

**Rational Pharmaceutical Management Plus  
Roll Back Malaria Consultative Meeting on the Role of Informal Private  
Providers in the Management of Malaria, Accra, Ghana: Trip Report**

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### **About RPM Plus**

The Rational Pharmaceutical Management Plus (RPM Plus) Program, funded by the U.S. Agency for International Development (cooperative agreement HRN-A-00-00-00016-00), works in more than 20 developing countries to provide technical assistance to strengthen 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 Therapies
AM	Antimalarials
CBO	Community-Based Organizations
CDC	US Centers for Disease Control
CFW	Cry for the World
FGD	Focus Group Discussion
GFATM	Global Fund to Fight AIDS, Tuberculosis & Malaria
GHS	Ghana Health Service
GMP	Good Manufacturing Practices
GNCSA	Ghana National Chemical Sellers Association
HBMM	Home Based Management of Malaria
HMM	Home Management of Malaria
IMCI	Integrated Management of Childhood Illness
IPP	Informal Private Providers
IPSP	Informal Private Service Providers
LCS	Licensed Chemical Sellers
M&E	Monitoring & Evaluation
MAC	Malaria Action Coalition
MCMWG	Malaria Case Management Working Group
MNH	Maternal and Neonatal Health Program
MS	Medical Stores
MSH	Management Sciences for Health
Mx	Management
NAPPMED	National Association of Patent Medicine Vendors
NGO	Non Governmental Organization
NMCP	National Malaria Control Program
NTN	Neighbour to Neighbour
OTC	Over-the-Counter
PMV	Patent Medicine Vendors
PP	Private Providers
PPD	Pre-packaged Drugs
QA	Quality Assurance
QAP	Quality Assurance Project
RBM	Roll Back Malaria
RDT	Rapid Diagnostic Test Kits
RPM Plus	Rational Pharmaceutical Management Plus
SEAM	Strategies for Enhancing Access to Medicines
SMoH	State Ministry of Health
TBA	Traditional Birth Attendants
USAID	United States Agency for International Development
VTV	Vendor to Vendor
WANMAT	West African Network for Monitoring Antimalarial Treatment
WARN	West Africa RBM Network
WARP	West Africa Regional Project
WHO	World Health Organization

*Roll Back Malaria Consultative Meeting on the Role of Informal Providers  
in the Management of Malaria, Accra, Ghana*

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## **Background**

More than 90% of the clinical cases of malaria each year occur in Africa with much of the burden in children under five years of age. Pregnant women are especially at risk and strategies to decrease the morbidity in this group have been found to be effective. Strategies to address these challenges must be implemented in collaboration with programs aimed at integrated approaches to childhood illness and reproductive health.

Management Sciences for Health's (MSH) Rational Pharmaceutical Management Plus (RPM Plus) Program has received funds from USAID to develop strategies to implement malaria policies and to provide technical assistance in drug management issues for malaria. RPM Plus is a key technical partner in the USAID Malaria Action Coalition (MAC), a partnership among four technical partners: The World Health Organization (WHO), the US Centers for Disease Control (CDC), the Maternal and Neonatal Health Project (MNH) and RPM Plus. A key objective of the MAC is to create partnerships and linkages with other Roll Back Malaria (RBM) partners. MSH has been working through its Strategies for Enhancing Access to Medicines (SEAM) programs and through RPM Plus to support innovative strategies targeted at improving access to antimalarial treatment through private sector providers.

## **Purpose of Trip**

The purpose of the trip was to attend the Roll Back Malaria (RBM) consultative meeting on the role of informal private providers in the management of malaria in Accra, Ghana which was organized by the Task Force on Private Providers of the RBM Malaria Case Management Working Group. The meeting was to provide a forum for discussions on interventions to improve the role of private providers in malaria case management for children in Africa. The Task Force recognized that there was a need to assess the current state of experience working with Informal Private Providers (IPPs) to improve their ability to correctly manage malaria in children. Based on this recognition of need, the Malaria Case Management Working Group (MCMWG) approved a two part activity: the first of which would undertake a comprehensive review to assess the strengths, weaknesses and potential for taking IPP interventions already being implemented to scale, as well as identifying gaps in current experiences. The second activity would be the Consultative Meeting that would use the review as the basis for developing a set of recommendations to the MCMWG.

RPM Plus being a member of the Task Force provided technical input regarding drug management issues to discussions at the Consultative Meeting.

In addition to attending the RBM Consultative Meeting, Gladys Tetteh followed up with RBM stakeholders in Ghana to discuss current RPM Plus Malaria/Ghana Health Service planned activities and potential activities for the coming fiscal year.

RPM Plus also has some funding from WARP/USAID for malaria activities and it was planned that while in Ghana, Gladys Tetteh would join a separate RPM Plus team visiting WARP/USAID to have discussions with partners on potential activities under that funding; she

would act as technical lead for malaria activities on that team. A separate Request for Country Clearance was sent to WARP/USAID in this respect.

## **Scope of Work**

Gladys Tetteh's scope of work on this trip was to:

- Attend and participate in the RBM Consultative Meeting
- Provide technical input for drug management issues during the discussions
- Meet with RBM partners attending the RBM Consultative Meeting to discuss malaria issues
- Meet with the Director of Public Health, the National Malaria Control Program manager, and other relevant stakeholders to discuss current and future activities on the RPM Plus Ghana workplan
- Meet with WARP/USAID mission, West Africa RBM Network (WARN), West African Network for Monitoring Antimalarial Treatment (WANMAT II) to have discussions that would help finalize the WARP/USAID/RPM Plus workplan
- Provide an arrival briefing and /or departure debriefing to USAID upon request

## **Activities**

### **Attend and participate in the RBM Consultative Meeting**

This two day meeting aimed to:

1. Provide guidance for country managers and other RBM partners on different approaches to involving Patent Medicine Vendors (PMVs) for case management of malaria in children under 5 years of age
2. Identify sources of information on PMVs which could be used for planning
3. Provide guidance to ensure collection of useful data from PMV interventions, and
4. Identify and prioritize key knowledge gaps where further research is needed

The meeting took the form of presentations, group work and plenary sessions. Presentations included an overview of the intervention to improve the role of informal private providers in malaria case management for children in Africa, home management updates from RBM, training with respect to informal drug providers, franchising, negotiation and persuasion, vendor to vendor interventions, informal private provider perspectives, consumer and government perspectives of PMVs.

The two main categories of activities presented under interventions reviewed were rapid versus long-term interventions with PMVs – The relatively rapid approach was seen to have a limited change in case management practices (resulting from short training, facilitated by PPDs). The long term approach gave a longer term change in PMV roles and health systems (a goal of

franchising, requires strong policy support and money). The review showed that both types of interventions led to increased PMV knowledge and practice – specifically increased knowledge of malaria signs, symptoms, and appropriate medicines; increased stocking of recommended drugs; increased sales of appropriate drugs and dosages; increased history taking and communication on drug use and increased display and use of behaviour change communication materials.

Group work debated three important issues surrounding informal providers, namely

1. Whether RBM should recommend investment in Informal Private Service Providers (IPSPs)
2. What universal name to call the target group of IPSPs
3. Possible short and long term strategies and the role of stakeholders.

A review of group work saw discussions providing answers to the following questions posed by the meeting:

***Should RBM recommend investment in IPSPs based on existing evidence?***

- Yes, with qualifications

***Name to call the target group of IPSPs***

- Medicine sellers – licensed / unlicensed
- Private service providers (PSPs)

***Short and long term strategies***

- Should consider that there is an urgent need for rapid action
- Start work from the existing situation.
- With ACTs important to make sure that it is accessible to the poor and attractive for the medicine sellers to sell – likely to require substantial subsidy
- Short term interventions can still be combined with longer term systems changes

Rapid approaches were seen as: Feasible, acceptable, practical but variable impact was noted.

Long term approaches were seen to be potentially more sustainable but were more expensive and susceptible to commercial market

***Roles of stakeholders***

- Government needs to take ownership and deal with tracking and coordination of donors and medicine sellers.
- Donors – advocacy for donor diversification
- NGOs/CBO – have a substantial role especially in dissemination of information
- Private providers offer a large resource
- Medical stores partnerships – easier to work with medical stores where there are associations

Further consensus was reached by the meeting to identify a universal name, preferred method of intervention, and whether or not interventions with informal private providers was justified:

**Name:**

Inclusion of different groups makes it difficult to limit the name.  
It was **agreed** to call them “**Medicine Sellers**”

**Assessment of slow vs. rapid approaches.**

The meeting recognized that there are pros and cons between choices and that there is no one way. **It was agreed that** the choice of strategy in each country has to be determined according to the situation and that it will probably be adapted through a learning process.

- Even the rapid approaches have long term implications and benefits
- There are a series of important components common to all programmes which increase the chances of being successful – One approach may be highly focused the other more service related these will be important in different contexts and will not be mutually exclusive.
- A spectrum of activities is required according to the situation.

**Is intervention with medicine sellers justified?**

**Agreed that:**

- Mixed model is probably the most appropriate.
  - There is sufficient urgency to promote medicine sellers but there is a requirement to continue implementation research, especially in the countries where attempts to go to scale have already begun
  - Consensus that RBM should be encouraged to include medicine sellers in its strategies.
  - the risks of not doing this at all are significant but that many questions remain. The problem is not a question of funding or not but an issue of how to implement.
  - Clear that it is feasible to involve MS. Not clear how best to do it. How effective it will be and at what cost.
  - Necessary to ask the partnership to put effort into the process.
  - The lessons of the past are important (e.g. TBAs)
  - Guidelines to help countries implement are required.
  - The decision making process requires a discussion of the whole scenario, consideration of the different components of the interventions, identification of where there is complementarity between programmes and what the real objectives are.

Below are the MAIN CONCLUSIONS from the workshop (*see Annex 1 for Rapporteur’s notes*). These were the main take home messages to both Ministries of Health and RBM partners in attendance –

- On the basis of encouraging results from trials and projects to improve private sector practices and on the risks associated with non-intervention, **it is necessary for Ministries of Health and RBM Partners in those countries, where a large part of the population obtains its treatment for malaria from “medicine sellers”, to engage with**

**the private sector as soon as possible to strengthen implementation of programs for improving access to effective antimalarial treatment.**

- There appear to be 2 main categories of intervention, forming a spectrum of activity from rapid to long-term implementation. **Countries will need to find a balanced approach as there is not a real dichotomy. Selection of strategy in each country will therefore be according** to need; based on situation analysis and probably adapted through a learning process. Long-term components of rapid implementation, such as continuation of supervision and refresher courses will require planning.
- **Monitoring and Evaluation (M&E) and sustainability are important parts of the process** – operations research, documentation – to add to knowledge
- There is urgency but **intervention should be focused on achievable objectives. Partnerships will be required to integrate ways of evaluating impact and determining sustainability.**

**Meet with the Director of Public Health, the National Malaria Control Program Manager, and other relevant stakeholders to discuss current and future activities on the RPM Plus Ghana workplan**

Separate meetings were held with the Director of Public Health, Ghana and the National Malaria Control Program Manager. RPM Plus Malaria has one remaining activity on its fiscal year 2003-2004 Ghana workplan which it plans to undertake in July, 2004. In this activity, RPM Plus will provide technical assistance to the Ghana Health Service to assess the availability of antimalarials in the public and private sectors and investigate the quality of antimalarials in the private sector.

With regards to future activities, the main requests by the NMCP for drug management technical assistance amongst others were support for the antimalarial drug treatment policy transition period, standardization of pre-packaged Artesunate/Amodiaquine, as well as pharmacovigilance for and deregulation of Artesunate/Amodiaquine.

**Meet with USAID/WARP mission, West Africa RBM Network (WARN), West African Network for Monitoring Antimalarial Treatment (WANMAT II) to have discussions that would help finalize the WARP/USAID/RPM Plus workplan**

*(See Annex 2 for WARP Trip Report)*

**Provide an arrival briefing and/or departure debriefing to USAID upon request**

An arrival briefing with Dr. Jan Paehler, Child Survival and Infectious Diseases Advisor, USAID Ghana Mission was not possible due to a pre-scheduled absence from the office. Upon his return, a scheduled departure debriefing was not achievable due to the ongoing Health Summit in Ghana.

**Collaborators and Partners**

*(See Annex 3 for list of participants at RBM meeting)*

**Next Steps**

**Immediate Follow-up Activities**

- Debrief USAID and RPM Plus on findings
- Finalize Ghana workplans on the basis of NMCP requests



## **Annex 1.**

### **RBM Consultative Meeting on the Role of Informal Private Providers in the Management of Malaria**

**May 26<sup>th</sup> 2004**

<b>Rapporteur's Notes</b>	<b>Morning Session</b>
<b>Opening Ceremony</b>	<b>James Banda</b>
<b>Chairman's comments</b>	<b>George Amofah</b>
<b>Objectives of Meeting</b>	<b>Sylvia Meek/George Greer</b>

Gave context of the meeting – basically that current public sector health providers do not have the capacity to achieve the Abuja Targets of high coverage of priority interventions by 2005. In addition, RBM promotes partnerships to involve all potential contributors.

In many countries Patent Medicine Vendors (PMVs) are a major source of health care and use of medicine vendors ranges from 15-82%. While PMVs give many people access to treatment the quality is often poor.

The meeting is part of an undertaking to explore ways of making better use of the resource provided by PMVs.

Origin of meeting - RBM Malaria Case Management Working Group (MCMWG) – advising on best practices to go to scale: sub-group for Communication and Training. Set up Private Provider Task Force

- To provide guidance and recommendations to the Roll Back Malaria (RBM) partners, via the Working Group, on promising and appropriate strategies for engaging informal private providers to improve management of malaria in children.

Specific objectives of the meeting - using the review as a guide,

- provide guidance for country managers and other RBM partners on different approaches to involving PMVs for case management of malaria in children under 5 years of age.
- identify sources of information on PMVs which can be used for planning
- provide guidance to ensure collection of useful data from PMV interventions
- identify and prioritize key knowledge gaps where further research is needed

**Presentation – Overview of “Intervention to Improve the Role of Informal Private Providers in Malaria Case Management for Children in Africa”**

**Bill Brieger/Alasdair Unwin**

Defined IPSPs; Status Issues; Methods; Inclusion Criteria; Alternative Training Interventions; location of the 15 studies (all Anglophone); discussed the conceptual framework used; and shared the findings.

Conclusions-

- Interventions can change PMV knowledge and practice, though not 100%
- Few measured, but changes in consumer knowledge and practice possible
- No knowledge of impact on child survival
  - Especially in terms of socio-economic groups
  - Though utilization suggests low income can be reached
- Don't know best combination and differential value of intervention components
- Limitation – not all reached by PMVs

**Presentation: Home Management of Malaria – Update and Discussion by Wilson Were**

*Home Management of Malaria Strategy - Outcome of the Technical consultation January 2004 & Meeting on Implementation Guidelines in AFRO, Harare, May 2004*

Highlights:

- Although different levels of intervention exist, HMM focuses on points of intervention at the community and home level.
- There are available WHO documents on community involvement in malaria management
- A technical consultative meeting held in January 2004 had objectives of reviewing current evidence and experience, defining strategic components, recommending and outlining implementation steps, tools and guidelines and identification of gaps.
- Definition of HMM was re-stated and the fact that it should be designed as an integral part of the overall RBM strategy on case management
- Presentation enumerated good public health gains from HMM and evidenced this
- Strategy document and Implementation guidelines to be out soon

**Discussion:**

*Home Management of Malaria*

Whether recognition of malaria by caretakers was a problem was debated as well as whether or not emphasis should be limited to what action is taken when malaria is recognized by caretaker. It was agreed that recognition of malaria by caretakers is a problem when looked at with respect to the whole spectrum of malaria – uncomplicated to severe malaria.

HMM, although not stated explicitly in the definition, includes prevention as well as treatment of malaria – RBM emphasizes that HMM fits within the overall malaria control strategy. Integration of prevention and treatment of malaria within HMM is very important during implementation of malaria programs in the field.

It is a fact that surveillance with drug reactions is not listed under strategies for HMM. This is because it is believed that education to communities on the use of antimalarial drugs will include “what to do regarding reactions from any antimalarial drug”.

*Impact of Use of Pre-packaged Drugs*

It was determined that making drugs free at public health facilities has not necessarily increased use of facilities. Implementation of such policies varies in individual districts of countries and other fees such as consultation fees, card fees etc. cancel out the “free” aspect. Pre-packaging has been shown to improve access to case management in the private sector, particularly in areas where access is poor. The intention of promoting pre-packaged drugs through private retail outlets has not been to draw patients from the public to private sector but to move services closer to clients.

**Presentation: Training – Kenya, Kilifi     Vicki Marsh**

*Training anti-malarial drug retailers in Kenya*

Highlights:

- Described phases of work of intervention
- Comparison of % OTC treated fevers given adequate dose of a recommended antimalarial (AM) drug in early and late implementation
- Evaluation of % OTC AM users taking an adequate dose
- Incremental cost effectiveness measured
- A strategic framework for home care interventions developed and shared
- Components of an effective programme seen to include Advocacy, Availability, Affordability and Quality and result in uptake of drugs to benefit users and adherence by retailers also to benefit users

- Strengths and weaknesses of program and challenges to scaling up enumerated
- Research gaps identified

**Presentation: Training – Nigeria, BASICS      Leila Maueke**

***Patent Medicine Vendors: Abia - Nigeria Experience***

Highlights:

- Defined PMVs as having a fixed drug shop structure to sell from; not having any formal training; shop is not registered with Pharmaceutical Society of Nigeria
- Shared PMV intervention concept and design
- Enumerated essential components of PMV intervention in Abia State, Nigeria
- Described training
- Listed achievements and discussed scaling up issues including total cost per PMV

**Presentation: Training – Nigeria, SFH      Michael Alagbile**

***Pre-packaged Malaria Drug Project NFH/PSI***

- Provided overview of project components
- Activities to date enumerated
- Described the program strategies, PPD distribution strategies, promotion – generic & branded
- Discussed challenges and scaling up issues

**Discussion:**

*Inclusion of Traditional Healers*

Whether or not traditional healers should be considered under PMVs was discussed. Informal providers in the community cater to needs for uncomplicated malaria; however traditional healers seem to be the providers visited by communities with respect to severe malaria. Discussion to be continued.

*Focus of PMV programs*

Programs seen to focus on children only. There was a query as to whether field experience indicates shows no problem with adults regarding access to antimalarials. It was agreed that adults are more likely to obtain and use antimalarials than antipyretics from drug retail outlets.

*Peer to peer counseling*

Peer to peer counseling deemed to be better than organized training in some circumstances. Organized communication strategy is important. One to one peer group should be used as a follow up.

*Advocacy with Stakeholders*

Some policy makers say that PMVs should not be trained. Therefore there is the need to show results to convince policy makers that PMVs are useful. In addition pharmaceutical groups are usually difficult so need evidence to convince them

*Scaling Up*

Typically projects receive funding from a source and have multiple partners. The issue of scaling up becomes a problem because expanding of projects with multiple partners is not easy. The group needs to deliberate further on how to go to scale when many partners are involved in a project.

*Drug quality*

The extent to which pre-packaged drugs (PPDs) will solve quality issues was debated. PMV programs seem to acknowledge the importance of drug quality and are said to have put strategies in place to maintain drug quality. Some of these include independent testing of products, liaison with regulatory bodies, PMV education on counterfeit drugs and consequences of purchasing them from manufacturers/wholesalers. Drug quality assurance, however needs to be considered realistically with respect to implementation of programs as the appearance of counterfeits on the market are directly a result of introduction of PPDs. It was suggested that good manufacturing practice (GMP) can be regulated better so the quality assurance issue should be controlled at the manufacturing level.

**Afternoon Session**

**Presentation: Franchising Kenya – SHEF/CFW**                      **Liza Kimbo**

***Sustainable Healthcare Enterprise Foundation***

Highlights:

- Status of CFW shops – Acceptance by national authorities, problems faced
- Strengths and weaknesses of program
- Problems affecting scale up include political/legal, environmental, technological and people problems
- Main knowledge/experience gap is cost of the intervention

**Presentation: Franchising Ghana – SEAM**                                      **Kwesi Eghan**

***The Role Private Providers: A case for an Essential Medicines Franchise in Ghana***

Highlights:

- Discussed the CARE shop franchise
- Franchisor/franchisee expectations
- Current status of the intervention
- Strengths and weaknesses of franchise conversion model
- Factors affecting sustainability
- Monitoring and evaluation plan

**Presentation: Negotiation/Persuasion – Uganda**                                      **Jesca Sabiiti/Youssef Tawfik**

***Improving Formal & Informal Private Practitioners' Quality of Care for Child Survival and Malaria - Case study: Education, Negotiation and Persuasion approach. Lessons from Luwero District, Uganda.***

Highlights:

- Background and rationale to approach
- Steps in Negotiation, persuasion and education of private providers
- Results showcased case management of simple malaria and effect on treatment of complicated malaria
- Acceptance of intervention at national and district level shared
- Strengths and weaknesses of approach
- Costs of approach
- Modifications necessary for scale up

**Presentation: Vendor to vendor – Kenya, Bungoma QAP project     Steve Harvey**

***Impact of two community interventions on private retailer practices and consumer demand in Bungoma District, Kenya***

Highlights:

- This project like many other PMV projects is a multi-partner project including USAID, AMREF, Government of Kenya, QAP
- Location of interventions shown
- Description of two main types of interventions - vendor-to-vendor (VTV); neighbour-to-neighbour (NTN) and the respective conceptual framework
- Evaluation results of VTV (2000-2002) - some indicators discussed were *Reported usefulness of the job aids, among outlets that received them (2002); Specific malaria knowledge by intervention status of outlets; Proportion of outlets with SP drugs in stock, 2000 vs. 2002; and Proportion of shoppers that sold approved antimalarials, 2000 vs. 2002*
- Evaluation results of NTN 2002 – some indicators discussed were *Exposure to some aspect of NTN by district visited, May 2002; Percent who requested approved SPs, of those who asked for drugs by name; Consumption of correct SP dose; Reported consumer practices by patient age (NTN vs. Non-NTN areas)*
- Current status of the intervention and training approach effectiveness, strengths, weaknesses and ways to improve effectiveness were discussed
- Spread and costs of VTV interventions noted
- Costs of NTN if replicated
- VTV and NTN continuing challenges enumerated

**Discussion:**

*Focus of PMV interventions*

It was recommended that inasmuch as it might be good to broaden scope of PMV interventions to include other child survival issues, it is wise to stay focused on malaria so as not to overburden vendors and annul any potential benefits. The decision on how broad or narrow the focus should be is one that should be made in light of the location of and priorities in the district of intervention.

*PMV interventions that mix formal and informal providers*

Such mixes were not seen to be a problem as these two groups could be evaluated separately.

*Franchising issues*

Franchises sell only drugs agreed upon by franchisor/franchisee. Drugs on list are Food and drugs board approved, pharmacy council approved, typically on essential drugs list and usually in demand. Sundries and toiletries not supplied by franchisor.

Franchisors try to maintain tight regulatory systems and have contracts with franchisees. Occasionally, there is the need to revoke a franchisee's contract on the basis on non-compliance to set regulations.

Franchisee owners must be full time employed. Some programs receive applications from nurses who are public sector employed but these are not processed.

Some governments do not allow for mass communication to be applied to conversion franchised retail outlets – this does not help with visibility of the outlets. They do however allow mass communication on products.

It is the aim of franchises to sell medicines at 5% below market price but this can only be achieved when critical mass is achieved.

**RBM Consultative Meeting on the Role of Informal Private Providers  
in the Management of Malaria**

**May 27th 2004**

**Rapporteur's Notes**

**Morning session**

**INFORMAL PRIVATE PROVIDERS PANEL**

**Chair. Caroline Jones**

**Presentation: - PMV association Nigeria – Abia state. Chief M.O. Nwogwugwu**

**Highlights:**

- strong motivators for vendors
  - to gain knowledge on how to help children who were not getting better
  - methodology was good enabling passing on of Knowledge
  - relation ship with governments has not been good but after the intervention it improved
  - but, some not keen to participate. Feared retribution and loss of profits
- Sustainability - PPDs, training materials, training and updated training good for sustainability. Supervision is necessary; Licensing will help; Monitoring of skills necessary; Store from which to purchase PPDs would help.
- Problems
  - Fees of licensing a stumbling block to getting more members
- Supervision
  - activities of the PMVs must be supervised.

**Presentation: - Ghana Licensed chemical sellers assoc. Djan Mantey**

**Highlights:**

- Important motivators for vendors
  - Improvement of knowledge and skills
  - Increase level of service that LCS can provide
  - BCC materials boost image of shop
- Deterrents
  - High cost of training; Distance to training. centre; unwillingness to leave shops for training.
  - Posters may be a nuisance; Image of posters may be a deterrent.
- Sustaining factors
  - On going training. with refresher courses
  - Training practical not theoretical
  - Targeting of outreach to service providers
- Improvements
  - Reduce cost of training; More suitable times and venues
  - More refresher courses
  - Improve efficiency of poster/leaflet distribution
  - Target LCS as a group not individuals or splinter groups.

- Relationship with Government.  
Generally regarded as cordial, through the Pharmacy council and has improved down the system with decentralization. Having GNCSA has provided a channel for communication. Representation by GNCSA on subcommittees of pharmacy council suggested.
- Suggested that LCS should be viewed as an arm of the GHS

**Presentation: - Kenya experiences of franchise. Rose Mutton** – presented by George Greer  
Highlights:

- Motivators:
  - Training is excellent and not available through normal channels; members are supported by franchise and have access to cheap drugs that are delivered.
- Deterrents
  - Cost to join system high, loan repayment rates high, loss of investment if closed.
  - Length of supply cycle is long so have to carry high stocks, cannot stock some products that may be prescribed in hospitals so cannot compete with unrestricted outlets. Lab testing is limited and causes diversion of clients to places that do offer them.
- Improvements
  - Increase joint training.
  - PHOs harass the nurses so poor communication with Government services needs to be improved. Harassed by municipal license enforcers but should not pay because they are providing essential medicines.

**Panel discussion: -**

*Referral of complicated cases to Health Centres.*

LCS have a limit to what they can dispense – where cases are complicated they do refer. Do perceive that the service component is important and that the profits will come if the service is good. The association wants to help members to see this.

*What led to the organisation of LCS?*

LCS are controlled by the Pharmacy council; the association oversees the LCS and has been able to organise through a national council. At district level have members with a local chairman so that a chain of command exists which aids communication; regional chairmen to district chairman to members.

In Nigeria not possible to know for sure what proportion of the sellers are covered by the associations nor how to bring more into the associations. But the associations do want all the sellers to be licensed. During the training they do try to make sure that people are licensed but it is the ability to sell the right medicine that is more important to the users than the license  
In Ghana - Regulation and prices are the same for all groups of sellers so the franchisees do not get any regulatory advantage.

*Training content.*

Ghana: pharmacy council coordinates the content. Shop owners get the training but what about the attendants? Also considered that owners of shops do tend to stay in them as it is their business so concerns about target group may not be so important.

*Fake drugs:*

SP drugs are now being used – PPD stocks from a central source would help encourage QA. Associations are suggesting to NGOs that if there is a central storehouse it could encourage PMVs to buy there. A belief that customers are able to make judgments about good drugs persists; as sellers know that they depend on what they sell, they will try to sell what is recommended.

## **CONSUMER PERSPECTIVE PANEL**

### **Ghana Health Services - Irene Agyepong**

**Highlights:**

- Presented synthesis of data from local studies. What is known what would they like.
  - From 1990s Bamako Initiative in place many failed. In 20 rural communities, most had LCVs of some sort. Mostly petty traders, older women and semiliterate. Turnover too low to enable them to maintain fees. Drugs generally not cheap are were frequently expensive branded antipyretics. Main motivator was proximity
- From user FGDs most wanted to use licensed vendors who had had some training. 50-60% treated at home without advice. Either used left over drug or bought from vendor, 0-30 % sought advice from a drug seller.
- Basic issue is **access** – easier to buy in the village and not spend money on transportation. Or suffer opportunity cost. Quality – people want good quality and tend to prefer blister packaging. Do not like to see people using their hands to service drugs
- TMVs people interpret biomedicines along TM lines. Should not let the social practice obscure fundamentals of access and quality assurance and cost. Information access is valued but people do respond to information – consider using the techniques of the TMVs People make do with what they have from necessity it does not mean that they do not want good information and service.

**Panel discussion: -**

*Need more information on interventions*

Concern was expressed that there is a tendency to dodge the issues of: Systems, Economics and politics. Most information from users reports what is the first thing they do. Noted that many reports do not identify what is sought first. Lowest level treatment is often just paracetamol.

*Access to Medicine sellers*

When doing research if perceived as officials then will not get co-operation. Noted that itinerant peddlers may be a problem because of storage conditions balancing the public good with the public risks so they may be targeted by officials even though they are providing a necessary service to remote communities. Recognised that pushing people underground can make the service even less good and create more problem.

Care seeking is dynamic and the progression is determined by day to day review. Over time the use of vendors declines and clinics and hospitals go up. Within 2,3 or 4 days care will be sought from a place other than a shop. In Ghana there is now a move to locate nurses nearer to the community but there is not any evidence of how this impacts on morbidity and mortality.

**Presentation: Issues around introduction of ACTs. – Sylvia Meek**

**Highlights:**

- Rapidly changing situation.
  - Nevertheless there is a need for a policy – which may need to be updated.
  - Unclear what would happen in MS shops if ACTs are excluded from list of what they can sell. But ethics of allowing ineffective drugs to be available in the private sector over a transition period remains questionable.
  - Problems with non co-formulated products persist
- Benefits of allowing ACTs in Private sector:
  - Cost saving to the system by having effective Rx early
  - Minimise use of mono-therapy
  - Greater access to effective drugs
- Drug supply:
  - Whether supplies are sufficient in the short term is uncertain probably looking at a 3 year gap for supply to catch up with demand during which prices are likely to rise then fall.
  - Much malaria treatment is not needed, so could reduce the need through more rational drug use, either through better diagnosis or better targeting (limit use for under 5s).
  - Noted that cost of RDTs in private sector will be much greater than in public sector. Training might improve use.
- Subsidy:
  - Likely that subsidy will be required in order to ensure that the most poor have access.
  - Range of mechanisms and levels possible but will require better estimates of need and cost. Targeting of subsidy would increase equity – biological risks groups and /or economic targeting
  - Risks if not available to MSs. Inequitable, risks of theft higher, risk of fakes higher, continued use of monotherapy
- Introduction of ACTs
  - Develop strategies for formal and informal sector. Insufficient data to know if ACTs will favour one intervention strategy over another. Containment of cost will be important but bulk purchasing should bring cost reductions favouring pooled procurement.
- Priorities:
  - Include medicine seller issues in policies. Begin process of registration as OTC
  - Research: diagnostic strategies, implementation research for different subsidy routes

## **Discussion**

### *Cost:*

The cost will depend on which ACT is used. Coartem – \$2.40 for adult dose (.7 child) ART/AQ may be a bit less but cost likely to be 10 times current costs. Prices expected to come down but through 2005 prices likely to go up possibly could go down by 50% after that.

WHO estimates minimum need of 90 million doses for 2005. But a phased public sector approach would probably meet only 50% of real population need. 600 million people at risk US\$ 1.6 billion per year to treat all (Snow) WHO estimate is for \$1 billion annually. WHO expect some bottlenecks in 2005. main manufacturer concern is that they need to be able to sell what they produce. Reported that WHO believe manufacturers do have the capacity to respond to demand. Subsidy is already extensive on ACTs.

### *Resistance:*

Very little resistance at the moment some suggestion that there may be higher levels than hoped in East Africa.

### *Introduction mechanisms*

A dilemma exists on how to fill the gap for HBMM – how can the drugs be deployed into the community – what happens to the private provider who sells chloroquine. Policy is changing not to allow

sales of ACT. There is no clear OTC replacement now yet campaigns will have to continue to promote early treatment. This raises the problem of promoting ineffective drugs during a transition to ACT when it is not available.

Treatment needs will not stop while ACTs are being introduced. If governments ban existing drugs there will be increased morbidity. A pragmatic approach would be phased introduction that will require very clear communication at all levels so that there is knowledge freely available to all. Governments should refrain from banning treatments till there are alternatives.

Concluded that approaches should be very realistic – policy change is a process and even with all the drugs needed it is not possible to flood the whole country at the same time. Implementation is a process. Private sector as partners already know how they get the drugs from manufactures including artesunate. Need to look with this perspective and be pragmatic. Countries need to make time for themselves to introduce new drugs.

## **GOVERNMENT PERSECTIVE PANEL**

**Chaired by Allan Schapira**

**Presentation: - Government perspectives on IPSPs – Pharmacy Council, Ghana**

**Kojo Puni**

**Highlights:**

- brief description of Pharmacy council history, role and functions
- 2,058 registered pharmacists / 9,000 licensed chemical sellers
- interventions to modify IPSP practice – regulation and enforcement, training for LCSs

- Drug quality assurance – enforcement and persuasion
- Voluntary licensing, examination and interview required of LCSs
- Training is available from council
- Lack of regulation is not an option

**Presentation: - Abia State PMD intervention pilot – Abia State Pharmacist  
MC Uzuegbu**

Highlights:

- State support sought prior to inclusive intervention planning process
- Combined with approved pre-packaged drugs
- Pilot successful in 2 LGAs, 9 other LGAs showing potential for scaling up
- Relationship between SMOH and NAPPMED (national association of PMVs) improved
- Use of PPDs increased confidence in the drug quality

**Presentation:- National Home Management Strategy – Kenya**

**Liza Kimbo / WM Mutemi**

Highlights

- National Malaria Strategy developed into **business plan**
- Business style approach encouraged confidence of private sector
- Strategy considered the successful examples in the country (Kilifi / Kisii; Bungoma; CFW shops)
- Involvement of community and shopkeepers in the planning process emphasised
- Skill based training and use of visual aids important
- Effective management essential, requiring training and support
- Drug policy includes probable free treatment for under 5 yr olds.
- Plans exist for National health insurance scheme
- Adherence to ACT will be a challenge

**Presentation: - Uganda experiences of introducing - Uganda IMCI focal point.**

**Jessica Sabiiti**

Highlights

- Review of care seeking and service provision showed low Government sector use
- Private practitioners often beyond educational reach
- Working group active with developing analysis and communicating findings
- Limited knowledge of PP practice and skills – tailored interventions to different types of PP
- Requirement to be simple, cheap and feasible for district implementers
- Framework includes: policy and regulations, provider interventions and consumer interventions
- Multiple challenges – supported public/private partnership, required wide consultation
- Encouraged by GFATM approaches and Pharmacy Council
- Enabled dissemination of drug policy changes
- Partnership challenged by change to free AM drug distribution for children

**Panel discussion:**

*Linkage of PP interventions with HBMM*

– these approaches should be part and parcel of malaria control and a component of child survival. Linkages between IMCI and malaria remain important. A gap still exists for ARI so may need to consider complementary components

*Expenditure – at the expense of public funding?*

National budget for health has increased in Uganda but is due to be scaled down, at the same time as a drive to push more money to the private sector.

*Who is doing the training?*

Need a participatory approach within an environment dominated by more didactic approaches. Felt that training can be done in the district by existing staff after PRAs in the district. May need some technical support. Biggest problem when working with PPs is the attitude rather than skills of trainers. Content should focus on a small number of core changes.

Are there criteria for deciding what is and what is not suitable for scaling up? - Understanding of the process involving visits to the shops rather than classroom learning - limited expectations makes model more practical. Pilot in one district encouraged belief that it was possible in Uganda.

**Summary**

- Scale up is possible once a decision is made to move.
- Necessary to trust the decentralisation process and district capacity.
- The training processes are different from the traditional ways of learning within the health sector, requiring thorough preparation, planning and flexibility.

## **REVIEW OF GROUP WORK**

Should RBM recommend investment in IPSPs based on existing evidence

- Yes, with qualifications

Name to call the target group of IPSPs

- Medicine sellers – licensed / unlicensed
- Private service providers (PSPs)

Short and long term strategies

- Should consider that there is an urgent need for rapid action
- Start work from the existing situation.
- With ACTs important to make sure that it is accessible to the poor and attractive for the medicine sellers to sell – likely to require substantial subsidy
- Short term interventions can still be combined with longer term systems changes

Rapid approaches were seen as: Feasible, acceptable, practical but variable impact was noted.

Long term approaches were seen to be potentially more sustainable but were more expensive and susceptibility to commercial market

Roles of stakeholders

- Government needs to take ownership and deal with tracking and coordination of donors and medicine sellers.
- Donors – advocacy for donor diversification
- NGOs/CBO – have a substantial role especially in dissemination of information
- Private providers offer a large resource
- MSs partnerships – easier to work with MSs where there are associations

The chairman encouraged the participants to find consensus following the group work, identifying 3 areas.

### **Name:**

Inclusion of different groups makes it difficult to limit the name.

It was **agreed** to call them “**Medicine Sellers**”

### **Assessment of slow vs. rapid approaches.**

Recognized that there are pros and cons between choices and that there is no one way. **It was agreed that** the choice of strategy in each country has to be determined according to the situation and that it will probably be adapted through a learning process.

- Even the rapid approaches have long term implications and benefits
- There are a series of important components common to all programmes which increase the chances of being successful – One approach may be highly focused the other more service related these will be important in different contexts and will not be mutually exclusive.
- A spectrum of activities is required according to the situation.

## **Is intervention with medicine sellers justified?**

### **Agreed that:**

- Mixed model is probably the most appropriate.
  - There is sufficient urgency to promote medicine sellers but there is a requirement to continue implementation research, especially in the countries where attempts to go to scale have already begun
  - Consensus that RBM should be encouraged to include medicine sellers in its strategies.
  - the risks of not doing this at all are significant but that many questions remain. The problem is not a question of funding or not but an issue of how to implement.
  - Clear that it is feasible to involve MS. Not clear how best to do it. How effective it will be and at what cost.
  - Necessary to ask the partnership to put effort into the process.
  - The lessons of the past are important (e.g. TBAs)
  - Guidelines to help countries implement are required.
  - The decision making process requires a discussion of the whole scenario, consideration of the different components of the interventions, identification of where there is complementarity between programmes and what the real objectives are.

## **CONCLUSIONS**

1) On the basis of encouraging results from trials and projects to improve private sector practices and on the risks associated with non-intervention, it is necessary for Ministries of Health and RBM Partners in those countries, where a large part of the population obtains its treatment for malaria from “medicine sellers”, to engage with the private sector as soon as possible to strengthen implementation of programs for improving access to effective antimalarial treatment.

2) There appear to be 2 main categories of intervention, forming a spectrum of activity from rapid to long-term implementation. Countries will need to find a balanced approach as there is not a real dichotomy. Selection of strategy in each country will therefore be according to need; based on situation analysis and probably adapted through a learning process. Long-term components of rapid implementation, such as continuation of supervision and refresher courses will require planning.

3) Importance of M&E and Sustainability – operations research, documentation – to add to knowledge.

4) There is urgency but intervention should be focused on achievable objectives. Partnerships will be required to integrate ways of evaluating impact and determining sustainability.

**CLOSURE.**

JJ Banda thanked the Case Mx working group pointing out that at the global level there is a need for consensus mechanisms regardless of the funders.

Next steps: three products required

- A good report from the meeting
- Strategic framework is still pending –
- 2005 brings to a close most country strategic plans. So most have now reached the time to prepare the strategic plans that will be taken to 2010. Planning tool kits will need to be available for use by mid 2005 in order to ensure that the second generation strategic plans will be of the highest quality. With the conclusions from this meeting the tool kits should now include medicine seller interventions.



## **Annex 2.**

### **Rational Pharmaceutical Management Plus Planning Visit West Africa Regional Health Program, Accra, Ghana May 2004**

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Dated: June 10, 2004

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### **About RPM Plus**

RPM Plus works in more than 20 developing and transitional countries to provide technical assistance to strengthen 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.

### **Recommended Citation**

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## **Acronyms**

AWARE	Action for West Africa Region
CILSS	Permanent Interstate Committee for Drought Control in the Sahel
CRHCS	Commonwealth Regional Health Community Secretariat
CS	Child Survival
CPM	Center for Pharmaceutical Management
ECOWAS	Economic Community of West African States
FHI	Family Health International
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
MAC	Malaria Action Coalition
MIP	Malaria in Pregnancy
MSH	Management Sciences for Health
RBM	Roll Back Malaria
RH	Reproductive Health
RPM Plus	Rational Pharmaceutical Management Plus Program
RTLII	Regional Technical Leadership Institution
STI	Sexually Transmitted Infections
TA	Technical Assistance
WAEMU	West African Economic and Monetary Union
WAHO	West African Health Organization
WARP	West Africa Regional Health Program
WHO	World Health Organization

## **Background**

The West Africa Regional Program (WARP) deals with those West African development challenges most effectively addressed at a regional level. The WARP program works in partnership with USAID bilateral missions, U.S. Embassies, and leading regional intergovernmental organizations such as the Economic Community of West African States (ECOWAS), the West African Economic and Monetary Union (WAEMU), and the Permanent Interstate Committee for Drought Control in the Sahel (CILSS). The program serves the 18 nations of Benin, Burkina Faso, Cameroon, Cape Verde, Chad, Cote d'Ivoire, The Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, and Togo.

The objectives of WARP are:

- 1) Fostering regional economic integration;
- 2) Increasing the adoption of sustainable policies for and approaches to reproductive health, sexually transmitted disease, HIV/AIDS, and child survival;
- 3) Strengthening food security and environmental policies and programs; and
- 4) Supporting the establishment of regional conflict prevention mechanisms.

USAID's program in the areas of reproductive health (RH), child survival (CS), and sexually transmitted infections and HIV/AIDS (STI/HIV/AIDS) aims at expanding regional coverage from four to 18 countries. At the same time, a strategic shift will reorient the approach from increasing West Africans' use of health products and services to one that promotes wider adoption of state-of-the-art practices by national governments, regional organizations and non-governmental organizations; increases regional stakeholder advocacy for policy change; increases the capacity of regional institutions and networks; and promotes health sector reform. The program will support activities in 12 non-presence countries as well as undertake joint activities with the USAID bilateral health programs in the region.

HIV/AIDS funds are focused on launching an innovative, region-wide program to contain the epidemic with a focus on advocacy and transfer of proven best practices. Child Survival and Health funds will support reproductive health and child survival activities that address the seemingly intractable issues of high fertility and maternal and child mortality in the region.

WARP interventions in health are implemented through two complementary partnerships forming the Action for West Africa (AWARE) Project: the AWARE/Reproductive Health (RH) and the AWARE/HIV/AIDS cooperative agreements. The managing partners are Engender Health and Family Health International (FHI) respectively.

In support of the goals of USAID/WARP, Management Sciences for Health (MSH) is funded to provide technical assistance in pharmaceutical management to WARP through three mechanisms:

- Implementing partner of the Engender Health - managed Action for West Africa Region/Reproductive Health (AWARE/RH) partnership-This partnership is designed to strengthen regional capacity in delivering RH and selected associated services through support to key regional institutions.
- Rational Pharmaceutical Management Plus (RPM Plus) cooperative agreement with MSH-This is designed to strengthen global, regional and national capacities in pharmaceutical management, improving drug management practices so as to measurably improve health measures in key public health intervention areas. Field support funding in the amount of USD 250,000 for FY 2003 has been obligated. Funding through this mechanism gives priority to regional as opposed to global and/or national capacities.
- As one of four partners and the secretariat for the Malaria Action Coalition (MAC), RPM Plus has also received FY 2003 funding for case management and malaria in pregnancy (MIP) activities in the region. Total funding received from WARP for the MAC partners is \$400,000 for FY 2003.

The above three sources of funding are intended to be used for reinforcement of activities led by AWARE HIV/AIDS and AWARE RH, and those activities led by the MAC. Duplicative efforts can thus be avoided, and system-wide strengthening activities will be encouraged, thus avoiding a vertical approach.

### **Purpose of Trip**

Bannet Ndyabangi, Suzanne Thomas, Francis Aboagye-Nyame and Gladys Tetteh traveled to Accra, Ghana for meetings with USAID/WARP, AWARE RH and AWARE HIV/AIDS. The primary desired outcome was to develop a tentative scope for activities at the regional level in areas of pharmaceutical management strengthening.

### **Scope of Work**

Hold Meetings with USAID/WARP, AWARE RH and AWARE HIV/AIDS to discuss work plans for Regional pharmaceuticals and health commodities management activities for RH and HIV/AIDS from May 23 – 25, 2004.

## **Activities**

### **Collaborators and Partners**

During this visit, we met with USAID/WARP, the AWARE/HIV/AIDS project, the AWARE/RH project, and participated in the Roll Back Malaria Sponsored meeting on private sector participation in preventing and treating malaria.

A detailed schedule and list of contacts is found as Annex One.

## Next Steps

### Immediate Follow-up Activities

- Debrief USAID and RPM Plus on findings
- Develop concept papers and scopes of work for agreed upon activities

### Agreement or Understandings with Counterparts

The following general areas of assistance were identified with USAID and AWARE:

1. Undertake a survey of the Readiness for Regional Collaboration for Procurement in the Region. This will build on the CRHCS experience<sup>1</sup> and the results and recommendations of the survey conducted by Center for Pharmaceutical Management (CPM)<sup>2</sup> on regional pooled procurement in sub-Saharan Africa. It was further agreed to await the outcome of the DELIVER Pooled Procurement Survey to better inform the focus of the survey so as to avoid duplication of efforts. DELIVER is expected to report on the survey at the WAHO Ministers meeting in July 2004.
2. Provide technical assistance in developing and implementing a Regional training course in commodity management
3. Develop capacity in RTLIs to offer technical assistance and training in pharmaceutical management in the region.
4. Undertake a policy review vis a vis malaria to monitor development and implementation of malaria prevention and treatment policies and resultant practices.
5. Await the outcome of the Emergency Plan meeting in South Africa to determine activities to be done in Cote d'Ivoire to support pharmaceutical management under the Cote d'Ivoire COP

### Important Upcoming Activities or Benchmarks in Program

The West African Health Organization Ministers of Health meeting is tentatively scheduled to be held in July in Abidjan.

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<sup>1</sup> Onyango, C. 2003. *Readiness for Regional Pooled Procurement of HIV/AIDS-Related Drugs and Commodities in Sub-Saharan Africa: An Assessment of 11 Member Countries of the Commonwealth Regional Health Community Secretariat, 2002*. Submitted to the U.S. Agency for International Development by the Rational Pharmaceutical Management Plus Program. Arlington, VA: Management Sciences for Health.

<sup>2</sup> Center for Pharmaceutical Management. 2002. *Regional Pooled Procurement of Drugs: Evaluation of Programs*. Submitted to the Rockefeller Foundation. Arlington, VA: Management Sciences for Health

## **Annex 1: Schedule of Visits and Persons Met**

Saturday/Sunday May 22/23

- Arrival in Accra. Brief with Kofi, Bannet, Suzanne, Gladys

Monday May 24

- Meet and brief USAID/WARP staff: Kristin Cooney (Sr. Technical Advisor, RH/CS); Joseph Akuamoah (RH/CS Survivalist); Suzanne Church (USAID/Washington, TDY)

Bannet Ndyabangi, Kofi, Gladys Tetteh, Suzanne Thomas

- Meet and brief Antoine Ndiaye (AWARE/RH – MSH Commodities Specialist)
- Meet and brief Isaiah Ndong (AWARE/RH – EngenderHealth –Director) and Jeanne Rideout (EngenderHealth – Deputy Director)

Bannet Ndyabangi, Kofi, Gladys Tetteh, Suzanne Thomas

Tuesday May 25

- Meet and brief Antoine Ndiaye (AWARE/RH – MSH Commodities Specialist) and Steve Redding (AWARE/RH – MSH Technical Support/Boston)
- Technical discussions with above by CPM staff, developed outline for proposed work plan for various technical support roles for MSH-CPM and CPM-RPM Plus

Wednesday May 26

- Meet and brief Claudes Kamenga (AWARE/HIV/AIDS – FHI –Deputy Director, Technical Support) and Antoine Ndiaye (AWARE/RH – MSH Commodities Specialist). Further developed strategy for technical support.
- Attended/participated in Roll Back Malaria meeting (Day One) to review specific lessons learned under the SEAM project and discuss strategy for continuing and expanding work with other support once SEAM funding is expended.

Thursday May 27

- Attended/participated in Roll Back Malaria meeting (Day Two) to review specific lessons learned under the SEAM project and discuss strategy for continuing and expanding work with other support once SEAM funding is expended.

Friday May 28

- MSH/CPM/RPM Plus debrief with USAID/WARP and reviewed draft work plan/trip report.
- MSH/CPM/RPM Plus/MAC participated in MAC conference call to discuss work plan for on-going and future MAC interventions.
- Departure from Ghana for Arlington



### **Annex 3.**

#### ***RBM Consultative Meeting on the Role of Informal Private Providers in Management of Malaria***

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