ADDO PROJECT EVALUATION WORKSHOP

(Organized by TFDA in Collaboration with MSH)

Meeting Record

VENUE: KUNDUCHI WET & WILD HOTEL

DATE: FEBRUARY 22nd – 24th 2005

I. Objectives of the Workshop

A. Common understanding of the findings from the evaluation process of the ADDO Project
B. Agree on explanations for what contributed to differences, changes, and achievements
C. Discuss implications, develop ideas and options to take forward what has been learned

II. Opening Presentations

A. Welcome

B. Opening Address

[See E. Alphonse]

C. Background and Objectives of the Workshop

1. Goal of the Duka la Dawa Muhimu Project

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

2. Why did we choose to work with Maduka Ya Dawa Baridi?

- Very few full fledged pharmacies in Tanzania (~330), 60% located in Dar es Salaam, 40% scattered throughout the country

- DLDBs are the largest network of formally licensed outlets for basic essential drugs (Estimated number was 4600 DLDBs in 2001)

- The number of DLDBs per capita is 50% higher than for all public health facilities and 11% higher than for all public, voluntary and religious facilities combined

DLDBs are often the first and sometimes the only places, people seek care when they are ill

3. What challenges did we face?

- DLDBs had:

Insufficient number of qualified staff
No assurance of drug quality
Insufficient variety of drugs legally available for meeting needs
Stocking of drugs unauthorized by the TFDA

- These problems were exacerbated by:

  Inadequate enforcement of regulations
  Difficulty in finding reliable, legal sources of drugs
  Limited list of authorized drugs

We needed a new approach to working with private sector businesses and we needed new systems to make it work.

4. Why Ruvuma Region?

- Substantial need for improvement in access to essential drugs, transport and communications were feasible, yet it was "representative" of a region outside the main population centers.

- Few pharmacies with lower access to prescription drugs but with a reasonable base of existing DLDBs.

- An infrastructure at village and regional levels existed as part of Health Sector Reform and CHF development that could potentially be used to mobilize people.

- This included village and ward CHF committees (which became the health committees at that level), and the CHF District Board (which became District Health Board).

- Regional and district leadership was reputed to be "keen to bring changes".

Characteristic	Songea Urban	Songea Rural	Namtumbo	Mbinga	Tunduru	Total Ruvuma
No. of DLDBs at outset	**49**	**32**		**17**	**20**	**118**
No. of DLDMs as of February '05	**50**	**25**	**13**	**46**	**17**	**151**
DLDM awaiting registration	**2**	**4**	**2**	**2**	**4**	**14**

5. Did we achieve what we set out to do?:

- Did we improve the *quality of drugs* that people in Ruvuma were buying?

- Did we increase the *availability* of those products throughout the region?

- Did we improve the *quality of dispensing services* from both technical and consumer perspectives?

- Did we do it such that drugs and pharmaceutical services are *affordable* to people in the region?

- Did we do it in such a way that DLDMs are *sustainable*?

D. Findings of the Regulation and Inspection Assessment Study

[See O. Kowero]

E. Overview of DLDM System

Overview of Duka la Dawa Muhimu System

National Actors

PORALG

TFDA

MOH

Categories of Activities

Planning & Resource Mobilization

Coordination (partnerships)

Establish and Communicate Policies, Standards, Guidelines

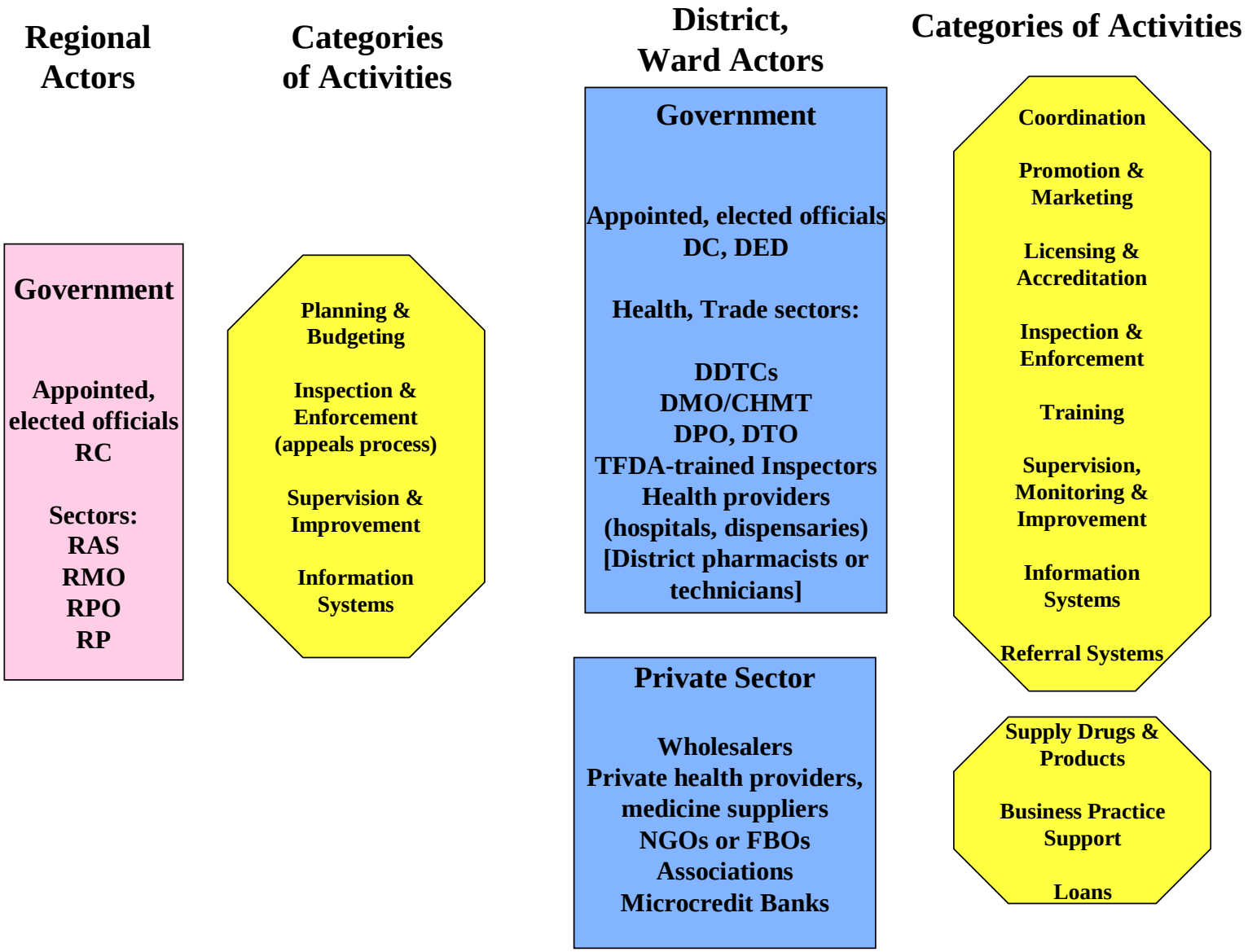
Licensing & Accreditation

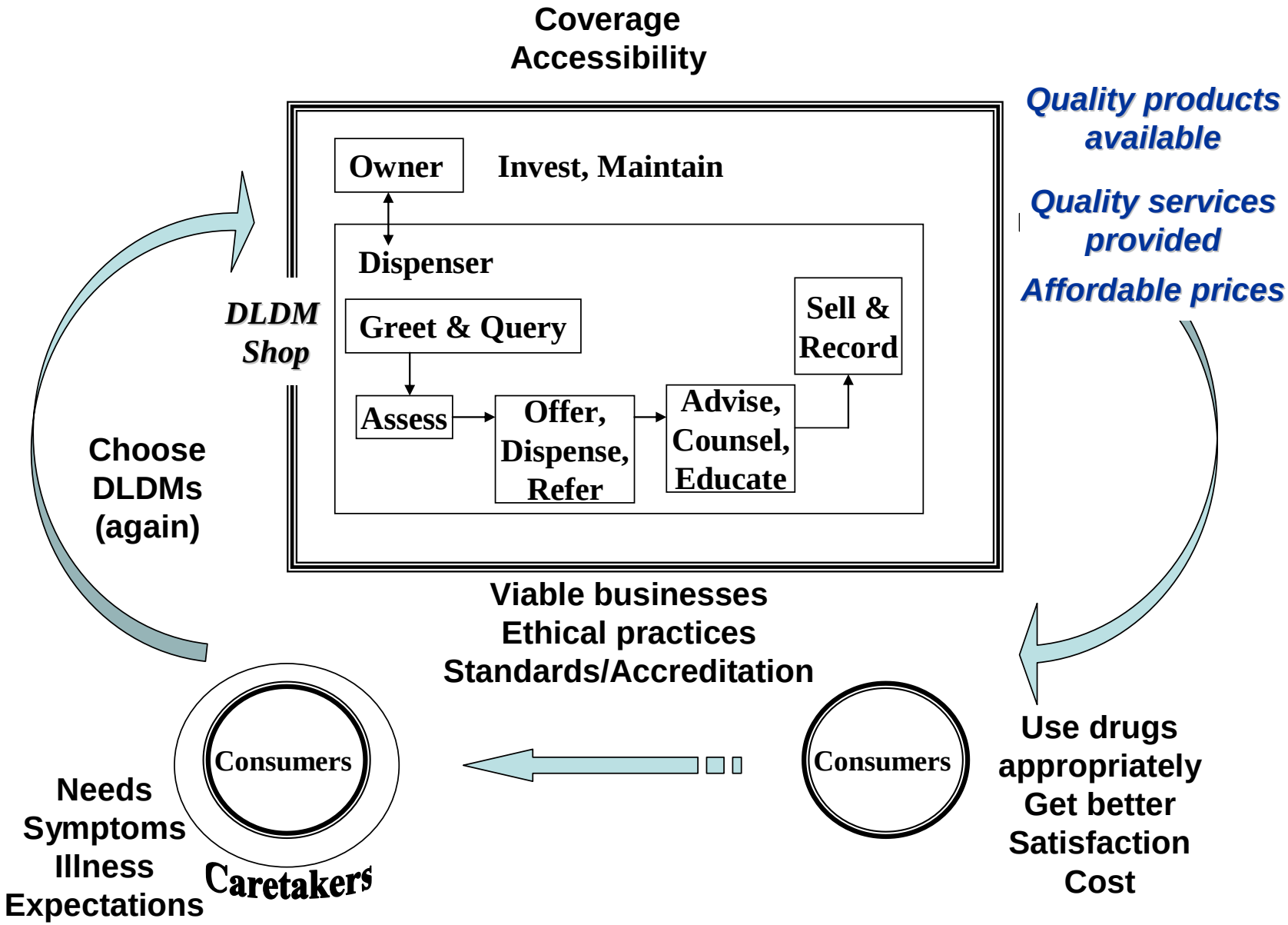
Inspection & Enforcement

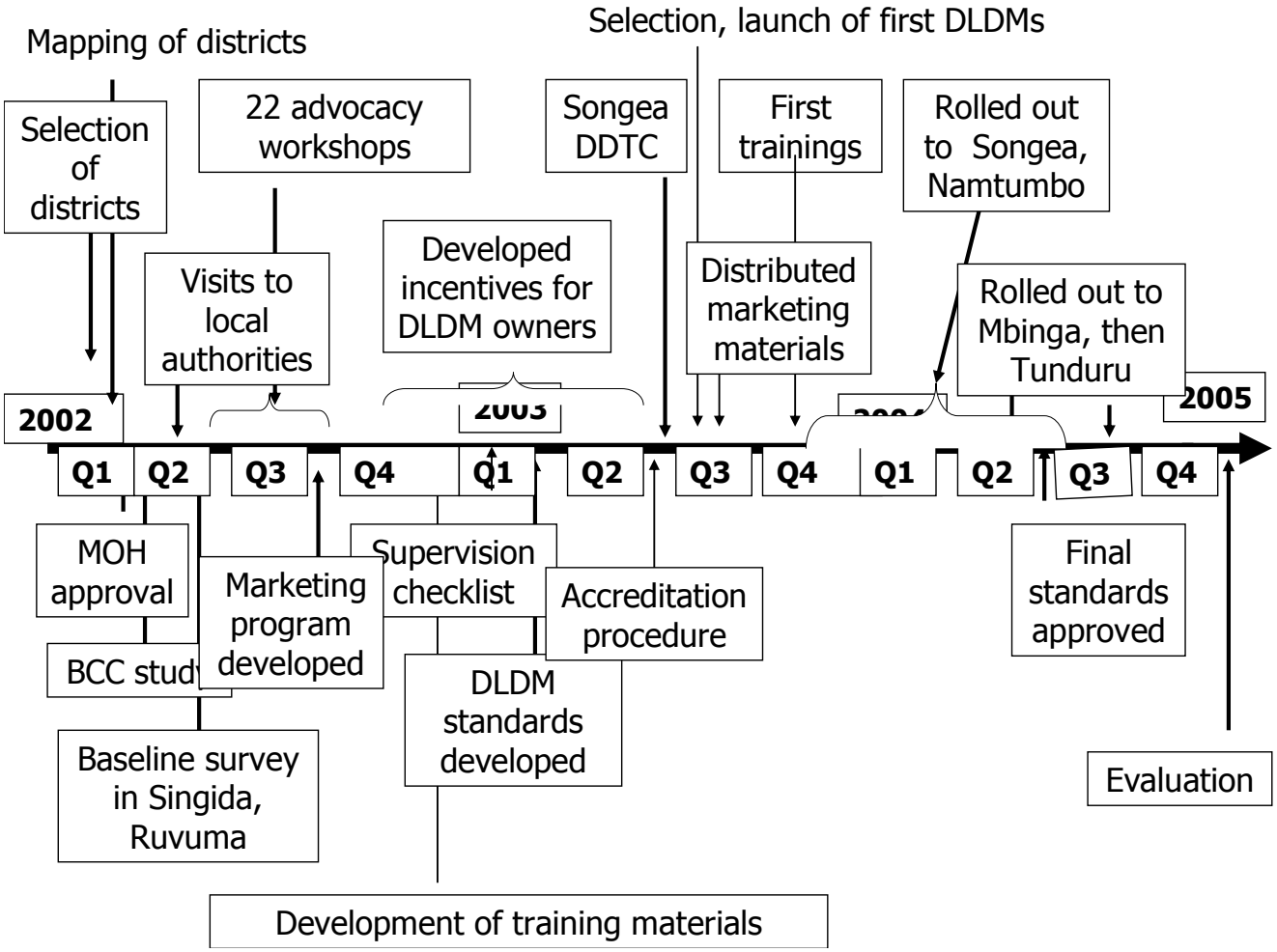
Training

Supervision, Monitoring & Improvement

Information Systems


Regional Actors
Government
Appointed, elected officials
RC
Sectors:
RAS
RMO
RPO
RP
Categories of Activities
Planning & Budgeting
Inspection & Enforcement (appeals process)
Supervision & Improvement
Information Systems
District, Ward Actors
Government
Appointed, elected officials
DC, DED
Health, Trade sectors:
DDTCs
DMO/CHMT
DPO, DTO
TFDA-trained Inspectors
Health providers (hospitals, dispensaries)
[District pharmacists or technicians]
Private Sector
Wholesalers
Private health providers, medicine suppliers
NGOs or FBOs
Associations
Microcredit Banks
Categories of Activities
Coordination
Promotion & Marketing
Licensing & Accreditation
Inspection & Enforcement
Training
Supervision, Monitoring & Improvement
Information Systems
Referral Systems
Supply Drugs & Products
Business Practice Support
Loans


Coverage
Accessibility
Quality products available
Quality services provided
Affordable prices
Owner
Invest, Maintain
Dispenser
DLDM Shop
Greet & Query
Sell & Record
Assess
Offer, Dispense, Refer
Advise, Counsel, Educate
Choose DLDMs (again)
Viable businesses
Ethical practices
Standards/Accreditation
Consumers
Consumers
Caretakers
Needs
Symptoms
Illness
Expectations
Use drugs appropriately
Get better
Satisfaction
Cost


Mapping of districts
Selection, launch of first DLDMs
Selection of districts
22 advocacy workshops
Songea DDTC
First trainings
Rolled out to Songea, Namtumbo
Visits to local authorities
Developed incentives for DLDM owners
Distributed marketing materials
Rolled out to Mbinga, then Tunduru
2002
2003
2005
Q1
Q2
Q3
Q4
Q1
Q2
Q3
Q4
Q1
Q2
Q3
Q4
MOH approval
Marketing program developed
Supervision checklist
Accreditation procedure
Final standards approved
BCC study
DLDM standards developed
Baseline survey in Singida, Ruvuma
Evaluation
Development of training materials

F. Evaluation Process

1. What have we done to evaluate our progress and achievement?

- Reviewed documents and reports from the project

- Conducted studies during the project including:

Mapping and inventory of DLDBs
Behavior change communication study of expectations of DLDB/Ms by shop owners, dispensers, community leaders and members (focus groups, indepth interviews)
Market testing of logo design
Study of a sample of DLDM drug dispensing register data
Study of business practices in Mbinga (MEDA)

- Reviewed monitoring data

  DLDM drug registry records
  DLDM financial records
  Sensitization activities
  Training reports
  Supervision reports
  Licensing and inspection records
  Marketing and promotion activities

- Conducted indepth interviews of key actors in Ruvuma and Dar es Salaam to review project activity

- Conducted baseline and endline sample surveys

Regions	Baseline Districts	Baseline Sample	Endline Districts	Endline Sample
Ruvuma	**Songea Urban Songea Rural* Mbinga**	**70 randomly selected DLDBs**	**Songea Urban Songea Rural Namtumbo Mbinga**	**50 selected randomly out of 69 DLDMs**
Singida	**Iramba Manyoni Singida Rural Singida Urban**	**76 randomly selected DLDBs**	**Iramba Manyoni Singida Rural Singida Urban**	**60 randomly selected DLDBs**

- Surveys included:

  Shop inventories of availability, market approval status, and prices of drugs
  Simulated client visits for malaria and URTI

Exit interviews for satisfaction of clients

- *Participatory analysis and interpretation of end of project findings and monitoring data*

- Final country report

G. Key Results

[SEE HANDOUTS to WORKSHOP]

III. Analysis and Interpretation of Findings: Small and Large Group Discussions

A. Day One: Working Group Assignment

Availability/Affordability of Quality Drugs Group
Service Quality Group
Sustainable Businesses Group

Resources for each group:
Detailed data and information notebook
Participants with experience in Ruvuma
Participants with experience in the project and/or in the MOH
Facilitators who will first present information and then help guide discussions

Discuss the following questions:

Question 1: What are the findings? Explain what they mean.

Question 2: What inputs, factors, processes, or events contributed to each finding?

Question 3: Among these elements, which were the most important, value added, or critical to achieving results?

Prepare the presentation on flipcharts:

1. List the key findings and summarize explanations with bullet points under each

2. Display elements that contributed to the finding in "fish bone" format

3. Circle or underline those that you decided were most important.

B. Availability, Affordability of Quality Drugs Group

1. Discussion of Findings

a. Did we improve the quality of drugs that people in Ruvuma were buying?

Figure 8: (presented earlier)

In Ruvuma, the percentage of drugs unapproved for the local market dropped from 26% to 2%. This is in comparison to Singida where the drop was from 29% to 10%.

Figure 10: When respondents were asked to rate the "quality of drugs" at endline, a higher percentage of Ruvuma clients answered "Excellent" compared with Singida. (28% to 15%) This contrasts with the baseline BCC study which identified "expired" and "low quality" drugs as important consumer concerns.

Conclusion: Something may have been happening nationally but the drop in Ruvuma was considerably more and there is now a very low level of unapproved drugs. In Ruvuma have a 1 in 50 chance of getting an unapproved drug, while in Singida there is a 1 in 10 chance. Consumers appear satisfied.

b. Did we increase the availability of those products throughout the region?

Figure 10: Average availability of all tracer drugs in Ruvuma was 80% at endline as compared with Singida (53%). Ruvuma started out better than Singida (61% compared with 47%) but showed much greater change.

Most of this difference is accounted for by Part I drugs (See accomplishments section). Ruvuma increased from 56% at baseline to 79% at endline as compared with only 4% increase in Singida. The availability of Part II drugs increased slightly in both regions.

Statistical significance tests for availability indicate a mean "intervention effect" in Ruvuma of 13.7 (4.9-22.5). Part II differences were not statistically significant and Part I was 19.7 (1.5-28.9).

Increases were especially marked for Amoxicillin and Procaine penicillin (antibiotics in general in Figure 12.)

Availability of antimalarials is higher in Ruvuma but has increased in both regions.

c. Did we do it such that drugs and pharmaceutical services are affordable to people in the region?

Figure 14: Median prices for all tracer drugs increased 11.1% in Ruvuma and less than 1% in Singida. However, initially Ruvuma prices were 10.8% cheaper than in Singida.

Figure 18 and the one from the accomplishments section: Part 1 drug prices increased nearly 9% in Ruvuma and decreased slightly in Singida. Part II drugs increased substantially but similarly in both Ruvuma and Singida.

Why are there price increases in Ruvuma?

Looked at individual items Table 4 – most of the price differences are accounted for by only a handful of drugs (doxycyline, nystatin in particular) However, running this analysis without doxycycline does not change the overall medians much.

Looked at rural/urban split for endline survey. Figure 17: Prices increased in both urban and rural locations in Ruvuma, but in both cases they started out lower than Singida. Urban prices rose to be similar to Singida levels, rural prices are higher in Ruvuma.

In terms of Affordability:

Figure 20: Full course of Amoxicillin treatment (adult treatment) – same in Ruvuma and Singida at endline. However, prices at baseline were much higher in Singida.

At baseline an average resident would have taken more than 17 hours of work in Ruvuma to purchase, in Singida it would have taken 45 hours. This changed to 18 and 34 hours respectively. (Difference is in HH income – prices are the same).

What do people think? (Satisfaction interviews)

Almost the same rating of prices in Ruvuma as Singida, if anything Ruvuma is slightly better. (Figure 5 in Satisfaction section of notebook)

Qualitative statements – virtually no complaints about price in Ruvuma, some in Singida.

The increase in prices does not seem to be a significant issue to people in Ruvuma. What we do not know is who may not be coming at all to the DLDMs because they cannot afford to pay.

2. Presentation

Quality

a. Did we improve the quality of drugs that people in Ruvuma are buying?

Answer: Yes

Findings – refer to page 9, Figure 8, Table 1

Decrease in % of unregistered tracer drugs from 26% to 2% in Ruvuma and 29% to 10% in Singida.

b. What factors possibly contributed to the findings?

Training of dispensers and owners in Ruvuma
Existence of ADDO Regulations (Ruvuma)
Drug registration
Decentralised inspection and close supervision (Ruvuma)
Availability of reputable wholesaler
Improved drug storage conditions (proper premise set up)
Authorisation of Part I products – decrease in illegal procurements of Part I drugs

c. Among the above elements, the most important, value added or critical are:

Training

ADDO Regulations
Wholesaler
Decentralised inspection and close supervision

Availability

d. Did we increase the availability of those products throughout Ruvuma?

Answer: Yes

Findings: Refer to page 11, fig 10, Table 3 and page 12, Figs 11 and 12

% of available tracer drugs was higher in Ruvuma (61% b/l; 80% e/l) than Singida (47% b/l; 53% e/l)

e. Possible factors contributing to findings

Per capita income is higher in Ruvuma than Singida
Illegal sourcing from well established, privately owned health facilities in Ruvuma and crossing border of Malawi
Presence of a reputable and reliable wholesaler (missing before) enabling stockists from remote areas to get their supplies
Financial support and proper resource management skills as provided by MEDA, including supervision
Marketing campaigns in Ruvuma. Raised confidence in ADDOs in community leading them to buy more from ADDOs
Leaders commitment and involvement at all levels in the region
Establishment of DLDM authorized to handle some Part I tracer drugs

f. The most important factors

Establishment of DLDM authorized to handle some Part I tracer drugs
Wholesaler
Financial support and proper resource management (MEDA – loans and business skills training)

Affordability

g. Did we do it in such a way that drugs ad pharmaceutical services are affordable to people in the region?

Findings: refer to pages 13 – 22, figs 14 – 25, Tables 4 – 8. Prices increased at endline survey in Ruvuma (11.1% in Ruvuma compared to 0.3% in Singida)

h. Possible contributing factors

Cost incurred during transition from DLDB to DLDM
Increased number of dispensers per shop
Cost for covering interest on loan
Purchase of blister packs instead of hospital packs (tins) in Ruvuma

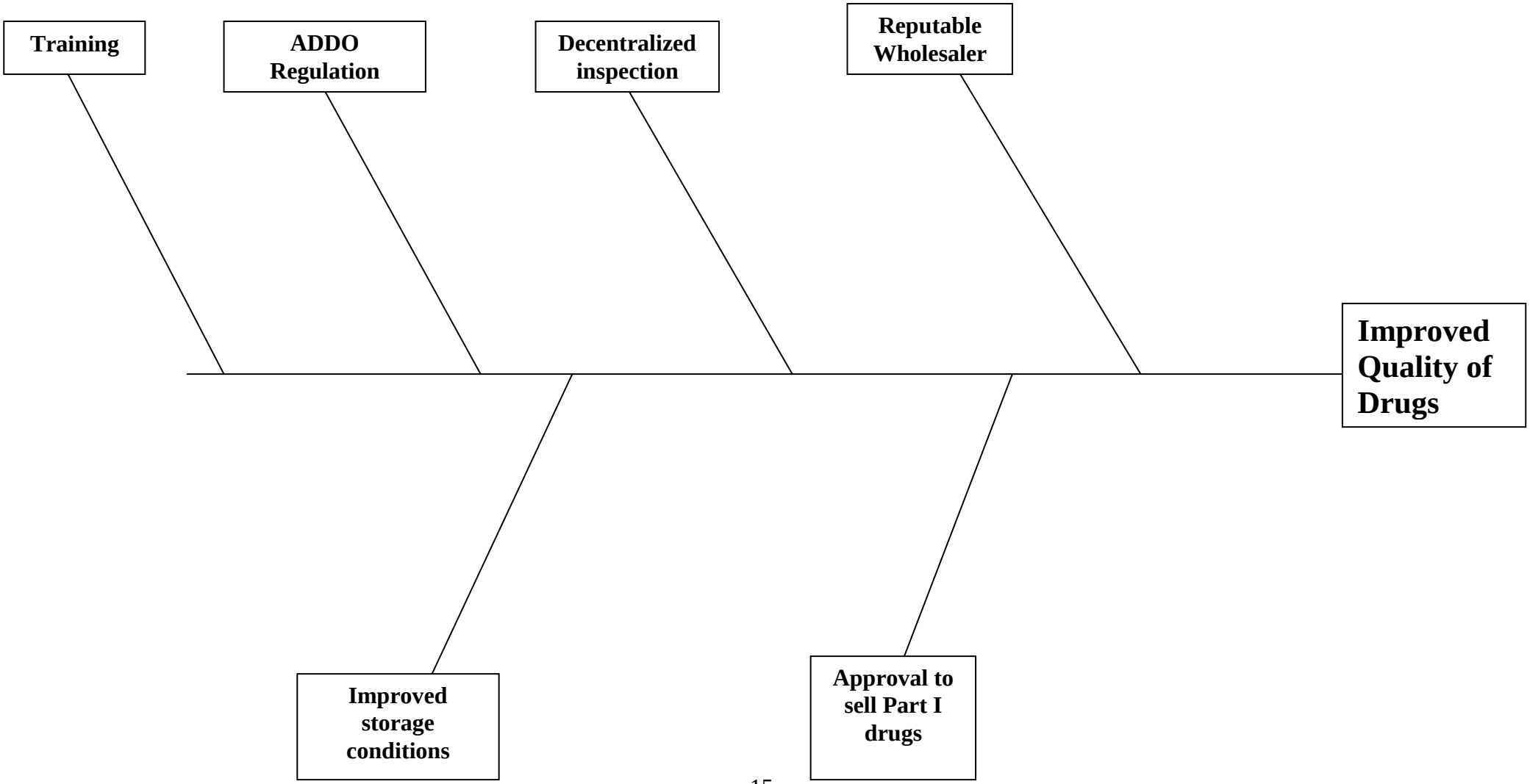
The most important possible factors:

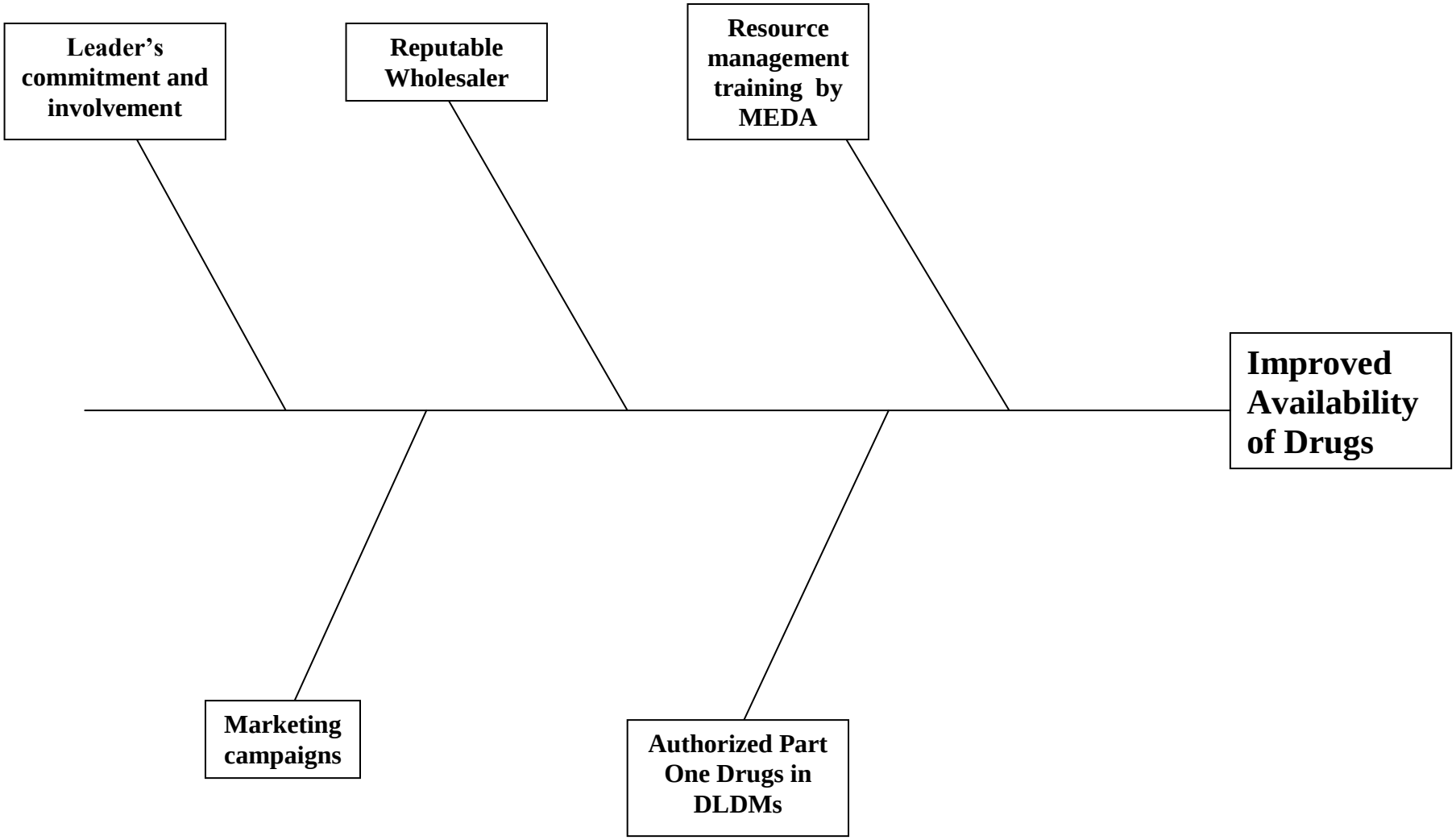
Cost incurred during transition from DLDB to DLDM
Increased number of dispensers per shop

i. Comments on affordability

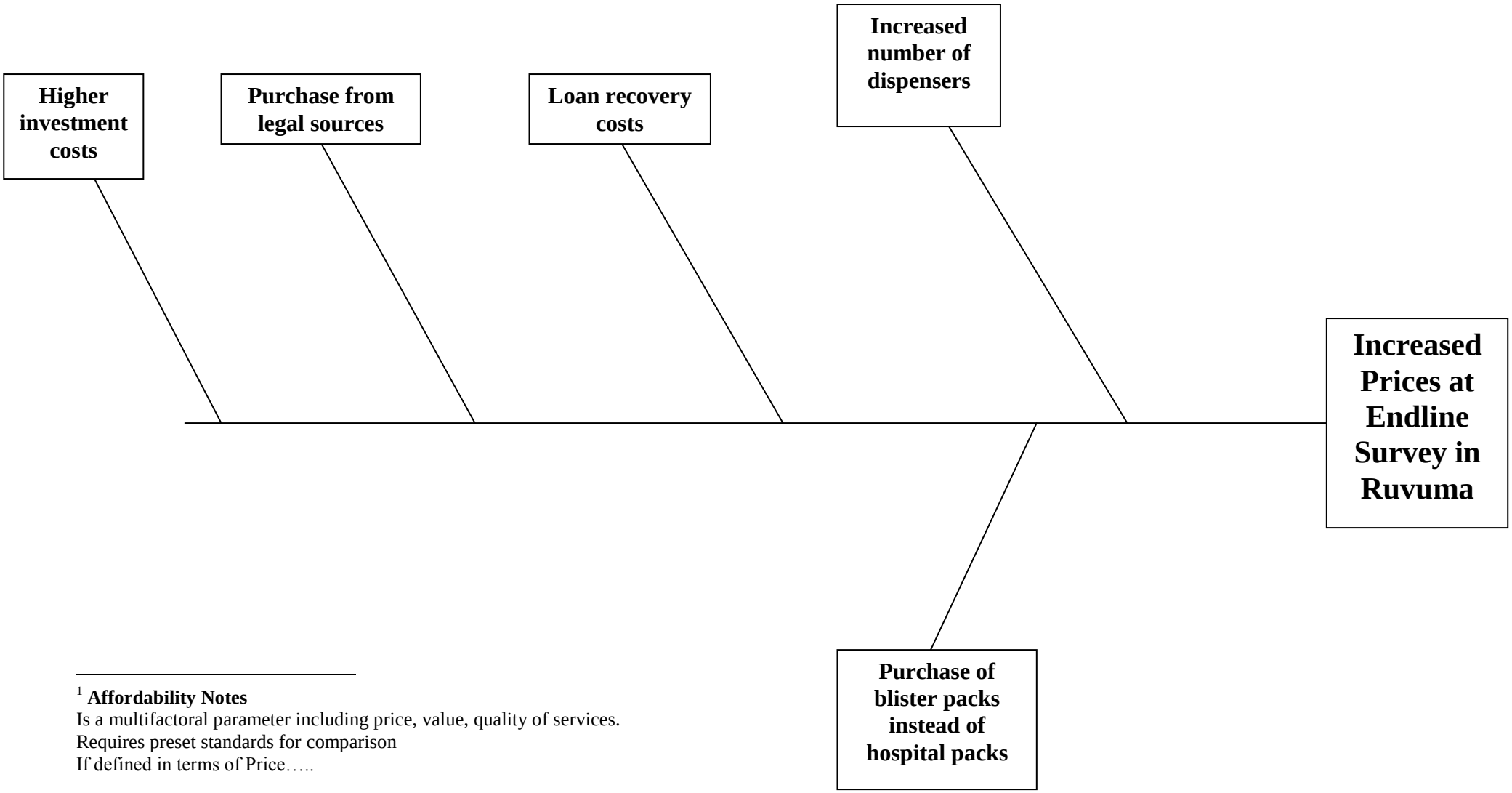
Affordability is a multifactorial parameter
It needs standards for comparison
Can be counted n form of value and quality of services

Conclusion: Prices were fair


Training
ADDO Regulation
Decentralized inspection
Reputable Wholesaler
Improved Quality of Drugs
Improved storage conditions
Approval to sell Part I drugs


Leader's commitment and involvement
Reputable Wholesaler
Resource management training by MEDA
Improved Availability of Drugs
Marketing campaigns
Authorized Part One Drugs in DLDMs

[1]



[1] **Affordability Notes**
Is a multifactoral parameter including price, value, quality of services.
Requires preset standards for comparison
If defined in terms of Price…..

3. Discussion, Questions, and Comments

a. Investments are high in Ruvuma. Considering this, prices did not rise substantially. Ruvuma did well. Owner commented that you have to maintain prices or you drive people away.

b. Do we know if there is a problem with affordability from consumers perspectives? Answered with satisfaction ranking question (more people in Ruvuma think prices are good than in Singida but pretty close – would indicate not a major complaint among people coming to DLDMs). Also price is not significantly different in Singida than in Ruvuma.

c. Prices similar across Tanzania

d. Did supervision/inspection contribute to availability at DLDM?

e. Affordable – we need more information and different comparative data

f. Dispensers from Tunduru – will they stay after contracts end?

g. Raising prices is not easy. Market conditions/competition prevent that. Investments can't be easily passed on through price increases

h. Look at national market prices. ADDO prices are very similar to those/ Prices in Ruvuma have settled around national market prices by and large

i. Can't recoup investments all at once. Spread over time.

j. Referring to Satisfaction Survey data: In Ruvuma, 5% thought prices 'excellent', 58% 'good', while in Singida, 3% said excellent and 43% said good. This is an indication that price is not a major concern for customers in either region

k. Also noted that Ruvuma price rises were not statistically significant

l. It was noted again that price is not a good indicator of affordability. Product price is not the only consideration for customers (also service quality, product quality, etc.)

C. Service Quality Group

1. Group Members

S.S Kalembo (Chairperson)
M. Ndomondo-Sigonda (co-chair)
Mbwasi (Facilitator)
G. Mtawali (Co-facilitator)
Malisa (Reporter)
Busuguli (Reporter)
Malekela
Kimolo
Mshimba
Frank Samwel

M. Kinyawa
H. Irunde
Marsha
Budotela
Katenga
Kissa

2. Discussion, Questions, and Conclusions

a. Handling of patients, properly:
- Correct Questions asked
- Drugs dispensed straight /information given
- Right dosage?
- Right Drug?
- Right patient?
- Right Frequency?
- Right Duration?
- Right Diagnosis?

b. Key Findings

i. In dispensing antimalarials, the following was observed:

Awareness among dispensers: The ADDO dispensers hesitate to dispense antimalarials (Ruvuma: 80% to 68% while Singida: 82% to 87%)

Awareness of existence of Referral systems (Ruvuma: 13% to 30% while Singida: 14% to 13%)

ii. What contributed to the above findings?

ADDO training made dispensers abide to ethics
Community awareness brought by advocacy
Education imparted to the community as a consequence of ADDO training

In malaria case management, in dispensing antimalarial or referral:

Ruvuma: 86% to 98% while Singida: 94% to 98%
Significant increase observed in Ruvuma as a result of ADDO training while in Singida they had already been an ongoing malaria awareness campaign

iii. Areas Looked Into:

Handling of Patients
--Reception
-- Questioning
--Instructions on correct use
-- Patients knowledge at exit

Assessing the technical part of the dispenser

Observation of the six rights:

Right patient gets
Right drug for the
Right diagnosis in
Right does in the
Right frequency for the
Right duration

iv. Percentages in the baseline and endline were compared between Ruvuma and Singida using Malaria Simulated Client and URTI Simulated Client.

v. Findings from Malaria Client

Any drug dispensed:

Ruvuma 80→ 68% = 12% decrease
While Singida had 82% → 87% = 5% increase

Referrals:

Ruvuma 13% → 30% = 17% increase
Singida 14→ 13% = 1 % decrease

Why?

Awareness of dispensers as DLDM: where not confident, they refer in Ruvuma. In Singida there may be less hesitation in giving drugs.

Might it be a consequence of training with emphasis? They should never delay malaria treatment. However, if they are not confident, they may refer to avoid uncomplicated malaria going to complicated malaria. However, the higher percent of referrals may also be due to the way the simulation was presented. It was possible to mislead dispensers for a different condition.

Ruvuma dispensers abide more to ethics and there may be higher community acceptance to go when referred. This implies that the community in Ruvuma may be more aware and understand the benefits of referral. Is this an outcome of ADDO advocacy and marketing?

However, the changes seen in treatment/referral are not enough. There needs to be more emphasis in the future on training in this area.

Giving antimalarials according to STG:

Ruvuma 6% -- 32% , 22% increase
Singida 22% -- 25% , 3% increase

Improvement in all cases.

However more in Ruvuma → training

Shift in Singida is due to malaria campaigns

Figures still low in both → More efforts in training in the future to emphasize communication between patient and dispenser (better recognition of symptoms, instructions on how to take meds, etc.)

First line SP dispensed according to STG

In both regions there was an increase but it was slightly higher in Ruvuma. This is likely to be due to training. For Singida it may be related to outcomes of the malaria campaign that was conducted. But both regions figures are still too low.

Second Line Amodiaquine dispensed according to STG

There was a slight increase in Ruvuma and a slight drop in Singida. In Ruvuma, this may have been due to dispensers training. For Singida, the drop is due to dispensers moving out and employing new dispensers who may not have received input from the malaria campaign.

Third Line Quinine Dispensed according to STG

No region dispensed quinine according to STGs . There is a problem with the 7 days course due to severe side effects and difficulties with compliance. WHO has advocated a combination of 3 days of quinine plus one day of SP to cope with this problem. It is possible that dispensers were using WHO regime rather than the STG regime.

Antibiotics Dispensed with Antimalarials

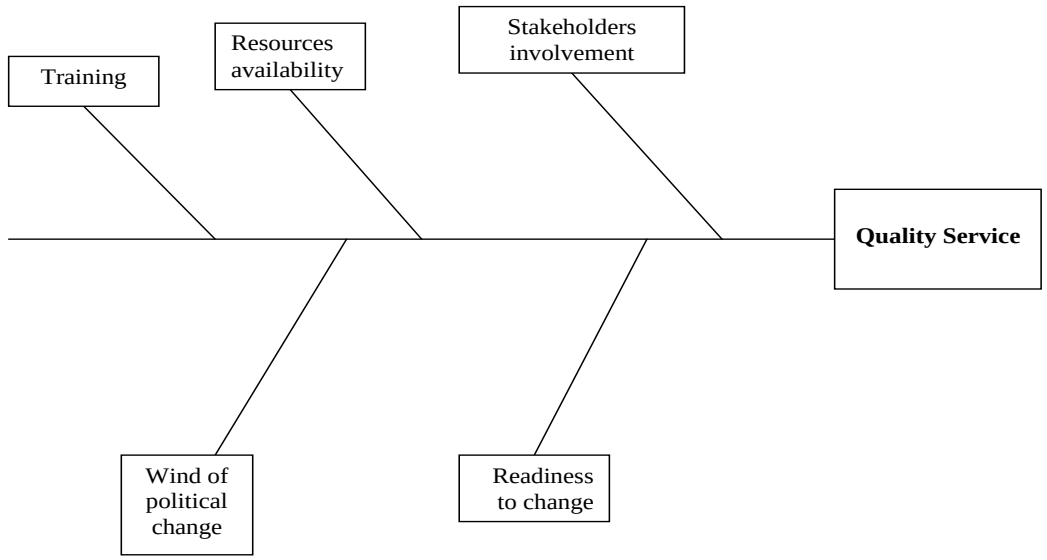
In Ruvuma at baseline it was 4% and at endline was 0%. In Singida, it was 12% at baseline and this decreased to 5%. Malaria cases are not supposed to get antibiotics. Singida is still dispensing them. Ruvuma is better as a consequence of training

vi. Findings from URTI:

Awareness of the use of antibiotics (from Table 15, p 32) A drop in percent shows that ADDO dispensers at the endline, knew which drug is supposed to be dispensed according to the symptoms given. Per STG, there were 75% correct in ADDO and 36% correct in DLDBs.

The ADDO dispensers were asking questions about which medications were being taken before dispensing anything new. There is evidence that they were asking both: Probe questions and pre medication of a patient

Dispensers giving instructions about taking medications was better in ADDOs than in DLDBs in Singida. This was also true for instructions on how to look for danger signs. In ADDOs, there was a tendency to refer or give referral instructions



3. Questions and Conclusions

a. Where is inspection? It is in monitoring and supervision.

b. What was happening in Singida that may have influenced the findings? There was a nationwide malaria awareness campaign. So both Ruvuma and Singida may have experienced some decrease from that. Ruvuma was probably able to distinguish the cases (malaria vs needing antibiotic). National Roll Back Malaria day will be celebrated this April and Singida is one of the focus districts. (so preparations have been going on)

c. Were there prescriptions? Simulated clients do not have prescriptions. This is one reason why DLDMs were created, because despite not having prescriptions, people come for medicines. But dispensaries are expanding and first line drugs must be available at the community level. However, WHO studies say that 80% of the people obtain their drugs from local sources such as shops.. We are addressing reality by working with DLDMs.

d. Did Singida know they were a control and was there behind the scenes activity? This is unlikely to have made a large difference. When we have problems, it is better not to stick to just the books. We must go see how to solve the problems so people in rural areas get the same benefits as those of us who have easy access.

D. Business Practices and Sustainability

1. Discussion and Conclusions about Findings

Observations: DLDMs are sustainable businesses. Why?

- Making Profit
- Wholesale being nearby
- Acceptable by Society
- Frequent Inspections
- Access to Loans

- Expansion of Drug list
- Business Training
- Unfair Competition is not allowed

a. Evidence for making profit

Average Profit is 50,000-65,000 STH per month
No ADDO has run bankrupt
More applications become ADDO
All Mbinga
Business owners cited 91% increase of Profit as a benefit

b. Wholesaler being nearby

Easy accessibility
Reliable and Affordable
Supplies Credit

c. Acceptability by public and government support

Quality Services from Dispensers
Marketing Strategy by the Project
Availability of many varieties of drugs
Consistent number of customers every month

d. Frequent Inspections

Evidence from page 8 assures quality services to customers
Decentralization of regulatory services

e. Access to Loans

Able to purchase more stock
Able to support other commitments (e.g., buying farming inputs)
Reason: Keeping Capital in place increased from 3% to 23% means "sufficient financing"

f. Expansion of Drug List

Meet demand of customers
96% of owners cited expansion of drug list is a benefit
They make more money on Part I drug

g. Business Training

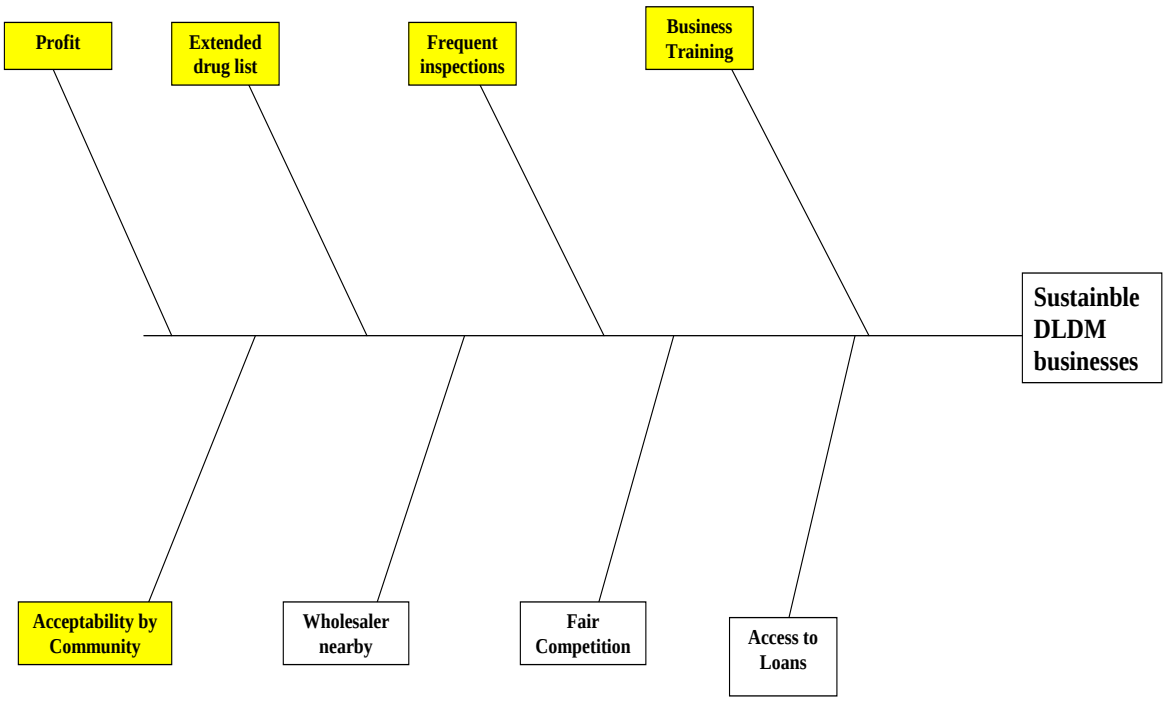
Able to assess profitability
Able to manage business
96% cited business training has a benefit
Improved customer care
Regular supportive supervision/consulting

h. Competition

Unfair competition is not allowed
Effective enforcement of regulation
Controlling / providing license according to distance and population

i. Challenges

Insufficient supply of trained dispensers
Improvement of health services – competition??
All new applicants need to be trained in order to be accredited
Continuous public education (mass)
Insufficient wholesalers especially in Tunduru (hard to access areas)



2. Questions

a. How do you maintain the pool of dispensers in a region (given who gives certificates and potential for mobility)? This is a challenge. How do we train them? What are the roles of training institutions, ZTCs, etc.?

b. Why is profitability, wholesaler availability not ranked as key contributors? We should look at these again

c. Challenge of providing loans in other regions? What is the role of MEDA? What they have done in Ruvuma is to first help owners to become "good borrowers" then turn them over to the NMB.

d. There is a consistency of customers every month. How could this be? They are not necessarily the same people, number of customers is the same and perhaps increased.

e. 96% of owners say "did not get benefits they expected" What is the effect of this on sustainability?

f.. Challenge of pools of people who can be trained in these rural areas. There is an insufficient supply of trained dispensers. To TFDA: how can a pool of trained dispensers be maintained in all regions? What is to stop certified dispensers leaving remote area for urban areas like Arusha? Pharmacy Council needs to discuss dispenser issues.

g. Wholesalers are still not conveniently located for all parts of region.

h. Loan conditions and interest rates at commercial banks are burdensome. Question to Meda: how can access to loans be assured during a roll out?

i. The wholesaler service is very important, especially for Tunduru.

j. Why did group not consider profitability a key factor for sustainability? (should be considered)

k. In Singida DLDBs have malaria treatment posters on wall. This is evidence of campaigns.

3. Conclusions

a. Main factors contributing to improved quality:

Political reforms – health sector and local government reform
Involvement of stakeholders
Monitoring, supervision, inspection
Recognition/professionalisation of dispensers
Training
Availability of resources
Community involvement
Marketing
Incentives to owners
Meeting community expectations

IV. Panel Discussion of Experiences with Implementation

A. Strengths

1. Participatory approach (involved political leaders too)

2. Professionals doing supportive supervision

3. Leadership teaming up

4. DCs do practical/applied work also (inspectors)

5. Very fair DDTCs and decision making

6. Involved all stakeholders from the beginning (owners, leaders, dispensers, consumers)

7. ADDO regulations – decentralized inspection, licensing, etc – are clear

8. Dispenser training

9. Ability to "transcend" bureaucratic systems

10. Sensitized everyone

11. Respected what came from the local level (eg DLDM name)

12. Worked to be accepted by all levels

L. What is the Vision for the Way Forward?

V. Vision for DLDM

A. Vision for Ruvuma

1. DLDM in every village

2. DLDM abiding to regulations

3. A reputable wholesaler in every district

4. Sustainable systems in Ruvuma (in 2 years)

5. Ensure wide community awareness

6. Ruvuma DLDM program is Centre of Excellence

7. Good dispensing practices

8. Continuing education for dispensers in place

9. All ADDO/DLDM integrated in Council Health Plans

10. A community enjoying quality life free from manageable diseases at DLDM level, with strengthened referral systems

11. Consider being realistic

12. Chairman, Secretary of DDTC position placed outside current practice.

B. Vision for Tanzania

While redefining the vision:

Avoid vertical approaches
Consider current strengths and constraints
Rolling out will need to be in phases

1. Integrated system

2. National policy for establishing ADDO in rural, peri urban set up with no pharmacies

3. A well regulated pharmaceutical system

4. In five years, Tanzanians have integrated DLDM into their culture and day to day activities.

5. Tanzania ADDO is a center of excellence for other countries.

6. Enough public and private sector pool of human resources to manage pharmaceutical services country wide

7. All DLDB become DLDM for peri urban and rural areas.

8. Regulation that controls mushrooming of DLDMs in limited areas

9. ADDO program becomes fully fledged business (sense of ownership well perceived)

10. DLDM dispensers absorbed in the hierarchy so they are recognized in system as trained manpower

VI. The Way Forward: Planning the Specifics

A. Working Group Assignment

1. If the objective is to roll out the DLDM Program to all regions of Tanzania in ten years….what will it take to do it?

What scale and complexity are we talking about?

More than 20 regions
Perhaps 120 districts
75% rural population

More than 4,500 duka la dawa baridi shops

There are +/- 330 pharmacies -- And 60% of those are in Dar es Salaam, 20% in Mwanza, Arusha & Moshi

You will need to work with government institutions including the MOH, TFDA, PORALG, , Regional Administrations, District Councils, Ward Development and Health Committees

Regulation Group
Training & Continuing Education Group
Supervision, Monitoring & Improvement Group
Supply, Marketing, & Business Support Group
Promotion, Sensitization and Political Support Group
Coverage & Roll out Choices Group
Resource Mobilization Group

2. Consider and Discuss:

a. What and how will this be different than Ruvuma? (What context or environment do you need to take into account?
b. What will you need to do?
c. What will the challenges be?
d. What are the *options* for addressing the challenges?
e. What resources will be needed?
f. Where might they come from? (Consider all levels including central, local, NGOs, donors, private commercial sector, individuals)

3. Presentation:

Bullet list of what you need to do
Table of challenges with options for addressing each of them
Table of resources needed with potential sources

B. Discussions, Plans, and Resources

1. Regulation Group

a. Establish, train, supervise, monitor DDTCs and RDTCs.

There won't be any differences as regulations for appointing these committees at district and regional level are the same.

Challenges	Options
Composition of the RDTC	Include RHO (health officer) Include member of the community
DDTC	Include DHO and utilize CHMT/DHMT for support

Resources: People, finance, might come from Local Government

b. Establish dedicated department/section at TFDA for oversight, monitoring of DDTC and RDTCs.

Ruvuma no such department – assignment was good to one person only.

Dar es Salaam: At the TFDA. No particular department or section for such monitoring
Have to establish a section at the TFDA.

Need resources (human, space, financial).

Challenges	Options
Communication, information (chain of command)	Improve the chain of communication

c. Train and deploy inspectors in every ward where there are shops.

Ruvuma and Dar there won't be differences at ward level
But in Dar, find competent inspectors.

Challenges	Options
Inspectors should be trained in all wards and not only in areas where there are shops. Why? Because in the future the establishment of shops might need those inspectors.	Contract out inspection to a reputable institution Inspectors team should include any other personnel who is not in the government system but knowledgeable in health matters and inspection

Human, financial resources needed:

Private, commercial sectors
Central government
Donors

d. Set up reporting and administrative systems for ward to district to regional to national level.

In Ruvuma, the flow of information and administration systems are vertical. Sometimes there is a bypass over levels.

Challenges	Options
Problem in sustainability of this kind of set up	Currently this system should be integrated (including all levels) Train and deploy pharmaceutical techs. Might put them into district level Establish a section for conducting this system

Resources needed: human, financial, time, raining

Come from: Community if can create appropriate stakeholders that will …. Written a potential/?

Donors, commercial private sectors, government

e. Budgets developed and approved for ward, district, regional, and national regulation.

This is not currently an existing system. Establishment of needs for budgets in terms of activity. Must first identify the needs for budget at various levels.

Challenges	Options
Source of funds	Incorporate appropriate budget in all levels

Resources:

Financial, Working tools
Donors, central, local government

f. Discussion

i. Would there be a need for an "ADDO Security force?" (Query about outsourcing inspectors.) We have seen this happen. It's an alternative. A good example of contracting for inspection is Zimbabwe. They do it there and there are many countries doing this. Organizations which have the same interests like the government. The TFDA could just be doing the auditing. One would have to appoint them inside the law. Have to give them all necessary powers. How will you control them? I don't have answer to that question but it should be given thought. We are trying to outsource several things. Perhaps that is one of the things that might be considered.

ii. All the time talking about donors, donors, donors. If donors are not there what will you do for resources? "ADDO is essential to our life. If you put too much dependence on the donors…"

iii. There is no verticality in this project. No one can go to Ward to Region. Have to go through Ward go to the District, and so forth.

iv. Councils are not allowed to levy everything they want to. Last year a lot of levy's were passed over. Told specifically not to charge them. The sources of funds at local government are actually quite limited. We should be careful because we might commit someone who doesn't have control/authority.

2. Training & Continuing Education Group

a. Observations about Ruvuma

i. Resource personnel were hired from outside
ii. Limited region of outlets in Ruvuma
iii. Organization of the training was done by the project itself

iv. Cost for training the dispensers & owners were met by the project (stationeries, pocket money, transportation, accommodation, foods)
v. Community of Ruvuma had less resistance (culturally)
vi. Majority of owners in Ruvuma have less political/government influences and authority
vii. Economical ability of owners in Ruvuma is low, hence difficult to contribute for training, rehabilitation and other investment costs
viii. Most of shops in Ruvuma are situated at rural or peri-urban area and in poor environment.
ix. A limited base of candidates for dispenser training.
x. The project were not able to embark on continuing education in Ruvuma

b. Challenges, Options and Resources

Challenges	Options	Resources	Sources
Huge training needs / High training cost / Cultural environmental changes / Readily human resouces not available for training such huge group	ZTC, Training institutions, hire individuals	Funds, Human	Government, donor, private, NGO, Private company
Large # of DLDBs	TFDA to establish a special regulatory criteria for accredition in urban areas / High competition	Human, Funds	TFDA
Beaurocratic system of the government / Readiness and commitment of assigned institution for training / Centralization of examination	Extensive sensitization and involvement of the leaders in every step of implementation	Human, Funds	Government, donor, private, NGO, Private company
Variation of economical capability of the owner / Setting different requirement in sharing training cost ; applicability of who should be supported and who should not	Cost for the training to be contributed by owners ; Government, donors to support economically weak area ; set clear criteria for who should be supported and who should not	Funds, Human	Government, donor, individuals, NGO, Private company

To face the cultural and behavior changes	Detailed BCC(behaioral change communication) studies to identify behavior and cultural differences ; Training ; Mass media sensitization	Human, Funds	Government, donor, individuals, NGO, Private company
High probability of political and government interference of the process	Strong sensitization of leaders at all levels ; Participatory approach by all stake holders at all levels	Funds, Human	Government, donor, individuals, NGO, Private company
Some areas have less favorable trainig environment	Centralization of training	Funds, Human	Government, donor, individuals, NGO, Private company
To develop an continuing education which suits all groups ; Disseminating training materials and providing feedback ; Cost of organizing and implementing the continuing education	To share the cost at defferent levels eg. include ADDO in CCHP ; Assign special team to develop training materials after need assessment	Funds, Human	Government, donor, individuals, NGO, Private company

c. Plans

i. Identification of who and how the training is going to be carried out
eg. who – ZTC, Training institutions (public and private), hired individuals.

ii. In order to meet the realistic number according to needs, the TFDA should establish special regulatory criteria for accreditation in urban areas like Dar or similar cities which in turn will minimize the number of trainees to a reasonable number of dispensers. This will depend on who will organize it. Organization will be done by TFDA but the training will be carried out depending on who is appointed by TFDA as responsible for that.(eg, ZTC, Pharmacy council, Training institution)

iii. Any examinations must be done institutionally under the supervision of the TFDA.

iv. Need to identify the cost for the training (materials, cost for dispensers & trainer)
Cost should be subdivided. Depending on the place and demand, the cost for the training can be contributed by the owner (material, dispenser and trainer) It is not necessary to centralize their accommodation depending on the environmental conditions in which they stay. They can be attending on a daily basis from their home

v. Identify the educational level of the group and train them in groups according to their educational level.

vi. Develop continuing education material centrally, then send it to DDTC for distribution to dispensers. On a specified date attend a quiz, get feedback and those weak areas identified must be discussed in a one day session.

d. Discussion

i. Continuing Education is difficult. If material is flowing freely all the time, people see no value in it. So asking for a minimum payment for it will make it more valuable. We talk about "quizzes", not examinations. Look at the results quickly and give feedback. Take more time to explain issues where they are still very weak.

ii. Point of clarification: The cadres for nursing assistant are no longer recognized by the government. So in the future they may not be there. It would be more appropriate to refer to them as medical attendants. If you look at the list there are many and some don't have background in training. Regulation is clear that the nursing assistant has had a year of training recognized by TFDA or government. So this gives us a demarcation or a minimum level of qualification we should look for.

iii. What is most important is supporting them to think whatever their basic qualification is – what in the characteristics, attitude, knowledge, skill is the basis for training them as dispensers? When we do that we will forget about the names. We will know what helps the training of the dispenser. When we set our standards – need them on a broader level. Standards for training, supervisions, matching with accreditation. Need to define where we want them to be to start.

iv. There need to be a set of basic skills and knowledge of dispensers. When talking about training, need some entry inclusion and exclusion criteria. As we roll out, find some highly qualified (NMs, retired pharmacists). Do we need them to join the training? Otherwise we risk training people what they already know and incur extra cost.

v. Training is both formal and informal. Informal training involves private reading by dispensers and owners. The TFDA or MOH should make translations of ADDO regulations so everyone can understand it. (Will be done)

vi. Which institution is responsible for training? The Pharmacy Council is responsible for good pharmaceutical practices – this includes dispensing practices. For the Pharmaceutical Association, one of roles is to encourage good practice. TFDA cannot be the trainer and the regulator (conflict of interest). But ADDOs are the "baby" of TFDA. The responsibility of the TFDA is to say we've brought this baby here. The Pharmacy Council and Association sit in the same compound. TFDA has to do the handover.

vii. We know in Dar es Salaam we have COs, NMs, etc. who do not have jobs and they are working in DLDBs. We don't want to train them in the same fourteen day content. We need to match what they know with what they need to be trained in.

3. Supervision, Monitoring & Improvement Group

a. Assumptions

In rural areas there are scattered families, poor infrastructure, agricultural activities, and a relatively poor economy.

In urban areas, there are more small scale businesses, slightly higher income, infrastructure is somewhat more developed, high density of population, relatively higher income depending on employment and business

b. What and how is this different than Ruvuma?

Dar es Salaam is highly developed, lots of competition, health facilities, and pharmacies so it will need closer supervision and monitoring compared to Pwani which is more or less like Ruvuma..

c. What should we do there?

i. Need to have integration of supervision and monitoring in health plan in all levels.

ii. Adopt/adapt tools for supervision and monitoring
-checklist
-training manual
-indicators and standards

iii. Identification /selection of community level supervisors. Then they need to be trained on checklist and how to use it during sensitization and advocacy.

iv. Training of village and ward level supervisors on supervision and in use of checklist.

v. Development of a well scheduled and simplified reporting system.

vi. Need to harmonize the trainers who train the supervisors to work together in the initial stages. Harmonize supervision by trainers with expected community supervisors.

d.. Challenges and Options

Challenges	Options
1. More competition in urban areas than in rural → violation of regulations will be greater because of intensity and desire to make profit	Close monitoring and supervision Encourage feedback and suggestions from clients
Existence of ADDO pharmacies and pharmacies in urban areas	ADDO to be restricted to peri urban and rural
Inacceptance of ADDO activities in CCHP – initially expect some resistance	Thorough sensitization of issue and advocacy

e. Resources needed

Resources	Sources
Financial resources	District funds NGOs and donors Community initiatives ADDO owners contribute to their own program
Human Resources	Community itself (supervisors) Also need manpower from existing health system RHMT, CHMT, higher levels
Material Resources -checklists -manual -standards -transport	CHMT, RHMT, Central level of government Donors, other NGOs
Time	ADDO need to be incorporated in whole health plan so ADDO is part of whole time for it

f. Discussion

i. Group suggested to avoid competition between pharmacies and ADDO, restrict to peri urban and rural areas but this is not the spirit behind the introduction to ADDO. It's my feeling that competition should be left to continue. It has positive elements – efficiency and effectiveness. ADDO should also be in urban as well as peri urban areas. Also have a concern regarding have DLDM in urban areas especially Dar es Salaam – cannot demarcate the peri urban. We are thinking of having DLDMs where other facilities are not available. Could be a good contribution if we have DLDM in urban areas. For the case of Dar es Salaam where pharmacies are, I don't see importance of DLDM rather than looking for extra profit for those owners. Transport possible to get full service from a full service pharmacy. When really far away, no pharmacies, it really has an impact.

iii. First proposed for rural and peri urban areas. When we move to other regions we should concentrate where there are no pharmacists. DLDMs depend on DLDBs. When I move around Dar es Salaam there are many DLDBs. They are not going to exist? Do we think that? There are many in Dar es Salaam. What are you going to do about this?

iv. You have reminded me a similar problem. We should appreciate that in most TZ communities, our immediate past is a primitive past. I say this in order to emphasize the cultural situation. Where abject poverty is the order of the day. The quality of life, people not sitting on couches and sleeping on modern beds but rather than sleeping on mats of reeds. Some of us, although the life is changing but still we have hangovers of this primitive culture. Could be carried even to the dispensers. It's not something very bad for a primitive person to take tablets from a bottle in a pharmacy and put them in a hand. There is a need to build this new culture even in the dispensing business. Its why supervision, monitoring, inspection are very, very important for the success of this program. Remember my personal experience – when I first drove, I had an old car without a seatbelt. Used to not using it, new car, police stopped him, now he uses his seatbelt. It's an educational operation.

v. Group needs to highlight good dispensing practice.

vi. Two things seem to worry me. How big is Dar es Salaam? What is the population which lives in lesser circumstances that in Songea. That's the population. That's where people live. And it is miles away to the center. So when look at DLDB in Dar es Salaam – which Dar es Salaam are you referring to. We should map it. Where can DLDM be justifiable and where not? Not just say no DLDMs in Arusha, Moshi, etc. Otherwise we will say just say no service, there is no need without paying attention to services that ARE really needed. We should know how the environment is, then solve the problem. If you look in places where we have DLDBs, they are in the center. We can see them in the periphery also. We have all these DLDBs – what are you going to do with these shops? If you don't bring in an alternative? You think you can close them without an alternative? So we shouldn't think we have solved the problem. This is going to come back on us.

vii. We should look at Dar es Salaam as peri urban, rural, and urban and decide where DLDM fits.

viii. When we mentioned standards we have to do more – manuals that explain how you should be, what you should do. So it was not detailed but we think there is a need to have supervision standards which are in the regulations for QOC. We even need to define quality. We are not proposing we are going to develop a new checklist. We are going to adapt one.

4. Supply, Market, & Business Support Group

a. What should we be doing?

In urban areas:

i. Encourage development of wholesaling in local areas. We might appoint, locate a few wholesalers who will be dealing with ADDO owners in each location.

ii. We can find special products which will be obtained in the DLDMs only. For example, nets for pregnant women, HIV/AIDS packages.

For both urban and rural areas:

iii. Can negotiate with government for favorable tax rates so they can compete and reduce costs for initial investments

iv. Increase the drug list base so that they can have more sales in these competitive areas.

v. Important to provide intensive training, more long training for dispensers to compete with pharmacists

vi. If possible, these ADDOs should refer to appointed pharmacists to increase relationship with them.

vii. Monitoring of both appointed wholesalers and ADDOs in the area of product purchase.

For rural areas:

viii. Facilitate strengthening of market mechanism to provide wholesaling service to ADDOs in all regions.

ix. Sensitize dealers of pharmaceuticals to see the importance, hope of opportunity to open wholesale outlets where ADDO will be introduced, Raises awareness.

x. Regional authority can establish a conducive environment – eg business license, premises. Giving preferences to interested wholesalers.

xi. Important to facilitate or create linkage with the bank and big suppliers. Link big wholesalers with bank or manufacturers/suppliers in order to satisfy demand.

xii. Sensitize all ADDO owners to buy supplies from local wholesaler

xiii. Can talk with wholesalers to charge affordable prices to attract buyers not to go further and not to compete with ADDO owners.

b. Challenge and Options

Challenges	Options
Failure of above	Link individual ADDO with suppliers outside the region Link owners of ADDOs with financial institutions in order to have access to loans so they can buy from the wholesaler and meet demand of customers.

c. Microfinance

i. Provide them business training and monitor performance. Training is very important – Can keep books, know what they are earning, build confidence, understand growth of business

ii. Link to financial institutions like banks, SACCOs.

iii. Assist ADDO association to form SACCOs

d. Business Training

i. Very important to build relationships between owners and dispensers. Provide training to BOTH owners and dispensers and this should be done prior to any training.

ii. Keep it as one of the qualification to be an ADDO

iii. Very important to train to be owners of the ….

iv. Frequent monitoring. Will help them to know things in the field. To train them in the field. Train them in class but in field you can do together, solve problems. Can practice the real thing.

e. Discussion

i. To me the question of supply has got two dimensions. One, the supply from outside to the country. The supply within the country. What extent did the group attempt to deal with supply outside the country? If wholesaler is appointed, he has to make sure supplies are there. You can't tell the wholesaler where to source from. It is up to the wholesaler to source from inside and outside the country. It depends on his resources.

ii. Group suggested that in order to facilitate the establishment of the business of ADDO in urban/peri urban areas. Meet with wholesalers to charge affordable prices. This is something like fixing, negotiating prices. This is illegal. This may not work. Should look at market price.

iii. Correction. Should be careful about language. ADDO is set not to compete with the pharmacists. We should train them long to compete with pharmacists. ADDO is to help pharmacist to provide services where pharmacist is not able to reach. How do we go about solving the problem of Dar es Salaam? If you close DLDBs in the center, you can go and have this shop in suburbs of Dar es Salaam. There is no way to compete. This is a subsidiary unit. In other countries, main pharmacy here and where its not economical to establish an outlet, you link a substation with a minimum amount of requirements. This is why DLDMs. Not a competition with pharmacies.

iv. Requests for having the list expanded. Have to be careful here. Not even sure whether we have assessed the performance of the present list. Asking for the list to be expanded – I am afraid we are empowering them with things they can't handle. Seriously there should be a team to see whether the list is handled effectively. Don't think we can expand the list.

v. We are not talking about expansion. Geographically there are diseases which are in certain areas. If you take the disease pattern, you should review the list in that sense.

5. Promotion, Sensitization and Political Support Group

a. How will marketing campaigns be developed and periodically changed?
Marketing for cities and rural areas – how to do it?

Development of marketing campaigns		
To be Done	Urban	Rural
Integrate ADDO in health plan at all levels	X	X
Publicity on media	X All channels available	X in some instances (radio)
Launching the program	X	x
Billboards	X	x
Using artists (drama, songs, etc for events)	X	x
Brochures and other promotional materials	X	x
Political support	X	X

b. Challenges and Options

Challenges	**Options**
Negative attitude towards the project – people who do not accept	Education, advocacy for ADDO program. And where possible visit successful ADDO
Misguided/inconsistent messages by the media	Educate, orient media. If possible select certain journalists for ADDO coverage
An effectiveness of message during sensitization (it doesn't work)	Creativity is needed. Because if not impressive, the public won't use it. Need to be careful, knowledgable. Pretest in both urban and rural areas
Making the promotion, sensitization part of central, local, district health plans	Important to do advocacy at all levels by certified ADDO officials

c. Resources needed

Resources	**Sources**
Funds	Fovernement – councils, NGOs, Private commercial sector including media houses, individual and donors
Professional people - artists marketing officials, journalists, health personnel and community members	Community, relevant ministries
Materials and Supplies	Ask for funds

d. Discussion

i. Marketing campaigns will be periodically changed depending on monitoring and evaluation derived from the marketing strategy.

ii. Is rural and urban marketing different? Yes. A marketing campaign is more effective in using media in urban. Radio is most effective in rural areas (newspaper and TVs not big).

iii. Involvement of political leaders in public activities and meetings can help in marketing campaigns. Easier for them to sensitize people in their own areas.

Launching
Introduction
Training/Opening and Closing Remarks

300 to 400 people to region – tee shirts, caps, etc. Have to train them on how to promote. Cannot take all of them sometimes. Use them as TOTs. (Perhaps more in major cities)

iv. Choose some members of the community who can be trainers in their own community.

v. We did something on marketing side. People went to Ruvuma and asked them how do you think marketing should be done. During roll out need to get essential information - ngoma groups, school children, etc. Rather than buying tee shirts – do this. Encourage them to work – this is very influential people around. These things should be identified.

vi. In rural areas, the methodology differs (for promotion).

vii. It might be possible to advertise yourself, but owners cannot afford air time. In Radio Tanzania, the air time of 30 seconds is 30,000 TSH once. How can ADDO owners afford that? Otherwise, TFDA can buy air time. It is what TASAF has done. Two programs of 15 minutes two time per week. Helps to educate them to importance of that program.

viii. The drug owners association is another possibility. Owner groups could be a source of group advertising if the membership paid some dues. It might be possible for the organization to advertise on local radio. The national level is very expensive.

6. Coverage & Roll out Choices Group

a. Choices

Underserved-Rural areas
    Cover whole country in phases (zonal approach)
    Control region (Singida) should be given a priority
Possible to work in more than one region through a zonal approach
    DDTC's
    Supported by Regional committees
Major cities?
    YES

Mapping done to cater the underserved areas

b. Challenges and Options

Challenges	Options
I. Human Resources A. Trainers	 Existing Trainers Use Zonal Training centres for TOTs Build regional capacity to train
B. Dispensers	Recruit enough candidates to cover the needs
C. Supervisors	Arrange refresher courses Use DDTC's Supportive supervision from regional Team Supportive supervision from National level

Challenges	Options
II. Financial	Donor District own funds (Budget) Private contribution
III. Local Government initiative for "Change"/Development	Promotion of PPP Participatory approaches (Planning, Coordination, Monitoring)

Challenges	Options
IV. Socio-Cultural context	Acknowledgement Education Involvement of Stakeholders
IV. Economic	Sensitization towards MDG's Sustainable economic empowerment (soft loans, SACCOS etc) National Health Plan: ADDO to be included Integration of ADDO in other health activities Budgetary allocation

c. Resources

i. Human
ii. Financial
iii. Systems and Materials (monitoring tools, training tools, SOPs,)
iv. Time

d. Potential Sources

i. Multisectoral
ii. CCHP-budget, NGO's, Donors

iii. Existing (adopt/adapt/strengthen)

iv. Integrate and harmonize

e. Approach to minimize Bureaucracy

i. Participatory approach to all stakeholders (Planning, execution of Plans, Coordination, Monitoring and Evaluation)
ii. Decision making at the District level (DDTC's
iii. DDTC's to have well elaborated TOR's (Chairman, Secretary, Members)
iv. Day-to-day duties of the Secretary should be well spelt out

f. Discussion

i. In order to avoid emergency meetings, why don't we add the number of sittings per year. Most of the institutions/committees do have a quota (4 times per year). Increase from two to four per year.

ii. How should we roll out? Given the limited resources, the proper and appropriate approach is phase it in starting on underserved, remote areas, then move toward where there are more services available now.

iii. There are only two issues. First one is on decentralization of training activities. This is a good approach but we need to be careful about diluting quality of training. There must be a way of centralizing the evaluation system. Final exams from one source for example. The dispenser must qualify the same way.

iv. This is very big program – huge. With the current TFDA coordination with only one person who deals with this, very difficult to deal with the bureaucracy. If there is to be a roll out, there would have to be a unit within TFDA just for this. (TFDA has this on their program)

v. The number of meetings is in the regulations – at least two meetings. Section 10:2 provides for extraordinary meetings.

vi. Here on behalf of Director of Human Resources: Decentralized training approaches: Why don't we learn from some of the models that have taken place in this country. Decentralized to zones. What did we do to ensure equal quality and consistency.

Imbued control mechanisms for consistency
Common curriculum – basic contents, being flexible enough to allow for other teaching that is relevant
Developed a guide for each zone – process of training, inputs/outputs
Developed indicators
Trained the trainers in methodology and content

7. Resource Mobilization Group

a. How should financial resources for ADDOs be mobilized?

Funding of ADDO activities to be incorporated in CCHP
There should be a centrally organized unit in MOH for mobilization and distribution of funds
GFATM to be linked based on ADDO objectives
Sensitize micro-finance institutions, wholesalers to offer loans and credit supplies respectively
Encourage DLDMs to join community based financing org. e.g. SACCOs,trade unions
Encourage finance institutions,
manufacturers to sponsor cost of marketing

b. Discussion

i. "If donors are not there will you close the program." ADDO is essential to our life, if you put too much dependence on donors…." Regarding depending on donors: "Take care of that we don't kill spirit of ownership." We said donors have stiff conditions – this is a challenge.

ii. Use of CHF funds with a private sector organization activity like training a dispenser?

iii. For those trainees who cannot pay for training. If we incorporate this in the CHF, we can decentralize training by training the individuals who will be able to conduct the training at the lowest possible expenses. By doing so, those individuals who can't attend or pay will be able to attend. Ranking of resource mobilization – in order to sustain programs.

iv. Responsibility of government to provide health services to its population. So we think NGOs, etc should be supplementary to the government. But we can't in a practical sense cannot do without grants of donors. But we shouldn't make them major components.

v. We are saying that some of the trainees, dispensers-to-be might be facing financial difficulties so they really cannot afford. To reduce the cost of training we introduced the TOT and decentralized the TOT so closer to their own homes. So don't have to pay transport cost. On the question of those who completely cannot pay (indigents). Since it is the responsibility of the government to provide health services, council can incorporate into health plans – council will pay for them as we do them for secondary education. We should not restrict ourselves to the Council. Even the central government can set aside some funds for this.

vi. Low income of individuals in certain localities is a challenge in terms of meeting training costs.

vii. Should also have an objective of teaching ourselves, less dependence on donors. There are organizations who train on how to resource mobilize.