PSA TRANSFORMING THE SUPPLY CHAIN

3rd Annual Health & Humanitarian Supply Chain Summit Report

HOSTED BY

Pamela Steele Associates
in partnership with Strathmore Business School

SUPPORTED BY:

Ecumenical Pharmaceutical Network
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Pamela Steele Associates Ltd
2nd Floor, Eaton Place, United Nations Crescent, P.O Box 63946-0061, Muthaiga, Nairobi, Kenya
T +254 795 901470 **E** info@pamsteele.co.uk **W** www.pamsteele.co.uk
company/psa-ltd PamelaSteeleLtd @PamelaSteeleLtd

1. Executive Summary

Recognising the gap in the drive to achieve universal health coverage, PSA and its partners came together to create a platform for discussion on the role of supply chain management in the health sector in connection to the successful achievement of Universal Health Coverage (UHC). This theme was identified in alignment with the global call for realising UHC. Universally accessible healthcare means that all people can access essential health services of good quality without facing financial hardship. It involves effectively promoting and protecting health by making preventive, curative, palliative and rehabilitation care available and affordable to everyone, everywhere, whenever needed. It requires integral participation of communities in the governance of strong health systems with long-term vision and intersectoral coordination, since the 'attainment of health goals is dependent not only on actions within the health sector, but also on economic, social, cultural and environmental factors,' as discussed during the World conference on social determinants of health in 2011 by World Health Organisation Member states, Civil society and Social movement representatives in Rio de Janeiro, Brazil.

Of the four critical factors identified by World Health Organisation (WHO) as contributors to the achievement of UHC, the two that the summit focused on were 'Affordability and Access to essential medicines,' because they are controlled by Supply Chain operations. A strong efficient health service, well-run by capable, motivated, trained health workers, will certainly deliver UHC to the population.

Addressing the supply chain challenges would contribute to the quality, affordability and timely provision of healthcare services. The Summit was convened as an opportunity for professionals to share updates and insights from reliable and appropriate health and humanitarian supply chain experiences to enable UHC.

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2. Glossary

DHIS	District Health Information System
BMGF	Bill & Melinda Gates Foundation
SOLVE	Supply Optimization through Logistics, Visibility, and Evolution
E2OPEN	Provider of cloud-based, on-demand software for supply chains
WFP	World Food Programme
KEMSA	Kenya Medical Supplies Association
PSA	Pamela Steel Associates Ltd
EPN	Ecumenical Pharmaceutical Network
SBS	Strathmore Business School
HRH	Human Resource for Health
KISM	Kenya Institute of Supply Chain Management
E&HA	East & Horn of Africa Region
FBO	Faith Based Organisation
SC	Supply Chain
SCM	Supply Chain Management
AAR	Africa Air Rescue (HealthCare & Insurance)
MOH	Ministry of Health
VAN	Visibility Analytics Network
HIS	Health Information Systems
GHSC	Global Health Supply Chain
LMIS	Logistics Management Information System
CDP	Customer Data Platform

3. Background

Pamela Steele Associates (PSA) works with committed partners who are passionate about solving healthcare access challenges by enhancing capacity to extend coverage of affordable quality services and reducing dependency on external support, in developing countries, including in the Horn & East Africa region. We make the most of the existent, evidence-based good practice, seeking information wherever it is not readily available or systematized, co-developing innovative approaches and monitoring the incorporation of new technologies.

PSA, along with the key partners, Ecumenical Pharmaceutical Network (EPN), Humanitarian Logistics Association (HLA), Strathmore Business School (SBS), John Snow Inc (JSI), Africa Resource Centre (ARC) and Kenya Medical Supplies Authority (KEMSA), identified a gap in the drive for Universal Health Coverage (UHC). Developing countries are working towards achieving the 3rd Sustainable Development Goal, focusing on technical aspects with little or no reference to Supply Chain Management and the role it plays in organisational effectiveness and success. The **SDG Target 3.8 reads**:

"Achieve UHC, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."

'Efficient procurement and supply chain systems are a pillar of strong health systems and are critical to achieving universal health coverage.'[i] More than ever, health and humanitarian supply chain professionals are called to facilitate good stewardship in covenant with all stakeholders towards self-determination and resilience. Besides lack of 'sound health financing, leading to high out-of-pocket payments and financial catastrophe or impoverishment for families', challenges include 'inadequacies in health workforce and infrastructure (especially in the rural areas), medical products (poor access, inappropriate use and reports on substandard, spurious, falsified, falsely labelled and counterfeit (SSFFC) medicines entering the supply chain), service quality and information and accountability.'[ii]

The ongoing incorporation of information and communication technology (ICT) in health supply chain raises concerns about the 'sustainability of innovations, and their feasibility, scale-up and inclusivity.'[iii] The design and implementation of technological innovations such as the digitalization of supply chain involves public-private partnerships[iv] and governance models that require systems thinking.[v] The UHC target encourages 'a more sustainable approach through system-wide reform, based on the principles of efficiency and health service integration and people-centred care.'[vi]

Strong health systems are required with long term vision and strategy adapted to local context to ensure that health services and goods are available and affordable for everyone - 'so no one is left behind.' UHC is not achievable without a sustainable supply chain - sustainable systems are required to address financial and capacity challenges, through system-wide reforms and health service integration. Supply Chain must be integrated into the UHC approach at operational and policy levels. The summit provided a platform for a start to that integration and it is the organisers' hope that the event inspired initiatives and partnerships to achieve it.

PSA applies research to ensure that the technical information and support is evidence-based and, in partnership with SBS to inform decisions and the improvement of healthcare. The summit is also an opportunity for collective thinking, which is essential to find solutions and achieve UHC.

Summit objectives:

This Summit was an opportunity to share updates and insights from reliable and appropriate health and humanitarian supply chain experiences for enabling UHC and aiming to:

1. Recommit supply chain and health practitioners to transforming supply chains towards realizing UHC.
2. Inspire integrated approaches by public, private, humanitarian and academic sectors towards UHC.
3. Enhance partnerships and cooperation among supply chain practitioners and organisations.

4. Welcome Address

Dr Frank Ofula, Faculty, Institute of Healthcare Management, Strathmore Business School (SBS)

The distribution chain is key to the success of any enterprise, but it has not been done effectively in healthcare [in Kenya]. Strathmore's Institute of Healthcare Management is increasingly focusing on supply chain and capacity building in their research, teaching and partnerships. The Institute values especially harmony and coordination among staff in supply chain. 'The system has to work as one and be seen as such by the public.' Integration with partners is, therefore, key to strengthen the chain and ensure access to services and commodities.

National supply chains operate independently, which means there are huge differences between countries in terms of systems and efficiency. There is very little opportunity to exchange knowledge internationally and learn from one another. Yet, challenges such as fragmentation, illegal acts and lack of control systems are common to many Sub-Saharan Nations. Although, Supply Chain Management is now the focus of many donors, their initiatives have not yet overcome those challenges.

Often the problems are tackled at national leadership and policy level, but the change is better enforced throughout the chain. 'It doesn't matter how strong the chain is at the top, when it does not reach the public at the end. We have to make the *whole* chain work.' When it works, health is guaranteed, and more investment can be attracted to ensure sustainability and further development.

Ms. Yvon de Jong, Ecumenical Pharmaceutical Network (EPN)

EPN is an international network of faith-based organisations, active in health supply chain in Kenya and in other Low- and Middle-Income countries. EPN focuses on rural populations, who are not normally served by government facilities, thus contributing towards the achievement of SDG 3.8.

At national level in developing countries, medicine-based interventions are the main form of healthcare in developing countries, constituting 40% of healthcare cost. 70% of Kenyan patients do not seek healthcare; of these, 50% cannot afford it. There is a long way to go in ensuring the affordability, access and sustainability of supply chains.

EPN has found that staff involved in supply chain are rarely pharmacists and hardly ever supply chain experts. 'You need to know your products for the supply chain to work.' Often, the challenge is pharmacies that cannot afford to stock sufficient medicine. Shelf-life and storage conditions also tend to be overlooked.

Private/Public Partnerships and sector-wide dialogue are of key importance in ensuring full access in Low and Middle-income countries, as is with government leadership and its concrete action to support health supply chain efforts. For those reasons, it is encouraging to have representatives from non-profit, commercial and government entities in one event to engage in a thoughtful and results-based discussion on UHC in Kenya.

Eng. Chris Oanda, Chairman, Kenya Institute of Supplies Management

'The world has never had a shortage of medicine. The problem is how to distribute that medicine to where it is needed.'

Less than 40% of every Kes.100 invested in health commodities is dispensed to and used by the patient. The greatest concerns in the Health sector are how to make the products accessible, affordable, how to avoid wastage, maintain the quality of the medicines all the way to patient, educate practitioners, implement systems, and withdraw counterfeit products from the markets. None of those require additional resources, but rather a better utilisation and management of existing resources.

The solutions to problems in the health sector lie in policy design and implementation at the highest level. For example, polio in Kenya was discussed and debated for a long time until it was championed by the President, leading to a national focus on vaccines. This reiterates the fact that, beside the technical input, the softer side of business, such as communication and advocacy, plays a significant role in the improvement of public health services and encourages investment and political action to address the gaps.

Engagement at the field level, at the grassroots, as opposed to continuous focus on policies and high-level decision-making would also yield better results. It is at this level that the effectiveness of supply chains is put to the test.

By raising the profile of supply chain over the last 10 years, through the introduction of formal training courses such as Degree, Masters and PhD programmes, the sector has recognised the importance of supply chain. Kenya is a leading country in research and in producing supply chain experts. This has contributed to making healthcare more available and affordable with emphasis on '*making best practice common practice*.' Through the Kenya Institute of Supply Chain Management (KISM), similar best practices have been introduced in several East African countries.

An integrated, business approach is key to achieve SDG 3.8. It places value on efficiency, as is evident in the private sector. Public/Private and humanitarian sector partnerships are required to develop effective ways of working, to develop best practices, and harness the best practices in the sector to turn learning into policy, and keep supply chain at the forefront.

Attendees were encouraged to engage in a deep dive effort to examine how Kenya can address UHC. The recommendations from the summit will not be just advice, but will include technical and consultative discussions with useful outcomes.

5. Partner Presentations

‘Supply Chain as a key enabler for Universal Health Coverage’
Dr Simeon O. Onyango, Chief Pharmacy Superintendent, Meridian Health Group

When talking of universality, we need to look at quality and equity. The topic of Supply Chain in UHC requires questioning and examination. UHC has always been a concern, but the SDGs have been turned into a deliverable for 2022.

Equity in health services is of the utmost importance, and requires us to look at areas that have received little attention. Medicine and essential supplies comprise most of what we mean by improvement of healthcare, i.e. their availability, affordability, accessibility, appropriateness. That is what supply chain management is meant to address to ensure the delivery of UHC.

One of the greatest barriers to equity is financial strife. The cost of health commodities includes the cost at source, the cost of transport, of time, of damage, and of access. All those costs are influenced by the management of the supply chain.

Accessibility to quality products depends on infrastructure conditions, access to facilities, the capacity of providers, laboratory checks, and affordability. Those are patient rights that supply chain must ensure.

More critically, supply chain must be sustainable to ensure continuity. For that we need: staff capacity, including managerial skills and technical expertise; supplies; and processes. The process is vital to ensure quality and delivery. It is an often-neglected aspect, which requires full information and flow of data. It is also in the process that funds and goods can be wasted.

Questions to the attendees:

- Who is involved in supply chain?
- Do they have the capacity?
- Do they have all the support they need?
- Do they have the right decision?
- Do they have the right attitude/motivation?
- Do they have the right resources?

It is important to remember what happens and the impact of supply chain at the last mile. The chain of events in the supply pipeline does not end at the pharmacy, but rather in the patient’s hands. The number of patients is on the rise and so is the need for high-level decisions and solutions to the questions above.

‘Digitalization of Supply Chain’
Dr. Ooga Wesley Oghera - Ministry of Health, Health Information Systems (HIS)

From an analytical perspective, data is more valuable than materials. The Health Information System (HIS), is Kenya’s data management platform available to all stakeholders. The purpose of HIS is to collect and manage data for the betterment of health. Its targets are health practitioners, providers, leaders and policy-makers. HIS is timely, reliable and evidence-based, compiling information on disease (including spread), services, case studies and other health information.

Health data has several quality dimensions: timeliness, precision, source, availability, equity. HIS covers rural areas and areas of difficult access, namely facilities close to local communities. The system is web-based and open to anyone.

The District Health Information System (DHIS), the localised platform for data collection, includes relevant statistics, and it is available also for other countries to use (Kenya is currently the main user). It is easy to create maps locating health facilities and graphics from the system. Data is collected from the lowest end of the chain, – facility and community level - keeping a record of what happens at that level.

The information is checked regularly for quality. It can be used for forecasting, procurement and distribution, allowing institutional memory, and tracking of trends over time in real time.

Reported commodities:

- Vaccines
- Malaria
- Family Planning
- Laboratory
- HIV
- TB

The platform does not yet cover essential medicines. The attendants were challenged to use and contribute to it.

The MoH is working to protect the system against financial risk, to ensure it remains open and to increase the scope and reach of information on it. HIS is in partnership with KEMSA to connect their work to local consumption.

The recent move towards digitalization has led to the use of many different software systems. Feedback from the user is key to enable adaptation and ensure that the platform is fit for its purpose. It has also been a slow implementation process, as there is always resistance to change and new systems.

Presentation 2: "Digitalization of Supply Chain" – E2OPEN

By Mr. Denis Ndwiga Senior Business Analyst - KEMSA:

Kenya Medical Supplies Authority (KEMSA) is the state corporation tasked to provide reliable, affordable and quality health products and supply chain solutions to improve healthcare in Kenya and beyond. It operates a robust data management system - E2OPEN - to track, monitor and account for its stocks.

KEMSA has been in a process of transformation for 10 years to achieve an effective end-to-end supply chain with end-to-end data visibility. The organisation is looking at streamlining and integrating data all the way to the last mile, through the E2OPEN Tower project supported by BMGF, WFP and SOLVE, starting with 36 facilities and up-scaling soon.

The project consists of county-level and facility-level initiatives to automate data collection on consumption, procurement and tracking (so that it is processed by the system's Artificial

Intelligence). The data will support a mobile application that works online and offline to address connectivity challenges. It will allow practitioners to record events at the health-facility-level on the application, i.e. transactions with patients and suppliers. The software will be used by KEMSA but, in the long term, it can be used by the private sector and other national health supply chain stakeholders. The data will then be sent to the systems/agencies that require it.

Counties will also benefit, as it will enable the management of inventory at facility-level. The same information will be available at higher levels to empower decision-makers with information and data visibility across the whole chain. The system will create and store a national-level inventory. The AI will, inclusively, measure performance against organisational KPIs, based on the collected data, as it allows multiple analytics. This is known as VAN or 'data warehouse.'

6. Plenary Sessions

Session 1

Dr Simeon Onyango, Meridian Health Group, **Pamela Steele**, PSA, **Ms. Yvon de Jong,** EPN, **Dr Frank Ofula**, Institute of Healthcare Management

A plenary session provided opportunity for questions and answers following the presentations. This session gave the participants a better understanding of UHC and its dependency on Supply Chain as one of its key enablers.

Question 1
Mercy, Pharmacist, Kenya Dental and Medical Practitioners, a pharmacist in the public sector for 9 years.

These challenges are realities. In reproductive health medicine, one is expected to make orders without understanding the system and without tools to face economic issues and wastage. Is it prudent to train new staff or rather train available staff?

Answer
It is best to train current staff because they are already familiar with the issues and it is a more effective use of resources for a developing country. All pharmacists and doctors in the room are encouraged to further their education and enrol in available courses.

Q2
Pharmacist

On who is involved in supply chain – How can we support the regulator and initiator of market access rules that condition quality and affordability/price? How do we support them to ensure the quality and authenticity of products?

A
There are policies and regulations in place; the problem is always enforcing and implementing those policies by holding staff accountable. It is important to ensure an environment where they have no external pressure or influence over their job.

Support to the regulator should be a regular task. If you work with integrity, you are supporting the regulator. The regulator leaves no room for banned medicines - it is practitioners who allow them to filter in. Those who procure medicine from sources which are not approved should take responsibility. Education in supply chain is required to ensure this.

Q3
Mercy Lutukai, JSI

JSI have been implementing an ‘impact team’ approach in working with counties. The questions raised here are what they are addressing. The main gaps are leadership, coordination and use of quality data – ‘The link between the top guy and bottom guy.’

Knowledge is high at national level, but how do we pass it down to the counties? How do we ensure continuity in counties, where staff change according to political results?

A
It is leadership that should ensure an enabling environment and should advocate and communicate effectively to the public. Within the sector, it is important that the leadership allows communication and integration between stakeholders, as opposed to isolated competition. Clear coordination and clear control are required for the system to work effectively.

The Healthcare Management Institute at Strathmore have been developing research on leadership and 'alternative access.'

Session 2

Dr. Ooga Wesley Oghera MOH HIS, and **Mr. Denis Ndwiga** KEMSA,

This session focused on the importance of data management in the health sector, how it is currently managed and the available platforms.

Q1
Private sector pharmacist

How do you access the data? Is there any data available for the private sector?

A
In the E2OPEN Tower project, the whole health sector is covered, therefore, the private sector is expected to collaborate and provide data. The aim is to ensure that both sectors are represented and to include data across supply chains. However, the main focus is on collecting data at facility and pharmacy level. That should allow them to work with full information and relieve the workers from generating reports, as the system will automatically do it.

Q2
DHIS deals with aggregate data, rather than client level data. Does it also include faith-based and other private providers?
For KEMSA - how does the system cut across sectors? Private data should also be consolidated as national data.

A
Anyone who is a Kenyan citizen can and is encouraged to access the information on the DHIS website, including information on diseases. Data is collected continuously, and the reports are put together by health facility. All data is reported and looked at national level. The current reports are accurate and have a back-up of 3 years.

To deliver UHC, the government endeavour to automate reports on all dispenses of products. The challenge is to make information available at the client-level, namely, because of lack of clarity in the law.

It is up to the stakeholders to inform DHIS of what data they require; DHIS's role is only to facilitate and maintain the software.

DSL lab is at pilot stage and aimed at cross-analysing data, for instance to look at return on investment.

Q3

Cecilia, Pharmacist in consultancy, interested in data management.

To KEMSA - This is not your first effort to collect data. How does this differ from past initiatives? What are the direct linkages to commodities? Is there any connection to DHIS? Why is there no master commodity list? What efforts are you taking to make sure that historical data is backed up? Indicators do exist – WHO and others have produced supply chain manuals. Another software is required to cross data from DHIS. E2OPEN looks only at KEMSA product information. What about other services and other agencies

A

KEMSA is a state operation, mostly focused on the social aspect rather than the commercial. It does not offer services to the private sector. KEMSA was established to serve the Ministry of Health and has a public mandate. It is only monitoring faith-based, humanitarian and non-profit institutions. The inclusion of the private sector may be reviewed, involving stakeholders, to ensure there are no negative consequences to the national healthcare.

Q4

Ismael

Do we need all these platforms? Could we have just one system for decision-makers?

A

HIS is the only national platform for all facilities and it has been accepted nationally. We do come from different approaches, but DHIS are clearly the only opensource country-wide platform. DHIS is building capacity across the country, including for the defence force, on how to use it.

7. World Café

The World Café is an activity involving group discussions. It was used to provide a platform for the professionals to discuss, share information and opinions on pertinent issues related to the theme and sub-theme. Six key topics were identified for discussion and facilitated by subject matter experts to lead the conversation to the role of Supply Chain in UHC.

Summaries

1. What are the advocacy opportunities within our governments to lobby for increased stakeholder uptake in realising UHC? ***Dr Nancy Njeru – Ministry of Health*** 	There are lobby opportunities through professional associations, religious organisations, community health workers, big organisations, and civil society at large. We can make use of media to share success stories, highlight benefits, inclusively of essential medicines. We can create opportunities by approaching political leaders and government representatives – ministries, counties and other relevant branches – as well as development partners. The key is to identify the right stakeholders with whom to advocate. We can use data, or evidence, to lobby for coverage of known gaps. There is already a structure in place to raise these issues, through the Public/Private Partnership Framework. We must create space for stakeholders to convene and think of practical ways to do it, using existing structures and communication channels to ensure useful discussion.
2. Health supply chain is critical to achieving UHC - How do we mainstream it? ***Dr. Stephen Njunguna- Ministry of Health*** 	The first step to mainstreaming supply chain is making it a priority as a key pillar for UHC. Then, supply chain departments should be involved in decision-making from its very beginning as an integral part of health delivery. On the other hand, politicians should also be involved in supply chain discussions – Supply Chain is no longer an operational issue, but rather a political issue. Nationally, KEMSA should sit at the board lead in decision-making, and other organisations, such as faith-based organisations and private sector in policy framework on commonly used commodities (e.g. anti-malarias, TB, HIV, FP). Additionally, the role of the Kenya Institute of Supplies Management (KISM) as a governing body must be strengthened in the health sector. Supply Chain Management should be included in the curriculum for medical students in universities, colleges and even lower levels like high school. Current staff should also be trained in supply chain and UHC.

We have three main audiences: the politicians, the caregivers and the users. The politicians must be involved for funding, the caregivers will know what is needed, we should also empower the user, so that their experience is included. Users should have a voice when it comes to the consumed commodities. Using different platforms of Social Media can help to spread those messages.

Many people may not even know what UHC is. Health and supply chain documents should be widely publicised, and the population should be alerted on what stocks are found in public/private/faith organisations.

The master commodity list, once established, should be widely publicised in the sector. The DHIS2, LMIS and CDP should be linked for data to be shared across agencies and more widely.
Mainstreaming supply chain would increase funding, including to non-essential commodities. It would lead to stronger laws and regulations as well as more effective enforcement from regulatory bodies, as the quality of the commodities will have a direct impact on the quality of healthcare. It would additionally lead to predictable taxation for importation of pharmaceuticals and non-pharmaceuticals and exemptions on donations.

3. How does health supply chain affect UHC?
Mr. Eliud Muriithi, KEMSA

Universal Health Coverage means affordable and accessible health commodities and services without discrimination. Supply Chain plays an essential role in that. Specifically, supply chain impacts on:

- Cost
- Standard
- Inventory management
- Stock
- Financing
- Distribution
- Timeliness
- Tracking
- Emergency preparedness
- Information.

However, a review of the current data and essential commodities list would bring us closer to the goal, because the current list is from 2016.

4. Public, humanitarian and private sector working collaborations in supply chain aimed at achieving UHC. ***Dr. Hellen Kalili, ARC***

The collaboration needs to be owned by the government. There are several policies in place, that partnerships need to be aligned to. Partnerships should use government policy as an implementation framework. Partnerships should address public sector gaps, bringing in private resources, knowledge and tools.

We must change the narrative that the government does not have the capacity to manage supply chain. Once the government is seen as capable, the partners can effectively support it. The private sector's profit-based efficiency and the humanitarian sector's flexibility are characteristics from which the government has learned.

5. *How is poor quality of medicines affecting Universal Health Coverage?*
Dr Louis Machogu, Pharmaceutical Society of Kenya

UHC means that quality medicines are available without the financial burden.

By that definition, the quality of medicine is critical. In supply chain we should be aware of what is good quality, or fake. Poor quality means that the medicine contains fewer active ingredients leading to ineffective treatment. Medicine also lose their quality due to poor storing conditions.

There is little national capacity for regulation and quality assurance – in terms of funding and capacity/skills. Price and quality are closely related – the client wants a cheaper product, so they get less quality. So, there is a lack of public awareness about the medicine and of skills to determine whether the product is of good quality.

Lobbying for good quality products and professionalism in our sector is important. Pharmacists and regulators must be involved in checking the quality of products that come into the country. If practitioners bring in medicine of poor quality, there must be a penalty as lack of responsibility in our area of work is criminal.

Transparency is key to ensure quality. There should be a list of official accredited suppliers, linked with the procurement authority.

***6.** Linking Health Insurance with Supply Chain Design.*
Ms. Caroline Nekesa, AAR

Private insurance is part of UHC. The right to health is assured in the constitution, but there are hinderances to implementation, such as poverty - healthcare is too expensive for most Kenyans.

The private sector lacks a legal framework around cost, and prices are not standard. Regulation is required to safeguard the patient.

Since the devolution of healthcare in Kenya, counties have been inadequately funded and even insured patients are affected by the scarcity of resources. Even privately, prices go unreasonably up for these reasons. We need to reconsider that structure – health should receive as much investment as education. Support to the national structures will also support the patient's right to choose between the sectors. A Capitation Model would support facility resources, reduce costs and ensure availability and affordability.

1. Recommit supply chain and health practitioners to transforming supply chains towards realizing UHC.
2. Inspire integrated approaches by public, private, humanitarian and academic sectors towards UHC.
3. Enhance partnerships and cooperation among supply chain practitioners and organisations.

Outcomes

In line with the set summit objectives the teams agreed to:

1. Continue the lobby for good quality medicines through their various roles in the organisations they work and represent.
2. Insurance companies to consider the creation of a framework around cost of services and quality drugs to safeguard patients
3. Continue lobbying for Private sector involvement in UHC with the Government taking the lead.
4. Raise the profile of Supply Chain in organisations represented and including supply chain in curriculums for health and medical education programs
5. Final report to be shared with the UHC Government appointed Task Force group Lead and contribute to the on-going discussions

8. Recommendations

1. Identify a commodity care package for UHC
2. Develop a commodity security framework starting at the National Level.
3. Link commodities that are required to deliver UHC e.g. Cancer
4. Determine the cost of delivering UHC, identify reliable sources of funding UHC and work with stakeholders on making health services affordable.
5. Utilize technology for inventory management and traceability
6. Train existing staff to understand their needs – "Trigger Value" and inventory management
7. Conduct a disease mapping exercise
8. UHC Task Force to work with the following:

a. Private Health Facilities, NHIF, Insurance, Professional Bodies, Health Workers, End Users, Public and Academia (Capacity Building

9. Create a system that facilitates the transfer of medicines from one county/facility to another. (Transfer of surpluses to deficit areas)
10. Decision should be data/evidence based. E.g. 47 Malaria drugs declared poisonous by FDA but still in use.
11. Need to invest in hardware for IT
12. Need to have a shared database accessible by both Public and Private sector
13. Need for Government support for private initiatives that are for the good of the population
14. Allow Private sector to augment services initially offered by the Government, where the Government is unable or struggling to deliver.
15. Develop a common implementation frame work to eliminate duplication
16. Build exit strategies into every initiative to avoid over-dependence on partners and to ensure business continuity when partners exit
17. Do public awareness on counterfeits, importation restrictions and create feedback mechanism for the public on the quality of medicines
18. Introduce a system for reverse logistics for poor quality medicines
19. Insurance companies explore pricing for the elderly, standardise treatment and pricing of insurance across different service providers
20. Looking at the National Health Insurance Fund, insurance companies should consider adopting a community model, Explore Community Based Health Finance but implementing the NHIF model and have a reporting mechanism
21. Insurance companies should standardise their services across board
22. Consolidation of Health Insurance for schools, old people, general cover patients and trickle down

9. Conclusion

The summit closed on a high note, with a consensus that Supply Chain is integral to the UHC process and achievement. An all-inclusive approach will yield better and more sustainable outcomes. The summit discussion will be shared with the task force that has been appointed by the Kenya Government to lead the national discussions on the UHC development process, policy and implementation.

10. Acknowledgements

The summit was possible and successful thanks to the commitment and hard work of many who contributed to its organisation and promotion. Our sincere gratitude goes to:

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The Kakamega County Governor, His Excellency Hon. Wycliff Oparanya; Kakamega Deputy County Governor, His Excellency Prof. Philip M. Kutima; Member of the County Assembly Kakamega County, Hon. John Luvisia Ngome; National Governing Council Member - Pharmaceutical Society of Kenya & Vice Chairperson of the Kenya Medical Women's Association - North Rift, Dr. Mercy Nabwire; County Programme Coordinator – Agricultural Sector Development Support Program, Kiambu County; Ms. Abigail Taabu, The Management of the Alexandria Cancer Center – Eldoret, Uasin Gishu County; Moi University MTRH – Eldoret, Dr. Rose Shitsinzi; Public Relations Officer – Trans - Nzoia County – Mr. Fred Neyole Wanyoni; Chief Health Officer Kiambu County, Dr. Andrew J Toro;

All those who supported and participated in the summit because they believe in the role of supply chain in the delivery of such a critical service, not forgetting those who would have attended but were not able to due to technical challenges in the accounting year end at the county level.

Finally, we would like to show our appreciation to the staff of Strathmore Business School for being such fantastic hosts and making the event memorable.

[i] Global Fund. Focus on Universal Health Coverage.; 2017.

[ii] Idem

[iii] WHO member states. WHA Draft Resolution A71/A/CONF./1 Digital Health. 2018.

[iv] WHO. Report A71/20 MHealth: Use of Appropriate Digital Technologies for Public Health. 2018.

[v] Evans T, Kieny MP. Systems science for universal health coverage. *Bull World Heal Organ*. 2017; 95:484.

[vi] WHO. Health in 2015: From MDGs, Millennium Development Goals to SDGs, Sustainable Development Goals. Geneva: World Health Organization. 2015.