ADDO PROGRAMME – SUMMARY OF ACTIVITIES
April 19, 2002

Background

An assessment of the Tanzanian pharmaceutical sector, co-sponsored by the Ministry of Health and Management Sciences for Health (MSH), was carried out in April-May 2001. The assessment resulted in a proposal to establish a network of accredited drug dispensing outlets to provide selected essential medicines and other health supplies in two to three rural and peri-urban districts. Dr. Gabriel Upunda, Chief Medical Officer, and Ms. Margaret Ndomondo, Pharmacy Board Registrar, presented this proposal at a recent Conference on Targeting Improved Access to Medicines, in Washington, D.C. On the basis of this work, MSH/CPM through its Strategies for Enhancing Access to Medicines (SEAM) program, funded by the Bill and Melinda Gates Foundation, has decided to offer its technical support to implement the accreditation programme over the next three years.

With assistance from SEAM, the PB intends to establish a system of accredited drug dispensing outlets (ADDO's) that will provide a range of essential drugs, including a limited formulary of part 1 poisons and services based upon those authorised for public dispensaries. Personnel standards would demand staff with Primary Health Care (PHC) training adequate to work in a government dispensary. Additional training would be provided to facilitate the provision of diagnostic, prescribing, dispensing and information services following public health guidelines for PHC level. Regulation would remain the responsibility of the Pharmacy Board, but mediated through a range of local government, community and NGO bodies. ADDO's may also become approved outlets for Community Health Fund members.

Through the implementation of this strategy it is intended that rural and peri-urban populations will gain access to a reliable source of quality essential drugs and services.

Selection of Districts

The first task in selecting districts where ADDOs might be initially established was undertaken in February. A committee composed of PB personnel and MSH staff utilized a set of criteria to prepare a short list of districts where it was felt that we could expect cooperation from regional and local government and health officials and where obstacles to successful implementation would be minimized. Pre-selection criteria included:

- Community Health Fund activity: CHF activity was considered to be advantageous but not critical to selection. It was recognized that where the CHF was established, considerable advocacy and training at regional, district and community levels had taken place and with these processes having already taken place, similar processes necessary for establishment of ADDOs would be easier compared to locales where activity was minimal or not existent. It was also felt that a possible financial linkage between the CHF and ADDOs might be possible.

- Health Sector Reform / Local Government Reform: Formation of District Health Boards, village/ward health committees and plans were seen as necessary forums for inspection, regulation and advocacy. Evidence of local officials accepting responsibility for health affairs was also seen as an important factor. In this regard, it was felt that Phase I districts, where block grants were received would be strongly preferred but Phase 2 would be acceptable if the process was going well and block grants were being received.

- Leadership: While it is recognized that that staff changes can take place, strong leaders in permanent key positions – RC, RAS, RMP, RP, DC, DMO, DED, Municipal Director – was considered very important. For example, where CHF activity was present, this would be an indication of leadership preparedness to advocate for new idea.

- Number of Part II shops: In the districts selected, there would need to be a good number of licensed shops. The target for the first phase of ADDO implementation is to have 50-70 ADDOs operating within two to three districts. Since we are targeting existing Part II shops for accreditation as ADDOs and since not all shops are likely to meet initial application criteria or wish to participate, an estimated 80 to 100 duka la dawa baridis located in the districts was considered minimal for selection.

- Number of Pharmacies: Since it was felt essential to avoid conflict between ADDOs and pharmacies, very few or preferably no pharmacies should be located in the test districts

- Donor Activity: Districts where donor activity/projects was low or none at all would assure attention of leadership for the ADDO project.

- Urban/Rural: The districts should be reflective of population residing in both urban/peri-urban and rural areas.

- Financial Consideration: Per capita income in the districts should be able to support revenue requirements for a sustainable ADDO operation.

List of Districts Considered and Final Selection of Short List for possible ADDO implementation

The following Regions/Districts were considered: Mbeya – Urban/Rural and Rungwe; Shinyanga – Urban/Rural, Kahama, Bukombe; Nzega; Igunga; Hanang, Singida – Rural and Urban, Iramba and; Ruvuma – Songea Urban and Rural and Mbinga.

After applying our selection criteria to this group of Regions/Districts and discussing the rationale for final selection with Dr. Upunda, CMO, Joseph Mahume, Chief Pharmacist

and Margaret Ndomondo, Pharmacy Registrar, Mbeya, Shinyanga, Songea and Ruvuma were recommended for site surveys. The site surveys took place during the period from February 24 through March 28, 2002.

Evaluation of Trip Reports

The PB/MSH working committee met on April 9 and 10 to share information gathered during site visits, establish objective criteria for evaluation of districts for the ADDO program and finally to prepare a recommendation to the MOH indicating those districts where ADDO implementation is advised.

A rating system for selection criteria was devised where weights were assigned to each criterion based upon the following:

A. Critical: essential for programmes' success. Without these elements the programme cannot proceed.
B. Important: valuable for programmes' success. In the absence of these factors, programme implementation would be significantly hindered.
C. Helpful: supportive of the programme, but not essential to success.

General Weights:

Critical:	25
Important:	15
Helpful:	5

In general, if a district met a criterion, the full weight (points) was awarded; if not, none were granted. There was however some variation applied to the critical and important categories. Considerable time and thought was given toward development of criteria that are defensible and as objective in nature as possible. In the end, we believe that for the most part, this was achieved but admittedly, a degree of subjectivity is inherent in the process. A listing of criteria and rating is shown below.

1. CHF:	CHF is considered an advantage but not necessarily critical. It is preferable rather than essential. If a district has completed preparations for initiating a CHF (ex. committees formed and are active), the full weight was awarded. Rating: Important: 15
2. Health Sector Reform:	HS reform is considered very important for inspection, regulation and licensing and is linked to local government reform. Rating: Important: 15

3. Local Government Reform: Phase I and receiving block grants strongly preferred. Phase 2 acceptable if process going well.

Rating: Important: 15

4. Number of dukas:

Rating: Considered critical but scored depending on number.
Over 40/district: 25
31 to 40: 15
21 to 30: 10
<21: 5

5. Number of Pharmacies:

Rating: Important, but scored in accordance with number per district.
0 pharmacies: 15
1-3: 10
4-5: 5
>5: 0

6. Leadership:

Permanent staff willingness to implement new programs and actual/perceived level of cooperation and enthusiasm is considered critical for program success.

Rating: Critical: 25

7. Donors/Projects

The lower the amount of donor/project activity could help assure leadership attention for the ADDO project.

Rating: Helpful: 5

8. Attitude of duka owners:

Apparent interest in ADDO concept, openness to participation, willingness to achieve standards, etc.

Rating: Helpful: 5

9. Duka Association:

If a local association was present, considered to be helpful for facilitation of ADDO program meetings.

10. Local govt. initiatives:

If local officials (DMO, WEO, DS) have initiated regulation/inspection of Part II shops, reflect well on local officials, leadership and success of local government reform.

Rating: Helpful: 5

11. Labour Availability:	For initial ADDO districts, a pool of skilled labour for staffing ADDOs (nurses, nurse-midwives) who will require minimal training is advantageous for getting the program started as soon as possible. Rating: Important: 15
12. Access to suppliers:	Existence of registered wholesaler in the region will facilitate the purchase of registered drugs at reasonable prices. Rating: Helpful: 5
13. Security:	Must be a safe/secure area for SEAM and other staff working on the ADDO programme. Rating: Critical: 25
14. Communications:	Availability of electronic communication (phone, fax, e-mail) and existence of a reporting system from sub-district officials to district officials would facilitate inspection and monitoring of ADDOs. Rating: Helpful: 5
15. Training Facilities:	Existing training facility in region is helpful. Rating: Helpful: 5

Final Recommendation

Attachment A, Evaluation of Districts for ADDO Programme illustrates the consensus rating for each criterion for each district along with the average for each region. Based upon the scoring obtained, Ruvuma Region which includes Songea Urban and Rural and Mbinga appears to be the best choice for initiation of the ADDO programme. However, even if we disregard the actual scoring and look solely at the most significant points gleaned from our site surveys, Ruvuma Region would still be the committee's recommended Region.

For example, Singida was ruled out due to almost complete lack of interest/cooperation from Regional/District Health leadership. Shinyanga Urban and Rural scored high ratings however security issues in the rural districts (Kahama and Bukombe) were so significant that the team visiting this region felt it would not be safe for SEAM personnel to work in the districts. The Mbeya Region was found attractive but it was felt that the number of pharmacies located in Mbeya Urban would present an unavoidable obstacle to ease of ADDO implementation in this district. On the other hand Rungwe was rated very highly. However, choice of districts in different regions, distant from each other was felt to present project logistical issues that should be avoided if possible. A final

consideration for district selection was selection of districts which combined regional town and rural districts. In this way, experience could be gained in different social and economic environments.

In the end, the process of first short listing districts for site surveys and then applying criteria to the team survey findings resulted in a unanimous recommendation. Again, that recommendation was to initiate the ADDO programme in Songea Urban and Rural and Mbinga.

Selection of Control Districts

The working committee recognizes that measuring the impact of the ADDO programme is a critical component of the project. As such, selection of control districts is important. An attempt was made to find districts that closely matched the most important features of the Ruvuma districts. It was not found that any urban districts had implemented a CHF programme. However, Singida Urban and Rural with Iramba was found to be similar to Songea Urban and Rural and Mbinga for most of the important features that yield a good control region. Singida is recommended as the control region.

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