Assisting the Implementation of Private Sector Engagement in Ghana

For the UN Commission on Life-Saving Commodities for Women and Children: Supply Chain Technical Reference Team

JSI Research & Training Institute, Inc.

March 2016
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## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>artemisinin-based combination therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>antiretroviral drug</td>
</tr>
<tr>
<td>CMS</td>
<td>Central Medical Store</td>
</tr>
<tr>
<td>DDA</td>
<td>Deputy Director of Administration</td>
</tr>
<tr>
<td>DDPS</td>
<td>Deputy Director of Pharmaceutical Services</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
</tr>
<tr>
<td>FDA</td>
<td>Food and Drugs Authority</td>
</tr>
<tr>
<td>GDP</td>
<td>good distribution practice</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>GHS</td>
<td>Ghana Health Service</td>
</tr>
<tr>
<td>GOG</td>
<td>Government of Ghana</td>
</tr>
<tr>
<td>IGF</td>
<td>internally generated funds</td>
</tr>
<tr>
<td>IHS</td>
<td>Imperial Health Sciences</td>
</tr>
<tr>
<td>IQC</td>
<td>indefinite quantity contract</td>
</tr>
<tr>
<td>IUD</td>
<td>intrauterine device</td>
</tr>
<tr>
<td>P&amp;S</td>
<td>Procurement and Supply</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PFSCM</td>
<td>Partnership for Supply Chain Management</td>
</tr>
<tr>
<td>POD</td>
<td>proof of delivery</td>
</tr>
<tr>
<td>PPM</td>
<td>pooled procurement mechanism</td>
</tr>
<tr>
<td>PPP</td>
<td>public-private partnership</td>
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<tr>
<td>PSE</td>
<td>private sector engagement</td>
</tr>
<tr>
<td>RDT</td>
<td>rapid diagnostic test</td>
</tr>
<tr>
<td>RMNCH</td>
<td>reproductive, maternal, neonatal, and child health</td>
</tr>
<tr>
<td>RMS</td>
<td>Regional Medical Store</td>
</tr>
<tr>
<td>SOP</td>
<td>standard operating procedure</td>
</tr>
<tr>
<td>SP</td>
<td>sulfadoxine-pyrimethamine</td>
</tr>
<tr>
<td>SSDM</td>
<td>Supplies, Stores, and Drug Management</td>
</tr>
<tr>
<td>TH</td>
<td>teaching hospital</td>
</tr>
</tbody>
</table>
Acknowledgments

The *Private Sector Engagement Guidance Document* was developed by organizations and individuals that include VillageReach, John Snow, Inc., People that Deliver, LMI, Management Sciences for Health, United Parcel Service, Imperial Health Sciences, Transaid, USAID, United Nations Population Fund, Riders for Health, United Nations Children’s Fund, PSI, World Health Organization, Clinton Health Access Initiative, Deloitte, Maeve Magner, and Barbara O’Hanlon. The authors of this report, *Assisting the Implementation of Private Sector Engagement in Ghana*, wish to gratefully acknowledge the efforts of the USAID | DELIVER PROJECT staff based in Accra, Ghana, particularly Paschal Mujasi; the project’s Arlington-based regional management team; and William Adjabui of Imperial Health Sciences in Ghana for their cooperation and participation in this Ghana-based private sector engagement activity.
Executive Summary

The Private Sector Engagement (PSE) Guidance Document was developed under the auspices of the UN Commission on Life-Saving Commodities for Women and Children (the Commission) to provide guidance for public and private sector stakeholders who are interested in strategic collaboration to address challenges related to in-country supply chains for medicines and health supplies, with an emphasis on reproductive, maternal, neonatal, and child health (RMNCH) commodities. A PSE activity was planned in Ghana for 2015, to be partially supported with Commission funds.

However, after a major fire at the Central Medical Stores (CMS) in Ghana in January 2015, priorities and plans shifted. The Government of Ghana (GOG) established an interim public sector storage solution for public health commodities: the Temporal Central Medical Stores. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the U.S. Agency for International Development (USAID) secured private sector warehousing for their program commodities at the central level, from Imperial Health Sciences (IHS).

Commission funds were then used to support a stakeholder meeting on May 4, 2015, which convened stakeholders to refine and communicate the resupply and coordination mechanisms operating between public and private sector organizations, and to establish next steps. This report and its appendices include details about the meeting’s agenda, purpose, and contents, participants, issues discussed, and next steps. The report also discusses the context of the overall PSE activity, provides a brief summary of the activity, and documents potential future challenges and contingency plans/actions developed. Last, the report offers suggestions to enhance the PSE Guidance Document, based on lessons learned during the PSE activity.

Shifting from public sector to private sector warehousing at the central level for GFATM and USAID commodities was a significant modification to the supply chain; for any change of this scale to the supply chain, it is important for stakeholders to consider potential future challenges in their planning, as well as how to counter such challenges, if they should arise. Table 1 lists potential future challenges that have been identified, including tentative contingency plans/actions on which stakeholders have reached agreement.

Table 1. Potential Supply Chain Challenges and Tentative Contingency Plans/Actions

<table>
<thead>
<tr>
<th>Potential Supply Chain Challenges</th>
<th>Tentative Contingency Plans/Actions</th>
</tr>
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<tbody>
<tr>
<td>Poor warehousing practices at the regional level (e.g., need for dejunking) may result in insufficient levels of storage space.</td>
<td>MOH may improve warehousing practices through dejunking training and exercises to be conducted at the Regional Medical Stores (RMSs).</td>
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<td>Low prioritization of program commodities for regional-level storage; RMSs often prioritize available space to give preference to commodities that produce internally generated funds (IGF).</td>
<td>Regions have been asked to identify hospitals with large storage areas that can serve as additional regional storage, if required.</td>
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<td>Tentative Contingency Plans/Actions</td>
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<td>-------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Limited availability of service delivery point logistics data (e.g., consumption data) to guide the RMSs in ordering from the central level may result in oversupply or undersupply situations within the regions.</td>
<td>MOH may improve information availability by regularly conducting supportive supervision and using data on stock status from the Early Warning System.</td>
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<td>Limited active distribution by RMSs to lower-level facilities; this can lead to stocks building up at the RMSs and to undersupply/stockouts at lower levels.</td>
<td>MOH and partners may conduct advocacy with regions to implement scheduled delivery, and to consider private sector involvement in lower-level distribution; also, unlock some of the GFATM resources to support lower-level distribution.</td>
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<td>With a more structured ordering and distribution cycle, coupled with limited availability of consumption data for use by regions in placing orders or limited storage space, some regions may stock out before the next scheduled distribution cycle.</td>
<td>MOH, IHS, and partners may establish processes for processing emergency orders, which must be approved by officers at the appropriate levels.</td>
</tr>
</tbody>
</table>
Context for Private Sector Engagement Activity

Initial Activity Plans

The original intent of the private sector engagement (PSE) activity in Ghana, under the auspices of the UN Commission on Life-Saving Commodities for Women and Children (the Commission), was to support the implementation of regional outsourced distribution models in the Upper West and Volta regions. The Ministry of Health (MOH), the U.S. Agency for International Development (USAID), and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) were actively supporting this intervention. Phase 1 was to include a cost/benefit analysis, in-country validation, distribution model design workshops, standard operating procedures (SOP) training, and a baseline assessment. Phase 2 included implementation of the distribution models, associated monitoring and supervision activities, an endline evaluation, and a stakeholders’ workshop.

Crisis Management

However, events occurred in early 2015 to alter these plans. In January 2015, a major fire gutted the primary Central Medical Stores (CMS) warehouse in Tema, which is about 25 kilometers from Accra in the Greater Accra region. All medicines and health supplies in the warehouse were destroyed, and the warehouse’s capacity for storing commodities in the near term was lost. At the highest level of Ghana’s public health supply chain, the Ministry of Health (MOH) has historically used the CMS to store health commodities, including those for reproductive, maternal, neonatal, and child health (RMNCH). Health commodities worth more than U.S. $80 million were lost in the fire.

Following this national emergency, the MOH’s plans and priorities understandably shifted, and the regional outsourced distribution model intervention was indefinitely postponed. This did not mean, however, that the opportunity to engage with the private sector for health commodities was ending. Instead, the impetus for private sector engagement shifted rapidly from the regional-level to the central-level of Ghana’s public health supply chain.
Summary of Private Sector Engagement Activity

Establishing Private Sector Engagement at the Central Level of the Supply Chain

Following the fire in the Central Medical Stores, the Government of Ghana (GOG) and international partners, specifically GFATM and USAID, quickly took action to procure warehousing services. This was done because procurements of critical medicines and health products were in process for the Pooled Procurement Mechanism (PPM), on behalf of GFATM, and for the USAID | DELIVER PROJECT, on behalf of USAID. Additionally, shipments were expected from the Partnership for Supply Chain Management (PF SCM), on behalf of GOG, using funds that had been channeled through USAID. Commodities, expected to arrive soon in the country, would require safe and secure storage. These commodities were supposed to be stored in the CMS, but this was not possible because of the fire.

Commodities Storage Arrangements

The government established an interim public sector commodity storage solution, the Temporal Central Medical Stores; however, primarily because this facility did not meet pharmaceutical grade storage requirements, GFATM and USAID did not use this facility for storing their program commodities. Instead, GFATM and USAID secured warehousing for their program commodities in the private sector from Imperial Health Sciences (IHS). The first commodity shipments were received at IHS in March 2015.

Before this time, the MOH and Ghana Health Service (GHS) did not have formal arrangements in place with IHS; although, in the past, the MOH has informally asked IHS to support temporary storage of commodities that require cold storage (e.g., oxytocin) when the GHS cold chain storage has not been functioning properly. PPM and PF SCM already had arrangements in place with IHS, so they could directly ship their procured commodities to the IHS warehouse; however, additional agreements were required, given the new scope of the relationship. And USAID, through the USAID | DELIVER PROJECT, needed to establish new contracts with IHS for commodity storage and distribution.

Commodities Distribution/Resupply Arrangements

Arrangements for commodity storage were made, but commodity distribution also needed to be addressed. Prior to the fire, CMS was supposed to conduct bi-monthly distribution to the regions. In reality, however, it was not doing any active or routine distribution. Instead, staff from the regional medical stores (RMS) (regional warehouses) was traveling to the CMS to retrieve commodities when they needed them.

For the program commodities, new arrangements were required. IHS does not currently have its own transportation fleet in Ghana; instead, IHS works with multiple transport contractors, whose capacity they have recently helped to bolster. As such, IHS made arrangements with appropriate transport contractors and to resupply the RMS warehouses on a bi-monthly basis.

During early 2015, to effectively deal with the fire’s aftermath, all parties were in crisis management mode; all the stakeholders took many actions in a very short period of time to ensure that health commodities were being stored and distributed securely and efficiently. Because of this situation, there
was an urgent need to not only develop effective resupply and coordination mechanisms between the organizations and sectors, but also to clearly communicate these mechanisms and ensure that these mechanisms would be used at the central- and regional-levels.

IHS Perspective

IHS History in Ghana

IHS began operations in Ghana in September 2006 to support the President’s Emergency Plan for AIDS Relief (PEPFAR). IHS shared space with CMS until 2011; in February 2011, IHS’s own warehouse construction was complete. They built an ultra-modern International Organization for Standardization (ISO)-certified and good distribution practice (GDP)-compliant pharmaceutical-grade facility, which is 2,000 square meters in size and has a storage capacity of 2,500 pallets. The CMS facility that IHS had been occupying was then refurbished and turned over to the MOH, also in 2011.

Since this time, IHS has worked with a variety of clients in Ghana, including PPM and PFSCM, as stated previously. IHS was therefore well-positioned to step in after the fire and provide pharma-grade storage for GFATM and USAID program commodities.

Figure 1. Imperial Health Sciences’ Tema Warehouse Interior

Contractual Agreements

The contract used between IHS and USAID was an indefinite quantity contract (IQC), with specific work orders for different task orders, covering warehousing and transportation of commodities to the regions separately. The GFATM contract was through Task Order 3, under a subcontract between PFSCM and IHS, with the prime contractor being PPM.
In setting up these contracts, the primary challenge was reaching consensus on performance expectations to be met during contract implementation. While, on one hand, GFATM and USAID had expectations for performance, the MOH, on the other hand, had their own expectations, and these expectations did not always align. Meetings held with stakeholders, before and during the contract implementation, have helped gradually in bridging these gaps over the contract period.

**Communications**

Communications between IHS, GFATM, and USAID have been working well. The communications process with the MOH has been improving over time, as all parties become increasingly comfortable with their roles and responsibilities in this new framework. Specific communications challenges concern the coordination of information flow from the regions and various programs. IHS does not often interact directly with the regions unless this interaction occurs during planning of commodity deliveries or during the review meetings convened by the MOH after each distribution cycle.

**Risks**

The primary risks assumed by IHS through the storage and distribution of program commodities include—

- accountability to all stakeholders in providing accurate and timely reports, to aid in the demand planning and ordering process;
- responsibility for securing and safeguarding the chain of custody when stock is received by IHS, until the final delivery to the regions and Teaching Hospitals, and;
- potential product losses during storage and/or distribution to the regions.

**Contingency Systems**

Prior to this contract’s implementation, IHS had established comprehensive risk management systems and business continuity plans across all its businesses, designed to fully counter all identified risks inherent in any healthcare supply chain. Examples include product traceability (batch level), insurance against losses, training and development of key staff, corporate governance structures, and GDP compliant processes and facilities.

**Level of Effort**

The level of activity has proved to be consistent with what was expected, because the IHS systems had always been in place to run GDP-compliant warehousing and distribution services for other entities. IHS’s prior experience in other countries—including Malawi, Nigeria, and South Africa—has also been helpful.

**Long-Term Benefits**

The long-term benefits of supply chain efficiency, public-private collaboration, and reliable storage and distribution of health commodities will accrue to all stakeholders, not only to IHS. This offers the opportunity to evaluate practically the feasibility of the public-private partnership (PPP) concept in the healthcare supply chain of Ghana. To effectively shape any future PSE strategies, this PSE arrangement
is, therefore, a sort of test case from which all parties will be able to draw useful lessons and experiences in order to most effectively shape any future PSE strategies, as highlighted in the Supply Chain Master Plan document for Ghana.

**Stakeholder Meeting to Establish Mechanisms for Resupply and Coordination**

As these new relationships and contracts were being enacted, there was great need to convene stakeholders to refine and communicate the resupply and coordination mechanisms, and establish next steps; therefore, funding support from the UN Commission on Life-Saving Commodities for Women and Children was used to implement this valuable stakeholder meeting.

The one-day meeting was held on May 4, 2015, in Dodowa, in the Greater Accra region. The MOH, in collaboration with the GHS, and with technical assistance from the USAID | DELIVER PROJECT, had earlier drafted a basic set of procedures for managing the resupply process between the central level, regional levels, and the private sector. The primary purpose of this May meeting was to bring together key stakeholders from relevant institutions, programs, and regions to consider the draft procedures, agree on roles and responsibilities, determine next steps, and begin instituting a resupply process. Refer to Annex A for a full report on the May 4 meeting. Annex B includes the agenda for this meeting, Annex C contains the “Framework for Accessing Health Commodities from Central Level Warehouses to the RMSs and THs,” as presented during the meeting, and Annex D provides a view of the “Ministry of Health – Report & Requisition Form for Regional Medical Stores and Teaching Hospitals.”

The meeting was attended by appropriately high levels of staff from the Procurement and Supply Division of the MOH, Stores and Drug Management division of the GHS, Regional Health Directorates, RMSs, IHS, and the USAID | DELIVER PROJECT.

Participants reviewed and discussed in-depth the draft procedures for resupply of health commodities from the central level to RMSs and teaching hospitals; they considered the suitability of the draft procedures to the underlying resupply process objectives. The discussion included: commodities to be covered in the resupply process; requisitions and reports to be prepared and submitted by the RMSs and teaching hospitals within the regions; generation and submission of consolidated regional orders and reports; processing of approved orders for resupply; and preparation and dissemination of stock and shipment status reports. Participants also examined the details of the report and order form, which is to be used by the RMSs and teaching hospitals; they agreed on the steps to be followed to complete, approve, and submit this form to enable the consolidation of regional commodity requirements.

As the private sector organization engaged in this supply chain that combines private and public sector actors, IHS plays a critical role in ensuring that the storage and resupply of commodities is efficiently performed. The meeting participants, including IHS staff, examined the tasks that IHS will perform regularly in support of the resupply process. IHS is now responsible for performing a variety of services: storing commodities procured by the GFATM and USAID; submitting monthly data on receipts and stock on hand to the appropriate recipients; providing warehouse accessibility to an MOH-approved list of individuals; conducting bi-monthly scheduled deliveries to the RMSs and teaching hospitals after having received clearance from the Food and Drugs Authority (FDA) about product registration and quality; and obtaining proofs of delivery and sharing delivery reports within two days of the completion of deliveries.
Prior to the meeting’s conclusion, participants agreed on the next steps to be taken to implement the resupply procedures, moving this private sector engagement activity forward. These actions included the sharing of information with relevant actors at the central and regional levels, identifying who will have access to the IHS warehouse and who will sign for deliveries at the RMSs, and scheduling additional meetings as needed.
Challenges Encountered and Lessons Learned

Throughout this process, since the time of the CMS fire, many challenges have appeared and been effectively dealt with.

Public Sector Concerns

Table 2 summarizes the primary concerns that were voiced by the public sector during this process and brief descriptions of how these concerns were effectively resolved. The concerns voiced by IHS during this process were stated earlier in the document.

Table 2. Concerns of the Public Sector and How They Were Addressed

<table>
<thead>
<tr>
<th>Concern Voiced by Public Sector</th>
<th>How Concern was Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>The public sector had rented a warehouse, the Temporal Central Medical Stores, and expected partners to use it.</td>
<td>GFATM and USAID advised that they could not use the warehouse because it is not presently of pharmaceutical grade.</td>
</tr>
<tr>
<td>Additional (private sector) warehouses at the central level would complicate coordination.</td>
<td>The USAID</td>
</tr>
<tr>
<td>This new arrangement would increase costs.</td>
<td>GFATM and USAID committed to paying the costs associated with their program commodities.</td>
</tr>
<tr>
<td>Concerns were expressed about who could access the IHS warehouse.</td>
<td>The USAID</td>
</tr>
<tr>
<td>The government wanted resources spent to improve the Temporal Central Medical Stores warehouse, instead of using the funds for private sector engagement.</td>
<td>Partners insisted that MOH must upgrade the Temporal Central Medical Stores to pharmaceutical grade and ensure that safeguards (e.g., security, insurance) are in place before the partners will agree to use the Temporal Central Medical Stores.</td>
</tr>
<tr>
<td>The government asked if IHS could also store and distribute government-procured commodities.</td>
<td>Partners insisted that the government must take responsibility for the commodities procured by the public sector to demonstrate the government’s commitment to building a more robust and sustainable public health supply chain.</td>
</tr>
</tbody>
</table>
Potential Future Challenges

Potential future challenges in the areas of commodity distribution and in management of inventory and demand at the regional levels have been identified that may impact IHS, MOH, and/or the partners. Table 3 summarizes the primary potential challenges that have been identified, as well as contingency plans for dealing with them.

Table 3. Overcoming Potential Future Supply Chain Challenges

<table>
<thead>
<tr>
<th>Potential Supply Chain Challenge</th>
<th>Tentative Contingency Plan/Action</th>
</tr>
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<td>Poor warehousing practices at the regional level (e.g., need for dejunking) may result in insufficient levels of storage space.</td>
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Enhancing the Private Sector Engagement Guidance Document

The first draft of the *PSE Guidance Document*, completed at the close of calendar year 2014, comprises five chapters, as well as three supporting appendices. As the Ghana PSE activity progressed, a few ideas for enhancing the current draft of the *PSE Guidance Document* have emerged:

- While the PSE Guidance Document’s P3 framework tables (see figure 3 in chapter 2 of the guidance document), are useful conceptually and as broad guidelines, each PSE activity will progress at its own speed; the speed of planning and implementation is not under the control of any one actor. Therefore, the nonlinear nature of the framework tables, and the uncertainty of the timeframes, should be emphasized.

- If the private sector actor(s) involved in the PSE activity already has an established professional relationship with international funding partners and/or with the MOH, the nonlinear steps for activity planning and implementation may vary quite significantly from the P3 framework tables.

- Clearly identify the templates and tools listed in the *Inputs or Tools* column of the P3 framework tables. For instance, it would be helpful to provide hyperlinks and/or to identify the organizations that authored the tools.

- Last, continue to simplify so that the most useful elements are readily available to users of the guidance document, and that the supporting/background elements are identified as such.

These recommendations were shared with the authors revising the PSE Guidance Document and incorporated into the updated version that was released in January 2016.
Annex A

Stakeholder Meeting to Establish Mechanisms for Resupply and Coordination

DRAFT REPORT - MEETING ON PRIVATE SECTOR WAREHOUSING AND DISTRIBUTION OF HEALTH COMMODITIES

Dodowa, Ghana

4 May 2015

Introduction and Background

Following the fire that gutted the Central Medical Stores (CMS) on Tuesday, January 13, 2015, the government and development partners took various actions to secure warehouses for health commodities that subsequently arrived in-country. This resulted in the Government of Ghana (GOG) and development partners procuring different warehousing services to store various commodities. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the U.S. Agency for International Development (USAID) have indicated that, apart from securing warehouses for the commodities they support, they will also contract transport services to deliver commodities directly to the various regional medical stores (RMS) and the teaching hospitals (TH).

The different warehouse locations and changes in their management emphasized the need to have effective coordination mechanisms for consolidating and submitting orders from the regions and THs; and to, also, ensure an effective system to deliver commodities to RMSs and THs.

Pursuant to the above, the MOH, in collaboration with the Ghana Health Service (GHS) and with technical assistance from the USAID | DELIVER PROJECT, has developed modalities for commodity orders from the RMSs and the THs, approving authorities and processes, delivery processes, and timelines.

The meeting was, therefore, convened to bring together key stakeholders from the THs, regional health administrations, and the programs to deliberate further on the proposed modalities, gather inputs, reach agreements, and determine next steps and responsibilities.

Participation

The meeting was attended by senior officers from the Procurement and Supply (P&S) division of the MOH; Supplies, Stores and Drug Management (SSDM) division of the GHS; deputy directors of Pharmaceutical Services and Administration from the Regional Health Directorates; managers of RMSs; pharmacists and supply officers from the RMSs; and staff from IHS and the USAID | DELIVER PROJECT.
Framework for Accessing Health Commodities from Central Level Warehouses by the RMSs and THs

Highlights of the above framework include the following –

1. **Commodities to be covered**
   a. Malaria commodities: artemisinin-based combination therapies (ACT), rapid diagnostic tests (RDT), and sulfadoxine-pyrimethamine (SP)
   b. HIV: antiretroviral drugs (ARV), test kits, and condoms
   c. TB: treatment kits, laboratory reagents, sputum containers, etc.
   d. Family planning: pills, injectables, implants, and intrauterine devices (IUD)
   e. Nutrition: food supplements and therapeutic milks
   f. Other high-risk items: anti-rabies vaccine, anti-snake venom, oxytocin, ATS, tetanus vaccine, toxoids, etc.
   g. Other essential medicines.

2. **Generation and submission of regional orders and reports**
   a. There will be a monthly meeting of all stakeholders—RMS team; GFATM logistics officers; regional program coordinators/focal persons for HIV, TB, malaria, and nutrition; Expanded Programme on Immunization [EPI], etc.—at the regional level to determine consolidated regional need/order. This meeting will be convened by the Deputy Director, Pharmaceutical Services (DDPS) or the Deputy Director, Administration (DDA) of the Regional Health Directorate.
   b. The RMS manager will prepare the consolidated order for the region after the stakeholder meeting has been held and agreement has been reached on regional needs.
   c. The regional director or the DDPS/DDA should sign the consolidated order from the regions.
   d. The Director of Pharmacy should sign the orders from the THs. Further engagements will be made with management of the various teaching hospitals about the future generation of composite requisitions and to determine the roles of the various departments in this process.
   e. To avert stock imbalances, the regions, as well as the THs, must prepare and submit, on a monthly basis, stock status reports that highlight critical areas requiring action. In the case of the regions, the RMS Manager will lead that effort, in collaboration with the GFATM logistics officers and the regional coordinators/focal persons of programs.
3. **Submission, receiving, reviewing, and approving orders from the RMSs and teaching hospitals**
   a. All requisitions and reports from the regions (RMS) should be submitted to the office of Director, SSDM for collation.
   b. Similarly, all requisitions and reports from the THs should be submitted to the office of Director, Procurement and Supply, MOH.
   c. Director of SSDM shall convene a team—composed of representatives from the various programs, SSDM, the Office of the Chief Pharmacist, P&S, the USAID | DELIVER PROJECT and the Global Fund Logistics Support Project—to review the orders from the RMSs and the THs.
   d. Based on recommendation(s) from the review team, the program managers will give initial approval to the orders from both the RMSs and the THs, with respect to program commodities: malaria, TB, family planning, HIV and nutrition.
   e. Based on recommendation(s) from the review team, the chief pharmacist will give initial approval to the orders from both the RMSs and the THs, with respect to high-risk commodities: anti-rabies vaccine, anti-snake venom, oxytocin, ATS, tetanus toxoid, etc.
   f. Based on recommendation(s) from the review team, the Director, P&S will approve the orders from both the RMSs and the THs, with respect to other essential medicines.

4. **Transmission of information (data) on final approved orders**
   The Director, P&S will submit all approved orders (in the agreed-to formats) to the respective warehouses (Temporal Central Medical Stores, Imperial Health Sciences, and any others that may be determined).

5. **Processing approved orders by warehouses for dispatch**
   a. The warehouses, having received approved orders from Director of P&S, will process the orders for distribution to RMS and THs.
   b. The warehouses will liaise with the respective RMSs and THs regarding delivery dates and times.
   c. The warehouses will obtain proof of deliveries (POD) from the regions and THs and share them with the Director, P&S, Director SSDM, and partners.

6. **Preparation and sharing of monthly inventory and upcoming shipment reports by warehouses at the national level**
   On a monthly basis, the warehouses will share detailed information/data on monthly stock status and on upcoming and received shipments. Recipients of these monthly reports will include Director, P&S; Director, SSDM; programs (program managers and logistics officers); and partners (GFATM, USAID, Department for International Development [DFID], UN Population Fund [UNFPA], etc.).

7. **Preparing and sharing monthly stock status reports by programs at the national level**
The SSDM, in collaboration with the programs, shall prepare and share monthly stock status reports at the national level. The reports will be shared with the Director, P&S; Director, SSDM; program managers; partners (GFATM, USAID, DFID, UNFPA, etc.); and other members of the PSM. These reports should include detailed information that can trigger appropriate responses to ensure commodity security.

**Report and Order Form—for Regional Medical Stores and Teaching Hospitals**

During the May meeting, participants reviewed step-by-step the report and order form to be used by the RMSs and the THs. Apart from indicating the stocks needed, the new form will collect other vital logistics data—such as stock on hand, consumption (issues), losses, and adjustment needed for effective decision-making. The new requisition form is formula-based and will automatically adjust the various columns as data is being filled in. The columns to complete are A (opening balance), B (total quantity received), C (total quantity issued), D (losses and adjustments), and F (average monthly issues). Columns E (total closing balance), G (months of stock on hand), H (maximum stock quantity), and I (quantity to order) include formulas and will automatically fill.

The following steps shall be followed to submit the completed and approved forms from RMSs and THs.

**Step 1**: RMSs and THs shall submit the completed forms via email to the appropriate address at the central level.

**Step 2**: The review committee at the central level will indicate approved quantities and return the form via email to the respective RMSs and THs to endorse (get the appropriate signatures on the forms).

**Step 3**: RMSs and THs shall submit the endorsed (approved) forms either through email or hard copy to the appropriate address at the central level.

**Processes for Emergency Orders**

All emergencies—requests that come between scheduled deliveries or one-offs—shall be approved on a case-by-case basis, and the approval systems shall be flexible (e.g., in case someone who is supposed to sign the form is not available, someone else should be able to sign this form because it is an emergency). It was agreed that although these requests would be treated on a case by case basis, there is the need to maintain the visibility required for approval of requisitions so as to have proper documentation for auditing purposes.

**Imperial Health Sciences—Services to be Rendered**

- IHS will store commodities procured by the GFATM and USAID.
- IHS will submit data on receipts and stock on hand, on a monthly basis, to Director, P&S. This will be a detailed report that lists the stock status of all commodities in the warehouse. The MOH can, in turn, share this report with the RMSs so they know what they can order.
- Accessibility to the IHS warehouse would be by an approved list to be provided by the MOH. Similarly, there will be limited access to an online portal, which shows stock reports and
transaction history. This will also be based on an approved list that the MOH and development partners will provide.

- IHS will conduct bi-monthly scheduled deliveries to the RMSs and THs. These will take place in May, July, and September.
- After IHS receives an approved order from the MOH, IHS has 2 days to pick and pack and 10 days to deliver to the 10 RMSs and the 4 THs.
- IHS will obtain PODs after all deliveries have been completed and will share the delivery report within two days.
- IHS will distribute (deliver) commodities to the RMSs and THs only after receiving clearance from the Food and Drugs Authority (FDA) about the registration and quality.

**Related Issues Discussed**

1. **Fast-tracking registration of medicines**
   A meeting participant suggested that shippers of drugs would have to send samples first before the actual drugs arrive at the ports so that the clearance can be fast-tracked. Another person also suggested that because all the products are pre-qualified, the commodities should be released; then the FDA can do a post-market surveillance.

2. **Limited space at RMSs**
   A meeting participant indicated that most regional warehouses stock more slow-moving goods and less fast-moving goods. Also, there is no space management at most of these warehouses (no racking, so no multiple stacking). These factors have resulted in low availability of space at the RMSs to accommodate the maximum stock levels.

3. **Challenges with consumption data generation at RMSs and service delivery points (SDPs)**
   Meeting participants complained about the inaccuracy of consumption data and that the data being recorded was based on issuances instead of actual use; also, they discussed the perception that the community health nurses are not helping to collate actual consumption data because they think it is an added responsibility. Moreover, in areas where national service personnel are used to collate data, they usually finish their term of service within nine months, and this means that new service personnel have to be trained all over again.

   Another participant suggested that capacity building is needed to ensure that more personnel are trained for accurate data recording.
**Next Steps**

- Staff from all RMSs should meet their regional coordinators, brief them about the new system, and explain how to fill out the requisition form.

- RMSs should provide a list of contacts who can sign for deliveries.

- MOH will provide a list of all people who can access the IHS warehouse (and the IHS Online Platform).

- MOH will forward monthly reports (including stock status reports) to all stakeholders.

- MOH to provide IHS with an address list of all RMSs and THs.

- MOH will schedule a meeting with the USAID | DELIVER PROJECT to draw up programs that help address the challenges being faced by the various warehouses in the regions.

- MOH will ensure that the scheduled delivery system is strengthened.
Annex B
Agenda of Meeting Held on May 4, 2015

<table>
<thead>
<tr>
<th>Meeting on Private Sector Warehousing and Distribution of Health Commodities</th>
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<td><strong>May 3 – 4, 2015</strong></td>
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<td><strong>Sunday, May 3rd, 2015</strong></td>
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<td>Arrival of Participants from Regions</td>
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Annex C

Framework for Accessing Health Commodities from Central Level Warehouses to the RMSs and THs

This annex contains the content from the PowerPoint slides presented for this topic area during the May 4 meeting. This content has not been edited since the meeting.

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### Framework for Accessing Health Commodities from Central Level Warehouses to the RMSs’ & THs

Proposal for Stakeholders’ coordination

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### Background [1]

- Post CMS fire incidence on the 13th of January, 2015 has led to;
  - Government and Developing Partners taking key decisions regarding commodity warehousing for the short and medium term;
  - Involvement of Third Party logistic players (SPL) in the warehousing and distribution of public health commodities

---

Slide 1

Slide 2
Background [2]
• Key decisions taken include but not limited to the following:
  ➢ MOH renting a warehousing facility;
  ➢ Imperial Health Sciences (IHS) provide temporary warehousing and distribution services for GF procured commodities from IHS’s pharma-grade facility
  ➢ USAID has also engaged the services of Imperial Health Sciences (IHS) to provide warehousing services for USG procured commodities.
  ➢ Other Development Partners also working on their warehousing and distribution arrangements.

Background [3]
Impact of current decision;
• Different warehousing facilities located at various locations
• Different public health commodities scattered in different warehouses
• Same type of public health commodities with different expiry dates available at the central level stored in different locations.

...effective coordination is thus required to effectively meet regions’ requirements timely....

Proposed Framework
Commodities to be covered include
• Malaria commodities: ACTs, RDTs, SP
• HIV: ARVs, Test kits and condoms
• TB: Treatment kits, Laboratory reagents, Sputum containers etc
• FP: Pills, Injectablets, Implants and IUDS
• Nutrition: Food Supplements, therapeutic milks
• Other High Risk Items: Anti Rabies, Anti Snake, Oxytocin, ATS, Tetanus Toxoid, etc.
• Other Essential Medicines

Slide 3

Slide 4

Slide 5
Central Level Coordination

- Approval Process for RMS, THs [1].
  - Receiving orders from RMS, THs
    - Responsible Parties – Director P&S, Director SSDM
  - Review of Orders
    - Responsible Parties – SSDM, P&S and Programs (Logistics Officers), Representative from OCP; Technical Assistance Projects.
  - Approval of Orders (Program Commodities)
    - Initial Approval – Program Managers
    - Final Approval – Director P&S
  - Approval of Orders (Essential Medicines)
    - Responsible Party – Director P&S

Slide 6

Central Level Coordination

- Approval Process for RMSs and THs [2].
  - Approval of Orders (High Risk Commodities)
    - Initial Approval – Director Pharmaceutical Services
    - Final Approval – Director P&S
  - Transmission of information (data) on final approved orders
    - Responsible Party – P&S
    - Recipient of Data – Warehouse Managers (TCMs, Partners - Global Fund, USAID, UNFPA, DfID, UNICEF, WHO, etc.)
    - Information Transmission Mode: Scanned or hard copies of approved requisition.

Slide 7

Central Level Coordination

- Processing Approved Orders byWarehouses for Dispatch
- Distribution to RMS and THs
  - Organize Transport Resources
    - Responsible Parties – F&S, SSDM, Logistics Officers of Programs, Transport Units (MDH/GHS), Partners
- Evidence of delivery
  - Obtain and share proof of delivery (PODs)
    - Responsible Parties – Warehouse Managers (TCMs, Partners)
    - Recipient of PODs – Director P&S, Director SSDM and Partners
- Inventory and Stock Status Reports [1]
  - Prepare and Share Monthly Inventory & Upcoming Shipment Reports at National Level
    - Responsible Parties – Warehouse Managers (TCMs, Partners)
    - Recipient of Stock Status Report – P&S, SSDM, Programs (PMA and Logistics Officers), Partners

Slide 8
Central Level Coordination
- Inventory and Stock Status Reports [2]
  - Prepare and Share Monthly Stock Status Reports at National Level
    - Responsible Parties – SDDM, Logistics Officers of Programs
    - Recipient of Stock Status Report – R&S, SDDM, Program Managers, Partners

Regional Level Coordination
- Generation of Regional Orders
  - Convene monthly meeting of all stakeholders (RMS team including Global Fund Logistics Officers, Regional Program Coordinators/Focal Persons for mHealth, TB, Malaria, Nutrition, EPI, etc.) to determine consolidated regional need/order
    - Responsible Parties – DDPI/DOA
- Signing Regional Orders
  - The consolidated order from the Regions should be signed by the Regional Director or the DDPI/DOA
  - Orders from the Teaching Hospitals should be signed by Director of Pharmacy.
- Monthly Regional Reports
  - Prepare and Submit Monthly Regional Stock Status Report
    - Responsible Parties – RMS Manager and GHTSO in collaboration with regional coordinators/Focal persons of programs

Distribution from RMS to Lower Level facilities
- Meetings with Regional Health Management Teams to discuss implementation of schedule delivery from RMS to service delivery points. - Discussions
Quality Assurance Systems & Framework
Contract To Avert Price Variations
Open Discussions

Slide 12

Next Steps

Slide 13

THANK YOU

Slide 14
# Annex D

## Report and Requisition Form—Regional Level

**MINISTRY OF HEALTH**

**REPORT AND REQUISITION FORM FOR REGIONAL MEDICAL STORES AND TEACHING HOSPITALS**

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Regional Level Approval
Name/Signature: ____________________________ Designation: ____________________________ Date: ________________

Program Level Approval
Name/Signature: ____________________________ Designation: ____________________________ Date: ________________