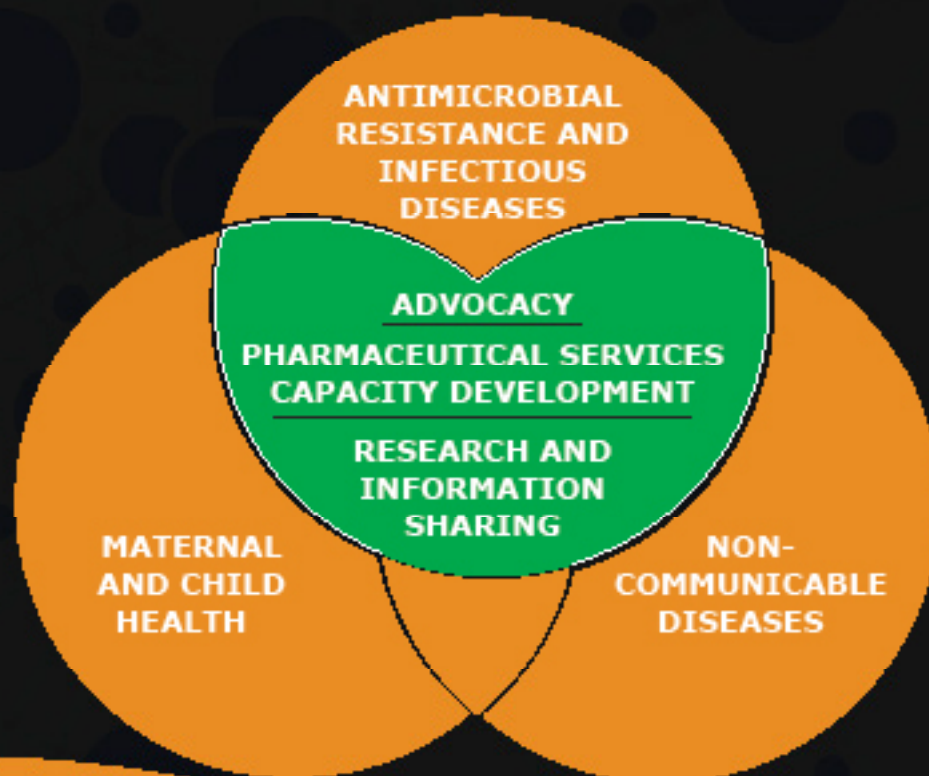
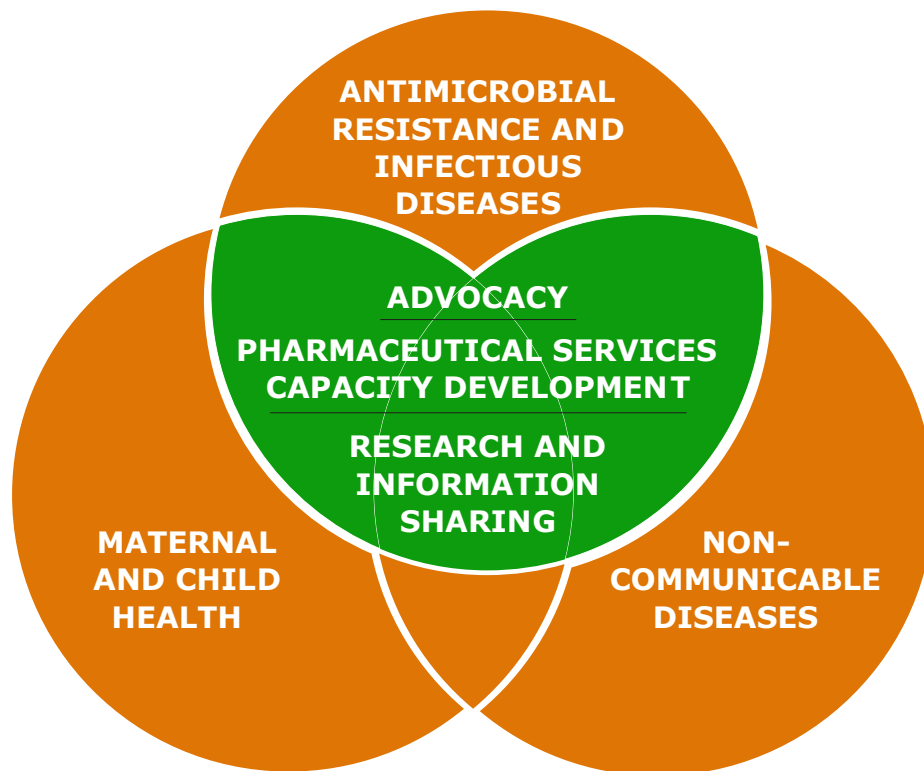


EPN

Ecumenical Pharmaceutical Network
Réseau Pharmacologique Œcuménique



STRATEGIC PLAN 2016 - 2020



STRATEGIC PLAN 2016 - 2020

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LIST OF ACRONYMS

| | |
|-----------|--|
| AMR | Antimicrobial resistance |
| ARC | Antibiotic Resistance Coalition |
| ART | Anti-retroviral therapy |
| ARV | Anti-retroviral |
| BURFMAR | Bureau des Formations Médicales Agréées au Rwanda |
| CDMU | Community Development Medicinal Unit |
| CHA | Christian Health Associations |
| CHAK | Christian Health Association of Kenya |
| CHAZ | Churches Health Association of Zambia |
| CIFA | Center for Interfaith Action on Global Poverty |
| CMC | Christian Medical Commission |
| DAH | Development assistance for health |
| DIFAEM | The German Institute for Medical Mission |
| DSO | Drug supply organization |
| EED | Evangelischer Entwicklungsdienst |
| EHAIA | Ecumenical HIV and AIDS Initiative in Africa |
| EPN | Ecumenical Pharmaceutical Network |
| EPP | Essentials of Pharmacy Practice |
| ESP | Ecumenical Service for Peace |
| FBO | Faith-based organizations |
| GARP | Global Antibiotic Resistance Partnership |
| HAI | Health Action International |
| HAU | Hospice Africa Uganda |
| ICCO | Interchurch Organization for Development Cooperation |
| IHME | Institute for Health Metrics and Evaluation |
| IPC | Infection prevention control |
| JMS | Joint Medical Stores |
| KENERELA+ | Kenya network of religious leaders living with or personally affected by HIV |
| MDGs | Millennium Development Goals |
| MEDS | Mission for Essential Drugs and Supplies |
| MEMS | Mission for Essential Medical Supplies |
| MSH/SIAPS | Management Sciences for Health/Systems for Improved Access to Pharmaceuticals and Services Program |
| MTCs | Medicines and Therapeutic Committees |
| NCDs | Non-communicable diseases |
| PAG | Pharmaceutical Advisory Group |
| PCC | Presbyterian Church in Cameroon Health Services Central Pharmacy |
| PEPFAR | U.S. President's Emergency Plan for AIDS Relief |
| RAN | ReAct Node Africa |
| STGs | Standard Treatment Guidelines |
| TWN | Third World Network |
| UHC | Universal Health Coverage |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| WCC | World Council of Churches |
| WHO | World Health Organization |
| ZACH | Zimbabwe Association of Church-related Hospitals |

1. Executive Summary

EPN aims at improving the quality of pharmaceutical services provided by its member institutions and guaranteeing equal access to all without discrimination. EPN believes that access to quality-assured medicines is a basic human right. Every effort should be made to ensure that all stakeholders in faith-based health systems and the broader health system play a role in ensuring the availability and accessibility of affordable quality medicines, especially to the poor and marginalized. Moving forward EPN recognizes that all its activities and programs are aimed at improved access and appropriate use of quality-assured medicines.

The 2016-2020 strategy is based on the recognition of changing trends in global health with respect to the growing importance of non-communicable diseases and antimicrobial resistance and the anticipated priority given to child and maternal health in the post-2015 sustainable development agenda. Further, EPN occupies a unique niche as the only FBO that focuses solely on addressing issues related to pharmaceutical services in the faith sector and has a network that spans five continents. EPN therefore plans to exploit this niche by serving as an advocate promoting issues of access to and rational use of medicines and increasing the visibility of its members as credible and suitable partners for the planning and implementation of pharmaceutical services. EPN's strategic plan for the 2016-2020 period is therefore structured around 6 priority areas:

1. Advocacy
2. Pharmaceutical services capacity development
3. Research and information sharing
4. Non-communicable diseases
5. Maternal and child health
6. Antimicrobial resistance and infectious diseases

The network's continued success depends on its ability to address the needs of its members while maintaining relevance in an increasingly crowded field of global health actors. The 2016-2020 strategic plan, aims to do both while also building on EPN's recognized strengths.

2. Background

Ecumenical Pharmaceutical Network (EPN) is an international non-profit Christian network. EPN was first established in 1981 as the Pharmaceutical Advisory Group (PAG), an advocacy and advisory pharmaceutical program of the Christian Medical Commission (CMC) at the World Council of Churches (WCC). PAG has since evolved from a WCC-linked program to an independent network of members known as EPN, a registered non-profit organization in Kenya since 2002. The network consists of Christian health associations (CHAs); church health institutions; Christian secretariats; church-related pharmaceutical agencies, donor agencies and health care providers; as well as individuals interested in promoting the objectives of EPN. The network currently has 92 members representing Australia, and 35 countries in Africa, Asia, Europe and the Americas (Annex 1). Members represent both Catholic and Protestant organizations and EPN works with other faith-based organizations (FBOs).

3. Vision, Mission and Values

The work of EPN aims at improving the quality of pharmaceutical services provided by its member institutions and guarantee equal access to all without discrimination. EPN also encourages providers to follow Christian principles, being empathetic and sympathetic to patients so they feel valued and cared for as individuals. The network addresses pharmaceutical issues in the faith sector by providing technical and expert advice to the members of its network.

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 Christian teachings, with the desire to uphold the following Christian 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.

4. Review of the 2010-2015 Strategic Period, Key Achievements

The 2010-2015 strategic plan affirms access to medicines as a basic human right and outlines four strategic areas focused on improving access to medicines and their rational use in the faith-based sector. The four strategic areas include: access to and rational use of medicines, HIV and AIDS treatment, professionalization, and information sharing. In 2012, EPN commissioned Baffour Amoah and Bernward Causemann to conduct an evaluation of EPN's performance from 2008-2011. A summary of the report's findings and recommendations is provided in Annex 2. The evaluation found that among the strategic priorities mentioned here-above, access to and rational use of medicines was ranked as the most relevant; professionalization of pharmaceutical services received the highest ranking in terms of member benefits; while HIV and AIDS treatment was ranked the least relevant and received the least amount of resources from EPN. A summary of the key achievements in each of the current strategic areas is provided below.

4.1. Access to and Rational Use of Medicines

EPN's work in this area targets all components of pharmaceutical supply systems. Special areas of emphasis include: drug supply organizations (DSOs), interventions that target faith-based health institutions, the availability of pediatric medicines, and antimicrobial resistance. EPN has undertaken numerous program activities in this strategic area with much success. They include:

- Studies on the availability and affordability of essential pediatric medicines in Ghana, Chad, Uganda, Kenya, and most recently in Tanzania and Cameroon;
- An initiative on pooled procurement, which involves several collaborations among four DSOs (MEDS, JMS, BURFMAR and MEMS) across East Africa and three organizations in Cameroon PCC, CBC & EEC aims at improving access to essential medicines in FBOs in Cameroon and East Africa;
- A simple quality system test for antibiotics called "Ubora Wa Dawa Test System Project", piloted in Kenya with stakeholders from the Ministry of Health, Pharmacy and Poisons Board and research institutions;
- Promotion and establishment of Medicines and Therapeutic Committees (MTCs) as an important structure for promoting more efficient and rational use of drugs in health facilities. Trainings have been conducted in countries such as Moldova, Zambia and DRC;
- Promotion, production and implementation of Standard Treatment Guidelines (STGs) in member institutions as a measure for cost savings and avoiding stockouts. Members in India, such as the Community Development Medicinal Unit (CDMU) and most Sub Saharan African member institutions have benefited;
- A campaign on antimicrobial resistance (AMR) launched in collaboration with ReAct (at the World Health Assembly in 2009) with continued activities including:
 - o Development and implementation of several training courses on AMR;
 - o The AMR Comic Strips Project, which is a tool for raising awareness among patients and health professionals. These comic strips have been translated into many languages;
 - o Hosting various meetings among key stakeholders on AMR issues;

- EPN has conducted several AMR initiatives through its role as a partner with Global Antibiotic Resistance Partnership (GARP), USAID, MSH/SIAPS and WHO;
- Assurance and promotion of quality of medicines through initiatives such as the adoption of the Minilab system in CHIs. The Minilab system was developed by DIFAEM, a German member institution of the network that promotes the use and quality of medicines in FBOs. Several members currently use this technology and EPN has facilitated knowledge sharing among members across Africa and India. In addition, the World Health Organization now recognizes EPN as the leading medicine quality reporting organization in Africa and has so far issued 3 drug alerts as a result of EPN's reporting;
- Other quality assurance of medicine projects include Joint Audits done by EPN members, Joint Medical Stores (Uganda) and Action Medeor (Germany) on three Chinese pharmaceutical companies;
- EPN has successfully hosted forums biannually for its members to promote access to essential medicines through knowledge sharing around selected themes and facilitate networking opportunities. The theme for the Forum in 2012 was Access to Quality Medicines, Priority Needs, Priority Actions for Today and Tomorrow. It attracted over 60 participants from 40 institutions. The 2014 Forum theme was Maternal and Child Health care – Access to Safe Pharmaceuticals.

4.2. HIV and AIDS Treatment

EPN works with different players in the church health system to improve access to the commodities required for the comprehensive care and treatment of HIV/AIDS. Special attention is given to capacity building for the non-clinical personnel involved in supporting treatment. In addition, church leaders are targeted as key players in promoting adherence to HIV treatment, acceptance of HIV/AIDS patients and promotion of overall health. Current activities include:

- Research at faith-based health institutions in Kenya (and a proposal to conduct similar research in Ghana) on the determinants of non-adherence in HIV/AIDS treatment;
- A treatment literacy program, which includes training religious leaders to enhance their mobilization efforts in the community to address issues of HIV/AIDS care and treatment and their capacity to support people with HIV/AIDS;
- Collaboration with EHAIA, KENERELA+ and local government agencies in several countries on HIV/AIDS treatment, socioeconomic and psychosocial support efforts;
- A popular and well-received HIV Comic Strips Project which uses graphic art to educate patients, health professionals and the general public on faith healing, stigma, prevention of mother to child transmission, antiretroviral therapy and related topics;
- Research on pediatric ART supply, sources of ARVs in Africa and perceptions of church leaders on the church's response to HIV. Results were published in the 2012 edition of Pharmalink.

4.3. Professionalization of Pharmaceutical Services

EPN seeks to address the human resources gap in pharmaceutical services, especially in FBOs, by training pharmacy personnel to provide a reasonable level of professional and quality pharmaceutical services. Significant resources have been expended in this area. Programs include:

- Development and implementation of the Essentials of Pharmacy Practice (EPP) course and its customization to fit different country contexts and facility needs. This has led to documented improvements in the facilities of member organizations that have participated in the training. EPP courses have been conducted in Malawi, DRC, Chad, Kenya, Tanzania and Cameroon;
- Sponsorship and management of several scholarship programs to train pharmacy personnel at various accredited institutions across Africa to work in FBOs;
- The translation of the book, "Where there are no Pharmacists" into French. It is meant to provide basic information about personnel and training issues in pharmacy.

4.4. Pharmaceutical Information Sharing

EPN provides its constituency with information related to all aspects of pharmaceuticals and pharmaceutical related services. It also conducts and supports research and market models of good pharmaceutical practice.

- Information is shared through the following:
 - o E-pharmalink, a bi-monthly electronic newsletter sent to over 3000 subscribers on key publications and news related to pharmacy practice and broader health issues;
 - o Netlink, an email newsletter sent to member organizations to keep them updated on information, events and opportunities within the network;
 - o Contact Magazine, published on behalf of the World Council of Churches, which highlights various health issues around the world and the work of churches in the health sector;
 - o Distribution of pharmaceutical reference books;
 - o EPN website, Facebook and Twitter.
- EPN has also launched several targeted information sharing programs including a recent pilot program targeting dispensers through mobile phone technology with information on the 20 most commonly prescribed medicines across Africa.

5. Strategic Analysis

EPN's continued success depends on its ability to address the needs of its members while maintaining relevance in an increasingly crowded field of global health actors. The network is unique as the only Christian non-governmental organization concerned with pharmaceutical services beyond the country level. While there is value in that uniqueness, the network cannot afford to be complacent. As with any strategic organization aiming for impact and sustainability, EPN needs to clearly define its strengths and decide how best to mobilize resources to maximize the impact of those strengths moving forward. Table 1 provides a summary of some of EPN's perceived strengths and weaknesses.

Table 1 Summary of potential strengths and weaknesses that affect EPN's operations

| Strengths | Weaknesses |
|--|---|
| <ul style="list-style-type: none"> A network that spans five continents and facilitates knowledge/technology transfer. | <ul style="list-style-type: none"> Human resources and facilities gaps at the secretariat. |
| <ul style="list-style-type: none"> Ability to form and maintain strong collaborations with partners. | <ul style="list-style-type: none"> Limited capacity for monitoring and evaluation of programs. |
| <ul style="list-style-type: none"> Strong track record of fiscal responsibility and accountability towards donors and partners. | <ul style="list-style-type: none"> Poor ownership and lack of initiative by members towards the network. |
| <ul style="list-style-type: none"> Partnership or engagement in several global initiatives which has boosted the recognition of EPN as a regional and global partner in various health initiatives. | <ul style="list-style-type: none"> Lack a clearly crafted message regarding the benefits and expectations associated with membership in EPN. |
| <ul style="list-style-type: none"> Proven capacity to develop and run projects. | <ul style="list-style-type: none"> Members have varying degrees of ability to pay membership fees. Smaller organizations with limited resources struggle to pay membership fees. |
| Opportunities | Threats |
| <ul style="list-style-type: none"> The leading medicine quality-reporting agency in Africa. | <ul style="list-style-type: none"> Low visibility beyond a core group of key stakeholders. |
| <ul style="list-style-type: none"> Increasing interest of donors in engaging with FBOs | <ul style="list-style-type: none"> Lack of donor support. |

5.1. External Analysis

FBOs in Health Services

EPN's viability and potential impact has to be considered in the context of the role of FBOs in health services in Africa and other regions. The classification of faith-based or faith-inspired health institutions varies across countries, which puts them in a gray area and makes it difficult to compare the sector across countries or estimate their role and impact in the health care market (Wodon et al. 2014). They may be considered as public, private, non-governmental, traditional, government-assisted health facilities or some variation thereof. They may also receive subsidies from the government or they may be a government-owned institution operated by a faith-inspired organization. With respect to the engagement of FBOs in pharmaceutical services specifically, there is

little evidence or existing estimates of the market share. It is expected that they play a significant role given the estimates of market share for general health services and a few studies have implied that to be the case (Banda et al. 2006; Budge-Reid et al. 2012). Using data based on the number of beds or facilities, studies have found that the health market share of FBOs in Africa can vary from 10-20% in Chad (Boulenger et al. 2014) to 50-70% in the Democratic Republic of Congo but most estimates fall within the 30-40% range (Wodon et al. 2014). However, the estimates also vary depending on whether it is the demand or supply side being considered. Recently published estimates based on data from household surveys across 14 countries, show a much lower market share ranging from 1.5% in Niger to 15.1% in Cameroon (Wodon et al. 2014). These various estimates have associated caveats, including issues with data quality.

FBOs have long struggled for visibility and recognition as suitable partners among government and donors in providing health services (Boulenger et al. 2014; CIFA 2010; WHO 2009). This is evident in the lack of engagement or consultation of most FBOs in health sector planning activities at the country and regional levels. However, recognition has been improving, particularly at the global level with efforts to address the HIV/AIDS epidemic and achieve the Millennium Development Goals (MDGs). Global health donors such as the Global Fund and U.S. President's Emergency Plan for AIDS Relief (PEPFAR) explicitly recognize FBOs as key partners and implementers (Global Fund 2011; PEPFAR 2012). For example, 5% of the Global Fund's grant disbursement in 2010 went to FBOs either as principal or sub-recipients or as support to FBO managed health facilities (Global Fund 2011). The Global Fund signed a US\$102 million agreement with the Churches Health Association of Zambia (CHAZ), a member of EPN, to implement programs in support of Zambia's national HIV response. The Christian Health Association of Kenya (CHAK) and other EPN members have also been sub-recipients of the Global Fund's grant disbursements. Projects such as Novo Nordisk's Base of the Pyramid Program in Kenya, which involves partnerships with CHAK and MEDS, members of EPN, indicate that the pharmaceutical industry is also beginning to recognize FBOs as viable partners in their access programs. However, there is a continued need for FBOs to increase their visibility as professional and viable partners in health service provision and advocate for better integration in public health systems (Boulenger et al. 2014; Olivier & Wodon 2012; WHO 2009).

One implication for EPN is that it operates in a sector that is still poorly defined and understood. EPN occupies a unique niche as the only FBO focused solely on addressing issues related to pharmacy services in the faith sector and has a network that spans five continents. This puts the network in the position of perhaps having the clearest view possible of the existing scope of engagement of FBOs in pharmaceutical services, particularly across Africa. EPN therefore has the opportunity to serve as a voice for the faith-sector in Africa with respect to pharmaceuticals and serve as a platform for engagement with donors and the pharmaceutical industry at the regional and global levels. It could promote its expertise beyond its current group of core stakeholders and become a more overt and strong advocate for issues related to access and rational use of medicines.

If EPN decides to embrace this advocacy role, it would address an expressed need from EPN members for more promotion and advocacy of key policies, government intervention in pharmaceutical sector and FBOs' involvement in pharmaceutical service globally (Amoa & Causemann 2012; EPN 2014). There are existing relationships and initiatives that EPN can use as a starting point for expanding its advocacy role. EPN has excellent working relationships with many of the ministries of health in their program countries.

At the international level, EPN is actively involved in several initiatives. It has a strong relationship with the WHO, which often provides the network with technical support and seeks its input on matters related to FBOs and essential medicines. In the past few years, EPN has attended the World Health Assembly, various WHO regional meetings and Technical Briefings on Essential Medicines. EPN is also a member/partner of the Antibiotic Resistance Coalition (ARC), the Reproductive Health and Supplies Coalition, and the International Pharmaceutical Federation where it gained observer status in 2013. Most recently, EPN participated in the World Council of Churches consultation in Geneva on the Ebola outbreak in West Africa. These examples demonstrate some of the available avenues for EPN to play a stronger advocacy role.

In order to be a successful advocate, the network should be clear from the outset about the scope of its advocacy role and focus on its identified areas of strength. The board should also consider how it may best use its influence to promote EPN's visibility and give serious consideration to the recommendation of creating an advisory board of eminent experts (Annex 2). The network will also need to address two immediate challenges. First, both the previous strategic document and evaluation report (Amoa & Causemann 2012; EPN 2010) noted that many of the stakeholders in the network are unaware of EPN or its activities. It is unclear if that situation remains. If so, EPN cannot validly claim itself as a representative of the faith sector. The second threat relates to significant resource gaps at the secretariat, which would make it unfeasible for the current staff to take on the additional functions that such advocacy would require.

Post-2015 Development Agenda

As the 2015 target date for achieving the MDGs approaches, there are ongoing discussions at the global level about the post-2015 development agenda. Significant progress has been made on the health-related MDGs but targets for child and maternal health (Goals 4 and 5) and HIV/AIDS, malaria and tuberculosis (Goal 6) will not be achieved in the majority of low-and middle-income countries by the end 2015. Targets related to access to essential medicines in MDG 8 are also expected to fall short. These goals are likely to remain top health priorities and feature prominently in the post-2015 development agenda (Task Team 2013; United Nations 2013). In Sub-Saharan Africa, the relative burden of child and maternal causes of morbidity and mortality have declined but remain the top drivers, along with communicable diseases, of health loss in most countries (IHME et al. 2013). Many millions of women and children die each year from preventable causes. The inequitable access to medicines and health supplies remains a major driver (UNFPA 2012). According to the UNFPA (2012), there are three main barriers to the access and appropriate use of medicines and health supplies: insufficient supply of high quality commodities; the inability to effectively regulate these commodities; and the lack of access and awareness of how, why and when to use them, resulting in limited demand.

Momentum to address these causes is evident in several actions at the global level. In 2010, the UN Secretary General launched Every Woman Every Child, a global movement to mobilize and intensify international and national action to address the major health challenges of women and children. In 2012, 175 countries and over 400 civil society and faith organizations signed a pledge in support of A Promise Renewed, the goal of fewer than 20 deaths per thousand live births in all countries by the year 2035. More recently, the World Health Assembly endorsed a global newborn action plan which included the goal to reduce preventable newborn deaths in every country to fewer than 10 deaths per 1000 live births by 2035 (WHO, UNICEF 2014). There are also plans for a similar measure on family planning (USAID 2014).

These efforts are of relevance to EPN both because of its expertise and the potential for partnerships with new donors. Donor agencies increasingly recognize the role of FBOs in scaling up efforts to address maternal and child health. USAID, for example, has explicitly acknowledged the ability of FBOs to help the agency expand its reach to the poorest, most vulnerable populations and has committed to improve maternal, newborn and reproductive health by partnering with faith-based and other community organizations (USAID 2014). As EPN tries to maintain relevance and mobilize resources, these various discussions and events at the global level should at a minimum help frame the context of the network's new and existing programs.

Universal Health Coverage

Globally there is a growing momentum in support of universal health coverage (UHC). The goal of UHC is that all people who need health services receive them, without undue financial hardship. The UN General Assembly adopted a resolution recognizing the role of health in achieving international developmental goals. The resolution urged member states to avoid significant direct payments at the point of service delivery and to develop risk-pooling mechanisms to avoid catastrophic healthcare spending (United Nations 2012). Resolutions were also adopted at the most recent World Health Assembly in support of UHC. Close to half of the countries of the world are currently engaged in health reforms that aim to improve coverage with needed health services and/or financial protection (Boerma et al. 2014). UHC has also been viewed as critical for achieving the MDGs and has been advocated as one of the possible goals of the post-2015 agenda (United Nations 2013; Task Team 2013).

EPN's longstanding work on access to and rational use of medicines and recent work on monitoring the quality of medicines seems particularly relevant in the context of UHC. Access to essential medicines and their appropriate use are indispensable for achieving UHC and are being advocated as an explicit focus in efforts towards UHC (Bigdeli et al. 2014). The inappropriate use of medicines is a major source of inefficiency in national health systems. Approximately half of medicines in primary care settings are inappropriately prescribed and dispensed (Bigdeli et al. 2014). The network can therefore contribute to the goal of UHC through their continued work on issues of access and rational use, the monitoring of medicines quality and building capacity in pharmaceutical services.

Global Epidemiological Trends and Non-communicable Diseases

Non-communicable diseases, which were long considered the burden of richer countries, are now a major health challenge in all countries. Eighty percent (80%) of annual deaths attributable to NCDs occur in low- and middle-income countries. Further, NCDs such as ischemic heart disease, diabetes, and cancer now contribute 49.8% of the disease burden in low- and middle-income countries (IHME 2013). In Sub-Saharan Africa, communicable, maternal, newborn and nutritional illnesses continue to dominate as the causes of death and disability. However, NCDs are expected to be the leading cause of death and disability in the region by 2030 (WHO 2010). These changes in the global epidemiological profile have led to the recognition of the prevention and treatment of NCDs as a major challenge for health and development (United Nations 2012, 2014). The recent World Health Assembly resolution on NCDs urged member states to, among other things, prioritize NCDs and integrate their prevention and control into policies across all government departments.

A key strategy in the prevention and treatment of NCDs is improved access to medicines and their appropriate use. These diseases usually require chronic treatment but

price and availability of medicines continue to be an obstacle. Many of the medicines needed to treat NCDs are often excluded from insurance and reimbursement schemes in countries where health insurance is available and can therefore be a catastrophic burden on households (WHO 2011). In some cases, policy barriers and political neglect at the national and global level can be a hindrance. For example, low-cost and effective treatments exist for many of the cancers that pose the greatest burden in developing countries. However, treatments remain inaccessible for many of those afflicted in low- and middle-income countries (Farmer et al. 2010). Palliative care is also an essential part of treatment for NCDs, especially cancers. However, access to these treatments has been hindered by restrictions on importation of medicines and the absence or shortage of trained personnel, treatment guidelines and regulatory mechanisms (Farmer et al. 2010; WHA67.19).

Within the area of NCDs, EPN has the opportunity to expand its work on pooled procurements, treatment guidelines and other access programs to include palliation and other treatments for NCDs. The network could also play a role in advocating for increase awareness of NCDs and policy changes on the restrictions surrounding palliative treatments. Some of EPN members are already involved in projects specific to NCDs. As noted earlier, both CHAK and MEDS are partners in Novo Nordisk's Base of the Pyramid program, which aims at improving access to insulin and comprehensive diabetes care. CHAK and MEDS are also partners in AstraZeneca's Healthy Heart Africa program, which aims at increasing awareness of the risks and symptoms of hypertension, and provide education, screening, treatment and control. EPN's work could also complement the work of other local actors such as Hospice Africa Uganda (HAU). HAU has been effective advocates for the availability of palliative treatments and have helped usher in changes in legislation to allow the importation and administration of off-patent medicines such as morphine powder in Uganda.

Engagement in NCDs as an issue area would be timely for EPN given the WHO's Global Action Plan for the Prevention and Control of NCDs 2013-2020 (WHO 2013). The Plan, which was endorsed by the World Health Assembly in 2013, sets a target of 80% availability of affordable essential medicines required to treat major NCDs in both public and private facilities (WHO 2013). The plan calls for multi-sectoral action and urges international partners to foster partnerships with FBOs and other civil organizations to address NCDs.

Antimicrobial Resistance

Although the burden of infectious diseases is declining, antimicrobial resistance (AMR) is an increasing threat to the progress made in the control of these diseases. AMR by common bacteria is reaching alarming levels and is considered one of the world's greatest public health threat and an economic and environmental risk (Howell 2013; WHO 2014). Addressing AMR requires multi-sectoral action with stakeholders ranging from the health, agricultural, veterinary and wastewater management sectors, industries, and regulators. The misuse and overuse of antimicrobials are among the key drivers in AMR. Better national and international regulatory mechanisms and practices are needed in order to optimize the access to and use of good-quality antimicrobials (WHA 67/39). EPN is currently engaged in several programs that focus on AMR under its access and rational use strategic area. Its AMR campaign, for example, is a demonstration of EPN's knowledge and expertise in raising awareness of AMR. EPN is also a partner with GARP and a member of the Antibiotic Resistance Coalition (ARC) and has a history of collaboration with ReAct. It has recently agreed to host the ReAct Node Africa (RAN) for ReAct's activities in Africa. Given these collaborations and EPN's portfolio of programs

focused on AMR, it seems logical to have AMR as a standalone strategic area. This move also seems prudent given the recent ascendance of AMR as a priority on the global health agenda. The World Health Assembly Secretariat recently produced a report articulating the growing threat of AMR (WHA 67/39). In a related resolution adopted by the Assembly (WHA 67.25), it urged member states to develop measures for AMR containment, and strengthen pharmaceutical management systems and laboratory infrastructure to ensure access and proper use of antimicrobials. As part of this resolution, the WHO is also developing a Global Action Plan against antimicrobial resistance and is currently hosting several multi-stakeholder consultations at different global and regional forums.

Development Assistance for Health

EPN has long depended on ecumenical donors for funding its core operations. Other traditional global health funding channels are a potentially overlooked source of funding. Development assistance for health (DAH) has continued to increase over the last few years despite the lingering effects of the global financial crisis, austerity measures implemented in traditional donor countries and reductions in bilateral funding flows (IHME 2014). Much of the increase in DAH has been driven by public-private partnerships, such as the Global Fund, and private donations. In terms of focus area, Sub-Saharan Africa continues to be the single largest recipient of DAH as a region. HIV/AIDS also continues to be the single most funded disease area but funding has leveled off (IHME 2014). Despite slight increases between 2010 and 2011, NCDs remain one of the smallest areas of funding. A potential opportunity lies in the fact that DAH allocated to maternal, newborn and child health has been growing substantially, which may reflect donor's interest in addressing the unfinished agenda of MDGs 4 and 5 (IHME 2014).

5.2. Internal Analysis

EPN's Secretariat

The 2012 evaluation report (Amoa & Causemann 2012) portrays a mixed picture of the performance of the secretariat. It notes that the secretariat has a high level of competence and has produced a tremendous amount of output. However, the secretariat was showing the negative effects of an excessive workload. In addition, EPN has not been strategic in following-up on its activities. Since that report, the secretariat has undergone major staff changes over a very short time period including the departure of at least 5 staff members and the appointment of a new executive director. For the secretariat to continue performing well and provide benefits to its members, it needs the resources and facilities to do so including a robust and capable staff at the secretariat.

Core Funding

EPN is currently working on 11 funded projects (Table 2) across 8 countries. EPN also has a strong record of accountability and fiscal responsibility among its donors, which puts it in good stead in competing for future grants. As described in the evaluation report, it is a vicious cycle with staff constantly chasing deadlines. One issue seems to be that many of the grants are relatively small, which increases the workload needed to manage those grants. This also affects the time available and the ability of the secretariat to properly plan and reflect on lessons learned.

Table 2 Overview of current projects, 2013-2015

| Project Donor | Description |
|--|--|
| Bread for the World | Maximizing health outcomes through effective pharmaceutical systems and services. |
| DIFAEM | Support quality of medicines efforts, publications and capacity building. |
| ESP | Essential pharmacy practice course and scholarships for pharmaceutical trainings. |
| ICCO | Appropriate medicines use interventions & monitoring activities. |
| IMA World Health/ Johnson & Johnson | EPP Francophone activity. |
| Kindermissionwerk | Children's medicines survey in Tanzania. |
| | Intervention to improve the access of essential children's medicine in faith-based health facilities, Tanzania. |
| Misereor | Strengthening church health systems: Investing in human resource development for just and compassionate quality pharmaceutical services. |
| | Improvement of access to medicine and training of the pharmaceutical staff through EPN. |
| Porticus | Children's medicines survey in Cameroon. |
| ReAct SIDA | Logistical support to develop IEC materials for African audiences and other AMR activities. |
| SIAPS | Pooled procurement and pharmaceutical strengthening activities. |

Impact Assessments

Many of EPN's currently funded and proposed projects include a monitoring and evaluation requirement but there is no mechanism in place for adequate monitoring and evaluation of programs beyond what is needed to meet funding requirements. There are numerous instances and anecdotes of improvements in pharmacy practice and personnel capacity as a result of EPN activities. However, there is no clear and systematic picture of the impact of EPN's programs on member organizations or at the patient level. Given the nature of health, it is impossible to directly attribute changes at the patient level to EPN's various programs. However, it is possible to track changes at the member organization level and it is a worthy endeavor.

Adopting a proper monitoring and evaluation system can produce numerous benefits for the network. It will improve the credibility and accountability of EPN with its members and donors. It will also provide the evidence-base needed to, among other things:

- Effectively communicate to network members the potential benefits to be gained from their engagement in the network;

- Transparently justify investments in specific programs and projects with member organizations;
- Allow the secretariat to prudently reflect on lessons learned and plan strategically as they seek new funding and develop new programs;
- Craft a clear, honest and effective message about EPN's goals and achievements;
- Allow for comparisons over time and between member organizations.

Human Resource Challenges

The issues with core funding and impact assessments are related to staffing challenges at the secretariat. Successful funding applications for numerous small projects have resulted in the staff implementing and managing multiple small projects across various countries. This is in addition to meeting other member expectations. The turnover of staff since the 2012 evaluation report and current efforts by the secretariat to improve its efficiency means that the staffing challenges have become even more acute. The secretariat has been delicately balancing the need to control staffing costs while also attracting and retaining qualified personnel. EPN has been using staff secondment from European supporting organizations to achieve this balance. While this has helped EPN to get the relevant expertise at minimal costs, it contributes to high staff turnover and threatens long-term staff development and institutional knowledge.

EPN Membership

The network consists of full members, who may include Christian health associations; church health institutions; church-related pharmaceutical agencies, donor agencies and health care providers or Christian secretariats. There are also associate members including individuals, institutions or organizations interested in promoting the objectives of EPN. Annex 1 provides a detailed membership profile.

While membership levels have remained steady since 2010, EPN faces several challenges with member engagement, one of which is the payment of membership fees. Members are required to pay an annual membership fee but there is currently no penalty for non-payment. On average, EPN has lost 37% of the revenue it derives from membership fees between 2009-2014. While membership fees represent only 2% of EPN's annual operating budget, an estimated loss of \$27,000 in unpaid membership fees since 2009 is a significant loss for any organization with limited resources. Member organizations also should recognize that their willingness to pay membership fees is a signal of their commitment to the network and perceived low levels of commitment may dissuade donors from funding the network. Likewise, EPN needs to understand the reasons behind the non-or under-payment of membership fees and how best to incentivize payment with limited administrative burden.

The problems with the payment of membership fees may be a symptom of another systemic problem in the network, which is a seeming lack of engagement in and ownership of the network by its members (Amoa & Causemann 2012; EPN 2014). This problem is evident in the level at which members participate in EPN activities and how responsive they are to the secretariat. A troubling observation is that staff members at member institutions seem to know little about EPN. Awareness of EPN and its activities within member organizations is often limited to staff members who are directly engaged with the network on project work. Some of the staff lack substantive knowledge of EPN beyond the specific projects they are working on (Amoa & Causemann 2012). In instances where the secretariat is actively engaged with members on specific projects,

staff recommended by members sometimes fails to deliver the project activities as expected. There are also issues with the involvement of the board members. The 2012 evaluation report noted that some board members do not have time to invest in EPN because of their own commitment to their own organizations. Finally, EPN has struggled to find volunteers for board positions.

EPN's ability to assist its members and achieve organizational goals will be limited by how effectively members communicate with the secretariat and each other, and how invested members are in the network. However, communication tends to be unidirectional in the network. Members are often tardy in their responses, if at all, to the secretariat. The secretariat often has to send numerous reminders to follow-up on initial messages. During the 2012 evaluation of EPN, the evaluators themselves had trouble getting responses from members for a survey distributed through Netlink with only a 35% response rate. There also seems to be reluctance to providing feedback to the secretariat. EPN needs to identify the underlying factors driving this poor level of engagement and seeming lack of communication.

Financial Sustainability

Bread for the World has consistently been the biggest donor for EPN's programs, accounting for 35.6% of funding received over the past 7 years. MSH/SIAPS, ICCO, EED and Misereor together account for another 43% of funding received over the same period. The board and secretariat should consider whether EPN's donor pool is sufficiently diverse and whether there are overlooked sources of funding. The 2012 evaluation recommended that EPN should seek more core funding and bigger grants to reduce the administrative burden associated with managing many small grants. There is also the potential for EPN to generate additional revenue by offering consulting services within the network and externally as was done recently with two non-member mission hospitals in Malawi and Tanzania. This could be a sustainable source of funding. It would also enhance EPN's visibility and utilize its acquired expertise on access to and rational use of medicines in FBOs.

6. STRATEGIC PRIORITY AREAS FOR 2016-2020

EPN believes that access to quality-assured medicines is a basic human right. Every effort should be made to ensure that all stakeholders in faith-based health systems and the broader health system play a role in ensuring the availability and accessibility of affordable quality medicines, especially to the poor and marginalized. Moving forward EPN recognizes that all its activities and programs are aimed at improved access and appropriate use of quality-assured medicines. EPN's 2016-2020 strategy is based on the recognition of changing trends in global health with respect to the growing importance of non-communicable diseases and antimicrobial resistance, and the anticipated priority given to child and maternal health in the post-2015 sustainable development agenda. Further EPN, plans to serve as an advocate to improve its visibility and that of its members as credible and suitable partners for the planning and implementation of pharmaceutical services. As mentioned earlier, EPN's strategic plan is structured around 6 priority areas for the 2016-2020 period:

1. Advocacy
2. Pharmaceutical services capacity development
3. Research and information sharing
4. Non-communicable diseases
5. Maternal and child health
6. Antimicrobial resistance and infectious diseases

6.1. Advocacy

Programs targeted at increasing access to and rational use of medicines need to be complemented by an advocacy approach that seeks to increase the priority given to access to medicines issues. Likewise, faith-based institutions need to increase their visibility as professional and viable partners in health service provision and advocate for better integration in public health systems. EPN seeks to develop a more systematic approach to raising the priority of access issues on national health agendas and raising the profile of the pharmaceutical services offered by FBOs. EPN is also in a strong position to establish monitoring and response mechanisms for key developments in the pharmaceutical sector that impact adversely on the faith sector.

Strategic objective: increase the priority given to access to medicines issues in faith-based health systems and national health systems.

Strategies

- Lobby faith-based institutions to put more emphasis on the health and cost saving benefits of the rational use of medicines and promote treatment literacy training for church leaders;
- Partner with faith-based institutions, other network members, ecumenical and other partners outside the network to influence national, regional and international discussions on policies related to access to and rational use of medicines;
- Facilitate engagement between network members and national and local governments on issues of access to, rational use of, and quality of medicines;
- Promote and publicize the successes, innovations and contributions of EPN members in pharmaceutical services within and beyond the network;

- Support the establishment and operation of drugs and therapeutics committees in focus countries;
- Facilitate linkages between partners in focus countries and pharmaceutical manufacturers offering concession or access prices on selected products to ensure that countries benefit from these schemes.

Indicators

- Number of collaborations with governments, ecumenical and other partners on issues and policies related to access to, quality of, and rational use of medicines;
- Number of meetings, forums or workshops organized by EPN among faith-based health institutions on issues of access to, quality of, and rational use of medicines;
- Number of treatment literacy training programs organized by EPN for church leaders;
- Number of publications documenting the contributions, innovations, and successes of EPN and its members;
- Percent of facilities with an adopted and accessible copy of their standard treatment guidelines;
- Percent of church health institutions with drugs and therapeutics committees.

Anticipated Outcomes

- Increased profile of EPN and faith-based institutions as valued partners in the provision of pharmaceutical services;
- Stronger partnerships between faith-based health organizations, governmental organizations and other institutions on issues of access to, quality of and rational use of medicines;
- Increased output of publications documenting the contributions, innovations, and successes of EPN and its members;
- Improved literacy rates among FBOs and faith-based communities regarding the appropriate treatment of communicable and non-communicable diseases

6.2. Pharmaceutical Services Capacity Development

If EPN's programs are to be sustainable, those efforts need to be complemented with professionalism and good governance in faith-based health systems to deliver efficient and effective pharmacy services. EPN will therefore need to continue strengthening the capacity of pharmaceutical personnel within the network for effective pharmaceutical service delivery and creating linkages to increase the effectiveness of these efforts.

Strategic objective: (1) promote and enhance professionalism and good governance through training and education, (2) support the delivery of efficient and effective pharmaceutical services among faith-based health systems.

Strategies

- Develop and disseminate comprehensive guidelines for pharmaceutical supply management and standards for pharmacy services;
- Perform capacity building and skills development activities for pharmacy services;

- Facilitate exchange of best practices in pharmacy services among network members;
- Promote issues of professionalism, transparency and good governance among leaders in faith-based health systems.

Indicators

- Percent of facilities with at least one trained/certified pharmacy personnel;
- Percent of faith-based health systems that have adopted pharmaceutical management/services guidelines over a given time period;
- Number of workshops and trainings organized by EPN for church leaders and hospital administrators and focused on governance and the support of pharmacy services;
- Availability and provision of counseling at facilities on proper medicine use and adherence to treatment;
- Adequate record keeping at faith-based health facilities;
- Percent of medicines with adequate labels at faith based dispensaries;
- Percent of patients that report satisfaction with information received about the proper use of their medications.

Anticipated Outcomes

- Increase in the number of trained pharmacy personnel in faith-based health systems;
- Increase in the quality of services offered at pharmacies in faith-based health systems.

6.3. Research and Information Sharing

Information about the role and impact of FBOs in the provision of health services is essential to increasing the visibility of FBOs as professional and viable partners in health service provision. A strong evidence base on the various aspects of the provision of pharmaceutical services by faith-based health institutions and their role in the broader health system is critical to identifying ways to improve access to and the rational use of medicines. EPN seeks to help build this evidence base, which is currently lacking. EPN also aims to support its members by serving as a channel of credible and relevant information regarding trends and policies related to pharmaceutical services and supply management. It also will facilitate contact and knowledge exchanges between the members of the network. Additionally EPN will continue to share pharmaceutical information on medicines both for prescribers and users, creating a center of excellence and fostering rational use of drugs. These information sources can help faith-based institutions improve the quality of services they provide.

Strategic objective: provide information on pharmaceuticals, pharmaceutical supply management and pharmacy services to network members and conduct relevant research for and on the use of pharmaceuticals and service provision in the church health system.

Strategies

- Partner with academic and other institutions to conduct relevant research on pharmaceutical access, use and management systems, and service provision in faith-based facilities;

- Develop and maintain a registry of consultants among network members and facilitate consulting services within the network and externally;
- Encourage and facilitate members to share their experiences and best practices within the network and externally;
- Improve the network's website and encourage members to integrate EPN related guidelines, standards, and information on their websites.

Indicators

- Number of research collaborations and resulting publications with academic and other institutions per year;
- Number of other publications per year documenting the research, contributions, innovations, and successes of EPN and its members;
- Number of consulting contracts per year facilitated by EPN through its registry of consultants;
- Number of networking events hosted annually by EPN;
- Traffic to EPN's website and the number of integrated web links from other members' sites.

Anticipated Outcomes

- Increased access to information on best practices and standards for pharmaceutical services among network members.
- Increased access to pharmaceutical information on commonly used medicines in faith-based health systems.
- Expanded evidence base of the role faith-based health institutions play in providing pharmaceutical services and best practices employed in these institutions.
- Increased research activity by EPN documenting innovations and best practices in pharmaceutical services in faith-based health institutions.

6.4. Non-communicable Diseases

In most developing countries, expenditure on medicines is the highest component of household health-related expenditures. NCDs usually require chronic treatment, which can put an enormous strain on household budgets and cause catastrophic health expenditures. EPN seeks to implement activities that will increase access to and appropriate use of affordable quality-assured medicines to treat NCDs. This will help to reduce the financial and health burden on households and the health system, and improve the quality of life for those afflicted with NCDs.

Strategic objective: promote awareness of NCDs and facilitate increased access and rational use of affordable quality-assured medicines for NCDs.

Strategies

- Promote the adoption and implementation of policies for the prioritization and rational selection of medicines, including palliatives, for NCDs;
- Build capacity of partner DSOs for procurement and supply of NCD medicines;

- Promote pricing control and the prescribing of generic medicines for NCDs.
- Establish quality assurance systems to monitor and increase the quality of locally manufactured generic medicines to treat NCDs;
- Develop information packages for rational diagnosis and treatment guidelines and training of health workers in faith-based health systems, to facilitate increased access to NCD treatments and medicines.

Indicators

- Percent availability of essential medicines for specified NCDs at faith-based health facilities;
- Average cost of essential medicines for specified NCDs at faith-based health facilities;
- Percent availability and dispensing of generics for specified NCDs at faith-based health facilities;
- Number of quality checks performed per year by EPN on NCD medicines;
- Number of information packages for rational diagnosis and treatment guidelines developed and disseminated by EPN;
- Number of partnerships developed with DSOs to enhance procurement and supply of NCD medicines.

Anticipated Outcomes

- Improved awareness of the burden of NCDs and the need for medicines;
- Improved access and appropriate use of quality assured medicines to treat NCDs.

6.5. Maternal and Child Health

Child and maternal causes of morbidity and mortality continue to be among the top drivers of health loss in most countries in Sub-Saharan Africa. These causes of morbidity and mortality are often preventable. However, insufficient supply of high quality commodities; poor regulation of these commodities and the lack of access and awareness of how, why and when to use them, are the main barriers to the access and appropriate use of medicines and health supplies for MCH. EPN seeks to address these barriers in faith-based health systems to help decrease the disease burden associated with MCH.

Strategic objective: facilitate the ability of faith-based health systems to provide quality pharmaceutical services to increase access to and use of medicines and supplies for maternal, newborn and child health.

Strategies

- Conduct baseline assessments on availability and use maternal and child health medicines and services at faith-based health institutions;
- Raise awareness among church leaders about the burden of maternal and child illnesses;
- Advocate for the prioritization of medicines and supplies to treat maternal and child health illnesses at faith-based health facilities;

- Increase access to family planning knowledge and methods at faith-based health institutions;
- Facilitate pooled procurements and other mechanisms to enhance availability of essential medicines to treat maternal and child illnesses;
- Develop guidelines and train pharmacy staff on the proper use of pediatric formulations and other pharmaceutical commodities.

Indicators

- Percent of faith-based health facilities that provide family planning services and maternal and pediatric care;
- Percent of faith-based health facilities with established guidelines on pediatric dosing and medication formulation;
- Percent availability of essential medicines for specified maternal and child health at faith-based health facilities;
- Number of pooled procurements and other mechanisms facilitated by EPN for MCH medicines;
- Number of guidelines and other information materials on proper use of pediatric formulations developed and disseminated.

Anticipated Outcomes

- Improved access to medicines for maternal and child health at faith-based health facilities;
- Contribute to the reduction of morbidity and mortality of illnesses associated with MCH in faith-based facilities;
- Increased knowledge and education on issues related to MCH in faith-based health systems.

6.6. Antimicrobial Resistance and Infectious Diseases

AMR is related to access to and rational use of medicines but it goes beyond that. It is a problem of human and ecosystem health influenced by economical, social and cultural factors. Addressing AMR requires inter-sectoral action with stakeholders ranging from the health, agricultural, veterinary, wastewater management sectors and industries, and regulators. EPN will build on its existing partnerships with stakeholders on AMR such as ReAct, GARP, other members of the Antimicrobial Resistance Coalition (ARC) and others to address AMR issues in the faith sector and broader health system.

Strategic objective: enhance and strengthen the capacity of FBOs in antimicrobial stewardship and infection prevention control (IPC).

Strategies

- Increase awareness of infectious diseases, antimicrobial resistance and appropriate use of antimicrobials;
- Increase awareness among faith-based health providers and the public of the threat posed by AMR;

- Develop and disseminate treatment guidelines for common infections;
- Conduct prescription audits and other surveillance on antimicrobial use in faith-based health facilities;
- Develop training courses on the rational use of antibiotics and other antimicrobials;
- Establish quality assurance systems to monitor the quality of antimicrobials.

Indicators

- Number of workshops and meetings organized by EPN focused on AMR;
- Number of information materials on AMR developed and disseminated;
- Percent of facilities with AMR monitoring programs;
- Percent of facilities that have adopted policies to address AMR;
- Percent of facilities with an active Drug and Therapeutic Committee and surveillance program.

Anticipated Outcomes

- Increased access to and rational use of quality antibiotics in faith-based health institutions;
- Increased knowledge and awareness of AMR and best practices to address the problem;
- Appropriate treatment of infectious diseases and a decrease in AMR prevalence;
- Establishment of new generation of antimicrobial stewards.

7. Implementation and Monitoring Strategy

Strategy Implementation

The outcomes for the strategic areas are dependent on the availability of donor funding to enable the implementation of the various strategies. EPN is committed to improving itself as a resource institution for its members and the wider community of FBOs in health. This will require the secretariat to develop the capacity and mechanism required to implement strategies previously discussed. Annually, the secretariat will prepare an organizational implementation plan with details on the specific activities to be undertaken under each of the strategic areas. 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. Specific implementation mechanisms for achieving the anticipated outcomes cut across all the thematic areas and are described below.

It should also be noted that the outcomes for the strategic areas are dependent on the availability of donor funding to enable the implementation of the various strategies.

Advisory Board

EPN will create an advisory board consisting of eminent persons of the regional and global health community. Members will be appointed by EPN's board. The role of the Advisory Board will be to support the advocacy and fundraising efforts of the EPN Board, provide conceptual advice on strategic priority areas, facilitate linkages between EPN and relevant regional and global institutions, and help improve EPN's standing and awareness of its activities regionally and globally.

Partnerships and Collaboration

EPN has several longstanding partnerships with ecumenical and secular international institutions, and some government and international agencies. EPN will continue active cooperation with these institutions and where appropriate, pursue formal links to increase the network's profile and the impact of its advocacy efforts. EPN will also focus inwardly on its membership and facilitate collaborations and maximize potential synergies within the group.

Membership

The Board and Secretariat will review the fee structure for membership and evaluate the feasibility of a tiered membership whereby fees are structured according to the annual revenue of the member organizations and non-fee-paying members forfeit their voting rights and eligibility for select program benefits.

Communication Strategy

The secretariat will develop and implement a multi-pronged and formal communication strategy to keep members informed of the activities of the secretariat and other network members. As part of this strategy the secretariat will develop a clear articulation of the membership benefits, develop mechanisms to gather feedback from members on their program needs, and where possible, establish linkages with member organizations' websites and other social media. The secretariat will complement these efforts by assisting network members with capacity building for communication, information gathering, information sharing and advocacy.

Technical Assistance

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

Capacity Building

EPN has been involved in capacity building at various levels and in various forms for many years. Many people have been trained and numerous tools have been developed and / or disseminated over the years. 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 faith-based health system will continue to be a key focus of EPN's work.

Monitoring and Evaluation

Monitoring and evaluation will be routinely done through existing governance structures. Periodic 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 areas 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. Additional steps will include the following:

- 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 as needed;
- Periodic evaluations will be done on a periodic schedule to be determined by the board. Findings from all evaluations will be circulated to the membership and funding agencies, when appropriate, for feedback.

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9. Acknowledgements

This strategy document is based on references cited throughout and the following key sources:

- The evaluation of EPN conducted by Baffour Amoa and Bernward Causemann in 2012;
- Report of consultations with members at the 2014 EPN Forum;
- Report of the Secretariat's Strategic Planning Meeting held September 17-19, 2014;
- Consultations with the board and select members at EPN's Strategic Planning Meeting convened on October 31 – November 1, 2014. Participants at the meeting included:
 - o Andreas Wiegand, Program Officer, EPN, Kenya
 - o Sujith Chandy (EPN Board member), Director, Christian Medical College Vellore, India
 - o Chitimbire Vuyelwa, Executive Director, Zimbabwe Association of Church-related Hospitals (ZACH)
 - o Daisy Isa, (EPN Board member), Head of Marketing, CHAN MEDI-PHARM, Nigeria
 - o Donna Kusemererwa, Pharmacist, Independent Consultant, Uganda
 - o Ernest Rwagasana, Managing Director, Bureau des Formations Médicales Agréées au Rwanda (BUFMAR)
 - o Fidelis Nyaah, Pharmacy Manager, Presbyterian Church in Cameroon Health Services Central Pharmacy (PCC)
 - o James Mireri, Accountant, EPN, Kenya
 - o Marlon Banda, (EPN Board member), Pharmaceutical and Logistics (Supply Chain) Director, Christian Health Association of Zambia (CHAZ), Zambia
 - o Mercy Naitore, Administrative Assistant, EPN, Kenya
 - o Michael Mwangi, (EPN Board member) Senior Accountant, Mission for Essential Drugs and Supplies (MEDS), Kenya
 - o Mike Upio, Doctor, Centre Médical Evangélique de Nyankunde (CME), DRC
 - o Mirfin Mpundu, Executive Director, EPN, Kenya
 - o Orgenes Lema, Managing Director, Mission for Essential Medical Supplies (MEMS), Tanzania
 - o Susanne Kuehle, Pharmaceutical Program Officer, EPN, Kenya
 - o Tamara Hafner, Independent Consultant, Denmark
 - o Sue Parry, Board Member, EPN Board Member, World Council of Churches.

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10. Annex

EPN's Membership Profile by Country

| Country | Full (Church related) | Associate (non-Church related) | Individual | Total |
|--------------------------|-----------------------|--------------------------------|------------|-----------|
| Australia | | | 3 | 3 |
| Belgium | 1 | | | 1 |
| Benin | 1 | | | 1 |
| Burkina Faso | 2 | | | 2 |
| Cameroon | 7 | 1 | 1 | 9 |
| Central African Republic | 1 | | | 1 |
| Chad | 4 | | | 4 |
| DR Congo | 9 | | 1 | 10 |
| Egypt | | | 1 | 1 |
| Ethiopia | 2 | | | 2 |
| Germany | 1 | 3 | 2 | 6 |
| Ghana | 2 | 1 | | 3 |
| India | 1 | 2 | 2 | 5 |
| Indonesia | 1 | | | 1 |
| Kenya | 3 | 2 | | 5 |
| Lesotho | 1 | | | 1 |
| Liberia | 1 | | | 1 |
| Malawi | 1 | | | 1 |
| Moldova | | 1 | | 1 |
| Namibia | 1 | | | 1 |
| Netherlands | | 1 | | 1 |
| Niger | 1 | | | 1 |
| Nigeria | 3 | | | 3 |
| Papua New Guinea | 1 | | | 1 |
| Peru | 1 | | | 1 |
| Rwanda | 1 | | | 1 |
| Sierra Leone | 1 | | | 1 |
| South Africa | 1 | | | 1 |
| South Sudan | 1 | | | 1 |
| Switzerland | | | 2 | 2 |
| Tanzania | 3 | 1 | | 4 |
| Togo | 1 | 1 | 1 | 3 |
| USA | 1 | | 2 | 3 |
| Uganda | 3 | | 1 | 4 |
| Zambia | 1 | | | 1 |
| Zimbabwe | 1 | | | 1 |
| Total | 59 | 13 | 16 | 88 |

Note: Membership includes 23 drug supply organizations, 15 Christian Health Associations, 12 Church Health Institutions.

Summary of the 2012 Evaluation Report

The evaluation covered periods under the current and previous strategic plans. It focused on EPN's performance in fulfilling its mission and meeting the needs of its members, the level of engagement of its members, EPN's standing, its sustainability options, the secretariat's capacity and the impact of formalizing membership. Key findings of the evaluation include :

- *Members were generally pleased with EPN's performance.* The evaluators found that 70% of interview respondents ranked EPN's performance as either good or excellent and 80% were enthusiastic about their organization's involvement in EPN;
- *Access to and rational use of medicines was rated as the most relevant strategic area.* HIV/AIDS treatment was ranked the least relevant strategic domain. The report also noted that EPN devoted the least amount of resources to this area. Members consistently ranked access to and rational use of medicines as the most relevant strategic priority for EPN. Activities in this priority area included the antimicrobial resistance advocacy campaign; improvement of decision making, governance and transparency among member DSOs; quality control testing; the development of a comprehensive portfolio of products and services; and research and identification of pharmaceutical practice standards. Members appreciated the activities in this strategic area and made improvements in their practice as a result of their participation;
- *Professionalization viewed as the most beneficial strategic area.* EPN dedicated many resources to curricular development for its Essentials of Pharmaceutical Practice (EPP) course and managed several scholarships for various pharmacy-training courses. This strategic area had the highest rating in terms of benefit for members and helped to improve the management of medicines and supply chain in some member organizations;
- *Netlink and e-Pharmalink regarded as valued resources for information sharing.* 56% of the members who participated in the survey for the evaluation said they read every issue of Netlink and 47% said they found the information very relevant to their practice. The report also noted, however, that members beyond East Africa should be encouraged to submit more articles for Netlink. With respect to e-Pharmalink, there was an increase in the number of subscribers. However, the evaluators recommended that a PDF version be made available for download in addition to the current html version to boost distribution. PDF versions are now available at <http://www.epnetwork.org/en/network/publications/e-pharmalink>
- *Monitoring and evaluation is routinely done but there is no system in place for monitoring impact.* Previous efforts for impact assessment have faltered because members have failed to report changes on the ground and the secretariat lacks the resources needed to do independent assessments. Further, there seems to be little effort to document lessons learned and use these lessons to inform future practice. Annual reports, for example, simply reported what has been done without any analysis of the value or impact of activities or any attempt to document lessons learned. The lack of impact assessments may affect EPN's ability to attract donor funding in the future;
- *Member engagement is lacking.* DSOs were most actively engaged in EPN activities, partly because EPN's activities have the greatest relevance for this

group. Communication between the secretariat and members in general seemed to be unidirectional and primarily in writing. Beyond a small core group of members, other members seemed to take little initiative or ownership of EPN and its mission. Besides the biannual general meetings, there were few opportunities for joint dialogue and reflection on EPN's accomplishments and challenges. This is further reflected in the poor response rate to surveys conducted for the 2012 evaluation report. The circle of members actively engaged in EPN activities needs to be expanded;

- *EPN is very visible for its expertise in pharmaceutical services.* However, this visibility is largely limited to stakeholders involved in pharmaceutical issues, particularly the faith sector in Sub-Saharan Africa. Further, the secretariat has not been systematically involved in advocacy. EPN was highly regarded by its members for the quality of its service and contribution to strengthening their pharmaceutical services. The general sense among respondents familiar with the organization was that the visibility of EPN could be improved internationally by EPN doing a better job of publicizing its success stories and possibly appointing an advisory board of influential stakeholders to serve as a bridge between EPN and relevant international institutions and possibly increase the participation and visibility of EPN in international debates;
- *EPN relies solely on donor funding.* The organization faces the challenge of securing more core funding and program funding. EPN has done well at attracting small short-term grants but this is not sustainable and it creates a heavy administrative burden for the secretariat;
- *The secretariat performs well.* However it is overworked and constrained by a lack of resources.

Based on these assessments the evaluators proposed 14 recommendations in the 2012 evaluation report:

1. EPN should continue working with and for its members. The benefits to the health system that it produces fully justify investment in it and its further strengthening;
2. EPN should seek more core funding or large projects that allow follow-up activities. Concentration should be less on small projects that create an excessive administrative burden. For increased fundraising efforts, it should organize synergy of skills within EPN to undertake consultancies by its skilled members, including participation in tenders for large projects. Funding needs to be secured so that members can at least partly be compensated for their participation in such projects;
3. Proposals should be designed such that information from one activity can be used in the next activity and in different EPN strategic priorities, thus including follow-up as an integral element of its way of working;
4. EPN should improve reflection on its impact, that is, on how EPN's products and services are being used by members or beyond membership, what changes occur and what effects it has on health care – and what that means for future policy: lessons learned from the impact of EPN's work. For this, EPN should rely less on written reports by members. This reflection needs to happen at EPN meetings where members share the information they have, and EPN staff – or contracted writers – need to write up the stories. This needs to be reported not only in the annual

report, but also on the website, with references in Netlink. The annual report should have more of a thematic focus and report more on the effects of EPN's work and lessons learned, not just its activities.

5. EPN should focus on higher membership involvement and commitment. Members should spread information about EPN within their organizations. More verbal communication of the secretariat with members should be aimed for;
6. EPN should find a way to have higher membership contributions for the larger members in a non-disruptive way. The concerns elaborated in chapter 3.5 should be considered;
7. High priority should be given to the succession of the Executive Director in order to ensure that the current strengths are being maintained and that the EPN secretariat can further develop its potential of cooperation in showing the contribution of the church health sector in providing access to medicines to poor communities;
8. EPN should influence church leaders, governments and the international discussion so that policies can be changed in favor of access and rational use of medicines. Given the specific nature of EPN, this should mostly take the form of lobbying, rather than campaigning. This should be done in partnership with Christian Health Associations and networks within and outside EPN;
9. EPN should create opportunities for experts from its members in developing countries to manifest their experience, skills and knowledge on an international level by presenting the relevant results and outcomes of their work in the Christian health system and the results of EPN efforts;
10. EPN with its members should lobby Christian health institutions and associations to put more emphasis on the health and cost saving benefits of a rational approach to the use of medicines. The pharmaceutical issue should enter the mainstream of Christian health service instead of remaining a specialized, delegated issue. EPN should use all its means, including treatment literacy training for church leaders to raise this larger concern;
11. The EPN secretariat should put emphasis on a time management that allows for more planning and reflection, being less pressed by deadlines. Prioritizing and reducing some activities might be a necessary consequence;
12. EPN should consider creating an advisory Board of eminent persons to support the advocacy and other efforts of the Board;
13. EPN needs to design ways to encourage half year and end of year interaction with members on EPN affairs like activity plans and challenges experienced. This will require going beyond the regular e-mail information in order to increase ownership and encourage initiatives from members.
14. EPN should consider publishing this evaluation report, or parts of it, after due consideration, with a statement by the Board in which the Board expresses to what extent it accepts the findings and conclusions, and what it plans to do about the recommendations. If the report is not published, it should at least be sent to members and some stakeholders. Many expressed interest during interviews, not just those who fund or funded EPN in the past.

References for Annex 2

- i. For more information on the strategic areas for this period, please see EPN's 2010-2015 Strategic Plan (EPN 2010).
- ii. The 2012 edition of Pharmalink is available at <http://www.epnetwork.org/Publications/Pharmalink-EN>.
- iii. Health Action International (HAI) and Third World Network (TWN) commissioned the book. It was prepared for publication by Beverley Snell (HAI Asia-Pacific) and Lean Ka-Min (TWN). Elisabeth Coffin and Anke Meiburg of EPN translated the text into French with the support DIFAEM. For more information, please visit <http://www.haiasiapacific.org>.
- iv. Global Fund grant data for 2013 retrieved from <http://www.theglobalfund.org/en/ccm/data/>.
- v. The Base of the Pyramid Program is an initiative by Novo Nordisk to improve access to insulin and comprehensive diabetes care. It was launched in Kenya in 2012. Base of the Pyramid programs are also operating in Ghana, India and Nigeria but do not include FBO partners. More information is available via Novo Nordisk at <http://www.changingdiabetesaccess.com>.
- vi. See WHA67/33 and WHA67/34, available at http://apps.who.int/gb/e/e_wha67.html.
- vii. See WHA A67/14 available at http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_14-en.pdf.
- viii. See WHA 67.19, available at http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R19-en.pdf
- ix. Health Heart Africa was launched in Kenya in October 2014 as a pilot with the view of expanding to other African countries. More information is available at <http://www.astrazeneca.com/Responsibility/Access-to-healthcare/healthy-heart-africa>.
- x. See WHA67/39, available at http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_39-en.pdf
- xi. See WHA67.25, available at http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R25-en.pdf
- xii. For more information see, http://www.who.int/drugresistance/amr_global_action_plan/en/.
- xiii. The findings of this report are based on 45 interviews and an online survey of members with a response rate of 35%. For the full report, please see Amoa & Causemann 2012.

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