FBOS ON A MISSION:  
30 YEARS OF SUPPORTING 
PHARMACEUTICAL SERVICES

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THE ROLE OF WCC’S HEALTH AND HEALING PROGRAMME IN A CHANGING WORLD

Consider these facts:

- 80% of the people of this world follow some faith tradition or belong to a religion.
- Faith, with its practice and belief systems, has a significant influence (both positive and negative) on the health and well-being of individuals and communities.
- Religious organizations and institutions play a significant role in delivering healthcare in the most needy and vulnerable regions.
- Faith is a major conduit for social mobilization, as it binds people together on the basis of common values, be it serving people in the margins of society or striving for justice and equity, and instilling hope, resilience and courage among individuals and the community.
- Religious communities and leaders often have a great influence on policy formulation and public opinion on issues that have profound influences on public health.
- Religious assets when mobilised, can greatly assist in achieving health for all.

World Council of Churches (WCC) started addressing health issues from the year 1968. As a worldwide fellowship of 349 churches seeking unity, a common witness and Christian service, from more than 150 countries from all regions of the world, WCC brings together 500 million people. A close working relationship exists with the Roman Catholic Church, Pentecostal and Evangelical Churches and with other faith communities and civil society.

WCC is a significant global instrument for positive transformation and continues to provide a vital and dynamic space in the international arena to mobilise society to achieve ‘health for all’. It provides the channel for voices from grassroots communities with special emphasis on the marginalised and vulnerable, to influence the discourse and decision making on health. The Ecumenical space also plays a key role in sharing of experiences on how challenging issues are dealt with in communities and for strategising and directing efforts aiming at transformation of policy and praxis and structural change within faith communities.

How effective has WCC been?

In its 42 year history with health & healing related work, WCC has had significant positive impact in promoting health globally:

- **Health for All and Primary Health Care**
  - The Christian Medical Commission of the WCC played a key role along with its faith-based and civil society partners in the different regions working with the World Health Organization and UNICEF to evolve, develop and promote the concept of Health for All, with Primary Health Care as key to achieving it. The Ecumenical space became a dynamic confluence of action-oriented thinking from the scientific arena, health service sector, theological, ethical and social arenas, to bring about a paradigm shift in international policy in health.

- **Strengthening the hands that heal: cooperation, networking & empowerment**
  - Lifting up the need for national, regional and international cooperation in all facets of the healing ministry of churches, WCC, along with other key Ecumenical partners, accompanied the formation of 33 National Christian Health Associations (CHA). Along with CHAs and other Partners, WCC also accompanied the process of formation of the dynamic ‘African Christian Health Association Platform’. On the same lines, the Pharmaceutical Programme was initiated by the WCC 30 years ago. This major programme has since evolved into the independent ‘Ecumenical Pharmaceutical Network’ which is the voice and arm of the faith communities, supporting and empowering the pharmaceutical service delivery in Church Health Systems.

- **Facing HIV: the competent and compassionate church**
  - WCC involvement with HIV and AIDS began in 1986, with much of its work focused on pastoral care, prevention, education and advocacy. Developing contextual biblical, theological, ethical, pastoral and liturgical literature and distributing them free of charge have been among the most significant contributions by the WCC. In 2002, WCC launched the Ecumenical HIV and AIDS Initiative in Africa (EHAIA) in cooperation with the All Africa Conference of Churches (AACC) and other stakeholders, including people living with HIV. EHAIA has trained thousands of church leaders, HIV activists and programming officers. It has also mobilised theological institutions to integrate HIV and gender studies into their curriculum in an endeavour to build HIV-competent churches and theological institutions. Simultaneously, other regional initiatives in HIV have been accompanied, notably, in Asia, the Pacific and Eastern Europe.

- **The healing community: health as central to the mission of the church**
  - The discourse in the Ecumenical movement has promoted a comprehensive understanding of health. Alongside the practice of medicine, practical caring, psychotherapy and counseling, the Christian duty to the sick also includes the addressing of explicitly spiritual needs, as well as working for justice and peace. Such diverse activities are encouraged to be seen and experienced as part of God’s work in creation, and God’s presence in the church. This has been promoted through the consistent and intentional engagements between health workers, theologians, ethicists and public health experts. The fruits of these interactions also reflect the broader understanding of Mission by churches. Churches and faith communities are increasingly acknowledging the healing ministry and this has a positive impact on the formulation and implementations of policies in many churches. The Strategy Group on Health and Healing which is being co-hosted with the dynamic support of the German Institute for Medical Mission (DIFAM) has been a key support for this work.

What is the possible future role of ‘Health and Healing’ in WCC?

A sacred space for theological reflection and social transformation: people reflecting to act

It is critical for faith communities to see the issues of health through the lens of their faith, so as to espouse the ethical and theological imperative to strive for health for all. Contextual bible studies on critical issues can explore the public health implications of different determinants.
nents of health, followed by interpretations from the biblical stand point. Such approaches can assist communities and congregations to re-frame the issue concerned from a perspective of Christian faith and suggest transformative processes to bring about health for all. To put this into practice, there are plans to designate the month of October as an ecumenical month of Healing, with a specific topic on health and healing each year. Each week will focus on a sub-topic that will delve deeper into the issue with reflections, analyses and discussions accompanied by prayers, liturgies and prayer resources.

An innovative space to face emerging challenges: tomorrow’s people influencing today’s agenda

WCC remains strategically positioned to provide the discerning and convening mechanism, to be able to find solutions for the challenges that society will increasingly face. The regional, denominational and contextual diversity is crowned by the relevance given to the marginalized and vulnerable communities in the ecumenical platform. It is only when the small voices of the people who face maximum challenges are kept in the centre that solutions can be found. It is the space where the prophetic and critical voice will find a place to remind, reprimand and challenge the vast majority. All the past successes of the health work of WCC are undeniably linked to this nature of the ecumenical space. It is important to preserve this space so as to maximize the effectiveness of the healing ministry well into the future.

An open space for learning, cooperation and action: Managing experience and knowledge for the greater good

Facilitation of dialogue and discussion among individuals, faith and communities to encourage critical reflection on holistic healing and the sharing of resources and experiences for enhancing their effectiveness will remain a key area of work. Motivating and building capacity among leaders, churches and theological institutions to prepare to think innovatively in addressing issues of health and wellbeing will remain a clear objective. A new initiative called ‘Safe spaces: Transforming faith communities’ which assists churches and partner organizations in addressing critical issues that are not openly discussed (such as HIV, gender-based violence, abuse within intimate relationships, sexuality and sexual relationships) is a good example of this new direction.

A critical space for advocacy in health: faith communities aware and willing to make ‘health for all’ a reality

It is vital that WCC continues to be a meeting place for the highly evolved church-related specialized services, networks of churches, key civil society movements and international organizations to connect and work on advocacy for international policy transformation and internal advocacy to bring about transformation within communities. In a more globalized world where business interests continue to infringe on the rights of communities and individuals, ‘Health Governance’ at the different levels of society and the interpretation and realization of the ‘right to health’ will continue to remain focal points of advocacy.

The moral imperative

Success in dealing with public health challenges can only be achieved if we see every human being, regardless of race, gender, nationality, educational or economic status, as an equally precious and loving creation of God. Acknowledging each community and individual as capable of contributing greatly to the wellbeing of our world, they are worthy of dignity and respect. Christ’s teaching that what we have done to the least of our sisters and brothers we have done to God (Matthew 25:40), has elevated the diagonal response from being charity and an obligation to being devotion to God. It is in a context of devotion to our Lord that we must continue to strive to utilize all available assets and talents of faith communities for the wellbeing and health of the world.

References


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30 years... longer than many of our careers, longer than some of us can remember. For 30 years, Ecumenical Pharmaceutical Network (EPN) has been strengthening church health services, supporting them to provide just and quality pharmaceutical services for all.

Church health services (CHS) and Faith-based organizations (FBOs) have been relentless in their courage and drive to keep on going. As Dr Kurian points out in his foreword, faith is a major conduit for social mobilisation. Faith indeed is what drives all those institutions, pushed out of the ground by churches to bring health care to those who need it, from the smallest church dispensary to the largest pharmaceutical supply agencies. It is also faith that has allowed for the creation and growth of the Ecumenical Pharmaceutical Network, out of the Pharmaceutical Advisory Group that was set up by the Christian Medical Commission of the World Council of Churches in 1981, into the independent international member organization that EPN is today. And it is faith that will continue to push us forward, as we give meaning to the command to “love our neighbour”.

This faith and the work it has made possible, is what EPN wants to celebrate in this edition of Contact. Of course in such a celebratory edition, we have to put our members in the spotlight. Their hands are the ones doing the work. The Kenya-based Mission for Essential Drugs and Supplies (MEDS) has become a beacon in the supply chain of East Africa and beyond. Also making a name for itself is St Luke Foundation, now an internationally recognized school of pharmacy. IMA World Health teaches us how healing the sick also means dealing with natural disasters, and coming out stronger. In providing health care, quality of course remains a major concern. Several EPN members show us how to keep a keen eye on quality aspects.

Wonderful stories, but we don’t shy away from taking a critical look at the health system either, noting that challenges related to workforce and budget make it often difficult to really put the patient first. Also read the research, analysis and opinion pieces to find out if church health services are really doing all they can.

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OVERVIEW

THE PAST, PRESENT AND FUTURE OF EPN

For 30 years, the Ecumenical Pharmaceutical Network (EPN) has been actively supporting church health systems, for the benefit of the patient who needs affordable and quality medicines. At this pearl anniversary, Board Chairman Albert Petersen sits down to tackle some important questions about the past, the present and the future of EPN.

With focus areas such as advocacy, training, networking and research, which do you consider to be EPN's most important achievements over the last 30 years?

EPN has been successful in raising the voice of the health and pharmaceutical systems of churches so that their contribution is recognized today by organizations like WHO. Of course still lots of efforts are needed, especially towards getting recognition from governments, NGOs and donors. One condition for advocacy is analyzing the present situation and then moving from there. On this aspect EPN has been very active in the past, carrying out little assessments and operational research projects to assess the current situation in different pharmaceutical fields like human resources, access to children’s medicines, and pharmaceutical systems in the hospitals.

Training has also always been on the agenda but has been concentrated mostly on key individuals in the member organizations. This is changing now with the new 3-month-curriculum training project. A pilot training is being run with 26 hospital pharmacy staff in Nairobi, on the essentials of pharmacy practice and I am sure this training will also be very successful in several other countries in the near future.

Most important for EPN from the beginning has been networking between the organizations and individuals working on pharmaceutical matters inside church systems and to link them and their issues to higher level organizations such as the WHO. I am thankful that I could be part of this from the beginning and can say out of my own experience that sharing, learning and planning together in plenty of meetings and workshops has been very important and useful for all the participants, for their organizations and finally for the patients benefiting from improvements in the pharmaceutical sector.

Which have been the greatest challenges over the years?

First, communication: How to establish close communication between members and the EPN secretariat if the number of key staff in member organizations is very limited: one is on a field trip, one on holiday, one is at an upgrade training abroad and the person left in the office has to reply to all the requests from donors and partners who are crying for reports, financial statements, answers to this and that. And that combined with power cuts, weak IT-systems, among other issues. For me this is understandable, but it poses a real challenge for the secretariat if responses from the members are needed urgently.

Second, the ownership: EPN can remain alive only through its members. But the strategy and activities agreed on in several meetings are not integrated into the members’ own local work plan, it will reach a dead end.

Thirdly, the increasing costs for holding sub-regional or international meetings. Members have to meet physically from time to time, but how can keeping this going if even the biannual General Meeting itself is a budgeting challenge?

Fourth, the dependency on very few very committed donors who are focusing more on projects than on core budgets needed to manage a network-secretariat.

Which role do you think EPN can or should play to counter the health workforce crisis in faith-based institutions?

EPN’s contribution started with painting the picture of the widespread lack of trained pharmaceutical staff in faith-based hospitals of different countries. These mappings have to continue and intensive follow up meetings in-country with members and stakeholders can analyze and strategize how the situation can be improved. The new EPN project on 3-month-basic training is one of the concrete responses to this HR issue that EPN is carrying out these days. Some EPN members are actively running their own training schools or are experienced in regularly supervising existing pharmacy staff. EPN’s role in this is to bring them together for sharing, learning, strategizing and to assist where possible in the process of recognition and accreditation.

We see the glass as half full, but it should be filled further. Lots of efforts have to be built up also to avoid that the glass gets emptier. How to avoid migration of pharmacy staff? EPN has made a contribution by identifying these individuals working in different countries, facilities, conditions. The EPN database already lists quite some pharmacy staff who are regularly receiving EPN publications by e-mail. This has to be strengthened so that they realize that they are not left alone “in the bush” with their questions and problems. Secondly, EPN has been successful in the past in addressing the issue of Medicines and Therapeutics Committees (MTCs) in hospitals. A well functioning MTC needs a very active contribution by the pharmacist, who would then be recognized by his
or her colleagues and hospital management as being important. This would lead to more satisfaction and could limit migration here and there.

The EPN HIV and AIDS treatment literacy guide for church leaders seeks to bridge the gap between the technicalities of the virus and the Biblical basis for the work in care and treatment. Given that community support and eradication of stigma are crucial factors to addressing this illness; can we dream of a future where HIV will be harmless?

The EPN treatment literacy project is successful by informing and convincing church leaders to be active in HIV and AIDS issues. Churches play a big role in the communities to eradicate stigma. These success stories will not dramatically change the world today or in the near future but will change the situation in the community, will change the situation of individuals. We can be proud that here and there EPN is part of the Christian movement that makes a difference in the lives of the hopeless and suffering, showing what God’s kingdom is all about.

In a market where private and public health services are on the increase, how should we picture the role of the church health system in developing countries?

Private market means profit – in many cases not necessarily for the benefit of the people. Private health systems are similar, especially when it comes to medicines. The more one can sell, the more profit there will be and sadly irrationality, life style products, fake or substandard products may creep in to keep this daily business alive. Church systems should be different: the patient is the focal point as an individual human being, while effectiveness and affordability are the indicators of success. Here “our” systems can show impact for the benefit of the people. And in addressing these issues, EPN is lobbying for their right to health that includes affordable, quality essential medicines. The achievements and impact of EPN have evolved in a growing curve over the last few years. Can we imagine a time when EPN's work will be done?

This would be wonderful but I can’t see it happening in the near future. There are still so many issues only touched but not solved, for example the situation in Francophone or in West-African countries, the development of “EPN-India”, implementation of EPN-guidelines in all FBO health facilities... There are other important issues not yet taken up by EPN, for example dignity: what about availability of Morphine for all patients suffering from severe and constant pain? Or the affordability of medicines to treat non-communicable diseases including cancer, and how to improve the pharmaceutical situation in the village dispensaries...? WHO continues to report that only 50% of the people living in sub-Saharan countries have access to essential medicines in good quality – church systems are playing a very important role because they could be able (and they are!) to develop projects successfully to change the situation inside their own surrounding. If EPN continues to make this visible, others will be aware and pick this up for their own systems. So yes, we will push so that the growing curve of EPN’s work and impact keeps on growing. But when our work will be done...what can I say?
In the 1960s, the foundations were laid. Literature from the 1960s to the 1990s still holds relevance for CHSs today, for example addressing mission-based health services and the changes they faced as African countries became independent and national health systems were restructured. This literature emphasizes the effect of different colonial administrations on the development of CHSs, e.g. contrasting CHSs in Anglophone Ghana with the lack of similar services in Francophone Africa.

In the seminal 1981 booklet, *The Quest for Health and Wholeness*, McGilvray described ground-shaking events for CHSs from the 1960s to the 1980s: the changes brought by independence, and the role of the Christian Medical Commission (CMC) and the Tübingen meetings in shaping new thinking on CHSs, the vision of primary health care (PHC), and the formation of Christian Health Associations (CHAs). McGilvray also described the state of the evidence on CHSs – mainly based on studies by the CMC in 1963-1964. He provided what would become pioneering national estimates of medical facilities contributed by church facilities: “43% of the national total in Tanzania, 40% in Malawi, 34% in Cameroon, 27% in Ghana, 26% in Taiwan, 20% in India, 13% in Pakistan and 12% in Indonesia”. Although he then added, “However, one should not see too much into the above ratios because, at the time of the surveys, this church-related sector was a very disparate group which, with few exceptions, had no collective existence.” We still struggle with these estimates today – but more importantly, the core questions McGilvray reported from the 1960s and 1980s are still mostly unanswered, and increasingly critical. Questions about the nature of CHSs, their role in facilities-based versus PHC/preventive care, what it means to be a ‘Christian provider’, whether it is possible to bear the costs of a ‘pro-poor’ mission, whether CHSSs are sustainable given new financial constraints, and queries about the ‘value-added’ of CHSSs. Critical questions – but how far have we come to answering them with solid evidence?

**1990-2000: comparative value**

In the 1990s, the literature showed an increased interest in ‘faith-based organizations’ (FBOs) and the newly divided public and private health sectors, with CHSSs being recognized as significant, and usually clustered as private-not-for-profit (PNFP) providers. Review suggests four main characteristics of the literature from this period: (1) recognition of the role CHSSs historically played in health provision, although not aligned with national systems; (2) ‘market share’ estimates indicating that CHSSs provide a high share of health care; (3) reports of weaknesses of FBOs such as dogmatic resistance to particular health strategies, lack of management capacity, or resistance to evaluation of finances; and (4) statements of ‘added value’ such as unique reach, trust and access into communities, resources such as volunteers and community leadership, networks, and means to motivate staff and sustain quality services.

**2000-2010: pockets of evidence**

The last decade has seen an expansion in the literature, but with gaps and the emergence of isolated informational ‘nodes’. The impact of the HIV and AIDS pandemic on research and data relating to religion and public health cannot be over-estimated. The civil society response to HIV and AIDS, and a skewing of vertical funds and CHSSs’ focus towards it, resulted in more literature addressing the ‘religious response to HIV and AIDS in Africa’. This literature reflects different approaches, but mostly takes slices of the ‘faith sector’, incorporating all AIDS-engaged FBOs (such as CHSSs, faith-based NGOs, Civil Society Organizations (CSOs), or congregational activities). Perhaps two-thirds of the literature on faith and public health in Africa is directly related to HIV and AIDS, to the detriment of work on the daily and holistic health activities of FBOs and CHSSs.

There has also been a growing emphasis on context- and country-specific evidence, recognizing that broad generalizations are rarely useful for policy. Countries in sub-Saharan Africa have starkly different histories resulting in different patterns of civil society and public health engagement in health, as shown by Schmid et al. in comparing Mali (where FBOs are few and Islam does not often manifest through formal health services) to countries such as Zambia which are inundated with a complex range of FBOs. There is better recognition of the complexity of the effect of religion itself – e.g. the pluralistic health-seeking behaviours of patients simultaneously utilizing traditional, religious and medical systems. Work has also focused on the provision and utilization of pharmaceuticals by CHSSs - with EPN and the WHO conducting several important baseline studies. However, these new pockets of literature do not generate a sudden wealth of new evidence. Even today, most work on religion and public health in Africa ends with caveats that the ‘missing evidence-base demands more research’. During ARHAP reviews, efforts were made to collate existing data from ministries, large studies and expert advisers with standard bibliographic searches. This demonstrated the obstacles CHSSs and stakeholders face: in-country datasets were often missing, not electronically available, or only accessible through personal relationships. Even for data that was accessible, challenges remained. More is known about CHSSs in countries that have CHSSs; less is known about health-engaged faith-based NGOs, CSOs and congregations; more is known about Anglophone countries and large FBOs than about district- and community level initiatives whether connected to CHSSs (such as mobile health services) or not (such as informal community care groups).

The interest in CHSSs is not located in one specific discipline, and available evidence is often difficult to use comparatively – with most studies resorting to a qualitative integration of data. There are few standard measures applied to the ‘faith sector’, and no shared typology or classification of FBOs. In addition, many CHSSs have been propelled from not having to monitor their funding streams (trusting in historical partnerships), to being suddenly faced with calls for harmonization and standardized Monitoring & Evaluation (M&E) requirements. While generalization is not fair, it has been noted that many FBOs and CHSSs lack M&E capacity, leaving little time for additional research to ‘make the case’ for the comparative value of CHSSs.

**Current opportunities**

Significantly more work has now been completed through qualitative lenses, e.g. anthropological perspectives on health-seeker behaviours, user preferences and health worker motivations. In addition, there has been an increase in quantitative data relating to CHSSs from Ministries of Health and the CHSSs – although the CHAs (and the ACHAP platform) still face challenges in gathering this data. Questions relevant to CHSSs have also recently been included by the WHO in their Services Availability Mapping survey – although it will take time before this data becomes available.

It is now also possible to tease out some useful data from nationally representative household surveys. When available and reliable, these have the advantage of linking the uptake of services with individual and household variables, including poverty status, the private cost of service for households, and the degree of satisfaction of the household with the services.
Such multi-purpose surveys now commonly distinguish between private/public providers and (as shown in table 1) several now also permit the identification of faith-inspired providers.

<table>
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Source: compiled by the authors

Table 1: Identification of faith-inspired health providers in some household surveys

In Burundi’s 2006 QUIBB survey, for example, ten types of providers are listed: public hospitals, missionary hospitals, private hospitals, public health centres, missionary health centres, private health centres, pharmacies, private doctors, private midwives, and traditional healers. It is therefore feasible to compare market shares between providers and analyze which segments of the population they reach, how much they cost, and whether households are satisfied with the services provided to them. Note that this method of identifying providers through a single question may leave out some CHSs that provide care in non-facility-based ways. An alternative way of identifying CHSs in survey questionnaires is to ask two questions (as in the Ghana GLSS5) to households are asked about the type of facility they use and whether the facility is public, private, religious, or private non-religious. Note also, that while Demographic and Health Surveys typically do not distinguish beyond public/private - they do ask useful questions about the role of churches in specific services, especially in relation to reproductive health and HIV.

The Next Frontier – Supporting Research by CHSs

At a time when more groups and individuals are interested in these topics, and more platforms and electronic tools are available to facilitate the flow of information, there are many new opportunities. There is also renewed vigour in some research areas such as health system strengthening and PHC, which directly impact on CHSs. However, substantial information gaps remain to be filled. Comparative research needs to be conducted, surveys to be developed further, histories remembered, comparative values assessed, lessons from HIV and AIDS research transferred to other areas, and protective behaviours overcome. In all these efforts, the most immediate tasks may be to help CHSs conduct their own research and to link informational nodes more effectively.

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30 years of strengthening pharmaceutical services in church health systems

30 ans de renforcement des services pharmaceutiques dans les systèmes sanitaires confessionnels

References
FAITH-INSPIRED HEALTH CARE PROVIDERS IN AFRICA: TARGETING THE POOR?

Faith-inspired institutions (FIs) state as their mission the aim to provide quality health services to all, and in particular to serve the poor or the rural poor. Are FIs then more willing to (cross)subsidize services for those who can least afford such services? And do FIs serve the (rural) poor more or better than other providers?

Box 1: Quoted estimates on market share and reach to the (rural) poor of FIs

Burundi: More than one third of health services in rural areas are provided by mission clinics

Ghana: Christian Health Association of Ghana members cater for an estimated 35-40% of the national population, mainly in the hard to reach rural parts of Ghana

Kenya: The majority of Christian Health Association of Kenya member health facilities are located in rural and remote marginalized areas of the country

Malawi: Christian Health Association of Malawi manages health facilities in mainly remote rural areas across the country. This makes up 37-40% of all health facilities, and particularly responds to the need for health facilities in some remote areas with little government coverage

Nigeria: Christian Health Association of Nigeria strives to deliver health care to the furthest and most remote parts of Nigeria (where most member facilities are positioned), providing 40% of health services with a special emphasis on the needs of the rural poor

Tanzania: Christian Social Services Commission estimates that faith-based organizations in Tanzania manage 40% of hospitals, 26% of all health facilities and provide 50% of health services in rural areas

Zambia: Christian Health Association of Zambia accounts for nearly 30% of Zambia’s total health care provision in general and 50% of rural health care provision

Zimbabwe: Zimbabwe church missions provide 68% of all beds in rural areas; in Zimbabwe 80% of public facilities, FFIs now collectively do not appear to be as comparatively strong in rural areas as they might have been twenty years ago. While not contesting the desire of FIs to serve the poor, there is unfortunately little current data beyond anecdotal evidence that can be used to strongly demonstrate that this is what is happening, or that they can reach the poor better than other public or non-profit providers, and therefore require different support.

Country Case Studies

The question of whether FIs in Africa reach the poor proportionately more than others begs some clarification: proportionally more than other population groups (internally, among their clientele) or proportionally more pro-poor in comparison to other providers such as other private or public facilities? We provide two examples, based on evidence recently gathered from Ghana and Burkina Faso (see Olivier and Wodon), for a more extensive argument including analysis of data from 14 countries.

Consider first the question of whether, internally, member facilities of the Christian Health Association of Ghana (CHAG) serve more socio-economically disadvantaged patients. This can be investigated first in terms of the location of facilities, given that the extent to which FIs reach the poor is likely to partially depend on this. The available data on the location of facilities owned by FIs suggests that CHAG facilities tend to be located in districts with a higher density of Christians (although facilities serve everyone in their catchment areas), but that overall, on a national scale they are not significantly more present in poorer areas than in better-off areas. One reason for this can be that CHAG is less present in some of the northern districts with a higher concentration of Muslim populations and significantly higher poverty levels. This is difficult to explain in national policy-level discussions, given the strongly expressed desire by CHAG members to serve the poor, primarily in rural and hardship areas. One explanation could be that the poverty geography has changed since these facilities were established. Another explanation may be that we are not clearly seeing how CHAG facilities might be providing preferential option for the poor, even located in less-poor areas, because of data gaps on who is served by whom within districts.

However, evidence from the most recent household survey data available for 2005-2006 (identifying where patients get their care within districts), confirms that while CHAG serves more of the poor than for-profit private providers (as would be expected), it does not necessarily serve the poor more than public providers. The data suggests that the clientele of CHAG tends to be less poor than the population as a whole, essentially because most CHAG facilities are hospitals and clinics, and as is observed in virtually all sub-Saharan Africa, care provided in these types of facilities tends to be more expensive and less accessible to the poor. This does not mean that CHAG facilities do not make special efforts to reach the poor and to make care more affordable for them. But, due to the nature of the service provided and the broad constraints faced by the population when seeking care, even if such efforts may indeed succeed in reaching proportionately more of the poor, overall the services provided by the facilities cannot be described as ‘pro-poor’.

Are CHAG facilities comparatively more pro-poor than the public facilities operated by the Ghana Health Service? (We do not make the comparison here with private for-profit providers, which generally tend to be located in urban centres and less pro-poor.) In one household survey with data from 2003, religious facilities tend to serve the poor slightly more than public facilities, but the reverse is observed in another survey with data from 2005-06. On average,
there are few differences between public facilities and FIs in the extent to which they reach the poor. These results for Ghana are comparable to observations from similar household surveys in several other SSA countries. This is not entirely surprising given the restructuring and challenges FIs have faced with in the last few decades. Of course, because many FIs are at least in part privately funded, the fact that they match public provision to the poor, and serve the poor more than other non-state, non-religious facilities-based providers is a positive and important achievement which certainly deserves more attention. However, such nuanced comparisons are rarely made in the broader literature. It should be clarified that this example from Ghana almost certainly does not tell the entire story - especially as robust data about the mechanisms and subsidization strategies are not widely available. Certainly the reader should not extract from this discussion a final conclusion about the reach to the poor of all FIs in Africa. There are many other examples, utilizing different kinds of data, where it is indicated that FIs have a special option for the poor. For example, in some countries (including Ghana) preliminary analysis of the private cost for households of health care suggest that FIs may indeed operate mainly in remote areas where public services are absent. However, the challenge lies in finding a way to demonstrate such lessons (which are commonly based on closer case studies), in a way that impacts on national- and policy-level discussions, in particular those on the place and role of FIs in national health systems.

Going Forward: A Dilemma for FIs
There is substantial diversity today in how FIs provide care in African countries, and whom they serve. This challenges us to push beyond broad, advocacy-oriented questions of whether FIs in Africa reach the poor proportionately more than others - towards more operational questions, such as what can be done to help FIs fulfill their desire to serve the poor more?

In addition to more statistical evidence, more research is needed in order to better document and learn from the multiple initiatives that are being enacted by FIs to better reach the poor. This is especially important if a case to be made that FIs require additional or special support from national and international policymakers. As public health facilities are expanding their coverage in poor areas and FIs are being incorporated in public health systems, these questions and initiatives become critical. What does a core commitment to the poor mean (operationally) in the context of our current health systems? With mobile populations and growing urban ‘hardship’ areas, does the FIl mission to serve the ‘rural’ poor need to be updated and re-articulated at a policy level? In settings where FIs play an especially important role such as in fragile states with very low per-capita income levels, how can they maintain high quality health services that are accessible and affordable for the poor? What data and evidence needs to be gathered by the FIs themselves to demonstrate these priorities?

As mentioned earlier, while FIs aim to serve all, they profess a special desire to reach those who are most vulnerable. Whether FIs should consolidate their current services, or whether they should (and can afford to) institute changes to direct their energies to again prioritize the poor is a difficult trade-off. It is also linked to other important decisions being made, for example, prioritizing primary health care versus facilities-based care. For all these reasons, this is a critical time in the history of health-providing FIs, as they are pushed to weigh their very reason for being against the realities of an expanding public sector, and the requirements of financial support and survival. As noted by Schmid et al. it is a challenge that cuts to the heart of the religious-health landscape, arguing that if FBOs do have unique strengths...a ‘value added’, then now is the time to consider just what that value added is ‘worth’ and therefore, in what ways it is to be supported” – before it is lost.

The authors are with the World Bank. The opinions expressed in the paper are however only those of the authors, and need not represent those of the World Bank, its Executive Directors, or the countries they represent. Jill Olivier is the Research Director at IRHAPP, University of Cape Town (previously a consultant at the World Bank). Quentin Wodon is Advisor and Programme Manager in the Human Development Network at the World Bank.

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MEDS’ ROLE IN BUILDING AND STRENGTHENING PHARMACEUTICAL SERVICES IN CHURCH HEALTH SYSTEMS

Mission for Essential Drugs and Supplies (MEDS) is a faith-based pharmaceutical supply organization with more than 25 years of proven experience and competencies in pharmaceutical supply chain management and capacity building. Those years have come with challenges, lessons learnt and proven impact.

It has been a challenging and fulfilling journey since 1986, when MEDS started out, with a passion to enable easy and affordable access to quality healthcare supplies, for faith-based (mission) health facilities who struggle to avail medicines to their poor patients. In its 25 years of service, MEDS has worked continuously towards this goal. The original passion has grown over the years, resulting in a formidable organization with a tremendous reach of over 1,700 local and international corporate clients. MEDS services have been enjoyed not only by the churches but also by donor organizations and the Government of Kenya in various partnerships that enhance accessible healthcare across the country.

Challenges

Counterfeit and poor quality medicines

One of the major achievements in MEDS’ 25 years of operations has been to set up an in-house Quality Control Laboratory – which attained WHO Pre-qualification status in March 2009. The laboratory is used to monitor the quality of products received and stocked in MEDS. Quality analysis is based on the British Pharmacopoeia (BP) and United States Pharmacopoeia (USP). The laboratory also offers its services to external clients including suppliers, manufacturers, government bodies and other organizations.

MEDS investment in state of the art facilities for quality testing is an important contribution towards dealing with the scourge of counterfeit and poor quality medicines that has plagued Kenya since the liberalization of the pharmaceutical market in 2002.

A second crucial component of MEDS medicines quality assurance system is manufacturer audits. MEDS’ Pharmaceutical Technical Committee conducts regular visits to manufacturers to check whether they are adhering to Good Manufacturing Practices (GMP). The Technical Team also screens all products at the time of tendering as well as delivery to ensure they meet international quality standards. MEDS does not hesitate to blacklist any manufacturer found not to comply with Good Manufacturing Practices (GMP) and Good Distribution Practices (GDP). Between 1995 and 2009, this has been the case for more than 10 local and international suppliers.

Ability to pay for health services

MEDS’ target populations are the needy of our society and at times, the health facilities serving the poor and disadvantaged communities are hard pressed in terms of payments. MEDS’ mission to provide reliable quality and affordable essential medicines, medical supplies, training, and other pharmaceutical services has been compromised to some extent by huge outstanding debts from clients that have either closed down or are struggling to survive. In its attempt to mitigate this challenge, MEDS has partnered with international and local partners to finance needy clients who are unable to pay for the medicines and medical supplies that they need.

Capacity building

The health sector has remained extremely dynamic and turbulent with new and re-emerging diseases demanding continuous knowledge updates. Empowering health workers enables them to make informed decisions and cope with the diverse health needs. MEDS’ capacity building seeks to ensure effective and sustainable interventions in response to the prevailing market needs. The purpose of MEDS’ capacity building programme is based on the health system building blocks as identified by the World Health Organization: leadership and governance; health systems financing; medical products and technologies; health information systems; human resources management; and health service delivery.

The need for continuous knowledge dissemination cannot be overlooked. MEDS invests in development and up-to-date curricula on health-related topics aimed at improving the quality of services offered by the facilities and clients served.

Impact and Lessons Learnt

Over the years, MEDS has developed key competencies in supply chain management which have helped shape the delivery of essential healthcare in Kenya and the region. These competencies include health commodities forecasting, procurement from both local and international sources, stringent quality assurance systems, warehousing and efficient order processing supported by an Enterprise Resource Planning (ERP) system as well as a wide and elaborate distribution network that guarantees door to door delivery across the country. Each challenge has been a learning opportunity steering MEDS to greater heights.

MEDS’ ability to offer these competencies to its core clientele in the faith-based sector, the Kenya Government, non-governmental organizations (NGOs) and international donors has placed it in a unique position to respond to supply chain issues especially in limited resource settings. Starting with only 47 items, MEDS now stocks over 800 items and also supplies non-stocked items based on clients’ needs. This is through an elaborate periodic review of stock lists by a Formulary Committee comprising of experts drawn from diverse fields of health. MEDS’ medicines stock list is based on the World Health Organization’s Essential Drugs Concept and guided by the Essential medicines list of Kenya.

MEDS has also managed to contain the prices of quality medicines as low as possible through good procurement practices and bulk purchasing (which leads to quantity discounts), continuous negotiation coupled with good supplier relationships, long term contracts and prudent financial management. MEDS is listed in the International Pricing Index (published by Man-
agagement Sciences for Health – MSH) and this helps in price benchmarking to ensure global competitiveness.

Meds has continuously kept abreast with technological advancement to enhance efficiency in operations, which currently stands at over 95% computerized. An integrated financial and inventory management software ensures fast processing of clients’ orders, comprehensive records on all transactions and quick access to information for planning and decision making. With the software, Meds is able to track all the batch numbers of commodities supplied to different clients. This helps in monitoring and controlling stock and inventory movement. A comprehensive networked system, including e-mail and internet access ensures up-to-date information and efficient communication between Meds’ clients and other partners.

Eye on quality

Med’s key learning during the last 25 years can be summarized in one statement: Quality is KEY; not only of the quality of the medicines and medical supplies but also of the systems that are in place to ensure supplies reach clients. The elements of efficiency and effectiveness go hand in hand in ensuring that Meds exceeds the expectations of its clients through a grounded quality culture.

Results of laboratory analysis since 1997 show a downward trend in failure rates for products supplied to Meds. These results demonstrate that the presence of a quality laboratory in Meds coupled with other quality assurance measures, has influenced the quality of products in the market as suppliers strive to adhere to Meds’ stringent quality standards.

Partnerships are inevitable in the health sector, which is why Meds is keen on forging strong partnerships with various players to ensure that key competencies are shared across different organizations – including other pharmaceutical supply organizations in Africa. Meds has been involved in several donor funded projects which have been a source of tremendous institutional learning for Meds.

Over the years, Meds has demonstrated the capacity to ensure continuous supply of a wide range of good quality essential medicines and medical supplies and thus established itself as one of the most credible and reliable non-government pharmaceutical wholesalers in the region.

Jonathan Kiliko is head of customer service at Meds, Kenya.

GUARANTEEING SERVICE DELIVERY AFTER A NATURAL DISASTER

IMA World Health (IMA) has been working successfully in Haiti for over 12 years, but the devastating earthquake of January 2010 and the events that followed, posed great challenges to the distribution of pharmaceuticals and supplies to clinics and people in need. However, thanks to dedicated IMA staff, partners and volunteers, these obstacles were overcome and new advancements within existing programmes were discovered.

Through the National Neglected Tropical Disease (NTD) Control Programme in Haiti, IMA has been working with the Ministry of Health, Ministry of Education and other partners since 2007 to conduct Mass Drug Administration (MDA) with two safe and effective medicines, diethylcarbamazine citrate (DEC) and Albendazole, to combat and prevent Lymphatic Filariasis and Soil Transmitted Helminthes. This year alone IMA will provide treatments to over 4.3 million Haitians at risk of these debilitating diseases. Medicine distribution is conducted at schools and community distribution posts, and a key factor in the programme’s success is the 18,000 Haitian trained volunteers that serve as medicine distributors and community leaders.

Facing the disaster

Following the earthquake, however, the MDAs scheduled for January-April 2010 abruptly halted due to the need for immediate disaster response and the breakdown of the Haitian government structures in Port-au-Prince. IMA immediately conducted a needs assessment to determine the future of the NTD programme and to assess how to use IMA’s distribution network to get much-needed supplies to health facilities. After consultations with Haitian government partners, it was agreed that MDAs should be rescheduled and conducted as planned. An important decision, because to be effective, MDA must be conducted annually for 5-7 years at minimum. A gap in medicine distribution could negate years of progress and
The successes in Haiti, both pre- and post-quake, are proof that strong partnerships between the government, faith-based organizations, non-governmental organizations and the community are critical to overcoming obstacles and achieving success.

The NTD control programme and IMA staff had to overcome immense challenges in order to continue service delivery. Tropical storms, flooding, population movement, loss of staff and infrastructure, cholera, and political instability threatened the continuation of programme activities. In the process, IMA identified three key lessons in overcoming these hurdles: 1) identifying needs/challenges immediately after the quake allowed for rapid response to restart activities, 2) coordinating all planning with government counterparts to ensure country ownership of the programme, and 3) capacity building of government officials and volunteers is a critical step to ensuring sustainability and sharing responsibilities by all partners.

Building upon these lessons and the established NTD distribution platform, since the earthquake, IMA has also provided over 2.2 million USD worth of medicines and medical supplies, including 1,162 IMA Safe Motherhood Kits™, 4,500 LifeStraws™ for water purification, 23,000 hygiene kits, and over 120,000 pairs of new TOMS shoes to children in need.

The importance of partnerships

Throughout its history in Haiti, IMA has built strong relationships with the Association of Christian Health Care Institutions of Haiti, supplying essential medicines and supplies to faith-based facilities throughout Haiti. IMA employs local Haitian staff, including a pharmacist and medical doctor who oversee procurement and distribution. In addition, all IMA programmes are implemented with coordination from the Haitian Ministry of Health and Population which has allowed IMA to train and work closely with the Haitian government to ensure sustainability. The successes in Haiti, both pre- and post-quake, are proof that strong partnerships between the government, faith-based organizations, non-governmental organizations and the community are critical to overcoming obstacles and achieving success.

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WHAT HAVE CHURCHES DONE TO GUARANTEE QUALITY OF MEDICINES?

Supported by umbrella organizations such as Ecumenical Pharmaceutical Network and various Christian Health Associations, church health institutions have been providing pharmaceutical services for as long as we can remember. Quality medicines are a crucial factor for safe and efficient treatment. That is why church health institutions also invest in monitoring the medicines they provide.

The impact of the different training programmes at KSP to the nation is great, as they contribute directly to the overall objective of the Tanzania National Drug Policy (1991) and the National Health Policy (NHP) which is to make available to all Tanzanians at all time the essential pharmaceutical products which are of quality, proven effectiveness and acceptable safety at a price that the individual and the community can afford, when these are needed to prevent, cure or reduce illness and suffering.

Training of pharmaceutical personnel takes place in most parts of the world, both in countries moving on to more advanced systems of technology and in those struggling to catch up with existing systems. In all fields of pharmacy, new skills have to be mastered and efficient training schemes adapted to solving local needs have to be developed. KSP continually strives to design appropriate training programmes for pharmaceutical personnel, from the lowest level to degree and Masters, tailored to solving the prevailing problems in African countries. Collaboration with partners and policy makers is the way to go for a better future of pharmacy profession.

Wilson A. Mlaki is the principal of Kilimanjaro School of Pharmacy, an institution of St Luke Foundation, Tanzania. The programme started in 2008 and the Industrial Pharmacy Teaching Unit was officially inaugurated in March 2011. So far 26 participants from 6 African countries graduated in March 2010 and a new group from 6 African countries is expected to graduate in March 2012.

The programme, providing in-depth training in the important aspects of industrial pharmacy, is intended for professionals working in pharmaceutical industries, national regulatory authorities and universities in sub-Saharan countries, enabling them to meet the highest international standards for quality and drug Regulation. The training thus contributes to the promotion of local pharmaceutical production in Africa, hence improving access to essential medicines.

Impacting the nation

The programme started in 2008 and the Indus-
Quality issues may culminate into erosion of confidence and trust by patients, their care-givers and the community, not only in the products but also in the health services and medical staff.

Cameroon Baptist Convention

The Central Pharmacy of the Cameroon Baptist Convention (CBC) Health Department is strictly quality-oriented. What started as a small Quality Assurance Unit in 1994 has grown into a full department. Its primary role is to ensure that medicines and raw materials procured or produced by Central Pharmacy consistently meet standards of safety, quality and efficacy as stated in the official monographs. This is the job of qualified staff in the fields of Pharmaceutical Chemistry (Analysis), Pharmaceutical Microbiology, Microbiology and Chemistry. The laboratory, which also surveys water quality, is used by several sister missions and individual researchers including university lecturers and students.

In February 2011, the department was equipped with a GPHF-Minilab, donated by Global Pharma Health Fund. Hundreds of samples have been received and analyzed for quality, safety and efficacy with a few of them turning out to be fake or substandard. For example, eye drop powders, supplied to the laboratory in 2010 by a sister mission (procured from a roadside vendor) were found to be poorly packaged and poorly labelled. Further investigations showed that these powders were actually Magnesium Trisilicate tablets molded and filled into the containers. One can only imagine the consequences to the eyes if these powdered products were used as intended. Some antimalarials tested in 2011 also raised concern. Maloxine (Sulphadoxine USP 500mg/Pyrimethamine USP 25mg) from a roadside vendor did not contain any of the active ingredients. Artemether + Lumefantrine (350mg +1080mg/60mL) supplied by a national distributor contained no Artemether and only little Lumefantrine.

The quality policy of CBC’s Central Pharmacy (CP) is intended to avoid such hazards, through several interventions which include:

1. Quality control of all medicines and raw materials procured or produced by CP.
2. Procurement of medicines is done only from reputable pharmaceutical companies.
3. Ensuring that the QA Department has a sufficient number of qualified staff to perform the tasks of the department at all levels.
4. Providing the necessary tools for the QA department to function.
5. Pharmacy staff receive continuous education so as to properly function in all health institutions of the CBC.
6. All premises, processes, and procedures for medicine manufacturing conform to the Good Manufacturing Practices of WHO.
7. The entire staff of the CBC Health Department is educated on the dangers of fake/substandard medicines, especially road-side medicines. Health talks on this are given to all who visit the health facilities.

Authors: A.C. Tambo, Joseph Ngijiah, Ann Likowo, Franklin Tagha, Mary Ndji, Francis Wango, Dr. T. Funjngard Gerald, Nathan Wanyu.

Koyom Evangelical Hospital, Chad

The promotion of generic essential medicines at an affordable price has been a major step towards increasing access to better health for the social classes with the lowest incomes. The new pharmaceutical companies that are developing these products in Africa and Southeast Asia are making access to these medicines a reality. Sadly, certain misinformed individuals still consider these medicines to be of secondary quality. It is true, though, that the multiplication of factories producing generic medicines, leads the common man but also health agents to question their quality.

Organizing regular quality tests for generic medicines would be ideal for all distributors. In the reality of Chad and several other countries, quality control is only possible on few occasions, because the cost and time needed for these tests are often high when one has to work with a foreign laboratory.

The confidence in local suppliers (central procurement stores) is not always justified because they rarely do quality tests on the products they are providing. For example, in Chad, the participation in the quality project organized by EPN and Difaem, revealed the importance of questioning the quality of medicines available in the market. Three of the products were sent over for testing, were found to be substandard. These results have led the faith-based institutions to take action towards the distributors. An advocacy campaign was set up, targeting the central procurement stores in Chad. This has made it possible to put the N’Djamena Central in contact with the MADS laboratory in Kenya, which resulted in a first contract on quality testing. Providing that the good relations continue, we will, in the short and medium-long term, help to regularly guarantee the quality of essential generic medicines in the country.

Still, this solution is one by default, as there is no local laboratory for quality testing in Chad. A desirable and more durable solution for the future would be to provide each Christian pharmaceutical supply organization with a Minilab to do quality testing. A big investment, but is it not worth it, given the many lives at stake, as well as the credibility of the pharmaceutical services offered by faith-based health institutions?

Author: Dr Ndita Dikadoum, Medical director Koyom hospital, Chad.
PUTTING THE PATIENT FIRST

Client satisfaction has a great bearing on the use of hospital services. For church-based hospitals to survive the competitive health care industry, health services must be patient-centred and responsive to patients’ expectations.

Hospital administrators should subordinate financial interests to patients’ demands.

Pharmaceutical services are core to the provision of healthcare services. In Uganda, 28.2% of general health expenditure goes to the pharmaceutical sector while, on average, pharmaceuticals in the hospital setting constitute 20% of the total expenditure budget. Church-based hospitals in Uganda meet over 80% of their operational costs through patient fees. The pharmacy department contributes over 30% to the operational income of the hospital and is often seen as a critical income generating department. Therefore, most administrators in these hospitals tend to prioritize making surpluses from the pharmacy, thus compromising on quality and efficacy of the services. Quite often, pharmacists have an uphill task of trying to strike a balance. For instance, having both high quality and affordable medicines means rational selection and pricing, which might have an effect on the hospital surplus realized from the pharmacy. This is quite challenging since most branded medicines are costly and for patients to afford them, the added profit margin must be lower than that of generics. However, the hospital authorities often expect a given margin on all medicines stocked by the pharmacy. Hospital pharmacists should utilize a medicines and therapeutic committee to overcome this problem.

Advice and guidance

Patients expect to get affordable, effective and safe medicines from the hospital pharmacy. The trust and confidence attached to church-based hospitals inevitably raises the client expectations further. Patients also expect professional advice and information on side effects and contraindications. Giving sufficient information to patients without compromising on the waiting time is often a difficult task for pharmacy staff, for example, in Kampala District where daily outpatient numbers in church-based hospitals average at 800, and staffing levels are low in a bid to reduce staff costs. In addition, when hospital settings are designed in such a way that the pharmacy is positioned inside, distant from the patients’ reception, this makes it difficult to get feedback from patients, for example when they experience problems or side effects.

Inpatients expect medicines to be delivered to them by qualified personnel with advice regarding the use and any anticipated side effects. But, where pharmacy personnel are few in number, the already stretched nurses on the wards have to perform this task. Given the nurse-patient ratio in these hospitals, it is clear this situation is not optimal.

Pharmaceutical requirements can also differ in different areas depending on disease prevalence and incidence. This calls for professional, evidence-based development of essential medicines lists. However, the drive for surpluses and pressure from pharmaceutical marketers usually influences this process negatively.

Clearly, putting patients first while offering pharmaceutical services in a hospital setting is challenging. Hospital administrators should never compromise on quality and affordable pharmaceutical services and should subordinate financial interests to patients’ demands, for the continuity of church-based hospitals with dwindling government support.

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A VISION FOR JUST AND COMPASSIONATE QUALITY PHARMACEUTICAL SERVICES

The vision of the Ecumenical Pharmaceutical Network (EPN) to become a global partner for just and compassionate quality pharmaceutical services provides a challenge which the Network members, partners and stakeholders would do well not to take lightly. Achieving this vision would mean that human suffering due to treatable illnesses becomes non-existent, through the provision of pharmaceutical services that serve all, are available to all and meet the needs to all without any discrimination. Such a state of being would indeed enable the Glory of God to be fully evident everywhere. Even while the vision appears to urge EPN to seek honour in the eyes of the world, of utmost importance is the need to strive to ensure that whatever EPN does is in submission to the will of God and contributes to building His kingdom. The bible says: “Let not the wise man boast of his wisdom or the strong man boast of his strength or the rich man boast of his riches, but let him who boasts boast about this: that he understands and knows Me, that I am the LORD, who exercised kindness, justice and righteousness on the earth in these I delight” (Jeremiah 9:23, NIV).

The calling to provide and promote just and compassionate quality services requires that the providers go beyond monetary benefit and seek to understand and empathize with the patients. Jesus provides numerous examples of healing driven by compassion as exemplified in Matthew 14:14 (AKJV); “and Jesus went forth, and saw a great multitude, and he was moved with compassion toward them, and he healed their sick.”

To sustain just and compassionate pharmaceutical services, the Network needs to return to the foundation of love, to truly believe in God’s love and trust Him as the ultimate source of justice and compassion. Services have to be built on spiritual resources to prevent them from diminishing in times of trial. This is to say compassionate love cannot just operate at human level but it also needs to recognize its spiritual source. The prayer of St Teresa of Avila provides the ideal to which everyone can strain to draw the Network ever closer to this beautiful vision of just and compassionate quality services for all; “Christ has no body now but yours. No hands, no feet on earth but yours. You are the eyes through which he moves Compassion on this world. You are the feet with which he walks to do good. You are the hands with which He blesses all the world.”

Reverend Baraka Kabudi is a pharmacist at Mission for Essential Medical Supplies (MEMS), Tanzania.

Services have to be built on spiritual resources to prevent them from diminishing in times of trial.
FBOS
UNLOCKING AFRICA’S POTENTIAL

Without trade, there is little chance of development. The ease of moving goods from one location to another, fundamental to successful trade, is one of the major challenges Africa faces today. Faith-based pharmaceutical supply organizations can be part of the solution.

A recent conference, Economic Development Minister Ebrahim Patel of South Africa showed a map that tells what he calls, “the story of Africa.” It is a story full of promise, potential and pitfalls. Patel’s map charts railways in Africa with blue lines in short threads tattooed mainly on the continent’s coastal margins. It illustrates how the colonial powers scrambled for Africa’s resources, from slaves to minerals and left the continent with an incoherent rail system tracking the shortest distance possible from the point of extraction to the nearest port for export overseas. Looking at the vast centre of Africa, there are no blue lines. “That is the missing middle,” says Patel. None connects north with south, west with east or any of the points in between.

Africa today consists roughly of one billion consumers. But, a billion consumers don’t automatically translate into a market of the same size... unless you can get the goods to people who can pay for them. To do this, the challenges posed by the blue lines on Patel’s map have to be met.

The winds are changing

The recent McKinsey study entitled “Lions on the Move” makes a compelling case for the economic growth in Africa. Excluding economies of less than 10 million people, six of the world’s fastest growing economies between 2000 and 2010 were in Africa. The International Monetary Fund projections for the next five years show 7 of the 10 fastest-growing economies will be in Africa. Africa’s gross domestic product (GDP) is projected to grow from about 1.6 trillion USD to 2.6 trillion USD by 2020.

The global pharmaceutical market is set to reach 1.1 trillion USD in the next five years, growing at a pace of up to 8% according to IMS Forecast for Global Pharmaceutical Market Growth. Emerging markets such as China, India and some African countries are expected to grow at a 14 – 17% pace through 2014. Considering this dramatic growth, the markets for generic infectious disease pharmaceuticals in sub-Saharan Africa hold considerable potential. Despite high levels of poverty and market price sensitivity, the region has a large and growing population that is increasingly able to pay for better health services and pharmaceutical products. New analysis from Frost & Sullivan finds the Infectious Disease Pharmaceutical Markets in key sub-Saharan African countries earned revenues of 403.2 million USD in 2006 and estimates this to reach 691.4 million USD in 2012.

International donor organizations have committed themselves to providing support for the expansion of HIV and AIDS, Malana and TB treatment programmes in multiple markets throughout sub-Saharan Africa. Such increases in donor funding are acting as key drivers in the growth of these markets.

Price sensitivity and the general preference for low-cost products by both public and private sector end users are increasing the demand for generic pharmaceuticals. Accordingly, generic pharmaceutical companies will benefit from establishing plants or distribution points in regional economic hubs, such as South Africa, Kenya, Ghana and Nigeria. These can be used as focal points for the distribution of generic pharmaceuticals into surrounding countries.

Potential investors have noticed

All of this sets the stage for the Ecumenical Pharmaceutical Network (EPN) and its pharmaceutical supply organization members to redefine their role in the growing African market place. Historically, these faith-based supply organizations have seen themselves as extensions of church mission health programmes in their respective countries. They derive income from trading (buying and selling essential medicines and supplies) and grants from foreign donors.

Today they have the opportunity to position themselves as a key part of the African logistics infrastructure needed to move goods and stimulate trade. The question is, can they see themselves as more than wholesaler’s serving faith-based health care providers in their country? Can they see themselves as viable and sustainable not-for-profit commercial logistics entities with the ability to move pharmaceuticals and medical supplies throughout their countries and beyond? Could they be part of overcoming Patel’s “missing middle” for logistics in Africa? If the answer is no, why not?

Financing has always been a challenge. The question is where will funding come from in the future? The donor world outside of Africa is changing rapidly. Organizations such as USAID, Global Fund and Gates Foundation have historically given grants to support their own sponsored projects. Funding is usually directed to foreign NGOs who carry out the work.

Today, there is a growing shift toward what is called “Impact Investing” and “Market-Based Solutions.” Foreign donors are increasingly looking to where they can make direct investments/grants in commercial businesses in Africa (both for profit and not-for-profit) that impact those at the “bottom of the pyramid” (BoP). Pharmaceutical supply organizations need to see these new funding sources as the key to their future growth. They must see and position themselves as experienced, well run not-for-profit businesses making up an important part of the African supply chain (goods movement) infrastructure. If they can do this, they will begin to attract the interest of funding agencies and investors looking to make an impact at the “bottom of the pyramid”.

Today as never before, Africa has the opportunity to develop itself. What are required are African solutions to African problems. If faith-based pharmaceutical supply organizations can seize the current opportunities, and extend logistics development integration from the Cape to Cairo, the continent is one step closer to achieving Kwame Nkrumah’s vision of a united and prosperous Africa. The linkages and synergies that are possible for them as members of the Ecumenical Pharmaceutical Network will provide further impetus to make this dream a reality.

Richard Wagner is the Chairman of Affordable Medicines For Africa (AMFA) in South Africa.

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CHURCHES IN THE DELIVERY OF ESSENTIAL MEDICINES AND HEALTH CARE: 30 YEARS ON

It is probably not by chance that the precursor of the Ecmenical Pharmaceutical Network (EPN) and the WHO Action Programme on Essential Medicines (Drug Action Programme, DAP) were both established in or around 1981. This was just a few years after the declaration of Alma Ata, in which the supply of essential medicines was recognized as one of the eight components of Primary Health Care. In that period, it became generally clear that the decreasing availability of medicines, largely due to reduced public financing in developing countries, needed specific action, both in the public sector in which WHO was largely operating at that time, and in the faith-based health care services. What has happened since that time, and how should EPN prepare for the future?

In general, we can say that in the early 1980s, the faith-based organizations (FBOs), with their large demand for services, limited budgets and common sense, quickly recognized and embraced the concept of essential medicines. At the same time, their combined field experiences were gladly used by WHO in the development of global policy guidance in this area. For example, experiences with estimating medicine requirements for mission hospitals in Ghana led to the ‘consumption-based’ method later adopted by WHO, and the interagency Guidelines for Drug Donations1 of 1999 were largely based on guidelines issued earlier by the Christian Medical Commission.

Over the years, the pharmaceutical policies and practices of the faith-based organizations have remained as dedicated as they always were, but have become much more professional. Through EPN, most faith-based institutions have gained rapid access to evidence-based WHO clinical guidelines and related lists of essential medicines, for example for the treatment of AIDS, tuberculosis and malaria. Their attitude to the quality of medicines has also changed, with most faith-based procurement agencies now following the WHO/UN Prequalification programme. In 2009, the first faith-based medicine quality control laboratory (MEDS) in Nairobi, Kenya was prequalified by WHO. Faith-based organizations are also fully recognized as one of three categories (besides the public and private-for-profit sectors) in the WHO/HAI standard protocols for measuring the price, availability and affordability of essential medicines in low- and middle-income countries. This involvement has resulted in a wealth of very objective and reliable information from faith-based institutions from over 50 countries.

This latter point also shows that the FBOs are now not only recognized as full partners in health care, but also in public health policy. Not only by WHO, but also within-country by the national governments, by national disease programmes and by important bilateral funding initiatives such as PEPFAR, the Global Fund, UNITAID and the President’s Malaria Initiative.

So what about the future? One of the most important future challenges is financing of health care. In most countries in which EPN is active, economic growth, the development of a middle class and increasing public awareness about treatment options will lead to more demand for health services. The demographic transition increases the need for chronic, often life-long treatment of non-communicable diseases (see below). There is also a trend to separate health care funding from service delivery, for example through increased coverage of the population by social health insurance schemes and through contracting out to private providers of services previously delivered free-of-charge by the public sector, such as mother and child care, vaccinations and treatment of AIDS and tuberculosis.

This trend, together with their full recognition as partners in national health care delivery, implies that faith-based organizations can (and should) demand full-cost budgeting from the government, health insurance schemes and bilateral/ multilateral donors for the services they are rendering for or on behalf of the government. On the other hand, that also implies a need for cost-efficiency and transparency from the side of the faith-based facilities to show clearly that the funds received are used well.

Differential pricing

The growing percentage of middle-income people in middle-income countries justifies special attention. These large sections of the population cannot afford the full-commercial cost of expensive branded and/or patented medical products supplied through private pharmacies in urban centres; but they are not so poor that they need free medicines. The solution is to make available to them a limited range of generic medicines purchased by the government at public sector prices and sold to the patients with only a modest markup. Such differential pricing can be achieved through regulatory market segmentation from the branded products, and through selling through special outlets such as licensed ‘public pharmacies’. FBOs could further expand their role in this field – recognized and supported by the government as a cost-effective partner to supply such services at very large numbers of middle income patients at modest cost.

In most low- and middle-income countries, death and disability from non-communicable diseases such as pulmonary diseases (e.g. asthma), cardiovascular diseases (e.g. hypertension), diabetes, mental and neurological disorders (e.g. epilepsy and depression), cancer treatment and palliative care are already much more than from infectious diseases. Nearly 90% of global deaths from non-communicable diseases now occur in low- and middle-income countries2. However, the problem is not easy to resolve as the treatment and secondary prevention of chronic diseases is a real challenge for any health system. All components of referral, diagnosis, good prescribing, adherence, life-long medicine supplies, affordable prices and sustainable finances must be in place for the system to work.

Historically, the treatment of chronic diseases has often been ignored by governments or has been left to the private sector where many patients may face catastrophic out-of-pocket expenditures and, ultimately, bankruptcy or death (or both). However, this is bound to change with the increased international attention for chronic disease in the UN General Assembly in September 2011. The faith-based health care institutions can play an important role in the diagnosis and life-long low-cost (generic) treatment of non-communicable diseases, with a focus on the middle-income people who can afford health care, provided it is reasonably priced. In achieving this, the faith-based organizations would do well to continue using the evidence-based clinical guidelines and model list of essential medicines developed by WHO, as well as information on medicine availability and prices, in order to prevent the prescription and use of unnecessary or less cost-effective medicines which is, unfortunately, still so common.

In conclusion, the health policy objectives of the faith-based organizations and of WHO have always run very much in parallel, and over the years both parties have benefited from the close collaboration and frequent exchange of information. There is no reason why this should not continue in the future, to the benefit of the many patients in rural areas that are not adequately served by public services and of the increasing number of patients with a modest income who cannot afford the high prices of the formal private-for-profit sector.

Hans Hogerzeil was director of the Department of Essential Medicines and Pharmaceutical Policies of the WHO. He retired in May 2010.

References
The text which is the topic of our reflection summarizes the mission that was given to us by God. This mission is vertical but also horizontal.

In its vertical dimension, the law asks us to love God without reservations and to surrender ourselves to his divine providence. Did He not say: “Do not worry about tomorrow, for tomorrow will worry about itself. Each day has enough trouble of its own.” (Matthew 6:34). The love of man for God comes from the love of God for man. It is because Christ loved us without reservation that he has accepted to die for the sake of our souls. In return, loving Him means respecting His commands, it means putting them into practice, it means answering God’s call, responding to the mission that He has entrusted us with, to the calling that is ours.

And this calling takes us to the horizontal dimension of love, which is to love our neighbour. This last aspect of the calling takes us to the horizontal dimension of the calling that is ours.

30 years at the service of the common interest, 30 years of breaking taboos on certain illnesses, 30 years of looking for the better-being; these are plenty of signals that illustrate the diaconal ambition of the Ecumenical Pharmaceutical Network. Yes, this is the ambition that God asks from us: to be at the service of others. Only love should lead us to go towards, to show solidarity with others. In most of our African countries, faith-based health institutions have preceded the organizations of the state. We have seen men and women devoted to their mission, going unimaginable distances for their sole ambition: to serve.

Of course, the context is no longer the same and our health institutions today have trouble maintaining quality care because of competition from the state and private sector where financial benefits are better. Even the staff that has benefited from faith-based scholarships are leaving their post, in their search for material happiness. We are not saying that the salary should not be an encouraging factor, because we are all aware of the cost of living these days. However, when responding to God’s call through our respective vocations, we make His will happening; and Jesus’ response makes so much sense: “Do this and you will live” (Luke 10:28).
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