Civil Society Organisations (CSOs) in the Medicines Transparency Alliance

November 2010 end-of-pilot report

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Introduction

This report provides an overall reflection on CSOs within MeTA during the pilot period 2007-2010, with a list of lessons learned and recommendations for future involvement of CSOs in development of the MeTA approach to medicines access and transparency. Secondly, a country-by-country analysis of the process and learning gained relating to each of the seven MeTA CSO coalitions.

This document is based on reports from CSOs, MeTA Councils and MeTA consultants, presentations at the MeTA Global Forum in June 2010 and the DfID HDRC Evaluation of MeTA Phase 1 2008-2010. The majority of these documents can be accessed on the MeTA website: http://www.medicinestransparency.org/

CSOs within the MeTA multistakeholder process

Civil Society Organisations (CSOs) have a long history of involvement on health and access to essential medicines, consumer protection and promotion of transparency, including many national as well as international groups. In-country CSOs are focused on health in different ways – as service providers, advocates for rights, or providers of care and support for people with specific health problems. The inclusion of CSOs as one of the three stakeholder groupings in the MeTA pilot is therefore entirely appropriate and must continue as and when MeTA continues.

During the pilot, CSOs have developed the ability to work together as coalitions of citizens' organisations with a common goal and to represent a community perspective on the challenges experienced by people most affected by the lack of reliable access to safe, effective and affordable quality medicines. Many MeTA CSO groups have roles both as stakeholders within MeTA and as actors involved in broader health issues. Many MeTA CSO organisations are themselves networks and alliances of smaller individual groups representing different interests, reminding us of the tiered nature of multistakeholder involvement and cooperation. However, the somewhat fragmented nature of civil society in many countries means that a new approach to multistakeholder working and dialogue with other sectors of society presents new challenges for many organisations.

Developing the role of CSOs in MeTA

MeTA acknowledged from the early stages that CSOs were likely to need assistance in building their capacity to engage with MeTA and to join in with a multistakeholder process. Two skills building workshops sponsored by DfID were provided by Wilbert Bannenberg and Andrew Chetley –in Uganda in February 2008 on communications and advocacy for Ghana, Uganda and Zambia and in June 2008 in the Philippines on 'Access to Medicines and Transparency' for Jordan, Kyrgyzstan, Peru and the Philippines. £50,000 per country was allocated as a separate CSO capacity building fund from September 2008. The granting of separate funding and the workshops were well received and generated enthusiasm, leaving each country to work out how further to engage more CSOs, build a CSO stakeholder grouping and increase CSO capacity to play an effective and distinct role in MeTA.

Although restricted time and funding was available, valuable assistance was provided to CSOs by MeTA's technical and communications directors and national and international consultants, particularly on technical aspects of medicines. International support was also provided on communications skills, but the ending of Healthlink's input in 2009 meant that many countries did not receive the technical support they had been led to expect. The CSO coordinator appointed in September 2009 had a limited budget and countries depended mainly on national consultants to help them meet training needs, even when external assistance had been requested. CSOs very much appreciated learning from the pharmaceutical policy and multistakeholder workshops and in inter-country visits.

CSO needs around organisational development, the process of developing coalitions and how to engage in multistakeholder processes seem to have received less attention in the initial development of MeTA than increasing their capacity on external communication and advocacy. Lack of experience and skill on work planning or engaging in dialogue with partners made the early stages more difficult than they need have been. It is also worth mentioning that difficulties in the development of the MeTA Councils had some adverse effects on the involvement of the CSOs.

In spite of the limitations, however, it is remarkable that by 2009 the CSOs in each country had come together as formal coalitions and by 2010 were making their voices heard. MeTA's CSOs have contributed considerably to the understanding of how civil society can contribute to a multistakeholder alliance. They have demonstrated their ability to mobilise grassroots opinion and to highlight the drastic effects of restricted access to medicines on people's health and wellbeing. They have also linked MeTA with other civil society work on medicines at national, regional and international levels.

Lessons learned and recommendations for the future

i. The CSO context in each country varies widely. This context should receive particular attention at the scoping and during inception of MeTA in each country, in order to understand the status and activities of CSOs and the political context in which they operate, as well as their potential to join in the MeTA multistakeholder process.

ii. The more CSOs want to join in a coalition, the more it is both a strength and a challenge for coordination, cooperation and capacity building. It may be helpful to develop a 'model list' of criteria for forming a coalition, including organisational aspects as well as a common interest in transparency and accountability and advocacy for poor or marginalised people.

iii. The inclusion of professional associations in the CSO pilot phase group has been somewhat contentious. Although they are technically part of civil society, they do not readily fit into the current usage of the 'CSO' term which focuses as bodies that represent public interests, rather than the interests of their peers. Inclusion of academics in the CSO grouping can also be problematic for somewhat similar reasons. It is recommended that in future, professional associations and academics should form separate stakeholder groups. However, individuals from both these groupings have an important role to play in building CSO capacities to engage in technical discussions on medicines and to understand, participate in and interpret research and other key data.

iv. CSO capacity-building should not be approached simply as a series of workshops, although these are often an essential part of the package, but should also include active support and mentoring to make use of existing resources, implement the skills and information learned and build on experience. A capacity building plan should be developed with each CSO group early in the start-up phase, which can be modified later as membership develops and new needs arise. The plan should include a baseline assessment of needs and resources and allow for access to mentoring and ongoing support from experienced civil society experts. This would facilitate speedier finalisation of workplans, disbursement of funds and timelier implementation of activities.

v. Specific capacity building needs that were not adequately addressed in the pilot include:
   a. development of leadership skills, including effective negotiation and presentation skills, supported by relevant technical knowledge;
   b. development of networking and organisational skills, based on existing models and tools
   c. improving CSO abilities to engage in political processes in a more developed way than simply as 'activists with loud voices', including political skill to engage strategically in moving policy and implementation forward to benefit target populations.
   d. The need for a cyclical approach to training in order to build on people's experiences and to allow for the relatively rapid human resources turnover that is a common feature of CSOs.

vi. Capacity building provided in the pilot phase may have to be repeated and extended in any renewal of MeTA in the pilot countries – the gap in funding has meant a loss of guiding force in some countries and some key people have moved to other employment and involvements.

vii. Dedicated funding for CSO capacity building was initially contentious when other stakeholders misunderstood its purpose and were apprehensive about CSOs acting as an autonomous pressure group. The funding was welcomed by the CSOs and enabled them to develop their own approaches in line with their workplans. Separate funding should be carefully targeted and its purpose made clear to all stakeholders in future.

viii. Workplans and activities are essential to implementation of MeTA but should be responsive to changing circumstances and needs, provided that any changes are still within the overall objectives of MeTA in each country. Methods need to be in place to monitor progress towards these objectives without solely depending on outputs from activities as indicators.

ix. Procedures for releasing funds to CSOs should ensure timely release of moneys so that activities are not delayed by bureaucracy; slow release of funds in the early stages led to later reduction of disbursements in countries and cancellation of some activities which could otherwise have been completed within the pilot.

x. In common with other stakeholders, CSOs need to be more involved in information sharing within MeTA and not to be wholly dependent on attendance at, or reports back from, Council

meetings. Means should be found to increase regular communications via whatever means are appropriate locally such as emails, cell phone messaging, newsletters etc.

xi. While MeTA's information work has largely focused on public sector information and transparency, it is important the MeTA stakeholders realise that they have their own commitment to transparency and should be sharing information from their own sector with other stakeholders; this includes information gained from their own research and advocacy as well as being organisationally open and accountable.

xii. CSOs had a limited number of opportunities for inter-country sharing of experiences – an informal joint meeting after the Jordan Pharmaceutical Policy Course in January2010 was well-received – 'the first chance they had ever had to talk together about what they are doing'. A small number of inter-country learning exchanges (e.g. Jordan to Philippines) also took place. It is important that any new version of MeTA should allow countries the chance to learn from each other in the future.

Ghana Medicines Transparency Alliance CSO Group

MeTA Ghana was officially launched in November 2008 and the first National MeTA Forum was held in December 2009. CSO involvement began with the formation of a National Core CSO Group, supported by an advisory group of professionals and experienced CSO workers. Members of the Core CSO Group attended the MeTA CSO & Media Orientation in early 2008 in Uganda and went on to develop the Ghana CSO 2-year workplan, signing an MoU between Health Access Network, the coordinating organisation, and the International MeTA Secretariat (IMS) in March 2009. CSO capacity building started with a workshop in May 2009, attended by 36 people from 32 organisations, followed by three zonal trainings that brought in more members. Close to 100 organisations are now engaged across the country.

Ghana MeTA CSO Group staged a formal public launch in April 2010 and has held workshops on medicines pricing, availability and rational use in 4 regions, average 100 people per workshop, with media coverage to generate greater public interest and understanding. A social networking site (on www.ning.com) was also set up for discussion and information sharing. The Group has covered all ten regions of Ghana through its linkages with community organisations, providing information through large graphic posters on four key topics in seven languages, aimed at literate and non-literate audiences.

The capacity of CSOs has been built sufficiently that non-health professional members are able to engage with a wide range of stakeholders and the media on issues relating to transparency and access to medicines. The CSO sector has gained valuable knowledge and experience through participation in the MeTA multi-stakeholder process. CSOs now have a louder voice than they would have had individually and a variety of partners are contributing increased knowledge to whole group. There is a strong desire to continue with theMeTA process depending on future funding.

Key learning from the pilot phase includes:

- CSO / Ghana MeTA Secretariat information-sharing needs to be more than through Council meetings to make it more timely and enable better use of CSO platform to engage in advocacy.
- Social networking site did not meet needs sufficiently – newsletters, quarterly meetings, telephone and emails would have reached many more members and provided more support.

- Initial approach to IEC materials had to be modified from leaflets in order to properly reach target populations through using graphic posters to support CSO information campaigns.
- Sensitisation and capacity building workshops were good in themselves but participants found it difficult to work out what to do next – support for further action planning would have helped.
- Further capacity-building support is needed for advocacy, community mobilisation and facilitation, and fundraising.
- With extra funding, more sensitization coverage could have been provided by individual network members and operational research could have been done to track government activities affecting access to medicines and run campaigns.

Jordan CSO Alliance on Health Issues

Work to establish MeTA Jordan started in 2008 and it was formally launched in May 2009. A CSO committee was formed with representatives from patient groups, a national consumer organization and professional associations – groups which had little or no history of working together. A mapping of CSOs assessed their capacity to cooperate and to engage with MeTA, setting a baseline for the CSO workplan. The committee drafted a CSO workplan based on the national MeTA workplan, with the aim of building CSO's capacity to monitor and increase accountability of all stakeholders with respect to the prices, availability, selection and quality of medicines in the public and private sectors.

CSO representatives attended the July 2008 MeTA capacity building workshop in the Philippines. A MeTA sub-committee supported further capacity building on monitoring and increasing accountability for prices, availability, selection, quality and promotion of medicines in public and private sectors. Regrettably, the HAI Jordan representative failed to deliver commitments to coordinate CSO meetings and workplan development, resulting in late agreement of the MoU and delayed launch of CSO activities. MeTA consultants, national and international, worked hard to mitigate this and ensure that CSO development progressed.

The CSO MoU was finally signed with IMS in November 2009. The CSOs participated in the Harvard Flagship course January 2010 and in a country exchange visit to the Philippines later in 2010. Training was delivered on advocacy and communications for improving access to essential medicines, in spite of difficulties in obtaining sufficient technical support. A CSO coordinator was appointed in August 2010 to assist conclusion of workplan activities by the end of September.

CSO groups have gained greater awareness of and access to information and previously 'unheard' groups have gained a voice. Capacity still needs to be built for CSOs to engage with parliament and political processes. With further funding, the CSO Alliance can have an increasing role in access to medicines in Jordan. At the September 2010 official launch of the Jordanian CSO Alliance on Health Issues, a venue for future meetings was offered by the Senior Pioneers Forum and an agreement was made to host the CSO Alliance under the umbrella of the national High Health Council.

<u>Key learning from the pilot phase includes:</u>

- Growth and participation of CSOs is officially encouraged but sector is still weak and unused to multistakeholder working, and lacks formal linkages with government or is blocked from decision-making in official committees.

- Capacity for CSOs to engage more effectively needs to be built; patients' groups are underrepresented (and many are supported by pharmaceutical companies).
- Other MeTA stakeholders are not fully aware of importance of CSOs in representing citizens and civil society; CSOs had limited participation of in Data Disclosure Survey and are still not represented in key committees (e.g. Pricing Committee or Higher Drug Committee).
- Budget for a CSO coordinator and an organised structure for the CSO coalition should have been included in CSO workplan at the outset.
- CSOs have had little influence in the MeTA Council - only 2 CSO members in a Council of 18 people – and there has been lack of clarity in Council decision making.
- Building capacity for dialogue and negotiation has been challenging - 'passionate dialogue' is part of the culture and building trust requires time and patience.
- Most CSO members are in full-time jobs and provide input voluntarily and out-of-hours, so they find it difficult to put in sufficient time for the CSO workplan.

Kyrgyzstan Coalition of CSOs for Transparency in Medicine Supply

Kyrgyzstan CSO involvement in health is relatively recent, providing alternatives to government for engaging and reforming the health sector. Health-related CSOs tend to have high levels of membership of health professionals and academics, who work part-time or full-time for CSOs.

MeTA Kyrgyzstan Council was established in 2008 and signed an MoU with the IMS in April 2009. A meeting of 12 CSOs in August 2008, in collaboration with HAI, identified key issues on medicines, developed a plan for capacity building and identified a coordinating CSO. The MeTA CSO Coalition signed an MoU with IMS in October 2009. Delays in finalising the workplan and budget resulted in delayed receipt of funding from IMS. This was resolved by borrowing from MeTA KG secretariat and a CSO member, allowing them to avoid severe reductions in time available for activities.

Two capacity building workshops were held in 2009 on promotion of medicines supply and on civil monitoring of medicines policy and state medicines supply programs. CSOs who attended both workshops were eligible for grants for activities such as reviewing legislation, monitoring medicines supply in rural areas and health facilities, surveying rationality of medicines use in hospitals, and assessing availability of medicines for specific needs (diabetes, psychotropic and cancer medicines).

Capacity building of the CSO Coalition is considered as the major success in Kyrgyzstan. The CSO medicines monitoring studies (nine were completed in 2010) revealed the need for ongoing training on state procurement processes, developed with help of specialists in procurement, law and pharmacy. CSOs have also been active in dialogues with private and government sectors and are now invited by government bodies to observe tendering processes for pharmaceuticals. The Coalition continues to look for funding post-pilot, aiming to decentralise Coalition resources and activities to the regional level in order to achieve greater impact.

<u>Key learning from the pilot phase includes:</u>

- Some of the CSO studies provided useable, validated information that will be utilised for advocacy; others served mainly as experience-building activities, highlighting needs for improving linkages with other sectors and for further capacity building on medicines supply, improved research skills.

- An uneven balance of knowledge and skills between CSOs and MeTA KG has led on some occasions to friction and allegations of censorship, leading to loss of trust; debates at council meetings have tended to lack constructive focus and fail to resolve issues.
- CSOs have felt held back sometimes when council members with less experience of action on public issues have failed to acknowledge and allow action by CSOs with greater experience; it has been challenging to find the right balance to engage in joint action with other stakeholders, and to avoid jeopardising MeTA when competing interests are involved.
- CSOs sometimes take strong stance on government and private sector failures, and need greater diplomatic skills to achieve a multisectoral approach to change; this highlights a need for shared risk analysis in early stages to plan how to deal with negative reactions to disclosure of information and mobilise necessary resources such as mediation or legal assistance.
- Some Coalition members need far more capacity building than others, and flexibility is needed on deadlines and completion of activities.
- Autonomy of funding for CSOs is a good thing, so long as mandates and boundaries are well defined between IMS, the Council and the CSO Coalition – it allows greater freedom and reduces bureaucracy in cascading funds to members and supporting their activities.

Peru Civil Society Coalition on Access to Medicines

Peru is culturally a sophisticated and cosmopolitan environment, in which key CSOs have a strongly developed human rights approach. CSO involvement in medicines information and access has been in place for many years, primarily in monitoring prices and availability and ensuring public access to objective, independent sources of medicines information.

MeTA Peru commenced in November 2008. CSOs were involved from the beginning, with representation on the Council and on the Executive Committee, although the numbers of CSOs involved were initially very few and it took time to involve more groups. A CSO capacity-strengthening project on access to medicines was launched in late 2009, starting work after the signing of the MoU with IMS in early 2010. The process was initially slow, but progress was made in 2010, primarily on developing a diploma course to train national leaders on access to essential medicines and engaging in medicines surveillance, enabling trained leaders to engage in surveillance projects and sharing the results through regional presentations supported by a national network on access to essential medicines surveillance. Many of the trained leaders are now influencing the regional ForoSalud Networks to include medicines and surveillance in their agendas. Some activities were only completed in October due to late arrival of funding from IMS.

CSOs have reached consensus with other stakeholders on development of the Peru medicines price observatory. Individual CSO members have also been engaged in activities outside the MeTA workplan and have been mobilising extra resources for this. A formal agreement has been made between ForoSalud and the Cayetano Heredia University to continue providing courses on human rights, health and medicines. There is a strong desire to continue participation in the development of MeTA process depending on future funding.

<u>Key learnings during the pilot phase have included:</u>

- CSOs are perceived to be least powerful partners in MeTA, a situation exacerbated by the role taken by the Executive Committee, chaired by vice-minister for Health, which acted as the decision making body rather than Council –stakeholders have experienced being kept in a passive role, feeling that needs of Peruvian citizens are being neglected.
- Lack of working groups on specific topics, at which members could have contributed more.
- Lack of indicators of success in workplans, so lack of engagement in moving MeTA forward.
- Professional associations have been part of the CSO grouping, although many professionals have roles in the other stakeholder groups and should form a separate grouping within MeTA.
- Lack of follow-up after MeTA start-up led to omission of patient groups from the CSO group – many disease-focused groups exist e.g. cancer, chronic conditions, high-cost treatments; this has resulted in lack of MeTA support in and to grassroots and citizens groups.
- Support, encouragement and mentoring required to develop local leadership – not only 'capacity building' or 'technical assistance' – "leaders need cultivation".
- Difficulties in distinguishing conflict of interest from competing interests and negotiating ways to manage and move through them towards multistakeholder dialogue.
- Lack of follow-through on offers of technical assistance added to poor relations with IMS, not all visits or requests felt to be relevant or supportive.
- Language is a constant issue in relations with IMS and in information sharing - inadequate translation services used.

Philippines Coalition for Health Advocacy and Transparency (CHAT)

The Philippines has a vibrant CSO sector including many with an interest in health. However, the presence of myriad organisations, widely varying politics and the geographical spread of the country across 7000 islands mean that there has also been a lack of working together on issues of common interest. Decentralisation of health system structures and financing are related to inequalities of access to health care, especially for poor and indigenous populations.

MeTA Philippines was established in November 2007. CSOs were involved from the start, but it was not until January 2009 that a one-day workshop was held to bring interested CSOs together to start developing their potential role as a MeTA stakeholder group. The outcome was an agreement to form a coalition to work with MeTA and to address wider health issues. CHAT was formally launched in March 2009 with 25 member organisations. Members include national advocacy and political action groups, trade unionists, support networks and not-for-profit service provider networks.

Development was rapid and the CHAT MoU was signed in July 2009. Initially, financial arrangements did not allow timely transfer of funds, partly due to the routing of CHAT funds from IMS through MeTA Philippines (later resolved and CHAT account is now held by a CHAT member). This situation caused delays in implementing the workplan, but members continued to work together and kept the momentum going. Capacity has been strengthened for participation in MeTA, improving communication and enabling engagement with other stakeholders.

The proactive approach of CHAT members has enabled them to contribute well to MeTA's multistakeholder partnership, although CSO representation on the MeTA Council has been restricted to three people and their ability to contribute at high level has sometimes been sidelined, for

example in limiting the number of CSOs invited to the MeTA National Forum and thus reducing their exposure and contribution to key information sharing sessions. In spite of this, CHAT members have developed highly articulate and interesting approaches and held their own first national Forum in January 2010, a number of public discussions on topics including patients' rights, health financing, freedom of information, and drug prices. CHAT members continue to work together post-pilot on reform of the Philippines health system and ensuring that the voices of poor and marginalised citizens can make their voices heard.

Key learning from the pilot phase includes:

- Mobilisation of existing capacity enabled the Coalition to pool human and material resources to achieve its objectives despite the late release of funds.
- By working as a Coalition, members were able to sharpen and sometimes broaden the scope of each organization's work.
- There is need to find a mechanism for debate within the Coalition, so that members with widely differing views can share ideas, get clarification, distil, and enrich the discussion. It may be better to find common ground rather than consensus, in order to push for specific policy reforms.
- The Coalition is an advocacy or lobby group, and members who are already well-versed in this are at an advantage - they do not have to re-invent themselves. Members who are service providers may not know the language or culture of advocacy or lobbying and need time to develop these new skills and understand the culture.
- Coalition work has posed risks to the reputation of the group when a member fails to deliver, and risks damaging the Coalition's collective image due to guilt by association.
- There is a need to build on the momentum created by CHAT. Advocacies that the Coalition has started can be continued by network members until such time that financing is found to revive the Coalition.
- The job of advocacy or coalition building should be assigned to experienced network members while grassroots members continue their service delivery activities until such time that the gap in skills can be bridged among the two types of members of the Coalition.
- There is a need to revisit the Covenant of the Coalition to check if it is still relevant to members and the need of the times; for example, should CHAT charge membership fees and register as a legal entity in order to mobilise new funds?
- Government bodies such as PhilHealth and the FDA want to engage CHAT but do not know what mechanism to use – CHAT needs to make sure that all its customers or major stakeholders are aware of how to engage so that CHAT can reach its target audiences on policy issues.
- The MeTA Philippines website has links to two CHAT documents, but does not show have ongoing news on CHAT activities and advocacy; unless CHAT has plans for its own website, it would be beneficial for the MeTA Philippines to have specific pages and links for each of the different stakeholder groupings.

Uganda Coalition on Access to Essential Medicines (UCAEM)

Civil society in Uganda has developed at grassroots level largely in the form of community and mutual help groups and is relatively weak in terms of more 'activist' involvement in political action and advocacy, although this is changing. Many CSOs are focused on health, but are often quite small support organisations or service providers; there are few with a focus on access to medicines.

MeTA Uganda Council was set up with a 6 monthly rotating chair between the three sectors; the first chair was a representative of a CSO (Coalition for Health Promotion & Social Development – HEPS). The first MeTA CSO capacity building workshop for Africa in February 2008 led to an interim CSO taskforce of seven organisations, but the evolution of MeTA Uganda was slow. A MeTA CSO capacity building workshop in Jinja in April 2009 brought more members together and by 2010 the group had developed into a coalition of over 30 organisations and networks. HEPS and UNCHO (Uganda National Health Consumers Organisation) currently represent the CSO Coalition on the MeTA Council.

During 2009-10 two important issues on medicines access engaged CSOs in Uganda (and other African countries). The first was the Stop the Stockouts Campaign supported by HAI Africa and the Open Society Institute (OSI). The second issue was the development of legislation on counterfeit goods, which was being influenced towards wording that would have confused counterfeiting with issues of patent protection and risked blocking access to legitimate generics. Work in Uganda on these topics was strongly supported by CSO Coalition members and the Council and was a means for increasing public debate on medicines. Links with the private sector were also established and the coalition developed new relationships with officials in the National Medical Stores and the Ministry of Health, which has allowed CSOs to monitor availability of medicines and to contribute to a national workshop on pharmaceutical sector strategies.

<u>Key learning from the pilot phase includes:</u>

- Challenges around the development of the MeTA Uganda workplan and the functioning of the Council had knock-on consequences for the development of the CSO Coalition.
- It is possible and important for all players in the medicine sector to work together if the country is to realize access to medicines and an empowered civil society plays a key role in a multi-stakeholder working group.
- The slow roll out of MeTA has very helpful for helping to understand how different sectors function and the processes for a multi-stakeholder group to develop confidence in one another.
- It has been a challenge to keep all members of the CSO alliance at the same level of interest since not all their desired activities can be included in the workplan; joint activities and joint advocacy plans involving all stakeholders helped to overcome this; however, individual CSOs have capacity and human resource constraints and need more support for advocacy and mobilisation of communities on medicine transparency.
- Especially among CSOs there were high expectations that MeTA would function as a funding mechanism – it should have been made clear from the outset that this was not the case and that MeTA would not support activities outside of the workplans.
- Visibility of MeTA Uganda, including CSOs, in the public domain and media has remained low; publicity and media component should have been planned in more detail at the start of pilot.
- Documentation of success stories should also have been given due attention to increase media and public interest in MeTA.
- Dissemination of available information from stakeholders is still not effective or sufficient; CSOs could do more to disseminate information that they gain from communities, for example on prevalence of stockouts in clinics and pharmacies and their effects on people's health and economic status (for example when medicines that are free have to be paid for out-of-pocket).

Zambia Medicines Transparency Alliance CSO Coalition

CSOs have a long history of involvement in health in Zambia, especially as service providers and trainers of health workers. They have worked alongside the Zambian government and have exerted varying amounts of influence on health development policy and implementation. The ability of CSOs to engage in advocacy has increased in recent years, although many CSOs are still relatively weak and lack capacity and human resources.

Transparency International Zambia (TIZ) has been the host organisation for MeTA Zambia since its inception in 2008. MeTA Zambia was formally launched in March 2009 and CSO members are closely involved in MeTA Zambia's workplan activities. CSOs attended the MeTA capacity building workshop in Uganda February 2008, and CSO MeTA Coalition started to meet regularly from April 2009 and implemented activities from July 2009 on. The Coalition has fifteen members.

The CSO workplan focused on capacity building and policy dialogue with government entities on health, medicines, finance, commerce, development and education. A Core Group meets monthly to support and advise the Coalition secretariat, and the Coalition meets monthly to share information and formulate advocacy. The Coalition provided a number of training workshops to members in 2010 on advocacy; drug supply chain management; government structure, policy formulation and analysis; budget tracking on medicines; and research skills. Technical support for the trainings was largely sourced in-country, with considerable support from the national consultant.

Members' experience of the Coalition has been that their numbers and grassroots involvement has given power to their voices and they are able to influence public opinion. They feel they now have capacity and tools to engage with policy makers, monitor and track the execution of funds in the health sector and engage in research relevant to their work in these areas. Coalition members are also active in the Zambia Civil Society Health Forum and in the Stop the Stockouts Campaign, but there is still a need for stronger coordination and strategic direction

<u>Key learning from the pilot phase includes:</u>

- Synergies between the MeTA Council and the CSO Coalition have not always been visible, partly due to delays in set-up and funding and partly due to close involvement of CSOs in implementing the national workplan making it difficult to discern specific contribution each sector was making.
- Two pronged approach in Zambia (sensitization/lobbying at grassroots and policy levels respectively), improved MeTA visibility, and a division of labour has been suggested on advocacy to government bodies – Council to concentrate on high level discussion, Coalition to concentrate on advocacy from grassroots.
- MeTA CSO Coalition still needs to include members that are able to engage in high-level dialogue at high profile level in order to act as representatives of grass-roots communities.
- CSO members also need medicines and management expertise, which should have been included in the workplan as well as skills building on communication and advocacy.
- Late receipt of funds from IMS to the CSO Coalition led to rushed implementation and modification of workplans.
- Removal of CSO Coordinator for financial irregularities in mid-2010 caused interruption in dealing with matters and supporting CSOs – resolved by appointing new coordinator.

- Members of the Coalition need constant contacts, visits and messages to remind them of importance of Coalition and keep them involved; this requires more time than was allocated for running the Coalition secretariat.
- Limited communication has taken place with other stakeholders outside face to face meetings, and a lack of financial incentives to help members attend meetings has been demotivating; many CSO members have very limited resources.
- MeTA Zambia website is live, but access to information, news and reports from the CSO Coalition was not available by the time of writing this report; any future development of the website should include specific sections for all stakeholder groups to post their information.