ECUMENICAL PHARMACEUTICAL NETWORK

REPORT ON EPN DSO FEEDBACK MEETING

13th – 17th August, 2007.
Lagos, Nigeria

EPN

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Acknowledgements

The Ecumenical Pharmaceutical Network (EPN) would like to sincerely acknowledge with thanks those who have made this feedback meeting successful.

We would like to acknowledge SIDA and ReACT for their financial support. The continued support from WHO/EDM is also recognized.

We acknowledge our excellent facilitator, Dr. Gilbert Buckle of Integrated Health Solutions Ltd. Ghana, who made the programme interesting, enjoyable and educative.

We also acknowledge the untiring efforts of our hosts, CHANMEDI-PHARM, and their team, whose tireless efforts and affable nature in no small measure contributed to the success of the meeting.

Executive Summary

The Ecumenical Pharmaceutical Network [EPN] commissioned a number of activities as defined by the DSO members held in June 2004 as a feedback meeting following the joint EPN/WHO study on drug supply organizations. These activities included three studies on;

- Distribution for EPN Drug Supply Organizations,
- Integrated computerized system/enterprise resource planning system software options available for DSOs
- Feasibility processes around DSO production activities and core methodology for the development of DSO quality control laboratories

The meeting in Lagos received and discussed the reports and three studies. Included in the feedback meeting were key emerging pharmaceutical issues of antibiotic resistance, new first line ART and the WHO RUM resolution.

In all 3 reports and 2 presentations were presented and discussed. The reports were:

1. Distribution Model Study for EPN Drug Supply Organizations, Draft Report May 2007 by Ron Wehrens Pharmacist MSc., MBA, Phasuma
2. Small Scale Local Pharmaceutical Production and Quality Control Laboratories; Background Report and Feasibility Tools, First Draft Report June 2007 by Marlon Banda, Pharmacist.
3. Inventory Control and ERP Software Options for EPN's DSOs, draft Report for Review, July 2007, Libby Levison, Public Health Consultant.

And the presentations were;

1. Antibiotic Resistance, by Marry Murray of ReAct
2. Antiretroviral, by Albert Peterson of EPN

The meeting was designed and facilitated for maximum participation of members present. Summary presentations of the studies were delivered by staff of EPN and discussions in plenary set out to achieve a common agreement and understanding on the findings and use of the reports. Group discussions were held primarily to discuss recommendations and determine next steps on how to use the study findings or issues raised in the independent presentation.

After exhaustive discussions and debates the participants made the following recommendations to EPN;

1. Distribution

i. EPN to review various suggested activities and develop feasible interventions it can initiate and support.

2. Local Pharmaceutical Production

ii. Apply the tools in the report in the 5 DSO's currently in local production.

iii. Applying the feasibility tool, further look into the hospital level local production and its potential.

3. Quality Control

iv. EPN to review and prioritize from the group discussions areas of intervention and support it can give to members.

4. Local Pharmaceutical Production

v. Apply the tools in the report in the 5 DSO's currently in local production.
vi. Applying the feasibility tool, further look into the hospital level local production and its potential.

5. Quality Control

vii. EPN to review and prioritize from the group discussions areas of intervention and support it can give to members.

6. Software Study

viii. Inform consultant that assignment is not complete and identify gaps. [ref TOR and comments]
ix. Develop further 'minimum DSO information needs' into a possible guideline for DSO's.

7. Antibiotic Resistance

x. EPN to discuss and define possible areas of collaboration and partnership with ReACT based on the group discussion suggestions (see annex….)
xi. EPN to review the group suggestions and develop feasible interventions it can initiate and support.
xii. EPN to develop a standard briefing document on the prevention and control of Antibiotic Resistance for its members to disseminate to all church health institutions.

8. Anti retroviral medications

xiii. Introduction of approved pediatric FDC in church health institutions is important. Suggestion on what EPN can do, written out by members will be analyzed to inform interventions.
xiv. Advocacy should be targeted to ensure that
    a. Regular review of treatment guidelines are done at international and national levels to keep abreast with the evidence and changes in ARV treatment regimes.
    b. Pediatric dosage forms of ARV are also discussed internationally

9. EPN Data Observatory

xv. EPN to constitute a technical team to develop further the concept of the Data Observatory and prepare a full proposal for discussion and by-in by members and submission to the indicated interested partners.

10. Relevance of DSO's

xvi. An assessment of the situation and options available to DSO must be carried out. This assessment should answer the following questions
    a. What is the role of FBOs in addressing drugs and medicines issues?
    b. What is the role of DSO in the larger health context?
    c. How can DSOs position themselves to continue being relevant into the future?

Section 1: Feedback on Reports and Presentations

The studies were a follow up to a study carried out by EPN and WHO *(Multi-country study of Medicine Supply and Distribution Activities of Faith-Based Organizations in Sub-Saharan African Countries)* which clearly indicated that these [DSOs] play a key role in complimenting and supplementing the work on the public sector. A number of key areas as described below were identified as needing further exploration.

1.1 Distribution Model Study for DSOs

The Draft Report of May 2007 by Ron Wehrens Pharmacist MSc., MBA, of Phasuma was presented for discussion.

This distribution model study showed that the customers of DSO's were generally pleased with the services provided. But amongst the more poorly rated services drug delivery was indicated as the root cause of the low rating. The new study was done in order to identify ways for the DSOs to improve their distribution service.

In all 10 DSOs participated in the study. The study showed that DSOs were in various stages of development and operated in different environments and circumstances. It further revealed the wide range of situations in which the DSOs find themselves.

The DSO comparison shows the differences in terms of warehouse surface, turnover, staff numbers and product range. Investments to improve distribution are generally justified as it is in line with the DSO's mission, needed to compete with the private sector and helps qualifying the DSO for collaboration with major programs like those funded by GFATM.

Good distribution service does not necessarily mean door to door delivery. The distribution process includes all the steps involved to get the correct products from the warehouse to the client. This starts when the client submits the order and includes picking and packing of the goods.

The study made several suggestions to DSO's to bring these elements to a higher service level, these were;

1. Make ordering easy, pleasant and worthwhile.
2. Increase stock range and improve availability to make ordering worthwhile.
3. Seek, create or promote new communication channels.
4. Ensure reliable checking and packing
5. Give distribution options

Discussion and Comments

The findings of the report and its recommendations were unanimously accepted as a reflecting the situation on the ground as well as generally satisfying the terms of reference of the assignment. The one exception was the lack of a feasibility tool to help guide decision making on choosing options available.

The recommendations were discussed further in group sessions and possible concrete activities to implement them were developed. The outcome of the group discussions can be found in Annex 1.

1.2 Small Scale Local Pharmaceutical Production and Quality Control Laboratories

The study report entitled; A Background Report and Feasibility Tools, First Draft Report dated June 2007 prepared by M Banda was presented and discussed.

In the EPN/WHO study it was clearly indicated that these [DSOs] play a key role in complimenting and supplementing the work on the public sector.

The study on QC was aimed was aimed at preparing methodologies for the DSOs to guide their decisions on whether to set up small scale local production of dosage forms and or quality control laboratories.

The study specifically set out to

- Carrying out feasibility studies around DSO production activities
- Strengthening existing activities in quality assurance and DSO quality control laboratories through a process of evaluation and recommendations

1.2.1 Small Scale Local Pharmaceutical Production

The study summarized the following as reasons cited for engaging in small scale local production as;

- To make available products of a certain quality which are otherwise unavailable of hard to get, for reasons of unreliable suppliers
- The need to reduce costs, due to transport from source, on taxes, imports, and foreign exchange;
- Poor access to medicines in the country, due to political instability
- The desire to control one's own production scheduling (it being easier to adjust to shifting supply/demand)
- The desire to develop a local employment base
- The need to increase technology transfer
- The wish to become 'self sufficient' in medicines;
- The need to reduce reliance on imports and manage foreign exchange flow;
- The desire to produce medicines for export

- The need to maintain design and process secrecy;

All but the first 3 of these reasons are incompatible with public health objectives to increase access in a cost effective way. The recommendation is that production activities should not be undertaken if they increase costs or if the production venture cannot achieve self sustainability.

Discussion and Comments:

The content of the report was largely accepted and DSO's identified with the findings and recommendations. In discussion it was realized that many DSO's have stopped local production, of those present at the meeting only 5 were still engaged in local productions.

The historic basis for DSOs going into local production was discussed and was agreed as based upon none availability of drugs and pharmaceuticals, weak public sector, weak regulation and a clear need for the services of the DSOs 30 years to 40 years ago.

The environment over the past 20 years to 30 years has changed, accounting for why many DSOs have stopped local production. The changes include stronger regulation and enforcement of standards by government, very high cost of production and finished products [much higher than imported finished products], increased competition from local manufacturers, retailers and agents of multinational pharmaceutical industry.

Other significant changes are the range of products that can be manufactured is limited by stringent production quality requirements, high cost of local raw materials and presence of cheaper similar products on the market. Some items produced are not available on the market and if available are 'more expensive' [this is considered debatable since most DSOs did not calculate the real cost of the items produced].

Furthermore the sustainability of most DSOs engaged in local production is masked by the fact that most do not assess the true cost of their products, since many are supported by external funding [which may cover cost of equipment, technical support and raw materials], which if withdrawn leads to institutions folding up their operations. An example was given by MEDS in Kenya which had a programme that was supporting hospitals with donor funds and when the donor support stopped the hospitals could not continue to local production. The place of hospital production was still considered an option but required closer attention to appropriate costing and management.

All participants agreed that production was feasible and sustainable only if it was done on a large scale. The scale and concept of local production should be that of "large scale manufacturing" and not combined with retailing. This paradigm shift requires major organizational changes for DSOs. The tool presented in the report was considered a good beginning for use by DSOs in

production as well as hospitals to use to objectively assess whether they should continue in local production.

Also participants agreed that quality control (QC, see also 1.2.2) even of self compounded products is crucial. If the costs of such QC were to be added, local production would be too expensive.

Next steps

The meeting recommended that;

1. EPN support the application of the tools in the report in the 5 DSO's currently in local production and share findings with others.
2. EPN further look into the hospital level local production issues and support the application of the tool in them.

1.2.2 Quality Control Laboratories

The study indicated that there is a need to ensure that the products procured by DSOs are of good quality and therefore a need to have access to a laboratory to assess the quality of products procured by a DSO. Depending on the size of a DSO an in-house laboratory may be more cost effective option for quality control sample analysis. A laboratory service represents a business venture in its own right that can contribute to the overall income and sustainability of the DSO.

The cost effectiveness of establishing an "in-house" laboratory has to be assessed before a decision is taken to establish one. Alternatives such as a more stringent pre-procurement quality evaluation and or use of an existing external laboratory should be considered. Establishment of centralized laboratories which provide service to DSOs in a given country or region seems a more prudent strategy to pursue. The use of mini-labs was discussed and agreed as a feasible interim measure, bearing in mind that the mini-labs were primarily screening tests and had a limited range of products it could test.

Discussion and Comments:

The findings and recommendations of the report were by and large accepted by the meeting participants. The general conclusion was that quality control is a fundamental requirement for all DSOs because of the changing environment and increased focus on product quality.

Group work was carried out to gather information on:

- Challenges to DSOs and HI in the establishment of quality control services
- Resources required for the establishment of quality control services
- Possible approaches for scale-up of quality control services
- The possible role of EPN in the promotion and scale up of quality control services

The results of the group work can be found in Annex…..

Next steps

The meeting recommended that;

1. EPN review and prioritize from the group discussions areas of intervention and support it can give to members.

1.3 Inventory Control and ERP Software Options in EPN's DSOs

The 2006 EPN/WHO report highlighted the need for DSOs to have software to manage their operations. In addition, DSOs have asked EPN for guidance in identifying a software package that will provide ERP functionality. Planning resource use in DSOs was recognized to have its own challenges including the specific requirements of tracking medicines. Furthermore the DSOs are of various sizes, with different numbers of products, warehouses, clients and annual turnovers – and thus different needs.

A study was commissioned by EPN to answer the DSOs request of EPN for guidance in the area of software options especially, the use of ERP and inventory control program options.

The report noted the following points:

- Selecting a software package which meets the DSO's functional and technical needs are not easy. ERP packages still seem to either be geared for much larger Northern institutions, or do not handle the specific requirements of pharmaceuticals.

- Within the DSOs surveyed, none had a package that provides strong ERP functionality, while spanning the demands of pharmaceutical management from warehouse management to dispensing.

- Technical support for both hardware and software continues to be a problem for DSOs running computer in remote (African) locations. While hardware support is often available now in the capital city, it is not in more remote areas where many EPN members run health facilities. And software support is erratic at best. Because of location, some DSOs (MEDS, Nairobi; JMS, Kampala) have more options for software packages as more companies have local offices and can provide technical support than is found by CHAM (Lilongwe, Malawi) or ASSOMESCA (Bangui, CAR).

- Due to the variability in size, mission, and location, there will be no one software package that all DSOs could adopt. There is also little reason for this, as little technical information must pass between the DSOs.For example,Navision will be far too large, complex and unsupportable in Central African Republic, and mSupply will be far too small to meet the ERP needs of CHAN MEDI-PHARM.

- There is still a large "digital divide" between the North and the South, but also between African countries. Software options open to DSOs in Nairobi are completely different than those open to a DSO in Central African Republic or Malawi. In addition, the needs of the DSOs preclude the use of one standard software package.

- Finally, there is always a rush to move to computerization to improve operations. Shifting to ERP packages might not be the best solution for all DSOs and might not solve all problems. Computer reports are only as good as the data fed into them. If good accounting practices are not already in place, if budgets are not already monitored regularly, if accurate consumption records are not kept, computerization will not make an organization function better.

- That said, there are some functions that computerization can do that are significantly more difficult to do on paper e.g. tracking medicine expiry dates and the number of months of stock in the stores are two examples.

- When selecting any software, the following are recommended:
    - ❖ Form a committee in the organization tasked with identifying software needs. Develop a complete description of desired computerized support as a first step, before researching available software tools.
    - ❖ Research what is available in the market in your location. Require all vendors to provide lists of other local users of their software and request recommendations of those users. This applies to both hardware and software. If the vendor cannot provide evidence of reliable and effective technical support, seriously consider dropping that product as an option.
    - ❖ DSOs specialize in increasing access to health care in their countries. Few of them are computer specialists. Allocate a portion of the software budget to outsource computer hardware and software maintenance.
    - ❖ If the final decision is to develop an application for the DSO, it is highly preferable to award this contract to a national company, with a staff who are likely to stay in country. Having software developed by ex-patriots, who might leave the country and also the software, leaves the DSO vulnerable.
    - ❖ EPN to discuss whether there is a need for centralized DSO operating data; if so, EPN to develop Excel templates for the required data. DSOs can then develop tools to export data from their computerized systems to share with EPN and other DSOs.

The consultant noted that in the light of the above, and given the scarcity of ERP packages of the right size, with adequate technical support located in some of the more remote sites where EPN works, some of the DSOs might be better off adopting two systems: an inventory control package, and an accounting package, and developing an Excel interface between the two. In this way they avoid the complications of modifying software to meet their needs (and introducing potential instabilities) and can work with simpler, more focused software packages.

This decision will have a direct relationship to the size of the DSO: smaller DSOs simply do not need and can not afford full ERP packages. Instead DSOs are advised to truly analyze their needs, and to identify software that meets their level of infrastructure and computerization.

Discussion and Comments

The participants were in general not satisfied with the report and expressed disappointment that the report did not meet their expectations as it seemed to be more of a study of what the DSOs are using and it did not provide information on the type of software available and their characteristics which would help the DSOs choose one for their own use.

Participants indicated that the report creates the impression that DSOs are unique and have unique software needs whiles this was not true; rather, all DSOs have the same basic functional responsibilities and these are operated upon the same principles but at different levels of sophistication. Participants further felt that the report did not give any software options for DSOs; participants expected the report to provide comprehensive information on the types and characteristics of software in the industry, especially those being used by drug supply organizations around the world, to inform and guide these DSOs in choosing one that will meet their needs. Another observation about the report was that not enough information on experiences of DSOs with their existing software was gathered.

Participants observed that DSO systems are in evolution and development, thus any software designed or adopted for use by DSOs must be able to adjust for growth and development of the DSOs.

A participant with experiences in software use with significant IT background, in no uncertain terms discouraged others from using the proposal to use Excel as an alternative to formal software package.

Participants agreed that what was fundamentally required was a Drug Management Information System [DMIS]; an ERP may be too much for the DSOs. Participants recognized that a DMIS in itself was not useful if the DSO did not already have existing and strong management systems and good internal control mechanisms for each functional area.

The meeting decided to define minimum information requirements that any DSO will need for efficient and effective operations. Discussion led to agreement on that any software option must reflect key functional activities a DSO must carry out. These functional areas were identified as follows

1. Finance and Administration
2. Procurement
3. Warehousing and inventory control
4. Distribution and customer relations

Participants went into group work to define the minimum information needs in each area. This list of minimum information needs is to be inputted into the consultants work to help address the omission of suggesting suitable software

options. The participants suggested that EPN secretariat further refine the list for possible use to develop a guideline that will help DSO's in their efforts to select appropriate software.

Next Steps

The meeting recommended that;

1. EPN inform the consultant that the assignment is not complete and the identified gaps and expectations addressed.
2. EPN support the development of a guideline on 'minimum DSO information needs' so it provides a guide to DSOs in selecting a software.

1.4 Antibiotic Resistance

Discussion and Comments

The issue of Antibiotic Resistance [ABR] was agreed upon by all participants as a challenge they all face and considered important. Participants recognize the issue as an old one but the present situation requires urgent action.

The 'antibiotic use culture' in many countries, was considered as a major factor leading to the increase of the problem. This culture included prescriber motivation and practices, poor diagnosis and improper use of antibiotics [doctors] and patient compliance or non-compliance behavior.

Other challenges identified include the aggressive marketing strategies of manufacturers, the weak drug regulatory environment in many countries where in some instances antibiotics are sold in the market place and fake drugs are predominant. Even worse is the presence of low quality antibiotics which are a higher risk factor in developing ABR. There is a lack of capacity in most countries and health institutions to monitor ABR

During this session, participants were also briefed on the WHA resolution on Rational Use of Medicines (RUM) and also informed that EPN was part of the lobby group for the resolution. The RUM resolution is important in this case as antibiotic misuse is one example of irrational use of medicines. The resolution has strategies for practical RUM implementation that countries can follow. In its intervention, EPN made a commitment to introduce the same to the CHIs. It was proposed that the Network would develop action plans to carry this forward.

Group work was carried out to find answers to the following questions;

1. What/how can EPN address the issue of ABR
2. What/how can DSO's address the issue of ABR
3. What/how can health institutions address the issue of ABR
4. What/ how can communities address the issue of ABR

Next Step:

The meeting recommended that;

1. EPN should discuss and define possible areas of collaboration and partnership with ReACT, based on the group work suggestions.
2. EPN should review the group work suggestions and develop feasible interventions it can initiate and support on its own.
3. EPN should develop a message on the prevention and control of Antibiotic Resistance for its members to disseminate and use.

1.5 Anti retro viral Medications

The presentation on ARVs was with the background that WHO has recommended an improved 1st line therapy that includes Tenofovir which increases the cost of treatment.

Three main issues were raised by the presentation

1. New first line drugs for HIV are being produced and introduced into the market but these are very expensive, are available only as brands and costs range from $360 to $680 as compared to present available first line generics of $99. The old first lines have been found to be significantly more toxic.
2. Soluble Pediatric dosage forms are coming into the market to replace the older suspensions. Their use will increase compliance and decrease costs.
3. New medicines in general are coming on the market for second line treatment in TB, Malaria and HIV that should be made available for CHIs.

On pediatric medication, the discussion focused on the 3 different dosage recommendations existing i.e. from WHO, Ranbaxy and Cipla. Memebrs expressed hope that WHO would discuss this issue with the two manufacturers. Noting the great advantages (price, compliance, easy of storage), the DSOs discussed their role in spreading up their availability in chich institutions. Samples provided by the speaker were taken by the participants from DSOs engaged in ARV procurement to start discussion their clients in the country and with project owners

Discussion and Comments

During discussions following the presentation participants gave personal experiences at country level in the area of ARV access issues. Some of the issues and experiences shared included:

1. DSOs find it difficult to influence national treatment guidelines or policy on HIV treatment etc. The Global fund has a lot of influence in-country.
2. What is EPNs relationship with Global Fund? Can it support member DSO's? Yes (has linkages can communicate with)
3. EPN to consider offering itself as principal recipient organization with Global Fund and work with members as implementing partners.
4. Raise concerns of DSO and country issues to Global Fund
5. Participants asked if ARVs were included on the rational use of medicines – guidelines?
6. How useful are the present treatment guidelines
   a. How are we influencing (updating or standardizing guidelines)
   b. How are we ensuring current evidence influencing new drugs, experiences
7. A lot of ARV expires on the shelves this applies to both 1st and 2nd lines products. This leads to wastage and costs.

8. What informs quantification of ARV to avoid wastage
    a. Needs based (population, side effects, toxicity etc. consumption)
    b. Resource based
9. Flexible contracts to accommodate changes in guidelines and treatment regimes with suppliers is an option to reduce waste
10. How are we soliciting the support of church leadership to support the ARV agenda?

Next Steps

1. Suggestion on what EPN can do, written out by members will be analyzed to inform interventions.
2. Advocacy should be targeted to ensure that regular review of treatment guidelines are done at international and national levels to keep abreast with the evidence and changes in ARV treatment regimes.

1.6 EPN Data Observatory

This issue was raised out of the presentation made by Albert Petersen. The presentation made a case for EPN to establish and maintain a data base on the trade aspects of access to medicines. The presenter also made it clear that there was interest in this area and possibly support from some funding agencies namely DFiD and SIDA.

Discussion and Comments

All agreed that a data observatory was a very good idea. EPN has been mandated to develop concept and operational arrangements for the establishment the data observatory,

- Define concept (purpose, use, benefits)
- Request for inputs from DSO on how and what information they would want
- Define structure/arrangements

In plenary discussions the following was generated:

1. What is the purpose of the observatory
   - Improve DSO performance
   - Data for advocacy
   - Information sharing
   - To improve systems in DSO
   - To empower EPN with data
   - To increase member awareness of country and global issues
   - Increase knowledge base
   - Data for members for self assessment [performance]
   - Provide country information to support others

2. The observatory is as useful as what we put in it.
3. Content
   - Usefulness of other data sources
   - Focus on new medicines
   - Avoid information overload
   - WHO could provide information needed
   - Information from Global Fund website and link to other websites
   - Trade issues
     - Drugs
     - Diagnostics
     - Things to do with DSOs (ref. EPN website)
4. General concerns
   - We need a high profile observatory to motivate use
   - Have to decide on type of observatory; internal or external use
   - Should be directly accessible and easily downloadable.
   - Challenges to data collection from members [sensitivity, availability, capacity, relevance]
   - Commitment of members to provide information

- Benefit of value of data requested for and its use to members. No general information on EPN will be there since EPN has a website with general information, rather information on quality, price, delivery etc of crucial ARVs, antimalarials and diagnostics etc. should be there.

Next Steps

1. EPN to constitute a technical team to develop further the concept of the Data Observatory and prepare a full proposal for discussion and by-in by members and submission to the indicated interested partners.

1.7 Advocacy

Participants were given feedback report on the EPN Advocacy training held in Zambia in November 2006. A paper on Advocacy Strategy Development was passed on to all the participants for reference and discussion. To highlight issues, the facilitator shared his own experiences accorded by his position in his organization to illustrate the basic questions and processes that form the basis for advocacy work.

In discussions after the presentation it was clearly realized that most DSOs have been carrying out advocacy activities, though they may not consciously relies that that is what they are doing. An example from Kenya MEDS highlighted the power of using the religious leaders. MEDS shared an experience where government funds to mission health institutions had been stopped for a few years and efforts to have it re-instated had failed. They then arranged a meeting between the religious leaders and the President and following that meeting the government support was re-instated.

Participants appreciated the power of their respective religious leaders and were encouraged to involve them as much as possible where necessary. Participants were also reminded that it was their responsibility to brief and prepare their leaders with information and material to ensure that their involvement would lead to success.

How EPN follows up on DSOs advocacy in the implementation of advocacy plans as well as support DSO in the implementation of advocacy plans was recognized and a major challenge. It was suggested that DSOs send in short briefs of what they are doing so EPN disseminates it to other network members.

1.8 Relevance of DSO's

Many DSOs are asking whether they are still relevant today or even into the future. They are facing many challenges in their efforts to continue providing services to the poor and predominantly rural populations. The question of sustainability and effective and efficient operations continues to be asked. What is the future of DSO's? Will they still be relevant? Are they presently sustainable?

A new direction for DSO

In discussing this issue, the participants articulated DSOs as a business with a clear, significant and unending social mission to help improve the quality of life in mankind. The churches are representative of the people and its agencies, such as the DSOs, are motivated to serve the people. The DSO is a business with a social mission. Asking whether the social aspects of its mission makes the DSOs redundant and irrelevant to the drug supply industry, there was an emphatic No!! The poor and marginalized will always be there and will require the services of the church health services and DSOs. The challenge for the DSOs as key agents of the church is how to maintain their identity and social mission while running as a business. It is this foundation and the genuine desire to represent the people that should be the motivating force for DSOs. This aspect of its mission should be the added value and competitive advantage over other public or private DSOs. In this light, the participants raised the following issues:

- Many changes are occurring in the pharmaceutical sector in many countries. National health sectors are getting stronger, partnerships between DSOs and governments are not always ideal.

- Global initiatives such as PEPFAR and Global Fund have the potential to kill DSOs. These donation programmes are not sustainable and therefore DSOs must take the opportunity to be strengthened during this period so that they can take over in future. It is important to note that churches were there before these global projects and will be there afterwards.

- DSOs were established by churches at a time when drugs and medical supplies were not easily available, the national governments were weak and there was no significant private sector to provide the needs of the health sector in the area of drugs and medical supplies. The DSOs were the pace setters, in drugs and medicines supply, especially to poor and rural communities. This was 30 – 40 years ago.

- The health sector has changed significantly since; the public sector has grown, drug use regulations and standards have been introduced and the private sector has established itself and continues to grow. There is

competition from the private sector and church health institutions have the option to go to the open market for their drugs and medical supply needs, and do not resort only to the DSOs. The captive market of the DSOs is eroding!

- However, government and the private sector are not always able to provide the full needs of the population and there is still a great proportion of need in the rural and poor segments of the population, the niche of the DSOs. DSOs are still respected and relied upon by many.

- In line with the church's pioneering spirit, DSOs need to consider new initiatives and innovations in the drugs and medical supplies area, that will address needs which government and private sector are either not able to fill for lack of capacity of because it is not profitable; such new needs in the area of drugs and medical supplies include quality issues, drug management, rational medicine use and general use issues in medicines. DSOs can also move into information dissemination and awareness creation programmes to improve consumer awareness on drugs and medicines issues, technical training to improve the human resource capacity in pharmaceutical care and increase their advocacy role in supporting increased access and availability of quality pharmaceuticals to the poor and disadvantaged.

- To move into these new areas DSOs will need to review their *modus operandi*.
  - The 'business models" being used which must maintain a non-profit orientation yet ensure the use of effective business principles and practices to guide it,
  - the governance structures
  - the limited autonomy from the "church hierarchy"
  - Being pro-active in negotiating partnerships and resources from government and local as well as international sources.

- The mission of the DSOs is still as relevant today as it was when they were started more than 40 years ago. DSOs need to capitalize on the fact that they are considered credible alternatives, provide high quality services, are respected and recognized by both government and the population. The DSOs have infrastructure already existing to support a shift in focus.

- DSOs can reposition themselves to support and strengthen "national" supply chain systems. In this, DSOs must develop new capacities and strategies. Such strategies include:
  - rural franchise operations of small dispensary units,
  - striving for quality and
  - increasing their consumer base to include non-church health institutions,

- Initiate and show how ethical business practice can improve and enhance access to medicines in countries..

The indicated changes in operations will require engaging the church leaders to understand the new environment and input into how the DSOs can reorganize and reposition to continue with their mission. DSOs were called to become centers of excellence in innovations and promotion of quality issued in pharmaceutical management.

The concerns and anxieties raised above notwithstanding participants were positive that DSOs should remain in 'business' and suggested the following;

- DSOs must be the moral compass of the health sector,
- DSOs should continue to tread the domain of the impossible, that is their mission and DSO's must know that God has not forgotten them but is with them always
- DSOs were primarily set up to be of service to church institutions, if this is no longer relevant then the logical thing is to close down and not be emotional about it.
- DSOs should review their situation and change accordingly to provide services that are difficult to assess by their members or services which they have a clear comparative advantage.
- DSOs should identify what added value they bring to the pharmaceutical sector as opposed to any other supplier in the market.
- DSOs should develop strategic alliances with government and other private sector organizations. They do not have to be in competition.
- DSOs cannot remain complacent in their markets; they have to expand and select a new niche as well as meet or set higher standards of service.
- DSOs should be innovative in looking for funds to continue their work.

Next steps

1. An assessment of the situation and options available to DSO must be carried out.
2. This should form the agenda of a conference between CHAs, the DSOs and their boards.

1.9 DSO commitments and assignments

To ensure that practical steps were taken by DSOs as outcomes of the meeting, commitments and self determined assignments were prepared by participants from respective DSOs. These commitments / assignments were based on their own real needs and challenges on the ground. They were not necessarily linked to the reports and presentations but reflected priority areas of intervention they wanted to address in their organizations.

A simple process was introduced and followed by the DSO in preparing their self assignments. Three simple questions were asked and answered
What is the issue
What is the desired change
How will the desired change be carried out
How will the change be identified and measured.
These questions led to the development of a simple yet practical action plan. Participants were expected to set time lines and implement their plans when they went back to their respective DSOs. These plans can be found in Annex 2.

ANNEXES

Annex 1: Outcomes from Group Works

The meeting discussions were supported with group work activities which enabled in-depth discussions into the various issues discussed. These group activities were designed to enable participants generate new ideas on how to move forward or improve on issues raised by the reports.

1.1 Distribution

Group work was carried out to reflect on the recommendations of the report on distribution and come out with suggestions on how to implement them. The report recommended that DSOs;

1. Make ordering easy pleasant and worthwhile for customers.
2. Increase stock range and improve availability of products to make ordering worthwhile fro customers.
3. Create or promote new communication channels for customers.
4. Ensure reliable checking and packaging of their products.
5. Offer distribution options to their clients.

The outcome of the group work is as follows.

1. ***What can be done to improve ordering, making it easy, pleasant and worthwhile?***
   - Catalogue – item code, description, latest price in local currency
   - Introduce standard order forms
   - Investigate possibility of electronic communication
   - DSOs to communicate regularly items in stock and prices update
   - Introduce ordering schedules
   - Keep up to date client information
   - Consider payment and delivery options
   - Assist clients in quantification
   - Maintain continuous relationship / follow-up on supplies
   - DSO staff should be trained on clients customer services
   - Maintain personal touch with clients
   - Introduce distribution points closer to clients
   - Conduct market and operations research to inform improvements

Challenges

- Local price fluctuations
- Lots of training required in order scheduling
- Reliable communication systems required (e.g. internet services for clients)

2. ***What can be done to improve stock range and availability?***

a. What can EPN do?

i. Engage in international advocacy for
   - Further support for essential drugs concept as a basis for national formularies
   - Countries to regularly update their essential medicines list and treatment guidelines.
   - DSOs to get technical and financial support to improve services

ii. Provide Leadership to DSOs through the use of its power and influence to
   - Providing the DSOs with current information on improving stocks range and availability issues.
   - Raising the profile of DSOs

b. What can DSOs do?

i. Stick to national medicines lists & guidelines as the basis for stock range.
ii. DSO's should build the capacity and sensitize customers on
   - Essential drugs concept
   - Introduction and use of hospital formularies
   - Rational drug use
iii. Define the system by which products are added to the stock range
iv. Keep product stock range that is informed by the country's / customers disease burden
v. Proactively determine customer needs & take action
vi. Increase their capacity for forecasting

3. ***What can be done to seek, create or promote new communication channels?***
   - Investigate more use of E-mail; Telephone; Website; Fax
   - See possibility of data transmission by mobile phones
   - Establish Customer fora
   - Use newsletters
   - Field visits
   - Organize meetings / advocacy with opinion leaders
   - Introduce and update regularly price catalogues
   - Introduce electronic order forms
   - Electronic data interchange (EDI)- LPOs / visibility of stock
   - DSOs can establish a customer liaison office
   - Introduce toll free lines for orders / issues / complaints
   - Customer profiling using all available channels
   - Use of the media such as radio and print
   - Use of suggestion boxes
   - Documentaries
   - Postal / courier
   - Prepare and use promotional documentaries and items

Challenges

- Cost implications – e.g. fdi, consultancy services
- Different levels of computerization of clients
- Limited access to mobile telephone services
- Poor infrastructure e.g. buses / courier
- Security concerns e.g. electronic means-viruses / hackers
- Lack of knowledge / understanding of available options (EPN could help in this area through providing information and training)
- Lack of standardization of facilities
- Expertise availability – technical back-up / support
- Capacity limitation – human resources
- Un-reliable postal services
- Legal concerns

4. What can be done to ensure reliable checking and packaging?

- Computerizing / automating the system
- Training staff in warehouse management and control
- Checking / confirmation of items picked to be done by at least 2 people
- Provide reliable self adhesive packaging pre-printed tape with DSO logo on it
- Use of triple layered carton boxes for packaging
- Always provide and make use of packaging list
- Label boxes that are to be delivered

Challenges

- Cost of implementation

5. What can be done to provide distribution options?

- Creation of new drop-off points
- Customer training / feedback
- Courier systems to be considered in some cases
- Zonal / pool distribution system
- Adopting the electronic data interchange with customers and suppliers
- Use of local transport systems e.g buses

Challenges

- Cost and infrastructure
- Cost of implementation

1.2. Quality Control Laboratories

Group discussions set out to answer the following questions

1. What is the role of EPN in promoting QC in DSOs
2. What resources are required to set up QC labs?
3. What are the possible approaches for introduction/scale up of QC.
4. Challenges of Setting up A QC Lab as a DSO/HI Health Institution.

1. What is the role of EPN in promoting QC in DSOs

i. Classification of Drugs e.g. according to the sophistication level needed and importance the appropriate type of QC approach may be the following ;
   - QC lab
   - Mini lab
   - Physical inspection
   - Mandatory drug testing list

ii. Making regulations simple for those DSOs that send drugs to other Regions (Advocacy)

iii. Circulate list of different levels of QC labs in Africa

iv. Sending reminders to DSOs that providing quality medicines is their responsibility

v. EPN requests WHO to assist in exploring where trainings of people working in QC labs is done. Then inform EPN (eg. MEDs has failed to send its staff for training)

2. What resources are required to use or set up QC labs?

i. Information
   - Location
   - Import and customs regulation
   - Costs of testing (examples given – MED (100-200USD), CENQAM (500-600USD), LANACOMEY (100USD)

ii. Money

Ways to fundraise funds:
   - Factor cost of QC into pricese.g. 2.5%
   - Request donor funding (questions of sustainability were raised)
   - Pooling of testing to share costs

iii. QC standard Guidelines
   - Guidance on testing protocol (EPN cans assist by informing on where information can be found)

3. Possible approaches for introduction/scale up of QC.

i. Assessments of needs and Development of implementation plan
   - Current position and self assessment
   - Human resources

- Financial resources
- Equipment
- Infrastructure
- Available options e.g. Outsourcing

ii. At the Clinic level the introduction of accurate diagnostic support, collaboration with higher level health facilities and improved networking to share treatment information can reduce abuse of antibiotic use.

iii. Consolidation of existing services/practices

4. Challenges of Setting up a QC Lab as a DSO/ Health Institution

i. Buy-in by the owners.
ii. Business evaluation
    - Feasibility study
    - Business plan
iii. Defining the scope
iv. Governance structure
    - Ethical issues
    - Independence and reliability
v. Financing – set up costs (building, equipment)
vi. Human Resources
    - Availability, training, validation
vii. Policy and procedures and establishment of standards of Good Lab Practices (GLP)
    - ISO Certification, WHO Certification

1.3 Software Options

The meeting decided to define minimum information requirements that any DSO will need for efficient and effective operations. Discussion led to agreement that any software option must reflect key functional activities a DSO must carry out. These functional areas were identified as follows

1. Finance and Administration
2. Procurement
3. Warehousing and inventory control
4. Distribution and customer relations

For each functional area group discussions defined the minimum information a software should be able to generate if it was to be useful to a DSO. These are indicated below under the respective functional area.

1. Finance and Administration

A. Managing accounts receivables
    1. Summary value of distribution
    2. Credits/debits – claims
    3. Summary of your debts
    4. Donations to clients
    5. Customer details

B. Managing accounts payables
    1. Summary goods received – value of purchases
    2. Summary of claims – returns
    3. Supplier details
    4. Outstanding debts

C. General ledger
    1. Balance sheet
    2. P/L A/C or income and expenditure
    3. Cash flow statement

D. Managing fixed asset

E. Managing cash book
    1. Summary – payments to suppliers
    2. Summary – receipts from customers

F. Contact management system or CRM
    1. Recording complaints
    2. Details of customers

G. Projects

H. Sales invoicing etc

2. **Human Resource and General administration**
   A. Payroll system
      1. Basic pay
      2. Benefits
      3. Employees profile
   B. Human Resource Profile
   C. Office automation/communication
      1. Email, telephone, fax, meetings
   D. Training and development
      1. Employees qualification
      2. Training needs
      3. Employee grading
      4. Conference attendance

3. **Procurement**
   A. Selection
      1. List of items – generic names, available brands
      2. Classify according to : Therapeutic groups, ABC, VEN
      3. Pick product code

   B. Quantification
      1. Consumption data
         i. Monthly average
         ii. Weighted average
         iii. Maximum stock level
         iv. Minimum stock level
         v. Safety stock
         vi. Re-order level
         vii. Buffer stock
      2. Mobility data based on specific diseases
      3. Volume of individual items (space)
      4. Weight of individual items

   C. Purchasing
      1. Tender processes – (procurement cycle)
      2. Interim purchases (emergency)
      3. Priority supplier, alternative supplier
      4. Analyze quotations
      5. Generate LPOs from selection
      6. Update stock module

   D. Supplier Selection
      1. Prequalification of suppliers
      2. Supplier data
      3. Supplier performance
      4. Expiry period

E. Monitoring Orders
    1. Pending orders
    2. Delayed orders
    3. Supplier sources (local, international)

4. Warehousing and inventory control

A. Inventory Management
    1. Expiry date
    2. Batch Numbers
    3. Supplier information
    4. Stock level
    5. Receiving vouchers
    6. Issue vouchers
    7. Item description
    8. Picking slip
    9. Packing slip
    10. First –in – first- out

B. Storage
    1. Storage conditions requirements
    2. Space
    3. Location/bin/supplementary store
    4. Environmental condition monitoring

C. Classification
    1. Coding system including error prevention
    2. Therapeutic, formulation, pack sizes strengths, ABC, manufacturers
    3. Cold chain, narcotic etc.

D. Infrastructure
    1. Floor space
    2. Location (satellite warehouses)

E. Reports
    1. Valuation
    2. Expiry
    3. Stock level – number, quantitys
    4. Stock turnover
    5. Stock outs
    6. Location
    7. Batch tracking - recall

F. Distribution and customer relations
    1. Sales Reports

2. Customer Details – segmentation
3. Order tracking/ordering cycle
4. Transport management (scheduling etc.)
5. Customer complaints
6. Delivery documents
7. Ordering patterns
8. Customer preferences (products)
9. Order translation, PI, quote
10. Customer feedback
11. Pick pack list
12. Incident tracking

1.4 Antibiotic Resistance

Group discussion were held on the following

1. What/how can EPN address the issue of ABR
2. What/how can DSO's address the issue of ABR
3. What/how can health institutions address the issue of ABR
4. What/ how can communities address the issue of ABR

The group outcomes are presented below;

What / how can EPN address the issue of ABR?;

1. Source and disseminate information on ABR
2. Advocate for regular review of STG
3. Advocate for the presence of essential diagnostic equipment in the DSO facilities
4. Conduct Training of Trainers courses
5. Collaborate with other stakeholders (e.g. P.S.F., M.S.F., WHO, H.A.I. etc.) to developing I.E.C. materials for communities [engage manufacturers in same ? conflict of interest]
6. Set up an Antibiotic stop clock (a suggestion for ReACT)
7. EPN shares widely experiences of its members in addressing AR

What / how can DSO's address the issue of ABR

1. Include ABR information in training programs both for DSO and clients
2. DSOs to be encouraged to provide basic diagnostic equipment and supplies in their formulary.
3. Document the kind of promotional incentives pharmaceutical companies are providing.
4. Can DSOs use their own "Med Reps" to offer leadership in RUM??
5. Positive promotion
6. DSOs to develop tool for formulary development and best practices in drug selection.
7. Advocacy: DSO to advocate to owners of Health institutions to provide necessary diagnostic tools.
8. Use websites to offer awareness to AR.
9. Provide information "Package Inserts" on AR e.g. "antibiotics are dangerous etc
10. DSOs should report to EPN secretariat on activities used to raise awareness on AR.
11. DSOs could collect data on AR due to use of AB.
12. Institute consumer compliance motivation programmes
13. DSOs should share information on their experiences with antibiotics especially those that have been reported as not efficacious for other DSOs to be made aware.

What / how can health institutions address the issue of ABR

1. Create awareness among HI staff and community (outreach)
2. Create drug and therapeutic committee to review AB use and training of prescribers and dispensers
3. Practice and improve infection control especially hand washing etc.
4. Monitor ABR and inform DTC (even occasionally) by capable HI's
5. Community sampling for ABR by capable HIs
6. Feedback to DTC and community leaders
7. Provision of simple cost effective equipment for diagnostic purposes
8. DTC to ensure availability and adherence to STG
9. DTC to develop hospital level treatment guidelines for antibiotic treatment of Common Infection Diseases based on ABR data
10. HIs to feedback into the treatment guideline through advocacy so that local treatment experiences are included into national treatment guidelines

What/how can communities address the issue of ABR

1. Community education on antibiotic use
2. Strengthening HBC programs
3. Community sensitization and campaign on antibiotic use
4. Involvement of traditional leaders
5. Creation of community radio programs
6. Public education to law enforcers (to understand why control is important)
7. Linking communities to other networks dealing with consumer rights e.g. Health Action International; Pharmacists without boarders (PSF) etc
8. DSO try and put stickers on antibiotics that are sold, advising on the hazards on abuse
9. Priority testing of antibiotics by DSO
10. Encourage consumer to demand information from prescribers
11. Advocate for antibiotics to be elevated from prescribed to controlled drug (challenge: this may lead to reduced access)
    - Advocate for better regulation
    - Tighten control
    - Plug leaks to open market
12. Use the churches to promote proper AB use and advise on the dangers of AB abuse eg. Youth GPs, mothers GPs, sermons, mentorship etc.

Annex 2 DSO Follow-up commitments /assignments

	Ghana, CDC	**Cameroon, CBC Central Pharmacy**
Issues	Distribution 1. CDC stocks does not meet customer needs 2. CDCdoes not deliver items to customer 3. CDC does not receive enough orders from customers 4. Ordering at service point is too cumbersome	Distribution 1. To be able to sell at affordable prices while ensuring sustainability 2. To improve on record keeping 3. To minimise supply errors 4. To improve on communication with our customers
Area of intervention	CDC does not receive enough orders from customers	
Proposed accomplishment	To receive orders from 80% of customers at least one week before the supply of products within 24 months	▪ All items ordered are supplied ▪ There are no supply errors ▪ Supplies are delivered within the agreed time frame
Proposed activities	1. Send updated list of items and prices to customers monthly 2. Provide phone numbers, e-mail addresses, fax number to all customers 3. Provide a simplified order forms – both manual and electronic 4. Send weekly reminder via e-mail where appropriate 5. Call customers on phone at least once a week for their orders 6. Visit selected customers monthly to collect their orders	1. We will raise funds to procure the required supplies in sufficient quantities 2. Prioritize procurement of supplies 3. Effectively quantify own needs 4. Purchase a small delivery van for smaller consignments, or subcontract with other transporters (the issue of purchase of a van raised the discussion on the need for a tool to assess if this is the best option)
Measure of improvement	▪ Percentage of orders received at least 1 week in advance ▪ % of orders from customers ▪ Number of days orders are received before the supply	▪ Customers will stop complaining that they have not received all the items they ordered ▪ There will be no discrepancies in own stock / inventory ▪ Emergency purchase of supplies will no longer be frequent ▪

	Nigeria, CHAN Medi-Pharm ltd	**Kenya, MEDS**
Issues	1. High inventory cost 2. Stock out syndrome 3. Attracting and retaining customer 4. Client loyalty 5. Delayed order processing 6. Ineffective communication between 7. Depots	1. Eliminating errors in order processing 2. Improving turnaround time 3. Timely update to clients on progress/status of their orders 4. Reorganizing dispatch or orders 5. Reducing the number of items out of stock
Area of intervention	Stock out syndrome	Eliminating errors in order processing:
Proposed accomplishment	Reduce the level of stock out from 40% to 10% By the end of 2008 with about 80% of our Customers	To eliminate complaints from clients on errors such as: ▪ Wrong item/quantity ▪ Invoiced but not supplied items ▪ Supplied but not invoiced items
Proposed activities	1. Define and stock adequate levels of tracer or other products 2. Review our stock lists to make it more robust 3. Support our MI's through training to adopt the concept of rational drug use and essential medicines list 4. Improve forecasting and demand generation	1. Automating order processing Electronic order form 2. Reduce ordering errors by clients 3. Reducing keying in errors by our data entry staff Bar-coding system 4. Reduce picking/packing errors Electronic data interchange 5. Allow clients to view order status 6. Allow clients to view items not packed (out of stock)
Measure of improvement	▪ When we begin to have a reduction in stock out from 40% of all orders from our customers	▪ Reduction in percentage of orders with errors from current 3% to less then 1% within the next 1 year.

	Nigeria, ECWA	**Malawi, CHAM**
Issues	1. Stock out of procured drugs 2. Improving access/marketing of manufactures products 3. Improve customer/supplier relationship 4. Maintenance/repairs of machines 5. Improve inventory control 6. Delayed payment from customers 7. Few distribution points	1. Stock availability of listed items 2. Delivery / logistics /distribution depots for rural based facilities 3. Inventory system deficiencies 4. Communication with CHAM facilities 5. Storage space 6. Availability of polling materials (i.e boxes, cartons, cold chain storage)
Area of intervention		Inventory system
Proposed accomplishment	ECWA is tying to improve access and sales of her products by 25% in 2008 for better customer satisfaction.	To have an effective inventory system to improve stock availability
Proposed activities	1. Create more distribution points or cost effective delivery trips 2. Improve packaging of products (packets, labels, shrinkwrapping) 3. Know customer/institutional profile for improved customer relationship 4. Organize stakeholders forum for feedbacks on products/services 5. Quarterly market survey on similar products 6. Distribute promotional items 7. Advertisement of products/services (media, magazines) 8. Procure a better delivery van	1. Explore software systems available and their suitability for CHAM drug store 2. Consultation with experts and experienced users on programs available before selection of program 3. Staff training on new system to be implemented (follow up) 4. Organise / co-ordinate stock located at warehouses (i.e. What stock is located at which warehouse and how much do we have?)
Measure of improvement	▪ Improved sales/marketing/accessibility of products ▪ Improved supplier/customer relationship and satisfaction	▪ Reduction in stock outs ▪ Satisfaction level of customers improved (questionnaires / feedbacks) ▪

Joint Medical Store, Uganda

Issue: Low Customer Satisfaction

Achievement Area: Higher level of customer satisfaction in the "Contact Moments"

Measure: Level of customer satisfaction about contact moments

	Activity	Action Owner	Timeline	Indicator
1	Define information requirements for a comprehensive customer profile.	HQ	30/09/07	Information requirements defined.
2	Update all customer order fields for the top 400 customers.	AA/sales	31/10/07	Status of Top 400 customers
3	a. Develop a database to capture the information in 1 above. b. Input and maintain database.	ITO CRO	31/10/07 31/12/07 and ongoing	Database developed. Status of Database.
4	Design and implement a skill building program for effective customer handling.	HRRA	31/11/07 31/03/08	Program design. Program implemented.
5	Incorporate a key performance indicator on customer focus on all functions within JMS.	HRRA	31/12/07	Performance management system in place.
6	Provide a mechanism for the use of SMS for communication to customers a. Mobile telephone b. Bulk SMS	AO ITO	30/08/07 31/09/07	Mechanism in place.
7	Prepare communication briefs after procurement team, management team and communication group meetings to inform relevant staff.	Chair/Secretary	Immediate and continuous.	Communication briefs.

Annex 3: Meeting Evaluation

Accommodation, feeding and meeting in general

Area of evaluation	Total	Very Good	Good	Fair
Archbishop Vining Conference Centre	5	1	1	3
Airport Hotel	18	2	14	2
Meeting in General	23	11	11	1

Comments: Only 40% of participants accommodated in the conference centre rated the facility as good or very good whiles 90% of those in the Airport Hotel were satisfied with the facilities there. 95.6% of participants rated the meeting good or very good.

Presentations

	Not Relevant	Relevant	Very Relevant	No record	Total
Production	6	6	10	1	23
Quality control	0	2	21	0	23
Distribution	0	2	20	1	23
Software	3	5	15	0	23
Antibiotics	0	6	17	0	23
ART	0	9	14	0	23
Advocacy	0	5	18	0	23

Comments: For all the presentations significantly more participants rated them as very relevant. With the exception of the presentation on Production and Software options all presentations were 100% rated as relevant or very relevant. In general participants found the presentation useful to them.

Participants Profile

		Comments
Anglophone Members		
Francophone Members	3	
1st time participants	7	Most of these were from the Francophone countries.
2nd time participants	12	Most of these participated in the Tubingen meeting in 2006
3rd time participants	4	These participated in addition to the Tubingen meeting other meetings in Moshi as well as in Nairobi in 2004 and 2005

Participants Inputs

Inputs from participants answering 3 questions

1. What topics can you suggest for future DSO Meetings?
2. What would you like to be done differently in the next DSO meeting?
3. Please give any other comments that you may have regarding the meeting.

The inputs from the participants on the above questions are listed below.

Suggested topics for future DSO meetings

- Sustainability of Church health services in the next 10 years.
- Drug resistance to antibiotics and ARVs.
- Building DSO capacity to handle scale-ups.
- Give members guidance on accessing funds.
- Customer care
- Strategic assessment an evaluation and plan of DSO.
- Presentation of activities implemented by DSO since last meeting and challenges, lessons learnt.
- DSO sustainability/quality assurance standards.
- Quality Control, Distribution
- The involvement of other health fields/NGOs in pharmaceuticals.
- Action plans implementation information for DSOs should be given enough time for discussion.
- Quality control again
- Tackling HR situation – approaches/methods etc.
- Information, Communications and Technology.
- ERP – Website design and maintenance.
- Advocacy for funding so that donor funds do not get into wrong hands continuously.
- Sources of generic pharmaceuticals and raw materials.
- Funding of DSOs especially on procurement.
- Drug sources (good quality less expensive) sustainability of DSOs.
- More on software options.
- Rational use of drugs.
- Discussion on illegal sale of drugs that affect DSO.
- Possible implementation of regional EPN (East Africa, Central Africa).
- Possible implementation of MED for Central Africa Region.

Suggested changes to DSO meetings.

- Move to small groups more quickly to save time in the agenda and get reports back more quickly to digest
- Remind DSOs about their commitments as soon as meeting is over and regularly there after instead of waiting till just before the meeting.
- More space to meet in small groups (garden, under trees, lobbies) for creativity to be fostered.

- Have smaller members describe their situations/challenges and have larger members give counsel on how they solved those problems.
- Focus – at times the issue(s) was/were not clear ie. direction we wanted to go.
- Need to tie things up better during discussions so that it is clear what the consensus is/higher priorities are.
- More time to be spent on important issues.
- Accommodation and meeting at the same venue.
- Give handouts for pre-prepared presentations.
- Have a session for DSO presentations.
- Open discussion of what DSOs have said to do.
- Presence of persons conducting study.
- A presentation by an EPN country member on a project they implemented.
- Presence of consultants who carryout studies of various aspects on various aspects to present their findings in person (rated high priority).
- Invite Donor agency too to tell us what they can do.
- If possible for everyone to be lodged at same venue. This give more chances for networking/info sharing.
- More than one afternoon free.
    - Invite more francophone countries/DSOs.

General Inputs

- ReAct looks forward to participating in future.
- Tabulate all commitments made by DSOs and give a regular update to all members as in incentive to encourage those who have not done their part to start.
- EPN should request institutions it uses to maintain some minimum hygienic standards eg. Provide adequate toiletries and have assigned kitchen for dish washing.
- An opportunity to go for walks to combat lethargy after lunch.
- A big thank you for a great meeting to our facilitators and Nigerian hosts.
- What a wonderful way to renew old friendships and meet new colleagues.
- Accommodation was fair but could be better.
- Facilitator did a great job.
- Well done Nigerian organizers, we enjoy the traditional dance.
- A job well done! Good hospitality by CHAN, good coordination by EPN,
- Sleeping in shared accommodation was not good.
- The day sessions were very long (10 hrs). Try to keep them short even if it means some overnight assignment.
- It is good indeed.
- Charming organizers, Mike (congrats).
- Good and tolerant facilitator (Gilbert).
- God bless you.

- I think on the 4th day people were tired and lost concentration. Possibly reduce meeting to 3 full days or if 5, have full day break (despite the ½day break on Wednesday, may increase productivity towards end of meeting.
- It is an excellent initiative, thank you.
- The meeting was very good and friendly. Lots of work but also much fun.
- Very interactive.

Annex 4. Meeting Programme

	Sunday August 12	**Monday August 13**	**Tuesday August 14**	**Wednesday August 15**	**Thursday August 16**	**Friday August 17**
8:15 am – 8:30 am	**Arrival**	Daily INTRO	Daily INTRO	Daily INTRO	Daily INTRO	Daily INTRO
8:30 am – 10:30 am		Session I Introduction	Session IV Distribution	Session VII REACT I	Session IX ARV	Session XI Plenary I
10:30 am – 11:00 am		TEA	TEA	TEA	TEA	TEA
11:00 am – 12:30 pm		Session II Production	Session V Distribution	Session VIII REACT II	Session IX Advocacy I	Session XII Plenary II
12:30 pm– 1:30 pm		LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
1:30 pm – 3:30 pm		Session III Quality Control	Session VI Computer Software Options	**Sight Seeing and Shopping**	Session X Advocacy II	Session XII Working Group Session IV
3:30 pm– 4:00 pm		TEA	TEA		TEA	TEA
4:00 pm– 6:00 pm		Working Group Session I	Working Group Session II		Working Group Session III	Next Steps Closure
6:30 pm	**Opening Reception**	Dinner	Dinner	Dinner	Dinner	Dinner

Annex 5: Participants List

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