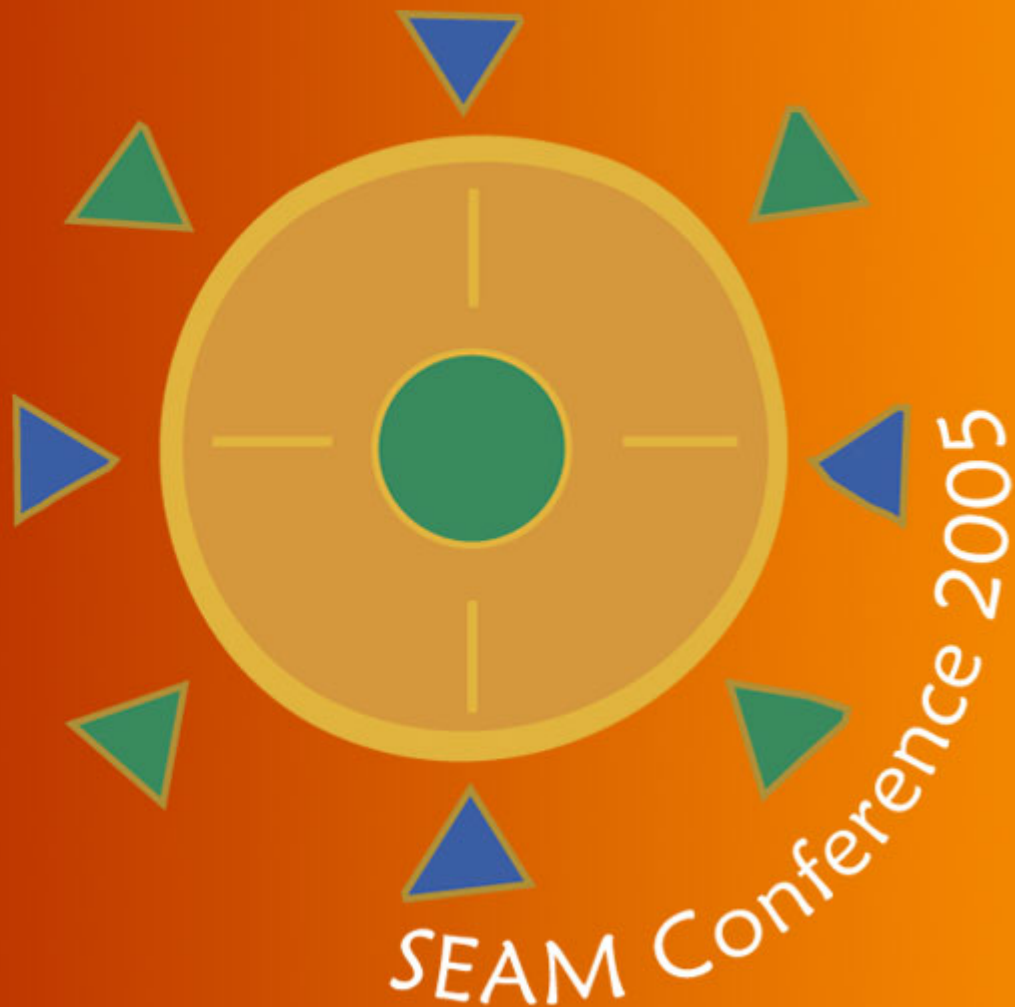




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Targeting Improved Access

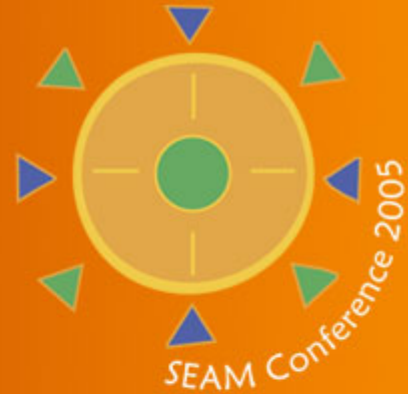


MANAGEMENT SCIENCES *for* **HEALTH**

SEAM | Strategies for Enhancing Access to Medicines

Funding for the SEAM Program is provided by the Bill & Melinda Gates Foundation.

Targeting
Improved
Access



Accra, Ghana • June 20–22

Enhancing Access to Medicines through Private and Multisector Initiatives: The Tanzania Experience



Romuald Mbwasi, SEAM

Funding for the SEAM Program is provided by the Bill & Melinda Gates Foundation.



MANAGEMENT SCIENCES *for* HEALTH

SEAM | *Strategies for Enhancing Access to Medicines*

Goal of ADDO Project

- ❖ To improve access to affordable, quality medicines and pharmaceutical services in retail drug outlets in rural or peri-urban areas where there are few or no registered pharmacies

Background

- ❖ Duka la Dawa Baridi (DLDB) are legal outlets
- ❖ Created to provide nonprescription medicines
- ❖ Intended to operate in areas where no pharmacies are available



Why Work with DLDB?

- ❖ Very few full-fledged retail pharmacies exist in Tanzania (427), 60–70% located in Dar, 30–40% scattered throughout the other major towns
- ❖ DLDB are the largest network of legal outlets for essential OTC medicines; estimated 4,600 in 2001
- ❖ The number of DLDB per capita is 50% higher than all public health facilities and 11% higher than for all public, V&RF combined
- ❖ DLDB are often the first, and sometimes the only, places people seek care when they fall sick

Major DLDB Problems

- ❖ Lack of skills and knowledge
- ❖ Legal violations
- ❖ Poor storage facilities
- ❖ Unreliable quality of medicines and services
- ❖ Shortage of Tanzania FDA (TFDA) registered wholesale suppliers in rural areas
- ❖ High risk of the business
- ❖ Shortage of registered suppliers within the region/district

Challenges Faced

- ❖ Insufficient number of qualified staff
- ❖ No assurance of medicine quality
- ❖ Insufficient variety of medicines legally available for meeting public needs
- ❖ Stocking of medicines unauthorized by the TFDA
- ❖ Inadequate enforcement of regulations
- ❖ Difficulty in finding reliable, legal sources of medicines nearby
- ❖ Limited list of authorized medicines

The Adopted Strategy

- ❖ Improving the quality of products and services
- ❖ Changing behavior of shop owners and dispensing staff through the provision of education and incentives
- ❖ Improving local regulatory capacity with efforts to affect client demand/expectation of quality products and services
- ❖ Improving awareness of customers on quality and the importance of treatment compliance



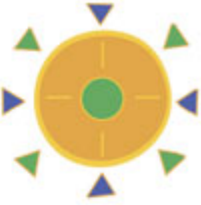
Strengths

- ❖ Broad-based support among all stakeholder groups and individuals from—
 - ❖ Public sector
 - ❖ Private sector
 - ❖ National authorities
 - ❖ Local authorities
- ❖ Participatory approach to project design and implementation



Major Project Interventions (1)

- ❖ TFDA accreditation based on approved STDs and regulations governing ADDOs
- ❖ Pharmaceutical and regulatory training
- ❖ Business development (business skills training and supervision for owners)
- ❖ Communication skills and reproductive health training
- ❖ Supportive supervision for dispensers



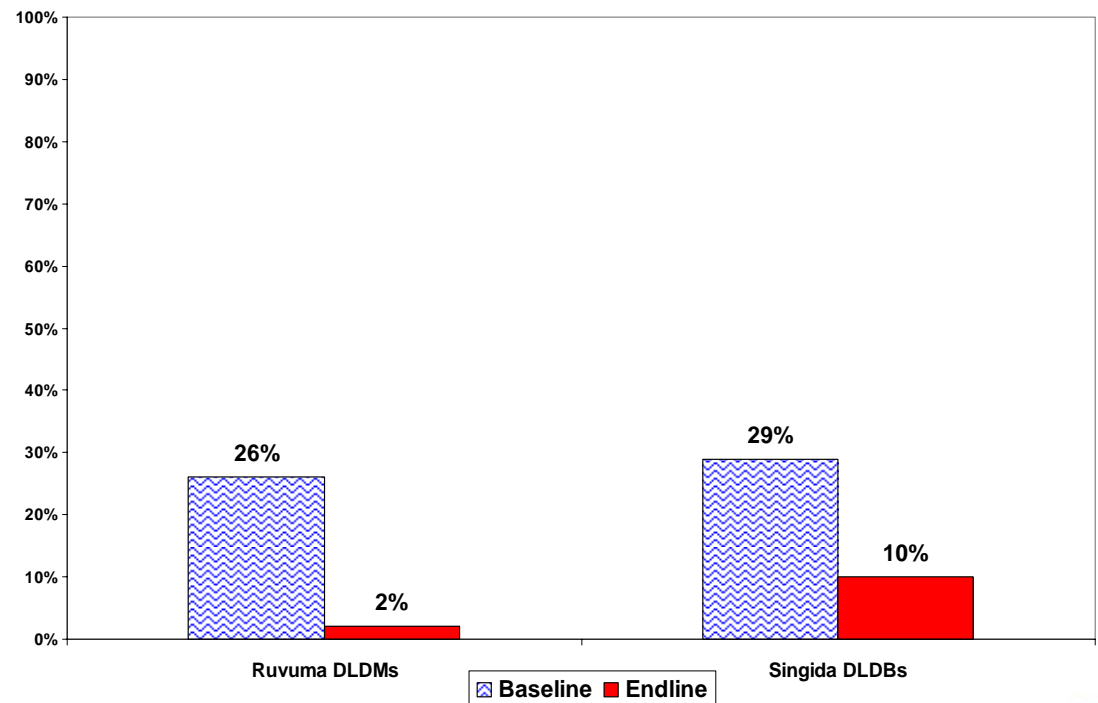
Major Project Interventions (2)

- ❖ Marketing and public education
- ❖ Decentralization of regulatory activities
- ❖ Commercial incentives to ADDO owners such as—
 - ❖ Access to micro loans
 - ❖ Sale of a limited number of essential prescription medicines

Did We Improve the Quality of Medicines That Ruvuma Population Was Buying?

- The proportion of unregistered medicines in Ruvuma was reduced by a factor of 13, from 26% to 2%; thus people in Ruvuma now have a 1:50 chance of buying an unapproved medicine compared with a 1:10 chance for people of Singida.

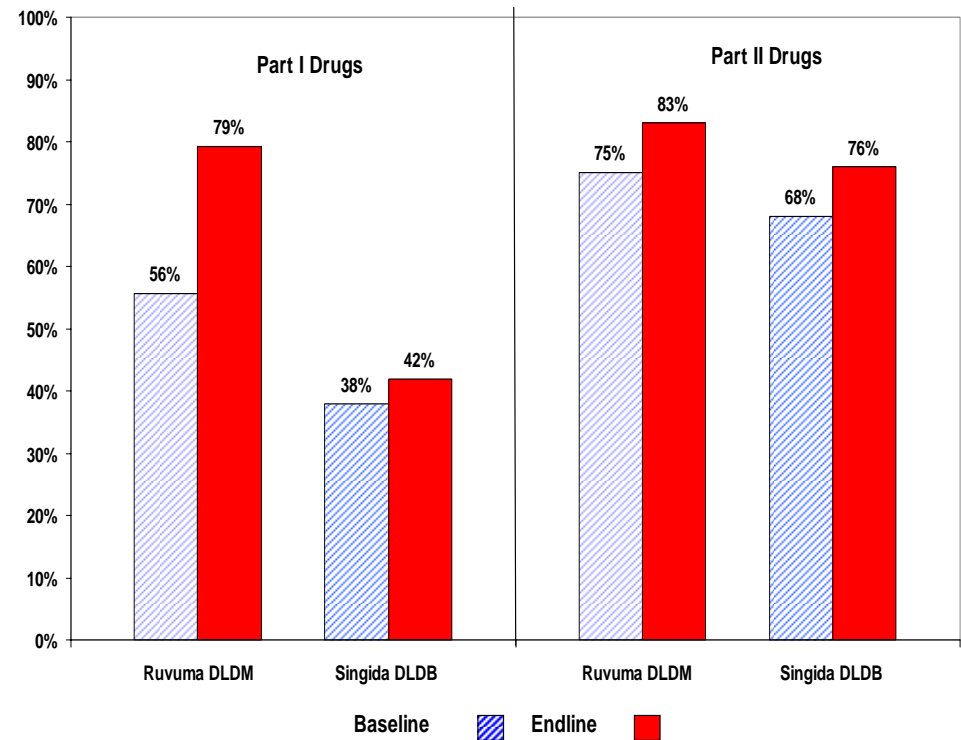
Figure 1. Comparison of the Percentage of Medicines Unapproved for the Tanzanian Market in Ruvuma DLDMs and Singida DLDBs at Baseline and Endline



Did We Increase the Availability of Essential Products?

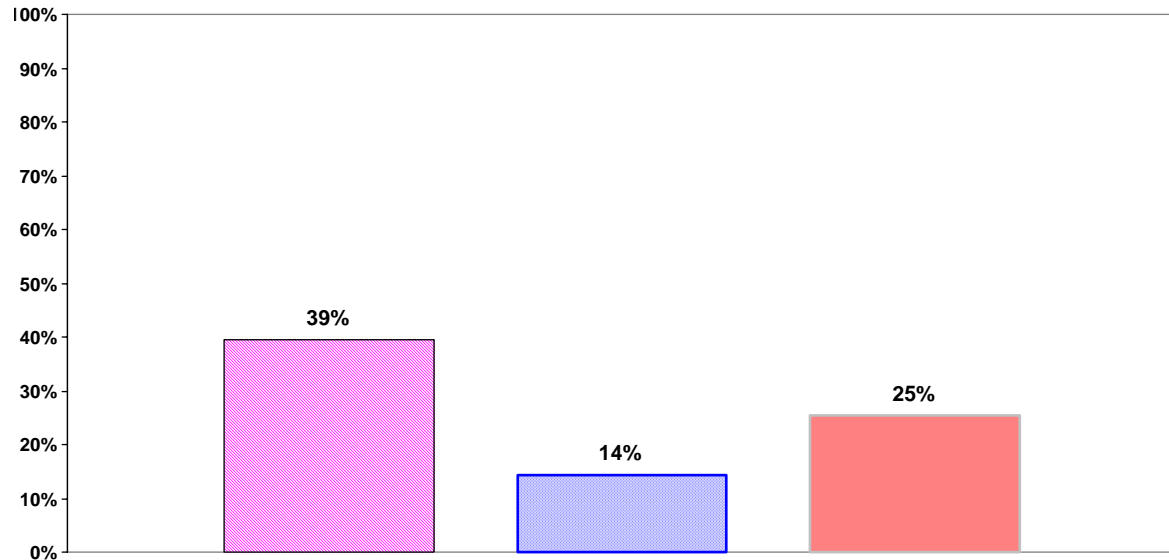
- ❖ Average availability of prescription medicines in Ruvuma was nearly double the average availability in Singida.
- ❖ Example: average availability for amoxicilline in Ruvuma increased by one-third and for procaine penicillin more than doubled.

Figure 2. Comparison of Average Availability of Part I and Part II Tracer Medicines in Ruvuma DLDMs and Singida DLDBs



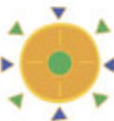
Did We Improve the Quality of Dispensing Services? (1)

- ❖ URTI
- ❖ Fewer dispensers were giving or recommending antibiotics in Ruvuma (14% ADDOs) than in the SEAM assessment in 2001 (39%) or Sigida DLDB (25%).

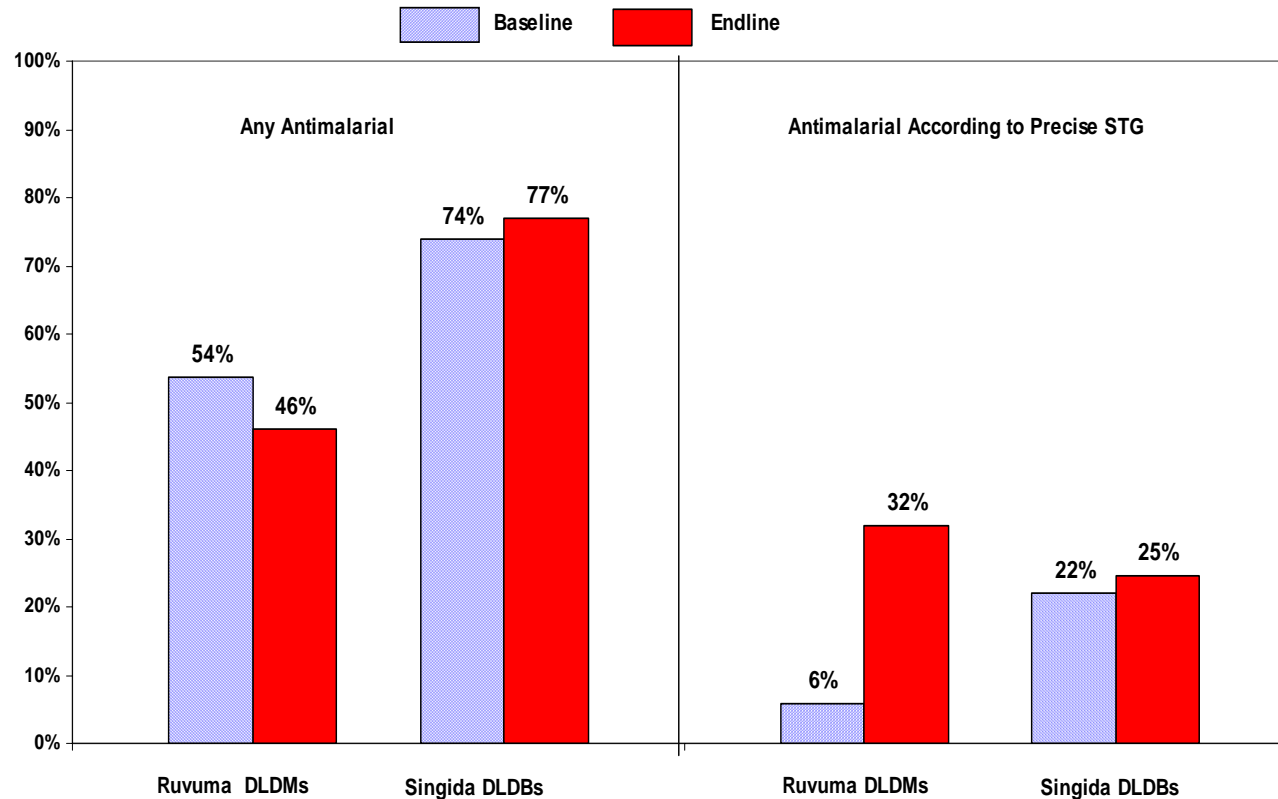


Comparison of proportion of URTI simulated clients for whom antibiotics were dispensed or recommended

Note: Compared to 2001 SEAM Assessment DLDBs as baseline



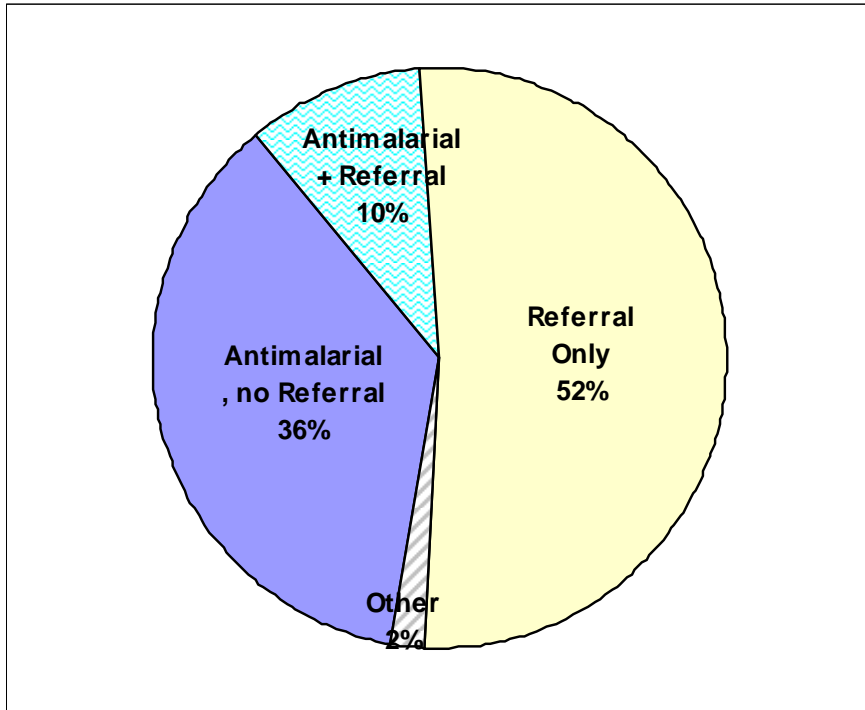
Did We Improve the Quality of Dispensing Services? (2)



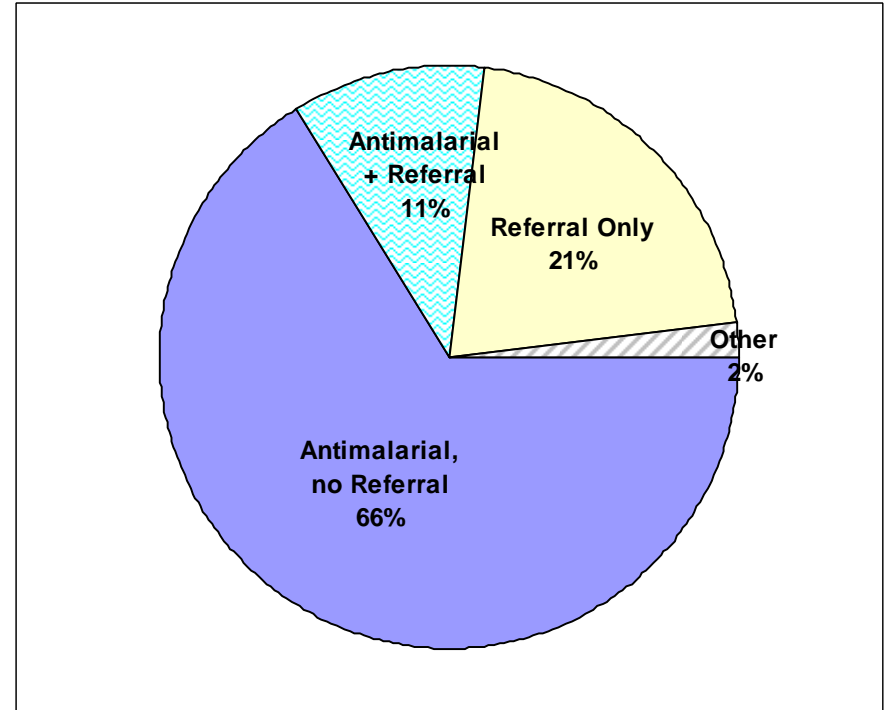
Comparison of results of malaria simulated clients percentage of facilities that dispensed any antimalarial according to precise STG, Ruvuma DLDMs and Singida DLDBs



Did We Improve the Quality of Dispensing Services? (3)



Ruvuma DLDMs



Singida DLDBs

Comparison of proportion of treatment and referral of malaria simulated clients





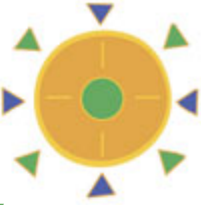
Did We Do It Such That Medicines and Pharmaceutical Services Are Affordable?

- ❖ Average median prices increased from baseline to endline in both regions but were more marked in Ruvuma (11%) than in Singida (<1%).
- ❖ Prices in Ruvuma were more in line with national market prices than they had been previously.
 - ❖ Legal sources available
 - ❖ Decline in sale of medicines from illegal vendors and public sources



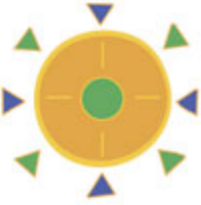
Did We Do It in Such a Way That ADDOs Are Sustainable?

- ❖ The MEDA study of Mbinga DLDMs concluded—
 - ❖ All businesses are able to gauge profitability and the majority earn a profit each month.
- ❖ Approximately an average of Tsh. 80,000/= is earned as profit monthly (varies individually from Tsh. 10,000 to Tsh. 500,000)



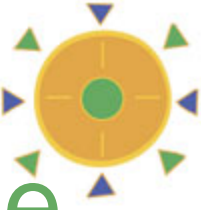
Did We Improve the Regulatory System?

- ❖ Decentralization of regulatory authority down to ward level as compared to the previous system at regional level only
- ❖ Formation of licensing and inspection committees at ward and district levels
- ❖ Regional authority involved in supervision, auditing performance at lower levels
- ❖ Nevertheless, more effort is being directed to supervision to strengthen the system



Challenges for Rollout

- ❖ Major challenges in the roll out include—
 - ❖ Training and continuing education (dispensers)
 - ❖ Training of local inspectors
 - ❖ Supervision (dispensers and local inspectors)
 - ❖ Regulating (inspection)



Justification for the Rollout and the Cost Involved

- ❖ A fully regulated private sector for the pharmaceutical services will—
 - ❑ Have a substantial effect on public health
 - ❑ Place Tanzania in a unique position regarding
 - ❖ Access of essential medicines at all levels
 - ❖ Availability and quality of medicines in all settings
 - ❖ Quality of pharmaceutical services at all levels

Conclusion (1)

- ❖ The project has been able to address the goal satisfactorily.
- ❖ It has been able to address the major access problems and rational drug use in Ruvuma.

Conclusion (2)

- ❖ The overall assessment of the ADDO program by the TFDA, MOH, and local and regional government representatives who participated in the February 2005 ADDO Project Evaluation Workshop is that the project has been a very positive experience and has contributed significantly to improving both access to essential medicines and rational drug use in Ruvuma.
- ❖ MOH/TFDA, recognizing the critical public health role of nonpharmacy retail outlets, is persuaded to approve the rollout of the program countrywide.



THANK YOU VERY MUCH