

Ecumenical Pharmaceutical Network

STRATEGY 2010-2015

Contributing to the attainment of the Millennium Development Goals through increased access to affordable essential medicines and stronger pharmaceutical systems

"What do you want me to do for you?" Jesus asked him. The blind man said, "Rabbi, I want to see."

Mark 10:51

Map showing the spread of EPN membership in Africa and Europe – November 2009. Other members in India, Peru, United States and Australia



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ACRONYMS AND ABBREVIATIONS



AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral therapy
AU	African Union
CHA	Christian Health Association
CHI	Church Health Institution
CHS	Church Health System
CMC	Christian Medical Commission
DSO	Drug Supply Organization
EAA	Ecumenical Advocacy Alliance
ECOWAS	Economic Community of West African States
EHAIA	Ecumenical HIV and AIDS Initiative for Africa
EPN	Ecumenical Pharmaceutical Network
FBO	Faith Based Organization
GAVI	Global Alliance on Vaccines and Immunization
HAI	Health Action International
HIV	Human Immunodeficiency Virus
ICCO	Interchurch Organization for Development Cooperation
IT	Information Technology
MDG	Millennium Development Goal
MSH	Management Sciences for Health
NGO	Non Government Organization
PACANET	Pan African Christian AIDS Network
PEPFAR	President's Emergency Fund for Aids Relief
SADC	Southern Africa Development Cooperation
TRIPS	Trade Related aspects of Intellectual Property rights
UN	United Nations
UNAIDS	International Drug Facility for purchase of drugs for HIV TB and Malaria
UNITAID	United Nations Joint Program on HIV and AIDS
US	United States
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WCC	World Council of Churches
WHA	World Health Assembly
WHO	World Health Organization
WHO -AFRO	World Health Organization Africa Regional Office

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- EPN board members who had the ultimate responsibility of approving the strategy

CHAPTER ONE: BACKGROUND

The origins of EPN date back to 1981 when a program within Christian Medical Commission of the World Council of Churches (WCC), aimed at providing advice and support in the area of pharmaceutical services was established. The program evolved to include an advocacy element and later emphasis was placed on promoting access to and rational use of medicines and strengthening church agencies in pharmaceutical management. In 1997 the pharmaceutical program, as it was known, shifted from Geneva to Nairobi and in 2004, a non governmental membership organization known as the Ecumenical Pharmaceutical Network registered to carry the work forward. Since the network was formed membership has been open to Christian health associations, drug supply organizations, church health institutions and other related organization and individuals. Currently, EPN has about 109 members from 37 countries in Africa, Asia, Europe and the Americas.

VISION MISSION AND VALUES

The work of EPN is not just aimed at having quality pharmaceutical services provided by church institutions but working towards services that allow no discrimination and guarantee equal access to all. The work is also aimed at encouraging providers to follow the example of Christ by being empathetic and sympathetic so that the patient feels that they are valued and cared for as an individual.

VISION

A valued global partner for just compassionate quality pharmaceutical services for all

MISSION

To support churches and church health systems provide and promote just and compassionate quality pharmaceutical services

VALUES

EPN values have their basis in the teachings of Christ and the desire to uphold virtues that enhance the dignity of humankind.

INTEGRITY

All our dealings and relationships are based on a high sense of integrity.

Proverbs 16:13: *Kings take pleasure in honest lips; they value a man who speaks the truth.*

COMPASSION

We are concerned about the suffering of others and would like to imitate Christ by taking action to address their needs.

Mark 6:34: *When Jesus landed and saw a large crowd, he had compassion on them, because they were like sheep without a shepherd. So he began teaching them many things.*

RESPECT FOR OTHERS

We treat each other with respect bearing in mind the bible teaching to do unto others as we would have them do unto us.

Philippians 2:3: *Do nothing out of selfish ambition or vain conceit, but in humility consider others better than yourselves.*

CONSCIENTIOUSNESS

We aim at doing everything we have to do to the best of our ability and in such a way that it achieves the desired results.

Ecclesiastes 2:24: *A man can do nothing better than to eat and drink and find satisfaction in his work. This too, I see, is from the hand of God.*

CONTINUOUS LEARNING

We use every opportunity to better ourselves through inquiry and learning.

Proverbs 1:5: *Let the wise listen and add to their learning, and let the discerning get guidance*

PROFESSIONALISM

We maintain a high level of professionalism in all that we do.

Romans 15:14: *I myself am convinced, my brothers, that you yourselves are full of goodness, complete in knowledge and competent to instruct one another.*

FAIRNESS

Justice and a sense of fairness underpin the choices we make as we go about our work.

Leviticus 19:15: *Do not pervert justice; do not show partiality to the poor or favoritism to the great, but judge your neighbor fairly.*

CHAPTER TWO: STRATEGIC ANALYSIS

2.1 EXTERNAL ANALYSIS

2.1.1 Introduction

Organizations depend almost as much on their external environment as their internal structures and value systems for survival. External analysis entails taking stock of developments in the external environment and assessing their impact to EPN. This analysis led to the identification of political, economic, social and other factors impacting on EPN's operations and performance. From this analysis, it was possible to identify implied opportunities and threats to provide the agenda for future strategic actions.

2.1.2 The Global Health Arena

The right to Health: The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The World Health Assembly has adopted a number of resolutions in the recent past to support fulfillment of the WHO objective which is the attainment of the highest level of health by all peoples. A number of these resolutions relate to EPN's work and will provide a reference for proposed interventions so that they are in line with national and international policy. Examples are:

- Resolution 55.14, WHO medicines strategy which recognized the importance of well functioning and equitable health systems including reliable supply systems as key elements in any framework for promoting access to essential drugs
- Resolution 58.27 on improving the containment of antimicrobial resistance which calls for stronger leadership from WHO and expansion and strengthening of the provision of technical support to member states and collaboration with relevant partners to promote the use of appropriate antimicrobial agents.
- Resolution on 60.3 public health, innovation and intellectual property in recognition of the growing burden of diseases and conditions which disproportionately affect developing countries particularly women and children. The specific role NGOs can play in this regard is highlighted in the global plan of action

Global Health Initiatives: This is the era of global health initiatives Global Fund, UNITAID, Global Alliance for Vaccines and Immunization (GAVI), Stop TB Fund to name a few. Global initiatives are typically programs targeted at specific diseases and are supposed to bring additional resources to health efforts¹. Some like the Global Fund are purely funding mechanisms while others are funding, coordination and implementation agencies. The implications of these initiatives for an organization like EPN are not very clear. On the one hand they represent a large reservoir of resources that are targeted for the very countries in which EPN is active but at the same time the conditionalities surrounding these funding streams have up to now made it seemingly impossible to access these funds. In addition because of their disease specific nature there is a feeling that their impact on the health system in general and particular on the private not for profit sector maybe, on the whole, negative².

¹ www.who.int/trade

² Dr. Giusti Between a rock and a hard place,

Millennium Development Goals: Three out of the eight Millennium Development Goals (MDGs) relate directly to health. The global community and many national governments are using these and other international goals such as universal access to care and treatment by 2010 to define local priority and action areas. It goes without saying that just as the millennium development goal on combating HIV/ AIDS, malaria and other diseases cannot be achieved without supply and proper use of medicines - ARVs and others, achievement of the MDGs on child mortality and maternal health also require guaranteed access to medicines and other health commodities which is the focus of EPN work. One of the indicators under goal 8 on developing a global partnership for development specifically measures the proportion of the population with access to affordable essential medicines on a sustainable basis. As such it is clear that the work of EPN makes a direct contribution to the achievement of the MDGs. It will therefore be prudent for EPN not only to clearly align its own targets to the MDGs but also to reference and document all the work done accordingly. In addition it will be important to continue to pay special attention to issues of access to children's medicines and medicines for maternal health as these will be important entry points for efforts to strengthen pharmaceutical services in general.

HIV and AIDS: New data show global HIV prevalence -the percentage of people living with HIV - has leveled off and that the number of new infections has fallen, in part as a result of the impact of HIV programs. However, in 2007, 33.2 million people were estimated to be living with HIV and 2.5 million people became newly infected. There were an estimated 1.7 million new HIV infections in sub-Saharan Africa in 2007 which is a significant reduction since 2001. However, the region remains most severely affected. An estimated 22.5 million people living with HIV, or 68% of the global total, are in sub-Saharan Africa³. This dynamic presents EPN with opportunity to continue undertaking advocacy and capacity building among CHIs for HIV and AIDS management more especially on access to ARVs and treatment of opportunistic infections. In addition attention will have to be paid to second and third line treatments as well as antiretroviral for children which are proving to be a challenge to provide to those who need them. There is also a growing concern that access to diagnostics for HIV is restricted and the market for some of the critical materials needed to support testing and monitoring of treatment is dominated by a few players.

Doctor Driven Health System: Another important social factor is the doctor driven health regime and its implications on health care provision in developing countries. The 'doctor' is for the most part responsible for the decisions about the set up and running of the health system. This is irrespective of the fact that in most of the poorer countries, the bulk of health care is delivered by nurses. The result of this often is marginalization of non clinical interventions such as promotion of rational use of medicines. The importance of a comprehensive approach to health policy development and health care delivery in which each professional's role is clear and respected cannot be over emphasized. The current situation presents an opportunity for EPN to facilitate and advocate for the professionalization of pharmaceutical services in CHIs. It is crucial in the face of limited financial resources and the human resources for health crisis that the most is made of the contribution each health professional can make to health service delivery. EPN will focus its advocacy on the role and contribution of the pharmaceutical professionals.

The Churches in Health: In much of Africa and in some other parts of the world, churches and other faith groups play a critical role in health care and pharmaceutical service delivery. There appears to be no indication that this situation will change in the short to the medium

³ 2008 report on the global AIDS epidemic UNAIDS

term in spite of the conviction by some major international players that public (Government provided) health care is the only sustainable solution for Africa⁴. As such the place for networks like EPN which provides a forum for churches to share information, learn from each and speak with a common voice remains undeniable. Furthermore it is important to keep in mind the fact that the church is itself not a coherent or homogenous body and different churches have different practices. These churches are governed by different dogmas and to some extent constitutions. Consequently, these differences are reflected in the way the church health and pharmaceutical institutions are run. For example some traditional and conservative church practices tend to impact negatively on the governance of the health institutions by promoting highly bureaucratic and hierarchical systems with very little delegation of authority. These kinds of institutions may not be able to attain their full potential as far as health service delivery is concerned. A non denominational but Christian organization like EPN is uniquely placed to advocate with all the different churches (owners) to adopt practices such as good corporate governance in their institutions so as to more effectively attain their objective of healing as many of the sick as they can.

2.1.3 Economic Factors

Global Recession: A major development in the economic arena is the implication of the 2008-2009 global recession. The global financial crisis could have profound implications for the health spending plans of national governments. The crisis is also bound to have the impact of reduced health funding from donors because of increasing number of competing priorities. For EPN, this is most threatening because of its complete dependence on donor funding and the fact that some of the partners who provide core support obtain their funding from individual contributions and church organizations. Current trends show a general decline in individual giving to charities and available data suggests that education and religious institutions are most adversely affected in times of recession⁵. In order to survive and become sustainable EPN will urgently need to broaden its donor portfolio and develop innovative sources of funding which can bridge gaps created by funding delays and shortfalls. Some of the possibilities in this regard include packaging and 'selling' some of the work EPN has done as commercial products which can be bought by a wider audience and the revenue generated used to support EPN's work with churches.

Funding Priorities: A further economic factor is the scale of preference of priorities that call for donor funding. The final report of the Commission on Macroeconomics and Health (2001) argues for a donor commitment of US\$27 billion or more per year by 2007 and beyond to address the health needs of developing countries. By 2003, at US\$8 billion, actual donor commitments for health were less than a third of that amount. A consequence of this persistent shortfall is that health initiatives, including efforts to control particular communicable diseases, find themselves in ongoing competition for scarce resources. The attention given to medicines compared to other priorities will most likely have an implication on EPN's funds mobilization efforts. Innovative approaches to funds mobilizations will need to be developed.

Funding Flows: For both the emerging and the more traditional funding agencies from Europe and America, the current preferred mode of providing funds is to have these channeled to specific countries through country level structures. This is a threat for EPN which is an

⁴ www.oxfam.org/en/policy/bp125-blind-optimism

⁵ Tom Watkins charities see donations drop as need spikes [online]. Available http://money.cnn.com/2009/02/13/news/economy/charity_donations

international/ regional body whose strength lies in working at multi country level to enhance synergies among the members. As a regional/international organization is disadvantaged by being stateless and therefore not able to easily tap into a number of funding streams for the kinds of interventions aimed at system strengthening that it wishes to undertake.

Poverty: The poverty status in developing countries has implications for EPN and its members. Improved estimates of poverty from the World Bank show that the number of poor in the developing world is larger than previously thought at 1.4 billion people. According to UN's *Millennium Development Goals Report 2008*, the prevailing higher food prices are expected to push many people into poverty, especially in sub-Saharan Africa and Southern Asia, regions already with the largest numbers of people living in extreme poverty. Further, the global economic slowdown and climate change will have a disproportionate impact on the poor reducing incomes and compromising livelihoods. This state of poverty has a direct impact on people's purchasing power; hence access to medicines by the masses will be largely affected. Lack of progress in fighting poverty has the potential to lead to renewed emphasis on the campaign to end poverty and hunger thereby reducing the funds available for health and medicines. What funding is available may be channeled primarily through public health systems leading to further weakening of the church system. Given the importance of the church health system in Africa in particular, the opportunity presented by this dire situation is one for EPN to enrich its role and that of its members as facilitators of access to medicines particularly to the poor and most vulnerable.

Pharmaceutical Industry: The high rate of consolidation of pharmaceutical companies through mergers and acquisitions has given rise to pharmaceutical companies exhibiting oligopolistic behaviors to the detriment of the masses in developing countries. The bargaining power of many medicine supply organizations is reduced, health facilities' medicine budgets are constrained because of high prices, hence a major threat to access to medicines. The consolidation also has implications on the availability of generics because the new structures have even greater power to invest in R&D and to bargain for patent protection. In contrast the lowly status of the pharmaceutical industry in Africa by international standards makes it difficult for the continent to take advantage of some of the available flexibilities for overcoming patent barriers. To complete this picture is the growing importance of India Pharma at global level and whether they will have the clout to turn the tide against Big Pharma⁶ and significantly improve access to all new medicines as they have done with antiretroviral treatments. The movements in the pharmaceutical industry provide an opportunity for EPN to increase its vigilance in advocacy, information gathering, processing and dissemination on issues that affect access to medicine.

Medicine Prices: For a number of years, Health Action international (HAI) has been involved in collecting data on medicine prices in public and private sector facilities⁷. Based on more than 27,000 pieces of price information collected from 850 pharmacy outlets and health facilities across 11 countries in Sub Saharan Africa in the period 2004-5, it was evident that in general medicine availability was low in all sectors in these countries and medicines were unaffordable by the majority of the population. The 11 countries surveyed; Cameroon, Chad, Ethiopia, Ghana, Kenya, Mali, Nigeria, Senegal, Tanzania, Uganda, and Zimbabwe, have a combined population of 390 million, which represents half of the total population of sub-Saharan Africa. The main findings from the surveys as they relate to the church sector were that:

⁶The multinational innovator pharmaceutical companies

⁷ www.haiweb.org/medicineprices

- Procurement prices in the NGO/not-for-profit sector at national level in 3 out of 5 countries were below the international reference price suggesting good procurement efficiency in terms of purchase prices achieved;
- In general procurement prices in the NGO/cost recovery sector were generally marginally higher than in the public sector. However in Senegal and Nigeria, the NGO procurement prices were 30% and 80% lower than the prices achieved in the public sector procurement respectively.
- Patient prices for generic medicines on the other hand were in general terms, higher in the NGO sector were than in the public sector. Cameroon had the largest difference between the NGO/cost recovery sector and the public sector generic patient prices at 3.1 times; whilst in Ethiopia, Ghana and Senegal, prices were just 10% higher than the public sector prices. Both Chad and Senegal which were in the top three in terms of high patient prices of in the public and private sectors, and Cameroon which was in the top three of high private sector prices – are all in the top three in terms of high NGO/cost-recovery sector patient prices.

The need for concerted efforts to guarantee the availability of affordable medicines continues to be crucial. EPN intends to take on the challenge of advocacy for sound medicines pricing policies which protect the patients as well as support the sustainability of the church institutions. There is also a need to promote innovative financing mechanisms which ensure that all people have access to good health care.

2.1.4 Political Environment

US Administration: A key political development in 2009 with far reaching implications was the change in the American presidency. The United States is the single largest donor to health, accounting for a quarter (24.9%) of funding commitments in 2006. This includes commitments for the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the U.S. global AIDS initiative. The new administration would like to increase funding for the President's Emergency Plan for AIDS Relief (PEPFAR) by \$1bn (£0.6bn; €0.7bn) over five years and double overall foreign assistance to \$50bn a year by 2012. They have also called for greater US support for the Global Fund and the UN Millennium Development Goals, as well as 100% debt cancellation for the world's heavily indebted poor countries. As a regional body, EPN has the opportunity to use its international recognition to advocate for increased funding of its and other church health programs. However it is still unclear whether the Obama administration will have the same kind of commitment that the Bush administration had on working with faith groups.

Emerging Powers: Emerging economic powers such as China and Korea are looking to invest in least developed countries and strengthen their social and economic ties with these countries in a bid to enhance their global standing. Such developments may provide opportunities for EPN to widen its donor base.

Regional Groupings: Regional groupings such as SADC are increasingly playing a role in development of pharmaceutical policy for their membership. As a regional network this could provide an entry point for EPN to be the linkage for these agencies to the faith based health sector in Africa.

2.1.5 Impact of Technology

The rapid and continuing growth and development of information technology (IT) is beginning to have a major impact in developing countries. EPN needs to position itself to adopt information

and communication technologies which provide potential for major improvements in organizational administration. An e-platform for example provides a forum that can enhance communication and collaboration within the membership. Using intranet technologies to capture data, simplify processes and deliver information provides the possibility to enhance efficiency and reduce networking costs. New technologies for medicines handling and distribution as well as for the delivery of other pharmaceutical services also present EPN with opportunities to facilitate sharing of such best practices among members and contextualization of practices to address context specific requirements.

2.1.6 Legal and Environmental Factors

TRIPS: Developments in intellectual property rights, specifically the Trade Related Aspects of Intellectual Property Rights (TRIPS) to protect patents, trade secrets, copyrights and trademarks have implications on the availability and prices of medicine. These developments are often unfavorable for developing countries from which EPN draws its membership. Given the wide range of vested interest and the complexity of these matters, there are many civil society and consumer groups actively responding to developments on these issues. Their effort is geared largely to ensuring that access for the common person especially in poorer countries is not compromised. This provides an opportunity for EPN to focus on other issues relevant to the churches and allow these groups which have a lot more expertise, experience and resources in this area further the agenda. However EPN will continue to be open to take action to ensure that any specific issues related to the churches is highlighted and where necessary EPN will be part of global and/or regional lobbying and advocacy in this regard.

Climate Change: The effects of climate change such as floods and desertification have both a short-term and long-term impact on people's health and therefore require attention of all organizations in the health sector including church health institutions.

IMPLIED OPPORTUNITIES AND THREATS

Opportunities

- Increasing appreciation of the contribution of FBOs in health
- Increasing number of organizations interested in medicines issues hence increased opportunities for bargaining
- Improving communication infrastructure and information technology
- Responsive donors
- Support for increased funding through PEPFAR and Global Fund by the new US administration

Threats

- Global financial crisis
- Changing donor priorities
- Incompatible working policies among members
- Improved public sector services hence dwindling clientele base
- Migration of staff to seek better terms of service in the public sector
- Donor confidence in Governments
- Increased poverty in developing countries
- Increasing proliferation of counterfeit and substandard medicines

2.2 INTERNAL ANALYSIS

2.2.1 Nature and Identity

The Ecumenical Pharmaceutical Network has its origins in the World Council of Churches where it was conceived 28 years ago as a pharmaceutical program of the then Christian Medical Commission (CMC). From this program through a number of evolutions the organization known as EPN gained its independent legal persona when it was registered in Kenya in 2004 as a non government organization⁸. According to the EPN evaluation report of the 2007 strategy, a Network is defined (in comparison to a membership organization) as ‘a loose spontaneous alliance where much happens through voluntary contributions of members’ where as an organization is a long term creation with own goals that prompt their members into action and access resources for this purpose⁹. It would appear that in its functioning EPN is somewhere between the two. While a lot is done with and through the members, a significant amount of activity is delivered from the secretariat and implemented by staff and paid consultants.

In its membership and outlook EPN is an international organization. Nonetheless it will be important to ensure that its legal status reflects this. EPN is also a Christian organization. Its full members must be Christian Church Owned. However the associate membership need not be Christian as long as they subscribe to EPN’s objectives and values. Given that the organization is in essence owned by its members there may be a need to be alert for any potential conflicts. Other attributes that have been used to describe EPN include independent, apolitical and not for profit organization. It will be useful to agree on the group of attributes that will be consistently used to describe EPN.

The word “Ecumenical” has implications on the way the organization is perceived by the broader community. The link could have either a positive or negative impact depending on the public perception. It is therefore both an opportunity and a threat in that individual donors may or may not want to be associated with the organization based simply on the perception built from the name. The organization may also need to consider investing more in branding and image building so that misconceptions are minimized.

2.2.2 Membership

While in a network model the membership is integral to the organization, for the purposes of this strategy the members are considered external to the secretariat which is the entity for which the strategy is primarily developed¹⁰. However the implementation of the strategy will be indeed for the benefit of the members and the people they seek to serve.

Since the network was formed membership has been open to Christian Health Associations, Drug Supply Organizations, Church Health Institutions, other related organization and individuals. By December 2008 the EPN membership register had approximately 81 full members and about 27 associate members. However it is likely that less than half of these can be considered active in that they engaged or were engaged by the secretariat at least once in the past year. Beginning 2009 those wishing to join and existing members will be required to pay an annual subscription fee of USD 150. While failure to pay will not immediately mean cessation of

⁸ The organization was at one point registered in Switzerland

⁹ Amoa B and Causemann B Final report, Evaluation of EPN December 2007

¹⁰ See organization model Annex I

membership it may result in loss of certain benefits and opportunities which will be open only to paid up members.

2.2.3 Mandate

Since its early days as a program of the World Council of Churches, EPN's mandate has always been to deal with pharmaceutical issues in the church sector particularly in Africa. Late 2008 the EPN mission was re-stated as '*to support churches and church health systems provide and promote just and compassionate quality pharmaceutical services*'. The way the organization has dealt with the issues though primarily supportive has varied from providing technical and expert advice to physical intervention in some crisis situations. From a global perspective EPN is often seen or engaged as the voice for the faith sector in Africa on pharmaceutical issues. EPN has been and could definitely continue to be the professional voice of the church pharmaceutical sector given the expertise and experience EPN has within the secretariat and among its membership. Additionally in Africa at least, EPN can claim a big number of the important organizations in this sector as either members or partners. However given that even in the institutional members EPN is often known by one or at best two people it is not clear how far churches and church systems have entrusted EPN to be their voice or indeed how aware they are of this expert institution that is "theirs". It may be necessary to seek ways for the churches to become more aware and make better use of their organization. Overall it would also appear that EPN has had a big global impact but far less local impact save from a few pockets within its membership where there has been active engagement. Going forward it will be necessary that mechanisms are put in place to determine what impact EPN really has and where and how its voice most needs to be heard.

2.2.4 Collaboration, Relationships and Alliances

EPN over the years has built sound relationships with various partners at local, regional and global level. Most notable are the good linkages with various units and departments within the WHO HQ which have boosted EPN's international reputation. However, much remains to be done especially since visibility among African and sub-regional organizations appears rather limited. A strategic linkage with WHO AFRO in particular needs to be explored given its key role in promoting the Access to medicines (ATM) agenda and its possible role in facilitating MOH NGO collaboration at country level and within regional fora such as Central African Economic and Monetary Union, ECOWAS, African Union (AU), SADC and the East African Community. It will also be important to develop stronger partnerships with church umbrella bodies both regionally and locally as a means to further enhancing acceptance and collaboration among EPN's constituency.

2.2.5 Governance

The highest authority of the organization is the general meeting. The general meeting which is constituted by the members at least every two years defines the broad mandate and identity of the organization. The board members of EPN are currently nominated from among the membership and appointed by the General Meeting. The 7 member board is responsible for the policy and strategic direction of EPN and has been critical in providing the leadership and guidance to the secretariat that has enabled it to grow and achieve success. The composition and membership of the Board seems adequate to ensure that the organizations agenda is member focused. Nonetheless there is room for improvement especially in clarifying the role of

the board with respect to funds mobilization , process of appointing board members and defining more concretely the role and contribution expected from each board member.

2.2.6 Human Resources

EPN secretariat currently¹¹ has 7 full time and one part time employee. The staff is professional in the areas of pharmacy, management, accounting and communication. Current critical human resource gaps are in the areas of fundraising and advocacy. Considering the lean secretariat over the period of the previous strategy the organizations achievements have been highly commended. In fact the recent evaluation¹² urged the Board to recognize that some EPN staff were overworked and there was a need to streamline tasks required of the secretariat in line with the available resources. Possibly some kind of prioritization is required for the tasks available so that fewer tasks are done but done very well.

2.2.7 Financial Analysis

In the period 2006-2008 due to large grants from SIDA and ongoing core funding from Bread for the World, ICCO and Misereor, EPN's operational budget grew steadily. The added responsibilities called for more staff, more administrative inputs and the cost of the organization also subsequently grew. More staff and more activity has meant that the amounts of funds available to carry forward into a new funding period have shrunk. In 2008 EPN was engaged by MSH under the SPS program to implement activities intended to strengthen pharmaceutical systems in the churches which provided crucial new funding. However the lack of other significant new commitments leaves EPN in dire need for commitments of substantial new long term funding. For EPN to survive it must be actively supported by members, funding agencies and partners. The question is in an environment of ever scarce resources how can "buy in" from the different stakeholders be maximized and their support guaranteed? This issue will have to be continually addressed over the next six years. There is also a question as to whether EPN should develop some internal mechanisms for income generation. The arguments in favor of this would include;

- Greater diversity in income sources and hence ability to meet expenses as and when they fall due
- Gradual development of a business-like mentality in the organization and hence greater focus on resource mobilization

While those against include;

- Greater requirement to pay and account for revenue with the possibility that current tax exemptions may be jeopardized.
- May require changes in the mode of operation and probably a change in the constitution.

2.2.8 Work Focus

EPN has over the last 5 years focused on three program areas: Networking, HIV and AIDS and access to medicines. Under Networking there has been a special effort to ensure that the French speaking members and potential members were brought into and became active in the work of EPN. The strategy for the Francophone work has been to have activities and programs developed for the English speaking countries replicated for the French speakers whenever possible. Reproduction of each and every activity undertaken for the Anglophone network in

¹¹ November 2009

¹² Amoa B and Causemann B Final report, Evaluation of EPN December 2007

the Francophone has not been fully achieved but some progress has been made. For the future greater emphasis is to be placed on defining more specifically the needs of members including addressing any specific needs of the Francophone region and promoting a bottom up or joint ownership approach to activity implementation. It will also be critical for EPN to focus and thus gain expertise in selected areas of pharmaceutical services support in order to better serve its members.

2.2.9 Methods of Work

The main methods of work currently are information sharing, capacity building, research and advocacy. The first three methods of work are well developed but more needs to be done on advocacy. EPN has been able to articulate issues that need to be carried forward/publicized but has been limited in advocating (obtaining policy change) on these issues. The global nature of the membership poses great challenges in defining the geographical spread of EPN work. As such a lot of activity has been carried out in and for many countries but the absence of follow up and sustained interventions in any one country makes it more difficult to demonstrate the impact of the work. There is a general feeling that EPN is doing a lot of good work, but the world or the larger community does not know it. Advocacy will go a long way in increasing EPN's visibility. In addition it would be wise for EPN to further invest in increasing the capacity of its members to do campaigns on issues so as to have greater local impact. EPN will need to decide whether it continues to use lobbying as its primary tool for advocacy and thus being able to tackle a wide range of issues at a time as opposed to doing more campaigning and thus following up issues until a policy change is obtained. In addition a lot of the advocacy work has been at global level it is important to decide whether investments are going to be made in national level activity.

Implied strengths and weaknesses

Strengths

- Having a constituency i.e. members
- Favorably positioned in the international arena, good reputation and well recognized, with strong linkages to WHO and other-like organizations
- Unique: the only church-based institution that is concerned with pharmaceutical issues beyond country level
- Dedicated, committed, professional staff with a record of good stewardship of donor funds
- High quality leadership/ effective leadership
- Participative approach in decision making and implementation of activities
- Not affiliated with pharmaceutical industry with respect to funding

Weaknesses

- Over-dependence on voluntarism from members and in the face of their limited commitment
- The limiting nature of a “Network” and an inappropriate “Network model”
- Policy and systems gaps within the secretariat, unclear performance measurement criteria, Limited follow-up of activities carried out and a weak feedback system
- Inadequate institutional linkages with members and limited pull of services by members
- Inadequate image build up and insufficient marketing of EPN
- Inadequate role clarity for some roles in the secretariat
- Complete reliance on donor funding and inadequate capacity for resource mobilization
- Limited knowledge and awareness of EPN among the member countries

CHAPTER THREE: REVIEW OF THE PREVIOUS STRATEGIC PLAN

The strategic plan of the past period (2005 – 2007 and extending to 2008 -9) had its focus on three program areas, Networking, Access to medicines and HIV and AIDS. The networking program was designed around developing the network with a focus on information sharing and collaboration among the members. The main focus of the access program over the years was building the capacity and standing of church drug supply organizations in Africa. The HIV and AIDS program on the other hand was geared towards increasing the capacity of church leaders to address HIV and AIDS issues particularly treatment. The general conclusion of the evaluation carried out at the end of the initial strategy period - end of 2007 - was that EPN's work was highly appreciated by many stakeholders and had made a significant contribution to improving the pharmaceutical services in church health institutions. However there was a recommendation for EPN to focus on fewer activities targeted at segmented groups in its membership and to ensure proper follow up. The Board was also urged to revisit the organization's network model as this did not appear to be delivering the desired results. The key achievements in each program over the period are given below:

NETWORKING

- Rapid growth in membership particularly in the Francophone countries in Africa to a total over 100 members from 37 countries by the end of 2008
- Active engagement of the network in lobbying WHO and PEPFAR on issues affecting the members which enhanced the image of the organization, influenced policies of international organizations and contributed to sustainability of the church institutions and better access
- Sharing of high quality information within the network and strengthening of inter member linkages

ACCESS TO MEDICINES

- Completion of a number of country baseline studies to define the level of compliance of church institutions to the EPN guidelines on effective and efficient pharmaceutical services
- The capacity of DSOs was built and tools developed for ongoing use in a number of areas including organizational assessment, quality control, distribution systems, computerized inventory management systems and standard operating procedures

HIV AND AIDS TREATMENT

- Church leaders from a number of countries were trained who thereafter implemented or advocated for implementation of programs for prevention and treatment
- A treatment literacy manual was developed to inform church leaders on relevant issues related to HIV and AIDS treatment

The 2007 evaluation also identified a number of areas which EPN could address including:

- Tackling the issue of lack of skilled human resources in pharmaceutical services in Africa
- The need to develop a system to assess the impact of EPN work through recording and analyzing change within the targeted institutions
- Reviewing the organizations approach to advocacy with the consideration of investing more in campaigning in addition to lobbying which is seen as the primary means that EPN is doing advocacy. However this is only possible if the advocacy issues are more focused

The evaluation concluded that the work of EPN remains very relevant to the Christian health institutions and its ultimate beneficiaries; and that EPN had made progress towards achieving its objectives. While it was recognized that EPN was operating quite efficiently, there was a need to ensure timeliness of outputs and to increase the cost effectiveness of activities wherever possible. In addition it was noted that it was not possible for EPN, in the foreseeable future, to generate from its members the resources needed for survival and renewal.

CHAPTER FOUR: STRATEGIC PRIORITIES, OBJECTIVES AND STRATEGIES

4.1 STRATEGY CONTEXT

Church based organizations continue to be active in health care delivery in many parts of the world and particularly in Africa. In addition many church founded organizations are involved in supporting health service delivery in one form or another. Currently in Africa there are over 30 Christian Health Associations and Networks and about 16 medicine supply organizations. These along with members from other parts of the world will be the primary beneficiaries and collaborators in the implementation of the plan.

4.2 STRATEGY FOUNDATIONS

EPN strategy for 2010-2015 has been designed to build on the achievements of the previous strategy period while addressing the factors that compromised success. The focus of the strategy is to use the areas of EPN's expertise as entry points for addressing broader issues in pharmaceutical service delivery in the churches with the aim of supporting the achievement of higher levels of efficiency and effectiveness that benefit the patient. In order to more effectively fulfill its mandate it is expected that EPN will need to redefine its institutional set up. A network by nature imposes certain limitations on what can be achieved. EPN will remain a membership organization but it will be important to ensure that the institutional set up allows the possibility to effectively fulfill the mandate in order to have impact on the ultimate beneficiaries.

4.3 STRATEGIC PRIORITY AREAS

The following are the priority areas that EPN will address over the strategic plan period. The areas have been identified based on the understood need of the church pharmaceutical sector, the expertise within EPN and informed by the experience of supporting church pharmaceutical system for over two decades. In addressing these priority areas EPN will seek to promote approaches that address strengthening of the health system as a whole.

- 1. Access to and rational use of medicines**
- 2. HIV and AIDS treatment**
- 3. Professionalization of pharmaceutical services**
- 4. Pharmaceutical Information sharing**

EPN believes access to medicines is a basic human right and every effort should be made to ensure that all actors in the health sector take up the challenge of ensuring that medicines are available, accessible and affordable to all including the poor and marginalised. Halting and reversing the HIV and AIDS pandemic is impossible without provision of the requisite medicines. The far reaching implications of the pandemic especially in the primary geographical area of EPN's work make it critical that special attention is paid to care and treatment issues. Professionalization of pharmaceutical services and provision of current accurate pharmaceutical information are both important pillars in the struggle to ensure that medicines reach all who need them. In addition, as stated earlier, it will be necessary to establish what organisational system is best able to fulfil this mandate and thus attention will be paid to building the

organization. At the heart of what EPN seeks to do is to make a difference to that patient especially the most vulnerable at the periphery of society who has nowhere to get help.

By their nature churches and church institutions have the poor and un-reached as their target and therefore it is under this framework that EPN seeks to make its contribution. The overall goal of the strategy is that Church Health Systems are strengthened and increasingly able to provide just and compassionate quality pharmaceutical services. The EPN guidelines provide a good proxy for the nature of services being provided and the level of compliance of church health systems with selected EPN guidelines¹³ will be one of the measures of the overall success of this work.

4.4 STRATEGIC OBJECTIVES AND STRATEGIES

I. ACCESS TO AND RATIONAL USE OF MEDICINES

EPN believes access to medicines is a basic human right and every effort should be made to ensure that all actors in the health sector take up the challenge of ensuring that medicines are accessible and affordable to all. Rational use of medicines is equally important to ensure that the available medicines continue to be effective.

Strategic Objective: To facilitate increased access to and ensure rational use of affordable quality medicines in the church health system

Strategies

- 1.1. Explore and propagate models that address access to and /or rational use of medicines
- 1.2. Develop capacities and support improved operations in DSOs and CHIs
- 1.3. Promote collaborations between church DSOs and government DSOs and others as appropriate
- 1.4. Develop and/or disseminate tools for medicines management
- 1.5. Raise awareness on medicines use issues at different levels and among different professions
 - 1.5.1. Facilitate institutionalisation of rational use of medicines
- 1.6. Develop and support the development of mechanisms for quality assurance of medicines
- 1.7. Promote interventions that address affordability of medicines within the CHS

Indicator

% of church health institutions complying with EPN guidelines for efficient and effective pharmaceutical services

Anticipated Outcomes

- Improved access to affordable quality medicines in the church health system
- Improved usage of available medicines in the church health system

¹³ Countries for which baseline data is available from the access studies will be used to measure the extent to which EPN interventions have resulted in greater access. The guidelines to be monitored may vary from country to country

Specific Focus of the work

As in the last strategy EPN work in this area will target DSOs. However emphasis is also going to be placed on interventions that are targeted at the church health institution level so as to more directly impact on the patient. One of the areas of interventions will be to promote the adoption and implementation of EPN guidelines for effective and efficient pharmaceutical services. Support of the CHA's will be critical for the success of such interventions. Other key areas of action will be addressing the issue of availability of children's medicines and addressing the issue of antimicrobial resistance. The work to ensure rational use of medicines will use the WHA resolution on rational use of medicines as its basis.

2. HIV AND AIDS TREATMENT

The challenges faced by church health institutions in addressing HIV and AIDS include limited access to second and third line treatments as well as ARVs for children. The lack of the diagnostics required to start and monitor people on treatment is another challenge. Addressing these issues is the major focus of EPN's activities.

EPN seeks to contribute to the attainment of MDG 6 on combating HIV and AIDS by supporting the church health institutions to strengthen their pharmaceutical services, improve their knowledge on antiretroviral therapy and to get involved in advocacy work. In carrying out its interventions EPN will seek to provide fora, where these do not exist, for CHIs and other players in HIV and AIDS care and treatment to meet and share information.

Church leaders are essential to changing attitudes, behaviour and practices that promote the negative trends of HIV and AIDS in the society. EPN in collaboration with its partners will also work to engage church leaders as advocates for greater access to HIV and AIDS treatment.

Strategic Objective: To promote greater understanding and involvement of churches and church institutions in HIV and AIDS care and treatment

Strategies

- 2.1 Build the capacity of church health institutions to address pharmaceutical gaps in HIV and AIDS care and treatment
- 2.2 Build the capacity of church leaders as key advocates for availability and access to HIV and AIDS diagnostics, care and treatment services
- 2.3 Use available church leaders' forums to propagate the messages on HIV/AIDS diagnostics and treatment options
- 2.4 Highlight and respond to emerging issues in HIV and AIDS care and treatment
- 2.5 Build capacity for mainstreaming the management of relevant HIV related commodities within the broader pharmaceutical service

Indicator

- % of church institutions providing comprehensive HIV and AIDS care including provision of antiretroviral therapy for both adults and children

Anticipated Outcomes

- Church health institutions are increasingly able to offer diagnostic services for HIV and AIDS treatment
- Church leaders advocate specifically for continued availability of paediatric formulations, diagnostics and second line treatments
- Increased uptake of VCT and treatment options and greater adherence
- Treatment receives appropriate attention and action in addressing HIV and AIDS

Specific Focus of the work

EPN will work with different players in the church health system to improve access to the commodities required for comprehensive care and treatment. Special attention will also be paid to capacity building for the non clinical personnel involved in supporting treatment. Church leaders will remain an important entry point for EPN to work for better management of HIV and AIDS as well as increased access to treatment.

3. PROFESSIONALISATION OF PHARMACEUTICAL SERVICES

Professionalization of pharmaceutical services is an important pillar in the struggle to ensure that medicines reach all who need them. Professionalism and good governance in church health systems as a means to support the delivery of efficient and effective pharmaceutical services cannot be overlooked. EPN seeks to strengthen the capacity of pharmaceutical personnel within the network for effective pharmaceutical service delivery and creating linkages to increase the effectiveness of their efforts.

Strategic Objective: To promote and enhance professionalism and good governance in church health systems as a means to support the delivery of efficient and effective pharmaceutical services

Strategies

- 3.1 Identify and if needed develop and promote adoption of appropriate and acceptable standards for pharmaceutical services
- 3.2 Carry out and support capacity building and skills development activities
- 3.3 Mentor, develop and use expertise of the members
- 3.4 Sensitise relevant organs within the CHS on issues of professionalism, transparency and governance

Indicators

- % of hospitals¹⁴ that have at least one pharmaceutically trained¹⁵ personnel
- % of church health systems in which mechanisms exists for support supervision of pharmacy personnel
- % of DSO's that meet EPN's desirable characteristics for a DSO

Anticipated Outcomes

- Delivery of efficient and effective pharmaceutical services in the CHS
- Increase in numbers of pharmaceutically trained personnel in the church health system

Specific Focus of the work

Cognizant of the huge pharmaceutical human resource gaps in many of the countries where EPN members are, the drive under this objective is to define which standards apply irrespective of who is employed to provide a service. The institutions that are targeted will be those providing care to patients i.e. Hospitals and other lower level health facilities as well as the pharmaceutical supply agencies.

¹⁴ For EPN's purposes a hospital is a facility that has more than 50 beds

¹⁵ Pharmaceutically trained personnel to be defined as a person having as a minimum the equivalent of 3 months formal training in pharmacy

4. PHARMACEUTICAL INFORMATION SHARING

EPN believes that information is power. Our network nature mandates us to keep track of international trends and policies on pharmaceutical matters by identifying, collecting, developing and disseminating essential knowledge, approaches and methods on pharmaceutical service delivery by the church health systems, while maintaining responsive communication with our network as well as the broader public. EPN aims to be a channel where members can learn from challenges and achievements of one another, therefore making an impact on pharmaceutical service delivery for all.

Strategic Objective: To establish a centre of excellence for provision of pharmaceutical information for and on the church health system

Strategies

- 4.1 Undertake and support research on pharmaceutical practices in the church health systems
- 4.2 Market the models of good pharmaceutical practice from the church health systems
- 4.3 Develop and maintain a current informative, interactive and attractive website
- 4.4 Establish and maintain appropriate mechanisms for continuous information dissemination

Indicator

- Centre of excellence established and functional

Anticipated outcomes

- Increased quality of pharmaceutical services delivery by the CHS
- Increased recognition of the contribution of CHS in the pharmaceutical service delivery
- Higher quality of pharmaceutical care to the patient

Specific Focus Area

EPN information is targeted to its entire constituency as well as the broader public.

CHAPTER FIVE: ORGANIZATIONAL ARRANGEMENTS

In order to implement this strategy successfully it will be necessary to establish the organisational mechanisms required for EPN to fulfil its mission. The kind of system that will enable EPN to fulfil its mandate will need to address six organisational areas: governance, resource mobilisation, human resource development, administrative systems, partnerships and linkages, and monitoring and evaluation.

Organizational System

Currently EPN is registered in Kenya as a Non Government Organization. Considering the limitations inherent in this kind of registration, it is expected that in the short term, the board will make a decision on whether another form of legal entity is more appropriate for EPN going forward. The organizational framework that is expected to deliver this strategy is shown on page 28. The organogram for the Secretariat at the start of strategic plan period is given on page 25. The details of this will be reviewed from the time to time by the board according to the areas of focus and taking into account the resources available.

Human Resources Requirements

The responsibility for the overall running of the organization and the ongoing implementation of the plan shall lie with the Executive Director. The Executive Director shall be accountable to the Board.

Program officers will be assigned responsibility for each of the main thematic areas i.e. Access to medicines, professionalisation of pharmaceutical services, pharmaceutical information and HIV and AIDS treatment. The officers will be responsible for developing activities both for the Francophone and the Anglophone arms of the network. It is envisaged that in the short term the officer responsible for pharmaceutical information will also be in charge of product and brand development.

The supportive functions will include information technology management, finance and accounts as well as human resource and administration. It is also envisaged that early in this strategic plan period there may be need for an officer whose primary task will be resource mobilization. Internships will be availed whenever a mutually beneficially possibility arises.

Relationships and Alliances

Over the years EPN has benefited from strong long standing relationships with partners such as Bread for the World (Germany), ICCO (Netherlands), Misereor (Germany), Evangelischer Entwicklungsdienst (EED) (Germany), and earlier on Cordaid (Netherlands). The relationships with these partners have enabled EPN (and earlier on the pharmaceutical program under the World Council of Churches) to have an impact in many countries around the world. These relationships will continue to be nurtured and strengthened. More recent linkages with non traditional (non church based) partners such as Management Sciences for Health and the Swedish development agency, SIDA will also need attention with the aim of further diversifying and making use of all possible resources that can further EPN work. Furthermore:

- Regionally the agencies with which relationships have to be explored or strengthened include PACANET, EHAIA, WHO AFRO and HAI Africa.
- At national level members will be encouraged to link up with all relevant players involved in pharmaceutical service provision including Government, UN agencies and other partners. In the design of country level activities every effort will be made to ensure the engagement of relevant partners as a means to facilitate information sharing and collaboration.

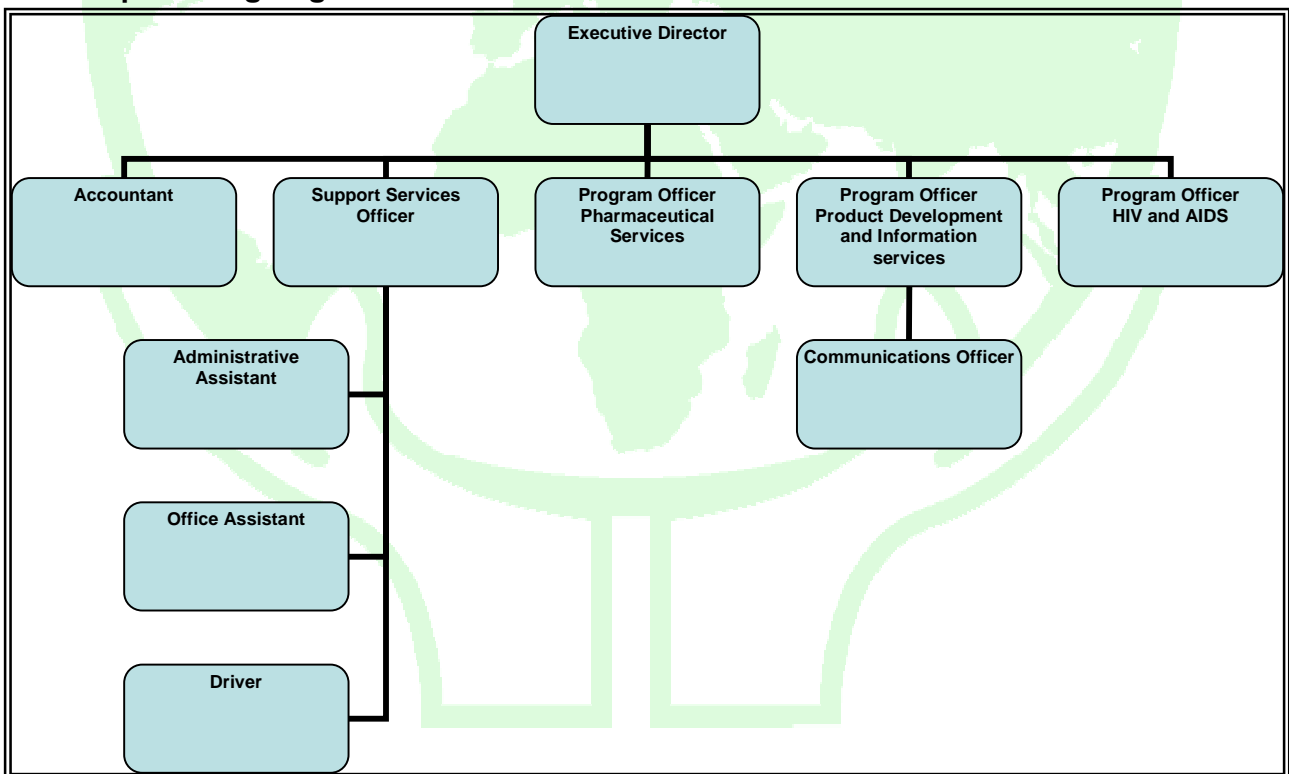
- Strategic partners will also be defined for and engaged as needed under each of the thematic areas e.g. Access to medicines and Pharmaceutical Information: WHO HIV and AIDS: EAA, AIDS-Relief Consortium; Professionalization: International Pharmaceutical Federation (FIP).

Resource Mobilization

The needs within the church health system remain daunting and therefore EPN must continue to do its utmost to mobilize the resources required to do the work. Given the challenges of financing worldwide innovative strategies will be required to ensure adequate and sustainable funding. Some of the strategies could be:

- Diversifying the mix of donors as well as establishing platforms for promoting EPN to different donors and funding sources
- Integrating an appropriate organizational cost into all activities at the time of planning and enforce the timely payment of all fees prescribed by the Board
- Offering consultancy service at market rate fees and respond to relevant call for proposals
- Mainstreaming fundraising into all the programs of the organization
- Encouraging members to mobilize funds to tap into the expertise and technical support that EPN can provide
- Providing EPN capacity building interventions on a cost recovery basis
- Responding to relevant and appropriate calls for proposals in line with the technical capacity and competence within the Network

Proposed Organogram for EPN Secretariat



CHAPTER SIX: IMPLEMENTATION MONITORING AND EVALUATION

6.1 STRATEGY IMPLEMENTATION

The philosophy for the implementation of this strategy is drawn from the New Testament in the gospel of Mark (Mark 10:51) where Jesus asks a blind man what he wants and the blind man responds immediately and concretely that he would like his sight restored. In the same way EPN expects to engage its membership with clear questions on what kind of support they require in order to build just compassionate and quality services. It is hoped that like the blind man, the church health institutions will be able to articulate their needs in such a way that they can be addressed efficiently and effectively. In order to be more effective, EPN will in the coming years, move boldly to develop further as a resource institution for its members and the wider community of churches in health. This will imply developing the capacity for direct implementation of certain activities and programs. At the same time the role as a coordinating and facilitating agency will continue to be equally important.

Every year a detailed organizational implementation plan will be prepared detailing the specific activities to be undertaken under each of the strategies. Indicators, targets and timeframes will be defined for each activity and every effort will be made to ensure that the requisite resources both financial and human are available during the course of the year. This plan will be presented to the board for approval prior to implementation.

Criteria for involvement and choice of priority countries and or regions will be defined taking into account the needs from the membership. A “12 to 5000” approach¹⁶ will be used where by even though interventions target a few countries they will be done in such a way that the lessons learnt and the successful models can be adopted, adapted and replicated throughout the membership and the broader church health sector.

The implementation mechanisms that will be applied to achieve the expected results cut across all the thematic areas and are described below:

Networking

Networking is a critical element of EPN's way of working and will continue to be proactively used to achieve the desired results. The focus will be primarily on the membership so that all the potential and synergy within the group is harnessed to fulfill common desires. But in addition beneficial collaborative arrangements will be sought with international and regional bodies, government agencies, NGOs and civil society among others.

Advocacy

To develop advocacy as a key method of work EPN will have to establish sound issues monitoring and response mechanisms for key developments in the pharmaceutical sector that

¹⁶ The 12 to 5000 approach is based on the reference in the gospels of the feeding of multitudes (5000 men not counting women and children) on 5 loaves and two fish which the disciples (12) had been able to find. As Christians we believe even with limited resources our work can reach and do good for multitudes and we need to structure the work in such a way that this can be achieved.

impact adversely on the church sector. The advocacy effort will not be just focused on the EPN secretariat but it will be crucial to get members able to do advocacy at local and national level as well as to have the capacity to join in regional and global campaigns.

Technical Assistance

EPN will seek to provide technical assistance to church health institutions aimed at enabling them improve pharmaceutical service delivery. EPN will also continue to play a role in representation of the churches on pharmaceutical matters.

Capacity building

EPN has been involved in capacity building at various levels and in various forms for many years. Over the years many people have been trained and numerous tools have been developed and / or disseminated. Countless opportunities for learning through interaction and sharing have also been provided. Direct and indirect provision of training for pharmaceutical personnel and on pharmaceutical issues particularly for but not limited to church health system will be a key focus of EPN work.

Research and information sharing

The research component will include both undertaking and encouraging and supporting members to carry out relevant operational research. Sharing of information within and without the network will continue to be a key method of work for EPN. With the right information the church instructions have the possibility to significantly improve the quality of service they provide.

6.2 MONITORING AND EVALUATION

Monitoring and evaluation will be routinely done through existing governance structures and reports will be prepared for the board, funding agencies and the general meeting as required.

- Each staff at program officer level and above will prepare at least every 3 months a report on the progress made on their individual area of accountability. These reports will provide inputs for a half year narrative report which will be presented to the board. EPN also expects to undertake an internal review at the end of every year to establish the overall progress being made in the implementation of the strategy.
- Project specific reports will be prepared and submitted to the donors according to the grant or contract requirements and any additional monitoring and evaluation will be done according to the grant requirements.
- An annual external audit will be undertaken by a competent firm and the report presented to the board and the general meeting. Audit reports will also be available to funding agencies and other parties who may need them.
- A mid term evaluation in the third quarter of 2011 and an end term evaluation at the end of the period will be conducted by external consultants. Evaluations shall be pre-planned and done in such a way that the results inform the next funding phase. As far as possible data will be collected from the countries where activities are carried out for a more thorough evaluation to properly guide future action. Feedback sessions on the findings of the external evaluations will be organized, to which whenever possible, representatives of the funding agencies shall be invited.

Annex I: Organization Model

