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HEALTH SYSTEMS STRENGTHENING: FOCUS ON PHARMACEUTICAL HUMAN RESOURCES

The World Health Organization (WHO) defines a health system as consisting of all organizations, people and actions whose primary purpose is to promote, restore or maintain health. It also emphasizes the values and principles of primary health care, including equity, solidarity, and social justice, universal access to services, multi-sectoral action and community participation, as the basis for strengthening health systems.

While a humanitarian approach centres around the immediate delivery of health services, health systems strengthening supports the building of sustainable public health systems. It entails improving performance and effectiveness of critical components of health systems, needed to improve health outcomes. According to WHO, these six essential building blocks are- Service Delivery, Health Workforce, Health Information and Knowledge Systems, Medical Products, Vaccines and Technologies, Health Financing, Leadership and Governance.

Of these blocks, the issue of human resources for health appears to have had the most publicity. In most parts of the world the numbers of health workers fall short of demand. However for some church health systems the danger of collapse due to human resource challenges is very real. The situation with respect to pharmaceutical personnel is particularly dire. Data from baseline studies carried out by the Ecumenical Pharmaceutical Network between 2005 and 2007, in church health institutions in Malawi, Uganda and Ghana showed that in all the three countries, the availability of pharmacologically trained persons was less than desired. In Malawi less than 20% of the institutions had a pharmacologically trained person (person with training in pharmacy at either degree, diploma or certificate level). Handling of pharmaceuticals is largely left to nurses. Uganda was only slightly better off with 22% of the 174 church health institutions employing a pharmacologically trained staff. In addition the vast majority of these were pharmaceutical assistants trained in a 2 year program run jointly by the Christian Health Associations in East Africa. This programme closed in 2002.
In Ghana, which has higher levels of pharmacists, pharmacy technicians and pharmacy assistants than most other African countries, only 40% of the institutions surveyed employed a pharmacist.

This edition of Contact magazine focuses on pharmaceutical human resources, who are crucial for the delivery of quality health care. Church health systems in particular have to take up the challenge of attracting, motivating and retraining qualified pharmaceutical human resource. Innovative approaches and creative solutions are required but the current situation is untenable as we strive to deliver just and compassionate quality pharmaceutical services.

Angela Mutegi is the Communications Officer for the Ecumenical Pharmaceutical Network.

**Training Health Workers in Africa: Documenting Faith-Based Organizations’ Contributions -**

**PEARL, Erika et al., 2009**

**Focus on lessons learnt and recommendations**

The World Health Organization estimates that faith-based organizations (FBOs) provide 30-70% of health care in the developing world (2007). However, there is very little recognition or documentation of the contributions that FBOs make in the pre-service and in-service training of health care professionals, especially in sub-Saharan Africa.

In many countries the only health care providers in rural areas are nurses and midwives. They are the individuals responsible for the health of their local communities. Data from these African countries clearly suggest that FBOs are making a significant contribution to their national health sectors through pre service and in-service training.

**Lessons Learned and Recommendations**

1. FBO networks need financial and technical assistance from partners, donors and national governments in strengthening the documentation of their contributions to the provision of health care and training of all health workers in their countries.

2. FBOs should develop an ongoing data set listing all training institutions, training courses, numbers of trainees and numbers of graduates to be used for planning and managing the health workforce both by the FBOs and the national governments.

3. They should share this information on their websites and with the African Christian Health Associations Platform, and continue to collaborate with other partner organizations to strengthen human resources information systems in order to track contributions to capacity-building.

4. FBOs should use these data to more effectively advocate for increased support of these training institutions.

5. FBOs are an important source of support for human resources for health capacity building in low-resource countries and in rural settings.

6. Nongovernmental organizations, donor institutions and governments should strengthen their relationships with FBOs; a strong mutual relationship could help to strengthen FBO capacity through information-sharing, networking, advocacy and data collection.

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The technical brief illustrates the nature of health-care training offered by faith-based organisations in sub-Saharan Africa, with a focus on nursing and midwifery pre-service training. To download the full document visit http://www.capacityproject.org/images/stories/files/techbrief_17.pdf.
WHO defines a health system as everything and everyone who contributes to the Promotion, restoration and maintenance of health.

This includes interventions that influence the determinants of health such as poverty, sanitation, water or education to name just a few but also everything that directly works to improve health care.

The foundation of a health system is determined by existing health policies and health leadership (See figure 1). There are good examples where country leadership has played an important part in the control of diseases such as HIV or Malaria. On the other hand the lack of leadership has detrimental effects on the provision of health care. The HIV epidemic in Africa has shown us the impact of leadership and policies that are supportive and on the other hand the effects if they are restrictive.

Senegal is an example for good leadership and a very early and effective intervention in HIV, both in prevention and in access to care and this has contributed to an early control of the epidemic.

While politicians in some other countries ignored the threat of AIDS for fear of alienating conservative supporters by initiating a discussion about safe sex, politicians in Senegal supported efforts to confront the epidemic. In fact the government in Dakar was the driving force behind a declaration on AIDS made by the heads of state of members of the Organization of African Unity in June 1992. The declaration focused on the need for political, religious and community leadership in the fight against the epidemic.

Christian organizations are important providers of health services in Senegal, and AIDS clearly threat-
ened to become a major health issue if it was not prevented. Led by a Catholic NGO, SIDA Service, the churches gradually developed a more supportive outlook towards prevention. They provided important counselling and psychosocial support, and frequently referred those in need to alternative providers where they could not meet needs, for example for condom provision.

Policy makers also realized that young people needed information about HIV and safe behaviour before they became sexually active. Although sexual activity starts relatively late in Senegal, an effort was made to introduce sex education early. By 1992, sex education was part of the curriculum in both primary and secondary schools. In addition, an effort was made to reach young people who were not in school, mostly through youth groups.

Another example is Uganda where a very proactive leadership identified HIV as a problem and as such helped the country to reverse a devastating epidemic to a prevalence of 6,1% from nearly 20%. On the contrary there are examples such as South Africa where the policy environment for many years was not conducive and this has contributed to the very slow response both in terms of treatment as well as prevention.

Other important building blocks for a functional health system, are health financing systems, qualified and trained health personnel, regular and uninterrupted medicine supplies, a health information system that informs clinicians and policy makers alike. In addition appropriate health infrastructure or functioning road networks can be life saving for example to a mother in labour that otherwise may never make it to a health facility. Therefore only if all these building blocks are functional, it will be possible to deliver quality care to patients and effective preventive interventions at community level.

Already in 1978 the concept of Primary Health Care (PHC) as a comprehensive approach to health was clearly defined. Over the past 30 years there have been a number of successful implementations of a comprehensive PHC approach, but in many countries a rather selective or disease based approach to PHC was implemented leading to limited impact.

Since 2001 the Millennium development goals were defined by the international community and signed by many governments. Three of these goals are directly health related, namely
MDG4 with the reduction of child mortality, MDG 5 with the reduction of maternal mortality and MDG 6 that defines the fight against the three main infectious diseases such as HIV, malaria and tuberculosis among others.

Since the MDG’s were announced a number of Global Health Initiatives such as the GFATM, PEPFAR, Bill and Melinda Gates Foundation among others were formed and investment in health has increased tremendously.

However none of these MDG’s will be reached without using such resources also for the strengthening of health systems. Therefore it is vital to identify gaps and invest in strong and sustainable health systems.

The aim of such interventions should be to:

1. Strengthen leadership within government and also within the FBO sector or civil society to develop and implement appropriate health policies within their national contexts.

2. Strengthen the participation of local communities in the management of health issues such as the identification and mobilisation of local resources but also in the identification of health needs and demands.

3. Train and retain qualified health personnel who will also be able to cover rural areas through innovative approaches.

4. Ensure appropriate health financing systems that will efficiently combine the use of locally available resources with national resources and global health initiatives to achieve a benefit that also reaches rural and marginalised populations and communities.

5. Strengthen and develop supply management systems and ensure national policies that will provide access to all essential medicines and diagnostics and use all possible flexibilities in terms of local production of generics and possible south-south trading.

6. Strengthen the health information system between primary care levels up to national level that will enable managers and policy makers alike to use resources appropriately.

7. Strengthen the network between government, faith based organisations, civil society and the private sector sharing of information and the effective use of resources.

8. Strengthen and develop the health infrastructure to accommodate the increasing demand for health care at all levels.

The role of church health services in health system strengthening

Churches are playing an important role in the delivery of health care in many countries. In some countries in Africa more than 40% of health care is delivered through the FBO sector and this often in rural areas reaching marginalised communities.

Churches have also been instrumental in developing both the Primary Health Care concept and programmes.

In addition churches have unique resources such as a vibrant institutional base and grassroots support. The values of social justice, compassion and care are important pillars for the delivery of comprehensive care. However, church and mission health services are often not integrated in the overall government health system and therefore operate outside the mainstream of funding and resources although providing essential care especially in rural areas.

In the light of the enormous health challenges such as HIV and AIDS, malaria, TB, non communicable diseases or the health effects of climate change, it is essential that within a given country church health services are integrated into the overall health system and resources are used efficiently according to need.

Over the past few years resources in health have increased and much has been achieved in terms of reduction of infant mortality rates or access to immunisations. The HIV epidemic has revealed weaknesses in health systems but at the same time much has been done.
through governments, local and global health initiatives and church health services. Today access to ART has increased 10 fold from 2003 to 2009 and at least 42% of all persons needing treatment have access today.6

These are enormous achievements. But at the same time the challenges remain and it is vital that health systems are strengthened and integrated in order to use available resources most efficiently.

In order to achieve MDG 4,5 and 6 on health, it will be vital that churches work together with government and other local partners in the delivery of comprehensive health care. Also the mobilisation and empowerment of the local community in the strengthening of local health services, both preventive and curative will create sustainable services with high levels of acceptability.

In addition church health services have to network together in a true ecumenical way and create a conducive environment for trained health workers to be recruited and retained into church health services at local level. Besides a fair salary scale this should include the possibility of a career structure, training opportunities, good working environment and the possibility of educating children to a good level. This can only be achieved if there is a broad network of churches and facilities that allow for the exchange of staff, facilities and support structures.

In addition governments should recognise the importance of FBO health work especially in rural areas and allow these facilities to be integrated in the mainstream of the health system.

In order to achieve MDG 4.5 and 6 on health, it will be vital that churches work together with government and other local partners in the delivery of comprehensive health care.

Case study

Situation in many systems in resource limited settings.

Mariama is a three year old child in a village in a resource limited country. Her mother reports at the health centre because of a three day history of fever. The night before she had a convulsion and the mother is very concerned for the little one. The nurse wants to do a malaria test; unfortunately the laboratory is not functioning because the lab-technician has left for the city where he earns more money.

Mariama is started on parenteral quinine but she is so pale that she needs a transfer to the next hospital for a blood transfusion. This means 45 minutes by taxi as the only ambulance of the health centre is broken and will only be fixed in a week’s time. The mother takes nearly all her money and finds a taxi in the village. Once at the district hospital she is admitted. Her HB is 4g% but there is no blood in the blood bank. Now it is up to the relatives to find an appropriate donor. Unfortunately the family lives in a rural area. This is one of many examples that health workers in one way or another have seen or experienced working in a rural health care setting in a resource limited country. It is not just malaria, HIV or TB that kills children or adults - it is the daily fight with the lack of resources, facilities or qualified staff that can be discouraging for staff and communities alike.

Dr. Gisela Schneider is a medical doctor, specializing in public and reproductive health. She is currently the director at the German Institute for Medical Mission (DIFAEM) in Germany.

References

2. The Global Fund to Fight AIDS, Tuberculosis and Malaria
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HUMAN RESOURCE CONSTRAINTS REMAIN A MAJOR IMPEDIMENT TO MEDICINE ACCESS IN EAST AFRICA

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2. Management Sciences for Health, Washington, USA

Over the past decade the East African region has experienced a tremendous increase in the volume of medicines for management of major ailments; malaria, HIV and AIDS and Tuberculosis. This has been partly due to a number of global initiatives that have implemented programs to improve access to essential medicines in the region notably; UNAIDS, the Global Fund, PEPFAR, among others. Despite these efforts, efficient distribution and supply, appropriate management of inventory and rational use of medicines continue to pose challenges in the region. Human resource constraints have been singled out to be the major cause of these medicines related challenges and the creation of a functional pharmaceutical management system. An effective pharmaceutical supply management system is critical in ensuring access to medicines.

Recognizing the need to build in-country and regional capacity in pharmaceutical management, Uganda’s Makerere University, with technical assistance from the USAID supported Rational Pharmaceutical Management Plus (RPM Plus) Program of Management Sciences for Health (MSH) established a network of academic institutions to build capacity for pharmaceutical management.

This included institutions from Uganda, Tanzania, Kenya and Rwanda and had the aim of improving access to safe, effective and quality-assured medicines for the treatment of HIV and AIDS, TB and Malaria through spearheading in-country capacity building and operational research activities.

Through this framework, an assessment was
Figure 2 Human resource related problems, perceived causes and possible interventions

<table>
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<tr>
<th>Identified Problem</th>
<th>Perceived cause</th>
<th>Suggested intervention</th>
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| Drug shortages/ Expiries | Inappropriate quantification methods / Poor inventory management practices | Training on quantification methods  
Training on inventory management |
| Inappropriate prescribing | Inadequate training  
Insufficient number of prescribers | Training on appropriate prescribing  
Training more prescribers  
Review prescribing laws and regulations to allow more health care cadres to prescribe |
| Inappropriate dispensing | Inadequate training | Training health care workers on appropriate dispensing practices |
| Non-adherence to ART | Inadequate counseling  
Inadequate monitoring and reporting | Build skills on appropriate counseling techniques  
Training on monitoring and reporting |
| Inadequate levels of staffing | Limited funding for training and education  
Poor remuneration and working conditions | Mobilization of more funding for training and education  
Improve remuneration and working conditions |
| Geographical staffing inequity | Preference for working in certain geographical locations such as cities | Introduce incentives for working in non attractive areas |

conducted to identify specific human resources constraints for pharmaceutical supply management in the region with specific reference to antiretroviral therapy.

Numerous problems were identified in the four countries with regard to the supply and management of ARVs. These problems included drug shortages and expiries, inappropriate prescribing, inappropriate dispensing and poor adherence to treatment. In addition, there was inadequate staffing to manage ARVs in almost all facilities surveyed. The details of the causes and possible solutions to these problems are outlined in the table above.

Nurses and midwives shouldered the burden of distributing medicines at the various stages of the supply chain, a role for which they had not been appropriately trained for. The distribution of healthcare workers managing medicines in Uganda is shown in the figure on the next page.

It is clear from this assessment that the training of pharmaceutical technicians in the region should be prioritized or courses offered to nurses and midwives should include aspects of managing pharmaceuticals.
Incentives for working in non-attractive areas and enacting appropriate legal frameworks to support task shifting are some of the issues that need to be explored to address this problem.

While the issue of electronic dispensing tools (EDTs) never came out as a possible solution to the problem of drug shortages and expiries, understandably due to the lack of infrastructure to support these systems, there have been recent reports of success with these systems in Namibia. There is need to explore the use of EDTs in public facilities. In addition to training, the availability of clear and concise guidelines on the supply management of medicines at various levels is necessary.

Conclusion

Problems with supply and management of medicines exist in all the countries in East African region. These problems include inadequate numbers of staff, limited capacity to select, quantify and distribute the drugs, and irrational prescribing and dispensing. Inadequate training was cited as the main reason for most of the problems identified in the region and training using specific competence packages recommended. On-the-job training with regularly follow-up sessions was generally preferred. Reinforcing training with clear and concise guidelines on the supply, management is necessary.

Paul Waako MBChB MSc. PhD. Is currently the head of the pharmacology and therapeutics department at the university of Makerere.
PHARMACEUTICAL HUMAN RESOURCE CRISIS: A COMPARATIVE ANALYSIS OF AUSTRALIA AND MALAWI

The shortage of health workers across the globe is an issue that continues to cause major challenges for health systems. Scarcity of trained pharmaceutical personnel impacts on access to quality essential medicines and limits the improvement in rational use of medicines by health professionals and patients.

The International Pharmaceutical Federation (FIP) recently released its Global Pharmacy Workforce Report 1. This report clearly demonstrated that to ensure a well functioning pharmaceutical system it is imperative that there are not only adequate numbers of pharmaceutical personnel but also that the personnel have appropriate competencies. The report also highlighted that less developed countries have a greater pharmacy workforce crisis than developed countries and in all countries there is a marked urban-rural distribution imbalance.

A brief comparison of Australia and Malawi showcases these issues highlighted in the FIP report.

The case of Australia

Australia is a country of 22 million people covering an enormous area of almost 7.7 million square kilometres 2. It is a country whereby 87% of inhabitants live in an urban setting 2. Like many countries, Australia has a shortage of pharmacists. However, in recent years the shortage has reduced significantly to a point whereby the deficiency is predominantly in rural and remote regions.

Moving from the traditional dispensary role, pharmacists are taking on a larger responsibility in medication management and providing primary health care services.
The improvement is mainly attributed to an increase in the number of universities offering a Bachelor of Pharmacy degree. Moving from the traditional dispensary role, pharmacists are taking on a larger responsibility in medication management and providing primary health care services. Many pharmacists are becoming accredited to provide government funded medication reviews for patients. To an extent, such changes in the role of a pharmacist have resulted in some task shifting. It has enabled pharmacy technicians to take greater responsibility in the ordering and dispensing of medicines thereby allowing pharmacists more time to use their professional skills. Despite the increased number of pharmacists there still remain challenges in workforce supply. These include more females (who make up a larger proportion of pharmacists) choosing to work on a part-time basis, in pharmacies opening extended hours and the continued challenge of retention of pharmacy personnel working in rural and remote areas. The lack of pharmacy personnel along with

A major challenge which threatens all health cadres in developing countries is to retain those that they train.

A pharmacist prepares medicines for a patient
other medical professionals in certain rural and remote regions of Australia is a contributing factor to the poorer health of Australians living in such locations. Despite various strategies being employed which have raised the numbers of pharmacies by 13% in rural and remote Australia, there remain significant differences in the availability of pharmacy services for rural and remote Australians compared to urban residents. Indigenous Australians have a life expectancy that is seventeen years below the average Australian. In the Northern Territory, where 30% of the population are indigenous Australians, there are only 85 pharmacists. In comparison, New South Wales has 4,836 pharmacists serving a population with only 2.3% of its residents being Indigenous.

The table below shows the number and distribution of pharmacists in Australia

<table>
<thead>
<tr>
<th>LOCATION</th>
<th># OF PHARMACISTS</th>
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<tr>
<td>Major City/Inner Regional</td>
<td>13,812</td>
</tr>
<tr>
<td>Outer Regional/Remote/Very Remote</td>
<td>1,126</td>
</tr>
<tr>
<td>Unknown</td>
<td>733</td>
</tr>
<tr>
<td>Total</td>
<td>15,673</td>
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**The case of Malawi**

Malawi has an estimated population of 14.5 million people yet only has 53 registered pharmacists and 161 pharmacy technicians. In contrast to Australia; only 14% of Malawians live in an urban setting. This means the majority of residents live in rural regions of the country. The Christian Health Association of Malawi (CHAM) supports 173 health facilities throughout Malawi. They are mostly located in rural areas and serve the poor and marginalised. In a 2008 study by Mukura, CHAM only had one pharmacist based at the secretariat in the capital city of Lilongwe and nine pharmacy technicians working in individual health facilities that are part of the CHAM network.

The study found that 88% of personnel working in the pharmacy departments of CHAM health facilities had no pharmacy qualification. It is clear that Malawi not only has a shortage of pharmacists but also other pharmaceutical cadre’s, particularly in rural areas where the majority of Malawians live. Until 2006, Malawi had no pharmacy school. In 2009, the first locally trained pharmacists at the College of Medicine will graduate. This is one strategy aimed at increasing pharmacist numbers in Malawi.

A major challenge which threatens all health cadres in developing countries is to retain those that they train. Malawi will also face this challenge and will need to develop and implement appropriate strategies to minimise the exit of qualified professionals. Most pharmacists are consumed by large amounts of administrative work and supply chain challenges. Mukura’s study showed that in CHAM facilities, pharmacy staff had limited opportunity to be more involved in pharmaceutical care.

There is potential for task shifting of pharmacist’s roles to become more clinically focused and ensure the safe, effective and appropriate use of medicines. Pharmacy Technicians have the technical capacity to perform supply chain roles and perform certain administrative responsibilities. Speaking at the FIP Conference in Istanbul, Director of the World Health Organisations medicines program, Dr Hans Hogerzeil raised the issue of task shifting, saying that there was a need to train lower staff in the health hierarchy to manage their responsibilities. Another major challenge in developing countries such as Malawi is that there is such a chronic shortage of qualified pharmacy personnel that often staff may be over-stretched. This leaves very little time to spend on quality improvement and process change. Opportunities for pharmacy personnel to participate in appropriate Continuing Professional Development (CPD) activities are essential to improve the quality of pharmacy services.

It is clear that the Pharmaceutical Human Resource situation is worse in Malawi as compared to Australia. However, one common
Opportunities for pharmacy personnel to participate in appropriate Continuing Professional Development (CPD) activities are essential to improve the quality of pharmacy services.

challenge in both settings is servicing those in rural and remote areas and also those from marginalised communities. It is important for countries to learn from each other and work together to provide solutions to the shortage of pharmaceutical personnel. A broad approach is required when developing strategies to improve the current situation. Consideration must be given to the roles and responsibilities of all pharmaceutical cadres, the varied specialisations in the pharmacy sector and the location and resources available. It is vital to remember that it is of little value to solely increase the numbers of pharmacy personnel. Assuring the quality and competency of those trained and ensuring availability of pharmaceutical cadres in disadvantaged communities and locations will be essential in improving pharmaceutical care throughout the world.

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John Carroll is a pharmacist and currently the Deputy Director of Pharmacy at North East Health Victoria, Australia
Several articles have highlighted the increasing trend of health worker migration though few have described the scenario for pharmaceutical cadres. Based on available data for the UK, Australia and Ireland, it has been observed that pharmacist migration has increased over the past ten years (FIP, 2006).

An international study conducted in 2006 with final year pharmacy students from nine countries showed that half planned to migrate within the next five years and more than a quarter of all students planned to remain abroad for long term (Wuliji et al, 2009).

The study also identified the need to understand the underlying factors that influence migration intentions. The intention to migrate seems to be as much as a reflection of the individual’s perception of the home environment as it is of the perception of opportunities abroad. However, attitudes do depend on the length of planned migration. Those intending to migrate on a short-term basis (less than two years) shared the same positive attitudes towards the home environment as those who did not plan to migrate. By contrast, those planning long-term migration held negative attitudes towards the home environment and positive perceptions of opportunities abroad.

The perception of opportunities to achieve success in both career and financial situation abroad are just one set of factors. The issue of salaries cannot be separated from professional development and both need to be addressed. Attitudes towards the local practice and professional environment, and social and political environment also influence migration intentions.

These findings imply that pharmaceutical human resources policy should comprise of a comprehensive package of strategies that improve the practice and socio-political environment, professional development opportunities as well as salaries where possible. It is also important to distinguish between those who intend short-term migration and those planning to migrate for the long-term. Short term migrants are more likely to return home, hold positive perceptions about their home environment and facilitate mutual gains from migration abroad. Those planning long term migration will be the most difficult group to retain and least likely to return from abroad.

In targeting strategies to address the underlying factors that influence migration, the retention of pharmacists in the health sector can be improved as the very same factors not only apply to migration intentions but also to attrition within the country.

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Tana Wuliji, is a pharmacist and she was the Editor of the 2009 International Pharmaceutical Federation (FIP) Global Pharmacy Workforce report.
TACKLING PHARMACY WORKFORCE ISSUES IN ZIMBABWE

Health workforce issues are receiving renewed global attention because of their potential impact on health service delivery and attaining the Millennium Development Goals. According to the FIP, Global Pharmacy Workforce Report (2009), fifty-seven countries, 36 of which are in sub-Saharan Africa, have a health workforce crisis\(^1\) in addition, Zimbabwe has been experiencing socio-economic and political problems in the past decade which led to a massive hemorrhage of health workforce.

There are also public-private and rural–urban disparities in the distribution of the remaining pharmacists. Chikanda A (2004) reported that 524 Pharmacists were registered in Zimbabwe in 1997\(^2\). Thirty seven of these registered pharmacists were in the public sector against a staff requirement of 198. This was before the massive brain drain which at one point left the whole public sector with a handful of pharmacist at referral hospitals and the head office. The FIP Global Pharmacy Workforce report (2009) stated that 1077 Pharmacists were registered in Zimbabwe in 2008.

However, the number of those who are resident and practicing in Zimbabwe might be far less than this figure as anecdotal evidence suggests that most pharmacists in the diaspora continue to maintain their registration status in Zimbabwe. The major destinations for pharmacists have been the United Kingdom, United States, Canada, Australia and neighboring countries.

Zimbabwe participated in the Moving On III project on migration trends of emerging pharmacy students from the University of Zimbabwe had an intention to migrate in the next 5 years\(^1\). Chikanda’s (2004) study on

\[\text{Image of a pharmacy with a sign saying 'Antibiotics'}\]
migration of health professionals revealed that the major reasons for the intention to migrate are primarily economic\(^2\).

To address the problem the government has introduced a mandatory one year community service following the completion of the pre-registration training where pharmacists receive a limited practicing license allowing them only to work in designated government institutions for one year. This only provides a temporary measure to the crisis in the public sector which has left most public institutions including some referral hospitals without pharmacists. This is because most of the pharmacists leave the public sector as soon as they finish serving their mandatory community service.

For a pharmacist practicing in a Zimbabwe, there are plenty of opportunities to pursue. However often financial incentives and the desire for international exposure make the call to migrate more attractive than the option to stay and make a difference for the country.

What can be done?

Opportunities for further studies especially sandwich programs would allow young pharmacists to pursue post graduate studies whilst in their countries at the same time gaining international exposure through short to medium term placements or fellowships at partner institutions in developed countries. This might be the ideal solution to sustainable workforce development in developing countries. The graduates will benefit from the attractive opportunities and technological advancement in developed countries and continue to provide service to their home countries. In addition, this can also serve as a platform for capacity building for the home institutions, sustainable pharmacy workforce development and technological transfer without prejudicing the developing nations facing a workforce crisis.

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1. FIP Global Pharmacy Workforce Report 2009

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By 2002 the Dépôt Central Médico Pharmaceutique (DCMP), a government structure which had been created to ensure the supply of medicines to public health institutions, was no longer able to fulfil its mission – after 20 years of existence. This led to a shortage of essential medicines in the majority of health institutions, the expansion of the private for profit health sector, the spread of medicines of doubtful quality, and the lack of coordination of interventions aiming at supplying medicines to the people.

In this time of crisis, the church created pharmaceutical depots for the procurement and distribution of medicines for their own health institutions. For example, the depot of the Hôpital Evangélique in Vanga in the province of Bandundu, the depot of the Hôpital de la Communauté Evangélique Ubangi-Mongala Karawa (Nord Equateur), the diocesan depots of Kisantu (Bas-Congo), Kananga (Kasai Occidental), and Mbuji Mayi (Kasai Oriental) just to name a few.

Even though the church depots often face limitations with regard to planning purchases and assuring quality of medicines, they were – and still are in some areas – the only source of medicines for health institutions and the population.

New national system of medicine supply

Facing this deficiency, the government decided in 2002 to create a new system of medicine supply with the support of the Belgian Technical Cooperation. The new system was based in two strategic principles –

1. Centralised purchasing by FEDECAM (Fédéra-
tion des centrales d’achat de médicaments essentiels)

2. Decentralised distribution through a network of Centrales de distribution régionale (CDRs) – Regional Distribution Centres.

Currently, about 15 Regional Distribution Centres are functional and integrated in the national supply system – out of the desired 30.

**The role of the church in the new system and its partnership with the government**

Churches played a major role in the development and the implementation of the national system. The following points demonstrate their role:

- Nearly half of the CDRs have either evolved from former church depots or have been set up by faith based organisations (Sanru/Eglise du Christ au Congo, the Catholic Church and the Salvation Army among others). In most of the cases, churches accepted that their former depots be upgraded and transformed into Regional Distribution Centres to serve a significant number of health institutions including those that do not belong to their denominations. This is the case for the diocesan depots of Kisantu, Kananga and Mbuji-Mayi which have become the Centrale Régionale de Kisantu (CAAMEKI), Centrales Régionales de Kananga (CADIMEK), and the Centrale Régionale de Mbuji Mayi (CADMEKO).

The government (or its representatives at the provincial level) and other stakeholders in the catchment area of the CDR are its members and are involved in management structures. Therefore you rarely see nowadays a church and another organisation involved in health to put in place two depots or drug supply organisations in one and the same area.

In two of the above mentioned CDRs the partner organisations have appointed church leaders as presidents of their boards. While keeping its role as a regulatory authority, the government is a co-actor in the implementation and management of the CDRs that enjoy their own legal status and financial and managerial autonomy.

The CDRs have basically become indispensable in some regions: there are more and more development partners in the field of reconstruction and health who sign contracts of collaboration with the CDRs for the supply of essential medicines in the respective health districts. This is particularly the case for AXxes, a programme funded by USAID, and FASS (Fonds d’achat de services) which is financed by qième FED/ European Union.

These programmes open credit lines for the health districts at the level of the CDRs. In DRC the health district is the operational unit for planning health development. Usually a health district includes 10 to 15 health centres to cover a population of 100,000 to 150,000. Christian health institutions also benefit from the assistance of development partners if the health district in which they are integrated is supported.

**Conclusion**

The implementation of the new system of drug supply in DRC offers a number of advantages with regard to sustainability of the supply system, quality assurance and governance due to the partnership principles which guide the CDRs.

The partnership between the Church, the government and other partners involved in health is one of the major factors contributing to the implementation of the system and assuring its sustainability.

We envision that this partnership will continue and serve as an example for other countries. Partnerships plays a vital role in ensuring permanent provision of quality medicines and services to our populations which also take into account their socio-economic, cultural and geographical situation.

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**EXPERIENCE**

Therefore you rarely see nowadays a church and another organisation involved in health to put in place two depots or drug supply organisations in one and the same area.
SUCESSES AND CHALLENGES OF CAMEROON BAPTIST CONVENTION (CBC) TRAINING SCHOOL FOR HEALTH PROFESSIONALS

The origin of the school dates back to some 54 years ago, the school has turned out hundreds of highly trained, competent and dedicated professionals who constitute most of the human resource pool of the CBC Health Board. The school also makes an important contribution to the overall health workforce of Cameroon; which is one of the countries con-
sidered as having a critical shortage of health professionals.

The main campus is located at Banso Baptist Hospital in Kumbo, Bui Division of the North West Region of Cameroon. The School is a brain child of the late missionary doctor and founder of Banso Baptist Hospital; Dr. Leslie Chaffee (1909 -1973), who was granted authorization in 1955 to open a grade II Midwifery School, after repeated applications to the Cameroon government of the time.

Over the years, it has developed into a reputable multidisciplinary learning institution for over 20 different categories of health care personnel. The main disciplines offered today are: midwifery, nursing, laboratory sciences, pharmacy, dentistry, physiotherapy, operating room technology, anaesthesiology, ophthalmology, radiology and ultrasonography.

The CBC Private Training School for Health Personnel operates under the motto “Teaching in Christ’s Name”. It has stood out, not only as an academic and professional institution for health care personnel, but also as an institution that emphasizes Christ’s evangelical message and moral standards on its trainees. To date hundreds of Cameroonians and a few foreign nationals have trained in this institution since 1955, and have contributed significantly to the health and spiritual well being of millions of people in Africa.

The school has continued to expand, as the need for health care providers continues to increase, and as hundreds of unemployed nationals continue to seek admission into the courses offered. This has necessitated the construction of a bigger campus, currently under construction in the premises of the Banso Baptist Hospital.

**Major Milestones:**

- 1955- Authorization granted to open a grade II midwifery school
- 1957- First five students graduate as grade II midwives
- 1963- First batch of grade I midwives take final exams (some were grade II midwives who did one additional year of training. For those who had no previous
training, the course lasted 2½ years)

- 1965- Last class of grade II midwives graduate
- 1966- First batch of nurses complete 3½ year course
- 1974- Combined course on nursing and midwifery started
- 1976- Nursing Aide training (one year course) started. Some did a second year termed “Nursing Aide Laboratory Option”
- 1981- The School undergoes a name change from “Banso Baptist Hospital Nursing School” to “CBC Private School for Nursing and Midwifery”, and becomes a separate institution from the hospital. Pioneer Director of the School (Eleanor Weisenburger) retires.
- 1991- The name of the School is changed again to “CBC Private Training School for Health Personnel”, to reflect the multiple disciplines offered.
- 1992- First Laboratory Attendants trained
- 1997- Dental Auxiliaries and X-Ray Technicians trained.
- 1998- Assistant Physical Therapists trained
- 1999- First batch of Pharmacy Technicians graduate. Physiotherapy Aides trained
- 2000- Ophthalmic Aides trained.
- 2001- Pharmacy Aides and Dental Therapists trained
- 2002- First Laboratory Auxiliaries trained
- 2007 - Ground breaking and start of construction of new school facilities.
- 2008- First Cameroonian appointed Director of the School.

Some challenges:
The major challenges of the CBC Private Training School for Health Personnel are two fold: infrastructure and staffing.

The current block occupied by the School has become grossly insufficient for the courses offered. This structure contains only three classrooms, a library, four offices and toilet facilities. Construction is already underway for a more spacious facility, but progress is rather slow due to financial constraints. The number of permanent faculty members is only seven. However, the School constantly draws on the expertise of medical and other health care professionals (some of whom are expatriates)
serving in the CBC hospitals for part time tutoring.

These two challenges have brought about a situation where some courses such as in pharmacy, anaesthesiology and ophthalmology are offered at other CBC hospital/facility sites (where the required trainers are based), miles away from the main School. Such courses are nonetheless done under the supervision of the school.

On the part of the students, raising the required tuition fees and training requirements is sometimes difficult for some.

These challenges may seem tough, and would require a certain amount of faith to overcome. The visionary leadership of the CBC Health Board is determined to overcome these challenges and believes that, like the biblical mustard seed the School will blossom into a beautiful tree of knowledge and professional excellence.

Some contributions to this article were provided by Bongkung Handerson of the CBC Health Board Press Division

References:

Nathan Wanyu is a Pharmacy Technician trained in the CBC PTSHP. He is currently Assistant General Manager of the Central Pharmacy of the Cameroon Baptist Convention.
CHRISTIANS believe that the bible is “Divine” that is being from God rather than from man. Whatever way one may want to consider it, there is no doubt that these sacred writings are pretty impressive; and undoubtedly they are some of the greatest works ever written. But some may be wondering what these writings have to do with building sustainable pharmaceutical systems. Well, everything. This article seeks to make the case on how scripture can provide guidance on this subject.

For believers “The Word” is food for the soul, likewise it would not be so misplaced or exaggerated to say that medicines are the lifeline of any complete functioning Health Care System, most especially in the poorer regions of the world. Access to pharmaceuticals in many cases is a life and death issue. We are faced with a moral obligation to ensure the global population has equitable and regular access to essential medicines.

Therefore there is a need to develop pharmaceutical systems that are grounded on principles of fairness and compassion. As Christians we ought to constantly ask ourselves what would Jesus do for instance in developing these systems. In this case, it would require that pharmaceutical pricing policies of the public and private sector take into account economic constraints of individuals, particularly the very poorest in resource constrained countries where public health insurance cannot guarantee access to pharmaceuticals for the poor. Medicines are delivered through pharmaceutical systems. Therefore in order to ensure constant availability of these all-important com-
modities with our limited resources we need to build and guarantee the sustainability of pharmaceutical supply systems.

What lessons are available from scripture that would help us?

Regulations and standard procedures

As should be evident to anyone dealing with medicines, all the steps or elements involved in the processes that take place from procurement to dispensing and use by the patient have a right way in which to be done as well as a wrong way. And all scriptural texts prescribe acceptable and unacceptable ways by which followers have to conduct themselves. We have a moral obligation to be designers of policies that promote compassion globally and take into full account the public health needs of the poor.

Financing

Truly it is our desire to do it all free. However, two points speak against this. In Holy Scripture, it says give unto God what is God’s and unto Caesar what is Caesar’s. Even with the best of wishes, the pharmaceutical companies cannot survive without reaping from what they sow. Also, it is very clear that in our secular societies the actual value of anything offered free is almost always underrated.

Use of resources

How often have we complained about the limited resources at our disposal and the lack of drugs when they are most badly needed? Well, Christ challenged his disciples: Mark 6:35-36, “You give them something to eat.” Now, this definitely was an appeal to the complaining disciples who saw what was at their disposal as inadequate. The call is, rather than complain do something about it. Not many would be in a position to feed 5000 with five loaves and two fish I admit. But this passage challenges us to think innovatively about how to use whatever we have for maximum benefit. It also challenges us to look at the world with the compassionate heart of Christ to see that the works of charity especially to those patients in resource limited countries that are not able to afford medicine, are still very much needed. It is against the teachings of the scripture to close our eyes to their appeal.

Every life counts

In contrast to the feeding of the five thousand, Mt. 26:11 presents Jesus rebuking his disciple for complaining about the “wastage” of expensive oil which had been used to anoint his feet. Jesus said to the concerned disciple “The poor you will always have with you, but you will not always have me”. And so there is the constant call for us to deal with each and everyone in our care as unique individual with a special purpose on earth. This person presenting at your clinic or pharmacy seeking your help could be destined to change the world, could be responsible for the lives of hundreds of other people or could be in the twilight of his/her own life. His/her situation does not matter. What matters is how we deal with them, you could be meeting for the very last time. What a torment it would be for most if they realized that their inaction or reluctant service led to the suffering or death of a fellow human being!

Questions for reflection

1. What other scriptures from the bible do you feel would shed more light on this issue?

2. How best can we practice servant leadership in setting global health systems?

3. How can give unto God what is God’s and unto Caesar what is Caesar’s help Christian health systems in issues of governance and financing?

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Systems Thinking for Health Systems Strengthening
The report offers a fresh and practical approach to strengthening health systems through “systems thinking”. This tool suggests ways to more realistically forecast how health systems might respond to strengthening interventions, while also exploring potential synergies and dangers among those interventions.

The Flagship Report can be downloaded on the following link.

Handbook on monitoring and evaluation of human resources for health, with special applications in low- and middle-income countries
This Handbook offers health managers, researchers and policy makers a comprehensive and standard reference for monitoring and evaluating human resources for health. It brings together an analytical framework with strategy options for improving the health workforce information and evidence base, as well as country experiences to highlight approaches that have worked. A joint publication of the World Health Organization, World Bank and United States Agency for International Development. http://whqlibdoc.who.int/publications/2009/9789241547703_eng.pdf

The Health Systems Assessment Approach: A How-To Manual was developed by Health Systems 20/20, Partners for Health Reformplus (PHRplus), Rational Pharmaceutical Management Plus (RPM Plus), and the Quality Assurance Project (QAP). It is designed to provide a rapid yet comprehensive assessment of a country’s health system. The approach covers key health systems functions and is organized around seven technical modules, which guide data collection and assessment http://www.who.int/pmnch/topics/continuum/hssassessmentapproach/en/index.html

Health Systems Database
The Health Systems 20/20 Health Systems Database is an easy-to-use web-based tool that compiles and analyzes country data from multiple sources, provides charting options, and generates automated country fact sheets, helping users to assess the performance of the country’s health systems.
http://healthsystems2020.healthsystemsdatabase.org/

Health Systems and the Challenge of Communicable Disease
Experiences from Europe and Latin America

Everybody's Business: Strengthening health systems to improve health outcomes: WHO’s framework for action
The primary aim of this Framework for Action is to clarify and strengthen WHO’s role in health systems in a changing world. There is continuity in the values that underpin it from its constitution, the Alma Ata Declaration of Health For All, and the principles of Primary Health Care. Consultations over the last year have emphasized the importance of WHO’s institutional role in relationship to health systems. The General Programme of Work (2006-2015) and Medium-term Strategic Plan 2008-2013 (MTSP) focus on what needs to be done. While reaffirming the technical agenda, this Framework concentrates more on how the WHO secretariat can provide more effective support to Member States and partners in this domain. Available at:
http://www.searo.who.int/LinkFiles/Health_Systems_EverybodyBusinessHSS.pdf

Contact deals with various aspects of the churches’ and community’s involvement in health, and seeks to report topical innovative and courageous approaches to the promotion of health and healing.

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