Rational Pharmaceutical Management Plus
Planning the introduction of a child health focus to the DLDMs in Tanzania: Trip Report

C. Jane Briggs
Ian Sliney
George Greer

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Rational Pharmaceutical Management Plus
Center for Pharmaceutical Management
Management Sciences for Health
4301 N. Fairfax Drive, Suite 400
Arlington, VA 22203
Phone: 703-524-6575
Fax: 703-524-7898
E-mail: rpmplus@msh.org

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About RPM Plus

The Rational Pharmaceutical Management Plus (RPM Plus) Program, funded by the U.S. Agency for International Development (cooperative agreement HRN-A-00-00-00016-00), works in more than 20 developing countries to provide technical assistance to strengthen drug and health commodity management systems. The program offers technical guidance and assists in strategy development and program implementation both in improving the availability of health commodities—pharmaceuticals, vaccines, supplies, and basic medical equipment—of assured quality for maternal and child health, HIV/AIDS, infectious diseases, and family planning and in promoting the appropriate use of health commodities in the public and private sectors.

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Abstract

RPM Plus will support the TFDA and other MoH partners to maintain and further improve the quality of care in the DLDMs with a focus on child health. The result of this trip was a program design produced as a result of a retreat of the child health DLDM working group
The program design consists of components of training and continuing education, community mobilization and education, supervision and monitoring and evaluation. The program will be presented to the MoH management committee for approval by the TFDA.

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Key Words

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Child health
Tanzania
Program design

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Acronyms

ADDO	Accredited Drug Dispensing Outlet
BASICS	Basic Support for Institutionalizing Child Survival
CSSC	Christian Social Services Commission
DLDM	Duka la dawa muhimu
DMO	District Medical Officer
IEC	Information, Education and Communication
IMCI	Integrated management of childhood illnesses
MOH	Ministry of Health
NMCP	National malaria control program
RPM Plus	Rational Pharmaceutical Management Plus Program
TFDA	Tanzanian Food and Drug Authority
T-MARC	Tanzania Marketing and Communications: AIDS, Reproductive Health & Child Survival

Background

The RPM Plus child survival portfolio aims to contribute to increasing access (geographic accessibility, availability, affordability, and cultural accessibility/acceptability) to and appropriate use of essential (efficacious, safe, and cost-effective quality) medicines, vaccines and related supplies for child survival. Over the last few months RPM Plus has been exploring options with counterparts in Tanzania for developing a package of linked interventions in the private sector with the aim of enhancing access and appropriate use of essential medicines for child survival. A meeting was held in Tanzania in February 2005, immediately following the MSH SEAM Duka la Dawa Muhimu (DLDM) evaluation meeting, to determine how RPM Plus could help the TFDA maintain and further improve access to medicines and the quality of care in DLDMs with a focus on child health. The meeting allowed participants to discuss key components of successful interventions elsewhere and to choose which pieces they wanted to include in a program in Tanzania. The key recommendations were:

- Utilize peer-to-peer and neighbor-to-neighbor behavior change activities to increase knowledge of child illness and appropriate treatment
- Incorporate local supportive supervision systems in the intervention
- Integrate key components of the IMCI and Malaria programs into the DLDM structure to ensure streamlining of activities and messages
- Design the intervention such that its successes are easily included in the national roll-out of the DLDM program

RPM Plus submitted a report of the child health meeting to the TFDA and got their approval to move forward with the work. The TFDA proposed the members for a DLDM Child Health Working Group. The working group will include the TFDA, MoH IMCI coordinator, the MoH malaria program coordinator, as well as MSH, and would be responsible for the development and oversight of the implementation of the intervention program. The TFDA has requested RPM Plus to assist the working group to develop a detailed plan for this intervention program in readiness for their presentation to the MoH advisory board in mid June to get approval from the MoH to move ahead. The timing of this visit is dictated by the TFDA and their calendar to prepare for the presentation to the MoH.

RPM Plus will collaborate with, and leverage from, the BASICS project on this activity. BASICS staff add specific child survival expertise and some private sector experience to the pharmaceutical management expertise of RPM Plus. The specific roles of BASICS and RPM Plus will be clarified once the program design and plan has been developed.

Purpose of Trip

To facilitate meetings of the recently formed DLDM child health working group and to assist in the development of a program design, detailed implementation plan and budget for the child health intervention program to be integrated into the DLDM package, and to recruit a senior program associate (SO3 funded) to manage the package of activities.

Scope of Work

Jane Briggs, Ian Sliney and George Greer had the same scope of work on this visit. Ian Sliney, having carried out much of the introductory preparation for this activity, played a key role in the program design discussions, and Jane Briggs, as the portfolio manager for RPM Plus Global Child survival funds, facilitated the discussions and will have continued oversight of the activity. George Greer of BASICS, provided particular child survival expertise to the planning exercise.

- Co-facilitate the first meeting of the newly developed DLDM child health working group
- Clarify coordination and role of the DLDM child health working group
- Assist the working group to develop a program design, detailed plan and budget
- Assist the MSH team and the working group in the selection of a senior program associate
- With the working group, develop indicators and discuss methodology for the baseline survey
- With the working group, discuss and draft a scope for the formative research
- Discuss the intervention program with other partners, not included in the working group if necessary.
- Discuss within MSH how the child health intervention program will be coordinated with the other MSH Tanzania activities
- Provide briefing and/or debriefing to USAID/Tanzania upon request.

Activities

- Co-facilitate the first meeting of the newly developed DLDM child health working group

A general orientation session to start of the planning exercise was held in the MSH office on Thursday 19 May 2005 and facilitated by Jane Briggs. The orientation reviewed the progress to data of the activity and presented the recommendations of the workshop of February 2005 as well as outlining the expected achievements over the next days. The full working group then met on Friday 20 May, Monday 23 May and Tuesday 24 May to discuss various aspects of the program design. The agenda and list of participants for the working group meetings are in annexes 1 and 2.

- Clarify coordination and the role of the DLDM child health working group

The roles and responsibilities of the different partners, including those of the DLDM child health working group were discussed and are outlined in the program design document attached in annex 3. The working group will have an oversight and technical review function and will report to the overall ADDO steering committee. The newly recruited RPM Plus activity coordinator will be a key member of the DLDM child health working group and will report primarily to the working group.

- Assist the working group to develop a program design, detailed plan and budget

After three days of discussion, the working group produced a draft program design document, implementation plan and budget. This is shown in annex 3.

- Assist the MSH team and the working group in the selection of a senior program associate

A shortlist of 7 candidates was agreed on by MSH staff in Tanzania and Arlington. Interviews were held on Friday 20 May 2005; of the 7 candidates invited for interview only 6 attended. The interview panel consisted of Dr Mbwasi and Mr Shirima of MSH Tanzania, Dr Margareth Ndomondo Sigonda, Director of the TFDA, and Jane Briggs of RPM Plus. Interviews continued until 7.30pm until all presenting candidates were interviewed. A clear first choice candidate resulted and MSH Human resources staff will follow up with that candidate to result in the ultimate filling of the position.

- With the working group, develop indicators and discuss methodology for the baseline survey

The key indicators needed to monitor and evaluate the child health component of the DLDM were discussed and are outlined in the annex 4 of the program design document (shown in annex 3 of this trip report). Further discussion is required to determine which indicators will be followed on a regular monitoring basis, or indeed whether further indicators will be developed.

- With the working group, discuss and draft a scope for the formative research

Discussion of the key messages for the community mobilization set of activities was part of the working group meetings. The draft key messages for the population were determined as:

- when your child is sick take them to the health facility or the DLDM where they will receive appropriate treatment and or advice
- antibiotics are not needed for all conditions especially cough/colds and non-bloody diarrhea
- ensure the child is given the full course of medicines as directed.

Further formative research will be needed to identify the barriers around these actions and thereby develop communication strategies for these messages.

- Discuss the intervention program with other partners, not included in the working group if necessary.

As members of the research team at the Ifakara Health Research and Development center were not able to participate in the meeting of the working group, a visit was made to their offices. Samples of the material used in their activities in malaria in the private sector were obtained.

George Greer held an exploratory meeting with T_MARC on the possibility of their involvement as an organization with BCC skills. This was in recognition by the Working Group that this area of expertise is not presently represented and input from others will be needed particularly around the development of training and IEC materials.

Due to time constraints, further discussions with other partners were not possible.

- Discuss within MSH how the child health intervention program will be coordinated with the other MSH Tanzania activities

This is an ongoing discussion as the other MSH Tanzania activities are developed. Discussions in country concluded that the RPM Child health DLDM project coordinator will report to the MSH country director and thereby assure coordination of activities in country. It is expected that there will be a point person for Tanzania within RPM Plus in Arlington who will coordinate activities and information on the USA side. As the workplan is developed for the RPM Plus Mission funded work with the DLDMs, there may be some necessary changes to the planned implementation for this child health component to ensure a coordinated project.

- Provide briefing and/or debriefing to USAID/Tanzania upon request.

Douglas Keene briefed Rene Berger of USAID of the RPM Plus team activities in Tanzania, including this activity. Due to other schedule constraints, Douglas was unable to de-brief with other members of USAID. George Greer debriefed with Jim Allman of USAID, giving an introduction to BASICS in Tanzania as well as debriefing on this activity.

Collaborators and Partners

USAID Tanzania
Margareth Ndomondo Sigonda Director of TFDA
Emmnauel Alphonce TFDA
Dr Neema Rusi Bamayila IMCI, MoH
Dr Azma Simba NMCP, MoH
Dr John Budotela DMO Songea
Marsha Macatta-Yambi, CSSC
Romuald Mbwasi, MSH Tanzania
Shirima Rogatien, MSH Tanzania
Jane Briggs, RPM Plus, USA
Ian Sliney, RPM Plus, USA
George Greer, BASICS, USA
Joanna Schellenberg, Ifakara Health Research and Development Center.
Anton Schnieder & Richard Kasejela, T MARC

Adjustments to Planned Activities and/or Additional Activities

The working group meeting and writing the first draft of the program design document fully occupied the daily agenda, making it impossible to meet with other external collaborators or partners. Those meetings will take place as the activity gets started.

Next Steps

Immediate Follow-up Activities

A draft version of the program design document, with implementation plan and budget will be circulated for comments internally within the MSH team before circulating to the DLDM Child health working group for comments for revision. The draft will be further revised and sent on to the TFDA for approval and or revision before being presented to the ADDO steering committee later in June 2005. After suggestions for revision and approval from the ADDO steering committee, the design document will be presented to the MoH management committee for approval and the subsequent implementation with some slight alterations subject to budget constraints.

A 3-day retreat will be held, with the goal of developing the training materials. Participants would probably include persons with behavior change and communication (BCC) experience from within the government and outside organizations, representatives of the training division of the MoH as well as the DLDM child health working group. The output from the retreat would be drafts of 1) a training for trainer manual, 2) a training of participants manual, and 3) all IEC materials (job aids, posters, etc.) that will be given out to participants.

Recommendations

The activity in the private sector will remain a large portion of RPM Plus SO3 child survival portfolio into FY05 to ensure full implementation of the Child survival components in the DLDMs of Ruvuma region and in the further regions of the DLDM roll-out.

Agreement or Understandings with Counterparts

The BASICS project will contribute to this activity in financial resources and technical assistance.

The child survival material developed will be included as an integral part of the DLDM program, and its extension, regardless of funding source.

Important Upcoming Activities or Benchmarks in Program

Presentation of the Design document to the MoH management committee
Start of the RPM Plus Child survival DLDM project coordinator.
Initiate implementation as per the implementation plan, in July 2005 if possible in coordination with the other RPM Plus activities in Tanzania.

Annex 1: DLDM Child Health Working Group - AGENDA

Thursday May 19 - Orientation

2:00 – 4:00
- Meeting purpose and objectives
- Outputs needed by conclusion of meeting

Friday May 20 - Develop specific components of program designs

9:00 – 11:00: Training of shopkeepers

12:00 – 2:00 Community Mobilization and demand creation:

{2.30 - 5.00 Sub group - interviews for RPM Plus coordinator position}

Monday May 23: Planning

11:00 – 1:00
- Finalize the program design's training and community mobilization components
- Discuss unresolved design issues

2:00 – 5:00
- Create an implementation plan and timeline
- Create a rough budget draft

Tuesday May 24: Finalize plan and develop M&E strategy

9:00 – 11:00
- Finalize the implementation plan and budget draft

11:30 – 4:00
- Discussion of M&E and baseline measures.
- Discussion of materials design

4:00 – 5:00
- Review of accomplishments
- Define Next Steps

Annex 2: DLDM Child health working group

MOH • Emmnauel Alphonce TFDA • Dr Neema Rusi Bamayila IMCI • Dr Azma Simba NMCP • Dr John Budotela DMO Songea	Emma_25551@yahoo.com 0744 622421 (mobile) 025 2600187 / 2602026 (tel) 025 2602320 (fax)
CSSC • Marsha Macatta-Yambi	marsha@cssc.or.tz mmacatta@hotmail.com
MSH • Romuald Mbwasi (MSH Tanzania) • Shirima Rogatien (MSH Tanzania) • Jane Briggs (RPM Plus, USA) • Ian Sliney (RPM Plus, USA) • George Greer (BASICS, USA)	rmbwasi@msh.org rshirima@msh.org jbriggs@msh.org isliney@msh.org ggreer@msh.org

Dr Hassan Mshinda of the Ifakara Health Resaerch and Development Center is also a member of the working group, but was unable to attend or send a representative to the working meetings.

Annex 3: Program Design Document

Rational Pharmaceutical Management Plus
Introducing a child health focus into the DLDMs

Ian Sliney
Jane Briggs
George Greer
Naomi Brill

May 27, 2005

Rational Pharmaceutical Management Plus
Center for Pharmaceutical Management
Management Sciences for Health
4301 N. Fairfax Drive, Suite 400
Arlington, VA 22203
Phone: 703-524-6575
Fax: 703-524-7898
E-mail: rpmplus@msh.org

Acronyms

ADDO	Accredited Drug Dispensing Outlet (or DLDM)
ARI	Acute Respiratory Infection
BASICS	Basic Support for Institutionalizing Child Survival
CBC	Communication for Behavior Change
CHWG	Child Health Working Group
C-IMCI	Community IMCI
CORPs	Community Owned Resource Persons
CSSC	Christian Social Services Commission
DDTC	District Drug Technical Committee
DHMT	District Health Management Team
DLDB	Duka la Dawa Baridi
DLDM	Duka la Dawa Muhimu (or ADDO)
DMO	District Medical Officer
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illness
ITN	Insecticide Treated Nets
MOH	Ministry of Health
MSH	Management Sciences for Health
NMCP	National Malaria Control Program
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PEPFAR	Presidential Emergency Plan For AIDS Relief
RPM Plus	Rational Pharmaceutical Management Plus Program
SEAM	Strategies to Enhance Access to Medicines
TFDA	Tanzania Food and Drug Authority
TOTs	Training of Trainers
USAID	United States Agency for International Development

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Executive Summary

The Duka La Dawa Muhimu (DLDM) program has achieved significant improvements in access to essential drugs and treatment of common conditions in southern Tanzania through an accreditation program for duka la dawa and their dispensers. The accredited drug shops and trained DLDM dispensers provide an ideal platform for a focus on child health in the private sector. Although IMCI reaches the community through the public sector, many caregivers approach the private sector providers first when seeking treatment for their children. The Tanzanian Food and Drug Authority (TFDA), MSH/RPM Plus and other partners have designed a child health program to maintain and improve the quality of services in the DLDMs with a focus on malaria, Acute Respiratory Infection (ARI), and diarrhea in children under five years of age.

The program will primarily address two areas: training and continuing education, and community mobilization. The training of the DLDM dispensers will focus upon improving their ability to recognize cases of malaria, diarrheal disease or acute respiratory infections in children under five years of age, to identify danger signs and refer children to a health facility or give appropriate treatment according to the recommended treatment guidelines, and to counsel the caregiver. A cascade training approach at district level will first prepare trainers who will in turn be made responsible for training the DLDM dispensers. Continuing education will be assured through two methods. First, facilitative supervision by the district pharmaceutical staff will provide a means of performance feedback from supervisor to DLDM dispenser where supportive and corrective action can be taken immediately. In addition, a regular newsletter that presents informative and educative quizzes to dispensers will be distributed. Selected dispensers will facilitate at periodic feedback meetings to assist to maintain and improve the performance of their peers and colleagues..

The community mobilization component will focus upon helping caretakers (usually mothers) of children under five years of age to recognize danger signs for malaria, diarrheal disease or acute respiratory infections, to select an appropriate course of immediate action and to administer medicines for the full treatment course. A variety of communications channels and materials yet to be determined, will be used to maximize coverage and penetration of appropriate key messages, using for example radio, village events and distribution of materials such as brochures and kangas.

The rollout of activities of the intervention will be monitored through routine feedback and reporting by the District Drug Technical Committee, District Medical Officer, Ward Inspectors, the RPM Plus Project Coordinator and the TFDA. Baseline and endline surveys will be used to measure changes in the DLDM practices and changes in knowledge and practices of caregivers of children under five years of age. The management plan for the child health program will ensure effective collaboration between all partners.

Introduction

Background

The Tanzanian Food and Drug Authority (TFDA) has successfully created a network of innovative accredited drug dispensing outlets (ADDOs, also referred to as Duka La Dawa Muhimu or DLDMs) in southern Tanzania. Using technical assistance provided by Management Sciences for Health (MSH) through the Strategies for Enhancing Access to Medicines (SEAM) program funded by the Bill and Melinda Gates Foundation, access to essential medicines has been improved in 149 drug shops in the Ruvuma region. A recent post-intervention evaluation has revealed a variety of improvements, including wider availability of tracer essential drugs, and significant improvements to the levels of treatment of common conditions, including malaria and respiratory disease, exactly according to the Tanzania standard treatment guidelines. The TFDA intends to replicate this very positive experience nationally, and USAID has agreed to finance the extension of the program with an additional HIV/AIDS focus, to one other region using funding from the Presidential Emergency Plan For AIDS Relief (PEPFAR).

The RPM Plus survival program child survival portfolio, also funded by USAID, aims to increase access (geographic accessibility, availability, affordability, and cultural accessibility/acceptability) to and appropriate use of essential (efficacious, safe, and cost-effective quality) medicines, vaccines and related supplies for child survival. These approaches are commonly applied in public sector interventions and national-scale programs such as IMCI, but recently RPM Plus has been exploring the possibility of inserting a child survival focus in a private sector context. There is now unequivocal evidence from many developing countries that a substantial number of community members use private drug outlets as their first stop outside the home for the treatment of most common childhood illnesses. The successful DLDM program in Tanzania provides a platform upon which RPM Plus may use USAID resources in Ruvuma region to maintain and further improve the gains produced by the SEAM funded program, with a special focus upon child health.

Following a trip to Tanzania in late November 2004, it was recommended that RPM Plus provide technical assistance to both maintain & improve the performance of dispensers of the accredited drug dispensing outlets in case management of childhood malaria, acute respiratory infections and diarrhea. In addition, the BASICS project was willing to collaborate with RPM Plus to provide technical assistance and support to field activities.

A one day stakeholder meeting was held in March 2005 that resulted in the TFDA accepting the technical assistance program to the DLDMs. In April 2005, after consultation with the TFDA and MOH authorities, the TFDA advised MSH to move ahead with detailed project planning. As recommended in the March stakeholder meeting, a DLDM child health working group was set up with the assistance of TFDA, and a date was set for the submission of a program design, plan and budget to the MoH during the second half of June, 2005.

A three day meeting was held in May 2005 to develop the program design, plan and budget with the child health working group. The resultant proposed program design is presented in this report.

Justification

It is expected that this initiative through the DLDM will contribute to reducing child mortality, especially as it is focused in line with the DLDM program and its eventual extension, on the less privileged areas of Tanzania such as those that are geographically isolated, rural or poor.

Program description

Concept and strategy

The successful DLDM program in Tanzania provides a platform upon which RPM Plus may maintain and further improve the gains produced by the Gates' funded SEAM program, with a special focus upon child health in the Ruvuma region. This is an opportunity to develop materials and tools to integrate child health into the DLDM program as it gets rolled out nationally.

Goal

The goal of this package of interventions is to improve access to essential medicines and commodities for child health.

Objectives

To maintain and improve the quality of services in DLDMs with a focus on malaria, Acute Respiratory Infection (ARI), and diarrhea in children.

Specific objectives

1. Ensure dispensers recognize symptoms and signs of ARI, malaria and diarrhea in children and can differentiate between simple and severe cases

2. Ensure dispensers recognize danger signs of malaria, ARI and diarrhea and refer those cases to a health facility, as well as providing the appropriate course of treatment where necessary.

3. Ensure the DLDMs stock the appropriate generic treatments for those conditions in children.

4. Ensure rational use of medicines for malaria, ARI and diarrhea in children in the DLDMs.

5. Equip dispensers to communicate instructions on administration of those medicines.

6. Equip dispensers to provide information to caregivers on signs of worsening disease and on prevention.

7. Educate communities and caregivers of young children about recognition of signs of uncomplicated and complicated malaria, ARI and diarrhea and the importance of timely care-seeking at an appropriate source.

8. Increase community and consumer knowledge and demand for appropriate treatment of childhood malaria, ARI and diarrhea and the importance of completing a course of treatment.

9. Raise awareness of preventive measures, such as use of Insecticide treated nets (ITNs) to prevent malaria.

Program components

The overall program is composed of two major components: training and continuing education, and community mobilization. Supervision is necessary to ensure improvements are maintained and monitoring and evaluation are integral in documenting program impact.

Training and Continuing Education

The training of the DLDM dispensers will focus upon improving their ability to recognise cases of malaria, diarrheal disease or acute respiratory infections in children under five years of age, to identify danger signs and refer children to a health facility or give appropriate treatment exactly according to the recommended treatment guidelines, and to counsel the caregiver. On the recommendation of the IMCI focal person, it was determined that the management of ARI at the DLDM level would include all basic evaluation techniques necessary to determine the seriousness of the problem so that appropriate steps (referral or treatment or both) are taken to save the life of the child. The management of malaria and diarrhea will be in line with the current recommendations of the MoH and the IMCI strategy, and some flexibility in the training and continuing education will be required as these policies change over the coming years for example with the introduction of ACT for malaria and the proposal of zinc for diarrhea. Some key preventive commodities and information will also be provided through the DLDM dispensers, such as ITNs and nutritional counseling.

The training program will make use of both participatory, peer–to-peer adult learning methodologies, communications and behaviour change materials, as well as more formal classroom-based instruction methodologies. These will draw upon relevant experiences, methods and instructional materials that have already been used successfully either in Tanzania or elsewhere.

A cascade training approach at district level will first prepare trainers who will in turn be made responsible for training the DLDM dispensers. For the sake of flexibility, two types of training approaches will be used first in Songea and Mbinga and their relative effectiveness assessed. In one scenario, two teams of trainers will be created consisting each of two DHMT members. In the second scenario, two teams each of three trainers will be created, consisting of one DHMT member and two “Elite” dispensers or peers. Elite dispensers will be chosen on the basis of their previous qualification (e.g. some of the dispensers are medical officers or nurses). If shown to

be equally effective, these two training alternatives will permit subsequent training to be configured according to the availability of DHMT staff and DLDM dispensers.

Using a training of trainers manual that will be developed specifically for this task, trainers will be prepared over the space of three to five days to train the DLDM dispensers in the district. Trainers will be evaluated before and after their training to determine whether or not they are sufficiently prepared for their training role.

The dispensers' training sessions are expected to last 5 days and class sizes will be held at between 15-20 participants to provide an optimal mix of quality and affordability of training. Using a dispensers training manual designed specifically for this purpose, the trainers will carry out the participatory training in a suitable venue that is convenient to the trainees and where some practical sessions will be possible. All communications materials that the dispensers will be expected to use in their daily work will be made available during the training sessions. These are expected to include posters, job aids, checklists and other CBC materials that will be designed, developed and produced in support of this program.

There are 149 DLDMs in the four districts and a maximum of two dispensers per DLDM. Approximately 16 training sessions will be sufficient to train all staff. DLDM owners will be sensitized about the importance of the training and will liberate all dispensers to attend this training, which will be considered mandatory by the TFDA and part of retaining accredited status. Trainers will be identified in July, while materials are being developed and tested. Training and CBC materials will be finalized and printed in early September and the two groups of trainers will be trained in mid-September. Dispenser training will begin in early November and continue for about 10 weeks. There will be immediate post-training skills assessments at the end of each training course, and repeated assessments after six weeks.

Continuing Education will be assured through two methods. Facilitative supervision by the district pharmaceutical staff (see Supervision) will provide a means of performance feedback from supervisor to DLDM dispenser where supportive and corrective action can be taken immediately. In addition, the TFDA will assist in creating a regular newsletter that presents informative and educative quizzes to dispensers. The newsletter will be distributed by wholesalers. Follow-up will be provided by the "elite" dispensers who acted as peer trainers of the dispensers. Through the organization of periodic meetings these "elite" dispensers will assist to maintain and improve the performance of their peers and colleagues. In such feedback meetings "elite" dispensers will be supported by the district pharmaceutical staff or DHMT member.

Community Mobilization and Education

Community mobilization and education efforts will focus upon improving the early recognition of malaria, diarrheal disease or acute respiratory infections by caretakers of children under five years of age, to identify danger signs and to select an appropriate course of immediate action.

Research on patterns of care-seeking behavior in the communities concerned will be conducted to design an effective communication and behavior change strategy. Any barriers to access to appropriate services will be documented and the CBC strategy will address these directly. Key messages will be developed that will form the foundation of the strategy.
A variety of communications channels and materials will be used to maximize coverage and penetration of key messages. Region, district, division and ward heads will be used to organize events at village level with the collaboration and participation of the DLDM owners. Meetings by local leaders including District Commissioner campaigns and religious meetings should also be used. Ward nominated counselors, who are often women, can be a mechanism through which leaflets could be delivered (as a type of neighbor-to-neighbor approach). The Community-Owned Resource Persons (CORPs) of IMCI may also be a community resource to be tapped, although currently these are only in place in 13 districts nationwide though not yet in all wards and only two of the CORPs districts are in Ruvuma region. In addition, mass communication channels such as radio spots, billboards, "ngomas" and song contests will be explored. Interpersonal communications materials such as posters, leaflets and kangas will be designed, tested and produced. The frequency of community level contacts through mass communications channels and the quantities of CBC materials produced will be maximized subject to available resource constraints.

The formative investigation of health care seeking behaviour and medicine use practices will be carried out in July and August, including a review of existing studies and materials from Tanzania and elsewhere. The communications strategy and materials will be designed and field tested in September and early October. Following review and finalization of all print materials, they will be produced in sufficient quantities in late October and distributed to the districts so that the launch of the CBC component of the program, including radio spots and billboards, will coincide with the training of dispensers in early November.

Monitoring and supervision

The rollout of activities of the intervention will be monitored through routine feedback and reporting to the Project Coordinator, who will provide feedback and take corrective measure as needed. The RPM Plus team in Arlington will also monitor the progress in order to justify funds to the USAID SO3 team.

The District Drug Technical Committee (DDTC), principally its secretary (the District Pharmaceutical staff), or DMO will carry out monitoring and inspections of the practices of the DLDM dispensers on a regular basis. Supervision activities are required to be conducted on a quarterly basis and include all points of sale for drugs in the district. This supervision is expected to be carried out by DHMT. The DDTC inspection of the DLDMs builds on a quarterly inspections by the Ward Sub-Health Committee which forms a team of Ward Inspectors. The aim of the Ward inspection is to ensure that there are no illicit or expired drugs in the shop, that the shop is not involved in any malpractices, and that it is well-organized and clean.

In addition to reviewing the Ward inspection report, which is left in the shop, the DDTC will review the DLDM records to determine if appropriate dispensing practices have been followed.

As part of the present child health intervention, the DLDM record book will be modified (or an additional register developed) to include key information around the management of sick children which will allow the monitoring of the services provided to assure quality. The DDTC will be taught to interpret the new child health records and determine if the drug dispenser has correctly identified and provided appropriate and full treatment for key childhood illnesses. The DDTC will also be trained on delivery of corrective, positive feedback in cases where dispensers have been in error. The DDTC records from all DLDM supervisory visits will be passed to the MSH team and TFDA for consolidation, analysis and review by the DLDM Child Health Working Group. Monitoring will be used both as a measure of the success of the intervention and to provide direction for continuing education component of the program.

The Community Mobilization components of the program will be monitored by measuring utilization over time at several DLDM sentinel sites, approximately on a quarterly basis or more frequently as needed.

Evaluation

The project will conduct two types of evaluations. One will compare the two training approaches used and the other will evaluate changes due to project interventions directed at the dispensers and caregivers. These will measure changes in the indicators listed in Annex 4 for both dispersers and caregivers.

The training approaches (described above in Training) will be evaluated to determine whether there is a significant difference in outcome between using DMHT staff or “elite” DLDM dispensers as trainers for the child survival intervention. Knowledge change among DLDM trainees will be measured immediately after their training course by comparing it to pre-training knowledge. There will also be a follow-up test administered at 6 weeks after training to measure retention of information and a practical quiz presenting scenarios to measure practices for hypothetically ill children. Results from these will be delivered to the MSH team for compilation and analysis before sharing with the DLDM Child Health Working Group.

The project evaluation will consist of baseline and end line surveys to measure changes on the DLDM practices and changes in knowledge and practices of caregivers of children under five years of age. A household questionnaire, structured observation and mystery client surveys are all possible tools that will be administered at a randomly selected, representative sample of DLDMs in September / October 2005 before the child health training begins, and one year later to assess the changes in knowledge and practices of the DLDM dispensers. Cluster surveys will be conducted with caregivers of children under five both within and outside of the intervention area in order to compare treatment seeking behavior, knowledge of the signs of severe illness in young children, choice and use of medicines, use of ITNs for children under five and appropriate feeding for the ill child. These surveys will be done in September/October 2005 and repeated one year later. Results from these will be delivered to the MSH team for analysis and shared with the DLDM Child Health Working Group.

Management Plan

This program will be recorded as a collaborative effort by the TFDA, MSH and BASICS in a short memorandum of understanding that documents and defines TFDA, MoH, MSH, BASICS and DLDMs expected contributions to this program.

The ADDO steering committee will provide long term oversight and guidance to the program through the DLDM child health working group (CHWG) which will report to the ADDO steering committee.

The DLDM child survival program will be managed by MSH, led by the in-country MSH senior technical advisor in collaboration with TFDA. A child survival program coordinator is being recruited locally by MSH to whom the senior technical advisor will delegate day-to-day management authority for program implementation in line with the agreed upon plan and budget. Technical inputs from the BASICS project will be managed at BASICS by the Senior Technical Officer for Malaria as defined in the plan. The technical oversight for the activity will predominantly be provided by the staff of the RPM Plus child survival portfolio in Washington DC.

The indicators of program performance (annex 4) derived from the goals and objectives of the program will be used to monitor the program on a regular basis, as will the workplan and budget.

The program coordinator will make frequent trips to the project site in Ruvuma regions to oversee implementation according to the workplan, and to assure that activities are carried out on time and within budget. Problems and their recommended solutions will be reported to the MSH senior technical advisor and to the CHWG, and appropriate and timely action will be taken.

The program coordinator will prepare regular quarterly progress reports that will be submitted through the MSH senior technical advisor to the ADDO steering committee.

Roles and Responsibilities of Partners

The Ministry of Health Tanzania will provide technical oversight and support to the program through the TFDA, the NMCP and the IMCI focal person, and particularly through the DLDM Child Health Working Group. The role of the working group is to design, plan and monitor the program and review technical materials.

USAID-funded partners to the MoH Tanzania, RPM Plus of MSH and the BASICS project will provide technical oversight, funds and monitoring of implementation.

DLDM owners and dispensers will play a crucial role in the intervention. The owners will contribute by allowing the participant to attend the training and assuring the appropriate drugs are available, and the dispensers are involved in attending the training and providing quality service in the DLDMs, as well as monitoring and, where necessary, initiating the community

mobilization activities. The regional wholesalers may also be involved as a mechanism to distribute material to the dispensers.

The DDTC is a key body for this program and for the DLDMs in general. The district pharmaceutical staff and the DMO sit on the DDTC, which is the body responsible for maintaining quality in the DLDMs through inspections and supervisions, encouraging participants, and assisting their appropriate use of medicine. The district pharmaceutical staff also acts as a link to the local government structure and the community. The DMO is responsible for universal supervision of all health services and therefore will oversee the supervision carried out in the DLDM shops.

The community mobilization activities will be organized by the divisional secretaries, the Ward Executive Officers (WEO), Village Executive Officers (VEO) and the ward counselors and the village chairpersons.

Annex 1: Implementation plan

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May
TRAINING												
Identify trainers as TOTs		X										
Identification of Existing Training Materials		X										
Preparation of Training Materials			X									
Testing of Training Materials			X									
Identify DHMT members as trainers for Dispensers		X	X									
Identify Elite Dispeners as Trainers for other Dispensers		X	X									
Identify Training Centers			X									
Printing of Training & IEC Materials				X								
Training of Trainers (DHMT & Elite)				X								
Training of Dispensers by DHMT & Elite Trainers					X	X	X					
Begin Package with Tunduru, Songea rural & Namtombo						X						
SENSITIZATION												
Sensitization of Regional, District & Ward Leadership		X										
Sensitization of Owners		X										
COMMUNITY MOBILIZATION												
Collect existing information of health seeking behaviour		X										
Develop additional research for key messages (Urban & Rural)			X									
Prepare Key Messages			X									
Review of Key Messages by Working Group			X									
Field Testing of Key Messages (Urban & Rural)				X								
Design Billboards, Radio Spots, Posters				X								
Design leaflets, Kangas				X								
Testing of Materials					X							
Final Revision and Production of IEC Materials					X							
Village & Ward Meetings (Ngomas, Drama, Songs)					X							
VILLAGE EVENTS												
Billboards						X						
Radio						X				X		X

	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May
Leaflets (Community)						X				X		X
Leaflets (DLDM)						X				X		X
Health Days									X			
SUPERVISION												
Post training evaluation after 5 days					X	X	X		X		X	
Revise supervisory checklist & propose changes to TFDA		X										
Orientation of Supervisors by DDTC				X								
Ward Inspection							X			X		
District Supervision							X			X		
DDTC Meetings								X			X	
Ward Dispenser Feedback Meetings									X			X
CONTINUING EDUCATION												
Develop quizzes & newsletter						X						
Sensitise and involve wholesalers						X						
Orient Elite Dispensers							X					
Plan and implement peer to peer meetings								X	X	X	X	X
MONITORING												
Develop Training Evaluation		X										
Orient TOTs to effect training evaluation				X								
Post Training Test After 5 Days					X							
Six Week Follow Up of Training by Central TOTs						X						
Decision about continuation of Elite Trainers						X	X					
EVALUATION												
Identify data that exists and plan baseline surveys		X										
Child Health Baseline for DLDMs and Communities			X	X								
SEASON EPIDEMIOLOGICAL TRENDS												
Malaria						M	M	M	M	M	M	
Diarrhea						D	D	D	D	D	D	
ARI	ARI	ARI	ARI	ARI								

Annex 2: Approximate budget

This budget estimate is illustrative only and is dependent on expected funds but as yet not received for the year 2005-2006.

This draft budget includes estimated field costs but does not include evaluation activities (baseline and end line surveys) or staff salaries covered by the activity. The Project coordinator for the Child health intervention in the DLDM will be supported at 100% by MSH.

The actual community mobilization activities are still to be determined depending on actual costs and budget implications.

	Cost Estimate
Training	$70,000.00
Sensitization	$5,000.00
Community Mobilization	$150,000.00
Supervision	$10,000.00
Continuing Education	$20,000.00
Monitoring	$15,000.00
TOTAL	**$270,000.00**

Annex 3: DLDM Child Health Working Group (CHWG)

MOH • Emmnauel Alphonce TFDA • Dr Neema Rusi Bamayila IMCI • Dr Azma Simba NMCP • Dr John Budotela DMO Songea	 Emma_25551@yahoo.com 0744 622421 (mobile) 025 2600187 / 2602026 (tel) 025 2602320 (fax)
CSSC • Marsha Macatta-Yambi	 marsha@cssc.or.tz mmacatta@hotmail.com
MSH • Romuald Mbwasi (MSH Tanzania) • Shirima Rogatien (MSH Tanzania) • Jane Briggs (RPM Plus, USA) • Ian Sliney (RPM Plus, USA) • George Greer (BASICS, USA)	 rmbwasi@msh.org rshirima@msh.org jbriggs@msh.org isliney@msh.org ggreer@msh.org

Annex 4: Monitoring & Evaluation Indicators

Knowledge of dispensers

1. Percentage of dispensers that know the signs of malaria (uncomplicated and severe), ARI (pneumonia and non-pneumonia), and diarrheal disease (bloody and non-bloody) in children.

2. Percentage of dispensers that know the correct treatment for malaria, ARI (pneumonia and non-pneumonia) and for diarrhea (bloody and non-bloody) in children.

3. Percentage of dispensers that know the correct doses and dosages of those appropriate treatments for children.

4. Percentage of dispensers that know that the use of ITNs can prevent malaria in children.

Practice of dispensers

5. % of DLDMs with specific appropriate medicines (in both tablet and syrup form) for the key conditions and ITNs in stock.

6. % of DLDMs with visual aids on display.

7. % of dispensers dispensing the appropriate drug for malaria, ARI and diarrhea for childhood cases of those conditions.

8. % of dispensers referring severe cases of childhood illness.

9. % of dispensers providing the caregiver with correct instructions on drug administration.

10. % of dispensers providing preventive information to the caregivers.

11. % of dispensers providing information on worsening disease to the caregivers.

12. % of dispensers providing nutritional information to the caregivers.

Caregivers in the community

13. % of caregivers taking their sick children to the DLDM.

14. % of caregivers purchasing medicines from the DLDM.

15. % of caregivers utilizing the DLDM for either advice or medicines.

16. % of children under 5 years receiving correct dose of antimalarial within 24 hours of onset of febrile illness.
17. % of children under 5 years receiving correct dose of antibiotic within 24 hours of onset of pneumonia .

18. % of children under 5 years receiving correct dose/formulation of ORS/ORT within 24 hours of onset of diarrheal disease.

19. % of households with children who slept under an ITN the previous night.