Health Systems Strengthening
Focus on Pharmaceutical Service Delivery

EPN Forum
18th - 19th March 2010 Nairobi, Kenya
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<tr>
<td>ACHA</td>
<td>Africa Christian Health Associations</td>
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<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<td>AMDS</td>
<td>AIDS Medicines and Diagnostics Service</td>
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<td>AMFA</td>
<td>Affordable Medicines For All</td>
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<td>AMR</td>
<td>Antimicrobial resistance</td>
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<td>ASSOMESCA</td>
<td>Association des Œuvres Médicales des Eglises pour la Santé en Centrafrique</td>
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<td>CAR</td>
<td>Central African Republic</td>
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<td>CHA</td>
<td>Christian Health Association</td>
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<td>CHAK</td>
<td>Christian Health Association of Kenya</td>
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<td>CHAM</td>
<td>Christian Health Association of Malawi</td>
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<td>CHAZ</td>
<td>Christian Health Association of Zambia</td>
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<td>CHS</td>
<td>Church Health Service</td>
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<td>COGRI</td>
<td>Nyumbani Children of God Relief Institute</td>
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<td>COMESA</td>
<td>Common Market of Eastern and Southern Africa</td>
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<td>DRA</td>
<td>Drug Regulatory Agencies</td>
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<td>DRC</td>
<td>Democratic Republic Congo</td>
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<td>DSO</td>
<td>Drug Supply Organization</td>
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<td>EM</td>
<td>Essential Medicine</td>
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<td>EPN</td>
<td>Ecumenical Pharmaceutical Network</td>
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<td>ERP</td>
<td>Enterprise Resources Planning</td>
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<td>FBO</td>
<td>Faith based Organization</td>
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<tr>
<td>GMP</td>
<td>Good Manufacturing Practice</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>HSS</td>
<td>Health System Strengthening</td>
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<td>HSSF</td>
<td>Health Services Sector Fund</td>
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<td>IFPMA</td>
<td>International Federation of Pharmaceutical Manufacturers &amp; Associations</td>
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<td>KAPI</td>
<td>Kenya Association of Pharmaceutical Industry</td>
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<td>KEMSA</td>
<td>Kenya Medicine Supplies Agency</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MEDS</td>
<td>Mission for Essential Drugs and Supplies</td>
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<td>MEMS</td>
<td>Mission for Essential Medical Supplies</td>
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<td>MIS</td>
<td>Management Information System</td>
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<td>MOLS</td>
<td>Ministry of Medical Services</td>
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<td>MoU</td>
<td>Memorandum of Understanding</td>
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<td>MSH</td>
<td>Management Sciences for Health</td>
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<td>NDA</td>
<td>National Drug Authority</td>
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<td>NGO</td>
<td>Non Governmental Organisation</td>
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<td>NHSSP</td>
<td>National Health Sector Strategic Plan</td>
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<td>PEPFAR</td>
<td>President's Emergency Plan for AIDS Relief</td>
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<td>PBP</td>
<td>Pharmacy and Poisons Board</td>
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<td>PPP</td>
<td>Public-Private Partnerships</td>
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<td>PSM</td>
<td>Procurement and Supply Management</td>
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<td>R&amp;D</td>
<td>Research and Development</td>
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<tr>
<td>SOP</td>
<td>Standard Operating Procedures</td>
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<td>SPS</td>
<td>Strengthening Pharmaceutical Systems</td>
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<td>SSO</td>
<td>Stop-Stock Out</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>TFDA</td>
<td>Tanzania Food and Drugs Administration</td>
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<tr>
<td>TOT</td>
<td>Trainer of trainers</td>
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<tr>
<td>US</td>
<td>United States</td>
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<td>WCC</td>
<td>World Council of Churches</td>
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<td>WHO</td>
<td>World Health Organization</td>
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INTRODUCTION
The 2010 EPN Forum was held in Nairobi, Kenya from 18th to 19th March 2010. A total of 53 participants from 20 different countries attended the two day forum whose theme was “Health Systems Strengthening: Focus on pharmaceutical service delivery”. The events at the forum included presentations by a number of speakers from a diversity of backgrounds, case studies and experiences from members, success stories and launches of several EPN publications.

EPN FORUM

1. Overview, financing and sustainability
The meeting was opened at 8:30am with a word of prayer from Ndilta Djékadoum of Chad. He gave a reflection from the book of Genesis 26: 1-6, 12-13. The main teaching was about triumphant faith. He said that through faith, EPN could become bigger and stronger.

A. Welcome from the Chair of the EPN Board
Albert Petersen, the Chair of the EPN Board, thanked Dr Ndilta Djékadoum for the devotion and welcomed everyone attending the 4th biennial EPN Forum. He presented apologies of a number of members who were not able to attend the forum. The Chair thanked the EPN Secretariat for their hard work in organizing the forum and briefly talked about EPN, its role and the mission it strives to fulfil for the benefit of the members.

While giving the background of EPN, the Chair mentioned the first forum was held in Moshi, Tanzania in 2004, focusing on quality of products and services. The second forum in Tuebingen, Germany in 2006 coincided with the 25th anniversary of EPN formation. The theme was “Ecumenical Health Services in Action”. In 2008, the EPN forum was held in Yaoundé, Cameroon where the theme was “Pharmaceutical Standards”.

B. Participants’ expectations
Participants expressed the following expectations for the 2010 Forum:

- To come up with an action plan for ensuring that the faith based health institutions do not collapse, especially the ones based in the rural areas.
- To learn from each other’s experiences on how to tackle the challenges in their respective health institutions.
- To plan how to strengthen EPN so that it remains committed to service delivery.
- To share information concerning pharmaceutical supply chain processes.
- To summarize the members’ competencies and see how they can help each other.
- To see how EPN can have a
real network that is able to strengthen the health sector.
• To find out which countries have good practices in pharmaceutical service delivery so that members can make use of them. This will help the members know where to look for partnership in trying to get a service or resource.
• To find out how the Network can help small organizations reach the same heights and standards of big organizations such as MEDS.
• To hear how EPN members have overcome various challenges so that other members can learn from them.

C. WHO perspective on key issues and challenges around health system strengthening
Dr Marthe Everard, WHO representative of Somalia, gave an overview of Health System Strengthening (HSS) from the WHO perspective. She discussed the six building blocks that were required for countries to create a single framework for a health system:
• Service Delivery
• Health Workforce
• Health Information
• Medical Products, Vaccines and Technologies
• Health Financing
• Leadership and Governance

A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies. It assures quality, safety, efficacy and is cost-effective.

She mentioned the challenges which are on the ground by citing some statistics. For example, it is estimated that 50% of medical equipment in developing countries is not used due to lack of spare parts, maintenance or health workers not knowing how to use the equipment. Every year, 100 million people are impoverished as a result of health spending.

Health systems that function well have certain shared characteristics:
• Procurement and distribution systems that actually deliver cost-effective medical interventions to those in need.
• Sufficient health workers that have the right skills and motivation to deliver health services.
• Financing systems that are sustainable, inclusive and fair.

The overall goal of a well strengthened health system is to ensure that health care services are affordable and accessible and not forcing impoverished households even deeper into poverty. Participants expressed concern about the level of funding going to HSS compared with the funding going to disease specific programmes such as AIDS and TB. As an example on the proportion of the Global Fund being directed to health systems in Somalia, Dr Everard responded by saying that HIV and AIDS enjoyed a funding of about 5 times that of health systems strengthening, which had about USD 10 million for the next 5 years.

D. Public sector contributions to strengthening church health systems: lessons from Kenya
Mr Stephen Cheruiyot from the Ministry of Medical Services (MOMS) Kenya gave a presentation that showed the activities which the government was undertaking to strengthen church health systems. The activities supported include health service delivery
that promotes community linkages and national health standards/protocols/guidelines, policy dialogue/collaboration and technical working groups that aim to strengthen the partnership.

Governance and management had been ensured through a coordination committee, health facility committees and their respective management teams. Funding mechanisms had been put in place to ascertain accountability and transparency. The government also provides financial and other support to FBOs through direct transfer of funds (HSSF), deployment of health care personnel and supply of commodities, e.g. drugs and vaccines.

The government, through its drugs and medical supplies programme, distributes kits to level II and III faith-based health facilities. On planning and implementation, the government had developed the national health sector plan and annual operating plans, and standardized the planning tools and budget guidelines. The FBOs use the national health sector Monitoring and Evaluation (M&E) tools -including registers- to compile timely data and participate in the national health sector HMIS technical working group by providing feedback.

The ongoing initiatives the government was undertaking are negotiations for implementing guidelines of the Memorandum of Understanding (MoU), creating a Public Private Partnership (PPP) policy or strategy and developing a master facility list to identify all the health institutions in the country.

In his discussion about PPP, Mr Stephen Cheruiyot showed the government’s perspective concerning the public private partnership in Kenya’s health sector. The public and private sectors have a vision of working together to ensure improved access to quality health care for all Kenyans. The mission of this partnership is to bring together the public, private, faith-based and non-government health sectors to foster on-going dialogue on key and emerging policy issues linked to PPPs in health.

In alignment with Vision 2030, NHSSP II and the ministries of health 2008 – 2012 Strategic Plan, PPP Health-Kenya will:

- Foster a common vision among the different health stakeholders on the national health priorities.
- Influence and contribute to policies that promote a greater private sector role in health.
- Identify and promote PPPs that leverage each sector’s comparative advantage and use resources efficiently.
- Build trust by strengthening coordination and communication.
- Raise awareness on the benefits of PPPs in health.

The guiding principles of the PPP are to focus on shared vision and common good of the health sector, respect for different perspectives, equity between partners, shared responsibilities, equal commitment to working together and finally, transparency and accountability.

During the ensuing debate, some participants wished to know how much of the health services sector fund (HSSF) was going to be channelled to the faith based health facilities, what the long term perspective for health care in Kenya was and whether there was a risk of FBOs losing their autonomy by getting with public funds. In terms of equity, PPP is like a double edged sword: it can promote as well as undermine the fairness in improving access, because there are profit generating ventures in the partnership.

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subsidies from the government. Replying to the debate, Mr Cheruiyot acknowledged that the government was very grateful for the role FBOs were playing in the health sector. To the question regarding autonomy, he said the government and the FBOs have an MoU that recognizes this autonomy. The clause in the MoU allows government funding, policy implementation and partnership, but does not allow the government to interfere with the day to day running of the FBO facilities.

Regarding the long term perspective of the health care, Mr Cheruiyot said that the government was addressing issues concerning partnership, financial sustainability and equitable distribution of resources. About health services sector fund allocation to FBOs, he acknowledged that the government has a duty to support the faith based health facilities but the allocation criteria have not been discussed.

E. The present and future perspectives of financing of medicines for the public and private not for profit health sector

Ms Anne Marie Bodo, representing the World Bank, shared her organization’s present and future perspectives on financing of medicines for the public and private health sectors. In her opening remarks, she gave the reasons for financing health systems which comprised of inequities in the health sector, an unclear health policy, a weak public system, a strong need for strengthening health systems and a need to provide the pharmaceuticals that are essential for services delivery.

In order to reach the Millennium Development Goals (MDGs), the Sub-Saharan African countries required an increase and better allocation of domestic and external funding for the purpose of strengthening their national health systems. There was a need for domestic advocacy to raise attention to national budgeting processes and a need to channel private spending into a risk pool. The areas which had made financing more efficient were results based financing, such as adequate training of health personnel, building of a system with a good flow of funds and goods, achievement of a defined performance target, a financing system to assure timely provision of rewards and purchasing of results and outputs, replacing input based financing.

With the MDGs finish line in view, funds are needed more than ever. Dialogue can be centred around the production of results. Both supply and demand side financing need to be tapped and hard issues need to be tackled.

There was a discussion on the degree to which the World Bank could consider working in partnership with FBOs since they offer a huge percentage of health care services. Another discussion centred around the question whether it is possible for the World Bank to help revive the church community health fund in Tanzania because this ended when the government reduced its premium in comparison to the church community’s premium. With time, the community health fund that was sponsored by the government also came to an end.
The consequence is that a large number of people who live in the rural areas and are unemployed don’t have a health fund.

Contributing to the discussion regarding partnering with FBOs, Ms Anne Marie Bodo stated that the World Bank was a global partner but first and foremost accountable to its members who are the different countries. Their work therefore centres around what the countries want. Funds go through the government, but there are a few cases where they partner directly with FBOs, e.g. in Rwanda. In countries such as Kenya, the World Bank contribution to health care is about 5%. With this small percentage, it is not possible for them to push the government on where to channel the funds.

About community health funds, she agreed that the social health insurance is a very important issue and promised to raise this matter in her organization.

F. Building sustainable pharmaceutical systems: lessons from the church sector

Dr Jane Masiga from MEDS discussed the lessons which the church sector had learnt in the process of building sustainable pharmaceutical systems. Starting off with some background information, she indicated that the Church Health Services (CHS) were responsible for up to 40% of all available health services in most developing countries. She went on to introduce EPN as the only global Christian membership organization that works specifically to increase access to medicines and strengthen pharmaceutical services, ultimately achieving better health for communities. The churches extensive involvement in health, both in funding and service delivery had necessitated a need for a technical organization to support them on pharmaceutical issues.

An important role to be played by the church sector is delivery of services in three ways. First is the quality of service. This is often considered as one of the key strengths of the CHS in the availability and commitment of staff and value system within the institutions. Secondly, the CHS offer specialized care in rural areas, e.g. chemotherapy, orthopaedic and eye care. Thirdly, the CHS offer holistic care for both body and spirit.

Examples of CHS influence on service delivery can be seen in the following countries that:

- ZACH provides 68% of health care services in rural Zimbabwe and 37% at national level.
- Churches in Ethiopia contribute 9% of the health care in their country.
- Faith based health providers in Ghana provide 40% of the care through their network of 59 hospitals and 99 clinics and health centres.
- Togo CHS represents 15% of the national health care system with 9 hospitals and 62 lower level facilities.

Extensive work has been done by EPN to describe the nature and involvement of the churches in pharmaceutical service delivery through EPN-WHO multi-country studies and EPN Access Baseline studies that were conducted between 2005 and 2008 in 8 countries: Ghana, Ethiopia, Togo, Nigeria, Uganda, Zambia, Malawi and Tanzania. The study assessed compliance to EPN guidelines and involved self assessment, guided desk reviews, guided self assessment for hospitals and focus group discussions in order to get a comprehensive picture of each country.

The EPN guidelines for efficient, effective pharmaceutical services consist of 23 guidelines that cover medicine supply and management mechanisms, systems to support rational medicine use, pharmaceutical human resources, pricing and financing of medicines, access to and sharing of pharmaceutical information, issues of governance and management and community involvement in health service delivery. The EPN guidelines were developed through a collaborative process by EPN members so that they could be used to assist churches with putting in place mechanisms that would facilitate increased access to medicines and address issues that are within the control of the health institution. A number of indicators have been defined for use with each guideline.
Even though CHS face many challenges, they are playing a critical role in health system strengthening. Recognition and appreciation of the multiple aspects of health and pharmaceutical service delivery that churches are involved in, and the extent of their contribution, are still not as widespread as they should be. International partners in health and governments need to work towards more win-win relationships with the church sector.

There was a discussion on whether EPN and the World Council of Churches had a working relationship between them and whether EPN had an advocacy campaign for the equitable distribution of medicines. In her response, Dr Masiga said EPN has a good working relationship with the World Council of Churches (WCC). Concerning the advocacy campaign, EPN was doing a lot of lobbying both in and outside of the church on issues of access to medicines.

G. Donor perspective on the role of FBOs in Health and Pharmaceutical Systems Strengthening

Mr Richard Wagner from AMFA in South Africa involved the participants in looking at the donor perception on the role that FBOs have to undertake in Health and Pharmaceutical Systems Strengthening. He explained this perception by highlighting three important things that needed to be understood: the market, the donor and the role of FBOs.

A study done in 2009 by a South African consultancy firm indicates how important it is to understand the market. This study revealed that the effect of economic downturn in Africa will trickle to the health care sector via two ways: rising health costs and constrained health care resources. Since the majority of African currencies have fallen drastically against the US dollar, the consequences are higher import costs, given that 95% of all medical products in Africa are imported.

The second aspect that needs to be understood is the donor. This has been attributed mostly by the changing nature of donor’s assistance whose new funding goes to specific diseases (HIV and AIDS, TB and malaria), called vertical programmes. Unlike in the past where healthcare funding given to a government was controlled by the finance ministry, the donor is now controlling the products and services. The vertical programmes have created an imbalance whereby most funds are in support of government healthcare, not FBOs. This consequently means that future flow of funding of health care in Africa will be directed to national governments. Something to worry about is that, up to now, the FBOs have not participated in any significant distribution of funds through vertical programmes.

Thirdly, it is important to understand the role of FBOs. Through a 2008 research study on the role of mission hospitals in achieving Millennium Development Goal No 5, it has been noted that there is a growing interest in the private sector and some agencies (including World Bank and USAID), suggesting governments should involve private and faith-based organizations in meeting health care needs. Many donor organizations recognize that NGOs complement national health plans. The same study also revealed that the mission hospitals enjoy a good financial support, have a better working environment, their drug supply is less likely to have stock-outs and they have a superior clinical care compared to the government hospitals.
them as resilient and creative entrepreneurs, as well as value demanding customers. The recent focus of interest lies on the impact of successful bottom of pyramid approaches (it refers to the potential market of 4 billion people who live on less than $2 per day) to sustainable development. The road which FBOs need to take to secure a sustainable future is to open up and embrace transparency. There is a strong need to shift our approach from business as usual to market responsive strategies. FBOs should embrace this opportunity of serving other clients as an opportunity for expanding their ministry reach and coverage.

H. The role of the pharmaceutical industry in strengthening not for profit pharmaceutical systems
Dr Moses Mwangi from the Kenya Association of Pharmaceutical Industry highlighted the role of the pharmaceutical industry in strengthening non profit pharmaceutical systems. He began by stating that the pharmaceutical industry structure is made up of pharmaceutical manufacturers, distributors, retail pharmacies, hospitals and clinics.

On the manufacturers’ front, the industry has two bodies which engage in this activity. The first one is Kenyan based Research and Development manufacturers which are found in developed countries, but are a growing trend in emerging markets such as India, China and Malaysia. The manufacturers work in a close collaboration with supranational bodies such as WHO, to identify unmet health needs so as to inform research. They have an umbrella organization: the International Federation for Pharmaceutical Industry and Associations (IFPMA), with headquarters in Geneva. Kenya Association of Pharmaceutical Industry (KAPI) is affiliated to this umbrella organization.

The second body is Kenyan Based Pharmaceutical Manufacturers who deal with generic essential medicines for supply to Kenya, East Africa and the COMESA Region. The industry is organized around Federation of Pharmaceutical Manufacturers of Kenya and plans are underway to have one umbrella association for East Africa. The government’s role is to regulate the industry and assure the final consumer gets a safe, effective and affordable medicine. This regulatory role is played by Pharmacy and Poisons Board (PPB) in Kenya, National Drug Authority (NDA) in Uganda and by Tanzania Food and Drugs Administration (TFDA) in Tanzania.

KAPI offers the voice of the industry, working in collaboration with regulatory authority, Pharmaceutical Society of Kenya, and other stakeholders to ensure an enabling environment for delivery of healthcare in Kenya. Member companies are those that invest in Research and Development of novel drugs. The key objective of KAPI is to ensure access to first class quality medicines for clinicians and patients in all regions of Kenya.

To achieve a strong pharmaceutical system, manufacturers should be regulated to comply with GMP, National and WHO standards. There should also be a competitive environment to provide consumers with various choices as this can lead to affordable prices and quality products.

The challenges that Kenya and its neighbours face in the pharmaceutical sector are a poorly regulated pharmaceutical subsector, lack of harmonized drug registration policies across different countries and inconsistent policies such as when some medicines are taxed while the policy provides for them to be zero rated.

With these gaps, the role of KAPI is to provide advocacy, address unmet health needs and be a partner to stakeholders. Examples of issues that KAPI has provided advocacy for are the poorly regulated pharmaceutical sector, especially in counterfeit trades, quality assurance of medicines that will ultimately lead to access of quality medicines and addressing the issue of unfair taxation.

I. Case study of CHAZ: Building a win-win relationship with non church actors
Mr Cryson Miyoba, Internal Audit Manager of CHAZ presented a case study profile of his organization. He defined CHAZ as an inter-denominational (Catholic and

“The road which FBOs need to take to secure a sustainable future is to open up and embrace transparency.”
Protestant) umbrella organization for 138 Church Health Institutions (Hospitals and Rural Health Centers, including 9 Training Schools) and Community Based Programmes (19 CBPs, including 9 Catholic Dioceses). Its national coverage is 30% of all the health services in Zambia and over 50% in rural areas. CHAZ is also one of the 4 principal recipients for the Global Fund in Zambia.

CHAZ fulfills its mandate in a Win-Win relationship with the government through a Memorandum of Understanding (MoU) that provides for the following:

• Technical working groups in which CHAZ is represented, e.g. human resources, national drug policy, steering committee, national formulary committee, consultative meetings, etc.
• Health workers secondment to CHAZ health facilities.
• Capacity building for church health facilities.
• Provision of equipment, transport and goods.
• Medicines provision to all CHAZ facilities.
• Technical support through provincial and district health offices.
• Refurbishment of infrastructure.

The challenges that CHAZ face are donor dependence, FBOs’ high expectations, inadequate infrastructure and human resource crisis in health due to death, transfers or migration. Due to the remarkable partnership between CHAZ and the government, participants wanted to know the secret to such a good working relationship and how CHAZ handles the human resource crisis in pharmaceutical areas. The response on the good working relationship between CHAZ and the government was that there is a very strong element of trust and accountability between the two parties. This is evident in how the government uses CHAZ to deliver medicines. Concerning the human resource crisis, Mr Miyoba said CHAZ gives its employees a small incentive on top of their salaries from government.

J. Implementing systems for good governance: the case of ASSOMESCA

Dr Ione Bertocchi presented a highly entertaining case study of how ASSOMESCA had succeeded in attracting donors so that they

“When the human resource capacity is weak, no one is ready to invest in any organization”

Dr Ione Bertocchi of ASSOMESCA, Central African Republic.
could provide better health care services. She said that while attending an EPN-DSO meeting held in Dar es Salaam, Tanzania in April 2008, they learned how the church can work with money for the benefit of the people, what the business concept of succeeding was and how this could be adapted by the church while maintaining their social mission.

To attract donors, ASSOMESCA was forced to restructure their organization to have more accountability and transparency in all the activities they were doing. They also invested in more professional staff at the secretariat. With all the new things in place, ASSOMESCA was able to get funds to undertake various projects that have been quite successful.

Despite the successful ascendency they have had in their work, there are still challenges that they need to overcome. Their major challenges are lack of enough funds (more capital must be injected into the business), lack of professional staff (e.g. pharmacists), lack of a procurement system in place and a lot of competition from the public and private sector.

Dr Ione Bertocchi thanked EPN for the highly enlightening meeting held in Dar es Salaam because it led to the genesis of ASSOMESCA’s journey in embracing positive change. She urged the participants to make use of the information they got from the forum.

2. Human Resources, products and technologies

The second day of the forum started with a word of prayer from Dr Barthelemy D. Bodjrenou. He gave a bible teaching from the book of Joshua 5:2-9 that touched on how God had made various alliances with the Israelites. He pointed out several examples of how people like Abraham and Moses made alliances with God and said that everyone today has made an alliance with God in a special way. Although every alliance has its own difficulties, people should not run away from them but try to persevere until they succeed because God never abandons someone who is doing according to His will.

A. Current innovations and technologies for sustainable strengthening of pharmaceutical systems

The first presentation from Joseph Mukoko of MSH/SPS described how sustainable capacity building can strengthen pharmaceutical systems. Through the capacity pyramid model adopted by MSH/SPS, an organization can be able to strengthen structure, systems, and roles through development of policies, regulations, guidelines, and other governance structures; strengthening of staff and infrastructure and developing skills through pre-and in-service training and sharing of the best practices, among others. The core systemic capacity building elements are:

- Performance capacity: tools, money, equipment, consumables, etc. available to do the job.
- Personal capacity: knowledge, skills (technical, managerial, interpersonal, etc).
- Workload capacity: staffing numbers to match workload, job descriptions and skill mix.
- Supervisory capacity: monitoring and reporting systems, accountability structures, supervision and incentives.

Some of the achievements that this pyramid model had brought, included scale up of trainings on pharmaceutical management, improved performance of supply chain systems that lead to increased
management capacity requires a mix of strategies, e.g. use of regional TOTs, mentorship, task-shifting, dissemination of job aids and tools. Collaboration, inclusive participation, and respect of country level institutions, private sector, local partners, and professional organizations foster the success rate and sustainability of desired interventions. A good example that showed the benefits of the pyramid model was Nyumbani Children of God Relief Institute (COGRI) – Kenya. The institute has had an incredible improvement in pharmaceutical management and strengthening of human resource and institutional capacities.

Several issues were raised in the discussion. One participant asked if there is an IT system that is able to handle both financial information and medicine supply management. Mr Mukoko explained that although systems which could do Enterprise Resources Planning (ERP) are available, they are very expensive. At MSH/SPS they opt to find out what the needs of an organization are, so that they know which system would be the most appropriate one to recommend. Another participant wanted to know how MSH/SPS could help to strengthen the systems in other countries. Mr Mukoko responded by advising participants to contact MSH/SPS offices in their countries and to form country focal teams which can easily be used to link the church sector. However, organizations that want any assistance from MSH/SPS, could also use the EPN Secretariat to channel their requests.

B. Case study on products and technologies: PSM toolbox
Ms Clarisse Morris of i+solutions in the Netherlands engaged the participants with a case study on the Procurement and Supply Management (PSM) Toolbox. In her opening statement, she said despite the fact that a large variety of PSM tools are available, they are not accessible to health staff in low and middle income countries. Due to this, WHO AIDS Medicines and Diagnostics Service (AMDS) started the development of a central repository of tools in 2006. The various types of tools included in the database are software quantification spreadsheets, websites, fact sheets, guidelines, manuals, standard operating procedures (e.g. checklists, pricelists), catalogues and training course material.

The key PSM areas are quantification, procurement, inventory control, rational use, monitoring and evaluation, pricing, policy, quality assurance and capacity building. The various tools’ characteristics are also displayed on the PSM toolbox. Clarisse Morris concluded her presentation by doing an offline demo of how the PSM toolbox works. Participants were urged to visit the website and download the tools that would be useful for their health facilities.

C. Which pharmaceutical HR are available in the church system: results from EPN mapping studies
The results of the mapping study done by EPN to find out which pharmaceutical HR are available in the church system were presented by Ms Anke Meiburg of EPN. The purpose of the EPN mapping was to identify the capacities of pharmaceutical human resources available in the Church health system and to get connected with pharmaceutical personnel availability of medicines and the application of pharmaceutical management SOPs, checklists and job aids.

The key lessons learnt were that collaboration is critical for developing and implementing various training materials, tools, SOPs for local stakeholder buy-in and sustainability. National adaptation of identified interventions promotes ownership at central and peripheral levels and ensures continued utility. Scaling up pharmaceutical

Dr Francis Kimani, Director of Medical Services
MOMS, Kenya, accepts the EPN carving
in member organizations who would wish to get support in the form of pharmaceutical information. Countries involved in this study were Cameroon, Kenya, Tanzania, Malawi and Nigeria. The methodology used by EPN to carry out the study was through questionnaires which were completed at institution level, individual pharmacy staff level and national levels.

The results generally revealed that, except for Nigeria, there were very few pharmacists in the Church health sector. While in Cameroon and Tanzania 64% and 63% of the staff in pharmaceutical departments had received some pharmaceutical training, in Malawi only 12% of staff had. In Cameroon and Tanzania, 15% and 19% of the surveyed institutions had no pharmaceutically trained personnel at all. In Nigeria and Kenya 33% and 31% of the pharmacy departments are headed by non-pharmaceutically trained staff.

Some of the challenges EPN experienced while conducting this study were difficulties in getting completed questionnaires (several questionnaires were poorly filled with missing data or contradictory data), biased results and the reluctance by some respondents to complete the questionnaire, especially those who did not know EPN.

Following this presentation, issues discussed included the plans EPN had after collecting the data, whether they would examine the content of pharmaceutical training to find out if it was of the proper quality, the requirements to become a pharmacist and why pharmacists were very few. Ms Christine Häfele-Abah of Action Medeor gave attention to the experience her organization had on capacity building in the pharmaceutical sector. She began by explaining that Action Medeor is a non-profit organization founded in 1964, whose headquarters and warehouse are located in Tönisvorst, Germany. Action Medeor deals with distribution of high quality – low cost essential medicines and equipment. It has 45 employees and serves 2.000 to 3.000 customers (NGO hospitals) in approximately 130 countries.

Some of the Pharmaceutical-medical projects Action Medeor has undertaken are local production of ARVs and Malaria medicines, capacity building for local manufacturers on Good Manufacturing Practices and training of pharmacy students using the research and development lab at the Muhimbili University in Dar es Salaam.

Action Medeor had learnt that the challenges that hamper local production of medicines in Sub Saharan Africa include shortage of skilled personnel, technical standard of production, compliance with WHO good manufacturing practices, lack of research and development (R&D) laboratories and training of staff on areas of production, quality control, quality assurance and maintenance of equipment.

D. Case studies from Action Medeor on capacity building for pharmaceutical services in Tanzania

Ms Christine Häfele-Abah of Action Medeor gave attention to the experience her organization had on capacity building in the pharmaceutical sector. She began by explaining that Action Medeor is a non-profit organization founded in 1964, whose headquarters and warehouse are located in Tönisvorst, Germany. Action Medeor deals with distribution of high quality – low cost essential medicines and equipment. It has 45 employees and serves 2.000 to 3.000 customers (NGO hospitals) in approximately 130 countries.

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The major intervention Action Medeor has engaged in is capacity building for pharmaceutical key personnel. Since 2005, numerous workshops conducted in Tanzania (Moshi, Arusha, Dar es Salaam) have had topics about good manufacturing practices and quality control of drugs to drug development. The workshops target groups such as pharmaceutical industries, DRAs, drug supply organizations and bigger hospitals. Participants from Kenya, Uganda, Tanzania, DRC, Rwanda, Malawi and Botswana have attended these workshops.

Local production of medicines in East Africa has its main challenge in research and development. 
in research and development. Generic medicine requires a good knowledge of pharmaceutical formulation technology, e.g. modern artemisinin based antimalarials are extremely humidity sensitive and therefore need to be compressed in a dry way. However the traditional method widely used in Eastern Africa is wet granulation and afterwards compression.

The new approach Action Medeor has taken to meet the local challenges is to have a Public Private Partnership that has led to the establishment of a pharmaceutical teaching, research and development (R&D) laboratory in Dar es Salaam, Tanzania. The objectives of this lab are:

- To create sufficient numbers of well-trained pharmacists and technicians.
- To build R&D capacity for local and regional drug manufacturers, to transfer to modern efficient GMP compliant production technology.
- To create a centre of excellence for ongoing R&D capacity, continuing professional development and operational management supports.
- To facilitate the modern efficient GMP compliant development and production of Malaria and HIV and AIDS drugs.

A question was raised as to how one could join the training on pharmaceutical services and why the prices of medicines from Action Medeor are high. In response, Ms Häfele-Abah said that if an organization wanted to be trained on pharmaceutical services, it could approach Action Medeor to find out how to write a proposal. About the prices of the medicine, she said Action Medeor is not for profit making but the prices were high because they procure the medicines mainly from Europe.

E. Lessons for the church sector from HAI pricing studies and stop stock-outs campaign

Ms Christa Cepuch and Mr Gichinga Ndirangu of HAI Africa shared their experiences on the lessons that the church sector could learn from HAI pricing studies and their Stop Stock Outs campaign. Ms Cepuch indicated that the availability of essential medicine in Africa was only 38% in the public sector and 59% in the private sector. Public sector availability of medicines is consistently lower than in the private sector. Add-on costs in the supply chain could more than double medicine prices in the private sector, while public sector mark-ups could also be substantial.

On the issue of Stop-Stock Outs (SSO) campaign, Ms Cepuch explained the background and structure of the campaign by saying that 30 years after the introduction of the Essential Medicine (EM) concept, still not enough medicines were available on the pharmacy shelves today. Stock-outs are worst in rural areas where they harm poor people by forcing them to purchase medicines from much costlier suppliers in the private sector or simply to go without needed medicines. The failure to properly stock public health pharmacies and clinics stems in part from economic constraints and bureaucratic obstacles. But above all, it is a failure of political will. If governments commit to get essential medicines on the shelves, they can do it.

The SSO campaign was calling on governments and health departments to end stock-outs by:

- Giving financial and operational autonomy to the national medicines procurement and supply agency.
- Allowing representation of civil society on the national medicines procurement and supply agency board.
- Ending corruption in the medicine supply chain to stop theft and diversion of essential medicines (EMs).
- Providing a dedicated budget line for essential medicines.
- Living up to commitments to spend 15% of national budgets on health care.
- Providing essential medicines for free at all public health institutions.

By sharing the lessons with the church sector, it is possible to deepen the analysis and develop an action of addressing issues about high medicines prices, to develop ways of promoting generic competition, consider pricing policy, advocate for free medicines in the public sector for poor people and to ensure accountability through civil society representation on the boards of central medical stores.
F. Vision for the future

The Director of Medical Services in the Ministry of Medical Services of Kenya, Dr Francis Kimani gave a speech on the way forward in terms of what the future holds. He began his speech by thanking the church and their health facilities in all the countries that were represented at the forum for the good job they are doing in providing health care.

In Kenya, the government owns 58% of the health centres. 12% are owned by the private and 30% by the church. In some areas, the faith based health facilities are doing better than the public ones. For a health system to deliver health services to a patient satisfactorily, it needs good governance of resources such as human resources, infrastructure, equipment, finances, research, monitoring and evaluation. Therefore, no resource should be taken for granted. There is a strong need to have a good management in the health centres that makes certain the resources are utilized efficiently to produce excellent result, which is very important.

All health facilities require a pharmacist. Pharmacy is a specialty whose role in the day to day running of a health centre is extremely essential. A good pharmacist will help the health centre on how to store drugs at the right temperature, will also counter check the doctor’s prescription to a patient, does quantification of which drugs are needed, advises the hospital on which drugs are essential to procure and in some cases pharmacists can assist in operational research because they work closely with the doctors. The faith based health facilities also need to come up with an efficiency evaluation method for their staff. The formula to use to calculate an employee’s efficiency would be as follows:

\[
\text{Efficiency} = \left( \frac{\text{The actual work done}}{\text{Work expected to be done}} \right) \times 100
\]

For example: if one surgeon is supposed to operate 10 patients in one day and he operates 6, his efficiency is 60%.

When an efficiency analysis is done properly by a health centre, it would greatly solve problems to do with over-working, under-working, over-employment and under-employment.

During the discussion, participants inquired whether the government could assist the FBOs to employ medical personnel that they could not afford. In response, Dr Francis Kimani said the government had assisted the FBOs with medical personnel and would continue doing so where possible. He added that since the government was having a shortage of medical personnel because of not having enough money to pay them, they deploy medical personnel to the health institutions that are the only ones offering health services in a certain area. He once again congratulated the FBOs for the good collaboration they have with the government, especially when doctors are deployed to work in their faith based health centres.

3. EPN/member projects and activities

A. Launch of the EPN 2010-2015 Strategic Plan

Ndilta Djékadoum, an EPN Board member, gave a brief presentation on the EPN 2010-2015 strategic plan. He highlighted the priority areas that EPN will address over the strategic plan period. The areas had been identified based on the need of the church, pharmaceutical sector, the expertise within EPN and the experience of supporting church pharmaceutical system for over two decades. The areas are:

- Access to and rational use of medicines
- HIV and AIDS treatment
- Professionalization of pharmaceutical services
- Pharmaceutical Information sharing
Each area has its own objective and well outlined strategies for tackling it. The implementation of the strategic plan will be routinely monitored and evaluated through existing governance structures. Reports will be prepared for the Board, funding agencies and the general meeting as required.

B. Launch of the EPN website
Elisabeth Goffin, the consultant working on the EPN website gave a presentation on the new exciting features that have been added to new website as well as the improvements made.

Apart from accurate, useful and comprehensive information on pharmaceutical services which is continuously updated, the website has new features such as an interactive segment of polls and forums, and a multimedia section that has a photo gallery, audio and video files. The website content has been made identical in both English and French. Members were urged to make sure they log in to the website in order to access all the members-only information.

C. Launch of the EPN HIV Treatment Literacy Manual
Archbishop Benjamin Nzimbi, retired bishop of the Anglican Church of Kenya launched the HIV and AIDS Treatment Literacy Guide for Church Leaders and praised EPN for the commendable effort they had made in developing it. The manual was developed to inform church leaders on relevant issues related to HIV and AIDS treatment.

Studies in Kenya, Rwanda and Burkina Faso had showed a lack of ARV information on materials geared for church leaders, a fast speed of change in approach to AIDS, access, costs, and attitudes, a need for patient-focused treatment literacy and the importance of understanding links of food and nutrition to treatment. Armed with this information, EPN started the production of the HIV and AIDS Treatment Literacy Guide for Church Leaders.

The treatment literacy guide was developed with input from members and stakeholders in the church sectors and experts in the area of HIV and AIDS treatment. The guide is divided into three major parts. The first part consists
The second part comprises of exercises that will help the leaders better understand the content and engage other people, i.e. the congregation. The third part is a supporting information section that gives more technical information on antiretroviral treatment, sample HIV and AIDS policies among others. The EPN Secretariat expressed thanks to all the people who participated in the publication of this book. The guide is available in both French and English.

D. Overview of selected EPN projects
EPN staff briefly gave an overview of some of its ongoing projects:

- AMR advocacy and containment action, which many members were undertaking in their different countries, in response to the global threat posed by antimicrobial resistance.
- Standards Project which involved the development of standards for hospital pharmacy practices.
- Children's medicines project which aimed at determining the level of availability of children’s medicines within the network, the barriers to access and how these would be addressed.

E. Africa Christian Health Associations (ACHA) update
Mr Mike Mugweru of the Africa Christian Health Associations Platform (ACHAP) gave an update on the platform. He began by explaining that ACHAP is a networking forum for Christian Health Associations (CHAs) and Networks from Sub-Saharan Africa. It was established through a declaration of the 3rd Biennial CHAs Conference held at Bagamoyo, Tanzania in January 2007. The Platform Secretariat is currently being hosted by CHAK in Nairobi and its governance structure and mandate was affirmed by the 4th CHAs Conference held in Kampala, Uganda in February 2009. The core functions of ACHA are networking, advocacy and capacity building through peer-to-peer learning. CHAs are inspired by their Christian foundation, faith and commitment.
to get involved in compassionate services and their mission outreach to the underserved areas and vulnerable groups following the example of Christ. The roles of CHAs in health are to offer:

- Integrated Primary Health Care (PHC) services.
- HIV prevention, care and treatment programmes.
- Health education and training for health promotion and disease prevention, including training of Community Health Workers.
- Dependability in Drug Supply systems - e.g. MEDS, JMS, CHANI-Medi-Pharm, CHAZ, MENS and CHAM - for procurement, warehousing and distribution of Essential Medicines and other health commodities.
- Extensive reach of CHA services to remote underserviced areas.
- Contribution to the body of knowledge through M&E and research.

The challenges they encounter comprise of financial sustainability, limited recognition by the government and international development agencies in some countries, the global economic crisis, limited documentation of their work, demands by regulatory authorities which have no consideration for the inequities in resource distribution and a limited technical capacity to compete for international funding opportunities.

F. FBO– Private sector partnership: the case of MEDS and J&J
Dr Jane Masiga made the last presentation of the day with a case study that showed how the partnership between Johnson & Johnson and MEDS had helped to support HIV and AIDS initiatives in Kenya since 1997 to ensure medicines supplied meet the acceptable quality, obtained WHO pre-qualification so that it can play a bigger role in the country and the region. Johnson & Johnson offered support for MEDS to achieve this status in the form of grants to strengthen the laboratory service and equipment.

As the way forward, EPN members were encouraged to participate in Church - Private Sector Partnerships which are beneficial to enhance their work. However, there is a need to evaluate the partnerships regularly, so as to ensure the facility’s mission is not compromised.

3. Conclusions
Overall, the forum’s attendees came away with a sense that the two day forum provided them with an immeasurable learning experience and access to information and resources that would help them do their jobs more efficiently and effectively.

The EPN Chair, Albert Petersen, thanked all the participants for their attendance and the Secretariat for organizing a quite successful forum. This showed that the network is growing and very much alive in its effort to accomplish its goals. He encouraged the members to communicate with the Secretariat to channel any requests they had.

He also said there is still much to be done, especially in establishing more and stronger partnerships among the members and finding more donors.

The forum ended on Friday 19th March, at 5:45 pm with a word of prayer from Gladys Mburu of MEDS, Kenya.

“The network is growing and very much alive in its effort to accomplish its goals.”
Annex A. Forum Evaluation

Feedback was received from 29 participants who were asked to answer two questions: What did you like about the forum, what could have been done better? The responses received could be grouped under 6 main themes: organization of the forum, participants, topics presented, opportunities for learning and sharing, provision of practical tips and ideas and other.

1. Organization of the forum

While many participants described the forum as well organized, the following suggestions for improvement, especially with regards to networking and interaction, were made:
- “Have more time for members to share what they are doing, this will facilitate learning from each other”
- “More sharing of members on their experiences and success stories”
- “There was no time for networking, except for break time”
- “Each organization represented should have given a short presentation”
- “Sharing/exploring partnerships”
- “More group discussions”
- “More time/occasions for breakout sessions”
- “More group discussions would encourage interactions by members so we get to know each other”
- “Time management, more time for discussions”
- “Time management by some presenters”
- “Better time management to stick to the programme”
- “Time allocation to presentations, some too long, others too short”
- “The programme was not finalized”
- “Over-packed programme”

2. The participants

With regards to the participants who attended the forum, the only suggestion for improvement that was made was to invite church leaders from across the country. Positive comments were:
- “Great people”
- “Reconnecting with old friends”
- “Meeting several new people who attended for the first time”
- “People I met from a wide variety of backgrounds”
- “A friendly team of participants”
- “The mix of French and English speaking participants”
- “The fact that many participants were brought together, including other organizations to share what they do. This allowed us to know they exist and how they can benefit us”

3. Topics presented

On the subject of the topics that were presented during the forum, several opinions were heard:

What did you like?
- Information/topics chosen for the forum such as:
  - Overview of HSS WHO perspective
  - Building sustainable pharmaceutical systems
  - EPN mapping studies
  - Innovation and technologies for sustainable strengthening of systems
  - The role of the pharmaceutical industry
  - Strengthening non profit systems
  - EPN Strategic plan 2010-2015
  - Presentations showing improvement impact of involvement in EPN forums workshops
  - EPN website
  - Children’s medicines project which is one of the greatest tasks that EPN and its partners should work hard on”
  - “The rich experience from partners like the journey of CAR, CHAZ, CHS and government MoUs like in Zambia and Kenya”
  - “The selection of the topics that were discussed were very relevant to our institutions”
  - “The scope of presenters/institutions was very comprehensive i.e. WHO, WB, DSO, Government”
  - “Presentations from different institutions with interesting information”
  - “Interesting discussions”
  - “We have heard much from Kenyan experts and good practice”
  - “The presentations were clear and concise”
  - “Clarity of message”
  - “The knowledge I gained from the various topics”
  - “Invited guests/speakers were very resourceful”
  - “Diversity of enriching speakers”
  - “The wide range of information on EPN work”
  - “Broad range of presentations all linked to HSS - well presented”
  - “The contents of the different topics shared”
  - “Information was well portrayed by the presenters”

What could have been done better?
- “More details provided about the EPN strategic plan”
- “Presentation needs to be clear”
- “Materials for presentation need to be clear and formatted professionally”
- “Make presentations available to all participants after the forum”
- “Provision of sheets (handouts) on what had been presented and discussed”
- “Too many one way presentations; need more time to react and interact on subjects”
- “More case studies as happened in the session on PPP”
- “More information on technologies and innovations for strengthening pharmaceutical systems”
4. Opportunities for learning and networking
While one participant wished that a concrete idea for further work together had been established, other participants were positive:

- “Networking and sharing information across the membership”
- “Opportunity to Network and know various people”
- “Meeting members and getting to know each other”
- “Learning, sharing experiences, case studies”
- “Learning what people have done over the past two years”
- “Learning of new experiences and what is happening in other countries”
- “Learning from organizations which have been able to put Catholics and Protestants together in one association”
- “Platform for like minded FBOs to reach out to the needy”
- “Learning success stories/lessons for success”
- “What I liked was the true networking of the forum. This has come out so strongly as we were sharing from the presentations by most members of the forum on what they are doing and what has helped them be where they are. This is indeed good as we know who to contact at every level of strengthening pharmaceutical service delivery”
- “Success to bring network together to share and learn”
- “Deeper and better understanding of EPN work”

5. Provision of practical tips and ideas
The following positive comments were heard from participants:

- “The innovative idea to develop HIV and AIDS treatment literacy guide”
- “HIV and AIDS TL manual is a good guide”
- “The presentation of practical documents like the treatment literacy guide”
- “Information sharing from case studies and i+ solutions are more relevant”
- “Gotten information which will help my organization and for JMS the information obtained is going to impact on planning for next year’s activities”
- “Info was very helpful for us and will certainly inform decision making at local institutions”

6. Other comments
Finally, on various issues, the following opinions were expressed:

What did you like?

- “Translation”
- “Genuine desire to improve the health care provision to those in resource limited settings”
- “It was enlightening to know of the role the FBO facilities have played and are planning in offering community health service”
- “Asking members to support their own transport was a very good test to show who is committed and wants EPN to go forward”
- “Everything was done excellently well, keep it up, EPN, for the good work”

What could have been done better?

- “Action plans for capacity building within DSOs or way forward related to HR training”
- “Accommodation at the same venue of the workshop”
- “The vegetarian guest house”
- “At end of meeting questionnaire to take home and return the next morning”
- “Allowing a bit of time to see the environment especially for those coming from outside Kenya”
ANNEX B. GROUP DISCUSSION RESULTS

1. What do churches and church institutions at policy making level need to do to:
   • Build pharmaceutical systems
     - Understand the concept of pharmaceutical systems.
     - Master drug policy and health system of countries.
     - Establish a means of lobbying and advocacy (this can act as an association which speaks with one voice).
     - Establish a Memorandum of Understanding/Agreement with the government/state.
   • Strengthen existing pharmaceutical systems
     - Assess existing resources.
     - Establish associations.
     - Build the capacity of staff.
     - Establish an effective management mechanism for the sustainability of resources.

2. Which successful models for government support for church health and pharmaceutical systems are available?
   • Grant the governments in the fields of health and pharmacy after submitting a budget by the churches (Ghana).
   • Grant staff salaries (Chad).
   • Exemption of drugs charges (Rwanda).
   • Subsidies materials (Rwanda).
   • Grant as drugs (Chad).

Which aspects could be promoted for adoption by others?
   • Grant the governments in the areas of health and medicine after a budget presentation by the churches.
   • Grant staff salary.
   • Exemption of drugs charges.
   • Subsidies material.
   • Grant as drugs.

3. Can church health institutions be sustainable while ensuring access to medicines by poorer people in our societies?
   • Moving away from one time donations, i.e. engaging the private sector to support some initiatives (Friends of Kijabe Hospital-Kenya).

4. How should church health and pharmaceutical systems engage with the pharmaceutical industry for the benefit of the ordinary people?
   • Pooling of resources.
   • Negotiating special price for the poor.
   • Consolidating and quantification in pool ordering.
   • Bulk procurement to limit number of supplies.
   • Seconding staff as part of the corporate social responsibility.
   • Sharing priority areas for commodities that are critical.

5. To what extent have church systems benefited from global initiatives for financing of medicines e.g. UNITAID, Global Fund, PEPFAR?
   • Church systems have access to drugs and also preventives.
   • Access to capacity building for malaria etc.
   • Some infrastructure development, especially for HIV and AIDS, 30 mission hospitals + 100 satellite clinics have been a huge relief in Kenya.
   • Improvement in Diagnostics in non-profit institutions has increased. There are now CD-4 machines.
   • Increased access to logistics.
   • MEDS were supported by PEPFAR greatly and this has led to the development of an ultra-modern warehouse.
- Reductions in communicable disease due to support.
- Storage of medical products has improved.
- Refresher courses have been improved and the training has improved.
- With the availability of ARVs, patients are now coming out to access the medicines.
- A lot of partnership in distribution.

**Limitations**

- Not receiving enough funding.
- Donor communities tend to support only diseases that have public health bearing, other diseases are not being supported.
- Availability of essential drugs is reducing due to the overbearing influence on communicable diseases.

**How should the churches position themselves to get greater benefit?**

- Advocacy in terms of what they need.
- To partner with government since they have the money.
- For the CCM to be recognized, the FBOs' funding can be directed to them. This can be done by signing MoUs.

**6. Which longer term perspectives do you have on the involvement of churches in health and pharmaceutical service delivery?**

- Partnership is the future.
- To learn across countries and support where we can.
- Positioning ourselves as an alternative to the government.
- Business orientation in terms of efficiency.
- Churches can go into manufacturing regionally.
- Leadership and governance to be exercised diligently.
- Strengthening our systems, in terms of accountability and not leaving issues to chance.
- The reality is that churches have to change to achieve sustainable changes, both globally and country-level.
- Churches need to improve on how they document the information of what they do.
- Improve service delivery in terms of being competitive.
- John 10:10, people must have a healthy living, it is a duty. It is a duty to serve people. Changes will come and go, but people will always need our help.

**7. How do we convince bishops that DSOs have to do business?**

- Have proper data/information with regard to what it costs to buy drugs and the benefits for introducing more sustainable ways.
- Involve the Bishops from the beginning of the process.
- Need to address their fears and give them correct information since Bishops have a reputation to protect.
- Convince the Bishops for change in mindsets, treating health care as a business.
- Separate ownership /duties.
- Capacity building.
- MEDS to help health secretariat to advise the Bishops and be Mediators.
- Speak a language that they can understand, e.g. instead of using big words such as marketing, let’s talk about growth and sustainability.
- To allow our church members who are professionals to work for us.
- To relate it to reduction of poverty. In which development can lead to increase church contribution.
- Bishop must be made to understand that business is a profession, in order to create sustainable result.
- It can be a policy issue, so they must be made to understand the business aspects.
- Case studies must be shown by providing factual evidence.
- By convincing them of the need of a service.
- The DSO must be a separate unit for it to function more effectively. However it must not lose its vision as a FBO.
- Explain to them by empowering them with the knowledge of these issues.

Archbishop Benjamin Nzimbi, retired bishop of the Anglican Church of Kenya
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Acknowledgements

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Editorial team:
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