

SSFFC Malaria Medicines Communication Strategy Design Workshop

June 16-17, 2015

Bolton White Hotel, Abuja, Nigeria

Workshop Report

Background and Introduction

The continued availability and use of substandard, spurious, falsified, falsely labeled and counterfeit (SSFFC) medicines impedes global efforts to eradicate malaria, as such medicines result in treatment failure, death, and a distrust of the health system. According to the World Health Organization (WHO), 10 to 30 percent of all medicines in developing countries are substandard or falsified (Mackey & Liang, 2013; WHO, 2011). Anti-malaria medicines constitute the bulk of SSFFC medicines, contributing 52.5 percent and 92.6 percent of all substandard and counterfeit medicines respectively (Hajjou et al, 2015).

The SSFFC medicines situation in Nigeria mirrors global trends but stands out because of Nigeria's peculiar nature—a vast and diverse population with a complex health system. Nigeria's pharmaceutical products are either imported or manufactured domestically, however they reach majority of consumers through Patent and Proprietary Medicine Vendors (PPMV), most of who are unlicensed and operating illegally. In 2001, an alarming 40 percent of medicines across Nigeria were substandard or fake. Due to aggressive and sustained efforts of the National Agency for Food and Drug Administration and Control in Nigeria (NAFDAC), the proportion of such drugs in circulation has decreased tremendously reaching 16.7% in 2005 (Ogundipe, 2011). Preliminary findings from a study conducted by NAFDAC and the United States Pharmacopeia (USP) indicate that less than 10 percent of artemisinin-based combination therapies (ACTs) in circulation are of poor quality with states in the North East of Nigeria reporting the highest percentage.

Although the Government of Nigeria has continued to fight SSFFC medicines through the NAFDAC and the Pharmaceutical Council of Nigeria (PCN), such efforts have mostly targeted the supply side of the problem. Efforts directed at the consumers of SSFFC medicines have been few and have not been evaluated. Only 18% of respondents in a perception study conducted by NAFDAC were aware of messages regarding the Mobile



Authentication System (MAS) introduced by NAFDAC to enable consumers verify the quality of the medicines they buy. Few consumers take advantage of the MAS, while most still self-prescribe. Even when fake drugs are encountered, consumers rarely report to relevant authorities.

In response to this situation, the Health Communication Capacity Collaborative (HC3) is providing technical support to the National Malaria Elimination Program (NMEP) with funding from USAID/PMI for the purpose of developing and producing tools that can be deployed to change current self-prescribing and malaria treatment practices that encourage the proliferation of SSFFC malaria medicines in Nigeria. The workshop reported here is the first step in a process that will culminate in the production and dissemination of various communication materials. Work done in Nigeria will inform the development of guidelines and tools for use in other countries interested in addressing SSFFC malaria medicines.

Workshop Goal and Objectives

The overall goal of the two-day workshop was to develop a communication strategy to guide the production of required tools for communicating SSFFC issues in Nigeria. The specific objectives of the workshop were to:

- 1) Review what is known about SSFFC malaria medicines in Nigeria, and
- 2) Design communication briefs for priority audiences.

Workshop Outputs/Outcomes

Participation

The workshop was well attended by participants who represented an array of key stakeholders including:

1. NMEP
2. Food and Drugs Services
3. NAFDAC
4. National Primary Health Care Development Agency (NPHCDA)
5. PCN
6. Pharmaceutical Industry Practitioners Association of Nigeria (PIPAN)
7. National Association of Patent and Proprietary Medicine Vendors (NAPPMED)
8. WHO
9. Society for Family Health
10. Malaria Action Program for States (MAPS)
11. Malaria Care
12. SuNMAP Project
13. United States Pharmacopeia

The representative of USAID/PMI Nigeria attended the workshop briefly on day one, but could not be part of day two. (*See appendix 1*).

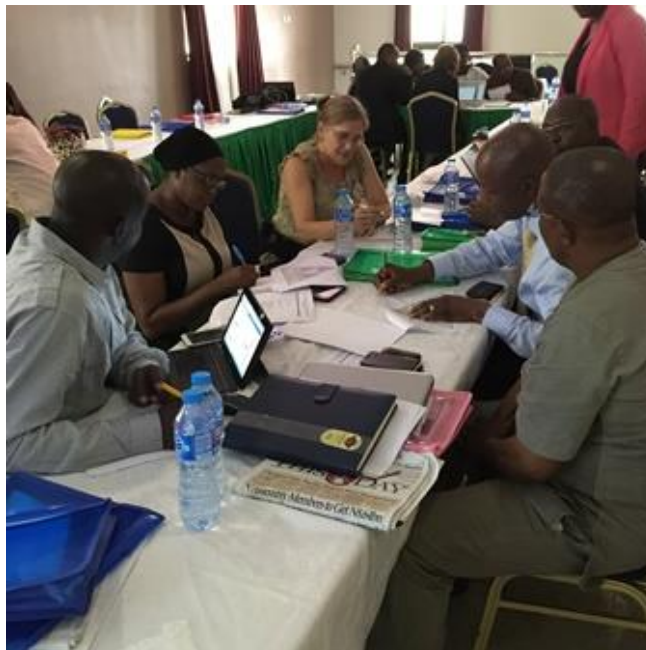
Workshop Day One, 16 June 2015

Dr. Godwin Ntadom, Head of Case Management at NMEP, opened the workshop and welcomed participants on behalf of the National Coordinator. In his remarks, Dr. Ntadom reiterated the Government of Nigeria and its partners have made tremendous progress towards the eradication of malaria and evidence for this will come out when the MIS survey

is conducted later in the year. He acknowledged the importance of SBCC in these efforts especially given the reality that there is still a lot of misinformation regarding malaria. At the end of his remarks, Dr. Ntandom excused himself from the meeting after handing over the responsibility of chairing meeting proceedings to Mrs. Itohowo Uko- Head of the Advocacy, Communication and Social Mobilisation (ACSM).

To set a proper tone for the rest of the workshop and provide the necessary background for all participants, HC3 Malaria Team Leader Nan Lewicky made the first presentation. She provided an overview of the HC3 project globally and in Nigeria before zeroing-in on the global SSFFC malaria medicine issue. This was followed by a presentation made by Chimezie Anyakora of the United States Pharmacopeia Promotion of Quality Medicines Project (USP/PQM) in Nigeria. Anyakora's presentation focused on the extent of SSFFC malaria medicines in Nigeria drawing information mainly from a recent and yet to be published research conducted by NAFDAC and USP/PQM. The highlight of the presentation was that less than 10% of ACTs in the market are substandard, and that the North East of Nigeria had more than 10 times the share of substandard malaria medicines when compared to the South East.

After these presentations, participants were given time to reflect, ask questions and make comments as necessary. Two key questions related to why the North East in particular had such a high level of substandard medicines in comparison to other zones – and why this research did not make reference to counterfeit medicines. Anyakora explained that the research did not ask the question of why, but that the discrepancy might be due to degradation of medicines in the North East due to factors to be explored in a follow-on survey being planned by USP. He also explained that it was difficult to identify counterfeit medicines—except in cases where the amount of active pharmaceutical ingredient (API) is very low. The research focused on identifying substandard medicines.



During this time, four panelists representing key stakeholder organizations made presentations as follows:

PIPAN

Dr. Ade Adeagbo, Executive Director of PIPAN made the presentation on behalf of this group. His presentation titled 'Understanding the Issues: Distribution of Malaria Medicines – Manufacturing, Importation, Regulation and Enforcement highlighted the fragmented and chaotic nature of Nigeria's drug distribution system and how this contributes to the problem of SSFFC malaria medicines. Currently, manufacturers and importers supply drugs directly to wholesalers, retailers, national health programs, illegal open drug markets and private/public health facilities. This unstructured distribution system provides loopholes for

illegal and or unethical practices. He informed that government has approved a new medicines distribution plan that includes the establishment of mega and state drug distribution warehouses to streamline how drugs reach consumers. If enforced, such a plan will help check SSFFC malaria medicines. Other issues that contribute to the problem include frequent stock-out of recommended malaria medicines as well as poor drug handling and storage practices.

MalariaCare Project

Represented by its Country Director, Kachi Amajor, the MalariaCare project shared findings from a qualitative study carried out recently in Ebonyi State, Eastern Nigeria. The study was conducted among PPMVs and caregivers of children less than five years to ascertain their knowledge, attitudes and practices with regards to malaria, diarrhea and pneumonia diseases. The findings from this study indicate caregivers in rural communities still have misconceptions about malaria. Some respondents thought that malaria could be caused by exposure to bad weather and hard labor. The study also found self-prescription through the use of herbal remedies at home before going to the chemist when fever persists. Caregivers tended to first try home remedies, then purchase medicine from a PPMV, and only visit a health facility if all else failed.



Society for Family Health/ACHIEVE Project

Chimwoke Isiguzo of Society for Family Health (SFH) made a presentation on the prescribing/dispensing practices of PPMVs and clinical providers. The presentation shared findings from a qualitative survey that included the mapping of PPMVs in 16 states. She informed participants there are an estimated 200,000 PPMVs (owner-operated retail drug outlets) in the country and in rural and remote communities; these may be the first or only contact with some form of healthcare delivery. Care seekers interact with PPMVs in two distinct ways: simple retail transaction or medical consultation. Retail transactions are dominated by customer demand (self-prescription) but sometimes are the result of prior consultation with a qualified provider. Where the caregiver feels a lack of knowledge about the illness and/or drugs; where the PPMV is a trained health provider; or where there are no alternatives, the PPMV (trained or not) provides consultation services for caregivers. This presentation highlighted the importance of PPMVs to healthcare delivery in Nigeria.

NAFDAC

NAFDAC is Nigeria's food and drugs regulatory agency and was represented at by Mrs. T. A. Nimlan, Head of Post-Marketing Surveillance and Nwosu Anulika Princess, Regulatory Officer. The duo spoke extensively about what NAFDAC is doing to address SSFFC malaria medicines. NAFDAC works at the port of entry to inspect products to ensure quality. It also works with the Pharmacists Council of Nigeria (PCN) to inspect storage and dispensing practices at pharmacies and PPMV shops. NAFDAC also monitors sales and use of medicines and food products through a variety of methods:

- Truscan: this technology allows NAFDAC officials to test products in shops, at borders, warehouses, and other places and enables it to identify products that do not meet manufacturers' standards.
- Alerts: NAFDAC issues alerts to the public when it identifies substandard or falsified drugs
- Customer hotline: NAFDAC has a free telephone hotline- 20543 - that Nigerians can use to report lawbreakers and to ask questions.
- Stakeholder workshops: NAFDAC educates stakeholders through workshops
- NAFDAC is a member of a taskforce with PCN that inspects PPMVs and issues or denies licenses. NAFDAC does not have statistics on PPMVs.
- NAFDAC also runs secondary school clubs to teach children good practices concerning the use of medicines.
- They investigate complaints regarding SSFFC.
- NAFDAC also established the Mobile Authentication System (MAS) that allows consumers to scratch a pad on drug packets and text a number to a free mobile number to verify the authenticity of drugs. **Currently, more than 80% of antimalarials have scratchpads.**
- NAFDAC also inspects and licenses manufacturers to produce drugs. Drugs that have been licensed have NAFDAC numbers and are more likely to be genuine and good quality.

NAFDAC's key concerns or what it considered gaps were expressed as follows:

- Many PPMVs don't know about or worry about SSFFC drugs. How can we improve PPMV practices?
- Consumer treatment practices also need to change.
- Data is also an issue regarding PPMVs. We don't know how many there are or what their training is.
- The public needs to be made more aware regarding SSFFC drugs.

At the end of the panel presentations, participants were given time to ask questions on any or all of the presentations. This question and answer session enabled the clarification of issues and helped stakeholders learn more about what each organization is doing and can



do to help address the SSFFC malaria medicines issue. (See appendix 2 for detailed notes on the question and answer session).

After lunch, there was a presentation on the structure of the NPHCDA. The purpose of this presentation was to explore the potential of the NPHCDA as a partner in SSFFC malaria medicines control efforts. M.M. Abubakar, a Deputy Director who came on behalf of Dr. Nuhu, Director of Advocacy and Communications made the presentation for the agency. Abubakar informed participants that prior to 2000, the Nigeria Primary Health Care (PHC) system was fragmented and inefficient. Currently however, the Government is implementing the PHCUOR--primary health care under one roof policy--that puts all primary healthcare functions under a state primary health care board (SPHCB), which receives technical guidance and support from the NPHCDA. It is instructive to note that the National Agency does not really have powers over the state boards or agencies, and to collaborate with the PHCs, one must work independently with each SPHCB.

After a few discussions around this issue, participants were divided into three groups for the last session of the day – **Defining the problem**. Thomas Ofem, HC3 Nigeria SSFFC Project Coordinator, led participants through the process of analyzing the SSFFC problem in Nigeria, using the problem tree tool. The problem tree is a root cause analysis method that helps program officers define the underlying and direct causes of a problem and the resulting effects of that problem. Once participants understood the process, each group was asked to complete a problem tree for the SSFFC malaria medicines issue in Nigeria. It is worth noting that although the three groups worked independently, they all came up with largely similar analyses of the Nigeria SSFFC malaria medicines problem. The outcome of this group exercise is summarized below.

PROBLEM SUMMARY	
CORE PROBLEM	Spurious, substandard, falsified, falsely-labeled and counterfeited malaria medicines are available and being used to treat malaria in Nigeria
DIRECT CAUSES (Consumer & Vendor)	<ul style="list-style-type: none"> • Consumer preference and demand for inexpensive drugs (Why?) • Consumers (and vendors) do not know how to recognize SSFFCs • Poor storage and handling of drugs by vendors (Why?) • Consumer treatment practices; e.g. home remedies, PPMVs as preferred first line of action (Why?) • Consumers do not report SSFFCs and illegal vendors (Why?) • Trust in PPMVs and medicine hawkers (Why?)
DIRECT CAUSES (Systems & Structure)	<ul style="list-style-type: none"> • Weak regulation, poor monitoring of manufacturers, distributors, retailers. • Weak policies that do not protect consumer rights e.g. Scratch to confirm before paying • Stock-outs and limited purchasing options for consumers- e.g. only PPMVs and hawkers available in some locations • Non-availability and high cost of standard medicines
INDIRECT CAUSES (Consumer & Dispenser)	<ul style="list-style-type: none"> • Belief that there is nothing consumers can do to prevent SSFFC (Why?) • Focus on profits by dispensers • Low knowledge of the effects of SSFFCs among consumers and vendors • Availability of SSFFC drugs at lower prices through open markets

INDIRECT CAUSES (Systems & structure)	<ul style="list-style-type: none"> • High cost and bureaucracy for product registration • Inadequately trained personnel to assure quality control of vendors • Convoluted, unclear drug distribution system • Lack of a shared understanding/purpose between PPMVs and Pharmacists • Weak mobile phone infrastructure for scratch pad purposes • GREED???
UNDERLYING CAUSES	<ul style="list-style-type: none"> • Poverty • Low literacy • Little trust and confidence in the system/authorities • Myths, misconceptions and folk beliefs (Like?) • Decentralized health system (disconnect between Federal, State and LGA levels?)
EFFECTS	<ul style="list-style-type: none"> • Increased morbidity and mortality • Drug resistance and adverse effects • Loss of confidence in health care system and medicines • Economic loss

Day 1 of the workshop ended with participants having a shared understanding of the problem.

Workshop Day Two, 17 June 2015

Day Two started with a detailed recap of the previous day by Ahmad Njidda of the NMEP).

Maintaining the small groups that were formed the previous day, Thomas Ofem provided each group with the problem summary and guided them through identifying and prioritizing the three most important audiences based on the problem. Participants were advised to do this using the following criteria:

- The audience most affected by the problem (primary audience)
- The audience that influences the primary audience or that which will provide the most impact to the communication campaign if targeted (secondary and tertiary audiences).

Working independently, the three groups came up (again) with priority audiences that were more or less similar. A plenary discussion on the identified audiences helped the workshop to agree on the following as key audiences for the proposed communication campaign:

1. All consumers who buy anti-malarials
2. PPMVs
3. Policy Makers

Once participants were clear on the problem at hand and the audiences that should be included in the program, it was time to increase understanding of the identified audiences and develop appropriate communication briefs for them. Cheryl Lettenmaier, HC3 SSFFC Field Coordinator, led this process for the rest of the day. She requested participants to choose which of the three audience segments they would like to work with, and this formed the basis for three small groups tasked with developing communication briefs. Each group was given the audience analysis and communication worksheet (*Appendix 3*) and asked to complete it for their chosen audience.

After lunch, participants were given some more time to wrap up their group tasks before presentation in plenary. It was discovered at this point that groups were not able to complete their communication briefs as planned due to time constraints. However, all three groups got to the communication objective stage of the communication brief and made presentations based on this (*Appendix 4*).

The workshop came to an end at 5.00PM after participants agreed on the following immediate next steps:

1. HC3 will review and complete all three communication briefs before the middle of July. All three will be shared with a smaller group of volunteers for initial review.
2. NMEP with support from HC3 will facilitate a follow-on meeting of all key stakeholders for a final review and adoption of the communication briefs
3. HC3 will post the presentations, concept note and landscaping document on [Springboard](#) and invite all participants so they can download from there.
4. HCP will share the landscaping document with PMI, NMEP and NAFDAC for inputs.

Appendix 1: Participants

S/N	NAME	ORGANISATION	POSITION/TITLE
1	EZECHUKWU ADAOLISA	NMEP	SMLS
2	ITOHOWO UKO	NMEP	AD,HEAD/ACSM
3	CHERYL LETTENMAIER	HC3	REG. REPRESENTATIVE
4	NAN LEWICKY	HC3	HC3 MALERIA HEAD
5	THOMAS OFEM	HC3	COORDINATOR SSFFCS
6	DR.ADE ADEAGBO	PIPAN	EXEC.DIRECTOR
7	T.A NIMLAN (Mrs)	NAFDAC	POST MARKETING HEAD SURVERLLANCE
8	KACHI AMAJOR	MALERIA CARE	PROG COORD
9	OGECHI ONUOHA	ESMPIN/SFH	MCH MANAGEER
10	OLUMIDE FALEKE	SUNMAP	COMM SPECIALIST
11	AHMED M.NJIDDA	NMEP	MO
12	UWEM INYANG	USAID/PMI	MANAGER
13	NWOSU ANULIKA PRINCESS	NAFDAC	REGULATRY OFFICER
14	CHINWOKE ISIGUZO	SFH	PROGRAMME MANAGER
15	CHIMEZIE ANYAKORA	USP/PUM	COP
16	NFADOM GODWIN	NMEP/FMOR	HEAD CASE MGT
17	ALH ADEWALE BABATUNDE	NAPPMED	PRESIDENT
18	NWEKE KINGLEY	NAPPMED	SECRETARY
19	ZAINAB USMAN	SFH	SBC OFFICER
20	PHARM (Mrs) OLALERE EMILY	PHARM COUNCILOF NIG,ABJ	REP OF REGISTER PCN.DIRECTOR
21	M.M ABUBAKAR	NPHCDA	DEPUTY DIRECTOR
22	UMMA BABANJIRA	NPHCDA	INFORMATION OFFICER
23	OKORIE CHIDIEBERE	FMOH/FDS	SENIOR PHAMIST
24	OLOGUN TAYE J	FMOH/FDS	DEPUTY DIRECTOR
25	USMAN USMAN	MAP	BCC ADVISOR
26	LYNDA OZOR	WHO	NPO
27	EVE EYO	NMEP	PCDI
28	LAOYE NIKE	NMEP	SOL
29	ZUATI BABAFERI	HC3	F/A ASSIT.

Appendix 2: Audience Analysis & Communication Brief Worksheet

Worksheet 1: Audience Analysis and Communication Briefs

Audience: Describe your audience. What are the defining features of this audience? Average educational level, where do most of them live (urban or rural), average economic status?

Desired Behaviour/Practice: What is it that we want this audience to do in terms of SSFFC malaria drugs?

Current Behaviour/Practice: What is this audience doing currently regarding malaria drugs? SSFFC malaria drugs?

Key Constraint: What is the main reason why this audience is not adopting the desired behavior? First brainstorm the main constraints. Then agree on the one constraint that is the biggest problem. It should be a constraint that communication can affect in some way. This is the Key Constraint.

Opportunities: Who or what influences their current practices regarding malaria drugs? What factors can influence the audience to adopt the desired practice? How does the audience get information? What are the most reliable sources of information to this audience?

Communication Objective: What do we want this audience to do, feel and/or know as a result of our communication? The communication objective should address the key constraint. It should be worded:

“As a result of our communication, our audience will

The communication objective is normally not the same as the desired behavior, although it can be. Usually, though, it has to do with removing the key constraint.

The communication objective should be:

SPECIFIC: say exactly what we want our audience to do, know, and/or feel. Be precise.

MEASURABLE: ask yourself if you could measure whether or not we have attained the objective. Would it be possible to assess it through a survey, or through routine data?

ATTAINABLE: can we possibly hope to meet the objective, given the time and resources we have?

REALISTIC: can the audience reasonably be expected to make the change we are expecting?

TIME-BOUND: remember to indicate what the time frame is for this objective. This campaign will run for six – 12 months.

Worksheet 2: Communication Briefs

Audience:

Key Benefit Statement: How will this audience benefit from adopting the desired behavior? This should be a benefit that this audience really wants. You need to imagine you are this audience. What does this audience really want? It may not be a benefit that has to do with health. Sometimes the most compelling benefit is a by-product of the behavior, but it is something that the audience really wants.

Support Points: How will we help our audience make the decision to change? How will we support our benefit statement? Will we use facts? Demonstrations? Testimonies? Endorsements from influentials or peers?

Message Content: What key facts, information, and arguments should our communication contain?

Communication channels and activities: How will we reach this audience with this message?

Appendix 3: Communication Briefs

CONSUMERS

Describe your audiences: All consumers who buy antimalarials

Includes

Caregivers of children and others, people who are sick or not, people who self-medicate.

Low social status, living in rural areas, low income, low literacy

Perception about health workers – They won't treat them properly, in time, and their attitude. So they prefer going to the PPMVS, they are more convenient, easy to reach and they prefer them.

Health seeking behaviors – to go to the hospital is too expensive because of the distance and the amount of time they spend and takes a lot of time. Distance to the health facilities is far or not even there, transport isn't there. Service is poor. Attitude of health worker is not good.

People don't take malaria seriously.

People don't put much thought into what type of anti-malarial medicine, as long as they are told they are getting antimalarial. They don't question the health provider (PPMV or HF).

Desired Behavior:

People should understand the complications/serious effects of malaria.

People should know that home treatment and self-medication is not good.

People should first demand testing and diagnosis before getting medicines from their provider.

We want people to know and follow safe purchasing practices:

- Don't buy loose pills
- Only buy if you have a positive malaria diagnosis
- Checking for medicines expiry dates if possible
- Tell people to only buy medicines only with scratch pad
- If medicines have scratch pad, to do so before using/buying
- If scratched by vendors, demand to see the scratch
- (If medicines have scratch, do so before buying) – this was debated
- Complete your dosage

Current Behaviors/Practice:

People do home treatment, herbs, self-diagnosis. Don't perceive risks of malaria.

Patronize hocus places. When they go to PPMV, they ask for the name of the drug or ask for "something for malaria", often don't have prescription. Don't go to health facility. No consultation. Or consultation from PPMV (by looking in the eyes, feeling pressure.) They then are given an anti-malarial drug.

Key Constraints:

- hard to check expiry drugs if buying from a provider that buys in bulk
- some people don't want to buy drugs before they scratch

- Provider may not provide a complete dosage, or people may ask for half dosage because they don't have the money for all (they tell the provider they'll never come back, but they don't)
- Vendors won't want you to scratch before buying
- Consumers (and some vendors) don't have phone and don't know what to do with the scratch pad.
- PPMVs don't ask for prescriptions. PPVs can write prescriptions, but they don't have authority or access to RDTs.

Opportunities:

Community and religious leaders in the community.

Community base organizations (CBOs) – have association

Community Oriented Resource Persons (CORPS) – trained in different health issues (Pilot, but growing)

Ward development committees

Communication Objective:

As a result of our communication, our audience will **know** they could be purchasing fake drugs and that there are negative effects (they won't get better and may get worse, and they would be wasting their money), thus they should develop a sense of trust in safe health practices.

Action: they should test before treatment, buy only medicines with scratch pads, and use scratch pads appropriately.

Communication Brief: PPMVs

1. **Audience Description:** Our audience is Patent and proprietor medicine vendors. They operate as informally trained drug retailers. They are legally permitted to sell OTCs. There is a large variation in the qualification training of PPMVs. On average most of the PPMVs have secondary education and they are able to read and write. Most of them are in the rural areas. Their average economic status is low income.
2. **Desired Behaviour/Practices:** They should be able to identify SSFFC. They should buy from reputable manufacturers, whole sellers, check for NAFDAC registration numbers, check for MAS, get licensed, report colleagues to appropriate authority, store according to guidelines of regulatory bodies, register with appropriate regulatory bodies, ask consumers what they want the drug for, give instructions to customers on how to use the drugs, ATCs should be given to those that have tested positive to malaria
3. **Current/Actual Practices:** Uncoordinated procurement from unregistered distributors (open market), no knowledge of identifying SSFFCs, treat people without results proving they have tested positive to malaria, they don't report to the appropriate authorities when and if they identify SSFFCs, most of them are not licensed, they don't ask consumers what they need the drug for before dispensing
4. **Key Constraints:** Knowledge, no facility nearby for consumers to go for test, to reduce cost, PPMVs buy from open markets, distance to reputable suppliers, some don't respect regulatory authorities, they don't go for the licensing because they don't meet

the required requirement, some have applied for the licence but still have not gotten, they don't know the consequences of taking an overdose ACTs, some don't have training for the dosage to give, provide customers with whatever they ask for because they don't want to disappoint them. **Key constraint:** they want to make money

5. **Opportunities:** Consumers, sales representatives influence their current practices, collaboration with law enforcement agencies can influence the audience to adopt the desired practice, they get information from their union and regulatory bodies
6. **Communication Objectives:** As a result of our communication, PPMVs will:
 - a. Know how to treat malaria according to national guidelines, and Place the interests of their customers above financial gain by never selling SSFFCs.

Appendix 4: Communication Brief for Policy Makers

Audience	Description	Desired Behaviour	Current Behaviour	Key Constraint	Opportunities	Communication Objectives
PCN	Statutory body for standards and regulation of drugs practice in Nigeria. PCN license Pharmacist, technicians and PPMVs	Decrease the number of non- registered PPMVs Ensuring PPMVs do not sell outside recommended drug list Redefine relationship with PPMV, identify a new way of working and see them as part of the solution to the problem	Regulates approximately 10% of PPMV Don't do public awareness	Civil service bureaucracy & bottle necks e.g., previous gazette, outdated regulations. Change is difficult. Corruption Limited knowledge on volume and extent of SSFFC Poor partnership between PCN and PPMVs	Who/What influences- Govt Regulations/laws What can influence- Government, Pharmacy Organizations/association How they get Info- Official Government gazette Reliable source of Info- Official government gazette	As a result of our communication PCN relationship with PPMVs will be strengthened which will increase registration of members of NAPPMED from 10% to 70% by Dec 2016
NAFDAC	NAFDAC is responsible for registration and regulating of food and drug administration in the country. NAFDAC is responsible for safeguarding the public health by ensuring that only the right quality of food, drugs and other regulated products are manufactured, exported, imported,	Increased awareness on MAS coding more public campaigns More surveillance at import Name and shame offenders	Regulate food and drug use Public awareness but not through all channels of communication	Inadequate funding Limited capacity. Corruption	Who/What influences- Government Regulations/Policy What can influence- Government, Pharmacy Organisations/ association How they get Info- Official Government gazette Reliable source of Info- Official government gazette	As a result of our communication NAFDAC will increase public awareness on MAS coding that will enable consumers to identify SSFFC. As a result of our communication NAFDAC will increase pharmacovigilance which will reduce the amount of SSFFC in the market by x% by December 2016

	advertised, sold and used in the country					
Nigeria Custom Services	Customs regulates import and exports in to and out of the country. This include import of antimalarial drugs	More surveillance Share data with industry on volume of counterfeit Faster clearing of drugs Allow NAFDAC to inspect all containers that contain drugs	Surveillance of importation Focus is more on income Delay in clearing drugs makes the drug overstay and become weaker The volume of genuine/counterfeit Customs does not always inform NAFDAC of containers that have drugs hidden with other items	Re-define relationship with industry and practice Focus- income versus quality Porous borders Corruption	Who/What influences- Government Regulations/laws What can influence- Government, Pharmacy organizations/ association How they get Info- Official Government gazette Reliable source of Info- Official government gazette	As a result of our communication custom will give x% (time) priority clearing to imported antimalarials which will reduce the delays that result in making the drugs weaker As a result of our communication custom will give x% (time) priority clearing to imported antimalarials which will increase the number of genuine antimalarials in the market