EPN FORUM 2014 REPORT

28 - 29 April 2014 NAIROBI

Contents

MATERNAL AND CHILD HEALTH CARE-ACCESS TO SAFE PHARMACEUTICALS 3
  Introduction ........................................................................................................... 3
  EPN Achievements since 2012 ............................................................................. 4
  Priority Life-Saving Medicines for Maternal and Child Health ....................... 5
    Introduction ...................................................................................................... 5
  Paediatric medicines Regulators’ Network ....................................................... 7
  SIAPS Goal and Objective .................................................................................. 7
  Selection .............................................................................................................. 8
  Procurement ....................................................................................................... 9
  Distribution and storage .................................................................................... 9
  Inventory Management ...................................................................................... 10
  Use ..................................................................................................................... 10
  Management Support ...................................................................................... 10
  The objectives of SIAPS MNCH Work are to ..................................................... 10
  Examples of SIAPS tools .................................................................................. 10

UNIVERSAL HEALTH COVERAGE (UHC) TO IMPROVE MEDICINE ACCESS.... 12
  Access to medicines through UHC: Golden Ring or Trojan Horse? ............... 13
    Ghana ............................................................................................................... 14

FAMILY PLANNING FOR CHRISTIANS: VITAL FOR MATERNAL & CHILD HEALTH IN AFRICA ............................................................................................................. 15
  How should Christians respond? ........................................................................ 15
  Unintended Pregnancies and Abortion .............................................................. 16
  Concerns of Christians Working to Save Mothers and Children ...................... 16

MATERNAL AND CHILD HEALTH CARE – SAFE PHARMACEUTICALS .......... 17

STATE OF MATERNAL & CHILDREN MEDICINES IN NIGERIA ................. 18
  Introduction ...................................................................................................... 18
  Who is CHANMedi-Pharm? .............................................................................. 19

MEDICINE PROCUREMENT PRICES AND PROCESSES IN THE UN RELIEF AND WORKS AGENCY FOR PALESTINE REFUGEES IN THE NEAR EAST (UNRWA) ............ 20
  Background to UNRWA Study ....................................................................... 20
  Methodology ..................................................................................................... 20
  Analysis ............................................................................................................ 20
  Key recommendations on prices ..................................................................... 21

CHAZ PERSPECTIVES ON ACCESS TO MEDICINES FOR MCH ............... 22
  Which Factors affect access to medicines in Zambia? ..................................... 22

AVAILABILITY OF CHILDREN’S MEDICINES IN CHURCH HEALTH FACILITIES IN AFRICA .................................................................................................................. 23
  Results from Tanzania ..................................................................................... 24
Results from Cameroon

COMMUNICATION STRATEGY FOR EPN – A MEDICINE FOR A ATTENTION DEFICIT

- Situation Analysis
- Finance
- Donors and Cooperation Partners
- The Current Communication
- Additional Publications
- Communication with the donors so far
- Conclusion
- What should be achieved with a communication strategy and its implementation?
- The SWOT Analysis
- Ascertainment of the Communication Task
- We need to be attractive for other organisations and donors to cooperate with us.
- Strategy
- The next step
MATERNAL AND CHILD HEALTH CARE-ACCESS TO SAFE PHARMACEUTICALS

Introduction

The EPN Forum is the most important conference bringing practitioners, academicians, administrators, pharmacists who are dealing with pharmaceutical management together with experts from well known organizations. The biannual event took place at the Milele Hotel in Nairobi from April 28th to 30th 2014.

The progress achieving MDG 4 and 5 in last years has been significant. The number of under-five deaths worldwide has declined from 12.6 (12.4, 12.9) million in 1990 to 6.6 (6.3, 7.0) million in 2012 (UNICEF report 2013). Since 1990 the global under-five mortality rate has dropped 47 percent—from 90 (89, 92) deaths per 1,000 live births in 1990 to 48 (46, 51) in 2012. However the highest child mortality rate is still found in Sub-Saharan Africa.

For MDG 5 the statistics tell us that the maternal mortality ratio dropped by 45 per cent between 1990 and 2013, from 380 to 210 deaths per 100,000 live births (UN 2013). All regions have made progress but we will not meet the target. The maternal mortality ratio in developing regions is still 14 times higher than in the developed regions.

Pharmaceuticals and their availability play a major part for MDGs. EPN focus area number one is the access and rational use of medicines. The last years EPN has conducted several surveys on the access to children’s medicines which support child health care and is prerequisite to achieve the MDG4.

Faith based health institutions are represented through EPN members in over 30 countries within the network. They serve between 40 and 60% of the mainly rural population and therefore have a direct impact on the achievement of better health outcomes.

EPN invited experts from MSH, UNICEF and WHO beside its own members together with the secretariat to present the current results of surveys, programmes and interventions in order to learn and identify option to improve the situation for maternal and child health.
EPN Achievements since 2012

The key to improve pharmaceutical services is first and foremost the access to medicines. The last years EPN has conducted several surveys to analyze the access to children’s medicines based on the priority of Life-Saving Medications for Women and Children List (2012). Data are now available from Cameroon, Chad, Ghana, Kenya, Tanzania and Uganda. The latest surveys performed in 2013 covered Cameroon and Tanzania.

The main results reflecting the overall situation can be summarized as follows. The higher the level of the health facility the more qualified staff can be found. The lower the facility formally trained pharmacy staff gets scarce. Sources for medical information on medicines and especially on children’s medicines is still lacking in many facilities despite the book project which enabled EPN with the support from Difaem to distribute thousands of WHO Model Formularies for adults and children’s medicines.

Pharmacies also do not always use basic stock management tools to manage their stock which is one of the causes of medicines shortages. Standard Operating Procedures to manage stocks can hardly be find anywhere at lower level facilities. All over lack of knowledge skills, tools, standard procedures lead to a medicines shortage which results in an inadequate adherence to standard treatments of the most common diseases and health issues from birth onwards. EPN has seen better access to medicines, e.g. vaccines, HIV medication, as far as vertical programmes with good resources were involved. However, the focus of these focus programmes leaves behind the general weaknesses in the procurement and supply chain processes.

As one of the examples of poor adherence to treatment guidelines EPN recognized a lack of Zinc tablets in many health facilities. Zinc is an essential partner of Oral Rehydration Salt which reduces the severity and reoccurrence of diarrhea in children. EPN members JMS and MEDS distributed information and awareness raising material. The newsletters very used to pinpoint the topic. It was not possible to measure the outcome and impact due to a lack of funds. The direct consumption of ORS and Zinc even declined due to general influences on the orders and prevalence of diarrhea in general.

An important element to enforce the adherence to treatment guidelines are Medicines and Therapeutic Committees (MTC). Communauté Baptiste au Centre de l’Afrique - CBCA (DRC) actively engage to support existing MTCs. Hôpital Bon Berger (DRC) strengthened its MTC; reviewed their of formulary and updated the pharmacovigilance system. Coalition for Rational and Safe Use of Medicines - CoRSUM (Moldova) received EPN grants and held a four-day course on basic pharmacoeconomics with 79 participants representing MTCs of various health facilities.

Access to medicines depends also on the ability of our members to procure good quality and affordable medicines. EPN tries to strengthen the procurement in East Africa with a Pooled Procurement initiative and to support church organisation in Cameroon to do the same on a country basis.

The majority of pharmacy staff in Sub-Sahara Africa lacks any formal education. There is nowhere any national programme to improve the situation. Thus EPN had developed the Essentials of Pharmacy Practice course and conducted a pilot training in 2011. In 2012 EPN was able to run three 12 week course in Uganda (incl. South Sudan students), in DRC and Malawi. Two short courses were provided in CAR and Sierra Leone. Over 130 pharmacy staff could be trained. An adapted short course was conducted in South Sudan in 2013. The huge success allowed EPN to achieve further support from Christian donors for the next three years.
The other achievements EPN gained since the last EPN Forum are presented in the annual report 2012 and 2013. Thus they are not reflected in detail in this report.

**Priority Life-Saving Medicines for Maternal and Child Health**

*Abayneh Tamer Desta Regional Advisor - Essential Medicines Program Health Systems and Services Cluster Regional Office For Africa*

**Introduction**

Over eight million children under 5 years of age die each year, many from illnesses such as diarrhoea, malaria, HIV/AIDS, tuberculosis and pneumonia. Effective treatments exist for most of these conditions. However, these essential medicines are often not suitable for use in children. When paediatric dosage forms do exist, access to them can be problematic. An estimated 1,000 women die every day due to complications during pregnancy and childbirth. Many of these deaths could be prevented or treated if all women had access to simple and affordable health supplies, including medicines and contraceptives. MDGs 4 and 5 set targets for reductions in child mortality and improvements in maternal health.

More than one third of the world population lack access to essential medicines. In Africa less than 50% have regular access. The key milestones of the WHO are the World Health Assembly resolution WHA 60.20 with the WHO release of the first Model List of Essential Medicines for children, better medicine for Children (2009 - 2012). In 2009 WHO receives grant from Bill & Melinda Gates foundation to support research and country level work to improve access and use of children’s medicines as well as contribution from the Netherlands. This project has enabled WHO to promote R&D by providing evidence and guidelines, fill knowledge gaps, encourage access in selected countries, and advocate for better use of medicines in children at both the global and country level. In April 2011, WHO published a list of ‘priority medicines’ for maternal and child health (MCH) to support countries making choices about medicines for treating women and children. These medicines were selected based on the global burden of disease and the evidence of efficacy and safety for preventing or treating maternal, newborn, and child mortality and morbidity. The priority medicines are a subset of the WHO Model Essential Medicines List. It includes 26 individual chemical entities in 41 dosage forms and strengths. National essential medicines lists are a first step to ensuring access to medicines as they can guide procurement, regulatory decisions, manufacturing, and the rational use of essential medicines. They guide allocation of limited resources and can be used as an advocacy tool to promote the accessibility of essential medicines. They are also key policy tools for promoting the supply of priority medicines. What needs to be done?

1. Check that priority medicines are in national treatment guidelines and essential medicines lists.
2. Verify the supplier of a quality product.
3. Ensure that priority medicines are registered.
4. Make sure that priority medicines are regularly available in the supply chain.
5. Check that health professionals know how to use the priority medicines.
6. Check that there is consumer demand.

In 2007, WHO found that 131 of 151 countries surveyed had an essential medicines list. Essential life-saving medicines (n=25) for children and mothers are not universally listed on national essential medicines lists. Key medicines that would make a potential difference in survival, such as zinc for diarrhoea in children or
magnesium sulfate for eclampsia in women, are not included consistently in national documents. Many priority medicines were listed in less than 50% of the country lists analyzed. Evidence from developing countries suggests that, in addition to overarching health system and financial impediments for both governments and end-users, three main types of barriers prevent women and children from accessing and using appropriate commodities:

- the insufficient supply of high quality health commodities;
- the inability to effectively regulate quality of these commodities; and
- the lack of access and awareness of how, why and when to use them, resulting in limited demand

Ten leading causes of inefficiency are listed in the World Health Report 2010, (4/10)=Medicines

1. Medicines: underuse of generics and higher than necessary prices for medicines
2. Medicines: use of substandard and counterfeit medicines
3. Medicines: inappropriate and ineffective use
4. Health-care products and services: overuse or supply of equipment, investigations and procedures
5. Health workers: inappropriate or costly
6. Health-care services: inappropriate hospital admissions and length of stay
7. Health-care services: inappropriate hospital size (low use of infrastructure)
8. Health-care services: medical errors and suboptimal quality of care
9. Health system leakages: waste, corruption and fraud staff mix, unmotivated workers
10. Health interventions: inefficient mix/inappropriate level of strategies

The graph on the right illustrates the WHO Framework for improving Access to Medicines.

There is an initiative call The Muskoka Initiative on Maternal, Newborn and Child Health. It is a funding initiative announced at the 36th G8 summit which commits member nations to collectively spend an additional $5 billion between 2010 and 2015 to accelerate progress toward the achievement of Millennium Development Goals 4 and 5, the reduction of maternal, infant and child mortality in developing countries. However it underscores on strengthening health systems to improve maternal and child health. The partnership between EU, WHO & Countries in Africa has been renewed (2012-2016). It aims to contribute to the achievement of health-related MDGs (4,5,6 and 8) and of Universal Health Coverage (WHR 2010 & WHA 64.9) in 15 countries in Africa and to improve
availability, affordability and use of safe, effective and quality assured essential medicines.

**Paediatric medicines Regulators' Network**

As part of the WHO’s Better Medicines for Children initiative a Paediatric medicines Regulator's Network (PmRN) has been set up with representatives from national medicines regulatory authorities (NMRAs) from all regions. A regulatory pathway for pediatric commodities is defined through PmRN. ERP is in place and completed for Amoxicillin, Misoprostol, and combination OCS, fast track registration for PQ products signed by 15 NMRAs, 12 in Africa. Joint inspections and dossier reviews are done for Amoxicillin, Zinc and ORS. Device technical documents are developed.

Another process is aiming to assure quality. Risk based approach to evaluate quality issues has been developed and is available to country regulators. A study has been completed to target specific problems with RMNCH commodities to create targeted technical assistance. Support to manufactures has been provided for MgSO4, ORS, zinc, and dispersible amoxicillin.

The way forward is networking and supporting countries to seize opportunities in improving access to essential medicines, partnership and collaboration.

**Improving Access to Essential Commodities for Maternal, Newborn and Child Health - Improved Access. Improved Services. Better Health Outcomes.**

Dr. David Mabirizi, Principal Technical Advisor HIV&AIDS (SIAPS), explained the Systems for Improved Access to Pharmaceuticals and Services (SIAPS) which is a 5 year project funded by USAID. It has been awarded $197 million for the period from September 2011 to September 2016.

**SIAPS Goal and Objective**

**GOAL**
To assure the availability of quality pharmaceutical *products* and effective pharmaceutical *services* to achieve desired health *outcomes*

**OBJECTIVE**
To promote and use a systems-strengthening approach consistent with the Global Health Initiative that will result in positive and sustainable health impact

**INTERMEDIATE RESULTS**
The pharmaceutical sector governance needs to be strengthened by building individual, organizational, and institutional capacity for pharmaceutical supply management and services. The information for decision-making challenges in the pharmaceutical sector needs to be addressed. A cornerstone for the improvement of access to medicines is to strengthen financing strategies. These elements are key to achieve desired health outcomes.

Current global trends in increasing access to Maternal, Newborn and Child Health commodities
The strategy of SIAPS in Maternal, Newborn and Child Health Commodities is ending preventable maternal and child deaths to increase funding for MNCH and to coordinated its’ efforts. Among others a priority is to strive for a AIDS free generation. Dr Mabirizi first recalled the current achievements on Maternal Mortality and Child Mortality.

**Maternal Mortality**

Maternal deaths have dropped from 543,000 a year in 1990 to 287,000 in 2010; Concentrated in Sub-Saharan African and South Asian countries

**Child Mortality**

- Declined from 12 million a year in 1990 to 7.6 million in 2010
- Pneumonia and diarrhea still cause more than two million deaths annually
- Malaria causes at least 700,000 deaths per year
- 21,000 children die every day around the world

The MNCH Service Delivery Strategies recommends the promotion of facility births with skilled birth attendants, the community distribution of misoprostol and post-natal care (home visits). For mothers the integration of birth spacing and maternal health services leads to an improved health outcome. In neonates infection prevention reduces mortality rates. Good results can be achieved with the community distribution of chlorhexidine. For resuscitation and integrated management of childhood illnesses (IMCI) and integrated community case management (iCCM) is needed.

“The continuum of care for maternal, neonatal, and child health requires access to care provided by families and communities, by outpatient and outreach services, and by clinical services throughout the lifecycle, including adolescence, pregnancy, childbirth, the postnatal period, and childhood. Saving lives depends on high coverage and quality of integrated service-delivery packages throughout the continuum, with functional linkages between levels of care in the health system and between service-delivery packages, so that the care provided at each time and place contributes to the effectiveness of all the linked packages.” - The Lancet, 2007

The pharmaceutical management concerning MNCH requires thorough processes for the selection, procurement, distribution and storage, inventory management, use and management support. The following questions are part of the situation assessment which tackles the different elements of the medicine cycle:

**Selection**

**Maternal health commodities:**
• Do you consider storage conditions in the selection of uterotonics?
• Is misoprostol included in EML for obs/gyn indications?
• Who is allowed to prescribe misoprostol?
• Do current guidelines align with meds on EML?

Neonatal and Child health commodities:

• Does zinc have OTC (or equivalent) status?
• What formulations of zinc are available?
• What antibiotic for treatment of pneumonia is currently listed on STG?
• Is amoxicillin in 250 mg dispersible tablets available for CCM
• Do STGs align with EML?

Procurement

Maternal health commodities

• Do tender documents provide sufficient specificity on characteristics that may affect quality? (e.g. packaging for misoprostol)
• Will re-packaging be necessary?
• What data are used for quantification?
• Is data on morbidity available?
• Have needs of lower levels of the health system been considered?
• Have multiple uses of medicines (e.g. oxytocin) been considered?

Neonatal and child health commodities

• Has amoxicillin in dispersible tablets and blister packs been considered for CCM? Are those included in procurement?
• What data are used for quantification?
• Are suppliers available (e.g. zinc, chlorhexidine)?
• Have needs of lower levels of the health system been considered?
• Have multiple uses of medicines (e.g. amoxicillin) been considered?

Distribution and storage

Maternal health commodities

• Are appropriate conditions maintained (e.g. temperature and humidity)?
• How are medicines distributed to lower levels of system (e.g. community-based distribution of misoprostol)?

Neonatal and child health commodities

• What systems are in place to ensure that medicines reach lower levels of system (e.g. community case management)?
• What are appropriate storage options at community level?
Inventory Management

Maternal health commodities

- Is consumption recorded?
- Are records reconciled (e.g. pharmacy vs. delivery room)?

Neonatal and child health commodities

- What systems are in place to collect data from lower levels of system (e.g. community case management)?
- Is data from community-level separate?

Use

Maternal health commodities

- Provider biases? (e.g. misoprostol, mag sulfate)
- Is home use monitored when community-based distribution is implemented?
- Are referral systems in place?

Neonatal and child health commodities

- Care-seeking practices
- Diagnosis
- Appropriate use of antibiotics
- Adherence to zinc

Management Support

- Are SOPs available for lower levels of system?
- Who is paying for MCNH supplies?
- Are community health workers trained in re-supply process?
- Are health workers receiving the support they need to ensure appropriate use?

The objectives of SIAPS MNCH Work are to

- Support implementation of MNCH strategies in countries
- Provide global technical leadership for maternal and child health
- Develop innovative strategies and tools to improve access to MNCH commodities

Examples of support for country MNCH activities are the introduction of misoprostol at the community level in South Sudan, the cooperation with MoH in Mali, Burundi and Guinea to support implementation of CCM, the revision of EML, standard treatment guidelines and introduction of chlorhexidine in DRC.

Examples of SIAPS tools

SIAPS has developed innovative strategies and tools for the estimation of unmet need for maternal health commodities and the assessment of sub-national procurement of MH commodities.
PHARMADEX

National governments must effectively register and track pharmaceutical products to ensure that they are readily available and safe. When countries have weak medicine registration systems—backlogs of drug registration applications, inefficient drug testing systems, and incomplete data on suppliers and products—they can waste millions of dollars and put millions of people at risk of using unsafe and low-quality medicines.

A web-based tool that helps to streamline and track medicines registration for a national drug regulatory authority by:

- Recording and organizing information on suppliers and products
- Tracking product applications in the registration process
- Analyzing and comparing suppliers and products
- Tracking critical information for decision-making, such as costs, usage, and safety

QUANTIMED

This tool is designed to improve the accuracy of order planning and budgeting by providing a systematic approach to organizing and analyzing data. It facilitates the calculation of commodity needs using either a single method or a combination of any of the three primary quantification methods: past consumption, morbidity patterns, and proxy consumption. The advantages are that it removes the often tedious and mistake-prone calculations associated with quantification, relegating it to the computer. It also allows the user to manipulate variables (i.e, time, population, scaling-up rates) to adjust quantification figures without having to recalculate.

ELECTRONIC DISPENSING TOOL

Helps pharmaceutical providers accurately dispense medicines by collecting, managing, and generating the necessary data, including:

- Patient profiles and medicine history
- Medicines inventory
- Patient statistics needed for management decisions

Pharmaceutical service providers often lack the data they need to dispense the correct medicines in correct amounts as well as monitor the use and side effects of those medicines. Providers must be able to easily collect patient data and access patients’ medical history in order to optimize patient care, support management decisions, and appropriately manage stock.
UNIVERSAL HEALTH COVERAGE (UHC) TO IMPROVE MEDICINE ACCESS

Dr Jonathan Quick, the head of MSH

Dr Jonathan Quick, the head of MSH, presented the issues of UHC and the part essential medicines play. The general situation can often be described by unfair health financing, a high out-of-pocket spending where total health spending is lowest. Out-of-pocket (OOP) spending is a huge burden for many households. In 33 mostly lower-income countries out-of-pocket payments eat up over 50% of health spending (2007). Each year 150 million people suffer severe financial hardship. One third of poor people with acute illness receive none of the prescribed medicines.

Universal health coverage refers to the commitment of countries to provide basic health, prevention and treatment services to all their citizens without financially burdening them. Today, 50 countries, including 20 lower-middle-income countries offer such coverage.

The principles of UHC are Equity, focus on vulnerable populations, and Quality, services that people will use. It is necessary to increase the spending on health in financing but reduce the out-of-pocket expenditures and to pool the risks. It has to start with basic primary care and increase progressively over time based on needs of population. The elements on the service delivery level are infrastructure, workforce and essential medicines.
UHC has proven a powerful driver for women’s health in low- and middle-income countries. To improve maternal and child health we need to find a gender-sensitive approach how to build the essential health services, how to improve the access to services, how to eliminate financial burden, how to reduce the social barriers, and how to monitor performance.

The aim to expand coverage and effective quality services to all women, health systems must become stronger around leadership, management, financing, human resources, community involvement, and other critical elements. This target can only be reached if the different stakeholders of a state and society are actively engaged, e.g. political and health leadership, civil society, multilateral agencies, global health funders and others involved with women’s health and equity.

**Access to medicines through UHC: Golden Ring or Trojan Horse?**

The Golden Ring would be an increased access to medicines with improved health outcomes, a greater financing equity with reduced medical impoverishment and an increased UHC acceptance. The Trojan Horse implies adverse impacts of cost controls that reduce health impact, excess demand, more fraud and abuse and rising costs that threaten UHC program viability.

**Thailand** gives an example of an increase in coverage over more than for decades. Thailand has been striving toward universal health coverage since the 1970s. By 2000, a number of public health insurance schemes, in combination with a small number of private plans, were able to cover 75% of the Thai population. By the 2000 national election, universal health coverage had gained enough momentum to become a staple of many political campaigns and in 2001, the new government made a commitment to provide health coverage for all. ([http://www.jointlearningnetwork.org/content/thailand](http://www.jointlearningnetwork.org/content/thailand)) In 2002, the new Thai government passed the National Health Security Act with a great deal of popular support. It has since become one of the most important social tools for health systems reform in Thailand. The new Universal Coverage Scheme (UCS), or “30 Baht Scheme”, combined the already existing Medical Welfare Scheme and the Voluntary Health Card Scheme to expand coverage to an additional 18 million people. Through the Universal Coverage Scheme and other, existing schemes, Thailand has expanded coverage to 65 million people, or roughly 98% of the population.

The graph on this page illustrates that beside general regulations of the welfare system measure on the ground of the health facility, e.g. with focus on the rational use of medicines, have an impact an increase the resources thus the access to medicines.
Ghana

A community-based health insurance scheme (CBHI) in Ghana began in the 1990s as a community response to the high user fees charged by public and private providers. Coverage rates ranged from 2 to 25 percent. By 2003, such community schemes covered only 1 percent of the country’s population, while civil servants and formal sector employees were covered by social security. In 2003, Ghana passed the National Health Insurance (NHI) Act into law, which created the mandatory National Health Insurance Scheme (NHIS) that provides a broad minimum package of care (Witter and Garshong 2009). The NHIS built upon existing CBHI schemes at the community level and consolidated them into District Mutual Health Insurance Schemes (DMHIS) that were required to follow national rules on premiums and benefits as well as financing (World Health Organization 2011). The NHI Act established a regulatory body, the National Health Insurance Council (NHIC) to register, license, and regulate public and private health insurance schemes, including the DMHIS. The key responsibility of DMHIS is to enroll members, collect premium payments, and issue identity cards. Despite the development of national guidelines, districts differed in terms of premium payments, registration fees, and waiting periods as of 2008 (Ghana 2009).

The NHIS covers all 138 districts in Ghana with a predefined benefits package that covers 95 percent of the disease burden in the nation (World Health Organization 2011). NHIS membership grew from 6.6 percent of the population in 2005 to 45.0 percent in 2008, but there is great variation across the different regions (Witter and Garshong 2009). Registration among people in the informal sector and children has also increased.

The focus on medicines as one cornerstone of health services and medical intervention requires a strategy covering four areas which are illustrated and explained in the graph. The indicators for the achievement in UHC can be measures in terms of the extent of access, appropriate use, affordability and quality of medicines.

UHC requires a multi-factual approach Dr Quick proposed the following seven best practices as a guidance:

1. Stakeholder engagement and communication – the public, patients, providers, healthcare managers, policy makers, politicians
2. “Smart” therapeutics – priority health problems, outpatient coverage, essential medicines, clinical guidelines
3. Value-based policy design – incentivize most appropriate use
4. Increased efficiency – generic/therapeutic substitution, efficient procurement and distribution systems
5. Reliable partners – accredited health providers and dispensing outlets, competitive sourcing from quality assured suppliers
6. Performance management – robust management systems for inventory management, drug use review, fraud detection
7. Culture of adaption – learning from others, benchmarking, routine monitoring, evaluating, based on what’s working and what isn’t

In conclusion the Out of pocket spending is too often the largest source of national health financing and therefore a major source of impoverishment. It has both favorable and adverse health consequences. Universal health coverage emphasizes reorganizing domestic financing proving feasible through many national variations. It offers great promise to expand access to medicines. The success in expanding medicine access depends on strong policies and governance, informed pharmaceutical management strategies, and managing goals of health impact and program viability.

FAMILY PLANNING FOR CHRISTIANS: VITAL FOR MATERNAL & CHILD HEALTH IN AFRICA

Douglas Huber, CCIH

Every day, nearly 1,000 women die due to pregnancy-related causes. 99 percent of all maternal deaths occur in the developing world. Sub-Saharan Africa with 10% of the global population contributes 51% of global maternal deaths (2005; UNICEF Global database).

How should Christians respond?

A CCIH 2008 survey of member organizations shows that members support family planning where it is understood to mean voluntary prevention of pregnancy, not including abortion. CCIH members see Family Planning as part of comprehensive services for family health.

An important impact on maternal health derives from birth spacing. When a pregnancy occurs 6 months or less following a birth, the risk of miscarriage increases by 230% and the risk of maternal death within 42 days increases by 150% (US Agency for International Development ESD Project). Thus the goal is to increase birth spacing. To achieve a 36 months birth interval, both breastfeeding plus contraception must be used for 18-22 months postpartum before trying to become pregnant again. If the birth intervals decrease to less than 2 years the infant mortality doubles. There is still a huge need for contraceptives in Africa.
Unintended Pregnancies and Abortion

One-fifth of all pregnancies worldwide end in abortion, that means 42 million abortions each year. Many abortions are illegal and unsafe. Out of 4.7 million abortions in Africa each year, 4.5 million are unsafe (performed by people lacking necessary skills and in settings without minimal medical standards). 67,000 women die each year worldwide from unsafe abortions (Population Reference Bureau). Abortion is reduced when modern contraceptive use increases.

“‘The evidence is overwhelming that contraception prevents abortion. And this is what we all want most of all’”, says W. Henry Mosley, MD, MPH Professor Emeritus, Department of Population, Family & Reproductive Health, Johns Hopkins Bloomberg School of Public Health.

It is estimated that up to 100,000 pregnancy-related deaths occurring among women who had unintended pregnancies could be avoided each year with proper family planning (US Agency for International Development). The example of Kenya illustrates that by far injectables are by far the most commonly used method.

Concerns of Christians Working to Save Mothers and Children

An estimated 200 million couples want to delay or stop childbearing but are not using any form of family planning. Many faith-based clinics face severe shortages and frequent stock-outs of supplies. They need our help to reduce abortions, help families grow at a rate they can afford, and protect the health of women, children, families, and entire communities (World Health Organization and CCH).
The “Nairobi Declaration”, June 2011: In this Declaration, we commit to leveraging our networks to support family health by providing education and services that enable families to plan the timing and spacing of their pregnancies consistent with their faith. We call on others to support this initiative to influence government and donor policies and funding. Endorsed by over 200 organizations, Muslim, Christian, Hindu, Buddhist.

Although contraceptives might be available there are a lot of misconceptions. Here is an example from Kenya (adapted from MLE, Tupange, 3 June 2011). According the survey 53% of the responders believe that the use of injectable can make a woman permanently infertile. People who use contraception end up with health problems is reflected by 76%. 64% believe that contraceptives can give you deformed babies, and 58% mean that contraceptives can cause cancer.

There is proof that the interventions with education have an impact an increase the use of family planning methods with an impact on maternal health. It is us to overcome misconceptions: give good contraceptive method information to all - using written and verbal - e.g., WHO FP guide for specific method accepted or currently using (1/2 or 1/4 page from flip chart). That is also cost-effective. We should be able to give women their method of choice (injectables are popular in Africa).

USEFUL RESOURCES:
http://www.globalhealthlearning.org/
http://www.who.int/reproductivehealth/publications/family_planning/9789241503754/en/#

MATERNAL AND CHILD HEALTH CARE – SAFE PHARMACEUTICALS

UNICEF, Kenya

Like in other countries the child mortality rate decreased in Kenya, however it is not yet heading towards the defined MDG4. More has to be done to accelerate the reduction process. The same applies for the maternal health in Kenya.

The economic impact of pharmaceuticals is substantial -- especially in developing countries. While spending on pharmaceuticals represents less than one-fifth of total public and private health spending in most developed countries, it represents 15 to 30% of health spending in transitional economies and 25 to 66% in developing countries. In most low income countries pharmaceuticals are the largest public expenditure on health after personnel costs and the largest household health expenditure. And the expense of serious family illness, including drugs, is a major cause of household impoverishment (http://www.who.int/medicines/services/essmedicines_def/en/).
It is important to look who is currently paying for health services in Kenya. The following graphs illustrate the share of different sectors.

- Access to essential medicines play a major role for affordable and good quality health services.
- The existence of parallel markets increases the opportunity of counterfeiters.
- Erratic drug supplies and high process increase the motivation for counterfeiters.
- In developing countries ineffective drug regulation, smuggling of drugs, weak or absent sanctions and widespread corruption all contribute to make the presence of unsafe drugs a real problem.
- Apart from health related complications – counterfeiting stifles investment and innovation, retard economic growth through no tax payments and deterred investments.

UNICEF has a Drug Safety Program. UNICEF has in place a central pharmaceutical procurement center in Copenhagen – this is regulated by the Quality Inspection Unit - Pharmaceutical and nutrition products. This unit performs GMP evaluations of new and current suppliers of the above products using WHO GMP guidelines 2007. GMP inspections are planned yearly, with a supplier inspected every 2 – 5 years depending on the regulatory environment of the country of origin. The UNICEF warehouse is GDP licensed in accordance with European Community GDP regulations and is licensed by the Danish Ministry of Health. Random analytical testing of products is conducted. Centralized procurement ensures economy of scale and good access to efficient sea and air cargo services ensures goods are dispatched as quickly and efficiently as possible. This drug safety program is available only for UNICEF related procurement. National standards and enforcement are in the WHO/ UNODC domain.

STATE OF MATERNAL & CHILDREN MEDICINES IN NIGERIA
Matthew O. Azoji, Managing Director/CEO, CHAN Medi-Pham Ltd/Gte, Jos, Nigeria

Introduction
Maternal and Child mortality rates of any country serves as indicators of the health status of the country’s citizens. Nigeria constitutes approximately 2% of the world population, but accounts for over 10% of the world’s maternal and under-five deaths. It still ranks second in the world, after India, in the scale of maternal mortality
with 40,000 deaths per annum compared to India’s 56,000 per annum as per 2010 UN Inter Agency Report. However the Maternal Mortality has improved from 800 deaths per 100,000 live births to 630/100,000 as at 2010 UN Inter Agency Report. The MDG 5 target for Nigeria is 250 deaths/100,000 live births by 2015. The causes for maternal mortality are eclampsia (27%), post partum haemorrhage (25%), infection (15%), unsafe abortion (13%) and other causes (20%).

Children Under 5 Mortality

Under 5 mortality for Nigeria was estimated at over 1 million deaths per annum at the rate of 194 deaths per 1,000 live births by 2000. About 55% of these deaths were due to three diseases-pneumonia, malaria and diarrhoea. By 2010 UN Inter agency report Under 5 Mortality Rate for Nigeria dropped to 143 deaths/1,000 live births. MDG 4 target for Nigeria is 71 deaths/1,000 live births. The key issues are key issues are poverty, health financing, e.g. Out of Pocket Payment for health, very low health insurance coverage, poor health care seeking behaviour and a lack of Access to Priority Essential Medicines.

Nigeria has a scheme for addressing M&C Mortality with the following elements:

- Integrated Maternal, Newborn and Child Health Strategy (IMNCH)
- SURE-P
- Child Health Week
- National Midwives Service Scheme (NMSS)
- Free medical treatment for pregnant women and Children under 5
- Essential Childhood Medicines Scale-Up Plan 2012-2015

CHANMedi-Pharm as a stake holder in Nigeria healthcare delivery services through the contributions of the CHAN MIs is working to make the M&C Priority medicines accessible to all who need them. Looking at availability of the medicines on the list, we are happy to say that we have over 95% of the items on the list in stock.

The key actions to achieve the current status are collaboration with key partners, contract manufacturing & registration of priority medicines, training & capacity building on public health supply logistics for pharmacists, capacity building for CHANMedipham’s quality assurance.

Who is CHANMedi-Pharm?

It is an ecumenical organization owned by Catholic Bishops Conference of Nigeria, Christian Council of Nigeria, and Northern Christian Medical Advisory Council established in 1979 as CHAN Pharm. A department of CHAN became autonomous in November 2004, and was registered as a company Limited by Guarantee in July 2006. It
Initiated contract manufacturing in 2007. CHAN Medi-Pharm serves mission hospitals in Nigeria. In Nigeria, there are approx. 400 mission hospitals and 4000 primary healthcare centres affiliated to them, serving about 40% of the Nigeria population. CHAN member institutions are reaching the unreached.

MEDICINE PROCUREMENT PRICES AND PROCESSES IN THE UN RELIEF AND WORKS AGENCY FOR PALESTINE REFUGEES IN THE NEAR EAST (UNRWA)

Richard Laing, presentation based on resources provided by Margaret Ewen Coordinator, Global Projects (Pricing), Health Action International (HAI), Amsterdam

Background to UNRWA Study

In 2011 Akahiro Seita Health Director for UNRWA came to see him in WHO about concerns from their Board that medicines costs were high and increasing and that something should be done. Richard did a preliminary analysis of 3 products and told him that those prices were competitive. He requested a full study and Richard asked Margaret Ewen from Health Action International to undertake such a study with a Jordanian Co Consultant.

Methodology

Data collection: In July 2011 they spent two weeks interviewing staff at UNRWA HQ and selected field facilities, and collecting 2010 procurement price and volume data.

Medicines selection: 80 medicines were selected for international price comparisons, roughly equating to UNRWAs top 80 medicines by expenditure (93% of General Fund medicine expenditure). A comparison of central vs local procurement prices at UNRWA used data for all medicines was performed.

Price comparators: The Management Sciences for Health’s (MSH) International Drug Price Indicator Guide was used. Prices offered to low and middle-income countries by different suppliers are updated annually and publicly available http://erc.msh.org/

The Joint Procurement Department (JPD) in Jordan, host country, only procures quality-assured products approved and publishes prices on the internet www.jpd.gov. The Gulf Cooperation Council (GCC) pools medicine procurement across 6 countries in the Gulf Region and tenders usually for large quantities. The IDA Foundation is a not-for-profit supplier of a range of good quality medicines to LMIC, which is available from MSH website. The prices were sought (unsuccessfully) from MoH in Egypt, Lebanon and Syria.

Analysis
MSH and IDA added 15% for freight; IDA also added 1.5% handling fee. For some liquids, GCC permits supply within a volume range eg. chlorphenamine 2mg/5ml oral solution in 100 - 120ml bottles. Excluded packs were significantly different to UNRWA packs eg. 500g silver sulphadiazine cream. Four instances of slight variations in strength eg. benzylpenicillin benzathine GCC price was for 1MIU/vial whereas UNRWA and IDA prices were for 1.2MIU/vial.

Findings
The findings are presented in the table.

### Top Ten Medicines

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Strength and Dose Form</th>
<th>Therapeutic Group</th>
<th>UNRWA Purchasing Unit</th>
<th>Quantity Purchased</th>
<th>Expenditure USS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premixed 30/70 Human Insulin</td>
<td>100IU/ml vial</td>
<td>Antidiabetic medicine</td>
<td>10ml vial</td>
<td>476,650</td>
<td>1,478,122</td>
</tr>
<tr>
<td>Co-Amoxiclav</td>
<td>500+125mg tablet</td>
<td>Antimicrobial</td>
<td>100 tabs</td>
<td>54,653</td>
<td>973,521</td>
</tr>
<tr>
<td>Amoxiclav</td>
<td>250mg/5ml suspension</td>
<td>Antimicrobial</td>
<td>100ml bottle</td>
<td>999,566</td>
<td>716,602</td>
</tr>
<tr>
<td>Enalapril Maleate</td>
<td>10mg tablet</td>
<td>Antihypertensive</td>
<td>100 caps</td>
<td>667,500</td>
<td>661,834</td>
</tr>
<tr>
<td>Amoxiclav</td>
<td>500 mg capsule</td>
<td>Antimicrobial</td>
<td>100 caps</td>
<td>158,655</td>
<td>608,882</td>
</tr>
<tr>
<td>Co-Amoxiclav</td>
<td>250+62mg/5ml suspension</td>
<td>Antimicrobial</td>
<td>100ml bottle</td>
<td>219,110</td>
<td>567,409</td>
</tr>
<tr>
<td>Cephalexin</td>
<td>500mg capsule</td>
<td>Antimicrobial</td>
<td>100 caps</td>
<td>86,955</td>
<td>473,402</td>
</tr>
<tr>
<td>Metformin HCL</td>
<td>500mg tablet</td>
<td>Antidiabetic medicine</td>
<td>100 tabs</td>
<td>470,370</td>
<td>446,842</td>
</tr>
<tr>
<td>Gliclazide</td>
<td>80mg tablet</td>
<td>Antidiabetic medicine</td>
<td>100g</td>
<td>159,725</td>
<td>418,102</td>
</tr>
<tr>
<td>Paracetamol</td>
<td>250mg/5ml suspension</td>
<td>Antipyretic, Analgesic</td>
<td>100ml bottle</td>
<td>1,161,843</td>
<td>411,496</td>
</tr>
</tbody>
</table>

**Total**: 6,753,853

### Key recommendations on prices

- Explore procurement options for a limited list of 9 medicines (potential savings of $1.6m)
- Monitor the prices of the top 20 medicines annually
- Request WHO EMRO to establish a regional procurement price database
Key issues on UNRWA’s medicine procurement process UNRWA procurement responsibilities are well-defined, procedures are followed, and central procurement strictly adheres to UNRWA’s EML. Nevertheless the study discovered several process issues listed here:

- Pharmaceutical budget - decentralised, no ability for inter-field transfers
- Quantification – not based on need
- Prequalification of suppliers - no criteria for technical evaluation of potential suppliers
- Tender process – awarded tenders not shared with bidders or the public
- Product quality assurance – routine product testing only in Jordan
- IT - computer system not user-friendly and not integrated
- Communication - little knowledge sharing between fields and HQ
- Rational use – pharmacists focus on inventory control not medicine use

Based on the results it was possible to come with recommendations:

- Key recommendations on the procurement process
- Recentralize pharmaceutical budgets for a more equitable distribution of resources
- Develop standards for prequalifying suppliers and product quality assurance
- Expand the search for potential suppliers
- Base quantification on need
- Publish tender awards on UNRWA’s website
- Establish a user-friendly integrated IT system
- Build capacity of field pharmacists to undertake medicine utilization studies, patient education and medicine management programmes etc. (e.g. diabetes prevention and management, antibiotic use)

If you want to learn more, please consult the sources:

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60197-X/abstract


**CHAZ PERSPECTIVES ON ACCESS TO MEDICINES FOR MCH**

*Marlon Banda*

**Which Factors affect access to medicines in Zambia?**

In Zambia the target availability of essential medicines is rather 67% than 85%. The distribution system in operation is especially insufficient for the “last mile delivery”. Inadequate inventory management and reporting is one driving factor with a reporting rate of 60%. The staff skills in health facilities are not sufficient. There is a lack of rational use monitoring and sustainability of services.
An approach to improve the supplies is to open hubs and staging post in different regions of the country to overcome the limitations of one central hub. Pharmaceutical and Health Product Management (PHPM) undergoes a paradigm shift in Zambia.

In the past the approach PHPM had a traditional technical assistance approach. This was characterised by the elements:

- Supply & donor driven
- Fill capacity gaps - temporary PIU, advisors
- Focus on urgent short term needs
- Little local stakeholder participation
- Insufficient monitoring and evaluation
- Focus on technical training

The new capacity development approach follows the elements:

- Demand driven (Response to identified need)
- Focus on building health facility capacity
- Designed to achieve long term, sustainable changes
- Depend on local participation & ownership
- Results–based M&E with mutual performance dialogue between staff & advisor

Systematic design/implementation to deal with broader institutional, political context

CHAZ has been involved in various programmes which aim to improve the medicines supplies in Zambia. Better medicines the supplies are among the cornerstones to better maternal and child health.

**AVAILABILITY OF CHILDREN’S MEDICINES IN CHURCH HEALTH FACILITIES IN AFRICA**

*Mirfin M Mpundu, Executive Director EPN*

The 2009 WHO study “What essential medicines for children are on the shelf” investigated the public and private sector in capital cities in 14 countries in Central Africa. It showed poor availability of key essential medicines for children. According to statistics from the WHO the Under-five mortality in the African region is 95 per 1000 live births, in the European region 12 per 1000 live births. The major killers for children under five are
• Neonatal causes (37%)
• Pneumonia (19%)
• Diarrhoea (18%)
• Malaria (8%)
• Measles (4%)
• HIV/AIDS (3%)

Based on these facts EPN decided to investigate the state of medicines for children in the church sector. EPN developed tools and a methodology for investigating the availability, pricing and factors impacting availability of medicines for children modelled along the one used by WHO.

Main study objectives:

• Availability of children’s medicines in church health institutions (CHI)
• Pricing of medicines for children in CHI
• Facility level factors that impact on medicine availability

So far children’s medicines surveys have been conducted in Kenya (2010: 79 facilities), Chad (2010: 31 facilities), Uganda (2010: 61 facilities), Ghana (2011: 45 facilities), Tanzania (2013: 50 facilities) and Cameroon (2013: 50 facilities).

The table gives an overview of the facility levels investigated.

<table>
<thead>
<tr>
<th></th>
<th>Kenya</th>
<th>Chad</th>
<th>Uganda</th>
<th>Ghana</th>
<th>Tanzania</th>
<th>Cameroon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>30</td>
<td>7</td>
<td>19</td>
<td>43</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>Health centres</td>
<td>23</td>
<td>24</td>
<td>16</td>
<td>1</td>
<td>5</td>
<td>34</td>
</tr>
<tr>
<td>Dispensaries</td>
<td>26</td>
<td>0</td>
<td>26</td>
<td>1</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
<td>31</td>
<td>61</td>
<td>45</td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

**Results from Tanzania**

In 15 hospitals we found only 8 pharmacists, 14 pharmacy assistants and 20 pharmaceutical technicians. The health centres and dispensaries did not have any pharmaceutical staff. 80% of facilities have no guidelines specifically for children. Only 3 hospitals have the WHO Model Formulary for Children or a BNF for Children. Only 2 out of 50 facilities have access to internet.

Who decides on the medicines on stock? 11 out of 15 hospitals have a Medical Therapeutic Committee (MTC). Only 2 hospitals have an SOP on the selection of medicines. In dispensaries the head of facility decides, what is listed/stocked (13 out of 30). The most remarkable results on the availability of the medicines:

• Most remarkable results: Ceftriaxone 500 mg powder for injection vial: 10%
• Ceftriaxone 250 mg powder for injection vial: 16%
• Ceftriaxone 1g powder for injection adult dose: 50%
• Zinc dispersible tables: 46%
Zinc normal release tablets: 8%
Oral Rehydration Salts: 94%

The prices the patients have to pay vary a lot between the different health facilities. Some patients have to pay 50 to 140% more than the most commonly asked price for a medicine. The mark-up of a price for a patient can be up to 200% above the facility price.

The survey results were discussed by staff from the institutions and different stakeholders and follow up measures defined. The workshop participants recommended to pressurize the government to get access to the funds already allocated to the health facility. MEMS should develop to a competitive alternative supplier. Raise awareness and educate to increase the ordering of children's medicine. Issue guidelines on children's medicines. Train existing staff with short courses in health centers and dispensaries. Provide counting trays. Strengthen Private-Public-Partnerships. Set the standards of health facilities including all stakeholders, e.g. government, donors, representatives of health facilities. Set up branches for drug supply at strategic places throughout the country. Brand and market yourself (MEMS), e.g. incentives for the customers. Increase advertising for MEMS.

**Results from Cameroon**

In 16 hospitals the surveyors recorded only 2 pharmacists, 22 pharmaceutical technicians, 14 pharmacy assistants and 64 pharmacy auxiliaries. In 35 health centres the pharmaceutical qualified staffs were 10 pharmaceutical technicians, 15 pharmacy assistants and 55 pharmacy auxiliaries. About 50% of the health facilities have reference books or guidelines on how to use medicines in children. The most prominent results concerning the availability of medicines were Most remarkable results:

- Ceftriaxone 500 mg powder for injection vial: 6%
- Ceftriaxone 250 mg powder for injection vial: 2%
- Ceftriaxone 1g powder for injection adult dose: 30%
- Antiallergic medicines: 0%
- Zinc tablets: 2%

Like in Tanzania a stakeholders meeting defined the follow up measures. Most urgent measures needed is to promote the ORS & Zinc combination, to ensure that essential medicines are listed for ordering and stock management, to ensure that staff is aware what needs to be added to the stock, to inform staff about children's medicines and up-dated on treatment guidelines.
Overall some essential medicines for children are not sufficiently available. That most likely has a tremendous negative effect on the prevention or treatment of even life threatening diseases. The idea of essential medicines and primary health care lasts back 35 years. Till today a lot of health systems are insufficiently financed, lack appropriate supply chain management and face logistic challenges. Qualified pharmaceutical staff is under represented and skills in stock management on facility level lacking.

EPN tries to improve the situation in Cameroon and Tanzania with follow up projects. Other projects of EPN and its’ partners focus on strengthening stock management capacities also in small health facilities.

COMMUNICATION STRATEGY FOR EPN – A MEDICINE FOR A ATTENTION DEFICIT

Andreas Wiegand, Program Officer Product Development and Strategic Communication

Situation Analysis

The Ecumenical Pharmaceutical Network (EPN) is a NGO with a large dependence on donors. The network members are in the majority religious organizations that operate health care facilities which offer services to the poor including medicines. To ensure the financial support of aid organizations EPN needs to have a good reputation and the recognition among donors. Especially since the drug supply in many health programs receives less priority than in the past. For a network like EPN intensive communication is essential within the network. There is no programme or project which can be conducted through the secretariat without the cooperation with at least one member.

Finance

Only 2% of the budget is covered by membership fees! The other 98% is donor money.

Donors and Cooperation Partners
The biggest support is provided by Bread for the World (Evangelische Werk für Diakonie und Entwicklung (EWDE); Brot für die Welt). It is the main development and welfare organization of the protestant churches in Germany.

ICCO is the abbreviations for Interchurch Organization for Development Cooperation. The main office is in Utrecht, the Netherlands. The organisation was founded at the 9th of December 1964. The protestant churches in the Netherlands had decided to combine their development projects. As the financial resources of the government shrunk during the last two years also ICCO received fewer funds.

The catholic „counterpart“ of Bread for the World is MISEREOR. They support more than 100,000 projects all over the world.

The German Institute for Medical Mission (Deutsche Institut für Ärztliche Mission e.V. ((Difäm)) supports health initiatives and projects all over the world. Albert Petersen the Team Leader of the Pharmaceutical Services at Difaem is chairman of EPN.

EPN cooperated and receives the support from Management Sciences+ for Health (MSH) a subdivision of USAID with the programme called SIAPS. They also have reduced the support for EPN in the last months.

Action medeor is a member but also a cooperation partner of EPN. In 2014 action medeor is supporting a program in Northern Kenya which includes 50 small health facilities.

The Current Communication

There is no communication strategy at EPN. One year ago a consultant developed a marketing study. Some smaller isolated activities were proposed without given a comprehensive concept for the whole organisation one of the recommendations was to employ a communication expert. The forth focus area of EPN is information sharing. The following paragraphs give an overview of the current publication of EPN.

Pharmalink is published once a year. Each issue addresses one prominent pharmaceutical theme. The majority of contributions are received from the network members. The secretariats works of the editorial work and does all the artwork. This magazine is printed and available online.

The Contact Magazine is published twice a year. One issue is published through EPN. The official publisher is the World Council of Churches (WCC). This publication bridges pharmaceutical content with the spiritual aspects from our faith.

Specific programmes and projects also result in standalone publications.

All products follow a cooperate design with the main colours orange and green and the logo of EPN.

Every other month the electronic newsletters e-pharmalink and Netlink are published. Netlink reports about events, programmes and projects within the network. It also covers news from the secretariat. It is only sent within the network community. Every month another member organisation is presented. The e-pharmalink is covering news from the medical and pharmaceutical sector with key areas, e.g. malaria, HIV/Aids, NCDs, TB,
malaria. Also educational opportunities and courses offered are advertised. The number of recipients increased from 100 in 2006, 230 in 2007, to 1150 in November 2011. At the end of 2012 is reached 2300.

Additional Publications

The most important publications for an organisation are the annual report and the brochure about EPN. Another flyer informs about the advantages being a member of EPN. Towards the end of the year member receive a calendar with the most important dates of EPN, the World Health Days, conferences and congresses.

Since September 2012 a Fan Page www.facebook.com/EPN.epnetwork is online. On average the secretariat is posting twice a week. The Fan Page is linked via likes to other fan pages from important donors and similar organisations in the area of development cooperation.

The direct communication with members, representatives of the member organisation is managed mainly via email, phone or Skype. The most important conference to exchange is the EPN Forum which takes place every two years.

Communication with the donors so far

The contacts of the member organisations receive our electronic newsletter, the printed magazines, and the annual report. Hardly any contacts exist to the responsible people of public relations at the donors.

The donor and partner organisations which support EPN have been contacted and the responsible colleagues for public relations were asked to answer some questions. The results are summarised as follows:

- The objectives and the activities of EPN are unknown. The current newsletters and magazines are not covering these aspects.

- Format and design of the newsletters are not up-to-date. Teasers with links should be increasingly be used.

- Content from websites could be shared with other organisations. One organisation offered to forward press releases from EPN.

- The most suitable communication channels were defined as newsletters, direct contacts via email and phone.

Conclusion

The secretariat has developed several communication elements and channels. They have reached a good level of relevance. The external evaluation from last year reflected the high acceptance from the members and the good quality. The consultants praise the programmes in development cooperation. They criticise the lack of presentation to the outside. The interviews with partners and other organisation confirmed this statement. On the other hand donors are interested in getting information. The reputation of EPN is mainly based on the knowing Eva Ombaka who was executive director for a long time. She has given EPN a face over two decades. During the following years the design of the publications improved a lot.
What should be achieved with a communication strategy and its implementation?

The following statements should be achieved within the specific target groups of the communication strategy.

**Donors**

- Organisations in development cooperation know EPN as a competent network in the area of health programmes with the focus area medicines.
- Organisations in development cooperation use EPN and its secretariat in order to successfully implement health programmes which are linked to medicines.
- EPN has a good reputation at organisations in development cooperation because of its operational excellence in problem analysis, programme planning, implementation and achievement of objectives.
- The public relations departments of donors use contribution from EPN to illustrate and explain their engagement in development cooperation in health programs.

**Churches**

- EPN is an ecumenical organisation which is a valuable partner of church leaders to implement health programmes based on faith and able to reach out to the population in need.
- Church leaders know EPN to be able to combine spiritual and science-based health interventions as the basis for improving the health of the people.
- Churches recognise EPN as a being a heard voice at donor organisations for cooperation projects in the health sector.

**Partners and other networks**

- EPN is known at partner to be reliable in the cooperative implementation of health programmes.
- Partners and other organisations in contacts from other networks look at EPN as an important cooperating partner
- In Kenya EPN is well accepted as a competent organisation for the implementation of health programmes related to medicines or related objectives.

**EPN-Member Organisations**

- The communication departments of the member organisations share the publications with the network through the secretariat.
- Internet based platforms are used to connect with each other.

**Media**
- Media in Kenya take up health issues and the engagement of EPN member organisations of national and international relevance.

- German pharmaceutical journals report regularly about the engagement of German member organisations within EPN projects.

- Media with the main focus on development cooperation report regularly on issues of access to medicines in poor countries and programme activities of the network.
The SWOT Analysis

The SWOT-analysis is used to reflect the results of the situation analysis with the four aspects: strengths, weaknesses, chances, and risks. Using this method should make it easier to derive the communication strategy and reduce the risks.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Exceptional mission: a faith based institution with focus on pharmaceutical issues in 34 countries</td>
<td>• Dependent on the engagement and the input of their own staff and manpower at the level of member organisations</td>
</tr>
<tr>
<td>• A close relation to the World Health Organisation (WHO) and the World Council of Churches</td>
<td>• Missing engagement of some members</td>
</tr>
<tr>
<td>• Good reputation at the donors</td>
<td>• Weak communication structures within the network</td>
</tr>
<tr>
<td>• Responsible management of donor funds</td>
<td>• Big financial dependence from donor organisations</td>
</tr>
<tr>
<td>• Engaged employees</td>
<td>• Low number of staff at the secretariat</td>
</tr>
<tr>
<td>• No dependence on donor money from the pharmaceutical industry</td>
<td>• Weak reputation gaining activities</td>
</tr>
<tr>
<td></td>
<td>• Weak telecommunication structure in especially poor countries</td>
</tr>
<tr>
<td></td>
<td>• Poor presentation of achieved changes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chances</th>
<th>Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Good reputation of faith based health facilities</td>
<td>• Global economical crisis</td>
</tr>
<tr>
<td>• Member organisations in focus countries if development aid (e.g. South Sudan, Sierra Leone, DR Congo)</td>
<td>• Big dependency from donors and changes in supported focus areas</td>
</tr>
<tr>
<td>• Calls for proposals in the health sector by the European Union, DIFiD, Scandinavian organisations, and others</td>
<td>• Competition in health area with public sector and the danger of high staff fluctuation</td>
</tr>
<tr>
<td>• Increased interest in pharmaceutical issues in the health sector</td>
<td>• Preference of donors to cooperate with government institutions</td>
</tr>
<tr>
<td>• Broad basis of members</td>
<td>• Educational background and professional qualification of cooperation staff</td>
</tr>
<tr>
<td>• Location Nairobi as a basis to strive for new cooperation models with other organisations in development cooperation</td>
<td>• Missing acknowledgment of our member organisation by the government in some of our member countries</td>
</tr>
</tbody>
</table>
Ascertainment of the Communication Task

EPN implements programmes in the four strategic focus areas in pharmaceutical services. The current reputation and name recognition are not sufficient to safeguard the donor dependent financial sustainability.

This leads to a strategy for internal network communication and external communication strategy. For the latter the most prominent target group are the donors. They have to identify EPO as an essential partner whenever a programme is aiming on aspects in health with medicines involved.

Additionally the external communication has to reach partners and potential partner organisations. With reduced funds this strategy has to tackle with the more competitive situation.

The secretariat in Nairobi is small. It can implement the programmes only within the network, i.e. with the cooperation of its members. The full support of the health institutions and their staff depends also on the recognition and the reputation of EPN within the member organisations. The quality of the communication within the network has a massive impact on the quality of the external communication. This is a potential for synergies to strengthen the position of EPN in the area of development cooperation.

We need to be attractive for other organisations and donors to cooperate with us.

Strategy

OBJECTIVES

Economical and organisational objectives

- To reduce the decreased funding during the next two years and to bring it back to the level of 2011.
- To increase the engagement of network members in the achievement of our targets by 20% compared to the last analysis in 2012.
- To realise at least two more donors and/or cooperation partners in the coming two years to financially support the work of EPN
- The network members increase by 5% in the next 2 years.

Beside the quality of the proposals the donors also take the reputation of an organisation into consideration for the decision on granting support.

Strategic Communication Target

The Ecumenical Pharmaceutical Network is recognised by donors and partners as THE competent network for the implementation programmes which strengthen the pharmaceutical services/access to medicine and the staff who is responsible for these services.

General Communication Objectives
• EPN is recognised by church and secular donors to be a competent and trustful partner for the implementation of development programmes.

• EPN is recognised by church leaders in the countries of member organisations for its competence in strengthening the health sector in medicine related aspects.

• EPN is recognised by its members as an essential organisation for strengthening pharmaceutical competences in access to medicine, supply chain management, and dispensing.

The next step

EPN secretariat will contact all members to provide a contact for communication within and outside their organisation and network. A monthly call, telephone conference and email contacts will be the basis for the development of a commonly agreed communication strategy within the network.