

Hope: Would ministries be open to these types of approaches?

Michael: Tough sell for some drugs. Easier for ORS, iron. Harder for cotrimoxazole, antibiotics.

Holly: Looking toward HIV transmission from mom to kid and treatment with drugs – we should think not only of the existing matrix but of those products that might be added to it down the line.

Mary: We need to really plan for sustainability.

Holly: We can show progress on a continuum. We can be more creative than we are now on measuring success.

Mary: We need to give things a chance to succeed.

Susan: Is there something the regional bureau can do to orient toward a research attitude? It would be good to document methodology so that we have something to give to others later on.

Next Steps—Short-Term

Hope: As far as next steps, let's focus on where USAID has advantage. See other donors, but we want to move forward. Lot of good lessons learned. Can move ahead in two ways. 1) Segment it—Mary and others to talk specifically about anti-malarials, same with Vitamin A, ORS. Or 2) have a smaller meeting to decide whether it is better to have one contract and not take place of current mechanism, but no marketing plan, help with research.

Susan: Wise to focus on one or two particular product. If too much dispersal of effort, not get anything done well. Have concentrated meetings with international partners to be consulted, outline a framework, put a budget on it.

Mary: For anti-malarials, already included many operational research projects. Need meeting to consolidate, see where they are going. Problem with them is the whole world is in process of deciding an approach. It might be helpful to have this group of experts to ... might be strategically smarter to pick a commodity that everyone agrees on a strategy such as ORS, Vitamin A, etc.

Holly: I am fundamentally concerned with a post NIDs approach on Vitamin A. We need to document an approach for other products.

Lonna: It really varies with which quadrant on matrix the product is in. For those in quadrant C, they need to be moved in two directions.

Hope: Over the next several weeks, Mary should get a group together to plan the acceleration of a plan.

Mary: Anti-malarials are very different from ORS.

Hope: But there are a number of countries that have gone first step of choosing the correct first line drug, so look at those countries. It may mean bringing in UNICEF, WHO. Think about the same things on Vitamin A, Holly and Tim. With ORS we need to look at where we are in West Africa. I'll put something in writing. We need to use David's expertise. Susan and Michael, you've been on the ground. We'll bring us back together to see where we are, to see if it makes sense to put together a group for next year or are there already enough groups on the ground that we can use.

Suzanne: What about the country level?. They are not into vertical. We will not do them a great deal of service with vertical approach.

Hope: We need to build that in. I'm not sure family planning people would agree, but child health we haven't had. Country dialogue is very important. We need experience from David on bed nets, versus dialogue on broader issues. We need to get something working on the ground to show people it is working.

William: There have been successes, so maybe they need to be summarized together to find similarities.

Mary: What would a framework around ...

Holly: Notes from this will be useful in forming groups.

David: What jump started bed nets was getting together a bed net task force. Suppliers, marketers, WHO, UNICEF. We had four items and said here are the issues, and everyone put their ideas on table. Once the ideas were out, we said, now let's do something. What are possible countries? We chose Ghana. All the partners contacted their people in Ghana and jumpstarted the program there.

Hope: First meetings were here?

David: Yes.

Mary: What happened to the nautilus graphic? It is a step by step framework that could be useful.

Camille: I will e-mail the BASICS nautilus to all.

Hope: Thank you. I found this very useful and fun. I do really want to move forward on this. All of you, please continue to work with us—the advantage of CAs—to develop

ways, as with bed nets, that we can put this together. See if smaller groups could meet and come back together again, maybe in July, for about two hours so we can see where we are. We also need to identify our African counterparts, who they might be, how we might bring them into the process.

Adjourn 5:05

CONSULTATIVE MEETING ON ENSURING APPROPRIATE USE OF ESSENTIAL SUPPLIES FOR CHILD HEALTH AT COMMUNITY LEVEL IN AFRICA

Wednesday, May 24, 2000 Noon – 5:00 p.m. Vista B/C Rooms
AED, 1825 Connecticut Avenue, 8th Floor, Washington, D.C.

Introduction/Issue Statement

It has become clear that child health care in Africa is focused at the community level, as many children never get to a health facility. The Africa Bureau is concerned that not enough is currently being done to assure that child health products reach the community level and that they're effectively used by the community. The question is: "What approaches and actions should the Africa Bureau take to improve the availability and appropriate use of child health products at the community level?"

Output of the Meeting

Recommendations for child survival projects and their partners on how to improve availability and appropriate use of essential supplies at community level in Africa, based on the experiences of "best practices" to date.

AGENDA		ISSUES TO DISCUSS
Noon	Buffet Lunch	
12:15 p.m.	Welcome/Objectives Hope Sukin	<ul style="list-style-type: none"> ● What are best practices/lessons learned? Why was a particular approach effective?
12:30 p.m.	Better practices/lessons learned re commodities: essential supplies for child health	<ul style="list-style-type: none"> - Elements to consider: effectiveness, equity, cost-effectiveness and sustainability. - What were the policy and advocacy issues that you faced and addressed? - Who did you need to involve for program planning, design, and implementation? - What were the major constraints and how did you overcome them?
1:30 p.m.	Applying better practices/lessons learned from FP	<ul style="list-style-type: none"> ● What advice would you give based on your experience for child health programs? ● How can we build on existing approaches/relationships?
2:30 p.m.	Coffee Break	<p>What ongoing projects/ activities/ approaches (e.g., CBD, Bamako Initiative, etc.) could we work with, in order to move ahead quickly? Who is it necessary to coordinate with in order to take promising practices to scale? How could we benefit (e.g., economy of scale) from a regional approach?</p>
2:45 p.m.	To clarify the advantages, disadvantages, and complementarity of different approaches	<ul style="list-style-type: none"> ● Working with countries to "institutionalize" activities for major national impact.
3:45 p.m.	To identify issues that could benefit from a regional approach, as well as activities/ collaborations that such an approach would involve.	<p>What are the entry points to get local ownership of the approach/activities? Who are the stakeholders and the consensus-building activities necessary to involve them? What are the policy and other constraints? What kind of advocacy activities are needed?</p>
4:00 p.m.	To recommend next steps for child health projects to improve availability and appropriate use of supplies at community level in Africa.	<ul style="list-style-type: none"> ● How to build in sustainable elements when designing implementation?
4:45 p.m.	Synthesis/Closure Hope Sukin	<p>What needs to be done, at what stage, for the activity/approach to last/expand, etc.? What are the major constraints to this and how can they be overcome?</p>

Attendees

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Sustainability Through Public-Private Partnerships

