



# **ACCESS TO MEDICINES IN CHURCH HEALTH SERVICES IN AFRICA**

**A cross-country analysis of compliance with the  
Ecumenical Pharmaceutical Network  
Guidelines  
on effective and efficient pharmaceutical services**



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### **About EPN**

The Ecumenical Pharmaceutical Network (EPN) is an independent Christian membership organization whose mission is to support churches and church health systems provide and promote just and compassionate quality pharmaceutical services. EPN has been actively involved in various ways in promoting increased access to and rational use of medicines.

### **About the EPN Guidelines**

The EPN Guidelines for Effective and Efficient Pharmaceutical Services are intended to support health facility managers, pharmaceutical personnel and all those involved in pharmaceutical service delivery to increase access to medicines and improve the quality of patient care. Development of the guidelines started in 2004. In the course of time, the list of guidelines went through several modifications to the current list of 25 which are further grouped under the six building blocks for health systems, as defined by the WHO. These 25 guidelines are currently undergoing field-testing for further refinement. Several supporting materials, such as posters and explanatory notes, are available.

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## 1 Executive summary

This report analyses compliance with the EPN guidelines for access to medicines in the church-related health services (CHSs) of Ethiopia, Ghana, Malawi, Uganda and Zambia, and includes data from Nigeria, Tanzania and Togo.<sup>1</sup> **The report covers results from 363 health facilities, representing over 20 000 beds, over 4 million outpatients and budgets totalling more than 40 million US dollars.**<sup>2</sup> More than 50 focus groups were held with church leaders and more than 50 guided self-assessment meetings were held with hospital staff. Five national feedback meetings were also held.

The self-assessment survey results for the 127 hospitals, 178 clinics and 58 health posts describe the situation in a significant group of CHSs, from which it is reasonable to extrapolate results for CHSs across Africa.<sup>3</sup> Even when, for example, most of the responses from Ghana were from the wealthier Southern areas, the poorer North of the country can be assumed to be similar to the CHSs in Ethiopia or Malawi, where conditions are similar.

It is assumed that responses came from the more active and involved facilities, and that therefore the results could be weighted towards scores higher than the true average. With over 21% of the hospitals analysed coming from Uganda, the results could have a further bias towards higher rather than lower scores which would reflect the relatively advanced development of health services in Uganda.

**It is estimated that CHSs in sub-Saharan Africa provide 40% of the available health care, rising to as much as 90% in many rural areas.** The significance of the CHSs is recognized by parts of the WHO and the World Bank, both of which make special efforts to work with the sector. However, these same organizations and a large number of other health actors in resource-poor environments do not match the size of the service provision with their commitment to the church health sector.

Unfortunately, no comparison can be made with government-run health institutions as no comparable survey has been carried out. However this study has resulted in:

- five country baseline studies: Ethiopia, Ghana, Malawi, Uganda and Zambia (chronologically: Malawi, Ethiopia, Ghana, Zambia and Uganda);<sup>4</sup>
- partial country baselines for Nigeria, Tanzania and Togo;
- a situation analysis for church-related health services across Africa.<sup>5</sup>

**For the first time, it has been possible to involve Christian health associations (CHAs), drug supply organizations (DSOs), church leaders and CHS staff in the process of identifying priorities for interventions as well as possible approaches to address these priority issues.**

It is now also possible to describe some aspects of the Christian health services in Africa, such as to:

- assess levels of access to essential medicines through CHSs;
- identify the most prevalent problems in CHSs in relation to access to essential medicines;
- measure change in the level of access to essential medicines in CHSs and whether that change relates to changes that are within the control of CHSs or not.

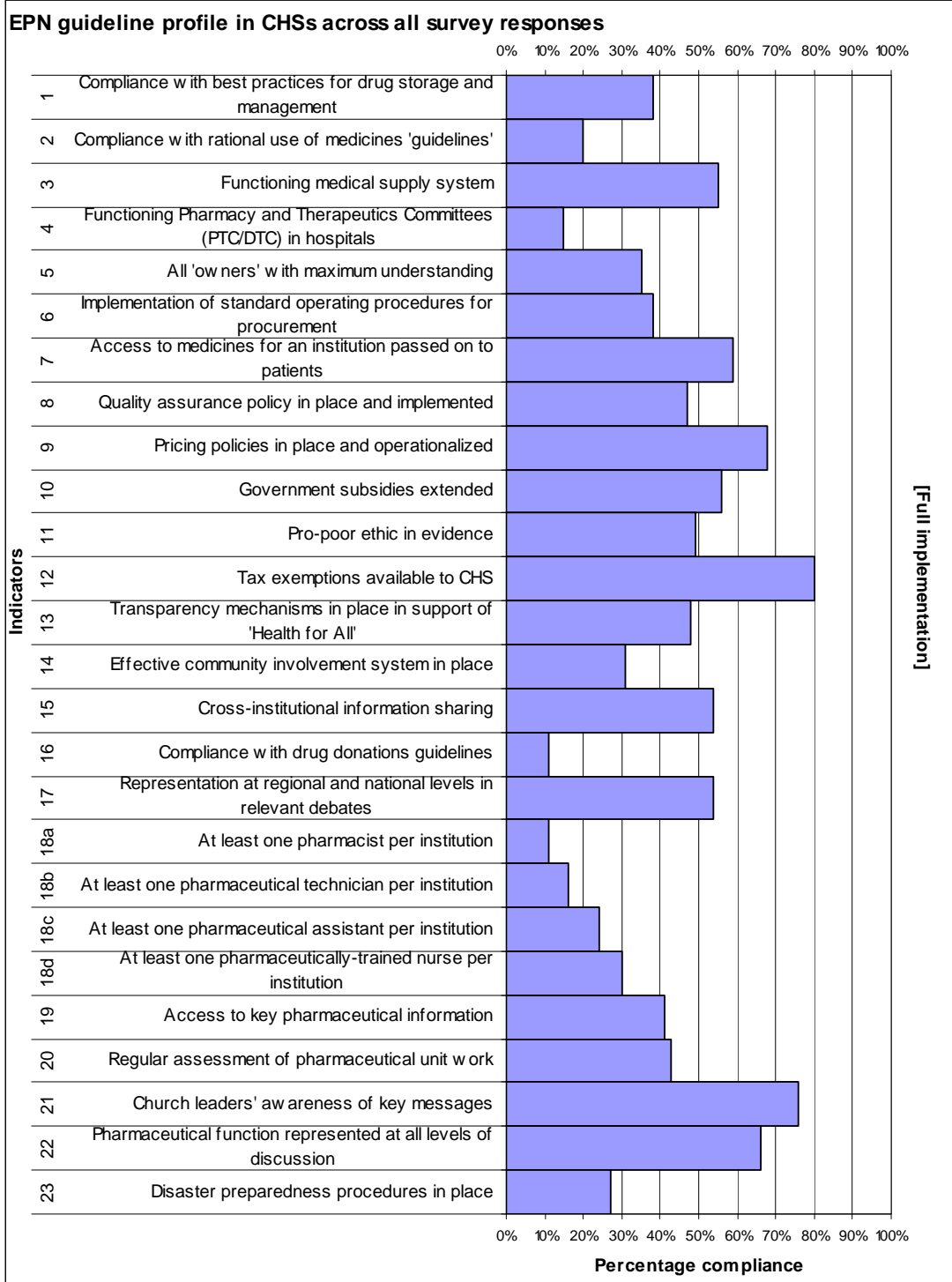
<sup>1</sup> For this study, access to medicines includes access for institutions and for patients.

<sup>2</sup> Dollar conversion rate at date of research (<http://www.oanda.com/currency/historical-rates>).

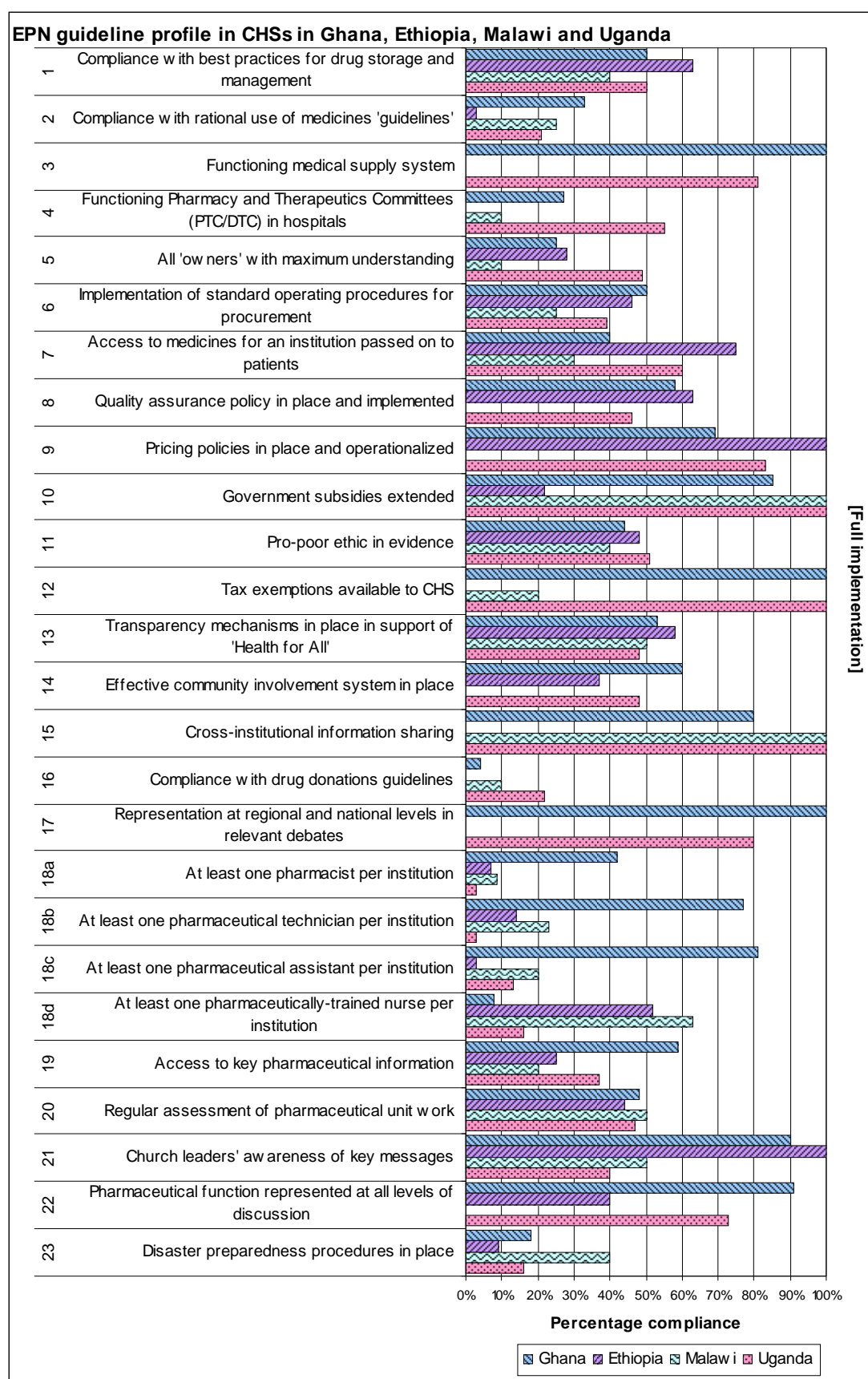
<sup>3</sup> For this study, hospitals are defined as having 50 or more beds, clinics having 1-49 beds and health posts having no beds.

<sup>4</sup> A baseline is produced from research into the level of an indicator at the starting point.

<sup>5</sup> A situation analysis is a review of the situation at a particular time – it has a broader context than a baseline.



## 1.1 Example country-specific results



## 1.2 Five key results in summary

### 1.2.1 Compliance with the rational use of medicines guideline

Overall results show a **20% compliance** with rational use of medicines guidelines. This reflects low scores for the indicators for this guideline:

- Known percentage of the essential medicines list available to the facility.
- Existing policy on the maximum number of items per prescription.
- Known average number of medicines prescribed per consultation.

Each of these indicators requires the investment of money and time to achieve. Just as institutional rational use of medicines cannot be proved without studies, the lack of financial resources to carry out studies does not necessarily prove that there is poor rational use of medicines, but it does indicate a lack of knowledge and monitoring of the environment.

Overall, **only 44% of facilities have printed rational use of medicines information** available on site.

#### Example country results: compliance with rational use of medicines guideline

Country	Score
Ghana	33%
Ethiopia	3%
Malawi	25%
Uganda	21%
Zambia	5%
<b>Overall</b>	<b>20%</b>

### 1.2.2 Compliance with the medicines storage and management guideline

**Overall compliance** with the best practices for medicines storage and management guideline is **38%**. Initially, 87% claimed compliance; however this is adjusted by taking into account scores for the following indicators:

- Checklist for storage conditions.
- SOPs for procurement of medicines.
- SOPs for issuing medicines to the pharmacy or wards.

This indicates a lack of knowledge of how best practice is achieved and monitored.

The following indicator results are also of interest here:

- 22% of facilities combine orders with others; 28% undertake individual price negotiations.
- Preferred suppliers are usually the cheapest supplier, whereas the second preferred supplier may have better product availability or delivery mechanisms.
- 69% of facilities indicate that the full range of required essential medicines is available through their suppliers.
- Only 36% of facilities have drug supply management information in the pharmacy area.



### Example country results: compliance with best practices for medicines storage and management

Country	Score
Ghana	50%
Ethiopia	63%
Malawi	40%
Uganda	50%
Zambia	43%
<b>Overall</b>	<b>38%</b>

#### 1.2.3 Compliance with the PTC/DTC in hospitals guideline

Overall, **only 15% of the hospitals that responded** to the survey did so in a way that suggests that they have a functioning Pharmacy and Therapeutics Committee (or Drug and Therapeutics Committee [PTC/DTC]). Initially, 57% of hospitals claimed to have a functioning PTC/DTC, but only a little over half of these had a terms of reference for the committee. Over two-thirds said they kept minutes of the meetings; but a third could not give the date of the last meeting.

WHO has produced a practical guide to PTCs/DTCs, but few facilities have a copy of this document or have undertaken the work described in it. The tools exist to support the introduction of PTCs/DTCs but perhaps what is lacking is the prioritization and financial commitment. Where Christian Health Associations (CHAs) have undertaken work to increase the number of PTCs/DTCs, there has been no follow-up to find out how many have become functioning nor why some of them might have failed.

#### Example country results: compliance with the PTC/DTC in hospitals guideline

Country	Score
Ghana	27%
Ethiopia	0%
Malawi	10%
Uganda	55%
Zambia	23%
<b>Overall</b>	<b>15%</b>

#### 1.2.4 Stock-outs

Each facility was asked whether it suffered stock-outs (of one or more days) of any of a list of tracer essential medicines. Stock-outs are definitely a problem and they **can be caused by a number of different factors**, from finances to poor procurement planning or poor rational use of medicines (see Table 1).

**Table 1. Average stock-outs of tracer essential medicines**

Tracer	Ghana	Nigeria	Malawi	Uganda	Tanzania	Togo	Zambia	Ethiopia	Average
Whitfield ointment (benzoic acid compound)	13%	31%	34%	49%	55%	70%	75%	64%	49%
Povidone iodine	28%	17%	31%	49%	43%	27%	62%	69%	41%
Amoxicillin	8%	7%	35%	38%	39%	33%	24%	75%	32%
Tetracycline eye ointment	19%	38%	27%	23%	45%	55%	67%	75%	44%
Quinine injection	17%	27%	21%	33%	24%	9%	35%	69%	29%
Paracetamol tablets	4%	7%	18%	36%	29%	8%	33%	58%	24%
Co-trimoxazole	4%	7%	12%	35%	31%	17%	33%	69%	26%
Oral rehydration salts (ORS)	4%	33%	21%	29%	31%	55%	43%	47%	33%
Procaine penicillin injection <sup>a</sup>	22%	30%	66%	21%	31%	36%	19%	49%	34%
Chlorpheniramine	4%	7%	34%	21%	24%	18%	52%	59%	27%
Mebendazole tablets	12%	27%	16%	18%	31%	92%	19%	58%	34%
Ferrous salts	4%	7%	35%	15%	38%	27%	5%	61%	24%
Aspirin	12%	0%	12%	16%	26%	18%	48%	64%	24%
Folic acid tablets	4%	0%	32%	13%	29%	36%	24%	63%	25%
Sulfadoxine-pyrimethamine tablets	4%	13%	3%	20%	21%	9%	35%	63%	21%

<sup>a</sup> Often not standard treatment.

### 1.2.5 Compliance with the 'at least one pharmaceutically trained person per institution' guideline

Overall, **51% of facilities claim** to have at least one pharmaceutically-trained staff member (this definition includes pharmacists, pharmaceutical technicians, pharmaceutical assistants and pharmaceutically-trained nurses<sup>6</sup>). Of all pharmaceutically-trained staff, just under half are pharmaceutically-trained nurses.

The availability of a pharmaceutically trained person in an institution without a supporting environment in which to deliver the service may not achieve the expected results. As such the results of compliance with two other closely related guidelines are also presented.

Overall, 64% of facilities said they have access to standard treatment guidelines and 66% of respondents said they have access to the essential medicines list in the facility. However, only 29% have access to international medicines pricing indicators or a list of new or obsolete medicines.

Overall, 43% of facilities have a regular assessment of pharmaceutical work.

#### Example country results: compliance with the 'at least one pharmaceutically trained person per institution' guideline

Country	Score
Ghana	96%
Ethiopia	53%
Malawi	86%
Uganda	24%
Zambia	90%
<b>Overall</b>	<b>51%</b>

<sup>6</sup> Each country and possibly CHS may have a different definition of a pharmaceutically trained nurse. For the purposes of this document it refers to a nurse who has received training in some aspects of pharmaceutical service provision.

### 1.3 Overall conclusions on potential interventions from feedback meetings



- There needs to be greater emphasis on the need to **coordinate and integrate interventions**.
- When **prioritizing interventions**, each country prioritized differently, so there is no single intervention that fits all countries. However, where there were similar priorities, a common approach might be valuable.
- There are indications that interventions to increase fundraising capacities, institutional management capacities, non-salary-based staff incentives and to provide a representational voice in dealings with governments would **support the CHSs in general** and therefore improve access to medicines. While these interventions are not directly related to the EPN guidelines, they were raised repeatedly during the study.
- There is evidence that introducing **drug supply systems** (where they are absent) that serve the CHSs and strong, vibrant CHAs are particularly important. Additional support could improve the rational use of medicines, PTCs/DTCs in hospitals and medicines storage and management and would be welcomed in all countries.
- Some aspects of CHSs are influenced by the government; some by the nature of the individual facility; and some by the fact of being church-owned. This **diversity of influences** needs to be reflected in interventions.
- There is need to develop approaches to interventions that are more **financially effective and efficient**, and include monitoring, evaluation and lesson dissemination.

## 2 Acronyms, abbreviations and glossary

Acronym or term	Definition
CHA	Christian Health Association
CHS	Church-related (or church) health service: this can be used to describe all the medical facilities that are run by a particular religious denomination, or one single medical facility that is run by a religious denomination.
INGO	International NGO: see NGO
NGO	Non-governmental organization
DSO	Drug supply organization: a wholesale medicines supplier
DTC	Drug and therapeutics committee: see PTC
EPN	Ecumenical Pharmaceutical Network
FDSO	Faith-based DSO: see DSO
Pharmaceutically trained nurse	For the purposes of this document, it refers to a nurse who has received training in some aspects of pharmaceutical service provision. (Each country and each CHS may have a different definition of a pharmaceutically trained nurse).
PTC	Pharmacy and therapeutics committee: a committee designated to ensure the safe and effective use of medicines in the medical facility or area under its jurisdiction.
SOPs	Standard operating procedures
WHO	World Health Organization

### 3 Study methodology

A full manual describing the process for completing the study is available as a separate document.<sup>7</sup> The development, testing and production of the manual was an output of the original project and provides the basis for further comparable studies in the future.

The first phase of the EPN Guidelines project generated the baseline for each EPN 'guideline' and fed this information back to an in-country group who decided which of the EPN guidelines should be prioritized and what further work should be undertaken.

**Tool 1.** Church-related health service self-assessment survey, which received 363 responses.

**Tool 2.** Faith-based drug supply organization survey.

**Tool 3.** Guided desk review. A structured questionnaire was used to collect information at the national level.

**Tool 4.** Guided self-assessment workshops in hospitals. Two trained researchers facilitated a workshop for up to 15 hospital staff members, at up to 10 hospitals in each country. Participants used trend analysis (using spider diagrams), force field analysis and problem tree analysis to examine a number of EPN guideline issues.

**Tool 5.** Focus groups. Two trained researchers facilitated focus group discussions for groups of community leaders, including church and local leaders, at up to 10 locations served by a hospital in each country.

#### 3.1 Summary of initial steps

The first phase of the study was focused on establishing **mechanisms to measure access** to essential medicines in CHSs.

The development of a set of 23 guidelines, with indicators for determining the level of compliance, was a key element of this phase, underpinning the development of the self-assessment surveys.

The second phase of the work focused on in-country **feedback meetings** that aimed to build on:

- the ideas of those closest to the issues, to develop interventions that benefit from economies of scale;
- the development of contacts and capacities to work together among church leaders and CHS staff.

<sup>7</sup> EPN, *Manual for the EPN access to essential medicines study*. Those interested can contact the EPN Secretariat.

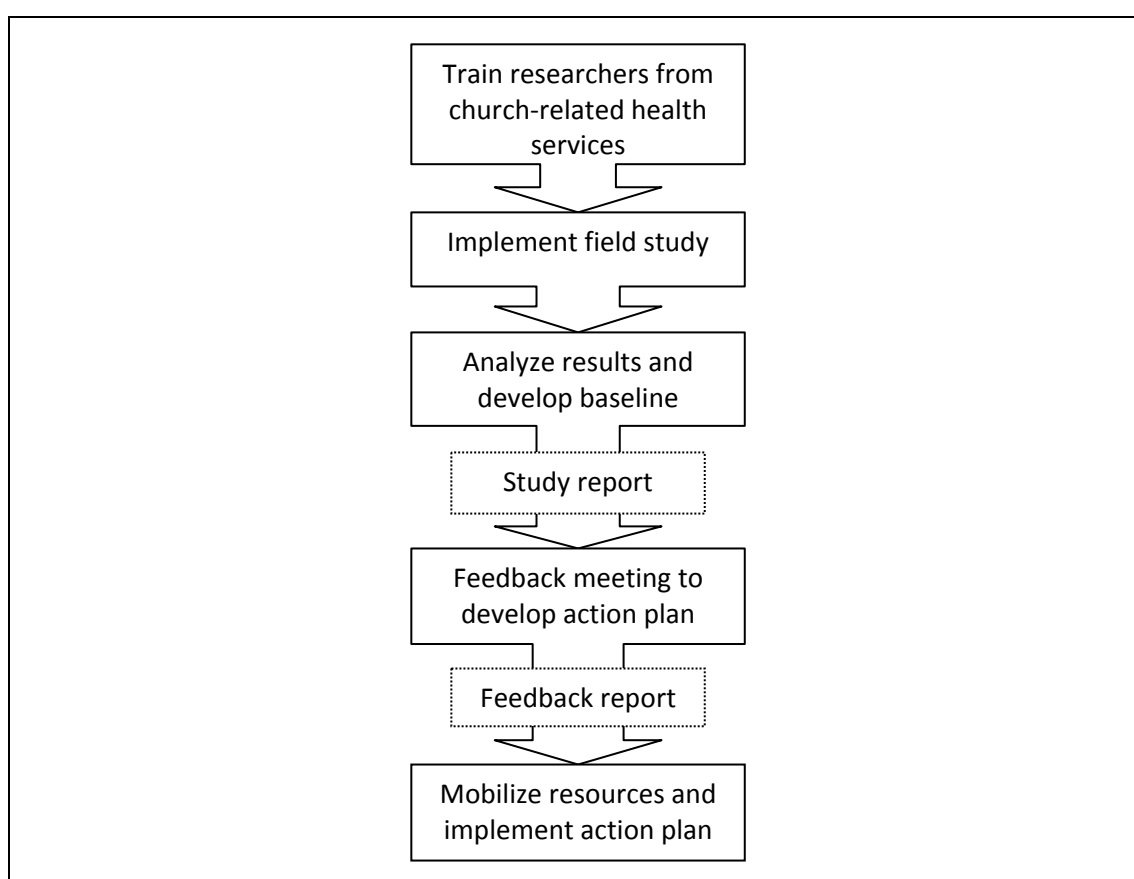
### 3.2 In-country methodology

The primary focus of the in-country methodology was the development of a baseline for future work. This baseline study is specifically designed to enable comparison over repeated studies. Through undertaking the baseline study in eight countries, a lot has been learnt about how to improve the efficiency of the process.<sup>8</sup>

The **baseline survey** was prioritized over a situation analysis approach (often a first step and one that does not involve specific indicators) because the programme had already identified indicators. The baseline survey therefore provides the required **starting point information** to enable the development of country-specific design and management processes for maximizing access to essential medicines.

This report presents a cross-country analysis of the results of the baseline study and the feedback meetings carried out in five countries (with additional data from three further countries). Figure 1 summarizes the in-country process. Section 3.3 details how individual country results were drawn together to produce a Cross-country analysis.

**Figure 1. In-country project process**



<sup>8</sup> These lessons have been used to revise the *Manual for the EPN access to essential medicines study*.

### 3.2.1 Response rates, by country

Five countries form the core of the results in this document, with data from a further three being included where possible.<sup>9</sup>

**Table 2. Response rates for the self-assessment survey with facility information**

Country	Surveys	Hospitals	Clinics	Health posts	Beds	Outpatients
Ethiopia	36	3	21	12	407	430,000
Ghana	26	21	5		2,545	694,500
Malawi	35	20	11	4	3,026	396,493
Uganda	174	27	112	35	5,700	1,325,000
Zambia	21	16	5		1,976	258,400
<i>Nigeria</i>	16	12	3	1	1,012	35,071
<i>Tanzania</i>	43	26	14	3	4,559	793,383
<i>Togo</i>	12	2	7	3	349	80,256
<b>Totals</b>	<b>363</b>	<b>127</b>	<b>178</b>	<b>58</b>	<b>19,574</b>	<b>4,013,103</b>

**Table 3. Response rates for other tools**

Country	Year of study	DSO surveys	Desk review	Self-assessment workshops	Focus groups	Feedback meeting
Ethiopia	2008	1	1	9	8	1 in 2008
Ghana	2005	1	1	9	9	1 in 2006
Malawi	2005	0	1	10	10	1 in 2006
Uganda	2006	1	1	10	10	1 in 2006
Zambia	2008	0	1	9	8	1 in 2008
<i>Nigeria</i>	2008	1	1	8	7 <sup>a</sup>	1 in 2009 <sup>b</sup>
<i>Tanzania</i>	2005	2	1	9	8	(not held)
<i>Togo</i>	2006	0	1	3	7 <sup>a</sup>	1 in 2007 <sup>b</sup>
<b>Totals</b>		<b>6</b>	<b>8</b>	<b>67</b>	<b>67</b>	<b>5</b>

<sup>a</sup> The notes from these meetings were not in the study format and are not used in the analysis for this report.

<sup>b</sup> These feedback meetings were not held in the study format and are not included in the analysis for this report.

Various issues affected the results from the three countries.

In **Tanzania**, 43 facilities responded to the survey (26 hospitals, 14 clinics and 3 health posts). However, the methodology used in the guided self-assessment workshops differed significantly from the other countries, and there was no completed desk review and no feedback meeting.

In **Togo**, 12 facilities responded (2 hospitals, 7 clinics and 3 health posts), reflecting the smaller size of the church health sector in the country. Due to a combination of survey staff turnover, a political crisis in country, translation into and out of French, and lack of prioritization by organizations, the baseline activities and feedback meeting were either not completed or resulted in non-comparable results due to the methodologies used.

In **Nigeria**, a total of 16 institutions responded (12 hospitals, 3 clinics and 1 health post). This is a very small sample given the total number of CHSs in the country.

<sup>9</sup> In Cameroon, efforts were made to undertake the study, but financial and staffing problems meant that the work was not completed.

During the feedback meeting in each country, participants were asked if the results for the guidelines appeared to be accurate as a picture of the situation among CHSs. In all countries except Nigeria, the results were felt to give a reasonably accurate picture. The participants felt that problems included the low response rate and the exclusion of some CHSs, such as those belonging to the Orthodox Church. Of the 23 guidelines, 15 were felt to give an accurate country-wide picture and eight were felt to be either too high (five) or too low (three).

### 3.2.2 Lessons learnt for the in-country methodology

Seven issues emerged relating to the methodology of the study.

1. The need for **cross-checking questions** in the survey design. Straightforward questions such as 'do you implement rational use of medicines guidelines?' often provoked a positive response (taken literally, what 'rational' health professional would say no?) However, on further examination of responses to additional questions in the survey, it became clear that the true answer was actually 'no'.
2. The problem of **who answers** the survey. Despite a request for the survey to be completed during a management committee meeting or to have the most senior staff member complete it, this often did not happen – as indicated by the high number of 'don't knows' or incomplete responses.
3. **Physical visits** get the best results. The facilities responded very positively to the visits by the survey teams (despite some organizational problems). The workshop and focus group participants were all excited about being asked to be involved and the way they were involved. There was also a stronger learning result from the visit than from the survey.
4. When **translating** into French, it is important to verify the translation against the original survey questions to ensure that the cross-check questions still work. (The translation may result in identical questions, instead of using different wording, and invalidate the cross-check aspect).
5. In some cases, a significant **period of time** passed between the completion of a certain activity and another. This reduces the validity of results as well as interest in the result. It is important to chase up survey returns in order to improve the response rate, to have a more representative sample of responses and to complete tasks as described in the manual.
6. This type of exercise costs **money** and trying to do it cheaply inevitably leads to problems.
7. **Staff turnover** for trained data collectors, facilitators and organizers reduces the speed, efficiency and effectiveness of in-country activities. Early commitment and momentum can reduce this issue.
8. **The need for verification.** Often respondents will report that a tool or document exists but are unable to produce it. Even with self administered questionnaires it is possible to include follow-on questions that will lend further proof to the existence of tools such as SOPs than a simple yes or no by the respondent.





### 3.3 Cross-country methodology

The responses to the self-assessment surveys from each country were entered into an Epi Info™ database and analysed using the Epi Info statistical analysis tools. This was done for each individual country<sup>10</sup> initially during the study and then repeated with the full set of data from all the countries for this cross-country analysis.

In order to calculate scores for compliance with certain guidelines at cross-country level, the following mechanism was applied to the full data set (Tables 4 and 5).

**Table 4. Analysis methods for guidelines (cross-country version)**

Analysis method	Description
A <sup>11</sup>	Find the percentage of all respondents that answered the question. If there is a supplementary 'is it implemented' type question, then use the percentage of respondents that answered 'yes' to both questions.
B	Take the lowest percentage score from the range of questions given.
C	Find the percentage of respondents that gave positive answers to <i>all</i> the questions in the range given.
D	Make a judgement based on the textual data given.
E	Find the average percentage score from the range of questions given.
F	Take the highest percentage score from the range of questions given.
G	Find the average country score, taking into account missing scores.

**Table 5. EPN guidelines and data sources**

Guideline	Data source [SAS = Self-assessment survey]	Analysis method
1. Compliance with best practices for medicines storage and management	SAS Q 2.3, 2.9–2.11	B
2. Compliance with rational use of medicines guidelines	SAS Qs 3, 6.5	B
3. Functioning medical supply system	DSO surveys – all questions SAS Q 4	G
4. Functioning Pharmacy (or Drug) and Therapeutics Committees (PTC/DTC) in hospitals	SAS Q 5	C
5. All 'owners' with maximum understanding or roles, best practice, and management information	Focus group discussions SAS Q 7.5	G
6. Implementation of standard operating procedures for procurement	SAS Q 2.9	A
7. Improvement in access to essential medicines for an institution, passed on to patients	SAS Q 6.12.1	A
8. Quality assurance policy in place and implemented	SAS Qs 2.10–2.11	B
9. Pricing policies in place and operationalized	SAS Q 6.10	D[1]
10. Government subsidies extended	Guided desk review Q 6 SAS Qs 6.14–6.15	G
11. Pro-poor ethic in evidence	SAS Q 6.1–6.4	E

<sup>10</sup> During the feedback meeting in each country, participants were asked whether the results for the guidelines gave an accurate picture of the situation among CHSs. In all countries except Nigeria, the results were felt to give an accurate picture.

<sup>11</sup> A limitation of the studies with this analysis method is that for some questions the conclusion is based on the responses to a single questions which may not reflect the actual situation.

<b>Guideline</b>	<b>Data source</b> [SAS = Self-assessment survey]	<b>Analysis method</b>
12. Tax exemptions available to CHSs	Guided desk review Q 8	G
13. Transparency mechanisms in place in support of 'Health for All'	SAS Qs 7.1–7.3	E
14. Effective community involvement system in place	Focus group discussions SAS Q 7.4	G
15. Cross-institutional information sharing	Guided desk review Q 3	A
16. Compliance with medicines donations guidelines	SAS Qs 4.7–4.11	C
17. Mechanism in place to allow for representation at regional and national levels in relevant debates	Guided desk review Q 5	G
18. At least one pharmaceutically trained person per institution	SAS Q 8.2	A
19. Access to key pharmaceutical information	SAS Qs 8.4–8.5	E
20. Regular assessment of pharmaceutical unit work	SAS Q 8.6	A
21. Church leaders' awareness of key messages	Focus groups	G[2]
22. Pharmaceutical function represented at all levels of discussion	Guided desk review Q 8 SAS Q 8.7	G
23. Disaster preparedness procedures in place (e.g. for earthquake, flood, influx of refugees, conflict)	SAS Q 7.6	A

[1] Make a judgement as to what percentage of respondents demonstrate a pricing policy. For example, a fixed mark up, such as 15%, is a policy, but 'discussion or consultation with others' does not constitute a policy.

[2] A 'message' in this case reflects an awareness of the hospital, its benefits and its challenges. If the group states a position that, for example, 'there is no nepotism', then they are aware of the possibility of nepotism.

## 4 Results for the EPN guidelines across all countries



The compliance scores for each of the EPN guidelines are listed below, in 'guideline' order.

Respondents to the self-assessment survey did not answer all questions in every returned survey. The percentage values in this report are based on the number of facilities that responded to the particular question.

### 4.1 Compliance with best practices for medicines storage and management

#### Guideline score: 38%

Of the facilities that answered this question, 87% (302 out of 346 facilities) answered 'yes', but this value is not consistent with answers to further verification questions, based on selected indicators. The result is the much lower figure of 38%.

- 67% (219 out of 325 facilities that answered the question) indicated that there is a checklist for good storage conditions for medicines, and 85% (186 of 219) of this group said that this checklist is actually in use, putting the use of a checklist at 57%.
- 55% (184 of 332) have written SOPs for procurement, and 68% (125 of 184) of this group actually implement them fully. This puts the use of SOPs for procurement at 38%.
- 62% (207 of 332) have written SOPs for issuing of medicines to pharmacies or wards, with 77% (160 of 207) of these facilities indicating that they are fully implemented, putting the use of SOPs at 48%.



Facilities were asked how often stock-taking reports on medicines are compiled (271 facilities answered the question):

Stocktaking frequency	Percentage
More frequent than once a month	31%
Once a month	38%
Less frequent than once a month	31%

Of the sample list of essential medicines provided in the survey, facilities experienced stock-outs of the following items most commonly<sup>12</sup>:

Do you ever run out of any of the following essential medicines?	Yes
Whitfield ointment (benzoic acid compound)	49%
Povidone iodine	45%
Amoxicillin	37%
Tetracycline eye ointment	35%
Co-trimoxazole	31%
Quinine injection	31%
Paracetamol tablets	31%
Oral rehydration salts (ORS)	30%
Procaine penicillin injection (often not standard treatment)	29%
Chlorpheniramine	26%
Aspirin	23%
Ferrous salts	23%
Mebendazole tablets	23%
Folic acid tablets	22%
Sulfadoxine-pyrimethamine tablets	21%

Does your clinic ever run out of any of the following supplies?	Percentage
Syringe disposable with needle 10cc	40%
Bandage crepe	40%
Gloves examination latex non-sterile disposable	39%
Syringe disposable with needle 5cc	36%
Tape plastic adhesive microperforated	36%
Gauze absorbent	33%

Does your hospital ever run out of any of the following supplies?	Percentage
Surgical sutures	42%
I.V. cannula 20G	37%
Urine collection bag for adults 2000cc	37%
Gloves surgical latex rubber sterile	33%
I.V. giving set	21%

<sup>12</sup> Because of the need to make this survey as simple and as widely comparable as possible, specific formulations, strengths, etc. were not used. The term "run out of" was used so that, in the perception of whoever was completing the form, the concept of "not being available for use" would be standard. World Health Organization staff and the EPN steering group also advised that including formulations and strengths could cause confusion, especially as dosages can be made up from a variety of strengths (take one tablet three times a day or take two tablets three times a day). What was required from these questions was a broad statement of availability of a medicine, so each one was only named. The non-availability of a medicine for any period is deemed unacceptable and is therefore a stock-out.

## 4.2 Compliance with rational use of medicines ‘guidelines’

### Guideline score: 20%

Of the facilities that answered this question, 86% (288 out of 333 facilities) answered ‘yes’, but this value is not consistent with answers to further verification questions, based on selected indicators. The result is the much lower figure of 20%.

- Only 23% (79 of 338) have ever carried out a study of the percentage of medicines prescribed in their facility that are on the Essential Medicines List.
- Only 20% of facilities (64 of 327 that answered the question) have carried out a study of the percentage of the Essential Medicines List that their facility has access to. The average reported percentage is 73% of the Essential Medicines List.
- Only 29% (93 of 322) have carried out a study of the average number of medicines prescribed per consultation.
- Only 27% (84 of 308) have a rule for the maximum number of items per prescription.



## 4.3 Functioning medical supply system

### Guideline score: 55%



- Facilities experienced stock-outs of a number of essential medicines, see 4.1.
- Only 23% of facilities (78 of the 345 that answered the question) join together to order medicines in bulk in order to reduce costs.
- 28% of facilities (94 out of 330) undertake their own price negotiations with producers or importers.
- The table below shows how respondents graded their suppliers according to three criteria. ‘Cost’ was graded highest for the ‘most important supplier’, suggesting this was the most important factor in selecting a primary supplier. For the secondary supplier, ‘availability of medicines’ was the most important factor.

Supplier characteristic (score out of 10)	Most important supplier	Second most important supplier
Cost	7.3	6.4
Availability of medicines	7.1	7.3
Delivery	6.3	6.3

- 69% (234 out of 338) believe that the full range of essential medicines is available to them.

#### 4.4 Functioning Pharmacy and Therapeutics Committees (PTC/DTC) in hospitals

**Guideline score: 15%** of hospitals (facilities with more than 49 beds)

Of the responding facilities, 126 were hospitals.

- 57% of hospitals (69 of the 121 facilities that answered the question) said they have a PTC/DTC.
- 80% of these (55 of 69) meet at least every three months.
- 84% of these (58 of 69) keep minutes.
- 57% of these (39 of 69) have a written terms of reference.
- 70% of these (48 of 69) have adapted the essential medicines list to fit local needs.
- Overall, only 15% of hospitals (18 of 121) were able to answer all questions to satisfy having a functioning PTC/DTC.



#### 4.5 All 'owners' have maximum understanding of roles, best practice, and management information

**Guideline score: 35%**



- 78% (255 of the 329 facilities that answered the question) have a Board or Committee, made up of individuals other than staff, who have overall responsibility for the running of the facility. They meet, on average, every 3 to 6 months, and members come from the synod, church, public sector, community services and business.
- 33% (85 of 255) of the Boards or Committees have received training in the last five years.
- 48% (122 of 255) of facilities with a Board or Committee were able to describe the information given to the Board, including annual and quarterly reports on activities and finances.
- 88% (285 of the 325 facilities that answered the question) have an annual planning process that identifies such things as budgets, shortfalls, targets or plans for growth or improvement.
- 45% (143 of 318) stated that they know what a revolving drug fund is (22% 'partially'), with 35% (104 of 296) actually using a revolving fund in their facility.
- 58% (126 out of 218 facilities that answered the question) thought that their facility could survive with current levels of funding for at least two years.

#### 4.6 Implementation of standard operating procedures for procurement

##### Guideline score: 38%

- 55% (184 of 332) have written SOPs for procurement, and 68% (125 of 170) of this group actually implement them fully. This puts the use of SOPs for procurement at 38%.



#### 4.7 Improvement in access to medicines for a facility, passed on to patients

##### Guideline score: 59%

- 59% (178 of 303) answered that they would reduce the price charged for a medicine if the cost was reduced.



#### 4.8 Quality assurance policy in place and implemented

##### Guideline score: 47%

- 67% (223 of 334) have written SOPs for receiving delivery of medicines, with 71% (158 of 223) of these indicating that they are fully implemented (23% said only partially implemented), putting the use of SOPs for receiving medicines at 47%.
- 62% (207 of 332) have written SOPs for issuing of medicines to pharmacies or wards, with 77% (160 of 207) of these facilities indicating that they are implemented, putting the use of SOPs issuing medicines at 48%.





## 4.9 Pricing policies in place and operationalized

Guideline score: 68%

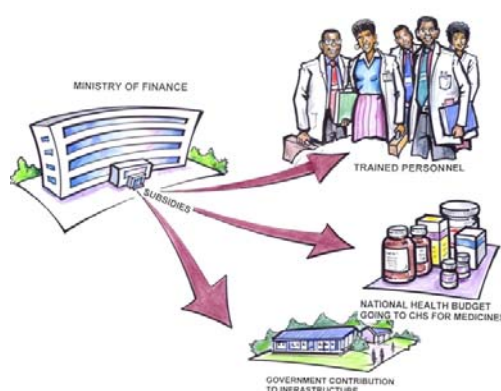


- 72% (263 out of 363) indicated that a pricing policy was in place for medicines and was able to give the percentage margin applied.
- 64% (233 out of 363) indicated that consultations were charged on a fixed price basis (95% of the total) or calculated based on the time and services required.

## 4.10 Government subsidies extended

Guideline score: 56%

- 68% (153 out of 226 facilities that answered the question) indicated that part of the overall salary costs for their facility was paid by the government, ranging from 0.1% to 100%, with an average result of 37%.
- 50% (149 out of 301) indicated that the government subsidized some of the medicines they provide.



## 4.11 Pro-poor ethic in evidence

Guideline score: 49%



- 45% (143 of 318) stated that they know what a revolving drug fund is (22% 'partially'), with 35% (104 of 296) actually using a revolving fund in their facility.
- 90% (290 out of 319 facilities) of facilities indicated that they provide free or subsidized medicines and treatment to the poorest. 90% (259 of 290) of this group

were able to describe how their facilities achieved this. This gives an overall result of 80%.

- 298 facilities responded to the question "What percentage of people seeking health treatment at your facility in the end cannot pay?", with an average result of 18% of people not being able to pay for treatment.
- Since the country studies were carried out, the construction of this guideline indicator has been revised. It is now based only on questions 6.3 and 6.4 from the self-assessment survey and the guideline scores for the countries have been recalculated (see table below).



Score	Ethiopia	Ghana	Malawi	Nigeria	Tanzania	Togo	Uganda	Zambia
Revised	48%	44%	40%	41%	49%	58%	51%	44%
Previous	64%	73%	70%	67%	53%	92%	60%	100%

#### 4.12 Tax exemptions available to CHSs

**Guideline score: 80%**

Only four of the eight countries in the study responded to this question, with three wealthier countries (Ghana, Uganda, Zambia) scoring 100%, while Malawi scored only 20% due to a lack of awareness of the availability of tax exemptions.



#### 4.13 Transparency mechanisms in place in support of 'Health for All'

**Guideline score: 48%**

88% (285 of the 325 facilities that answered the question) stated they had an annual planning process.



- 68% (219 of the 324 facilities that answered the question) produce audited financial statements, but only 53% (117 of 219) of these reports include pharmacy-related activities separate from other activities. This gives an overall result of 36%.
- 94% (305 of 326) produce annual reports, and 46% (141 of 305) of these reports include pharmacy-related activities separate from other activities. This gives an overall result of 43%.
- 66% (208 of 317) have written staff recruitment policies, with 62% (129 of 208) indicating that the policy is fully implemented. This gives an overall result of 41%.
- 51% (159 of 310) have a monitoring and evaluation policy with 63% (100 of 159) of these facilities indicating that the policy is implemented. This gives an overall result of 32% (26% of respondents to the question indicated that the policy was partially implemented).

(The French translation of this question omitted the word 'sanitaire' from the phrase 'formation sanitaire', which may have led respondents to answer the question 'is there a written M&E policy for your training', rather than for 'your health facility').

#### 4.14 Effective community involvement system in place

Guideline score: 31%



- 61% (221 of the 321 facilities that answered the question) reported 'Yes', with a range of descriptions of how the community was involved, coded in the table below. However, full involvement of the community would normally be indicated by community membership of the hospital management committee – in this case, 31% (101 out of 321) of facilities have an effective community involvement system in place.

Form of involvement	Percentage of total responding 'yes'
Management committee, includes all community representation on hospital management committees	46%
Outreach, includes all forms of 'public health involvement' between the health facility and the community (such as immunization and community health training)	23%
Consultation, includes suggestion boxes, surveys, and contact with local councils and community health workers	19%
Missing	7%
Labour, includes donations of effort by the community to the health facility (such as cleaning the compound and building new wards)	5%
(Described activity did not involve the community)	1%

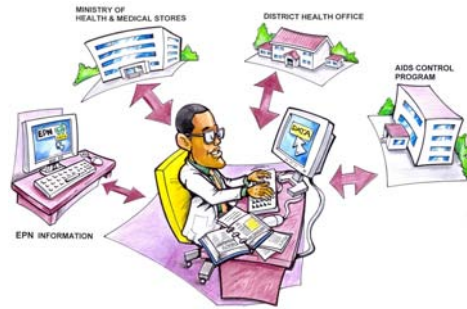
- 184 facilities answered the question "What has been the main issue raised by the community?" The most common responses are summarized in the table below.

Type of issue	Percentage of all mentions
Affordability of medicines and services	24%
Availability and quality of beds and services (additional structures or upgrading to the next level of service delivery)	20%
Other issues	14%
Transport, including ambulances and distance to facility	10%
Availability and quality of staff	9%
External to the facility, such as sanitation, water supply, income generation	7%
Outreach, such as malaria prevention, immunization	7%
Stock-outs of medicines and supplies	6%
Waiting times at the facility	5%
Attitude of staff	2%

#### 4.15 Cross-institutional information sharing

**Guideline score: 54%**

- The table below shows the results by country. For example, CHSs in Ethiopia, Nigeria and Tanzania do not share any information with their governments. At the other extreme, Malawi and Uganda share all their information with their governments.
- The guideline score of 54% is the average of the country values. However, in this case, it is probably more significant to note the 'all or nothing' results indicated by 0% or 100%.



Ethiopia	Ghana	Malawi	Nigeria	Tanzania	Togo	Uganda	Zambia
0%	80%	100%	0%	0%	50%	100%	50%

#### 4.16 Compliance with medicines donations guidelines

**Guideline score: 11%**



- 54% (158 of the 291 facilities that responded to the question) stated that they comply with medicines donation guidelines, while 80% (269 of 338) indicated that they actually accept donations.
- Only 29% (90 of 311) have a copy of national or international medicines donation guidelines.
- Of the respondents that also answered the question about the language used on donated medicines packaging, only 56% (146 of 263) indicated that there was **always** appropriate labelling.
- 11% of facilities were able to answer that they accept donations, have a copy of donation guidelines, comply with the guidelines and always receive adequately labelled medicines.

#### 4.17 Mechanism in place to allow for representation at regional and national levels in relevant debates

**Guideline score: 54%**

- The table below shows the results by country. For example, CHSs in Ethiopia, Malawi and Nigeria are not represented at regional or national levels in relevant debates. At the other extreme, Ghana and Zambia are well represented.



- The guideline score of 54% is the average of the country values. However, in this case, it is probably more significant to note the 'all or nothing' results indicated by 0% or 100%.

Ethiopia	Ghana	Malawi	Nigeria	Tanzania	Togo	Uganda	Zambia
0%	100%	0%	0%	50%	50%	80%	100%

#### 4.18 At least one pharmaceutically trained person per facility

Guideline score: 51%



- 51% (184 out of 363) of all facilities recorded pharmaceutically trained staff. The total number of staff was 613.
- 35% (128 of 363) of all facilities answered the question regarding the percentage of pharmaceutically trained staff that was trained by the government, with an average response of 20%. (58% [74 of 128] of these responses were scores of zero).

How many pharmaceutically trained personnel work in your facility?	Pharmacist	Pharm. tech	Pharm. asst	Pharm. trained nurse	Overall totals
Number of staff	48	111	183	271	613
Number of facilities where staff are present	41	59	88	110	184
<b>Percentage of facilities with this cadre of trained staff</b>	<b>11%</b>	<b>16%</b>	<b>24%</b>	<b>30%</b>	<b>51%</b>

How many pharmaceutically trained personnel work in your facility?	Pharmacist	Pharm. tech	Pharm. asst	Pharm. trained nurse	Percentage of total
Trained in quantification of medicines needs	40	72	69	85	43%
Trained in medicines store management	45	81	76	112	51%
Trained in quality assurance	40	82	54	79	42%
Trained in rational use of medicines	54	79	64	129	53%
Trained in unit costing	37	72	65	98	44%
Trained in record and data management	46	75	63	136	52%
Trained in appropriate financial management	38	33	25	68	27%
Trained in compounding of medicines, e.g. syrups and ointments	38	87	59	84	44%
Trained in dispensing	45	94	112	221	77%

#### 4.19 Access to key pharmaceutical information (available in the pharmacy area, and available in the facility)

Guideline score: 41%



Publications available	Yes
<b>In the pharmacy?</b>	
Essential Medicines List (national or WHO)	66%
National (or WHO) formulary	52%
Standard treatment guidelines	64%
New and obsolete medicines list	29%
List of medicines registered in the country	28%
International medicines pricing indicators	28%
Managing medicines supply manuals	37%
<b>In the facility?</b>	
National drug policy	43%
PTC/DTC guidelines	25%
WHO essential medicines publications	30%
Rational use of medicines information	45%

#### 4.20 Regular assessment of pharmaceutical unit work

Guideline score: 43%

- 60% (139 of the 230 facilities that answered the question) undertake regular assessments of pharmaceutical work, and 71% (98 of 139) of this group have assessment at least once every three months, leading to an overall result of 43%.





#### 4.21 Church leaders' awareness of key messages



**Guideline score: 76%**

- Church leaders' knowledge was estimated during the focus groups and the scores below were allotted to each country.

Ethiopia	Ghana	Malawi	Nigeria	Tanzania	Togo	Uganda	Zambia
100%	90%	50%	0%	90%	60%	40%	100%

#### 4.22 Pharmaceutical function represented at all levels of discussion

**Guideline score: 66%**

- 73% (161 of 221) indicated that pharmaceutical functions and needs are discussed at all levels in the facility.



#### 4.23 Disaster preparedness procedures in place



**Guideline score: 29%**

Unfortunately, this question was omitted from the survey form used in one country, and in another country the question was not worded clearly enough, meaning that respondents did not understand that the 'disaster' referred a large-scale natural disaster, such as flooding, or conflict-based emergencies.

- 27% (77 of the 290 facilities that answered the question) have a plan for what to do in the event of a large-scale natural disaster, such as flooding, or conflict-based emergencies.

## 5 Selected results from the guided self-assessment workshops

More than 50 guided self-assessment meetings were held with hospital staff.



### 5.1 Identifying issues affecting access to medicines

The **problem tree tool** was used to help workshop participants develop their understanding of access to medicines and the factors that affect it, and to use that understanding as an input into intervention development that would maximize access to medicines.

The problem tree exercise was used both in the guided self-assessment workshops and in the feedback meetings. The two sets of problem trees from these different situations are analysed separately in this report, as the participant profiles are significantly different (i.e. the workshops involved a range of staff from a single hospital; the feedback meetings involved senior staff from different institutions across a country).

The problem tree results are not necessarily directly comparable across countries or across issues. For example, the rational use of medicines is a well known concept and can be analysed within a single tree, whereas ‘funding issues’ may be seen as a more complex or cross-cutting problem and split across a number of trees. However, by analysing the frequency with which particular issues, causes and effects are mentioned, a picture of the key issues can be drawn (Table 6).

**Table 6. Issues identified that affect access to medicines (self-assessment workshops)**

Country	Number of workshops	Issues (combined results from all workshops in each country)
Ethiopia	9	<ul style="list-style-type: none"> <li>▪ Funding</li> </ul>
Ghana	9	<ul style="list-style-type: none"> <li>▪ Personnel</li> <li>▪ Funding</li> <li>▪ Management</li> <li>▪ Rational use of medicines (public awareness)</li> </ul>
Malawi	10	<ul style="list-style-type: none"> <li>▪ Poverty (funding)</li> <li>▪ Infrastructures (funding)</li> <li>▪ Donor fatigue (funding)</li> <li>▪ Lack of skilled staff</li> <li>▪ Staff turnover</li> <li>▪ HIV/AIDS resource drain (funding)</li> <li>▪ Low-skilled management</li> </ul>

Country	Number of workshops	Issues (combined results from all workshops in each country)
		<ul style="list-style-type: none"> <li>▪ Lack of DTCs</li> <li>▪ Poor MIS</li> </ul>
Nigeria	8	<ul style="list-style-type: none"> <li>▪ Staffing problems</li> </ul>
Uganda	10	<ul style="list-style-type: none"> <li>▪ Poor access to medicines</li> <li>▪ Staff losses</li> <li>▪ Funding</li> </ul>
Zambia	9	<ul style="list-style-type: none"> <li>▪ Staff retention</li> </ul>

After categorizing the problems analysed in the workshops, the following problem areas ranked the highest (with the most occurrences):

- Funding (7)
- Staffing (6)
- Management (4)

The issue of staffing is analysed in more detail in Table 7, listing only once each cause or effect that was mentioned – thus it is a list of unique points resulting cumulatively from across all countries. The most notable outcome is the **vicious cycles** that can be seen with, for example, the loss of staff being considered both a cause and an effect.

**Table 7. Causes and effects of an issue: staffing issues**

Causes	Effects
<ul style="list-style-type: none"> <li>▪ Burn out</li> <li>▪ HIV/AIDS resulting in staff deaths</li> <li>▪ Increased demands/referrals</li> <li>▪ Lack of accommodation</li> <li>▪ Lack of community contribution</li> <li>▪ Lack of job security</li> <li>▪ Lack of opportunities to increase salary</li> <li>▪ Lack of training opportunities</li> <li>▪ Loss of staff</li> <li>▪ Low morale</li> <li>▪ Low pay</li> <li>▪ National and international brain drain</li> <li>▪ No pension</li> <li>▪ Overworked staff</li> <li>▪ Poor community relationships</li> <li>▪ Poor management</li> <li>▪ Poor management communication</li> <li>▪ Poor resource allocation</li> <li>▪ Rural location</li> <li>▪ Task-shifting to lower-skilled and lower-paid staff</li> <li>▪ Theft/corruption</li> </ul>	<ul style="list-style-type: none"> <li>▪ Difficulty recruiting</li> <li>▪ Illness among staff</li> <li>▪ Increased irrational use of medicines</li> <li>▪ Increased loss of staff</li> <li>▪ Increased morbidity and mortality</li> <li>▪ Long queues</li> <li>▪ Loss of staff</li> <li>▪ Lower income for institution</li> <li>▪ Low morale</li> <li>▪ Low productivity</li> <li>▪ Poor communication</li> <li>▪ Poor management</li> <li>▪ Poor patient attendance</li> <li>▪ Reduced quality of care</li> <li>▪ Theft/corruption</li> </ul>



## 5.2 Spider diagrams

Using a spider diagram methodology in the workshops at hospitals, the following issues were identified as factors that affected access to medicines.

1. **Rational use** of medicines (12 mentions), comprising:
  - a. patient knowledge (6)
  - b. staff skill levels (5)
  - c. rational use of medicines (1)
2. **Availability** of medicines from suppliers (7)
3. Medicines **procurement** and management (7)
4. **Transport** of medicines to facilities (7).

### 5.2.1 Trend analysis

In individual countries the spider diagram mechanism was used to stimulate discussion and reach consensus about the **trend over time** for factors affecting access to medicines (over the previous three to five years). Table 8 summarizes the results of these discussions across the studied countries. Part of the importance here is to raise a question about whether CHSs all face similar problems and thus perhaps form a subsector in themselves, or are they more heavily affected by the nature of their country location.

**Table 8. Trend analysis for all countries**

Issue	Trend
<b>Availability of medicines from suppliers</b>	<p><b>Some countries showed increases in availability, others a decrease, as a result there is no overall trend across the countries.</b></p> <p>Of the countries surveyed, only Uganda has a complete medicines supply system through JMS and this is reflected by the highest availability score.</p>
<b>Procurement and medicines management</b>	<p><b>Increased capacity across studied countries.</b></p> <p>Overall, there has been an increase in capacity among staff of CHSs. However, all participants noted that increased capacity to procure and manage medicines is often offset by the difficulty of dealing with government suppliers and a brain drain of staff.</p>
<b>Transport of medicines to facilities</b>	<p><b>Stayed the same or improved slightly across studied countries.</b></p> <p>While road networks have grown (meaning that more facilities are near a road), the quality of roads is often deteriorating.</p> <p>A large number of the country studies showed that a loss of missionary staff has often meant the loss of a vehicle, reducing the ability to fetch medicines.</p> <p>The cost of maintenance of transport is becoming too much for facilities to afford.</p>

Issue	Trend
<b>Patient knowledge</b>	<p><b>Improved across all countries.</b></p> <p>Overall, a significant increase in patient knowledge was identified. This trend was attributed to successful communication and education activities.</p> <p>However within this improvement, issues still arise, such as patients wanting injections or not knowing that they must finish the complete course of antibiotics.</p> <p>In Zambia and Ethiopia in particular participants felt that improvements are not due to increased contact times in the facilities, which many reported as falling due to loss of staff. Rough estimates suggested as little as 3–4 minutes for diagnosis and explanation.</p>
<b>Recruitment and retention of skilled staff</b>	<p><b>No clear trend across countries.</b></p> <p>Some countries recorded an increase in skilled staff, while others noted a drop. The result in each country reflected the level of pay in relation to the State health sector.</p> <p>All countries reported a vulnerability to brain drain from the church health services, often to the government health services due to differences in salaries and benefits.</p>
<b>Institutional finances</b>	<p><b>Across all studied countries increasing demand for services has not been matched with increased income.</b></p> <p>In countries or institutions where funding had improved, there was also substantial desire to increase exemption policies for the poorest.</p>
<b>Cost of medicines to institutions</b>	<p><b>No clear trend across countries.</b></p> <p>There was concern in some institutions and countries that costs were increasing or money was being used inefficiently (except in Uganda where there was no such concern). There were also some reports of increased competition between suppliers leading to a reduction in prices. In addition medicines seemed in, for example Ethiopia, to be bought from local pharmacies rather than medical supply organizations.</p> <p>However, participants tended to know very little about the cost of medicines to the institution and this subject raised the most concern and accusations. There was a widespread call for increased transparency in this area.</p>

### 5.3 Strengths and weaknesses

In order to encourage institutional self-awareness, a **self-review exercise** was included in the workshops. In Ghana, Malawi and Togo, a balloons and stones<sup>13</sup> exercise was used to assess the positive and negative forces acting on access to medicines at the facility. However, it became apparent that this exercise was not easy for facilitators to lead, and the exercise was changed to a simpler SWOT (strengths, weaknesses, opportunities and threats) exercise for subsequent country studies.

<sup>13</sup> Participants are asked to identify the forces that are reducing success (stones) and the forces that are supporting success (balloons)

The main value of these exercises is to **stimulate self-awareness and discussion** in the individual facilities and during the feedback meetings. However, by taking the strengths and weaknesses (as well as the stones and balloons from the earlier workshops) together, it is possible to draw a picture of issues affecting church-related health services and further review the issue of the Church Health Sector being a sector in itself with cross country characteristics which dominate country-based characteristics.

**Table 9. Strengths and weaknesses**

<b>Strengths (total of 30 mentions)</b>	<b>Weaknesses (total of 39 mentions)</b>
Sufficient skilled, motivated and trained staff (7)	Insufficient skilled staff, staff burnout, low pay, lack of accommodation (12)
Existing partners and donors (6)	Low financial resources (7)
Good management (4)	Poor management, especially financial (7)
Quality of care (4)	
Church values (4)	
Increasing affordability of services and free treatment for the poorest (3)	
Improving socioeconomic environment (2)	Worsening socioeconomic environment (5)
	Poor government relations and lack of support (5)
	Stock-outs (3)

Four issues appear in both the list of strengths and of weaknesses, indicating that some facilities have problems in these areas, while others do not. There may only be a few positive experiences, but these are significant and can possibly be replicated<sup>14</sup>:

- Skilled and motivated **staff** (sufficient/insufficient)
- **Resources** (existing partners and donors/low resources)
- **Management** (good/poor)
- **Socioeconomic** environment (improving/worsening)

Other issues that appear on the positive side of the table include quality of care, church values and increasing affordability of services; on the negative side are poor government relations and stock-outs.

It is possible to conclude that, although there are places and examples of where things are going well, there are also significant problems.

<sup>14</sup> Reference to the individual country reports will give further detail.

## 6 Results from the feedback meetings



The feedback mechanism was used successfully in five countries. However, in a number of countries, the methodology used has produced **non-comparable results**. The results from the feedback workshops in Nigeria and Togo were not comparable with those from the other workshops. In Tanzania, a lack of commitment and funding meant that no feedback meeting was held.

In all the feedback meetings, there was a notable **absence of government, NGO, INGO and other actors from the host country's health and access to medicines sectors**. This was due to people either not being invited or not prioritizing attendance. It was difficult to even get the directors of CHAs to attend; on some occasions a WHO representative came for the first part of the meeting but did not stay long.

Key results from the meetings were:

1. In the **prioritization of interventions**, each country group prioritized differently so there is no single intervention that can be selected for an overall programme for all countries. However, where there were similar prioritizations, it may be possible to develop a common approach that would work across several countries.
2. There is a need for **integrated interventions**. Single-target interventions do not reflect the interrelations between problems as identified by the participants. Country groups stressed the need to integrate interventions in a coordinated plan that maximizes impacts through economies of scale, as well as cumulative benefits.
3. There are issues outside the scope of access to medicines that indicate a **wider problem of survival for CHSs**, while also affecting access to medicines. There is some indication that interventions that could increase fundraising capacities, institutional management capacities and develop a stronger representational voice in dealings with governments will not only support the survival of CHSs in general but will also increase access to medicines.
4. There is evidence of support for: introducing **drug supply systems** that serve the CHSs (where the supply systems are absent); rational use of medicines; PTCs/DTCs in hospitals; and medicines storage and management.
5. Where there is more than one actor (denomination) involved in the CHS sector, there is a need for **stronger coordination** between the actors.

## Why existing actions by main actors are not working: a response from Uganda

The Uganda feedback meeting realized that it was clear what needed to be done in the areas of rational use of medicines and SOPs, and that there was already a lot of work actually being done: indeed the Joint Medical Store (JMS), Uganda Catholic Medical Bureau (UCMB) and Uganda Protestant Medical Bureau (UPMB) all had current programmes in this area, as do WHO and a number of other organizations.

However, it was recognized that still more could be done.

1. WHO and other leaders in the field have developed **comprehensive supporting documentation for medicines storage and management and PTCs/DTCs**. These publications have been distributed to facilities but participants felt that further distribution would be very useful. Could either WHO or JMS set up a distribution system for these materials, as well as for the other information missing from the pharmaceutical areas? While the information itself is free, distribution is not and it was hoped that a distribution system could be developed.
2. There was concern about the **lack of coordination between the main actors** – for example, no actor was working on these issues in the west of Uganda. It was also clear that there was no real coordination in terms of activities and working together, nor indeed any knowledge of each other's activities.
3. There were training activities in these areas, but there was no knowledge of what was working, or why it worked or didn't work. For example, it is not known how many institutions were able to set up a PTC/DTC and maintain it as a functioning committee, nor was it known what had caused some to fail following PTC/DTC training in a hospital or SOP support. A **better understanding** of local circumstances, and ongoing monitoring and evaluation is required to increase the effectiveness and sustainability of interventions.

## 6.1 Prioritization of issues

Following a presentation of the country-specific results, participants were asked to prioritize the issues from the list of EPN guidelines that they thought were the **most urgent** in terms of intervention.

These were not necessarily the guidelines with the lowest or highest results in terms of compliance. Participants were encouraged to think about how to 'spend' intervention energy: a guideline with a high score could be prioritized if the group felt that a relatively small expenditure of energy might bring the result up to 100%; or a guideline with a low score might be prioritized because a significant expenditure was needed to make a difference in an important area.

The results show that each country has **individual priorities** and that participants were able to identify them regardless of the level of results in the guideline compliance study.

The issues of funding, management and staffing (that are mentioned in other areas of the study) were highlighted in the feedback meetings. These are areas that are not within the remit of EPN to address (as agreed during the guideline development process).

Nevertheless, participants chose to prioritize these issues. Table 10 and Table 11 show the prioritized results by country for the EPN guidelines and for the additional priority areas.

**Table 10. Guideline priorities for interventions, listed by country**

	Ethiopia	Ghana	Malawi	Nigeria	Uganda	Zambia
<b>Guideline 1</b> Medicines storage and management. Guideline result: 50%		1 <sup>st</sup>			1 <sup>st</sup>	
<b>Guideline 2</b> Rational use of medicines. Guideline result: 5%–33%		2 <sup>nd</sup>			2 <sup>nd</sup>	1 <sup>st</sup>
<b>Guideline 3</b> Functioning medical supply system. Guideline result: 0%	1 <sup>st</sup>		1 <sup>st</sup>			
<b>Guideline 4</b> PTCs/DTCs in hospital. Guideline result: 27%–33% (after review)		3 <sup>rd</sup>		2 <sup>nd</sup>		
<b>Guideline 5</b> All owners with maximum understanding. Guideline result: 10%			2 <sup>nd</sup>			
<b>Guideline 6</b> Implementation of standard operating procedures. Guideline result: 39%					1 <sup>st</sup>	
<b>Guideline 8</b> Quality assurance policies in place and implemented. Guideline result: 58%		4 <sup>th</sup>				
<b>Guideline 14</b> Effective community involvement. Guideline result: 44%						2 <sup>nd</sup>
<b>Guidelines 18,19 and 20</b> Pharmaceutical personnel, access to information and regular assessment. Guideline results: 3%–47%					3 <sup>rd</sup>	

	Ethiopia	Ghana	Malawi	Nigeria	Uganda	Zambia
<b>Guideline 23</b> Disaster preparedness procedures in place. Guideline result: 18%				3 <sup>rd</sup>		

**Table 11. Non-guideline priorities, by country**

	Ethiopia	Ghana	Malawi	Nigeria	Uganda	Zambia
1 <i>Establishment of a fully functional and strong CHA.</i>				1 <sup>st</sup>		
2 <i>Increasing fundraising capacities in order to address other guidelines.</i>	2 <sup>nd</sup>					3 <sup>rd</sup>
3 <i>Stronger representation at national level for CHSs.</i>			3 <sup>rd</sup>			
4 <i>Increasing management capacities in CHSs.</i>				4 <sup>th</sup>		4 <sup>th</sup>

## 6.2 Linkages with other results

Where EPN guideline results for a country were high, issues in those areas were not identified as priorities in the feedback meetings. The chosen priorities always came from areas with the lowest EPN guideline results, but did not correlate exactly with the very lowest scores. This suggests that the **results of the baseline study are not a direct indication** of what interventions would be prioritized by those who are closest to the issues. The baseline study followed by a local participant workshop gives a better country-specific prioritization.

Prioritization results will be affected by **participants' understanding** of the baseline results as well as their understanding of the local environment, including their sense of empowerment. While the baseline results were clearly useful to them, both in painting a picture and reminding them of the issues, they were not a direct guide.

## 6.3 Interrelationships between methodologies and priorities

In each country, the participants quickly recognized that, having identified several priorities, these priorities could not be addressed separately but needed to be addressed **together as a group**. For example, the first priority would probably not succeed unless the other priorities were also addressed.

In all five feedback meetings, it was stressed by participants that identified intervention methodologies should all be carried out together – in spite of the fact that most donors and actors prefer to support targeted, single-issue interventions.

This led to the development in the meetings of a proposal for action that addressed a number of priorities simultaneously. Examples from Ghana, Uganda and Zambia are described below.

### 6.3.1 Interrelationships of priorities and methodologies: an example from Ghana

The project design group in the Ghana feedback meeting recognized that the identified priority areas and the methodologies for improving those areas were interrelated. The fact that there were common methodologies to be used across a number of priorities made it easier to conceive of an intervention that addressed all priorities.

**Table 12. Interrelation of objectives and methodologies Ghana**

Priority issues Methodologies	Rational use of medicines	SOPs for medicines storage and management	PTCs/DTCs	Quality assurance
M&E of existing activities	✓	✓	✓	✓
Risk analysis for Ghana CHSs	✓	✓	✓	✓
Pharmaceutical training and support team	✓	✓	✓	✓
Pharmaceutical job descriptions for CHSs	✓	✓	✓	✓
Information publication and dissemination	✓	✓	✓	✓
Advocacy	✓	✓	✓	✓

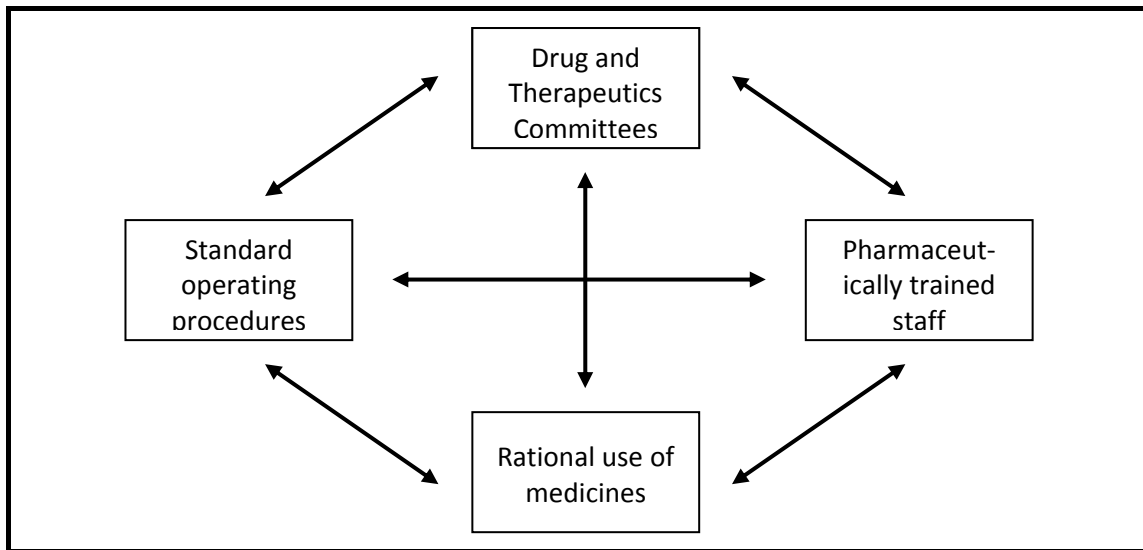
### 6.3.2 Interrelationships of methodologies and priorities: an example from Uganda

During the course of the Uganda feedback workshop, the priority areas were identified as being mutually reinforcing and therefore interrelated (see Figure 2 below). Then a series of activities were identified where increased efforts would yield benefits across all of the priorities:

- Monitoring and evaluation, as well as situation analysis.
- Greater coordination and joint work between the key actors.
- A focus on PTCs/DTCs and medical supervisors (or their equivalents) would increase the success of interventions.
- Internal networking and visits in order to learn from each other.
- Greater emphasis on the financial benefits to the facility of complying with EPN guidelines, in particular those relating to medicines (which make up a large proportion of budgets). Without management understanding of the benefits of this work, there would be no 'pull' for the interventions and only 'push' activities from the key actors.
- Stronger advocacy voice for government top-ups and recognition of pharmaceutical assistants in salary scales.
- Stronger system for the dissemination of information, particularly from WHO and the government medicines authority.



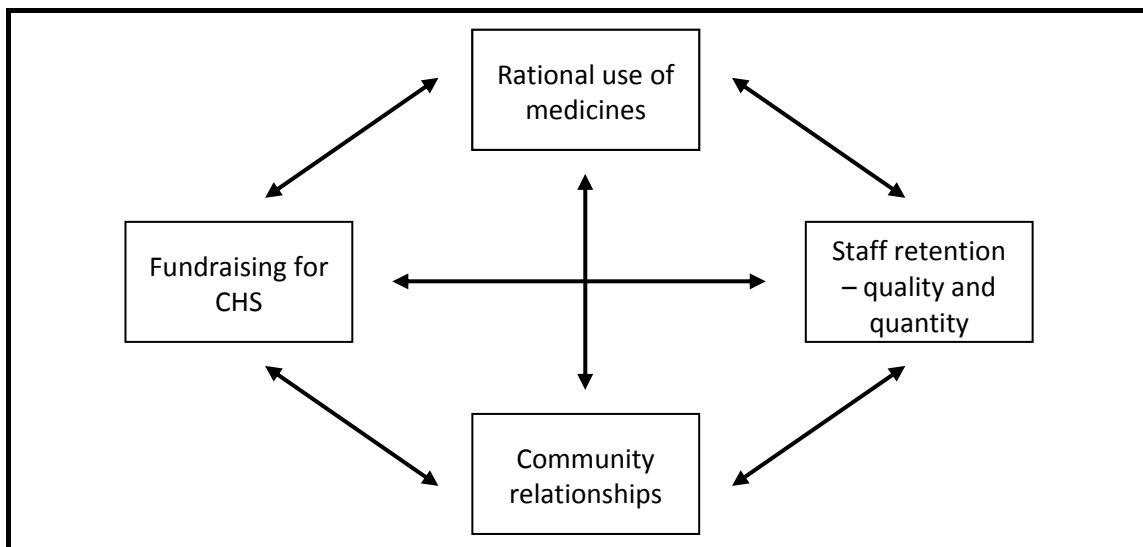
**Figure 2. Interrelationships between prioritized areas Uganda**



**6.3.3 Interrelationships of priorities resulting in plans for interventions: an example from Zambia**

The interrelationships between the four priorities chosen by participants at the Zambia feedback meeting were examined in an effort to identify a sequence in which work should be undertaken. However, it was discovered that each of the four priorities was in a 'chicken and egg' relationship with all the others and that it was not possible to determine which should be done first.

**Figure 3. Interrelationships between priorities Zambia**



Possible intervention methods were examined and the group decided that the Churches Health Association of Zambia (CHAZ) should be the main force for action. The group went on to identify six main challenges for CHAZ. These challenges were presented to the management group for discussion.

## **1. Increasing joined-up thinking**

Many of the areas discussed by the participants have a place within the existing CHAZ framework. However, there are some problems around the coordination of activities for maximum impact between different areas of CHAZ. This is an exciting opportunity to bring together separate activities into a mutually reinforcing framework. A lead staff member could be assigned the responsibility of coordinating and supporting this project even though the actual capacities required might lie in different departments.

## **2. Information**

A greater emphasis on information gathering, management analysis and sharing could better support the advocacy objectives of CHAZ.

Current systems of dissemination of information do not appear to be working for many subjects and areas. Access to free but important pharmaceutical information is low, including important WHO supporting materials on, for example, medicines storage and management, setting up PTCs/DTCs, and rational use of medicines studies and interventions.

The missing information often exists but is not reaching the places where it is needed most. Organizations such as EPN and WHO provide free information (for example, e-pharmalink, a two-page e-mail newsletter written for people dealing with medicines in resource-poor environments). All this information, as well as Zambia-specific treatment guidelines and government policy updates, could be delivered to CHSs through CHAZ.

## **3. Getting the CHSs to work together**

Despite strong commitments to do so, there remain examples of CHSs that find it difficult to work together in trust and to be transparent. As a result, many CHS staff teams feel alone in their struggle, as do some church owners. CHAZ provides a safe umbrella under which CHSs can work together, but the CHSs need even more direct encouragement to fully participate in this context than they are already receiving.

## **4. Training for hospital administrators**

The role of hospital administrators and leading staff in clinics is changing rapidly. A standard training in administration is no longer sufficient to deal with the demands of the role in today's complex environment.

Training is needed in:

- Fundraising, income generation and core package identification;
- Staff management (in particular, handling burnout and retention issues);
- Community relations (in particular, appropriate transparency, entry points, negotiation and conflict management);
- Rational use of medicines from an institutional perspective (in particular, PTCs/DTCs, monitoring and supporting rational use);
- Management of a faith-based business model for CHSs.

## **5. Community relations support**

Throughout the study, it was clear that there are examples of activities working well, even in problem areas, for every EPN guideline area. Support to community relations could take the form of individual materials or a pack that complements the training for hospital administrators and could be used by church leaders as well as CHSs. The materials would need to include:

- Example terms of reference for community link groups to clarify the nature of relationships.
- How to work with a Neighbourhood Health Committee and to encourage its formation.
- Working with an interfaith church leaders group.
- Sample agenda items for meetings.
- Examples of appropriate transparency mechanisms.
- Examples of issues that have been dealt with through good relations throughout the CHS network.
- Negotiation skills, managing meetings and conflict management.
- Community events – open days, celebrations, etc.
- Opportunities for fundraising support.
- Using rational use of medicines as a focus for community–CHS relations.

## **6. Fundraising and income generation support and coordination**

This is an area that needs to be developed both within and for CHAZ, as well as in individual CHSs. Many fundraising opportunities are currently being lost, as well as opportunities to reduce costs of certain materials, such as roofing and windows for housing for CHS staff.

Guidance and coordination is needed in the area of raising core funds and increasing staff incentives through:

- Raising funds in-country
- Raising funds from the commercial sector
- Cause marketing
- Corporate sponsorship

Income generation is another area that can be an important source of core funding, both in CHSs and for CHAZ. An additional consideration here is how this can be linked to improved incentives for CHS staff, for example, through bulk-buying of food staples, mobile phone top-ups, etc.

While both fundraising and income generation offer opportunities to bring many benefits to CHSs, these areas can also be dangerous if not managed properly as they can leave important areas of a facility's work unfunded or dependent on short-term funder support. The fact that there is now much criticism of revolving funds and user fees (both previously widely supported as funding approaches) has left many CHSs struggling.

## 6.4 Identifying issues affecting access to medicines

The topic areas analysed using problem trees<sup>15</sup> in the feedback meetings are listed in Table 13.

**Table 13. Issues identified that affect access to medicines (feedback meetings)**

Country	Issues
Uganda	<ul style="list-style-type: none"> <li>▪ Irrational use of medicines</li> <li>▪ Poor medicines storage, management and procurement</li> <li>▪ Poor staffing</li> </ul>
Ethiopia	Funding
Ghana	<p>Ghana participants felt they knew enough about their priority interventions without doing problem trees and wished to spend more time on project design. Their four priority areas were:</p> <ul style="list-style-type: none"> <li>▪ Medicines storage and management</li> <li>▪ Irrational use of medicines</li> <li>▪ PTCs/DTCs</li> <li>▪ Quality assurance</li> </ul>
Zambia	<ul style="list-style-type: none"> <li>▪ Irrational use of medicines</li> <li>▪ Poor staffing</li> <li>▪ Poor funding</li> </ul>
Malawi	<ul style="list-style-type: none"> <li>▪ Quality assurance</li> <li>▪ Irrational use of medicines</li> <li>▪ Poor pricing policy</li> <li>▪ Poor church and community involvement</li> <li>▪ Poor medicines storage and management</li> <li>▪ Distance between supplier and facility</li> <li>▪ Drug supply</li> <li>▪ Low numbers of pharmaceutically trained staff</li> </ul>

From a cross-country perspective, **merging the problem trees** developed around similar issues makes it possible to draw a picture of the main causes and effects experienced around these issues. This is not statistically valid, but it does have a value for those trying to develop an understanding of issues in church health services. Feedback problem trees were merged for the following topics.

- Rational use of medicines (across three countries: Malawi, Uganda and Zambia).<sup>16</sup>
- Staffing (across three countries: Malawi, Uganda and Zambia).
- Medicines management, procurement and supply (across two countries: Malawi and Uganda).<sup>17</sup>

There is not a particularly strong correlation between results from the problem trees in the self-assessment workshops and those in the feedback meetings.

- Two guideline problems (rational use of medicines; and medicines storage and management) have a stronger focus in the feedback meetings.

<sup>15</sup> Problem trees were also developed as part of the guided self-assessment workshops (Chapter 5, page 27). The results are analysed separately in this report as the participant profiles are significantly different (i.e. the workshops involved a range of staff from a single hospital; the feedback meetings involved senior staff from different institutions across a country).

<sup>16</sup> Ghana also prioritized this issue in their project proposal for interventions.

<sup>17</sup> Ghana also prioritized this issue in their project proposal for interventions.

- Two non-guideline related issues were raised in both situations (staffing and funding).

The causes and effects that were mentioned most frequently across countries for medicines storage, management and procurement are shown in Table 14.

**Table 14. Poor medicines management, storage and procurement**

Causes	
<ul style="list-style-type: none"> <li>▪ Lack of or failed PTCs/DTCs or lack of standard operating procedures (SOPs)</li> <li>▪ Failure to follow SOPs or lack of SOPs</li> <li>▪ Lack of trained personnel</li> </ul>	<ul style="list-style-type: none"> <li>▪ Lack of suitable storage infrastructure</li> <li>▪ Poor record keeping</li> <li>▪ Lack of supervision and auditing</li> </ul>
Effects	
<ul style="list-style-type: none"> <li>▪ Loss of medicines through pilfering</li> <li>▪ Poor quality of services, reduced patient attendance and increased mortality rates</li> <li>▪ Inefficient and expensive use of resources</li> <li>▪ Poor accountability to stakeholders</li> </ul>	<ul style="list-style-type: none"> <li>▪ Wastage – expired or damaged medicines</li> <li>▪ Reduced patient attendance</li> <li>▪ Inability to revolve funds</li> <li>▪ Low staff morale</li> <li>▪ Stock-outs</li> </ul>

## 6.5 Locally designed logical interventions

All participant groups showed a capacity to develop logical interventions. It was clear that all levels and types of staff were able to develop and negotiate ideas around interventions.

However, in every case, participants indicated this was the first time they had been:

- consulted on what needed to be done in order to address problems;
- invited to receive the results of a study of their activities;
- asked to prioritize and develop interventions;
- given the opportunity to work together across specialisations and denominations.

The outputs from the feedback meetings are listed in Table 15.

**Table 15. Outputs from the feedback meetings**

Country	Intervention focus	Result
Ghana	<ul style="list-style-type: none"> <li>▪ Medicines storage and management</li> <li>▪ Rational use of medicines</li> <li>▪ PTCs/DTCs</li> <li>▪ Quality assurance</li> </ul>	Proposal developed
Malawi	<ul style="list-style-type: none"> <li>▪ DSO</li> <li>▪ SOPs</li> <li>▪ PTCs/DTCs</li> <li>▪ Community involvement</li> <li>▪ Ownership knowledge</li> </ul>	Two proposals developed with logical frameworks

Country	Intervention focus	Result
	<ul style="list-style-type: none"> <li>▪ Access to pharmaceutical staff</li> <li>▪ Stronger voice</li> </ul>	
Zambia	<ul style="list-style-type: none"> <li>▪ Stronger CHA and a focus on <ul style="list-style-type: none"> <li>▪ Rational use of medicines</li> <li>▪ Community relations</li> <li>▪ Staffing management issues</li> <li>▪ Fundraising for CHSs</li> </ul> </li> </ul>	Presentation of results to CHAZ management
Uganda	<ul style="list-style-type: none"> <li>▪ Medicines storage, management and procurement</li> <li>▪ Rational use of medicines</li> <li>▪ Pharmaceutical staff</li> <li>▪ PTCs/DTCs</li> </ul>	Logical hierarchy developed for interventions Message to FDSO and the two CHAs contained in final report
Ethiopia	<ul style="list-style-type: none"> <li>▪ Start up FDSO</li> <li>▪ Increase fundraising capacities</li> </ul>	Next steps identified
Nigeria	<ul style="list-style-type: none"> <li>▪ Vibrant network</li> <li>▪ PTCs/DTCs</li> <li>▪ Disaster preparedness strategies</li> <li>▪ Management and staffing issues</li> </ul>	Next steps identified

Please see Annex 1 for details of proposals resulting from the feedback meetings.

- Ghana draws its four priorities together: medicines storage and management; rational use of medicines; PTC/DTCs; and quality assurance.
- Starting up an FDSO: a need in Malawi and Ethiopia.
- A full proposal: an example from Malawi.

## 7 Discussion points

Based on the results in this report and discussions with key informants, the following points describe areas that merit further investigation.

### 7.1 Staff participation in problem solving

This EPN study successfully used a **methodology of self-assessment surveys and participative workshops**. During the workshops and the feedback meetings, it was clear that the staff from the CHSs were pleased to be given the results of such research and, more importantly, to be involved in the development of problem-solving approaches. Across the development sector, the idea of **asking those closest to the problem to contribute their ideas** about how to solve the problem is a standard way of working. Good practice from the development sector indicates that organizations such as EPN have a unique capacity to work at this level and may have greater success in intervention design and implementation.

### 7.2 Monitoring and evaluation

While a great deal is known about what should be done in CHSs (it was relatively easy to draw up the list of guidelines), less is understood about **why there are failures in implementation** in some CHSs and not in others. In every country, there are examples of CHSs that are doing some things well – they are not the majority, but they exist and that suggests it is possible to succeed. More needs to be done to understand what the **success factors** are and therefore improve the quality and quantity of implementation of known solutions.

### 7.3 Professionalization of CHS management and staff retention

Low salary levels, among other challenges, has led to a lack of **management expertise and health knowledge** in many CHSs. As a consequence, senior management positions are often filled by staff who have limited management capacity. Often, senior nurses or doctors are filling the roles, thus increasing their management tasks and reducing the amount of health-care provision they can undertake. In the absence of sufficient health-care staff, this impacts heavily on the quality and availability of care.

**Staff retention** was often mentioned as a problem in discussions. While salary levels were mentioned, other issues were also identified, such as housing, transport and access to credit. Retention might be improved through further investigation of incentives for staff that do not necessarily include increased salary.

The issue of **accommodation**, both in terms of availability and the particular need for accommodation for married couples, was mentioned frequently across all the countries in the study. This is a particular problem in rural areas, which is where most CHSs are based. It might be possible for CHAs to leverage economies of scale by buying wholesale materials, and for individual CHSs to work with communities to negotiate for labour so that the cost of building accommodation could be reduced.

## 7.4 Funding

While the study did not aim to capture statistical data on funding the **financial problems of facilities** were frequently referred to in discussion. Many health facilities are dependent on donor funding for specific projects, such as antiretroviral therapy or tuberculosis management. Donors often refuse to fund the general activities of an organization, and staff and the provision of care are then moved onto funded activities. Many routine activities, such as dealing with a broken leg, become increasingly difficult to fund. Core funding is a major issue, yet donors are increasingly wary of funding ongoing costs. The failure of user fees and revolving drug funds to create sustainability continues to present a significant challenge for CHSs.

## 7.5 Greater understanding of CHSs as a group

More needs to be known about CHSs as a whole. The results of this study indicate a financial crisis and the need for monitoring and evaluation of interventions in the CHS sector, greater coordination and better representation. Increasingly, organizations such as WHO are focusing on national health policies, strategy and planning, the coordination of health information to inform national approaches and the strengthening of health systems.

The **coordination of health information** is becoming more important, particularly given the low contribution of information from some CHSs to national authorities (see Section 4.15). While CHSs provide a significant proportion of available health care, their involvement in national plans, PRSPs, budget-relieving donor plans is less significant. Possibly as a result of this, CHSs tend not to have equal access to government supply chains, subsidies, etc. This may raise the question of whether there is a CHS sector separate from the government health sector and, if so, what are its characteristics?

This study has shown that there is much to do in **improving adherence to good practice** in access to medicines in the CHS sector. In the future, the reuse of the methodology will indicate what change is taking place over time. However, until a similar study is carried out in government health facilities it is not known whether the problems are specific to CHSs or are similar across all health services in a country.



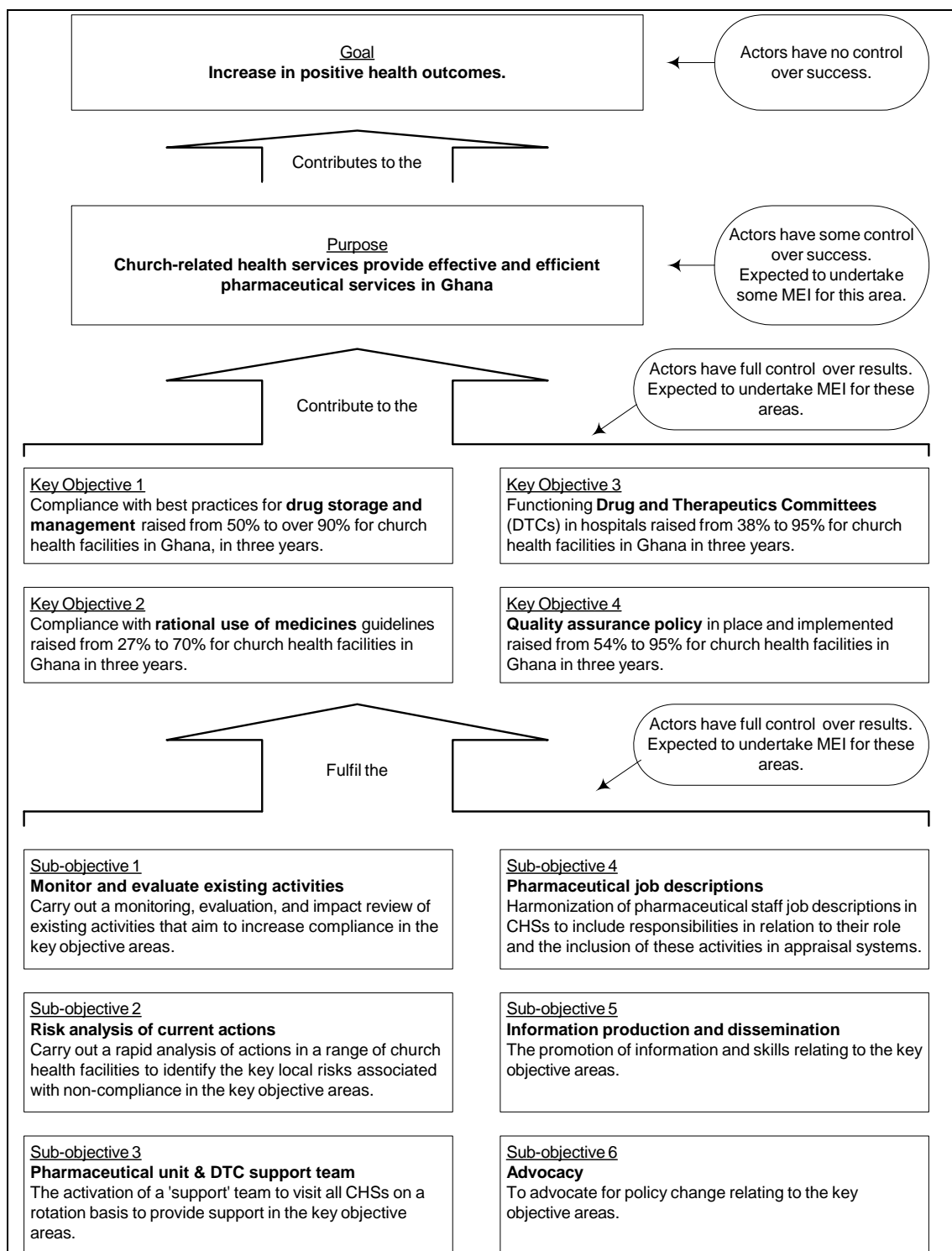
## 8 Annexes

### **A1 Proposals resulting from the feedback meetings**

Details of the following proposals resulting from the feedback meetings are included here.

- Ghana draws its four priorities together: medicines storage and management; rational use of medicines; PTC/DTCs; and quality assurance.
- Starting up an FDSO: a need in Malawi and Ethiopia.
- A full proposal: an example from Malawi.

## A1.1 Ghana draws its four priorities together: medicines storage and management; rational use of medicines; PTC/DTCs; and quality assurance



## **Phase 2 Ghana activities**

**Goal:** Increase in positive health outcomes.

**Purpose:** Church-related health services provide effective and efficient pharmaceutical services in Ghana.

### **Key objectives**

1. Compliance with best practices for **medicines storage and management** increased from 50% to over 90% for church health facilities in Ghana, in three years.
2. Compliance with **rational use of medicines** guidelines increased from 27% to 70% for church health facilities in Ghana in three years.
3. Functioning **Pharmacy and Therapeutics Committees** (PTCs/DTCs) in hospitals increased from 38% to 95% for church health facilities in Ghana in three years.
4. **Quality assurance policy** in place and implemented increased from 54% to 95% for church health facilities in Ghana in three years.

### **Sub objectives**

#### **1. Monitor and evaluate existing activities**

Carry out a monitoring, evaluation, and impact review of existing activities that aim to increase: (a) the use of SOPs for medicines storage and management; (b) the rational use of medicines; (c) PTC/DTC mechanisms; and (d) the use of SOPs for quality control. Identify changes that are required to increase the impact of these activities.

#### **2. Risk analysis of current actions**

Carry out a rapid analysis of current actions in the four priority areas in a range of church health facilities in order to identify the key local risks associated with non-compliance with 'guidelines' in the areas of: (a) the use of SOPs for medicines storage and management; (b) the rational use of medicines; (c) PTC/DTC mechanisms; and (d) the use of SOPs for quality control.

#### **3. Pharmaceutical unit and PTC/DTC training and review support team**

The activation of a 'support' team that visits all CHSs on a rotation basis to:

- Provide onsite staff training and support for pharmacy units.
- Review standards in the four identified areas: (a) the use of SOPs for medicines storage and management; (b) the rational use of medicines; (c) PTC/DTC mechanisms; and (d) the use of SOPs for quality control.
- Provide training and follow up for sustainable implementations.
- Disseminate materials with training on the four key areas.
- Support the harmonization of job descriptions.
- Improve environmental safety.
- Improve procurement practices.
- Identify key SOPs for adoption and implementation.

#### **4. Pharmaceutical job descriptions for CHSs**

Harmonization of pharmaceutical staff job descriptions in CHSs to include responsibilities in relation to their role and the inclusion of these activities in appraisal systems.

## 5. Information production and dissemination

The promotion of information and skills relating to the areas of: (a) the use of SOPs for medicines storage and management; (b) the rational use of medicines; (c) PTC/DTC mechanisms; and (d) the use of SOPs for quality control. For example:

- Identification and dissemination of generic policy on the four key areas.
- Production of long-lasting 'laminated poster' displays for office walls.
- Introduction of training in the key areas as part of the orientation package for staff joining CHSs.
- Implementation of SOPs for medicines storage and management.
- Rational use of medicines within the pharmacy.
- Supporting the rational use of medicines by patients and prescribers.
- Implementation of quality control policies within the pharmacy.
- IEC materials for use in and around pharmacy distribution to patients.

## 6. Advocacy

To advocate for:

- The increase of the impact of learning in the four key areas in government training systems for all health staff in Ghana.
- PTCs/DTCs for hospitals to become part of the charter under which CHS hospitals are allowed to function.
- Encourage inter-facility visits to observe successful PTCs/DTCs.
- Advocate for a quality assurance policy and its implementation.
- Rational use of medicines campaign across all CHSs, including (for example) numbers of medicines per prescription.
- Planned IEC activities with communities and patients.

### A1.2 Starting up an FDSO: a need in Malawi and Ethiopia

The problems faced in Ethiopia and Malawi are very different (from delivery distances to government responses) but the result is the same. In both countries, CHSs need to be supplied with medicines in a way that allows them to access low-cost, available medicines. In both countries, there have been previous failed attempts and CHSs face problems in accessing government stores. Currently, efforts are being made in Malawi to develop a functioning faith-based drug supply organization (FDSO), but there is no movement in this area in Ethiopia. In both countries, **government stores** could be managed in such a way as to increase CHS access but there would need to be high-level discussions. At the time of the EPN study, there was no open door for the adjustment of government stores policy or the development of an FDSO in-country.

However, there are some very successful FDSOs in Africa. This research and other sources indicate that **the presence of an FDSO does increase CHS access to medicines and therefore patient access to medicines**. Many lessons have been learnt across the FDSO sector and FDSOs have worked together with the support of EPN and WHO. Together, they could identify a best practice model for the establishment of a FDSO, as they have already done for various other policies and SOPs.

## An example of an FDSO for Ethiopia

The participants in the feedback meeting found the EPN guideline compliance results disturbingly depressing and there was not an immediate 'can do' response for solutions. However, after a great deal of discussion and searching for common causes, it was decided that (although many things needed to be dealt with) the two areas that would bring the best results across the sector would be the following:

1. Setting up a faith-based drug supply organization (FDSO).
2. Increasing fundraising capacities.

Although it was not an immediate priority, the group recognized that an Ethiopian Christian health association (CHA) would be of enormous value to CHSs in Ethiopia. The group also wanted an active independent church-based coordinating organization, along similar lines to CHAK, CHAM and CHAZ in Kenya, Malawi and Zambia.

The group recognized that forming a CHA would be extremely difficult in the current climate. With further discussion, it was felt that if the separate churches could come together to make an FDSO work, then this cooperation could be built upon to develop a cooperating and feasible CHA.

An FDSO would mean that CHSs would gain greater access to cheaper medicines. This would mean that more medicines could be sold at reasonable prices and that this would result in a small but significant increase in incomes for staff, leading to better staff retention and motivation. Keeping staff for longer would also enable increased rational use of medicines and the introduction of PTCs/DTCs.

In the past, there have been failed attempts to start an FDSO that make trying again more difficult. The greatest constraint would be the poverty of CHSs and the size of the country in terms of transport requirements. The experience gained from the previous attempts should reduce the costs of setting up an FDSO and help to avoid reinventing the wheel and repeating previous mistakes.

It was felt that EPN's links to other successful and diversely constructed FDSOs could give a head start to a new attempt, with the Ethiopian team gaining access to other important lessons already learnt. The effort to identify a **best practice planning document** based on existing FDSOs would be a valuable document for other countries and the identification of the document and testing in Ethiopia would make a coherent and interesting project proposal for significant funding – particularly through its value to other countries in the future.

It was agreed that, for Ethiopia to gain an FDSO, there would need to be close cooperation with EPN and that the existence of an external organization and successful funding support were primary factors and that these would also help in the development of relations between the government and the CHSs.

Feedback participants focused on understanding how an FDSO could work in the Ethiopian environment and what first steps would need to be taken. It was decided that:

1. A **joint church meeting** was required to present the idea and gain support for a feasibility study. This would need to be externally funded by an important funder who could draw the participation of government and churches and should be chaired by EPN to maintain a degree of independence from any one church.
  - At the meeting, it will be important to present examples of successful FDSOs and their development stories, as well as the rationale for an FDSO.

- Discussions will need to include the government and external sponsors.
  - The aim of the meeting is to agree to undertake a feasibility study.
2. Following support from EPN in the writing up of a proposal for a feasibility study and the finding of funding support, the **feasibility study** would be undertaken based on:
    - Estimating existing demand from supporting church health services;
    - The corresponding potential supply and its costs;
    - Addressing the issue of transport in relation to distribution;
    - Examining how the financial strength of church health facilities might be increased if demand is met.
  3. The **methodology** of the feasibility study would be made available to all and would become the first part of a 'setting up a DSO' manual and would contribute to the faith-based business model for FDSOs.
  4. A **second joint church meeting** would be held to present the results of the feasibility study. Here it would also be important that government representatives were present, as well as other actors in the health sector. This meeting would receive the results of the feasibility study and take advice on proceeding, as well as developing a response and subsequent steps to the feasibility study.

### **A1.3 A full proposal: an example from Malawi**

In order to develop the detail behind each of the objectives for the Malawi proposal, a process of problem tree analysis was used, followed by group identification of possible entry points and the prioritization of activities. These activities were then further developed into detailed descriptions of activities to be undertaken by sub-groups, using answers to two questions – 'What do we want?' and 'How are we going to get it?'

#### **Objective 1. The right medicines at the right price at the right time**

##### **1.1 Use of good practices for medicines storage and management increased from a baseline of 40% to 100% of church health services**

###### **Activities**

- Review the specific problems of each CHAM unit in this area.
  - Provision of advice to each unit to address issues.
- Distribution of standardized and documented standard operating procedures (SOPs).
  - Letter to CHAM units requesting that these SOPs be put into practice.
- Regional training workshop for the staff member in each hospital in charge of medicines storage and management.
  - Exchange visits to CHAM units implementing good practice.
- Annual review for three years to identify CHAM units with continuing problems.
- Where infrastructure is the problem, develop specific donor proposals (or a single proposal covering a number of units) to address sustainable infrastructure needs.

## **1.2 Use of standard operating procedures for procurement increased from a baseline of 25% to 100% of church health services**

### **Activities**

- Develop an inventory and procurement system to be adopted as good practice in all CHAM units, that reduces overall costs through joint ordering, improves access through inventory control, and supports cost-effective training mechanisms.
  - Obtain the government system and adapt it to fit CHAM requirements.
  - Review the specific problems of each CHAM unit in this area.
  - Distribute standardized and documented standard operating procedures (SOPs).
    - Letter to CHAM units requesting that these SOPs be put into practice.
  - Provide advice to each unit to address issues.

## **1.3 Use of good practice for the rational use of medicines increased from a baseline of 23% to 100% of church health services**

### **Activities**

- Carry out a detailed survey to identify good practice examples and the most common failures in the Malawi context.
- Develop standardized protocols through the adoption of national standards.
  - Produce a checklist for adherence.
  - Undertake a medicines indicator study of all CHAM units.
  - Hold an annual meeting on the rational use of medicines in CHAM units.
- Develop monitoring and evaluation of rational use of medicines in all CHAM units.
  - Evaluate the existing training course in rational use of medicines (40 people per year).
    - Adapt the course for stronger, more sustainable impact.
  - Develop disciplinary procedures for facilities that contravene rational use of medicines guidelines.
- Develop a set of simple in-service training modules that can be used by each CHAM unit to update and reinforce skills.
- Increase access to guidance documentation directly through WHO, EPN, and others, with CHAM acting in a stronger pass-on role for documentation and contact with international organizations.
- Discuss with in-country health-related training systems the possibility of strengthening the rational use of medicines.

## **1.4 Number of functioning Pharmacy and Therapeutics Committees (PTCs/DTCs) in church hospitals increased from a baseline of 10% to 100%**

### **Activities**

- Compile a list of existing PTCs/DTCs and review their functionality.
  - Prepare a case study of the best example and distribute to other hospitals.
- Letter to CHAM units advising the formation of PTCs/DTCs, with a deadline.
- Hold a training workshop in each region and invite local hospital staff that would sit on the PTC/DTC to attend.
  - Distribute the WHO DTC guidance book.

- Focus on the rational use of medicines.
- Follow up every three months during the first year and every six months thereafter for three years, to monitor the functioning of PTCs/DTCs.
  - Where there are particular problems, undertake exchange visits to hospitals with a working PTCs/DTC.
  - Where there are continuing problems, offer technical assistance and further training or retraining in PTCs/DTCs.

### **1.5 Expansion of the CHAM drug supply system**

#### **Activities**

- Visit drug supply organizations in Zambia, Kenya, and Uganda to observe their ways of working and develop a tried and tested model for Malawi CHSs to follow.
- Survey all CHAM units to ascertain medicines supply needs on an annual basis and storage capacities.
  - Integrate the procurement systems of CHAM units with the CHAM supply system.
- Expand the range of supplies jointly ordered and stocked by CHAM.
- Develop predictive ordering systems.
- Publish price lists that show the competitive pricing resulting from joint ordering and indicate where the cheapest sources are.

NB: It is recognized that, in the unlikely event of very rapid transformation of the current Central Medical Stores system, these activities will need to be reviewed.

## **Objective 2. Adequate numbers of well-qualified pharmaceutically trained personnel**

### **2.1 Church health facilities' access to at least one pharmaceutically-trained person per hospital increased from current levels of 9% with pharmacists, 22% with pharmaceutical technicians, and 12% with pharmaceutical assistants**

#### **Activities**

- Increase on-the job training for lower cadres of pharmaceutical staff.
  - Train pharmaceutical attendants in basic medicines management.
  - Introduce quality of care training for pharmaceutical personnel.
  - Introduce the EPN PAT course, to run annually.
  - Develop an upgrading mechanism for pharmaceutical staff.
  - Develop a coordinated in-service training approach for all pharmaceutical staff.
  - Increase supervision of staff through a combination of shared pharmacist supervision and a centralized system of visiting supervisors.
- Increase the retention of staff.
  - Give higher priority to the retention of pharmaceutical staff in the development of pay scales and top-up benefits.
  - Make policy in favour of staff loans.
  - Implement an upgrading mechanism.
- Increase the availability of quality staff.
  - Promote pharmaceutical roles to the general population and through schools.



- Encourage the verification of formal references during recruitment.
- Negotiate two or three places on the national pharmacist training course for CHAM unit pharmaceutical technicians.

### **Objective 3. Increased access to essential medicines for church health services and their clients in Malawi**

**3.1 Number of 'owners' with maximum understanding of roles, good practice, and management information, understanding of revolving fund concept, and implementation of methods of increasing access for the poorest increased from a baseline of 10% to 100%**

**3.2 Number of church leaders aware of key issues increased from a baseline of 50% to 100%**

**3.3 Effective community involvement system developed for church health facilities**

#### **Activities (combined)**

- Carry out a situation analysis and an attitudes survey.
- Hold a meeting with high-level church leaders and CHAM senior staff to examine the best approach to developing ownership skills, leaders' awareness of issues, and committee involvement.
  - Brief church leaders on the results of the baseline study and situation analysis.
  - Brief church leaders on the necessary characteristics of owner knowledge, awareness of issues, and community involvement.
  - Brief church leaders on the value of community literacy and the rational use of medicines, and the role of the church.
- Hold three regional meetings for local church leaders to examine the best approach to developing ownership skills, awareness of issues, and committee involvement.
  - Brief church leaders on the results of the baseline study and situation analysis.
  - Brief church leaders on the necessary characteristics of owner knowledge, awareness of issues, and community involvement.
  - Brief church leaders on the value of community literacy and the rational use of medicines, and the role of the church.
- Develop a strategy for action in this area to be carried forward by the churches.

### **Objective 4. Support of the development of a stronger voice to speak on behalf of faith-based health care facilities in Malawi**

#### **Activities**

- Review CHAM and CHS advocacy capacities, advocacy systems, and current undertakings.
- Hold a training course in private and public advocacy techniques for senior staff, to respond to the review results.
  - Devise a strategy for priority areas including the tax exemption system, access to pharmaceutical training, and the reform of the Central Medical Stores.
- Advise on and monitor the implementation of the advocacy strategy.
- Contribute to and make use of the Ecumenical Pharmaceutical Network's access to information in support of church health services and drug supply organizations.

### Logical framework from Malawi feedback meeting

Project Description	Indicators	Means of Verification	Assumptions
<b>GOAL:</b> Increase in positive health outcomes			
<b>PURPOSE:</b> Church-related health services provide effective and efficient pharmaceutical services in Malawi	<i>Outcome:</i> <ul style="list-style-type: none"> <li>Compliance with prioritized EPN-recommended guidelines increased</li> </ul>	<ul style="list-style-type: none"> <li>Survey</li> </ul>	That compliance with EPN guidelines results in the delivery of effective and efficient pharmaceutical services

Component Description	Indicators	Means of Verification	Assumptions
<b>Objective 1:</b> <b>Use of good practices for medicines storage and management increased from a baseline of 40% to 90% of church health services</b>	<i>Outcome:</i> <ul style="list-style-type: none"> <li>Use of good practices for medicines storage and management increased from a baseline of 40% to 90% of church health services</li> </ul>	<ul style="list-style-type: none"> <li>Survey</li> </ul>	That good practices for medicines storage and management increase access to medicines
<b>Activities</b>	<i>Output:</i>		
<ul style="list-style-type: none"> <li>Review the specific problems of each CHAM unit regarding medicines storage and management</li> </ul>	<ul style="list-style-type: none"> <li>No. of review visits undertaken</li> <li>Review visit reports completed by advisor and CHAM units</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> </ul>	
<ul style="list-style-type: none"> <li>Provide advice to each unit to address medicines storage and management issues</li> </ul>	<ul style="list-style-type: none"> <li>No. of follow-up visits undertaken</li> <li>Follow-up visit reports completed by advisor and CHAM units</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> </ul>	
<ul style="list-style-type: none"> <li>Distribute standardized and documented standard operating procedures (SOPs) for medicines storage and management</li> </ul>	<ul style="list-style-type: none"> <li>SOP developed</li> <li>SOP distributed</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> <li>Random survey of recipients on distribution list</li> </ul>	That standardized SOPs can be created
<ul style="list-style-type: none"> <li>Send a letter to CHAM units requesting that these SOPs be put into practice</li> </ul>	<ul style="list-style-type: none"> <li>Letter prepared</li> <li>Letter distributed</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> <li>Telephone survey of recipients on distribution list</li> </ul>	That CHAM units respond to CHAM encouragement
<ul style="list-style-type: none"> <li>Hold a regional training workshop for the staff member in each hospital in charge of medicines storage and management</li> </ul>	<ul style="list-style-type: none"> <li>Agenda and workshop report available</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> </ul>	That staff are able to attend the training

<ul style="list-style-type: none"> <li>Exchange visits to CHAM units implementing good practice</li> </ul>	<ul style="list-style-type: none"> <li>No. of exchange visits undertaken</li> <li>Exchange visit reports completed by participants</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> </ul>	That CHAM units are able to receive exchange visits
<ul style="list-style-type: none"> <li>Undertake an annual review for three years to identify CHAM units with continuing problems</li> </ul>	<ul style="list-style-type: none"> <li>Review reports available</li> <li>Lessons shared between CHAM units</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> <li>Survey of CHAM units</li> </ul>	
<ul style="list-style-type: none"> <li>Where infrastructure is a problem, develop specific donor proposals (or a single proposal covering a number of units) to address sustainable infrastructure needs</li> </ul>	<ul style="list-style-type: none"> <li>Note of CHAM units with infrastructure problems</li> <li>Proposal(s) to address infrastructure needs</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> </ul>	

Component Description	Indicators	Means of Verification	Assumptions
<b>Objective 2:</b> <b>Use of good practice for the rational use of medicines increased from a baseline of 23% to 75% of church health services</b>	<i>Outcome:</i> <ul style="list-style-type: none"> <li>Use of good practice for the rational use of medicines increased from a baseline of 23% to 75% of church health services</li> </ul>	<ul style="list-style-type: none"> <li>Survey</li> </ul>	That the rational use of medicines improves access to medicines
<b>Activities</b>	<i>Output:</i>		
<ul style="list-style-type: none"> <li>Carry out a detailed survey to identify good practice examples and the most common failures in the Malawi context</li> </ul>	<ul style="list-style-type: none"> <li>Survey report with examples</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> </ul>	
<ul style="list-style-type: none"> <li>Develop standardized protocols through the adoption of national standards</li> </ul>	<ul style="list-style-type: none"> <li>Protocols developed</li> <li>Protocols distributed</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> <li>Random survey of recipients</li> </ul>	
<ul style="list-style-type: none"> <li>Produce a checklist for compliance</li> </ul>	<ul style="list-style-type: none"> <li>Checklist developed</li> <li>Checklist distributed</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> <li>Random survey of recipients</li> </ul>	
<ul style="list-style-type: none"> <li>Undertake a medicines indicator study of all CHAM units</li> </ul>	<ul style="list-style-type: none"> <li>Medicines indicator report</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> <li>Site visits</li> </ul>	
<ul style="list-style-type: none"> <li>Hold an annual meeting on the rational use of medicines in CHAM units</li> </ul>	<ul style="list-style-type: none"> <li>Agenda and meeting report, with rational use of medicines focus</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> <li>Pre and post-meeting survey of attendees</li> </ul>	
<ul style="list-style-type: none"> <li>Develop monitoring and evaluation of rational use of medicines in all CHAM units</li> </ul>	<ul style="list-style-type: none"> <li>M&amp;E system documented and implemented</li> <li>Regular M&amp;E reports</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> </ul>	

<ul style="list-style-type: none"> <li>▪ Evaluate the existing training course in rational use of medicines (40 people per year)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Evaluation report by external consultant</li> </ul>	<ul style="list-style-type: none"> <li>▪ Documentation</li> </ul>	That records and trainees from previous years are accessible
<ul style="list-style-type: none"> <li>▪ Adapt the training course for a stronger, more sustainable impact</li> </ul>	<ul style="list-style-type: none"> <li>▪ Updated training materials and activities</li> <li>▪ Level of trainee knowledge and action</li> </ul>	<ul style="list-style-type: none"> <li>▪ Documentation</li> <li>▪ Pre and post-event survey of trainees</li> </ul>	
<ul style="list-style-type: none"> <li>▪ Develop disciplinary procedures for facilities that contravene rational use of medicines protocols</li> </ul>	<ul style="list-style-type: none"> <li>▪ Disciplinary procedures developed</li> <li>▪ Disciplinary procedures distributed</li> </ul>	<ul style="list-style-type: none"> <li>▪ Documentation</li> </ul>	
<ul style="list-style-type: none"> <li>▪ Develop a set of easy-to-follow in-service training modules that can be used by each CHAM unit to update and reinforce skills</li> </ul>	<ul style="list-style-type: none"> <li>▪ Training modules developed</li> <li>▪ Training modules distributed and made available to staff</li> <li>▪ No. of training modules completed by staff</li> </ul>	<ul style="list-style-type: none"> <li>▪ Documentation</li> <li>▪ Pre and post-study survey of those trained</li> <li>▪ Documentation</li> </ul>	
<ul style="list-style-type: none"> <li>▪ Increase access to guidance documentation directly through WHO, EPN, and others, with CHAM acting in a stronger pass-on role for documentation and contact with international organizations</li> <li>▪ Discuss the possibility of strengthening the rational use of medicines content in in-country health-related training systems with those responsible for them</li> </ul>	<ul style="list-style-type: none"> <li>▪ List of guidance documentation and sources compiled by CHAM</li> <li>▪ List distributed and updated regularly</li> <li>▪ No. of publications distributed to CHAM units through CHAM</li> <li>▪ No. of CHAM units with access to guidance documentation</li> <li>▪ Evidence of CHAM efforts to introduce CHAM units to international contacts</li> <li>▪ List of in-country health-related training systems</li> <li>▪ Contact details for those responsible for the training systems</li> <li>▪ Evidence of contacts made</li> </ul>	<ul style="list-style-type: none"> <li>▪ Documentation</li> <li>▪ Documentation</li> <li>▪ Documentation</li> <li>▪ Survey</li> <li>▪ Documentation</li> <li>▪ Documentation</li> </ul>	That organizations make publications available free of charge

Component Description	Indicators	Means of Verification	Assumptions
<b>Objective 3:</b> <b>Church health facilities' access to at least one pharmaceutically-trained person per hospital increased from a baseline of 9% with pharmacists, 22% with pharmaceutical technicians, and 12% with pharmaceutical assistants</b>	<i>Outcome:</i> <ul style="list-style-type: none"> <li>Church health facilities' access to at least one pharmaceutically-trained person per hospital increased from a baseline of 9% with pharmacists, 22% with pharmaceutical technicians, and 12% with pharmaceutical assistants</li> </ul>	<ul style="list-style-type: none"> <li>Survey</li> </ul>	That access to pharmaceutically-trained staff improves access to medicines
<b>Activities</b>	<i>Output:</i>		
<ul style="list-style-type: none"> <li>Increase on-the job training for lower cadres of pharmaceutical staff (through the following activities)</li> </ul>	<ul style="list-style-type: none"> <li>Success of training</li> <li>No. of staff trained</li> </ul>	<ul style="list-style-type: none"> <li>Pre and post-event survey of trainees</li> <li>Documentation</li> </ul>	That lower cadres of staff are able to cope with the additional training workload
<ul style="list-style-type: none"> <li>Train pharmaceutical attendants in basic medicines management</li> </ul>	<ul style="list-style-type: none"> <li>Training course prepared</li> <li>Training agenda and session reports (including lists of trainees and their organizational position)</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> </ul>	
<ul style="list-style-type: none"> <li>Introduce quality of care training for pharmaceutical personnel</li> </ul>	<ul style="list-style-type: none"> <li>Training course prepared</li> <li>Training agenda and session reports (including lists of trainees and their organizational position)</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> </ul>	
<ul style="list-style-type: none"> <li>Introduce the EPN PAT course, to run annually</li> </ul>	<ul style="list-style-type: none"> <li>Training course prepared</li> <li>Training agenda and session reports (including lists of trainees and their organizational position)</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> </ul>	
<ul style="list-style-type: none"> <li>Develop an upgrading mechanism for pharmaceutical staff</li> </ul>	<ul style="list-style-type: none"> <li>Upgrading mechanism developed</li> <li>No. of pharmaceutical staff upgraded</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> </ul>	
<ul style="list-style-type: none"> <li>Develop a coordinated in-service training approach for all pharmaceutical staff</li> </ul>	<ul style="list-style-type: none"> <li>Coordinated training approach developed</li> <li>No. of pharmaceutical staff receiving in-service training</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> </ul>	
<ul style="list-style-type: none"> <li>Increase supervision of staff through a combination of shared pharmacist supervision</li> </ul>	<ul style="list-style-type: none"> <li>Supervision roster</li> <li>No. of visits made by visiting supervisors</li> </ul>	<ul style="list-style-type: none"> <li>Documentation</li> <li>Documentation and telephone</li> </ul>	That pharmacists and supervisors are available to

and a centralized system of visiting supervisors		survey of supervisees	provide supervision
<ul style="list-style-type: none"> <li>▪ Increase efforts to retain staff (through the following activities)</li> </ul>			
<ul style="list-style-type: none"> <li>▪ Give higher priority to the retention of pharmaceutical staff in the development of pay scales and top-up benefits</li> </ul>	<ul style="list-style-type: none"> <li>▪ Evidence of improved pay scales and top-up benefits</li> </ul>	<ul style="list-style-type: none"> <li>▪ Documentation</li> </ul>	That resources are available to offer improved packages
<ul style="list-style-type: none"> <li>▪ Make policy in favour of staff loans</li> </ul>	<ul style="list-style-type: none"> <li>▪ Staff loans policy</li> <li>▪ No. of staff loans requested</li> <li>▪ No. of staff loans approved</li> </ul>	<ul style="list-style-type: none"> <li>▪ Documentation</li> </ul>	That cash flow is available to support loans
<ul style="list-style-type: none"> <li>▪ Implement an upgrading mechanism</li> </ul>	<ul style="list-style-type: none"> <li>▪ Evidence of upgrading mechanism</li> <li>▪ No. of pharmaceutical staff upgraded</li> </ul>	<ul style="list-style-type: none"> <li>▪ Survey</li> <li>▪ Documentation</li> </ul>	
<ul style="list-style-type: none"> <li>▪ Increase efforts to support the availability of quality staff (through the following activities)</li> </ul>			
<ul style="list-style-type: none"> <li>▪ Promote pharmaceutical roles to the general population and through schools</li> </ul>	<ul style="list-style-type: none"> <li>▪ Promotional materials developed</li> <li>▪ No. of radio or TV slots promoting pharmaceutical roles</li> <li>▪ No. of leaflets or posters distributed</li> <li>▪ No. of visits to schools</li> <li>▪ No. of applications for pharmaceutical training</li> <li>▪ No. of applications for pharmaceutical positions</li> </ul>	<ul style="list-style-type: none"> <li>▪ Documentation</li> </ul>	
<ul style="list-style-type: none"> <li>▪ Encourage the verification of formal references during the recruitment process</li> </ul>	<ul style="list-style-type: none"> <li>▪ Letter from CHAM prepared</li> <li>▪ Letter from CHAM distributed</li> <li>▪ Records of the verification of references</li> </ul>	<ul style="list-style-type: none"> <li>▪ Documentation</li> <li>▪ Telephone survey of recipients</li> <li>▪ Documentation</li> </ul>	
<ul style="list-style-type: none"> <li>▪ Negotiate two or three places on the national pharmacist training course for CHAM unit pharmaceutical technicians</li> </ul>	<ul style="list-style-type: none"> <li>▪ Meeting and telephone conversation reports</li> <li>▪ Allocation of places on the training course</li> </ul>	<ul style="list-style-type: none"> <li>▪ Documentation</li> </ul>	That the government is open to negotiation

## A2 Nigeria results discussion

In Nigeria, where the response rate was very low and there had been methodological problems, the feedback group felt that there were problems with some of the guideline results because of the low response rate and the exclusion of some CHSs, such as those belonging to the Orthodox Church. Of the 23 guidelines, 15 were felt to give an accurate countrywide picture and 8 were felt to be either too high (5) or too low (3). The feedback group identified 5 out of the 23 guideline results as needing to be revised in order to give a more accurate picture of CHSs in Nigeria.

- **Transparency mechanisms in place in support of “Health for All”.** 75% is a more realistic score and not 39%. They cited annual reporting, annual audits, occasional church audits and availability of the annual planning process as justification for this.
- **Community involvement.** 30% is a more realistic figure and not 0%. Participants felt the use of suggestion boxes; presence of hospital boards with some members from the community; involvement through organizations such as Friends of the Hospital; and implementation of patient satisfaction surveys in some facilities is justification for the score.
- **Cross-institutional information sharing.** 15% is more realistic and not 0%. Participants noted that cross-institutional information sharing is erratic and unpredictable. However they added that it occurs to some extent among CHSs belonging to the same denominations during workshops, seminars, meetings.
- **Church leader’s awareness of key messages.** 65% is more realistic and not 0%. They noted that hospital boards and executive committees inform church leaders about impending health activities such as campaigns, health emphasis weeks and mass immunization. In addition, some health education initiatives for church leaders are carried out by some CHSs.
- **Pharmaceutical function represented at all levels of discussion.** 50% is more realistic and not 0%. Participants noted that there are 3 levels where pharmaceutical representation may occur mainly in the hospitals. At Pharmacy and Therapeutics Committee (PTC/DTC) level, management team level and board level. Currently pharmacists are represented at PTCs/DTCs and management level in the majority of CHS hospitals. The situation at lower levels of care could not be verified.

Two guidelines were thought to be showing higher scores than probably realistic for the country.

- **Compliance with best practices for medicines storage and management.** Participants felt that at the time of the survey, the results must have been less than 33%. However, they noted significant improvement with the advent of ART programmes. Key players cited include: Institute of Human Virology Nigeria (IHVN); AIDS Relief; Hygeia Foundation (HF); International Centre for AIDS Care and Treatment Program (ICAP); and “Nongu u Kristu u ken Sudan hen Tiv” (NKST), also known as Church of Christ in the Sudan among the Tiv.
- **Functioning PTC/DTC in hospitals.** It was noted that the majority of CHSs lacked PTCs/DTCs and the group felt that 33% is more realistic and not 88%.