Management Sciences for Health

ADDO Marketing Plan
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1.0 PROGRAM DESCRIPTION

Management Sciences for Health (MSH), with approval from the Tanzanian Ministry of Health, conducted an assessment of the pharmaceutical sector in 2001. The assessment focused on the following issues of drug access- geographical, availability, quality and affordability. The assessment resulted in a number of proposals, one of which is the establishment of accredited drug dispensing outlets (ADDOs) to provide selected essential medicines and other health supplies in four rural and peri-urban districts in Ruvuma region. MSH is supporting the initiative over the next three years through its Strategies for Enhancing Access to Medicines (SEAM) program, funded by the Bill and Melinda Gates Foundation.

The adopted strategy for improving the quality of products and services through ADDOs seeks to combine changing the behaviour of shop owners and dispensing staff through the provision of training, incentives and regulatory coercion, with efforts to affect client demand/expectation of quality products and services.

The core of the system begins with clients who make decisions to seek or access care because of illness. These decisions are based on cultural beliefs about what type of treatment is needed for a particular illness or condition, distance to care providers, seriousness of the illness, income status and availability of cash, failure of primary and secondary treatments, drug availability in public facilities, the perceived quality of local care providers and provider referrals.[1]

Once clients have chosen to go to an ADDO shop, then an interaction with the seller begins. The intent is for the seller to listen to the client's description of symptoms and then assist the client with selecting an appropriate treatment plan.. "Treatment" might include filling a prescription with advice on how to use the drugs, promoting a health product such as an insecticide treated net for malaria prevention or referring the client to a health provider. Dispensers will need adequate qualifications including proper training, competence, a client-centered attitude including ethics and responsibilities for their new role and updated knowledge about drugs.

Generally the shop owners are different individuals from the dispensers. The owners of the shops need to be willing to invest in raising the standards of drug related services and products. It is necessary to understand fully the incentives the owners require to gain returns on their investment.

Systems of support will be required in order for the ADDO shops to provide consistent quality services. The source and supply of adequate and quality drugs at reasonable wholesale prices is an issue that will need addressing. Developing an ADDO purchasing group or facilitating access to a prime vendor may help in this regard. Training and refresher training of sellers to upgrade skills will be offered at the outset and options for sustaining it explored.

The Duka la Dawa Baridi (DLDB) is embedded in divisions and wards. The new ADDO system will need support from the Divisional and Ward leadership. These leaders, such as the Ward Executive Officers, Divisional Secretaries, Councilors, Ward Development Committee Chairpersons, must be willing to advocate for ADDOs as a new concept and work through the

[1] Robles A, Shirima RM, Kimary RT, Mapunda M. Masimba, D, MlayNH, Mongo LM, Mpingiriwa I, Mushi M, Sadalah M. Community acceptability of the CHF and its potential for improving health services and health situation in Madamigha Village, *Songea* District, Tanzania. Dar es Salaam, Tanzania: Ministry of Health. August 1998.

village and ward committees to inspect and report problems, help improve shops and report to higher levels.

The goal of the programme is to initially make affordable quality drugs and services available to the communities in Songea rural, Songea urban, Namtumbo, and Mbinga through improved and accredited *DLDB* shops (ADDOs). Based upon the success of the initiative in the pilot districts, the programme will be expanded to include all Regions in the country. The major program elements are the following:

1) **Development and approval of ADDO standards** (e.g. building standards, personnel qualifications, developed formulary, drug quality, record keeping, shop location).

2) **Training and continuing education** of sellers to educate them on drug dispensing, communication, ethics and record keeping, among others.

3) **Incentives to ADDO owners** (accreditation will include better staff, adherence to quality product and service, record keeping and more demanding regulation). Owners need incentives to invest in the accreditation. These incentives will include a broader legally approved drug list, marketing of shops, sourcing products, possibly tax reductions and linkages to health financing initiatives.

4) **Regulations and sanctions** will be important to ensure that established service and product standards are maintained following accreditation.

5) **Advocacy and marketing** will be essential to promote the services provided and convince consumers, shop owners and sellers, local government and community leaders to participate in the program.

The ADDO initiative projects to establish 50 to 80 ADDOs across the four districts, Songea urban, Songea rural, Namtumbo, and Mbinga. A series of focus group discussions and key informant interviews were conducted in the districts which have provided the basis for development of the ADDO marketing plan. The marketing plan is a guiding tool that should be revised as the project progresses and used to facilitate the design of the communications campaign. Several of the program elements listed above will be addressed in the marketing plan.

2.0 SITUATION ANALYSIS

The marketing plan is based on the Tanzanian country context, the existing health and media infrastructure, socio-cultural factors, political factors in the Ruvuma region, economics in the country and specific region, and the opinions of how the *DLDB* shops could be improved. These elements affect behavior change in a given population and must be considered when choosing target groups and communications for these target groups.

2.1 Country data, Demographic Health Survey, 1996

Population – Tanzania has a population of about 33.9 million people and the % of urban vs. rural is 30:70
Language – The national language is Kiswahili, which is spoken fluently by the majority, English is also used.
Religion – Muslim/Christian/Animist (40/40/20)
Literacy Rate- Male 87%; Female 61%
Life Expectancy – 52 years

GNP – USD 260 (TShs. 208,000).
Fertility rate – 195/100,000.
Crude birth rate – 41.4
Population breakdown – 49% male; 51% female

2.2 Infrastructure/Access to Health Care and Media

Health Care and Drug Availability

Evidence from the 1999 DHS survey suggests that geographic access to public health facilities is reasonable in both rural and urban areas with 84% of the population living within 10km of a public facility. There is similar access to private pharmaceutical retail outlets with 94% of the population reported to be living within 10km of either a pharmacy or DLDB. However, in relation to retail outlets, there is very uneven access to pharmacies. The population of Tanzania is served by 339 pharmacies (only retail outlet permitted by law to dispense Part I drugs) and more than 4,000 DLDB (sometimes referred to as Part II drug shops) Most if not all pharmacies are located in urban areas and 76% of the total is concentrated in the regions of Dar es Salaam, Arusha and Mwanza. It is estimated that only 17% of the population has access to a registered private pharmacy since 75% of the population live in rural areas.

The 1999 Tanzanian Reproductive and Child Health Survey (TRCHS) and the recently completed SEAM survey revealed that for a similar group of essential drugs and medical supplies in public primary health care facilities, out of stock rates of 20-30% were common. When public health facilities do not have stock, patients turn to other drug outlets to obtain needed medications and supplies. Since pharmacies are located primarily in urban areas, patients living in rural and peri-urban areas are forced to rely on DLDBs. These retail outlets often operate outside the Pharmacy Board (PB) regulation. The SEAM survey noted that 72% of the DLDB surveyed (39 in the survey) admitted to dispensing prescription drugs despite PB regulation that only permits the sale of non-prescription drugs. The drug quality was low with 48% of the drugs surveyed lacking PB registration or notification. In addition, 41% of the 39 DLDBs were utilizing, at least some personnel with no medical training to dispense the drugs[2].

Road Infrastructure and Supply Issue
More investment is being made into improving roads but the entire country is not accessible by road. Accessibility varies depending on the rainy season. Some areas of Ruvuma are impassable during the rainy season (January- April). This justifies the necessity of a central agent or wholesaler to stock drugs to supply the *DLDB* in Ruvuma. If planning is not done in advance, this can cause stock outs in the region.

Media
Three radio stations have a nationwide reach, including Radio Tanzania. More than 80% of women and 90% of men listen weekly to the radio. However, many other radio stations are local covering one administrative region or covering less than 25% of the country. There are also some local radio stations in Ruvuma such as Radio Maria.

Urban readership is high with 62% of men and 82% of women reading weekly papers. Distribution of papers in rural areas is poor.

[2] SEAM survey 2001.

There is a reasonable growth in number of TV stations in the country. The number of households owning TV sets is estimated to be about 900,000 in the whole country with more than 67% of those being in Dar es Salaam city. Of all the TV stations only 2 reach over 25% of the country. The highest % of radio listeners and TV viewers is the age group between 25 years and 34 years with peak time being evening time during news, drama, music and movies.

2.3 Socio-cultural

The socio-cultural issues focus on the current use and opinions of DLDB*s*. The information is drawn from the recent Behaviour Change Communication Study conducted in April/May 2002 in four Ruvuma districts. The results show that *DLDBs* are frequently visited for a variety of reasons however improvement in the shops is needed to better serve and improve the health of the community. This section also highlights how consumers, sellers, and shop owners get information about drugs.

Current use and Opinions (from focus group discussions)

The 16 focus group discussions (FGDs) conducted with consumers revealed that the primary places where people visit to attain medical assistance are hospitals, health centers, dispensaries and *DLDBs*. The majority of people understand the differences in the types of service that they receive at a hospital compared to a DLDB. One consumer stated, "There is no laboratory in a DLDB so one has to go to a hospital for examinations and then to the DLDB to buy drugs."[3] In some cases however the clients go directly to *DLDBs* where they are sold both non-prescription and prescription drugs.

People prefer to get drugs at *DLDB* because the services are fast, less complicated and less expensive than paying for consultation and medicine at the hospitals. Sometimes people get good advice on how to use the drugs at a DLDB. Others prefer to buy drugs at regional hospitals or health centers because they can get expert consultation. Hospitals or clinics frequently do not have drugs so the consumer visits the DLDB. When drugs are available some feel that the hospitals and health centers offer better quality and non-expired drugs as compared to those at a DLDB.

The DLDB owners noted that factors attracting clients are the politeness of the staff , express services, possibility to pay on credit, attention given to clients, cleanliness of the premises, availability of non expired stocks of drugs, services are cheaper, and discounts can be offered to clients.

The sellers within these shops noted that there are a number of problems associated with accessibility of drugs to clients. The problems include stubborn clients who determine their own doses, problematic clients who make self-prescription for antibiotics, and clients who insist to be supplied with drugs based on trade names or source (factory/country) rather than generic names. Other problems noted include not being allowed to dispense antibiotics and clients getting a reaction from drugs sold by the DLDB based on prescriptions from doctors.

The community leaders, acting RMO, DMOs and the Regional pharmacist all stated that people obtain drugs from health facilities (hospitals especially government hospitals, dispensaries, clinics) and other get drugs from *DLDB.* *DLDBs* were noted to have added advantages over

[3] Behavior Change Communication Study April/May 2002.

private and public health facilities because there are no queues, there are no payments for cards and no consultation fees, privacy and cheaper drugs.

The availability of drugs at the mentioned sources was noted to vary from one service delivery point to another. The differential factors were identified to include that there is no reliable source of drugs, the available drugs are not adequate, and some drugs are difficult to get. The Acting RMO noted that the quality of drugs in hospitals is good whereas the quality of drugs in *DLDBs* varies from one DLDB to another depending on the storage system, hygienic condition of the place and source of supply. The quality of drugs in the shops was noted to be generally poor; and is characterized by capsules not in standard packs, some of the drugs are expired, and their preservation is of poor quality.

Sources of information
The primary sources of information for drugs for consumers are radio, billboards, posters, hospitals, health centers, *DLDBs* and newspapers. The most trusted sources of information about drugs included hospitals, health centers, dispensaries, radios, *DLDBs*, ante natal and post natal clinics, newspapers and owners of *DLDB.* There is no proper information concerning *DLDB* however the participants suggested that hospitals, painted walls on the shops, billboards, radio Maria and RTD Songea, doctors and owners and neighbors could be sources of information for the shops.

The *DLDB* owners noted that they get information about drugs from a variety of sources. They named the sources to include radio, newspapers, an agent from the regional health officer, neighboring countries (mostly Malawi, a little from Zambia), drug manufacturers, colleagues who had attended a seminar in Iringa, from the regional pharmacy, from District Medical officer and television. Among these sources the most trusted were radio advertisements, posters, ministry of health directives, hospitals, pharmacist, seminars, and prescription from doctors.

During the discussion it was established that, the sources of information about drugs among sellers in general include posters, calendars, billboards, television, radio, small pamphlets (leaflets/brochures), MIMs, newspapers, journals, advertisement boards, leaflets and pamphlets, neighbors especially teachers, nearby hospitals and doctors. There were some complaints that the sellers did not always feel updated on changes in drug policy and proper dosages for drug use.

The community leaders said that they get information about drugs from seminars for leaders, health professionals, radio, especially Radio Tanzania, newspapers, and hospitals. They suggested that churches and mosques should also be used as avenues for disseminating information about drugs.

In general the RMO, Regional Pharmacist and DMOs get information about drugs from the Ministry of Health particularly the Pharmacy Board and the Newsletter from the Pharmacy Board. The frequency range of consulting this information was from daily basis to ‘as needed’. The information most district and regional leaders would like to be getting regularly is that about existence of fake drugs in the market or expired drugs and newly registered drugs. The DCs added that they get information from the radio, magazines, educational materials (like posters, leaflets and local newspapers), official meetings such as district health management meetings, seminars and workshops (for example replacement of Chloroquine by SP tablets for malaria treatment), and sometimes from medical doctors and other health experts. The information most would like get regularly is that about the new registered drugs and quality and source of drugs.

2.4 Political Context – Government Economic and Social Policy

In early 90's the GOT embarked on implementing major economic reform programmes with emphasis on private sector. Economically this has indicated a relative positive growth.
The major economic reform programmes have a great emphasis on the private sector. The government is directing its power towards community services, infrastructure and management.

The ruling party's manifesto concerning health has put an emphasis on:

- Preventive services especially to children under five years and pregnant women. This includes vaccination, nutrition issues and education on communicable diseases.
- Promotion of cost sharing for health services.

The Acting Regional Medical Officer in Ruvuma (RMO) reported that the implementation of the health sector reform in Ruvuma region is at the district levels and these are now moving down to the community and the performance is about two thirds (67%) of the planned expectations. She noted that there has been a change in the regional roles and funding as a result of the health sector reform. She stipulated the major changes as:

- Changing from direct authority to technical support to the districts.
- Introduction of basket funding.
- Supervision in terms of clinical and financial management.

The acting RMO noted that in urban areas, participation in the Community Health Fund (CHF) is very low because most of the people are workers and they are contributing to NHIF and have many other alternatives/options on where they can go to get the services. In the rural areas the acceptance is however a bit high especially in Mbinga district. She noted that the CHF has helped with availability of drugs in Ruvuma region and identified a number of inputs that are needed to improve and increase participation in the CHF.

The Songea DMO pointed out that Songea district in phase I of the health sector reform implementation and the district is currently receiving block grants and basket funding. One of the recommended organs in the districts in line with the health sector reform is the formation of District Health Service Board (DHSB). The Songea DMO noted that the district has not formed this board, however they are in the process of establishing the DHSB so that it can start functioning. The level of participation in the CHF in the district is only 8% membership. The fund was able to supplement some drugs that could not be met with government funds.

The Mbinga DMO noted that the district has not started implementing the health sector reform programme. He further noted that currently they receive funds through MSD for purchasing equipments and drugs and they do not receive basket funds. The funds are expected to commence in year 2003. He highlighted that the district team was expected to travel on Sunday May 21, 2002 to Mbeya to attend a workshop on how to manage the basket funds. It was also reported by the Mbinga DMO that the district has not formed the DHSB, however the plans are to form it soon. The CHF has enabled the district to purchase drugs, construct Health Centres in the community and purchase equipments. He pointed out that they have not received any complaints from the community because the people see what their money is doing.

The Regional Pharmacist noted that the Community Health fund (CHF) and the improved *DLDB* can be linked. This can be achieved based on the fact that the CHF is a program that contributes money to the Health Centre facilities, and thus the CHF money can be linked with the improved *DLDBs (ADDOs)* that offer prescription drugs. What is needed to make this work was identified

to include training both the CHF and owners of the improved *DLDB* on operational and financial modalities.

2.5 Economic

According to the Bank of Tanzania (BoT) economic and operations report for the year ending 30th October 2001, the per capita income of Tanzania is (USD 260 (TSh208,000/=) indicating growth as compared to the year 1992 when the per capita income was reported to be USD 62.5 (TSh. 50,000/=). The annual growth rate is 4.7%. There is high unemployment (80%), primarily farmers.

The inflation index according to BoT monthly economic review of October 2001 is 5.1% mainly due to prudent fiscal and monetary policies. This is an indicator that the community income is some how stable and will permit people to purchase medicines. The people in rural and peri-urban areas cannot afford several visits to medical facilities and medicine within a given period.

The economic trend indicates relative positive growth, a direct result of economic reforms being undertaken by the government. According to the message from the Governor, Tanzania's economic outlook has changed following the events of September 11, 2001. The reduced supply of foreign exchange from tourism, combined with lower receipts from traditional exports, have in turn put some pressure on the exchange rate of the shilling, which has depreciated in terms of the US dollar from Tanzania shillings 892 on September 10th 2001 to Tshs 940 on September 2nd 2002.

2.6 Policy

The Pharmacy Board has identified availability and accessibility of quality drugs as a priority health issue. The Ministry of Health and the Pharmacy Board are fully supporting the ADDO project and changing policy so that the project can be properly implemented. Currently the policy for *DLDsB* is to sell only non-prescription drugs. As noted earlier, 72% of the shops sell some prescription drugs. Only 29% of the drugs surveyed by SEAM in pharmacies and *DLDB* were registered with the Pharmacy Board, while 23% were notified. The remaining 48% were therefore neither registered nor notified. The responsibility for inspection and regulation of *DLDBs* lies with the Pharmacy Board. However, the financial and human resources available are insufficient for the number of required inspections. In 2000, for example, 148 *DLDB* were inspected out of an estimated 4,600 or more. The Pharmacy Board is willing to change the policy so that the *accredited DLDBs*, based on a variety of factors such as premises, trained personnel, approved stock of drugs etc., can sell some drugs that are on the Part I Pharmacies' list, to include some antibiotics and injections. The Pharmacy Board will approve a formulary for the *DLDB*, which must then be regulated by Pharmacy Board appointed authorities.

Ruvuma region operates under a local regulation requiring that the *DLDB* shop owner must have a medical background. Most business owners hire 'owners' with medical backgrounds so that the shop can continue. At the stakeholders meeting in Bagamoyo, September 30th the RMO said that the leaders should look into changing this requirement as long as the dispenser has a medical background or ADDO training and is a full time employee.

2.7 Recommendations for Improved *DLDB*

Consumers, shop owners, dispensers, community leaders, acting RMO, DMOs, DCs, and the Regional Pharmacist had recommendations for implementing the ADDO programme. Some of these ideas are highlighted below and are used throughout the marketing plan to provide insight into the distribution, incentives, pricing, and communications campaign.

Consumer Recommendations

- No expired drugs sold in the ADDOs.
- Dispensers should offer proper advice on how to use the drugs.
- Owners and dispensers should adhere to the laws and regulations governing the programme.
- Improvement of the DLDB should not be accompanied by higher prices.
- An inspection network should be established.
- Dispensers should be qualified and friendly.

Owner's Recommendations and Comments

- The owners understand that the net sum of the program is to meet the drug needs of low income earners and people living in remote areas.
- Need to sell antibiotics to make the investment worthwhile.
- Need a supplier that is located close by and has continuous stock.
- Training for dispensers is important but they worry about salary increases required by sellers.
- Requesting loans because the owners are worried that the improvement process will drain their money.
- A fear is that the trained dispensers will leave the shop to work in cities, thus turnover will be high.

Dispenser's Recommendations

- Uniforms are favored for a smart look.
- Salaries should be increased.
- Some are worried that the education requirement may be too high and they would not be allowed to continue working in the improved DLDB.
- The inspectors should operate within regulations and regularly inspect and report on all drug shops in his/her area of responsibility.
- Regular seminars should be held to update dispensers on drug changes or improvements.
- Owners should be availed loans from the government to get started with the accreditation.

Community Leaders' and Ward Councillors' Recommendations

- Need to sensitize the community about the programme.
- Dispensers should wear uniforms and badges.
- Dispensers should be trained to enhance service provision capacities.
- Dispensers should advise consumers on proper drug use.
- Improved mechanism for licensing should be available.
- Location of an improved shop should be clearly identified.
- Careful supervision is required to ensure the drugs are not expired. Inspectors should be rotated.
- Premises must be inspected before opened.
- Drugs should be offered at affordable prices.
- It is inappropriate to dispense drugs from the shops without prescriptions.

DED's, DMOs' Regional Pharmacist's and Acting RMO's Recommendations

- Equip and empower the improved *DLDB* sellers with skills on business and drug selling.
- The improved shop should be inspected by both the community and Pharmacy Board.
- The shop should be clean, attractive and spacious.
- Advocacy should be carried out among owners for improvement of the shops.
- The relationship between owners, sellers and District Council and the project should be fully stipulated.
- Educate owners and sellers and advocacy at all levels.
- Owners and dispensers should be knowledgeable in medical ethics.
- Community members and leaders should be involved and should know their roles.
- Empower the owners with capital support.
- Drugs should be available, affordable and not expired.
- The Pharmacy Board should enter into a contract with the approved reliable sources of quality drugs.
- Transport and fuel for supervision is critical.

3.0 MARKET ANALYSIS/ STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS (SWOT)

3.1 Competitive analysis

DLDBs are competing with pharmacies, however, since pharmacies are primarily located in urban areas they are not a large threat. There are over 4,600 *DLDB* in the country, 1 for every 7,400 people. This is over 50% higher than the equivalent figure for all public health facilities and 11% higher than all public, voluntary and religious facilities combined.
The new accredited shops in Ruvuma will be competing with non-accredited, 'old' *DLDBs*.

The following is a SWOT analysis of the current *DLDB* in regards to the strengths and weaknesses of the services offered (product), the price of drugs, the distribution network (place) and promotion that has been conducted. The SWOT analysis also highlights the opportunities and threats for implementing the ADDO program.

3.2 *DLDB* Service Analysis

Evaluation of the Service

Strengths/Opportunities	Weaknesses/Threats
Strengths • *DLDB* serve rural and peri-urban areas. • Sometimes sellers extend credit to consumers. • Owners are willing to invest in accreditation. **Opportunities** • Community leaders, the Regional and District leaders support the idea of improved *DLDB.* • Health sector reform in this area is a potential platform for the program to succeed. • Incentives for the shop owners are trained personnel, marketing the shops and increased profit. • The CHF and NHIF: it was noted that they could be linked to the improved *DLDBs* provided some groundwork is done. • Consumers more likely to purchase their drug and supply requirements from shops where quality and non-expired drugs are available.	**Weaknesses** • Some shops sell "expired" drugs. • There is insufficient variety of drugs legally available to meet consumer needs. • Sell Part I drugs while the owners do not have a license to do so. • Not all DLDB are registered with the Pharmacy Board. • Level of education of current sellers is lower than required to dispense drugs properly. **Threats** • Owners state that in order to invest in accreditation they need financial backing. • Since *DLDB* have been selling Part I drugs illegally it will be difficult to regulate the new system. • District authorities have a strong position in the health sector but are bypassed in the DLD licensing process. • Owners may fear increased scrutiny by inspectors.

3.3 Pricing of drugs in *DLDB*

Evaluation of pricing

Strengths/Opportunities	Weaknesses/Threats
Strengths • Credit, partial doses and in-kind payments are offered to some consumers to make the drugs affordable. • Price of drugs was not found to be a major consumer concern during FGDs but patients sometimes choose a DLDB because cost of drugs is less than expense associated with travel to health center, cost of consultation and charge for medication. **Opportunities** • CHF, NHIF, grants and loans would allow shop owners to invest and have returns on their investment. • Lower licence fees and taxes would lower business costs for owners • Group purchasing through an ADDO association would give owners access to better wholesale prices	**Weakness** • Prices of drugs are higher in *DLDB* than in hospitals or clinics. **Threats** • Prices of drugs may go up if owners have to pay higher salaries and license fees. • People have low incomes and will not be able to afford the drugs if prices increase. • Inability to pay for full dose of therapy

3.4 Place

Evaluation of Distribution

Strengths/Opportunities	Weaknesses/Threats
Strength • *DLDBs* have dependable hours of operation. **Opportunities** • Pharmacy Board is prepared to consider a system of Approved Restricted Wholesalers (ARWs) opening branches in Ruvuma to supply the accredited shops. • A prime supplier for the *DLDB/ADDO* would reduce distribution costs. • A prime supplier would decrease stock outs and expired drugs in *DLDB/ADDO.*	**Weaknesses** • It is difficult to establish and supervise reliable wholesale agents in the districts. • Most *DLDB* owners travel to Dar es Salaam to buy the drugs therefore there are often delays and stock outs. **Threats** • Roads are bad during the rainy season for drug delivery thus stock outs could occur. • Shop owners continue to source from non-approved suppliers • If owners and sellers do not follow regulations they could be disqualified as an ADDO shop.

3.5 Communications

Advertising/Training/Supervision

Evaluation of communication

Strengths/Opportunities	Weaknesses/Threats
Strengths • Mass media (radio), outdoor and print (newspapers) are sources of information people trust about drugs and *DLDB.* • The idea and plan for the improved *DLDB* program has been communicated and widely accepted by consumers, leaders and owners and sellers in Ruvuma region. **Opportunities** • Using a brand name and slogan for the improved *DLDB* shops will increase use and create demand for their services and products. • A mixed media campaign (print, mass media and interpersonal (IPC) will enhance the community's understanding of the importance of proper drug compliance.	**Weaknesses** • Current dispensers require training and possibly some may need to be replaced. • Transport for inspection to remote areas could be an issue. **Threats** • If communication between the ward leaders, the district authorities and Pharmacy Board is not transparent then there is likely to be problems with supervision, inspection and compliance with the ADDO regulations.

4.0 TARGET GROUP ANALYSIS

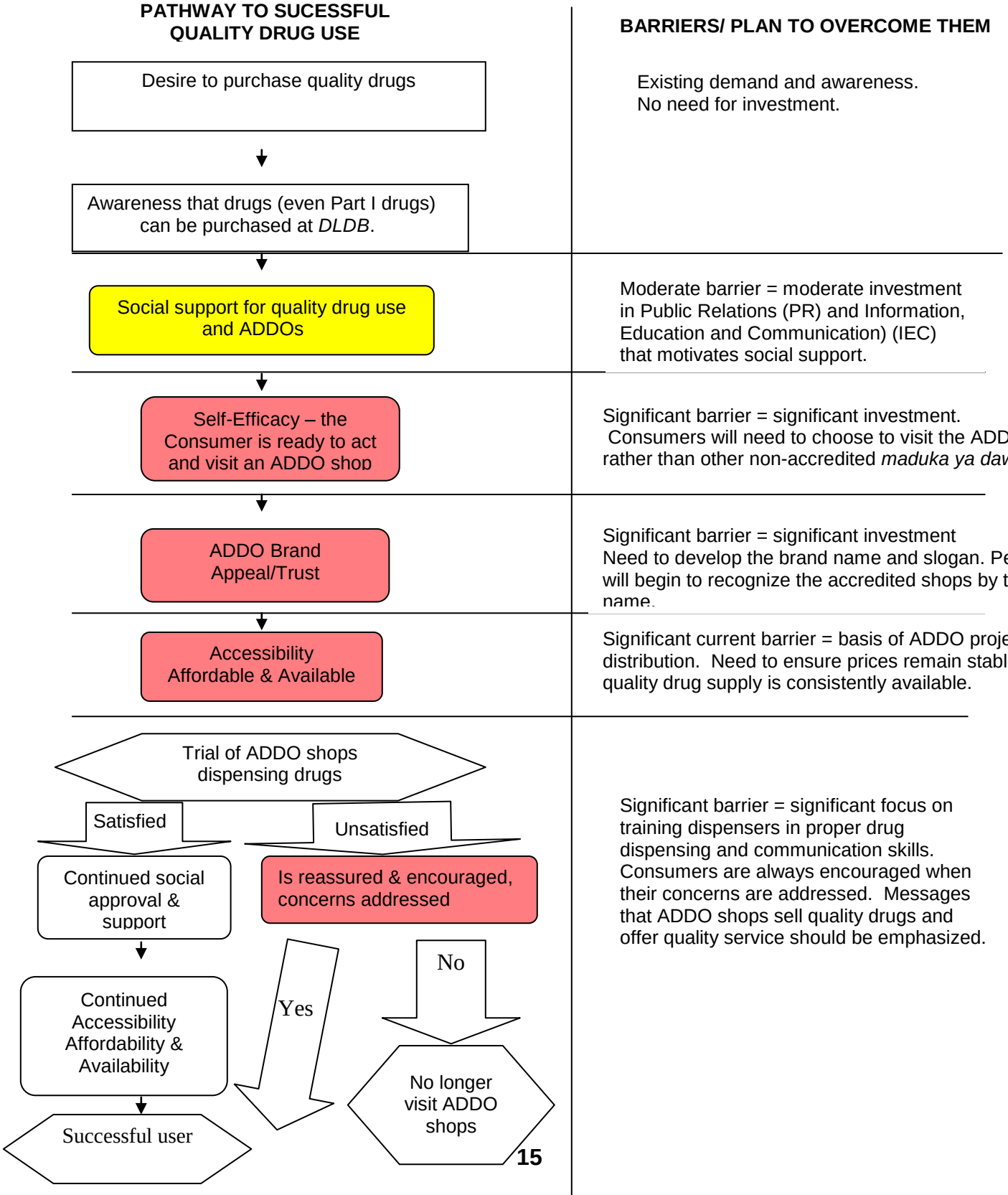
4.1 Priority Target Groups

The target groups will be geographically focused in Songea urban and rural, Namtumbo and Mbinga.

Target group #1 **Men and Women ages 15-49, varied educational levels.**	This target group is the primary purchaser of drugs. They are most often more sensitive to quality issues with drugs. Furthermore, women often care for the health of children, visiting a medical facility and *DLDB.*
Target group #2: **Shop Owners** **Shop Sellers**	The shop owners need to be enticed to invest in improving their shop and meet the requirements for accreditation. Sellers need training to increase the level of service and keep updated on drug policies and changes in regimes. There will be an advocacy role to play to ensure that the owners and sellers follow the regulations and comply with the ADDO standards.
Secondary Target group **Community, District and Regional Leaders and Medical Personnel**	Currently the leaders back the ADDO initiative but their support of the program and advocacy towards their contingency is critical. Medical personnel at hospitals clinics will be critical for referring patients to the ADDO shops when drugs are not available or as a choice where the patient can buy quality drugs.

4.2 Behavior Change Framework

The following chart maps out the basic elements of a behaviour change model in combination with the marketing mix needed to change behavior. While the model is presented in a vertical manner, it must be noted that the elements interact and affect each other. The colored boxes show elements that should be emphasized in the beginning of the project. The pink colored boxes require the most attention.



ADDO Behaviour Change Chart

The following chart explains the level of each target group within each behaviour change element. Low means that the program needs to concentrate on this area in the communications strategy or in its implementation of the key priorities. In some cases the groups will be lumped together because the explanation is similar for all groups.

Target groups: #1 Males and females ages 15-49, with varied educational levels

#2 Shop owners and Shop dispensers

Secondary Target Group: Leaders and Medical personnel

Perceptions	**Level**	**Explanation**	**Source**
Availability of (ADDO) services and drugs	Low	• ADDO initiative is in its preparatory phase. • Currently there is only one pharmacy in the pilot districts. • Prescription drugs in *DLDB* are being sold illegally, some are expired and personnel lack training. • Supply of drugs is not easily accessible. Drug shop owners have to travel long distances to purchase their drugs and supplies. • Difficult for leaders to regulate the shops due to lack of resources and clear mandate	Stock reports Retail tracker
Affordability of drugs	Medium	• People buy drugs from the shops regularly • The dispensers offer credit, in kind or people pay for one dose a day. • Prices in *DLDB* are higher than in clinics and hospitals.	Retail tracker (ADDO's and ARWs?) FGDs
Brand appeal	Low	• There is no brand name yet for the new network of ADDOs. • Brand needs to be developed and tested.	FGDs or Qualitative study
Awareness of drugs and services	High	• All target groups know that some prescription drugs are dispensed through *DLDB. DLDBs* are preferred places to buy drugs followed by hospitals and clinics. • Target groups are aware that an improvement in the *DLDB* is needed.	FGDs

Understanding of ADDO shops and proper drug use or dispensing	Low/ Medium	• The target group understands that expired drugs are not effective but emphasis is needed on the importance of proper drug use (eg taking the full dose). No communication on the ADDO shops has been done. • Owners are open to the idea of the ADDO shop and willing to invest in accreditation. Dispensers need training and owners need updated information on changes in drug policy. • The leaders, district govt. and regional representatives understand what the ADDO initiative means for their community. They could use more consistent information on changes and updates in drug policies or information on the program itself.	FGDs/ Mystery client surveys
Personal risk assessment	Low/ Medium	• The FGD participants noted a mix of feelings with the type of service received at *DLDB*. If consumers feel at risk because they are buying expired drugs then they know the shop is not reliable and may not return. Need to feel they are being 'cured.' • Owners and dispensers take a risk in investing in the improved shop but the benefit is increased profits and ability to legally sell some Part I drugs. • Leaders feel that the current drugs on the market and the lack of control put their people at risk and do not benefit their health.	FGDs
Perceived attributes of services	Low	• Consumers want sellers to be friendlier, dispense quality drugs and want more advice given to them when buying the drugs. • Dispensers feel the service is good but some drugs are expired and there are stock outs. Complaints of non-compliance by the consumer are reported. • Leaders say that services need to be improved, regulation enforced and inspection and supervision needs to take place regularly.	FGDs Mystery Client surveys
Social support for the use of services	Medium to High	• The leaders, owners, sellers and consumers want to see an improvement in the drug distribution through improved *DLDB*. • More information on the progress of the ADDOs will be needed to increase advocacy and support for the program.	FGDs
Self efficacy	Low	• Consumers need to understand (1) the importance of taking a full course of treatment and (2) the benefits of receiving quality drugs for health reasons. • Consumers need to feel they have been 'cured' through correct advice, proper dispensing of quality drugs and a friendly demeanor.	Observation /FGDs/ simulated client?

5.0 ADDO 2003 MARKETING PLAN

5.1 Strategic Priorities

Based on the situation analysis there are three main priorities to address in the first year of the ADDO program.

Priorities	Strategic issues	Program implications
Priority #1	Establish a solid distribution system to ensure retail coverage of participating *DLDBs* in Ruvuma region.	• Establish branches of approved wholesalers or in some way make supplies available (wholesaler could send a truck once or twice a month) in Ruvuma for ADDOs. • Participating *DLDB* must meet ADDO standards (includes standards for premises, dispensing, personnel, etc.) and apply for accreditation. • Establish a link for ADDOs to attain micro-financing through CHF, NHIF or micro loans.
Priority #2	Launch an intensive communications campaign through radio and outdoor advertising.	• Training of dispensers in drug dispensing and communications. • Design brand name, logo and messages • Meet with government leaders and medical leadership to officially introduce the ADDO program and gain support.
Priority #3	Establish a regular plan for monitoring and supervision.	• Ward and district leaders receive training on inspection visits. • Establish mechanism for inspection,reporting and deciding on any regulatory action required.

5.2 Positioning, Frame of Difference and Communication Messages of ADDO Services

Positioning (what does an ADDO have to offer): ADDOs offer an expanded list of affordable quality drugs, quality service and professional advice.

Frame of Difference (how is an ADDO different from a DLDB): ADDO shops are accredited, well supervised, regularly inspected, offer an extended list of drugs and have trained personnel.

Communication messages for the target groups
It is important to include both branded and generic messages for consumers. The issue of defining quality in the consumer's mind is complex. In order to avoid the blame being on the 'expired drugs,' for example, it is critical to educate people in proper health practices. The following are some of the communication messages that need emphasizing for the specific target groups:

Target group #1 **Men and Women ages 15-49, varied educational levels.**	• Visit ADDO for an extended list of affordable quality drugs and services and professional advice. (branded) • ADDO cares for you and your health. (branded) • Take the full dose of medicine to be cured. (generic) • Do not wait to get critically ill, visit your hospital as soon as possible. (generic) • Listen to the advice of your health providers. (generic) • Do not purchase harmful drugs from street vendors. • Only purchase drugs from approved DLDBs.
Target group #2 **Shop Owners** **Shop Dispensers**	• Serve the community through your experience by providing quality care and quality products. • Be the pioneer of ADDO. • Maintain professional services and consumers will visit. • Only purchase drugs from approved wholesalers. • [Training for dispensers will include messages on dispensing drugs and how to properly communicate with clients. E.g. Always explain why a full course of treatment is needed. Give advice, don't prescribe. Additional messages to be developed later]. • Adhere to ADDO ethics (refer to Code of Ethics)
Secondary Group: **Community, District and Regional Leaders and Medical Personnel**	• ADDOs mean an extended list of affordable quality drugs and services and professional advice for your community. • Promoting ADDOs is promoting social and economic progress.

5.3 Marketing Tactics and Activities

This section describes what activities need to be achieved given the priorities set and the target groups. The activities are broken into Place, Product, Price and Promotion.

Place

Area	Tactics/Activities	Responsible	Quarter			
			1	**2**	**3**	**4**
Outlet Development	• Enable and encourage wholesalers to open branches in Ruvuma to serve ADDO shops.	MSH/PB/Local Authority (LA)	X			
	• Introduce wholesalers to ADDO owners and dispensers	MSH/PB		X		
	• Continue sensitization on the ADDO program to owners.	LA/PB/MSH		X	X	X
	• Interested *DLDB* send applications for review according to PB standards.	Owners/LA/PB/MSH		X		
	• Approved *DLDB*s make improvements in shops to attain ADDO standards.			X		
	• Recording system integrated into ADDO recording of stock in, stock out, sales of prescription drugs.	Owners/PB/LA/MSH/Dispensers		X	X	X

Services and Products

Objective	Tactics/Activities	Responsible	Quarter			
			1	2	3	4
Improve the quality of drugs and services offered through *DLDB*.	• Set ADDO standards and get approval from MOH. • Design modules for training dispensers in drug dispensing and communication. • Identify dispensers • Train dispensers • Train inspectors • Train owners • Accreditation • Develop brand name and test in FGDs	PB/MSH/MOH School of Pharmacy (SOP)/MSH/PB/LA Owners/SOP/PB LA/PB PB/MSH/LA Advertising Agency/MSH/ Healthscope	X X X X X X X X			

Pricing

Objective	Tactics/Activities	Responsible	Quarter			
			1	2	3	4
Costs of drugs should remain affordable and not increase. Owners should be able to invest and still make a profit in the ADDO.	• Conduct a cost analysis of what owners pay for transportation, salaries, license, and other maintenance. • Identify ways for ADDOs to purchase collectively in bulk from wholesalers. • Implement various incentives affecting price e.g. waivers/reductions for taxes and business licences • Explore micro-financing ideas in order to offer loans and/or grants to owners.	MSH/Owners MSH PB/LA/TRA/PORALG, etc. ESRF/MSH/PB	X X	 X X X	 X 	

Communications

The major means of promoting ADDO shops in the first year will be radio, outdoor advertising and interpersonal communications. The radio spots will be branded and generic.

Point of sale activities/Promotional items

Target	Tactics/Activities	Responsible	Quarter			
			1	2	3	4
Owners/Dispensers	• Design and produce PVC signs for the outside of the shops. • Procure polo shirts with logo for owners and dispensers for becoming part of the ADDO program • Paint shops • Pens with logo on them for the shops. • Laminated price list for shops	Ad Agency/MSH Promotion company/MSH Owners/ local artists/MSH Printing company/MSH	X X X	 X X X		
Consumers	• Procure T-shirts to be given out during question/answer session of road shows. • Procure umbrellas for promotion at MCH clinics who receive full immunization for children • School cups with ADDO logo for primary schools. • Present essential drug-related educational programme to schools	Promotion company/MSH PB/LA		X X X X		
Leaders and Medical personnel	• Procure prescription pads with logo for clinics. • Procure clocks for clinics and hospitals and offices. • Procure writing pads for leaders.	MSH		X X X		

Special Events and Interpersonal Communication

Target Groups	Tactics/Activities	Responsible	Quarter			
			1	2	3	4
ALL	• Launch of ADDO shops with speeches, entertainment and opening of the shops.	Region/Districts/ PB/ MSH		X		
ALL	• Road shows in all districts. (need to decide # of shows and if shows should take place in all districts or in implementation districts as the program is rolled out.	Consumer Contact Communications (CCC)/MSH/PB/ LA		X	X	X
Leaders and shop owners/dispensers	• Workshop on the program and updates in policy	PB/MSH			X	

Mass media activities (radio, print, outdoor)

Type of media	Tactics/Activities	Responsible	Quarter			
			1	2	3	4
Radio	• Develop 45-60sec. radio spot (branded) • Develop generic radio spot 45 seconds on proper drug use. • Run radio spot three times a day for 5 months, break 3 months then run it again for 4 months.	Ad agency/MSH/ PB	X X			
				X	X	
Print	• Trade advertisements in newspapers- 48 total. • Brochure explaining ADDO program for clients, new government leaders, PB, MSH and NGOs. • Write articles for newspapers on ADDO program.	Newspapers/ad agency/MSH Print company/PB/ MSH PB/MSH	X	X X	X X	X X
Outdoor	• Write letter for free rental space to District Commissioners • Tender to place billboards or signboards in the districts (location to be decided). • Place billboards in districts (need to decide if billboards will be placed in all districts or only in those where ADDOs will be rolled out.)	PB Outdoor company/PB/ LA/MSH Outdoor company/LA	X X	X	X	

Monitoring and Evaluation

Subject	Question	Type of research	Quarter			
			1	2	3	4
Baseline		Various	X			
Consumer preferences	Monitor consumer purchasing, reasons for purchase, and impressions of change in ADDO shops.	Focus groups Exit interviews			X	 X
Retail Tracker and ADDO sales recording	Track stock changes, prices and volumes sold in the ADDO shops. Track sales of prescription drugs to customers.	MSH		X	X	X
Mystery Client surveys	Monitor services provided in ADDO and identify dispensing or communication problems.	MSH/Healthscope		X	X	X

Next Steps for the Communications Strategy

The next steps are based on the marketing plan components. The following is an outline of the next steps to follow for implementing the marketing plan.

1) After approval of the marketing plan the consultant will write a creative brief to send to the advertising agencies that meet the criteria for the project.
2) The advertising agencies will have one week to respond with a proposal, including a cost bid.
3) MSH, PB and the consultant will review the proposals and select the advertising agency that is best qualified to design the brand name and logo, develop and place the radio scripts and provide artwork for the various promotional items and outdoor billboards, at the best rate.
4) The selected advertising agency will develop the brand name and logo.
5) PB/MSH and Healthscope will test the logos and brand names by conducting 2 or 3 focus groups in each district.
6) PB will approve all logos and brand names that have been tested in the field.
7) Once the brand name has been selected, the advertising agency will make necessary changes and adapt the artwork to the promotional items such as t-shirts, cups and umbrellas and outdoor billboards.
8) MSH will tender to the three major billboard companies in Tanzania or choose signboards with the one company that provides them. Once a billboard agency has been chosen and specifications for the billboards selected, the advertising agency will adapt the artwork to meet those specifications and give the artwork to the outdoor company.
9) MSH will also tender to promotional item companies for the promotional items. Once the company is selected the advertising agency will adapt the artwork to meet the specifications of the items.
10) The consultant will write a brief for the interpersonal road show company who will conduct drama shows in the districts. PB/LA/MSH will need to review the show to make sure the messages are clear and correct.

This process is comprehensive of all the activities that must take place to advance the communications strategy.

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