

## **Rational Pharmaceutical Management Plus**

### **Introducing a Child Health Focus to the Accredited Drug Dispensing Outlets (DLDMs)**

#### **Tanzania: Trip Report**

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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**

A trip was made to visit project stakeholders in Tanzania to investigate the possibility of pursuing a number of innovative field interventions that may increase access to medicines for child health through the private sector. Following a three day evaluation meeting of the SEAM ADDO (DLDM) program in Ruvuma region, a one day meeting was held with key partners to discuss the development of a program of complimentary child health interventions with TFDA and MoH oversight. The participants recommended that the planning and design of the intervention move forward, in collaboration with the IMCI and Malaria programs under the Ministry of Health. Following the write-up of the meeting report, several meetings were held to gain approval from TFDA and solidify relationships with other key partners.

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### **Key Words**

Private Sector, Tanzania, Access, Pharmaceuticals, Child Health, Malaria, Diarrhea, Acute Respiratory Infection, ADDO, DLDM

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## Acronyms

ADDO	Accredited Drug Dispensing Outlet
AED	Academy for Educational Development
ARI	Acute Respiratory Infection
BASICS	Basic Support for Institutionalizing Child Survival
CHWG	Child Health Working Group
C-IMCI	Community IMCI
CMO	Chief Medical Officer
CORPS	IMCI Community Health Workers
DLDB	Duka la Dawa Baridi
DLDM	Duka la Dawa Muhimu (ADDO, or DLDM)
DMO	District Medical Officer
DPG	Donor Partner Group
DSS	Demographic Surveillance System
GPS	Global positioning systems
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IEC	Information Education Communication
IMCI	Integrated Management of Childhood Illness
ITN	Insecticide Treated Nets
MOH	Ministry of Health
MSH	Management Sciences for Health
NGOs	Nongovernmental Organizations
NMCP	National Malaria Control Program
RBM	Roll Back Malaria
RC	Regional Commissioner
RMO	Regional Medical Officer
RP	Regional Pharmacist
RPM Plus	Rational Pharmaceutical Management Plus Program
SEAM	Strategies to Enhance Access to Medicines
TFDA	Tanzania Food and Drug Authority
TFNC	Tanzania Food and Nutrition Centre
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USAID/W	United States Agency for International Development (Washington, DC office)
VHW	Village Health Worker
WB	World Bank
WHO	World Health Organization

## Background

The RPM Plus child survival portfolio 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; 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 the private sector is the first port of call outside the home for the treatment of most childhood illnesses. Thus, there is a need to identify how the private sector can be harnessed to target causes of child mortality and enhance access to and appropriate use of medicines. In principle, such an approach has a tremendous potential for reducing child mortality.

A trip was made in November 2004 by RPM Plus to Tanzania to explore options for developing a package of interventions in the private sector to enhance access to and appropriate use of essential medicines, vaccines and related supplies for child survival. The trip report recommended that RPM Plus:

- i. Provide technical assistance to both maintain & improve the performance of counter clerks of the accredited drug dispensing outlets (ADDOs, also referred to as DLDMs) in case management of childhood malaria, acute respiratory infections and diarrhea
- ii. Explore a partnership with the ACCESS Project (through the Ifakara Health Research and Development Centre and the Novartis Foundation) to provide technical assistance to improve the performance of DLDB and retail store counter clerks in case management of childhood malaria, as well as to improve community demand for and oversight of such services
- iii. Explore collaboration with manufacturers and/or wholesalers to develop appropriate detailing materials and job-aides targeted at management of childhood illnesses

Further discussions were held in Washington DC with SEAM, RPM Plus, USAID Global Bureau and BASICS with all parties agreeing to continue to move forward with project planning. A three pronged approach has been proposed, focusing interventions initially on the first recommendation of working with the DLDM shops. The proposed interventions will build upon MSH's experience in working with the DLDMs in Ruvuma region by adding a special focus upon child illnesses, and adding components for continuing education and community demand creation. Later, the DLDM experience may be shared with the Ifakara-Novartis ACCESS project to extend and strengthen private sector malaria interventions in Morogoro region. The program may also work with private sector manufacturers and wholesalers, in collaboration with national authorities, on detailing programs related to management of childhood illness.

### Purpose of Trip

The purpose of this visit was to assist the MSH-SEAM Tanzania staff and local project stakeholders to develop consensus on a program design, plan and budget for the RPM Plus Child Health / Private Sector interventions with the MSH-SEAM ADDOs.

## Scope of Work

Ian Sliney:

- Meet with stakeholders and orchestrate the planning meeting for program design
- Provide assistance to the MSH-SEAM Tanzania program staff in the design of the intervention package and serve as primary facilitator at the planning meeting
- Ensure that the RPM Plus child survival intervention package integrates smoothly with the existing SEAM-funded DLDM program and has the full support of Tanzanian government and DLDM program staff.
- Organize follow-up planning sessions to finalize program plan and budget
- Ensure the establishment of effective communications between RPM Plus HQ and field office, stakeholders and partners
- Ensure the production of a final concept paper, program plan and budget for the first year of the project
- Debrief USAID and other partners

Naomi Brill

- Ensure preparation for the design and planning meeting is completed, with logistics, materials and agenda in place and participants briefed and prepared
- Attend, participate and assist in the organization and facilitation of the 2 day meeting for program design
- Assist in the preparation of detailed program plans and budget for first year of project with in-country partners
- Prepare debriefing materials for MOH/USAID as required

## **Activities**

The week of February 21–25 consisted of meetings in Dar Es Salaam with key informants, and attendance at the SEAM DLDM evaluation review meeting. The child health meeting took place on Friday, February 25 after the SEAM Evaluation meeting. During the second week, February 28 – March 4, activities were centered on finalizing the meeting report for dissemination to the TFDA and meeting with other partners. A meeting with TFDA on March 8 gained the critical approval from the Director General to move forward with the planning process. A debriefing was held with USAID on March 3 and with MSH staff March 9.

### **Monday 2/21**

#### **Meeting with MSH SEAM staff**

This introductory meeting reviewed the purpose, objectives and expected outputs of the trip with SEAM staff, and to plan meetings with other partners and field trips. The agenda and objectives for the one-day child health meeting were also reviewed for input from the SEAM team.

### **Tuesday 2/22 – Thursday 2/24**

#### **MSH SEAM Evaluation Meeting Kunduchi Hotel**

The purpose of the three-day evaluation meeting was to gather key stakeholders and partners from the ADDO (DLDM) program to analyze the evaluation results, identify the critical factors contributing to results, and plan how to scale up the program. The RPM Plus team attended these meetings to better understand how these factors would influence the design and management of the child health intervention, and to identify the lessons to learn and incorporate in the next phase of the project.

The general consensus of the ADDO/DLDM program evaluation was that it has been shown quite convincingly to have met all its objectives. The program has resulted in measurable and significant improvements to the quality of care provided, to the availability of medicines, and to the sustainability of the DLDMs. While the gains are impressive, they were tempered by recognition that further improvements are both desirable, and possible. To maintain and further improve dispenser performance and to change community behavior, continuing education and community education and mobilization programs will be required. Of importance to the RPM Plus team were the key lessons learned, which showed that the participatory approach used to design and manage the program, and the strong national and local government support for the project were integral to its success, and provide a firm foundation upon which to build a child health focus.

The DLDM intervention represents a successful partnership between the MoH, local government and private sector business, and the Ministry has been pleased with how much this innovative program has achieved. Perhaps the most significant outcome of the SEAM Evaluation meeting is that the Tanzanian Ministry of Health now intends to scale up the program nationally. To this end, the MoH is prepared to consider soliciting Tanzanian Treasury Resources for national scale-

up during the imminent Medium term Expenditure Framework (MTEF) discussions. In summary, the accomplishments of the DLDM program provide a strong platform from which the RPM child health work can develop.

## **Tuesday 2/22**

### **Meeting with John Dunlop, Rene Berger and Jim Allman, USAID/Tanzania**

We attended an initial briefing with John Dunlop of the PHN Office at USAID, presenting our program of work and requesting Mission guidance. The Mission has been engaged in discussions with the MoH CMO (Dr. Upunda) and other senior staff in an effort to raise awareness of child survival issues. It is anticipated that a child survival meeting may be held in Tanzania in the summer or early fall with support from the Child Survival Partnership, including USAID, UNICEF, WHO, World Bank and the Bill and Melinda Gates Foundation. A separate meeting is also being contemplated by the Mission for the launching of the Lancet series in Tanzania.

Dr. Rene Salgado has recently been commissioned by USAID to prepare a paper that will examine how IMCI may be scaled up. In particular it will address how to scale up the new malaria treatment guidelines.

USAID wants to ensure that all the Mission child survival activities in Tanzania are coordinated to work together synergistically. To assure effective cross linking of the RPM plus child survival initiative with that of other partners, John suggested that we contact Jacqueline Mahon at the Swiss Development Agency, Kerida McDonald at UNICEF, Julie McLaughlin at the World Bank, as well as staff at the AED T-Mark project (the AID flagship project for social marketing) in Dar Es Salaam.

## **Thursday 2/24**

### **Preparation for the Child Health Meeting**

In view of the preceding three days of work at the evaluation workshop, the agenda for the child survival meeting was adapted to reflect the interest of participants and the discussions during the ADDO meeting. The duration was scaled back to one full day from a day and a half, and some of the desired outputs were changed to reflect the need for more preliminary discussions to take place first. Documents were prepared and presentations finalized to reflect the new agenda for the meeting.

## **Friday 2/25**

### **RPM Plus Meeting: Introducing a Child Health Focus to the DLDMs**

The child health meeting followed directly after the ADDO Evaluation meeting, with a subgroup of approximately 25 participants. The objectives of the meeting were:

- To review previous country experiences of improving treatment of childhood illness in private sector drug outlets

- To relate those previous country experiences to the evaluation findings of the DLDM program
- To arrive at a broad program design with components for an intervention package to maintain and further improve the quality of care in DLDMs with a focus on child health

The meeting opened with a presentation describing the global agenda for child survival and how private sector interventions in Nigeria and Kenya (Kilfi and Bungoma) have successfully addressed treatment of child illnesses (in particular malaria) in the community. The participants were then divided into three discussion groups which looked at issues of Continuing Education and Behaviour Change, Community Education and Mobilization, and Oversight and Regulation across the four private sector interventions, including the DLDM program. The groups produced recommendations on how to integrate successful components and strategies from previous experiences into the DLDM program. 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

The next step as suggested by participants was for MSH to prepare a meeting report with their recommendations for presentation to the TFDA. Following the approval of TFDA to move forward, a working group will be convened to write the program design which will be submitted to the Ministry of Health by the end of May 2005.

For a complete description of the meeting's proceedings, please see the Meeting Report (Annex A).

### **Monday 2/28 – Friday 3/4 Report writing**

The conclusions from the child health meeting needed to be written in a way that accurately reflected the recommendations of the participants and that clarified any concerns that the TFDA might have about the purpose of the child health intervention. The meeting report had to be as clear and succinct as possible to ensure rapid turn-around by the TFDA, as their approval to move forward was essential. Several drafts were reviewed and revised by SEAM staff in country and MSH staff in Arlington to ensure all sensitivities were covered. The report was sent to the TFDA on Friday March 4 to prepare the ground for discussion with the Director General the following week.

### **Monday 2/28 Meeting with Dr. Hassan Mshinda and Dr. Ahmed Makemba, Ifakara Research and Development Centre and Dr. Brigit Obrist, Swiss Tropical Institute.**

ACCESS is a joint venture between Ifakara Research and Development Centre and the Novartis Foundation. The project works at both the systems level, through IMCI training and working with private drug shops, and at the household level, through social mobilization, to improve appropriate treatment of malaria. The project is supported with approximately \$600,000 from the Novartis Foundation, and is implementing and evaluating interventions in two districts – Kilombero and Ulanga in Morogoro Region. The progress made to date by the ACCESS Project consists of a literature review of determinants of access to care, the development of interventions with shopkeepers (both DLDBs and general shops), the ongoing support of the Demographic Surveillance System (DSS) to permit the recording of all drug outlets using global positioning systems (GPS), and the registration of all births and deaths to permit measurement of mortality reductions. ACCESS has already conducted baselines on health-seeking behavior for malaria in children under five. They have developed a shopkeepers guide with advice for dispensing (based on the Kilifi project) and social mobilization activities based on the NMCP materials. They completed training of approximately 1000 drug shop vendors (2 each from 500 shops) in January 2005 and will be conducting a mid-term evaluation this May which they are willing to share with us.

#### **Thursday 3/3**

##### **Debriefing with John Dunlop, Rene Berger, Jim Allman and Michael Moshi, USAID**

We briefed the team on the results of the Child Health meeting, including presenting copies of the summary meeting report, and on the progress to date with the TFDA and MoH buy-in. USAID expressed their desire to see a working group on child survival in Tanzania, to include WHO, World Bank, Ifakara, UNICEF, and other members of the Donor Partner Group for Health to coordinate donor inputs to child survival activities in country.

#### **Friday 3/4**

##### **Meeting with Mr. M.S. Gulamhussein and Dipesh Shah, Salama Pharmaceuticals Ltd.**

We met with the Managing Director Mr. Gulamhussein and Dipesh Shah to review the RPM Plus meeting findings and recommendations, and to share IEC materials from Kenya and Nigeria. They were enthusiastic about using the IEC materials to influence the design of their new advertising posters and expressed a strong interest in collaborating with the project. Some of the products they are working on include artemisinin and paracetamol suppositories and a rapid test kit for malaria.

##### **Meeting with Dr. Sam Agbo and Dr. Kimata, UNICEF**

This was a courtesy call made upon the suggestion of Dr. Kerida McDonald. Dr. Agbo presented the scope and content of the UNICEF child health programs in Tanzania. The focus of the programs is upon the most vulnerable children in 57 priority districts of a total of 104 nationwide. In 2004 a new five year country program was developed with a focus upon:

- a) HIV prophylaxis

- b) Improvement of home based care of pneumonia
- c) Village Health Worker training and drug kits
- d) Community Resource Persons

In October 2004, UNICEF supported 5 day training courses for 1000 CORPS in Mbinga and 680 in Songea Rural. Dr. Agbo mentioned that the VHW kit program was suffering as a result of difficult relations between UNICEF and the MoH, and presently VHWs did not have drug kits.

We presented the purpose and results to date of our work, and we agreed to work closely together as we prepare the program design and plan for child health interventions in the DLDMs.

Dr. Agbo and Dr. Kimata provided us with copies of the UNICEF sponsored IMCI counseling cards that are currently in use by CORPS in Tanzania

### **Tuesday 3/8**

#### **Meeting with Mrs. Margaret Ndomondo-Sigonda, Director General, TFDA, and Dr. Romuald Mbwasi, Naomi Brill and Ian Sliney of MSH**

The purpose of this meeting was to discuss the workshop report that had been submitted to TFDA the previous Friday and gain the approval from TFDA to pursue the design and implementation of the child health intervention. The result of the discussion was the official agreement of TFDA to pursue this opportunity to incorporate child survival into the DLDM program.

A brief background was given about the origins of the renewed child survival agenda that had arisen as a result of the publication of the Lancet series in 2003. We explained that MSH was interested in assisting the MoH further support the DLDM program when Gates Foundation funding ends in the middle of 2005. RPM Plus had selected Tanzania as a potential site because of the success of the DLDM program and the IMCI work carried out by the MoH with assistance from the Ifakara Research and Development Centre.

The new component focusing upon child health had not been in the original memorandum of understanding between MSH and the MoH. The new evaluation results made it clear that continuing education in child survival and the potential use of IMCI CORPS (IMCI-trained community health volunteers) for community education and mobilization were important components that could be added.

There was a concern about whether this work was intended to be a complimentary program to the DLDMs, or a new concept outside the existing DLDM framework. We reassured Mrs. Ndomondo-Sigonda that this activity was supposed to be fully integrated in to the existing program, and was not a stand-alone project of USAID. This is not a pilot, and any improvements in dispenser practices that result from this work would be expected to be included in the nationwide roll-out of the DLDM program by the MoH and TFDA.

Another question concerned the availability of funding, and whether the MoH would be expected to provide any counterpart funding. We reassured her that the MoH would not need to provide funding at this stage, as funds were immediately available through the RPM Plus project. Although the funding level is not enormous, it would be sufficient to achieve the intended results which would include improving treatment for the most common causes of child mortality in the DLDMs, most likely including malaria, diarrheal disease and possibly ARIs.

It was agreed to associate the Ifakara team (including the Novartis Foundation and Swiss Tropical Research Institute) with our work to benefit from lessons they have already learned and experience gained in Tanzania.

We also mentioned our discussions with some local wholesalers and manufacturers, who would be willing to take on the costs of the job aids as promotional materials. Mrs. Ndomondo-Sigonda mentioned that promotion was a weaker area for the DLDM program and TFDA, and that they would be open to using the private sector as vessels for production and distribution of these materials.

We explained the tentative recommendations we were making for setting up the working group and preparing the program design and work plan, and she agreed that this was a useful way to proceed. We agreed to prepare to present this concept to the MoH such that the MoU may be amended and work can progress. It was decided that Dr. Mbwasi could present the proposed program of work to the MoH very soon, perhaps just after the MoH technical Review (March 15-17) and then thereafter, help set up the working group so that the work may progress rapidly.

#### **16:00 Meeting with Ms. Jacqueline Mahon, Health and Poverty Advisor and Chair of Development Partners Group (DPG) Swiss Cooperation Office.**

Ian made a brief presentation of the DLDM program, its history and its key results to date, and the way in which USAID resources were being proposed to be used through the RPM Plus program to provide further support to the DLDMs. Public-Private-partnerships are a focus of a joint health sector review that will take place from April 4-6, and Jacqueline suggested that Dr. Mbwasi could be invited to present the DLDM program to the review meeting as few members of DPG are aware of the success of the program, or of the intention of the MoH to roll it out nationally.

We discussed other issues related to the financing of the Tanzanian Health sector and promised to exchange relevant information in readiness for a return visit in mid April. We agreed to provide the following information:

- The ADDO movie
- A summary of the ADDO evaluation findings
- The draft concept paper developed for the child survival program
- The RPM Plus trip report from November 2004

Ms. Mahon agreed to provide in return:

- A study of health seeking behavior carried out in Dar Es Salaam
- The most recent public expenditure review for Tanzania
- Documents related to fiscal decentralization in Tanzania
- The recent study of the State of Health in Tanzania carried out by the Swiss Tropical research institute

## **Collaborators and Partners**

Dr. Sam Agbo, UNICEF  
 Jim Allman, USAID Tanzania  
 Rene Berger, USAID Tanzania  
 Malcolm Clark, MSH  
 John Dunlop, USAID  
 M.S. Gulamhussein, Salama Pharmaceuticals Ltd.  
 Ned Heltzer, MSH  
 Dr. Suleiman Kimatta, UNICEF  
 Tom Layloff, MSH  
 Jacqueline Mahon, SDC (Swiss Development and Cooperation)  
 Ahmed Makemba, Ifakara  
 Dr. Romuald Mbwasi, MSH  
 Julie McLaughlin, World Bank  
 Michael Moshi, USAID Tanzania  
 Dr. Hassan Mshinda, Ifakara  
 Margaret Ndomondo-Sigonda, Director General TFDA  
 Brigit Obrist, Swiss Tropical Institute  
 Deepak Saksena, Shelys Pharmaceuticals.  
 Rene Salgado, private consultant  
 Dipesh Shah, Salama Pharmaceuticals Ltd.  
 Rogotian Shirima, MSH  
 Mary Taylor, MSH Consultant

## **Adjustments to Planned Activities and/or Additional Activities**

The original scope of work to produce the program plan and budget was revised upon arrival in country. It was clear from discussions with the SEAM team and from observing participant reactions in the child health meeting that stakeholders in country were in tentative agreement with the project but not in a position to move forward with detailed planning. Specific TFDA approval was required before continuing with plans for a working group, and due to the sensitivity required, this process took longer than anticipated. This was due to the high levels of MoH and TFDA engagement, which ultimately is beneficial for the sustainability of the program. Although production of a program design, workplan and budget was not possible during this visit, the appropriate procedures seem to be in place for allowing work on those

activities to progress over the next two months, with the added benefit of TFDA and MoH ownership to propel the activity forward.

## **Next Steps**

### **Immediate Follow-up Activities**

The recommendations that follow need to be reviewed at MSH and USAID/W. The meeting report should be disseminated to all participants and relevant key partners. MSH will follow up with the DPG to discuss presenting the ADDO program at the donor meeting in April.

### **Recommendations**

#### **Recommendation #1 – MSH Tanzania staff solicits approval from the Ministry of Health to move ahead**

It is recommended that Dr. Mbwasi present the objectives of the child health work with the DLDM program to the Ministry of Health at one of their Monday meetings, and thereby gain agreement to proceed with next steps as documented in Meeting Report.

#### **Recommendation #2 – MSH staff to work with TFDA and MoH to convene child health working group (CHWG) members**

It is recommended that MSH staff in Tanzania and in Arlington work alongside TFDA and MoH counterparts to arrive at list of working group members by March 30. The procedures for how the group will work and a timeframe for the process should be defined.

#### **Recommendation #3 – Support to Production of Program Design and Plan by CHWG**

MSH staff from Tanzania and Arlington will work with the TFDA to develop a program design. This will involve the recruiting of a local RPM Plus staff member for the child health work, meetings with the working group and strategic planning and budgeting. It is expected that two trips of RPM Plus staff from Arlington may be needed to support this process.

#### Possible Trip 1 – Approximately 5-7 days in mid-April

RPM Plus staff travel to Dar Es Salaam to:

- a) Carry forward plans to interview and recruit local child health program coordinator, following the finalization of the scope of work
- b) Organize and conduct first meeting of CHWG with members from TFDA, IMCI, NMCP and MSH and other co-opted members as required
- c) Define the strategic planning process and required outputs for CHWG
- d) Assign responsibilities and tasks to CHWG members

- e) Set up phone, email and possibly web-based communications to allow ready exchange of information during CHWG assignments

#### Possible Trip 2 – Approximately 10-12 days in May

RPM Plus staff travel to Dar Es Salaam to:

- a) Reconvene CHWG for 1 day review
- b) Finalize program design and plan
- c) Hold 1-2 days meeting with key stakeholders to review draft program design and plan
- d) Produce final design and annual workplan plan to present to MoH and TFDA
- e) Prepare RPM Plus budget based on operational plan

#### Expected outputs by the end of Trip 2:

Program Design – Working Group

Annual Workplan – Working Group and RPM Staff

Budget – MSH RPM Plus & BASICS staff

### **Agreement or Understandings with Counterparts**

The TFDA has given approval to move ahead with a child health intervention within the DLDM program structure. MSH (both SEAM and RPM Plus) will work together with the oversight of the TFDA and Ministry of Health with the common goal of extending the success of the DLDM program in Tanzania and by providing a special focus upon child health with RPM Plus resources.

Immediate follow up will require the convening of a child health working group in-country and then the preparation of a program design and operational plan by May 2005, with technical support to this process being provided by RPM Plus.

It was agreed with all institutions and persons consulted that any recommendations would be reviewed at MSH and USAID/W.

RPM Plus and SEAM staff will coordinate their activities to ensure the quality of the DLDM program continues, with the benefit of continuing education for child illnesses.

### **Important Upcoming Activities or Benchmarks in Program**

The Child Health Working Group will be convened to produce the program design by the end of May for presentation to the Ministry of Health. RPM Plus will develop a workplan and budget based on the program design.

**Annex A: Final Meeting Report**

## **SUMMARY MEETING REPORT**

**Introducing a Child Health Focus to  
the Accredited Drug Dispensing Outlets (DLDMs)**

**From a meeting held in Kunduchi, Tanzania  
February 25, 2005**

**Prepared by Management Sciences for Health**

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## List of Acronyms

ADDO	Accredited Drug Dispensing Outlets (also DLDM)
BASICS	USAID-funded child survival project
DLDB	Duka la dawa baridi
DLDM	Duka la dawa muhimu (also ADDO)
IMCI	Integrated Management of Childhood Illnesses
ITN	Insecticide-treated Nets
MOH	Ministry of Health
MSH	Management Sciences for Health
NMCP	National Malaria Control Program
RBM	Roll Back Malaria
RPM Plus	Rational Pharmaceutical Management Plus
TFDA	Tanzania Food and Drug Authority
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

### A note about terminology...

The *duka la dawa muhimu* (DLDM) shops are synonymous with the ADDOS referred to in English, but for the purposes of this document and for the future, they will be referred to by the Tanzanian term DLDM.

The term *vendor*, which was used in previous documents from Kenya and Nigeria, carries a different meaning than the local term *dispenser* to which we are referring. Therefore, here and in future the term *dispenser* will be used. Previous documents may have used different terminology, but from this point onwards, *dispenser* and *DLDM* are the most appropriate terms.

## Background

This report is the result of the confluence of two complimentary initiatives. First, since 2001, the MSH Center for Pharmaceutical Management in Arlington VA has been supporting Tanzania Food and Drug Authority (TFDA) and Tanzania Ministry of Health (MOH) with the development of the *duka la dawa muhimu* (DLDM) program in Ruvuma, with funding from the Bill and Melinda Gates Foundation. This initiative, which provides accreditation for drug outlets and requires them to follow certain standards, has recently been hailed as a success. Following a detailed field evaluation of the program, a meeting was held in February 2005 to review the evaluation findings with key partners.

Secondly, in 2003 a series of five landmark articles published in the international journal *The Lancet* raised global awareness of the unfinished child survival agenda in developing nations. Of the 11 million children dying worldwide each year, it is believed that as many as 6 million children's lives could be saved each year by scaling up and targeting known and proven public health interventions. With assistance from USAID, the World Bank, UNICEF, WHO and other major development agencies, a child survival partnership was set up in 2004 with a renewed focus upon reducing child mortality in certain countries. Tanzania has recently registered impressive and significant reductions in child mortality through the effective implementation of IMCI, and is now the focus of potential donor support for scale up of proven effective child survival interventions.

As a result of these initiatives, in 2004 the USAID funded Rational Pharmaceutical Management Plus (RPM Plus) program at MSH was tasked to identify and promote initiatives with the private sector to enhance access to medicines for child health. A systematic literature review was conducted that identified those interventions that have been shown to improve treatment practices of child illness in the private sector. Thereafter, a strategy was developed outlining how RPM Plus could engage with developing country partners to implement these types of initiatives, and site visits were proposed. Due to the factors mentioned above, Tanzania was selected as one site where a package of private sector interventions, complimentary to IMCI, could possibly be scaled up successfully. The potential interventions include the use of pre-packaged medicines, short duration but frequent peer to peer adult education, community education and mobilization, and the use of targeted job aides and other behavioural change materials.

In November 2004 a short exploratory visit was made by RPM Plus to Tanzania, including brief visits to *duka la dawa baridi* (DLDBs – the non-accredited drug outlets) in Bagamoyo and DLDMs in Songea. This visit generated considerable interest amongst many in-country partners to develop a child health initiative. USAID Washington thereafter approved the use of RPM Plus resources to develop an intervention package in Tanzania, and limited additional USAID resources have also become available through the BASICS project. The goal of the intervention package was proposed to be to maintain and improve the quality of service offered by the DLDMs with a particular focus on child health. A follow-up meeting (documented in this report) was planned for

in-country stakeholders in late February 2005, and MSH staff prepared a draft concept paper of successful private sector experiences to be discussed at the meeting.

## **Meeting Organization and Program**

The child health meeting, held on 25 February 2005, immediately followed a three-day workshop to evaluate the DLDM program. The close timing of the two meetings was deliberate to benefit from the momentum generated at the DLDM evaluation and capture some of the same participants after they had spent several days reviewing the achievements of the private sector work in Ruvuma. Most of the participants were drawn from the DLDM evaluation workshop; these included high-level officials from the TFDA and Ministry of Health, local government leaders from Ruvuma, trainers, supervisors and one shopkeeper. Senior officials from the IMCI and Malaria divisions of the Ministry of Health and representatives from Shelys Pharmaceuticals joined the group specifically for the child survival discussions.

The objectives of this one-day child health meeting were:

- To review previous experiences from other countries of improving treatment of childhood illness in private sector drug outlets
- To relate those experiences to the evaluation findings of the DLDM program
- To arrive at a broad program design with components for an intervention package to maintain and improve the quality of care in DLDMs with a focus on child health

The meeting opened with an introduction presenting the justification for focusing on child health in Tanzania and within the DLDM program. The next presentation outlined the design of the DLDM program and three private sector projects in other countries which achieved improved treatment for malaria in children under five with simple and targeted education for dispensers and the community. The participants were divided into three groups, with broad representation from the various stakeholders present. The groups were tasked with comparing materials and methods across the four projects and producing recommendations for which, if any, aspects of these interventions might be incorporated into the DLDM program in order to further improve the quality of care for children, and how such integration could be coordinated. Each group absorbed an immense amount of information and detail to conduct in-depth discussions of complex concepts and issues and produce their recommendations. *(See Annex C for detailed notes of recommendations and discussion.)*

## Summary Recommendations

The *duka la dawa muhimu* (DLDM) program has already registered significant improvements in assuring improved access to medicines for the general population, including children. These results are at least in part due to the program's strengths in participatory program development and implementation with local stakeholders, and decentralized management and oversight. DLDM stakeholders are optimistic about continuing the successful work in the Ruvuma DLDMs and are moving towards developing a plan to scale up the program to the national level. After comparing the different private sector interventions, the group concluded that the Tanzanian approach in the DLDM program was shown to be the most thorough and best regulated method, and provides a suitable platform for building community-based interventions for child health. The task ahead would be to take the successful components of other programs and look to how they can be used to further improve the quality of the service provided by the DLDMs. Based on the strong foundation of the DLDM program, meeting participants recommended that in order to maintain and further improve appropriate treatment for children, the TFDA and MoH should:

- **Adapt and adopt dispenser-to-dispenser (peer to peer) educational and behavioural change methods** that have demonstrated significant improvements in dispenser performance, into the *duka la dawa muhimu* (DLDM) program. Wholesalers, distributors and manufacturers could also be used to provide short messages, as well as materials (posters etc.) that support continuing education for dispensers. As trusted members of the community, dispensers should be trained and used to inform their clients and the community at large on issues concerning medicines and other health commodities for child health.
- **Develop a supervision system based on the DLDM model which will effect a transition from using trainers at the central level to using local personnel** who work near the facilities they supervise. Supportive supervision should occur on a regular basis and involve several hours of attention, and checklists and other tools should be developed to support this process.
- **Adapt and adopt neighbour-to-neighbour (community based) educational and behavioural change methods** that have demonstrated significant improvements in community awareness about child health and demand for appropriate and accessible treatment into the DLDM program. Within the community, the intervention could potentially partner with the already existing IMCI CORPS to disseminate additional messages in coordination with ongoing IMCI activities. Community mobilization such as radio spots, ngomas, and drama should be used to take health messages to the community.
- **Integrate relevant components of IMCI into the DLDM program.** DLDM child health messages should be closely aligned with IMCI standard treatment guidelines and the two programs should coordinate their interventions to ensure synergy, particularly in the scale-up process. This step would promote better

service delivery, coordination and management, and ensure that all groups work together to improve health standards for Tanzanians. Such coordination would help to further integrate the relevant IMCI concepts into the public-private partnerships.

- **Integrate National Malaria Control Program (NMCP) goals, including those of the global Roll Back Malaria (RBM) initiative into the DLDM program.** This is to improve the case management of uncomplicated malaria and vector control, including insecticide treated nets (ITNs). The intermittent presumptive treatment of malaria in pregnancy will not be included for the time being.
- **When the Ministry of Health approves the intervention design, include the child health package as an integral part of the DLDM program during the roll-out** to scale nationwide. The child health components will be consistent with the overall goals and design of the DLDM program and should be integrated into the planning for national coverage.

## **Next Steps**

MSH should write up the proceedings of the meeting for TFDA and the MoH by March 7, 2005. A working group should be formed immediately to develop, with MSH support, a comprehensive detailed proposal by mid May for the Ministry's review. Membership of that working group should be restricted to a small number of active individuals for example drawn from the MoH (IMCI and NMCP), TFDA, and MSH.

## **ANNEX A**

### **Agenda**

# **Introducing a Child Health Focus to the Accredited Drug Dispensing Outlets (DLDM)**

**Kunduchi Wet and Wild Hotel  
February 25, 2005**

## **OBJECTIVES**

1. To review previous country experiences of improving treatment of childhood illness in private sector drug outlets
2. To relate those previous country experiences to the evaluation findings of the DLDM program
3. To arrive at a broad program design with components for an intervention package to maintain and improve the quality of care in DLDMs with a focus on child health

## **AGENDA**

<b>Time</b>	<b>Item</b>
9:00 – 9:30	Welcome, Background, Objectives of the Meeting
9:30 – 10:30	Experiences Working with Private Sector Drug Sellers
10:30 – 10:45	Tea Break
10:45 – 11:00	Reading – Review and Comparative Analysis paper
11:30 – 1:00	Discussion Groups
1:00 – 2:00	LUNCH
2:00 – 4:15	Discussion Groups
4:15 – 4:30	Tea Break
4:30 – 5:45	Report Back from Groups
5:45 – 6:00	What should be the next steps based on these recommendations?
6:00 – 6:15	Wrap-up

## **ANNEX B**

### **Breakout Group Assignments**

#### **Breakout Group 1: Continuing Education and Behaviour Change**

##### Tasks

- Review the various training and behavioural change methods and answer the following questions:
  - Who were the trainers
  - Who were the trainees
  - Who were the supervisors
  - How often did supervision occur
  - How long was the training
  - What was the focus and content
  - What was the cost
  - What were the characteristics of the materials that were used
- Compare different interventions and provide general recommendations appropriate to Tanzania
- What do you think Tanzania could actually do, and why?
- Identify the key partners required to make this happen
- Prepare summary report back to plenary

#### **Breakout Group 2: Community Education and Mobilization**

##### Tasks

- Review the various training and behavioural change methods and answer the following questions:
  - Who were the target groups
  - What were the messages
  - What methods were used
  - What were the results
  - What were the costs
- Compare different interventions and provide general recommendations appropriate to Tanzania
- What do you think Tanzania could actually do, and why?
- Identify the key partners required to make this happen
- Prepare summary report back to plenary

### **Breakout Group 3: Oversight and Regulation, Quality Assurance/Maintenance**

#### Tasks

- Review the various approaches to oversight and regulation and quality assurance, maintenance and answer the following questions:
  - What legal frameworks were used or reforms enacted
  - What rules and regulations were used
  - Who provided oversight and enforcement
  - How was service quality measured?
  - How was the quality of drugs assured, if at all?
- Compare different interventions and provide general recommendations appropriate to Tanzania
- What do you think Tanzania could actually do, and why?
- Identify the key partners required to make this happen
- Prepare summary report back to plenary

## **ANNEX C**

### **Meeting Notes**

## **Inserting a Child Health Focus to the DLDMs**

### **February 25, 2005**

#### **CONCERNS FROM THE GROUP DURING IAN'S PRESENTATION ON REVIEW OF COUNTRY EXPERIENCES:**

- The word “vendor” (used in Kenya and Nigeria projects) caused confusion because in Tanzania it is associated with street dispensers and people who carry out unregistered business. Hereafter the word “dispenser” will be used instead of “vendor” in order to avoid confusion.
- The level of education of the peer-to-peer workers used in these studies was not as high as those in Tanzania, and it could affect the quality of their messages
- The soon-to-be-implemented new malaria guidelines allow coartem to be distributed at discounted prices from the Global Fund to the public facilities ONLY. DLDMs or private pharmacies will be able to sell coartem but not at the discounted costs. It may not be practical to either promote a different (and affordable) malaria treatment from the public facilities in the DLDMs, or promote a drug that is not affordable for most people visiting DLDM shops. This is a critical access issue.
- Some participants were unclear about what IMCI does, and asked the IMCI representative for a quick overview

#### **GROUP REPORTS**

##### Group 1: Continuing Education and Behaviour Change

- Recommendations:
  - Utilize locally available people/experts as trainers, as in the Kilifi approach
  - Trainees should include owners and dispensers as in the DLDM system
  - Adapt the DLDM approach on supervision. Instead of using supervisors from the central level, train local people, as in the Kilifi model, to act as supervisors to reduce costs. A supervision checklist and another type of visual reporting (apart from a Yes/No checklist) should be developed. Following the supervisory visits, a report should be written to make supervision proper and comprehensive. Supervision takes a minimum of 1 hour and ideally four hours in the facility to observe interaction with clients, and often hours are required to travel to the facility. It takes a whole day to supervise two DLDMs.
  - Training should consist of 3 days of continuing education annually
  - The focus of the child health intervention should be on priority areas (such as malaria) and new information (such as malaria treatments)

- Materials should include IEC materials, audiovisual aids, and revised handouts
- Key partners should include the central and local government, NGOs, donors, development partners, the private sector, and individuals
- Discussion:
  - There was a question about whether donors are considered a partner in these projects. Unfortunately the funds donors bring are essential to carrying out some of these projects. The shared opinion is that the door is open for anyone to come in who would like to help and work with the team in the way that they want to work.

## Group 2: Community Education and Mobilization

- Recommendations:
  - Try the dispenser-to-dispenser approach where brochures and information can be distributed to DLDM dispensers through wholesalers.
  - Adapt the neighbor-to-neighbor approach by using the IMCI CORPS groups to visit households and provide information using brochures. Emphasize a partnership to use the already existing CORPS to put additional messages which do not conflict with what IMCI is doing. (CORPS are trained to go to households to promote messages about child health and currently work in 18 districts, including 3 in Ruvuma).
  - Radio spots, ngomas, drama and continuing education could be used to facilitate the initiative
  - Coordinate DLDM child health messages with IMCI standard treatment guidelines and coordinate separate interventions to ensure synergy
  - Tanzania was unique in their message of discouraging self-medication and this important detail should be maintained.
  - Poster job-aids are very useful tools to dispensers to give them information when they need it. Private sector companies like Shelys can be part of information dissemination through job aids given directly to the dispensers.
  - Key partners would include: MOH/TFDA, IMCI, District councils, pharmaceutical companies, NGOs, DLDMs, educational institutions
- Discussion
  - Some worried that having dispensers spend time on messages takes time away from their sales, although others said the dispensers should be taking time to communicate how to take the medicine and what to do if symptoms don't improve regardless of other messages, so it wouldn't take much extra time. Dispensers should provide information at the shop about the drug that they are selling as well as other treatment messages.
  - There was a question about whether DLDM dispensers should be out in the community doing education. Dispensers are well-trained and have the

community's trust, and there are two in the store all the time. Perhaps the second dispenser could use slow periods to go to markets or schools to disseminate information with posters, brochures.

- Dispensers could be used to provide information to mothers, after having some training, perhaps with CORPS. This should be discussed in the plans for the roll-out.
- This purpose of this approach is to improve dispenser practices as well as promoting education in the community. Quality of service is improved from both directions. It makes sense to use wholesalers to dispensers for education, the chain of neighbor to neighbor with CORPS (which benefits both) which is easy to do in communities, and general methods of communication that attract community and are part of the culture.
- How do we reach the families which do not go to either DLDMs or public facilities? If people can take important health information to the community, which in turn spurs them to use the available resources, it enhances both the DLDMs and health facilities.

### Group 3: Oversight and Regulation, Quality Assurance/Maintenance

- Recommendations:
  - After comparing the different private sector interventions, it was decided that the Tanzanian approach with the DLDMs was the best method, so now the task is to take the best of the other programs and look to how they can be used to improve DLDMs
  - Dispenser-to-Dispenser and Neighbor-to-Neighbor concept should be adopted/adapted in Tanzania to improve services in the DLDM context
  - Integration with IMCI to promote better service delivery, coordination and management, and to ensure that all groups work together to improve health standards for Tanzanians
    - Integrate the public-private partnership concept into IMCI, whose current focus is mainly on public sector interventions
    - Integrate IMCI program objectives into DLDMs to better provide information to the community
  - Integrate RBM components into DLDMs to improve case management and vector control (including ITNs) to complement the RBM strategy
  - Key partners: MOH (Preventive services – IMCI), TFDA (Pharmacy Council – PST), media, financial institutions, voluntary agencies, and NGOs
- Discussion:
  - IMCI does not work only in the public sector, although their focus is on facilities. Coverage may be restricted because of finances, but they do have trained health workers in private facilities.
  - Malaria and IMCI are closely related and MOH-NMCP (National Malaria Control Program) should also appear with partners. ITNs fall under vector

- control and are one of the major strategies of the MOH (with malaria in pregnancy).
- The DLDMs are already established in Ruvuma and this is a new proposal – if the DLDM program is getting ready to roll-out, is it possible to include these activities in all the aspects of the roll-out (training, etc)? In essence, there should be no separation between the two activities – it is just a question of managing the different sources of funding. This is not something new, this is just more stress on the illnesses for children so they can receive better treatment.
  - Why are we working with IMCI? Because this is the main unit of the ministry of health which is working with child survival.

### **WHAT ARE THE NEXT STEPS AFTER THIS MEETING?**

- The consultants will write a report of the meeting which will present the group's recommendations
- Having identified key partners for the effort, a smaller group (3-5 people) will be identified as a working group to prepare a comprehensive proposal. The proposal will be shared with the wider stakeholder audience for approval.
- Together the stakeholders will go as a team to present the idea to the Ministry of Health, and move forward from that point as appropriate.
- Timeframe:
  - report of meeting – first draft completed by March 5 and circulated for feedback
  - working group to produce a program proposal for the Ministry of Health by the end of May
  - present to MOH in May/June
- Final say: This will be a good approach if it develops according to the ways recommended by this group!

## ANNEX D

### List of Participants

<b>PARTICIPANT</b>	<b>ORGANIZATION</b>
Ollympia Kowero	TFDA
Emmanuel Alphonse	TFDA
Adonis Bitegeko	TFDA
Adelard Mtenga	TFDA
Dr. N Rusi Bamayila	IMCI MOH
Dr. Azma Simba	NMCP MOH
Dr. Malekelo	RMO Ruvuma
Jerome Ngowi	Regional Pharmacist Ruvuma
Dr. John Lindi	DMO Tunduru
Dr. John Budotela	DMO Songea
Dr. A. S. Mashimba	DMO Mbinga
Allen Malisa	Regional Pharmacist Morogoro
Sospeter Magambo	Regional Pharmacist Tringa
Godfrey Sende	DLDM Owner/Dispenser Mbinga
Marsha Macatta-Yambi	CSSC
Kharist Luana	PORALG
Dennis Busuguli	Muhimbili School of Pharmacy
Deepak Saksena	Shelys Pharmaceuticals
Sudhis Kulkarni	Shelys Pharmaceuticals
Umesh Rivankar	Shelys Pharmaceuticals
David Lutabana	Southern Highlands Pharmaceuticals
RM Shirima	MSH
Dr. R. Mbwasi	MSH
Grace Mtawali	MSH
Nakae Noguchi	MSH/JICA
Ian Sliney	MSH
Naomi Brill	MSH