**Sustainable Drug Seller Initiatives**

***Mobilization of ADDO Consumers to Take a More Active Role in Services Provided by ADDOs***

**Report on formative research to understand current need, experience, knowledge and expectations of ADDOs’ consumers in Kilosa, Songea Urban, and Namtumbo**

**TCAS**

**TFDA**

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**MSH**

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Table of Contents

[Acknowledgment 4](#_Toc412027264)

[Disclaimer 5](#_Toc412027265)

[List of Abbreviations 6](#_Toc412027266)

[Background of the Assignment 9](#_Toc412027267)

[Executive Summary 12](#_Toc412027268)

[Part 1: Research Methodology 17](#_Toc412027269)

[1.1 Ethical consideration 17](#_Toc412027270)

[1.3 Pre−testing of tools: 19](#_Toc412027271)

[1.4 Study Challenges and Limitations 19](#_Toc412027272)

[1.5 Data Analysis 20](#_Toc412027273)

[Part 2: General Research Findings 20](#_Toc412027274)

[2.1 Demographic and Social economic Information 20](#_Toc412027275)

[2.2 Consumers’ expectations 23](#_Toc412027277)

[2.3.1 Redress mechanism 24](#_Toc412027278)

[2.3.2 Consumers’ feelings of powerlessness 25](#_Toc412027279)

[Part 3: Taking inventory on consumer’s advocacy initiatives in Tanzania 26](#_Toc412027280)

[3.1 Country Situational analysis 26](#_Toc412027281)

[3.2 What is consumer and consumer advocacy? 27](#_Toc412027282)

[3.3 Existing consumers’ advocacy initiatives at central and local/district levels 28](#_Toc412027283)

[3.3.1 National framework on consumer advocacy 28](#_Toc412027284)

[3.4 Assessment of consumer advocacy needs and expectations 32](#_Toc412027285)

[Part 4: Assessment of ADDO’s consumers, households and local leaders on their knowledge about existing ADDO services and products within their localities 35](#_Toc412027286)

[4.1 Introduction 35](#_Toc412027287)

[4.2 Consumers’ views about ADDOs existing services and products 35](#_Toc412027288)

[4.2.4 ADDO services and Products: Availability and Affordability 38](#_Toc412027289)

[4.3.1 Knowledge on the list of medicines for OTC and those requiring prescriptions 41](#_Toc412027290)

[4.3.2 Knowledge on what are ADDOs’ allowed services 41](#_Toc412027291)

[4.3 Local leadership’s knowledge on ADDOs’ products and services 42](#_Toc412027292)

[Part 5: Knowledge related to rational medicine use 45](#_Toc412027293)

[5.1 Consumers’ knowledge on rational medicines use 45](#_Toc412027294)

[5.1.1 Knowledge on timing the Daily Dose 45](#_Toc412027295)

[5.1.2 The concept of buying ¼ or ½ a dose 46](#_Toc412027296)

[5.1.3 Consumers’ habits of not finishing their doses 46](#_Toc412027297)

[5.1.4 The habit of using pain killers to cure diseases 47](#_Toc412027298)

[5.1.5 The habit of Over Using Antibiotics 47](#_Toc412027299)

[5.1.6 The habit of not sharing information 47](#_Toc412027300)

[Part 6: Availability and use of IEC materials promoting RUMs 50](#_Toc412027301)

[6.1 Programs, Activities and IEC material promoting RUMs 50](#_Toc412027302)

[6.1.1 Brand awareness ADDOs 50](#_Toc412027303)

[6.1.2 Availability of IEC materials promoting rational medicines use 50](#_Toc412027304)

[6.1.3 Availability of Consumer safety alerts forms 51](#_Toc412027305)

[6.1.4 No IEC materials for health Insurance 52](#_Toc412027306)

[6.1.4 Media Programs 52](#_Toc412027307)

[6.1.5 Arts, Sports and drama 52](#_Toc412027308)

[6.1.6 Religious Initiatives on RUMs 52](#_Toc412027309)

[6.1.7 Village’s Health Committee 53](#_Toc412027310)

[6.1.8 Community Education on Rational Use of Medicines 53](#_Toc412027311)

[Part 7: General findings and recommendations 55](#_Toc412027312)

[Key findings on household information 55](#_Toc412027313)

[**Annex 1: Form for Suspected Adverse Drug Reaction 60**](#_Toc412027314)

[**Annex 2: Patient Adverse Drug Reaction Alert Card 61**](#_Toc412027315)

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This formative research aimed to explore on the level of understanding by consumers, households and local leaders so can take a much more active role as “watch-dogs” for the services provided by ADDOs.

TCAS is grateful to all individuals who contributed their time and expertise to carry out this research, these include the following: The registrar of pharmacy council (PC), Ms. Mildred P. Kinyawa; Mr. Bulula Ngwegwe from PC[[1]](#footnote-1); TCAS’s team members;-Mr. Stuart Heddi, M/s. Jehovaness Zacharia, Mr. Seif Hamis Simba, Sr. Leonarda Ludovick, Dr. Merida Makia, Ms. Happiness Mhina, Julius Edward and Ms. Theresia Meshack Gawile.

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# Disclaimer

This report is produced for MoHSW, Pharmacy Council, TFDA and Management Sciences for Health (MSH).The management of Tanzania Consumer Advocacy Society, is hereby expressing herein that the opinions in this report are those of the authors and can therefore in no way be taken to reflect the official opinion of neither MoHSW, PC, TFDA, ’Management Sciences for Health’’ (MSH).

Therefore any errors in the report are the sole responsibility of the authors and comments and questions can be addressed to [info@tcas-tz.org](mailto:info@tcas-tz.org).

# List of Abbreviations

ACT Artemisinin-based Combination Therapy-Dawa Mseto za Malaria

ADR Adverse Drug Reaction

ADDO Accredited Drug Dispensing Outlet

AHSAT Association of Health Services Administrator

AIDS Acquired Immune Deficiency Syndrome

AMREF African Medical and Research Foundation

ARW ADDO Restricted Wholesale

BoT Bank of Tanzania

CFDC Council Food and Drugs Committee

CHMT Council Health Management Team

CHF Community Health Fund

CPPP Consumer Private Public Partnership

COATA Clinical Officer Association of Tanzania

DC District Commissioner

DD Daily Dose

DMO District Medical Office

DLDB Duka la Dawa Baridi

DLDM Duka la Dawa Muhimu (ADDO)

DP District Pharmacist

EHPC Environmental Health Practitioners Council

EWURA Energy Water and Utility Regulatory Authority

F2FI Face to Face Interview

FGD Focus Group Discussion

GOT Government of Tanzania

HC Health Centre

HIV Human Immunodeficiency Virus

IEC Information, Education and Communication Materials

ICT Information and Communication Technology

KI Key Informant

MAT Medical Association of Tanzania

MELSAT Medical Laboratory Scientists Association of Tanzania

MCH Maternal and Child Health

MCT Medical Council of Tanganyika

MSD Medical Stores Department

MSH Management Sciences for Health

MoHSW Ministry of Health and Social Welfare

MEWATA Medical Women Association of Tanzania

NBS National Bureau of Statistics

NGOs Non-Governmental Organizations

NHIF National Health Insurance Fund

NSSF National Security Social Fund

OD Organization Development

OCT Optical Council of Tanganyika’’

PB Pharmacy Board

PC Pharmacy Council

PHFs Primary Health Facilities

PHLB Private Health Laboratories Board

PST Pharmaceutical Society of Tanzania

RPH Registrar of Private Hospitals

SP Sulphadoxine 500mg/Pyrimethamine 25mg

SEAM Strategies for Enhancing Access to Medicines

SDSI Sustainable Drug Seller Initiatives

STIs Sexually Transmitted Infections

STD Sexually Transmitted Diseases

STGs Standard Treatment Guidelines

SoW Scope of work

TARENA Tanzania Registered Nurses

TBS Tanzania Bureau of Standards

TCAS Tanzania Consumer Advocacy Society

TFDA Tanzania Food and Drug Authority

TNNC Tanzania Nurses and Midwives Council

TADATIS Tanzania Drug and Toxicology Information Services

RUM Rational use of Medicines

RP Regional Pharmacist

VEO Village Executive Officer

VOICE Voluntary Observers Interested on Consumer Empowerment

WEO Ward Executive Officer

WHO World Health Organization

# Background of the Assignment

|  |
| --- |
| **Scope of Work** |
| **Sustainable Drug Seller Initiatives (SDSI)** |
| *Mobilization of ADDO Consumers to Take a More Active Role in their Health and Health Care* |
| **Project Background**  The Bill & Melinda Gates Foundation provided Management Sciences for Health (MSH) with a three-year grant to continue its efforts in Africa to involve private drug sellers in enhancing access to essential medicines. The Sustainable Drug Seller Initiatives (SDSI) program builds on MSH’s Strategies for Enhancing Access to Medicines (SEAM) and East African Drug Seller Initiatives (EADSI) programs. Those programs focused on creating and implementing public-private partnerships using government accreditation to increase access to quality pharmaceutical products and services in underserved areas of Tanzania and Uganda. The new program’s goal is to ensure the maintenance and sustainability of these public-private drug seller initiatives in Tanzania and Uganda and to introduce and roll out the initiative in Liberia. Through our work in the three countries, we expect not only to expand access to medicines and treatment in additional geographical areas, but to solidify the global view that initiatives to strengthen the quality of pharmaceutical products and services provided by private sector drug sellers are feasible, effective, and sustainable in multiple settings.  In Tanzania, one of the SDSI objectives is to enhance the accredited drug seller initiatives’ long-term sustainability, contributions to community-based access to medicines and care, and ability to adapt to changing health needs and health system context.  The Ministry of Health and Social Welfare, through Tanzania Food and Drugs Authority (TFDA), introduced the ADDO program to Tanzania in 2003. The ADDO program has since increased access to both non-prescription and selected prescription medicines in Tanzania, as demonstrated in both the SEAM 2005 evaluation and a Danida commissioned independent evaluation in 2006. The program was first piloted in Ruvuma region and following its success, the Tanzania government approved the program to be rolled out nationwide. To date the ADDO program has been rolled out in 15 out of 21 regions with over 3,500 ADDOs established and more than 7,000 dispensers trained.  Although the ADDO pilot project in Ruvuma region featured a component of creating consumer interest and “brand” awareness, it lacked activities to stimulate and ensure consumer participation in monitoring the quality, appropriateness, or affordability of the products and services provided by ADDOs. If effectively engaged, consumers can play an important role in monitoring the quality of ADDOs services and products. Given consumers’ close proximity to the outlets and their regular utilization of ADDO services, consumers have a unique knowledge and understanding of ADDO operations. If well equipped with the necessary skills, information, knowledge, and resources, consumers can serve as natural watch dogs to notify the regulators about misconduct at ADDOs and also better manage their own health. In doing so, consumers can encourage the appropriate use of dispensed medicines, thereby minimizing the risk of drug resistance at the community level.  **Overall Objective:**  The overall objective of this component of SDSI is to mobilize ADDO consumers (patients, caregivers and communities) to take a more active role in their health and health care.  **The specific objective of this scope of work** :  To complete a situational analysis of ongoing consumer advocacy initiatives in Tanzania, assessing consumer advocacy needs and expectations, and identifying and recommending potential approaches to addressing these needs and expectations.  **Specific activities**   1. Identify existing consumers and advocacy initiatives at central and local/district levels  * Type of advocacy activity carried out by the identified group. * Explore geographical coverage for the initiative/activity * Health condition on which the initiative is targeting * Advocacy materials and tools used by respective initiative  1. In two regions, carry out formative research to understand current need, experience, knowledge and expectations of selected population where ADDOs have been implemented (see Proposed Geographical Area table below).  * Conduct interviews with ADDO consumers, households and local leadership to assess their knowledge about existing ADDO services and products within their localities. * Assess knowledge of ADDO customers and surrounding community on issues related to rational medicine use. * Assess availability and use of information, education and communication (IEC) materials promoting rational medicine use in that selected population.  1. Identify proposed strategies (options analysis) for consumer advocacy and education.  * Come up with a communication and advocacy strategy to involve consumers in monitoring accredited drug shops, or building advocacy support in existing community institutions (e.g., churches, mosques, schools, public health facilities). * Define strategy to eliminate inappropriate consumer use of medicines thereby reducing drug resistance.  1. Facilitate stakeholders workshop to develop consensus on consumer advocacy strategy and recommendations for next steps in relation to piloting of specific approaches to building advocacy.   **Timeframe:**  April 2012-October 2012  **Deliverables**   1. Report on inventory of advocacy initiatives and formative research (June 30, 2012) 2. Consumer advocacy strategy and options analysis completed (July 31, 2012) 3. Report of stakeholders consensus workshop and recommendations (September 30, 2012)   **Contractor**  TCAS (Tanzania Consumer Advocacy Society)  **Proposed Geographical Area**   |  |  |  | | --- | --- | --- | | **Region** | **District** | **Number of ADDOs in District** | | Ruvuma | Songea Urban | 58 | | Namtumbo | 31 | | Morogoro | Kilosa | 130 | |

# Executive Summary

The report entails on inventory of advocacy initiatives and formative research findings explored on an understanding on the current needs, experience, knowledge and expectations of ADDOs’ consumers, local leaders, and ADDOs’ dispensers from Kilosa, Songea Urban and Namtumbo. The study employed various interviews techniques such as focus group discussions (FGDs), teleconferences and face-to-face interviews (F2FI) with our key informants[[2]](#footnote-2).

The research purported to help the partners MoHSW, TFDA, PC, MSH and others to understand the ongoing consumer advocacy initiatives in Tanzania, assessing consumer advocacy needs and expectations, and identifying and recommending potential approaches to addressing these needs and expectations. The study also informs on ADDO services and products, the gaps in ADDOs’ operations, current medicines handling knowledge and attitudes among selected participants/consumers in the three localities.

The study key findings are summarized below:

**Part 1: Research Methodology**

This part shows ethical considerations taken by the research team including; paying curtsey calls to DMOs, and Council Directors, the drafted research protocols and how the research team adheres to them. About four-research’s tools developed including questionnaire for consumers, questionnaire for local leaders, questionnaire for ADDOs’ dispensers and FGDs protocol. Data collected using these tools through face to face interviews (F2FIs), focus group discussions (FGDs), field observation, teleconferences and literature review.

SPSS data analysis was used and all research findings are clustered in the six parts of this report, responding to respond to every sections of assignment one, as per scope of work (SoW) shown above.

**Part 2: General Research Findings**

This part highlights the demographic and social information data of research key informants including respondents’

* About 15% of KIs involved in F2FI (228) are between 9-15 years, while 50% are between 16-35 years; 20% are between 36-55 years of age while 16% are above 56 years.
* About 57% of respondents involved in F2FI were female, while male were 43%
* At the same time discussants involved on FGDs (298); 52% were female while 48% were male.
* On average 16% of those involved on F2FI (228) don’t know how to read and write; 47% have primary school education, 24% have secondary school education, while 13% have college education and above.
* 54**%** of the total respondents for F2FI with consumer were married, 32% were single and 11% are widows and 3% are divorced and living alone as single father or mother.
* The average number of people living in one household comprised of 6 people.
* Women (mothers) are said to have the leading role as family-caregivers at the household level.
* 14% of the respondents have permanent employment (PE); 73% are engaged into agriculture activities, 17% are engaging on petty trade[[3]](#footnote-3) and others.
* All the above information has the implications on the approach and methodology one is going to use for consumer advocacy.

**Part 3: Taking inventory on consumer’s advocacy initiatives**

Since 1967 Tanzania was practicing socialism policies whereby all means of production were under the state’s control during this period there was not any kind of consumer advocacy. In the mid 1980’s there had been policy change from socialism to trade liberalization, where market forces (demand and supply) control the market from this time onward Tanzania started to adopt sectorial regulatory statutes.

The shift caught consumers unaware and unprepared with very little consumers’ advocacy initiatives on how they can respond to current opportunities and threats associated free market economy in globalized world. Since then to date Tanzania consumers—

* Are unaware of the existing institutional mechanism for their rights protection
* Despite the fact they have wide range of products and services to choose but, they are at the mercy of unscrupulous traders who are taking advantage of flooding the market with unsafe products, counterfeits, using unethical trading tricks.
* Lack reliable and timely information;
* Out of all key informants (611)[[4]](#footnote-4) no one knows anyone who has been compensated after adversely affected with medicines – there is no redress mechanisms.
* Have the feelings of powerlessness as there are no clear complaining procedures i.e. issues service providers liability negligence aren’t yet been dealt using the current procedures.
* Starting 2012 PST is conducting national pharmacy week for consumers while there are other consumer advocacy efforts by civil societies such as TCAS, PSI, Benjamin Mkapa HIV/AIDs Foundation and MEWATA most especially on consumers’ rights and responsibilities, malaria campaign, HIV/AIDs, rational use of condoms, capacity building and women support on cancer

**Part 4:Consumers, households and local leader knowledge about existing ADDO services and products within their localities**

**Key findings**

* All our KIs agreed that since ADDOs inception, ADDOs are fulfilling the intended objective that is making medicines available in rural, peri-urban and urban areas at affordable prices compared to the situation before their establishment.
* Consumers don’t understand the difference between ADDO and pharmacy.
* Consumers don’t know the list of OTCs and those under prescription medicines as they are urging to ADDOs’ dispensers for all types’ medicines without prescriptions.
* Medicines peddlers if remain unmonitored in future can pose a challenge to consumers’ welfare and ADDOs business operations.
* Consumers do understand the importance of health insurance for their health care however there are missing links between ADDOs and the insurance initiatives especially in rural areas.
* There are few ADDOs (nine in number in Kilosa district) which provide medicines for NHIF beneficiaries however there is none in Namtumbo while in Songea urban NHIF beneficiaries are served by three pharmacies.
* More ADDOs are willing to be contracted to serve NHIF beneficiaries to ensure quality healthcare, medicines availability and affordability for consumers.
* Consumers urge for extra services such as injection, diagnosis, dressing of wounds and drips while some ADDO’s owners are taking the opportunities as they come.
* Local leaders are complaining to be side lined on inspecting ADDOs; the move has more negative impacts on the issue of ADDOs’ compliance at grassroots level.
* The team has observed that local leaders’ moral on doing ADDO related works is down.
* VEO and WEO have key and important roles to play to ensure a successful implementation of ADDOs program country wide.

**Part 5: Consumer’s knowledge on issues related to RUM**

**Key Findings**

* About 68% of respondents involved in F2FIs, agreed to get directives from ADDOs’ dispensers on how to use their medications.
* There are knowledge gaps among consumers on using the medicines timely
* Consumers revealed to experience medicines overdosing and under dosing due to non-adherence to dosing regimens.
* There are habits of under dosing as 48% agreed that they don’t finish their medication.
* The discussants revealed that the remaining dose can be stored for future uses or it can be shared to other member of the family or neighbour when fall sick.
* Some are buying ¼ or ½ a dose either due to poverty or low knowledge on the importance of completing the dose cycle
* Consumers have the concept of immediately get healed after using medicines
* Consumers don’t associate medicines with side effects

**Part 6: Assessment on availability of IEC materials promoting RUM**

**Key findings:**

* There is good ADDO brand awareness in all the three areas; however consumers fail to differentiate ADDO and pharmacy.
* There are posters and leaflets at ADDOs and PHFs focusing on rational use of malaria drugs (ACTs) and rational use of condoms all provided by PSI.
* There is Swahili poster on ‘’medicine dispensing guidelines and procedures’’ in almost every ADDO visited in Kilosa district.
* There are few posters/IEC materials with tips on the do’s and don’ts for consumers on rational medicine use at ADDOs.
* There are no IEC materials with pictorial demonstrations on the tips for consumers, who don’t know how to read and write.
* Radio is the most preferred advocacy method as in every 100 households there are 83 radios but still underutilized on educating the community on rational medicine use
* There are no religious initiative on rational medicines use neither at church nor at the mosque

**Part 7: Conclusion and Recommendations**

* The research findings showed that there is lack of awareness and understanding of ADDOs services and products by consumers.
* There is lack of awareness and understanding on rational medicine use.
* Consumers’ activism on rational medicine use is still very low.

# Part 1: Research Methodology

## 1.1 Ethical consideration

The team paid courtesy call to the registrar of Pharmacy Council, Ms. Mildred Kinyawa and she gave the team an introductory letter for Kilosa, Songea Urban and Namtumbo. The team visited DMOs’ and councils directors’ offices; they allowed the team to undertake the research while accompanied with the district’s pharmacists. They wrote introductory letters to all wards and villages’ leaders instructing them to mobilize the participants to this research.

Numbers of ethical issues were considered for example all information collected from KIs is treated confidential as per TFDA Act, 2003; Protection of informers sec 119, sub-sec (41).

The research was carried out between 16thMay – June.30th2012; the fieldwork involved three purposely selected districts of Kilosa, Songea Urban and Namtumbo. The research involved 23 wards randomly selected and visited, for instance in Kilosa the team visited 12 wards, namely;- Mbui, Kasiki, Rudewa, Msowero, Dumila, Ruhembe, Magubike, Gairo, Msingisi, Mikumi, Ulaya and Zombo. In Songea Urban, the team visited and interacted with 6 wards namely; - Bombambili, Lizaboni, Tanga, Lilambo, Ruvuma and Mfaranyaki (Mjini), while in Namtumbo district the team visited and interacted with five wards namely Rwinga, Namtumbo, Mchomolo, Litola and Namabengo.

During the field visits in Kilosa, Songea Urban and Namtumbo, the team conducted interviews with ADDO consumers, households and local leadership to assess their knowledge about existing ADDO services and products within their localities. Also the team explored relevant information so as to understand all required themes under this formative research, the team assessed consumer needs and expectations**[[5]](#footnote-5)**, identified potential challenges that address ADDO’s consumers’ needs and expectations. In so going team involved five practical data collection methods;-

1. Conduct face to face interview (F2FI)
2. Conduct focus group discussions (FGDs)
3. Teleconference interviews
4. Field observations
5. Literature reviews

**1.2 Research tools developed**

**1.2.1 Face-to-face interviews (F2FI)**

In order to do what is required in the SoW; the team conducted interviews with ADDOs’ consumers, dispensers and local leadership to assess their knowledge about existing ADDO services and products within their localities. Three research tools (questionnaires) were developed and tested for consumers, dispensers and local leaders.

**1.2.2 Number of FGDs and respondents to be involved**

In order to do what is required in the SoW; the team conducted FDGs with households to assess their knowledge about existing ADDO services and products within their localities. The team conducted one FGD in each of the 23 wards, involving representatives from 2 households from the community around[[6]](#footnote-6).

To ensure equal representation, the team focused on gender balanced approach and appropriate age cluster representation in accordance with demographic data given below.

The tools were prepared with questions focusing to explore the knowledge and skills gaps by attesting the level of respondents’ knowledge, skills, attitude and behaviour on medicines use, rational use of medicines, ADDO’s operations and pharmaceutical services in general.

The questionnaires were somehow identical; however probing questions were included to catalyse respondents to share wide knowledge and feedback.

**Table 1: Number of Study Participants**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| District | # of Wards | # FGDs | | # F2FI Consumers | | # F2FI Dispensers | | F2FI Leaders | |
| M | F | M | F | M | F | M | F |
| Kilosa | 12 | 69 | 74 | 45 | 63 | 8 | 22 | 10 | 02 |
| Songea Urban | 06 | 29 | 41 | 24 | 36 | 5 | 17 | 03 | 03 |
| Namtumbo | 05 | 45 | 40 | 21 | 39 | 03 | 08 | 04 | 01 |
| Sub-Totals | **23** | **143** | **155** | **90** | **138** | **16** | **47** | **17** | **06** |
| Grand | **23** | **298** | | **228** | | **63** | | **23** | |

## 1.3 Pre−testing of tools

The pre-testing of tools was conducted on 21st.May.2012 at Mwalusembe village in Mkuranga district. Through pre-testing exercise the team managed to assess the applicability of the tools in the intended communities.

From the pre-testing exercise, there had been few changes on the tools like adding issues of ‘*’health insurance’’* and ‘*’community health fund’’* so that to probe on medicine availability and affordability at ADDOs using the two, also relevant swapping and shifting of sections, omissions and additions were effected on the tools for instance using of the word ‘’*medicines*’’ instead of ‘’*drug*’’ while the way to approach the community was basically cemented in line with culture, age and gender so to have a deeper reflecting of their current behaviours**.**

## 1.4 Study challenges and limitations

The main challenges experienced in executing the assignment were, the limited understanding of rational use of medicines among many stakeholders, the absence of a consumer activism in all health segmentation models and the absence of specific research among consumers relating to levels of consumer protection in health sector.

In some cases the number of participants for FGDs was too high for instance, instead of eleven discussants invited, the attendance was up to eighteen to twenty five, and hence more time was taken in discussion to ensure that everyone gets involved. At some point, some of the discussants were village chairpersons; this was hindering free discussions.

Some of the ADDOs were found closed as the researchers were regarded as inspectors and sometimes closed as some of the dispensers are also engaged in farming activities; the team experienced this in the following wards; Msingisi, Gairo, Msowero and Mikumi in Kilosa, Mchomolo in Namtumbo and Lilambo in Songea Urban.

## 1.5 Data Analysis

SPSS system was used to analyse the information collected, data were presented in the form of social economic data, where the sample individuals’ information were divided into different groups based on area, gender, age, education, marital status, form of employment, household information, use of ADDO and health facilities service.

# Part 2: General Research Findings

## 2.1 Demographic and Social economic Information

**2.1.1 Age**

### The F2FI involved all those considered to be of schooling age from nine years and above, pupils, youth[[7]](#footnote-7), adult and the old, the total number of years for 228 respondents was 7752 years representing the average number of 34 years for those participated in the F2FI to be in the youth age group. To breakdown the statistics those between 9-15 years were15%, between 16-35 years were 50%, between 36-55 years were 20% and above 56 years were 16%.

**% of Age groups for F2FIs F2FIs: # of respondents by age groups**

**2.1.2 Gender**

About 228 respondents involved in F2FI with consumers, out of (228), 130 were female presenting 57%, while male were 43% presenting 98 males. At the same time about 298 participants attended FGDs; of those 52% (155) were female while 48% equivalent to (143) were male.

**F2FIs’ Respondents by gender FDGs’ Discussants by gender**

**2.1.3 Education**

On average the respondents in F2FI with consumers 16% of (228) don’t know how to read and write; 47% have primary school education, 24% have secondary school education, while 13% have college education and above.

**2.1.4 Marital status**

54**%** of the total respondents for F2FI with consumer were married, equivalent to 123 people, while 73.people equivalent to 32% were single and 11% are widows and 3%are divorced, and they live alone as single father or mother.

**2.1.5 Household information**

Of all respondents to F2FI (228), they were asked how many are you in the family, the total family members recorded stood at 1369 people, therefore the average number of people living in one household comprised of 6 people. Through FGDs, women (mothers) are said to have the leading role as family-caregivers at the household level, hence more women were engaged than any other groups in FGDs and F2FIs so to explore more information at household level.

**2.1.6 Occupation**

Out of 228 respondents; 14% of the respondents, equivalent to 32 respondents have permanent employment (PE) while the rest 86% (equivalent to 196) have got no wage employment instead, are engaged on self-employment either in business or agriculture. To break it further out of 196 are on self-employment, (143) equivalent to 73% are engaged into agriculture activities, while (53) respondents equivalent to 27% are engaging on petty trade[[8]](#footnote-8) and others.

## 2.2 Consumers’ expectations

Expectations have been described as "subjective notions of things to come, including type of hypothesis formulated by the consumer. Therefore in order to understand the current consumers’ needs, experience, knowledge and expectations. Interviews and discussions with key informants tried to explore greater in-depth understanding of consumer satisfaction and dissatisfaction[[9]](#footnote-9), for instance the following two key questions were asked i.e. ‘*’Based on your experience, what are the positive things about ADDO’’ and ‘’Based on your experience, what are the things need to be improved at ADDO’’.* From the two questions, we received about 1,582 answers; referring to consumer "attitudes" or "aspirations," or "images" of products, brands and these terms may be considered implicit forms of expectations as shown in table 2.

**Table 2: List of Consumer’ expectations**

| **Consumers’ Satisfaction** | **Consumers’ Dissatisfaction** |
| --- | --- |
| **COMPLIANCE ISSUES** | |
| * ADDO are professionally operated * ADDO adhere to all TFDA guideline * ADDOs are Clean and tidy | * There are unregistered medicines dealers in the community * Poor policy enforcement, few inspections are done at ADDO * Conflict of interest for medical personnel to also own ADDOs * High level of self-medication uncontrolled sale and use of medicines, * Some ADDOs are located close to hair cutting salon * We don’t know consumers’ complaints and redress procedures |
| **ADDOS’ PRODUCTS AND SERVICES** | |
| * There are good product’s health and safety precautions * Medicines bought at ADDO are good as they do cure us. * There is Good customers care- dispenser counsels their clients on RUMs * We cure our diseases based on “illness” including symptoms, progression of illness * We are allowed for self-prescriptions at ADDO * Antibiotics are easily available * There is user friendly services at ADDO compared to PHFs | * Fake and substandard medicines are sold * Government’s medicines are sold at ADDOs * No counselling IEC tips at ADDOs * Medicines instructions are in English * No pictorial demonstrations for those who don’t know how to read and write. * Side effects of medicines i.e. medicines with sulphur causes allergy for some of us. * ADDOs refuse to offer diagnostic, drip, blood pressure checks, and injections * Low awareness on RUMs * Dispenser don’t listen to our problems they are so fast when attending us * Dispensers being members of the community they share clients secrets - no confidentiality |
| **AVAILABILITY AND AFFORDABILITY** | |
| * There is good competition at ADDO to regulate prices * Products I want are always available * Some consumers with financial difficulties are given informal credit facilities * Presence of CHF and health insurance help people to get good health care * Just in time services as we get in and out of the ADDO. * ADDO maintain product availability and a flexible supply chain | * ADDO is business oriented and not service based due to high prices of medicines * Medicines are sold at high prices * No night services at ADDOs for people who fall sick at night * Not all contraceptives are available at ADDO * There are few ADDOs compared to demand * No government subsidies on medicines * CHF and National Health Insurance cards aren’t accepted at majority of ADDO * Elders don’t get proper care and are not even being treated free as promised by the government |

**2.3 Consumers’ protection as explored in Kilosa, Songea Urban and Namtumbo**

Consumers’ participation in monitoring the quality, appropriateness, affordability of the products and services provided by ADDOs should be linked with issues of consumers’ rights, responsibilities in the package of consumer protection.

**2.3.1 Redress mechanism**

To complement this part of assignment, the team probed on ‘’where do you go to lodge a complaint about medicines’’ The discussants revealed that as for now they don’t know where to go in case they have a complaint about medicines or health related complaint most especially for harmful or seriously unpleasant effects occurring at doses intended for therapeutic.

All the respondents revealed that they don’t know the presence of Adverse Drug Reaction (ADR) form attached as annex I and Patient’s Adverse Drug Reaction Alert Card attached as annex 2 and they don’t know where these two forms can be obtained.

The two forms are part of pharmacovigilance[[10]](#footnote-10) indicators for regulator. The regulator always takes action on a particular medicine with serious adverse reaction and not for specific consumers’ concerns[[11]](#footnote-11) seeking for redress.

Most of the discussants revealed that they haven’t heard any consumer been compensated for malpractice claims in the court of law. Also they don’t know who is liable to pay compensation in-case of adverse event i.e. severe body injury, disability or death.

As for the current situation, the market applies caveat-emptor principle that literally means to let the buyer beware on what they buy and consume from the market; The discussants revealed that ‘’*It is unfair to hold consumers liable for risks over which they have no control rather than the manufacturer/importer who profited and isn’t hold responsible for placing the defective product in the market’’.*

### 2.3.2 Consumers’ feelings of powerlessness

The KIs were probed on ‘’who is to take responsibility in-case one is adversely effected by medicines. One discussant gave a testimony on his family experience on the same ‘’*I bought metakelfin-Kenya for my daughter at ADDO - three weeks ago, unluckily my daughter was adversely affected by it and I spent about (350,000 Tshs) to get her recovered at Songea -Regional hospital, no compensation given, no ADR form filled, despite the report on the incidents been shared to our village dispensary, district and regional hospital. Ridiculously ADDO’s dispenser refused to take any responsibility on the matter’*’

*‘’Over years there are cases of fatal overdoses linked for the deaths of our family members; it is difficult to identify who is to be blamed most especially for us in rural areas, worse enough we don’t know the list of professionals with prescriptive authority (who is who in our health system) as for now everyone prescribes’’*.

Some KIs have said that ‘’always the cause of death is justified to be the disease or the health condition of the deceased suffering but nothing is probed on the scene of a medicine related death.

One respondent said ‘*’the course of death of the famous musician, Michael Jackson was easily linked to prescribed medicines in the USA, could that be possible in Tanzania?’’*

# Part 3: Taking inventory on consumer’s advocacy initiatives in Tanzania

## 3.1 Country situational analysis

Tanzania adopted socialism policy since 1967, but in the mid 1980’s there was a shift of policy to free market economy. The shift caught Tanzanians unaware and unprepared with very little knowledge on how they can respond to current opportunities and threats associated with globalized economy.

The government has provided several important pieces of legislations, the most important existing legislations classified into several sector and related regulations as per the list inserted at the footnote[[12]](#footnote-12). Despite the increasing speed in adoption of statutes for sectors’ regulations, consumer advocacy in Tanzania has yet been given the required attention as there are several missing links on policies, legislature actions and compliance with the present policies, laws and actual consumers’ welfare.

In general the attention of government and other development partners’ on supporting health sectors historically focused primarily on developing the supply side including building of health facilities at all levels, human resource development, resource mobilization, diseases prevention campaigns of which is good thing to do.

However as (D-Ellerman, 2002) argues, improving the investment climate for one group may make it worse for some other groups. Despite the reforms; fairness, non liability on abuses and transparent treatment of consumers isn’t always ensured, the low awareness vacuum by consumers is still being exploited negatively by unscrupulous traders.

While Section IV of the 1999-UN Consumer Protection guidelines, underscores the need for governments and international organizations to promote and facilitate capacity-building in the area of consumers advocacy and support.

## 3.2 What is consumer and consumer advocacy?

In (ISO 26000) Consumer is defined as an individual member of the general public, purchasing or using products or services for personal purposes; while the general understanding of the word ‘’consumer’’ is referred to as the end user of goods and services (in this case at ADDO we refer pharmaceutical products and services)**.**

In this report, consumer is also referred *to* sick person/patient who dwells in the general public or PHF whom in the end uses ADDO’s products and services for him/herself, by him/herself or through caregivers at the household level or/and PHFs’ personnel.Therefore in this report one will see ‘*’****consumer****’’* iscalled *‘’****patient****’’* also ***consumer*** be called ***person/customer*** interchangeably*.*

‘***’Consumer advocacy’’*** can simply be defined as the act of advocating on behalf of consumers/patients who buy products and services in the society in this case medicines and health services.

Sometimes consumer advocacy can take the form of awareness creation on rights and responsibilities, consumer organizations or any other may inform consumer about problems with services or products. Consumer advocacy focuses on various aspects of supply of services and products and weaknesses of demand by creating awareness on rational medicines use, tips on rights, and tips on obligations, tips on abuses or defective items.

**Table 3: Consumer Advocacy Activities**

|  |
| --- |
| * Helping consumers to rationally use products and services * Assisting consumers to ensure that their rights are respected. * Helping consumers to resolve complaints on products or services. * Creating awareness on where and how to file complaints * Encouraging consumers to air their voice including their satisfactions and dissatisfaction * Seeking for market fairness * Lobbying for policy change for more consumers’ welfare * Providing up-to-date information on quality and safety of goods and services, * Giving practical advice, where consumers can go for help. |

**The President of the United Republic of Tanzania issued a Notice on assignment of Ministerial responsibilities (Instrument) vide Government Notice No.494 of 17th December, 2010.  In that Instrument, the President has created a Ministry of Health and Social Welfare which is mandated for formulation of health and social welfare policies and monitoring and evaluating their implementation as well as ensuring that all Tanzanians access quality health and social welfare services; ‘’**[*a vision of a better quality health and social welfare services*](http://salsa.democracyinaction.org/dia/track.jsp?v=2&c=G0dsiKZbBDXJ4ElKuKazuohl2IShM%2FNe)*’*’

## 3.3 Existing consumers’ advocacy initiatives at central and local/district levels

## 3.3.1 National framework on consumer advocacy

Private health facilities including religious; in the form of dispensaries and hospitals Village Health Service, Dispensary Services, Health Centre Services, Health Centre Services, District Hospital, Regional Hospitals and Referral/Consultant Hospitals complement the public health care provision and on some cases tends to be a good consumers advocacy platforms as per given explanations above.

TFDA is a regulatory body under the Ministry of Health and Social Welfare which is responsible for regulating the quality of drugs, food and cosmetics. Amongst others functions; TFDA is also providing public Education; the public education section is responsible with marketing TFDA and its activities through educating and informing stakeholders on all issues related to institution’s functions such as control of the quality, safety and rational use of drugs, food, herbal drugs, cosmetics and medical devices.

TFDA on several occasions hold TV and radio programs and gives alerts to the general public on fake and substandard medicines proven to be found in our market and on some instances recall Medicines which aren’t fit for use.

* + 1. **Civic societies**

Civic societies are strong in Tanzania and cover many sectors and sub-sectors such as; public education, entrepreneurship, agricultural and healthcare. These institutions often have strong grassroots knowledge and footprints, but many are resource poor. However, they can form excellent partners for GoT and the private sector.

**Pharmaceutical Society of Tanzania (PST).** PST is an association formed by pharmacists. In June.2012 the society for the first time launched a ‘’National Pharmacy Week’’ which will be celebrated annually with a series of professional activities. The theme for this year was ‘*’informs the community on the proper use, storage and disposal of medicines in households’’*. This caters for the need to enhance community understanding on handling medicines at household level.

**Medical Women Association of Tanzania (MEWATA)** works to see Tanzanian population accessing quality health services that are affordable and sustainable through efficient and effective support systems. Also MEWATA is focusing “to advocate for and facilitate provision of quality health services among women, young people, children and men through existing social systems and capacity building among health professionals”. In so doing MEWATA

* Established an effective information centre for purpose of enhancing the standard of professional expertise.
* Prints, publishes and publicizes the IEC materials for the general public on health related topics including cervical cancer
* Advocates for policy changes in the health sector in favour of community well-being and medical professionals.

**Health Professional associations.** Despite the media coverage when these health profession associations are commemorating their world professional days, there are few consumer advocacy activities known from these association such as ‘*’Registrar of Private Hospitals’’* (RPH), ‘*’Optical Council of Tanganyika’’* (OCT), ‘*’Medical Council of Tanganyika’’* (MCT), ‘*’Tanzania Nurses and Midwives Council*(TNNC), ‘*’Private Health Laboratories Board’’* (PHLB); ‘’*Medical Laboratory Scientists Association of Tanzania’’* (MELSAT), ‘*’Environmental Health Practitioners Council’’* (EHPC), ‘*’Medical Association of Tanzania’’*(MAT), ‘*’Tanzania Registered Nurses’’* (TARENA), *‘’Clinical Officer Association of Tanzania’’* (COATA) and ‘*’Association of Health Services Administrator’’* (AHSAT).

**Population Services International – Tanzania branch.** PSI-Tanzania is a US base NGOs with a branch in Tanzania. It focuses to reach vulnerable population in its efforts to promote improved health for Tanzanians; PSI-Tanzania emphasizes implementation of activities that reach rural populations. With the support of its donors[[13]](#footnote-13), it developed a network of rural engagement teams (NGO and CBO partners) based in each region of the country.

Their teams are equipped with mobile video units, and are in charge of implementing and organizing activities ranging from community sensitization meetings, community theatre performances, road shows, mobile video unit shows, sporting competitions, essay writing competitions for school children and training of community own resources persons. These teams reach around half a million people per month in around 70 to 80 districts each month, mainly in remote and hard to reach areas. PSI-Tanzania reaches every district of the country with messages about Malaria[[14]](#footnote-14), HIV/AIDS, Reproductive Health and Safe Water.

**The Benjamin William Mkapa HIV/AIDS Foundation**. The Benjamin William Mkapa HIV/AIDS Foundation is a non-profit making, NGO established and incorporated under the Trustees Incorporation Ordinance, CAP 375. The focus areas are: Enhancing the delivery of quality HIV and AIDS care, treatment and other related services including Reproductive and Child Health to Tanzanians; to offer training and education, formal and non-formal, among Tanzanians for the purpose of increasing technical proficiency; to support vulnerable rural communities with insufficient Human Resource for Health to improve health care services; to carry out initiatives on prevention and control of HIV and AIDS, Tuberculosis, Sexually Transmitted Infections[STIs], and family planning education for both rural and urban communities; to involve People Living with HIV and AIDS in community education and fighting against AIDS.

**The Tanzania Consumer Advocacy Society (TCAS)** is an NGO and an independent consumers’ organization established to promote, protect and advocate for consumers’ rights in Tanzania. TCAS has touched on consumer advocacy on all its initiatives. The TCAS uses state-of-art public address systems, mobile video for road shows as well as several media channels to reach the public to promote consumer advocacy programs; these include radio and TV talk shows as well as newspapers.

Drama programs and famous comedians are also used; many press releases have been published dealing with various issues, including consumers’ rights with respect to health and product safety. At times, sector-level-regulatory-bodies provide support to TCAS including TFDA, TBS, EWURA and BoT on alerts need to be shared to consumers. TCAS started with 52 voluntary observers interested on consumer empowerment (VOICE). Today VOICE stands at 3891 members countrywide, including 705 university students who have become ambassadors of consumer advocacy in their respective localities and universities.

**Femi TV talks show - Ishi campaign, Sikika and Cheza Salama.com** through ITV and Star TV. These programs invite the general public, young people, experts, celebrities and politicians to discuss critical controversial issues relating to community with more specific note of youth lifestyles, HIV/AIDs, personal money management, family planning methods, use of contraceptives, promoting healthy lifestyles, livelihoods and green job creation. Segments also include testimonials, viewer letters, SMS and prize giveaways, as well as the comic element featuring comic character Bwana Ishi. Interactivity and commentary to the program are encouraged through SMS and email. Copies of the show are sent to schools, clubs and clinics for further use.

**3.3.3 Media**

There are several consumer advocacy programs in local media most of them are implemented by partners funded by USAID and other donor agencies most especially on malaria and HIV/AIDs initiatives programs. There are several TV channels[[15]](#footnote-15) and radio stations with consumer advocacy by civil societies mostly as mentioned above from the regulator (TFDA) to civil societies.

## 3.4 Assessment of consumer advocacy needs and expectations

Consumer advocacy needs can clearly be seen if one review and encounter the possible challenges in implementing consumer advocacy in Tanzania. Some of these challenges can be mitigated through carefully considered priorities *on what need to be done for* a smooth consumer education strategy. The possible challenges may include:

* Regulatory framework may limit the extent to which consumer advocacy may translate to access good quality pharmaceutical care and consumers rights i.e. does the regulation framework provide clear redress mechanism, does it give mandatory obligation to service providers to give consumers’ education.
* Lack of national dimension for consumer policy, law and enforcement including translation of the current legal framework to curb for consumer’s abuses.
* There are limited resources while the implementation of consumer advocacy can be costly
* The large dispersed rural population is difficult and costly to reach,
* Media channels are limited and expensive.
* There is limited information available for consumers in the context of consumer protection.
* Presence of negative consumption patterns and consumer behaviour i.e. over use of antibiotics, pain killers, under dosing and the like.

**Table 4: Approaches to addressing consumer advocacy needs and expectations**

|  |
| --- |
| Consumer advocacy strategy is therefore required to: |
| 1. Educate key stakeholders including government, private sector, health sector and civil society alike, on the benefits and importance of consumers advocacy. 2. Optimize resources through coordinating consumer advocacy initiatives and encouraging strategic partnerships for ADDO advocacy initiatives. 3. Guide and support stakeholders in the implementation and measurement of consumer’s advocacy initiatives. 4. Share lessons learnt to ensure continuing improvement of ADDO programmes. 5. Setting baseline criteria and measuring progress on a national level for ADDOs 6. Implementations activities amongst others should be undertaken at grassroots level by those who best understand the problem and have the mechanisms to reach ADDO’s consumers. 7. Implementing organizations should work together through strategic partnerships to improve their reach. 8. Implementing partners should follow a targeted approach and all players should set achievable targets i.e. ADDOs consumers. 9. A long-term vision and commitment is required from Government and stakeholders to form strong linkage between ADDOs and consumers. 10. Build evidence through projects which can achieve results over the short- to medium term. 11. Implement a monitoring and evaluation (M&E) framework during the design phase on both programme level and a national level. |

**3.5 Consumer advocacy expectations**

* + To help ADDOs meet the needs of those consumers who are most vulnerable or are at the greatest disadvantage.
  + To ensure that consumers are sufficiently well-informed to benefit from and stimulate effective ADDOs’ operations.
  + To ensure that products and services are safe and fit for the purposes for which they were sold.
  + To prevent practices which are not allowed and unfair to consumers?
  + To ensure accessible and timely redress is provided where consumer detriment has occurred.
  + To ensure that consumers are more aware of their rights, responsibilities, better able to act in their own interests to protect their rights and aware of their options to seek advice, assistance and redress.
  + Act as a watch dog to ensure that compliance and enforcement regimes deal with those that do not comply with the law.

# Part 4: Assessment of ADDO’s consumers, households and local leaders on their knowledge about existing ADDO services and products within their localities

## 4.1 Introduction

## 4.2 Consumers’ views about ADDOs existing services and products

**4.2.1 Why consumers prefer ADDOs over others options**

Despite the fact that there are several sources of medicines in these visited communities for instance; - PHFs are having min pharmacies, there are private pharmacies, ADDOs, peddlers, herbal kiosks and traditional healers.

Each of these sources attracts a certain market share i.e. out of 228 respondents, 92% of the respondents (210) agreed that they live close to ADDOs and always get their medicines from there; on average it takes about twelve minutes to reach an ADDO, this is approximately below one kilometre to reach most of the ADDOs in areas under review. However distances vary in rural, peri urban and urban.

The respondents with rural set-up like Mchomolo, Namabengo, Litola for Namtumbo District, Lilambo for Songea Urban and Ulaya, Zombo, Msowelo and Magubike for Kilosa district all have twenty seven minutes average time to ADDO[[16]](#footnote-16). We calculated the average by asking respondents how long it takes to reach the closest ADDO. The replies ranged from from 5 minutes to 90 minutes; 27 minutes was the mean.

While those with peri-urban set-up like Dumila, Gairo, Mikumi for Kilosa, Rwinga, Namtumbo for Namtumbo and Tanga for Songea Urban all in total have scored seventeen minutes to ADDO and those with Urban set-up like Bombambili, Ruvuma, Mfaranyaki (Mjini) for Songea Urban; Mbuni and Kasiki for Kilosa Districts and Rwinga for Namtumbo district have scored five minutes to ADDO despite the fact that there are places in the same area which can take more than the mentioned time.

**4.2.2 Medicine peddlers and ADDOs**

In comparative terms of ADDOs’ products with other sources, FGDs’ discussants revealed that, there are peddlers operating using motorbikes in some of the villages of Kilosa and Songea Urban; they do sell health herbal products, aloe vera (herbal plant) medicines and others. The peddlers do the-door-to-door marketing and the selling.

There are major concerns whether they are licensed and the medicines on sell are fit for human consumptions/application or not but unfortunately they are winning the market day by day; if remain unmonitored in future can pose a challenge to consumers’ welfare and even ADDOs by starting selling medicines allowed at ADDOs.

**4.2.3 Herbalists and traditional healers**

When respondents were asked, whether they are using herbal or traditional medicines, 26% of respondents said yes to these two options in comparison with ADDOs products. The respondents revealed that there are a good number of Masai[[17]](#footnote-17)traditional herbalists and herbal[[18]](#footnote-18) kiosks selling their medicines at the market places in Msowelo, Dumila and Gairo wards.

Consumers were asked why they do prefer using these medicines; the reply is that mostly if they don’t get healed with health problems such as barren mothers, epilepsy and mental disorders after using formal hospital treatment and medicines; the notion of being bewitched comes in.

The team observed that herbal medicine retailers operate entirely unsupervised. There may be a gap in our law of which regulator might wish to address on the quality of traditional herbal products sold.

**4.2.4 Perception as to why consumers opt for ADDOs**

The FGDs, discussants were asked to respond as to ‘*’why do they rely on these sources*’’ and ‘*’what are some advantages and disadvantages of these different sources’’* Patients are opting for ADDOs products and services, because ADDOs are close to where they are living and ADDOs’ dispensers gives advices on how to use their medicines, most of the time the essential medicines including those that satisfy[[19]](#footnote-19) the priority health-care needs of the population are available.

More so, some discussants said; *‘’going to the health facilities is expensive option as one need to have consultation fee between Tshs 1,500/=to 2,000/= per person; while at ADDO this amount can buy medicines straightway i.e. a dose of malaria such as ACTs’’*.

More so inability of government’s primary health facilities (PHFs) to meet consumers’ demands on medicines was said to provide a window of opportunity for ADDOs to fill the shortage. The discussants revealed that if one goes to PHFs always there are no medicines and there isn’t diagnosis equipment.

Some discussants revealed ‘*’that people are a bit hesitant to go to PHFs due to unavailability of medicines’’*. The F2FI revealed that 67% of respondents (153) are doing self-treatment[[20]](#footnote-20) by symptoms mostly malaria and they tend to buy medicines straight at ADDOs without having a valid prescription.

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| --- |
| **Facts Box 1: Key finding on why consumers prefer ADDOs services and products** |
| * *Easy availability of medicines i.e. OTC medicines* * *ADDOs are close to where we live as opposite to distance to PHFs* * *ADDOs’ products and services are reliable* * *No consultation fee required at ADDO* * *Public PHFs don’t have enough medicines* * *We get Just-in-time services no delays* * *Advice on rational use of medicines is given* |

## 4.2.4 ADDO services and Products: Availability and Affordability

ADDO dispensers revealed that medicines prices are high to the extent that some of clients fail to buy their medicines due to prevailing poverty. While, it is SDSI’s objective amongst others is ‘’*to enhance the accredited drug seller initiatives’ long-term sustainability, contributions to community-based access to medicines and care, and ability to adapt to changing health needs and health system context’’*

Taking into account of consumers’[[21]](#footnote-21) general views on affordability especially on high prices of medicines; the discussants in FGDs confirmed that it is through ADDOs ‘*’Nowadays there is no problem of getting medicines, the problem is how to get money to buy medicines*’’.

For ADDOs organization development (OD) and sustainability in future there is high need of linking Community Health Fund (CHF), National health Insurance Fund (NHIF) and other private health insurance firms to ADDOs.

The key informants[[22]](#footnote-22) (KI) agreed that public health support funds such as CHF, NHIF and other private firms have the potential to widen community ability to get good quality health care in a changing health needs (Adlung, 2001).

FGDs discussants revealed that they don’t have a say on NHIF and CHF initiatives as the rights of members to be heard aren’t clear[[23]](#footnote-23) and how one can lodge a complaints isn’t given.

**4.2.5 Affordability by the marginalized groups**

The discussants revealed that there isn’t adequate care for elderly; old people above 60 years of age are the most disadvantageous as they don’t have frequent income due to prevailing poverty. The old are struggling to get their medicines in all the sources including ADDOs due to lack of constant income; other disadvantageous groups are children and mothers therefore an issue of affordability becomes questionable to most of these groups.

|  |
| --- |
| **Facts Box 2: Generally consumer perceptions on NHIF** |
| * *Health insurance can assist majority of the people on receiving affordability health care services including pharmaceutical* * *People are aware of the NHIF initiatives* * *Some people have the perception that NHIF is for people with permanent employment* * *Most of the time we go to PHFs with NHIF’s card, we are told that there are no medicines.* * *Monthly deduction is done direct to our salaries for NHIF fee contributions.* * *There are nine ADDOs for NHIF members in Kilosa* * *There is none of the ADDO contracted for NHIF members in Namtumbo and Songea Urban* * *NHIF have contracted three pharmacies in Songea Urban for its members* * *Going to Songea to get medicines from Namtumbo or Lilambo is an expensive option when one is considering time and fare to and from* |

|  |
| --- |
| **Facts Box 3: General consumer perceptions on CHF** |
| * *People are aware of the CHF initiatives* * *if one doesn’t fall sick, is on the losing end of the money* * *Every time we go to PHFs, we are told that there are no medicines* * *There is discrimination of members; i.e. on the same disease and same list of prescribed medicines, ‘’A’’ can get medicines while ‘’B’’ can’t.* * *We don’t have a say on CHF initiatives as rights of members aren’t clear.* * *The initiative isn’t realistic as the household fee ranging from Tshs (5000 for rural, 10,000 for peri-urban and 20,000 for urban centre) is small to serve for health care and medicines of up to six family members per year while;* * *CHF ‘’matching funds’’[[24]](#footnote-24) from the GoT isn’t received on time or not at all.* |

**4.3 Consumers’ knowledge on ADDOs’ products and services**

F2FIs involved ADDOs’ consumers from several households revealed that, they prefer to get their medicines at public health facilities because medicines have government subsidies however they are always not enough.

Most of the discussants revealed that ADDOs are meeting their expectations[[25]](#footnote-25) as most of them have deeper product or service relationship after a satisfying experience on medicines efficacy and the good support received from ADDO’s dispensers.

KIs were asked on their knowledge on the types of the medicines and diseases these medicines cure, prevent pain. The following common diseases were mentioned; pain killers, malaria, typhoid, dysentery, and diarrhoea, STDs, coughing, flue, pneumonia, skin diseases, BP, pains killers and the like.

### 4.3.1 Knowledge on the list of medicines for OTC and those requiring prescriptions

ADDOs’ medicines fall into two categories; over-the-counter-medicines[[26]](#footnote-26) (OTC) and prescription medicines [[27]](#footnote-27)(WHO, 1994). OTC medicines are those that may be sold directly to consumers without a prescription while ‘*’prescription medicine’’* – may be sold only to consumers possessing a valid prescription. On this regards, discussants in FGDs revealed that they don’t know the list of OTCs and those under prescription medicines

Also the dispensers revealed that they always turn down many consumers coming to buy medicines such as diclofenac sod, erythromycin tablets, quinine tablets and injection, dextrose and many others without prescriptions while FGDs with members of the households revealed that they push to get their medicines without doctors’ prescriptions.

### 4.3.2 Knowledge on what are ADDOs’ allowed services

FDGs discussants revealed that ‘*’patients face several difficulties to access public health facilities including; long queues, lack of medicines, lack of money to pay for consultations fee, red-tape and bureaucratic procedures at PHFs, as a result they prefer ADDO-quick-services’’*. For instance some discussants revealed that ‘’*ADDOs’ dispensers being nurses and clinical offices, they are skilled enough to treat us with minor diseases’’*.

Some of the discussants at Bombambili Songea Urban said ‘’*in our society there are many people who don’t go to hospitals for diagnosis or doctor prescription, we just go to ADDO/pharmacy where we get the medicines we want for our various sicknesses’’*

Some respondents at Dumila and Msowero wards ‘*’perceives ADDO as a place one can get dispensary services such as; consultation, diagnosis, treatment including; - injection, dressing wounds and the like*’’[[28]](#footnote-28).Some discussants suggested that, doctors and lab-technicians need to be allowed to work for ADDOs so to improve ADDOs’ services.

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| --- |
| **Facts Box 4: Consumers’ Knowledge on ADDOs’ services and products** |
| * *Consumers portrayed that there is acute shortage of medicines in public PHFs hence provide a window of opportunity to ADDOs* * *Consumer are regarding ADDOs as reliable referral points for medicines availability* * *Consumers don’t know the list of medicines allowed for OTC and these require prescriptions* * *Consumers know that ADDOs dispensers are trained medical professional* * *Consumers urge for extra services at ADDOs like dispensary* * *Some consumers fail to differentiate between ADDO and pharmacy* |

## 4.3 Local leadership’s knowledge on ADDOs’ products and services

All the twenty three local leaders most specifically VEOs and WEOs interviewed applaud the good work done by ADDOs, since the initiative started.

The five WEO’s at Songea Urban pointed out that; *‘’During the first three years 2004-2007 of ADDO establishment here in Songea, local leadership was fully involved on approving new ADDO applications and inspection through ADDO-Village/Ward CDFC[[29]](#footnote-29)’’*, *but in the cause of time we are still approving new application but there had been less and less involvement on inspecting ADDOs, we no longer know what to do here at the grassroots!*.[[30]](#footnote-30)

**4.3.1 Local leaders’ roles**

Inspection and supervision of the ADDOs at grassroots’ level is vital for the sustainability of ADDO program including adherence to law, regulations and guidelines governing ADDO operations hence improving the quality of products and services provided to consumers.

Local leaders were asked on what could be their roles relating to ADDOs. Astonishingly no one out of the twenty three involved in this research happen to link his/her roles with the following;-

|  |
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| **Facts Box 5: No VEO/WEO linked his/her roles with ADDOs** |
| * *Inspect and supervise ADDOs at grass root level* * *Work closely with inspectors from higher level i.e. district, and regional, TFDA or PC* * *Prevent relationships that may lead to a conflict of interest like that of ADDOs’ owners and public health facilities employees* * *Prevent stolen medicines from public facilities being sold through ADDOs;* * *Report immediately any operational violation of law and regulation to CDFC/RDFC/NDFC* * *Mobilization of the community on rational medicines use.* |

* Local leaders are complaining to be side-lined on inspecting ADDOs; the move has more negative impacts on the issue of ADDOs’ compliance at grassroots level.
* The team has observed that local leaders’ moral on doing ADDO related works is down.
* VEO and WEO have key and important roles to play to ensure a successful implementation of ADDOs program country wide.

**4.3.2 Conflict of interest**

It was through FGDs, most of the discussant revealed that some ADDOs’ owners are also PHFs personnel “*Our nurse/s or doctor/s for village dispensary or HC, or DH or RH owns ADDOs close to where they work and they refer the patients to their ADDOs; one can see the prevailing conflicts of interest!.*

The common sense tells that when the same person owns ADDO, at the same time s/he is expected to do inspection and monitor the government’s medicines’ stock there is wide chance of conflict of interests.

**4.3.3 Presence of deteriorated premises and wrong set-up**

The team while in the field observed conditions for some ADDOs premises deteriorating since accreditation, some are located very close to bar, hair cutting and beauty salons[[31]](#footnote-31). One village chairman happened to say in FGDs ‘*’the most difficult aspect of maintaining good quality ADDOs’ services and products is maintaining frequent inspections’’*

# Part 5: Knowledge related to rational medicine use

## 5.1 Consumers’ knowledge on rational medicines use

The key informants to this research seem to understand what is ‘’*medicine*’ and what is it for, but there is a knowledge gap between medicines and rational use of medicines. For instance during F2FIswith consumers, respondents were probed on whether ADDOs’ dispensers direct them on how to take their medication; 68% of respondents (equivalent to 155) said ‘’yes’’ that they are getting directives on dosage regime.

The dispensers have the perception that consumers counselling is mandatory as they believe that consumer must be informed about safety precautions while using the medicines to avoid injury or adverse effects.

## 5.1.1 Knowledge on timing the daily dose

There is a perception by many discussants that medicines need to be consumed only during daytime between 06.00am to 7.00pm the latest and during night hours one is required to sleep. The reason behind this, may be, most of the rural areas lack electricity and people do hesitate to take their dose during night hour and hence mixing them or they are directed so by the dispensers.

Also few discussants said they take their medication within 24 hours, in the interval of eight hours i.e. first intake to start at 06.00 am, second intake at 14.00and the third intake at 22.00.

Also the team observed the way ADDOs’ dispensers were directing their clients on daily dose management in Swahili as; *‘’tumia hizi dawa tembe mbili, kutwa mara tatu, kwa siku saba mfululizo’’* and the translation by consumers is *‘’use these medicines, two tablets, three times during daytime for seven days consecutively*’’. Could this statement complement the perception by consumers to use their dose during daytime?

For those who prefer the daytime approach, some of them are complaining to experience difficulties when using their medication for instance; feeling dizziness, headache, vomiting, tiredness and the like; this habit of over-ingesting medicines within twelve hour assumption might be one of contributing fact for the implication of 48% of consumers aren’t finishing their doses, also in (Ofori-Adjei, 2001).This is to say majority of people don’t know appropriate timing to take their medicines.

## 5.1.2 The concept of buying a partial dose

ADDOs’ dispensers revealed that some of the clients fail to buy full doses due to poverty; instead of they allow for a dose to be bought on instalment i.e. in ¼ or ½ a dose so one can come to buy the other part of the dose later.

According to what had been revealed by ADDOs’ dispensers some of the customers who are buying ¼ or ½ doses don’t return to buy the remaining part of the dose.

And for those who don’t have money, sometime barter trade prevails like exchange of chicken/maize/beans and even goat when it comes for long illness which requires medicines and for those who are well known to ADDOs’ dispensers are given medicines by credit.

## 5.1.3 Consumers’ habits of not finishing their doses

The discussant revealed that in most case they stop taking their medicines based on the knowledge that; if symptom submerges one is cured. Also due to such knowledge some do stop their medicines soon after seeing disease’s complications aren’t felt.

The team also probed on what do people do with the remaining doses? The discussants revealed that the remaining doses are stored for future use or are used by other member of the family or neighbour when fall sick.

Patients are stopping to take their medicines without going back to see the medical practitioners. Several reasons might be given some are summarized in table 5 below.

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| **Table 5: Consumers’ Reasons for not finishing their doses** |
| * *Tablets are too many to complete the dose cycle i.e. quinine dose has about 42 tablets while ALU has 24 tablets* * *In the course of using the dose, we are getting much better at the middle of using the dose, and then stop the dose* * *We are buying ¼ or ½ a dose; the moment we don’t get money to buy the remaining dose; we just stop there* * *Medicines are too strong and we are getting dizzy and other complications* * *The moment we are getting a bit better we are saving the little we have (medicines) for future uses.* * *The habit of self-treatment by consumers* |

## 5.1.4 The habit of using pain killers to cure diseases

The FGDs discussants revealed that when consumers feel symptoms of diseases such as malaria, headache, stomach ache, and fever they are using pain killers instead of using the right medicines for the same; most of people are assuming that the cause of feeling discomfort might be work-fatigue. This habit is making diseases chronic hence difficult to cure.

## 5.1.5 The habit of over using antibiotics

The discussants revealed that they frequently buy antibiotics from ADDOs and use them for several purposes i.e. STDs, stomach ache, skins diseases and the like hence Over-use of antibiotics is leading to increased antimicrobial resistance they are facing.

## 5.1.6 The habit of not sharing information

It was through FGDs, the team noted the habit of double medication and overdosing i.e. some of caregivers like mothers do overdose their children when they use medicines, i.e. in the cause of using the medicines; sometimes the patient’s sickness gets serious, the caregiver[[32]](#footnote-32) takes the patient to the hospital/dispensary for more support; but due to amount of pressure the caregiver has, s/he doesn’t share with doctor the type of medication given to the patient as a results, if the practitioner in charge doesn’t ask there will be overdosing and adverse event occurs.

Consumers with the problem of drug reaction or allergy if identified are supposed to be given reaction alert card; of which they are supposed to carry all times and remember to show it to health care provider at each time of consultation. Discussants were asked if they have seen the Adverse Drug Reaction Alert Card before; Most of them said no.

The implication to the above line of argument is based on the problem of information sharing with medical personnel and this may bring several adverse events.

Consumers’ are using medicines with the notion of ***getting healed immediately***; while currently consumers don’t associate medicines with the side effects and other consequences, most especially if they are irrationally used.

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| **Facts Box 6: From the FGDs Why irrationally use of medicines (overdosing)** |
| * *Over prescription on the daily dose (DD) by medical professional* * *Consumer misunderstanding on the dosage regime* * *Many and different medicines are given per prescription to be used as DD* * *The habit of self-medication by consumes themselves* * *Easy availability of medicines* * *Consumer’s addiction /frequent use pain killers and antibiotics* * *Strong medicine is used on a weak patient i.e. quinine injection or drips* * *Prescribe medicines without regard to what another physician may have prescribed.* * *Failure to prescribe in accordance with clinical guidelines;* * *Prescribe medicines without taking into consideration what other medicines may have been used* * *Taking more medicine than what is required/directed i.e. the notion of using many tablets for quick recovery or* * *Mixing up the doses (double intake)* * *Loss of memory due to body-weakness caused by diseases* * *Intentions of committing suicide* |

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| **Facts Box 7: Key finding on consumer perception on ADDOs’ products and services** |
| * *ADDO’s are reliable referral points on medicines availability in rural and peri-urban and urban areas* * *Some consumers are regarding ADDOs as dispensary due to the extra services they are getting at some ADDOs.* * *Consumers don’t know the list of OTCs and those under prescription medicines as a result they are pushing ADDOs’ dispensers to sell all types of medicines without prescriptions* * *68% of respondents agreed that they are getting directives on dose usage by dispensers;* * *48% of respondents revealed not to finish their dose* * *Most of consumers prefers to take their daily dose during daytime (06.00am to 07.00pm) and not night* * *Some consumers go to traditional healers when they don’t get healed at the hospital* * *Some consumers don’t share valid information on other medicines used with medical practitioners* * *Consumers are more interested of getting healed rather than noting for medicines’ side effects* |

# Part 6: Availability and use of IEC materials promoting RUM

## 6.1 Programs, Activities and IEC material promoting RUM

## 6.1.1 Brand awareness ADDOs

The team has seen a number of IEC materials and brand awareness in Kilosa, Songea Urban and Namtumbo districts. There are massive “brand” awareness most especially at every ADDO no matter how small or big the outlet is, each ADDO had been tagged with a big similar advert ***“Duka la Dawa Muhimu’’***, hence gave a clear and broad brand awareness for ADDOs.

.



*Brand awareness for ADDOs - Duka la Dawa Muhimu*

## 6.1.2 Availability of IEC materials promoting rational medicines use

The team has observed some posters and leaflets placed on ADDOs’ walls and at PHFs; most especially insisting on rational use of malaria medicines, proper l use of condoms and consistent use of mosquito nets and we have seen posters at ADDOs demonstrating ‘*’medicines dispensing guidelines and procedures for ADDO’s dispensers’’ and Standard treatment guideline (STD) and* there are few tips on ’’the dos and the don’ts’’ on rational use of medicines for consumers in Kilosa and none in Songea urban and Namtumbo district.



The team observed some IEC material promoting rational use of medicines such as malaria, ARVs and HIV/AIDs(as per above pictures) with few tips for consumers on the possible side effects and what need to be done in case one is adversely affected by medicines. There are few pictorial demonstration IEC materials to support those who don’t know how to read and write[[33]](#footnote-33).

## 6.1.3 Availability of consumer safety alerts forms

There are ’’Patient Adverse Drug Reaction Alert Cards’’ which are supposed to be given to clients proved to have allergy; the holder of the card is supposed to carry it every time visiting health facility so to avoid been prescribed with medicines which can cause adverse reactions. Few discussants acknowledged knowing the presence of the form as attached as annex2.

## 6.1.4 No IEC materials for health insurance

There are no leaflets produced to help health insurance customers and their families so to enable them to understand parameters of services and who is the appointed service providers within their localities. There aren’t members meetings to enable them have their say and improve the way CHF and NHIF initiatives are managed.

## 6.1.4 Media programs

Radio is the most preferred media program in the three areas under review, at least in every 100 households, there are 83 radios. There are popular community radios which are owned by Kilosa and Songea Urban councils i.e. for Kilosa council has ‘*’Radio Jamii’’* while in Songea municipal has ‘*’Radio Jogoo’’* which also covers up to Namtumbo district.

There are other radios such as Radio Abood, Radio Maria, Radio Tanzania, Radio One Radio Clouds, and Radio Free Africa. Feedback received from KIs is, in all these mentioned radios there isn’t specific radio program giving education on RUMs however all revealed that the common and most listened programs are national news, sports, gospel songs, religious teachings and entertainments, while most of our KIs prefer to listen to a radio in the morning and in the evening.

## 6.1.5 Arts, sports and drama

In the communities of Kilosa, Songea Urban and Namtumbo, there are good numbers of arts, drama and sports groups for youth, women and men. Youth have concentrated on football, Bongo flavour[[34]](#footnote-34) and hip-hop music focusing love and relationship themes; while there are traditional drama-groups with a lot of traditional education songs but none on RUMs. In every primary and secondary school there are sports and clubs activities i.e. a club for environment, but is none which had been connected on rational use of medicines.

## 6.1.6 Religious initiatives on RUM

Most people listen to their religious leaders and attend a mass or mosque once a week or more however there aren’t program either at the church or at mosque on RUMs, despite the fact that majority of the people in all the three districts are devoted Christians or Muslims, and are strong believers of their religious leaders, sheikhs and clergymen.

## 6.1.7 Village’s health committee

Every village has a village health committee; the village committee deals with education and campaigns on environmental health and sanitation whoever some of the village committees are active and some are dormant. Usually each village Health post have two village health workers chosen by the village government amongst the villagers and be given a short training before they start providing services.

Some village committees’ have active members who are doing advocacy works on malaria environment and sanitation campaigns; however they don’t involve themselves on issues of RUM and the committee members are claiming not to have the capacity to deal with those issues.

## 6.1.8 Community education on rational use of medicines

The research team attested whether there is any community education on RUMs; majority of discussants in FGDs stated there is no specific program that provides education in their respective communities on appropriate use of medicines neither in Kilosa, Songea Urban nor in Namtumbo.

However there are few programs providing basic skills on rational use of medicines especially at MCH/maternity clinics, NGO such as PSI and AMREF have programs on appropriate use of malaria medicines and ARVs in Kilosa and Songea Urban and nothing is known in Namtumbo despite reliance to ADDOs’ dispensers for the same.

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| **Box 8: Availability and use of IEC material promoting RUM** |
| * There is good brand awareness for ADDOs in all the three districts involved * There are posters and leaflets at ADDOs and PHFs on rational use of malaria drugs provided by PSI * There are Swahili medicine dispensing guidelines in every ADDO visited * There are few IEC tips on dos and don’ts on RUMs for consumers at ADDOs * There are radio stations and community radios covering the three areas * In every 100 households there are 83 radios while newspapers are available at urban centres. * There are no religious initiative known at church or at mosque on RUM * There is village health committee in every village, some active village committee members use IECs materials for door to door community health campaigns especially on malaria and HIV/AIDs |

# Part 7: General findings and recommendations

## Key finding on household information

The average number of people living in one household comprised of 6 people while women (mothers) are said to have the leading role as family-caregivers at the household level.

**Key finding on inventory for consumers’ advocacy initiatives**

There is low awareness and understanding on ADDOs services and products by consumers which is classified onto their failure to differentiate the list of medicines available at ADDOs through OTC and those requiring prescriptions. More so *some c*onsumers ask for un-allowed services at ADDOs such as injection, diagnosis, dressing of wounds and drips while some ADDO’s dispensers are taking the opportunities as they come.

*There are few consumer advocacy initiatives as result consumers are lacking reliable and timely information about ADDOs products and services.* Radio is the most preferred advocacy method as in every 100 households there are 83 radios but still underutilized on educating the community on appropriate use of medicines and health care.

There is no religious initiative on rational medicines use neither at church nor at the mosque however in every primary and secondary school there are sports and clubs activities i.e. a club for environment, but is none which had been connected on rational use of medicines.

**Key finding on consumer activism**

Apparently lack of actions by consumers when their rights are violated may also be partially explained by the absence of a comprehensive accessible and affordable consumer protection and redress mechanism in Tanzania *i.e. out of all key informants (611)*[[35]](#footnote-35) *engaged in this research no one knows anyone who has been compensated after adversely affected with medicines and they revealed that there is no redress mechanisms.* Hence consumers have the feelings of powerlessness as there are no clear complaining procedures i.e. issues service providers liability negligence aren’t yet been dealt using the current procedures.

**Key findings on local leadership and ADDOs**

It had been revealed some ADDOs’ owners are also PHFs personnel *for village dispensary or HC, or DH or RH they also own ADDOs close to where they work and they refer the patients to their ADDOs; one can see the prevailing conflicts of interest!.*

VEO and WEO have key and important roles to play to ensure a successful implementation of ADDOs program country wide. However local leaders are complaining to be side-lined on inspecting ADDOs; the move has more negative impacts on the issue of ADDOs’ compliance at grassroots level and the team observed that local leaders’ moral on doing ADDO related works is down.

**Key finding on ADDO’s products and services availability and affordability**

All our KIs agreed that since ADDOs inception, ADDOs are fulfilling the intended objective that is making medicines available in rural, peri-urban and urban areas at affordable prices compared to the situation before their establishment. However due to prevailing poverty some are buying ¼ or ½ a dose or due to the assumption that there is low knowledge on the importance of completing the dose cycle or lack of money.

On other development, it was revealed that consumers do understand the importance of health insurance for their health care’s affordability however there are missing links between ADDOs and the insurance initiatives especially in rural areas. For instance discussants revealed that they don’t have a say on NHIF and CHF initiatives as the rights of members to be heard aren’t clear and how one can lodge a complaints isn’t given.

Despite the fact that more ADDOs are willing to be contracted to serve NHIF/CHF beneficiaries to ensure quality healthcare, medicines availability and affordability for consumers however there are few ADDOs (nine in number in Kilosa district) which provide medicines for NHIF beneficiaries and none for Namtumbo and Songea Urban however in Songea urban NHIF beneficiaries are served by three pharmacies.

**Key finding on consumers’ knowledge on issues related to RUM**

About 68% of respondents involved in F2FIs, agreed to get directives from ADDOs’ dispensers on how to use their medications. However there are knowledge gaps and bad habit[[36]](#footnote-36) among consumers on not using the medicines timely, do the overdosing and under dosing due to non-adherence to dosing regimens[[37]](#footnote-37). The discussants revealed that the remaining dose is stored for future uses or it can be shared to other member of the family or neighbour when fall sick.

**Key finding on availability of IEC materials promoting RUMs and advocacy initiatives**

There are posters and leaflets at ADDOs and PHFs focusing on rational use of malaria drugs (ACTs) and appropriate use of condoms all provided by PSI. There are Swahili poster on ‘’medicine dispensing guidelines and procedures’’ in almost every ADDO visited in Kilosa district but few posters/IEC materials with tips on the do’s and don’ts for consumers on rational medicine use at ADDOs and no IEC materials with pictorial demonstrations on the tips for consumers, who don’t know how to read and write.

**Recommendation 1**

This shortcoming need to be recognized by the GoT and start to incorporate consumer protection issues in key policies including a vision of a better quality health and social welfare services by MoHSW i.e. introducing patient/client charter, introduce medicine information centre-toll centre.

**Recommendation 2**

Consumers need to be told on the limitation and scope of ADDOs in terms of the services and products they can be provided legally, the fact that they ask for extra services; add pressure to ADDOs dispensers; this needs a gradual mind set re-orientation.

**Recommendation 3**

Likewise; consumers need to be told that disease treatment by medical practitioners is a complex and tricky process that requires a professional analysis; the current consumer habit of ‘’self-treatment’’ that is trying to copy what doctors prescribed and tend to memorize the same line of treatment in future is a very risky attempt and might not always be the right treatment.

**Recommendation 4**

The team recommends that IEC materials need to be produced and there is a need of introducing Consumer complain desk at district, regional and at the Pharmacy Council head quarter.

**Recommendation 5**

There is high need of improving consumers’ advocacy initiatives so to equip consumers with the necessary skills, information, knowledge, and resources, to ensure that consumers have the right confidence and serve as natural watch dogs to notify the regulators about misconduct at ADDOs and also better manage their own health.

**Recommendation 6**

These findings will be used as baseline data to propose and develop strategies for consumer advocacy with a communication and advocacy strategy involving consumers in monitoring ADDOs and eliminate inappropriate consumer use of medicines thereby reducing drug resistance.

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## Annex 1: Form for Suspected Adverse Drug Reaction

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **REPORT OF SUSPECTED ADVERSE DRUG REACTION  INCLUDING BIRTH DEFECTS**  **TANZANIA DRUG AND TOXICOLOGY INFORMATION SERVICES (TADATIS)**  (Note: Identities of reporter, patient and institution will remain confidential) | | | | | | | | | | | | | | | |
| Patient Initials or Record No | | | Sex | | | | | | | Weight | | | | Age / Date of Birth\*\* | |
| Male | | | | Female | | |
|  | | |  | | | |  | | |  | | | |  | |
| Adverse drug reaction description\*\* | | | | | | | | | | | Date on set reaction | | |  | |
|  | | | | | | | | | | | | | | | |
| All drug therapy prior to reaction or birth. Use **brand name(s)** if known and tick suspected drug. | | Route | Daily Dose | | | Date Started | | | | | Date stopped | | Reason for use | | |
|  | |  | ……...... | | |  | | | | |  | | ……………………………………………… | | |
|  | |  |  | | |  | | | | |  | |  | | |
| Treatment (of reaction)\*\* | | | | | | | | | | | | | | | |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  | | | | | | | | | | | | | | | | |
| **Outcome:** | | Recovered | | Not yet Recovered | | | | | Unknown | | | Fatal | | | Died |
| **De-challenge:**  (Did the reaction subsided after the drug was stopped or dose reduced?) | | | | | Positive | | | | | | Negative | | Not done | | |
| **Re-challenge:**  (Did the reaction reappeared after the drug was introduced?) | | | | | Positive | | | | | | Negative | | Not done | | |
| **Permanent Deformation:** | | | | | No | | | | | | Yes Describe | |  | | |
| **Comments (e.g. relevant history, allergies, previous exposure to this drug):** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Reporting Doctor, Pharmacist, etc.** | | | | | | | | | | | | | | | |
| Name |  | | | | | | | | | | | | | | |
| Address |  | | | | | | | | | | | | | | |
| E-Mail |  | | | | | | | | | | | | | | |
| Phone |  | | | | | | | | | | | | | | |
| Annex 2: Patient Adverse Drug Reaction Alert Card | | | | | | | | | | | | | | | |
| **TANZANIA FOOD AND DRUGS AUTHORITY** *Front side* **ADVERSE DRUG \**    **REACTION ALERT CARD**  **ADVERSE DRUG REACTION ALERT CARD** | | | | | | | | | | | | | | | | |
| **PATIENT NAME: .............................................................................................................................. AGE: ...................................................................... GENDER: ............................................................ DATE ISSUED: .......................................................ADDRESS: ......................................................... SUSPECTED DRUG(S): ....................................................................................................................... DESCRIPTION OF REACTION: ........................................................................................................ Other comments (if any): ....................................................................................................................... ....................................................................................................................................................................** | | | | | | | | | | | | | | | | |
| ***Please carry this card with you at all times and remember to show it to your health care provider at each time of consultation*** | | | | | | | | ***Tafadhali hakikisha umebeba kadi hii kila wakati na kumbuka kumwonyesha mhudumu wa afya unapo pata matibabu*** | | | | | | | | |
| P. O. Box 77150, EPI Mabibo, Off Mandela Road, Dar es Salaam, Tel: +255-22-2450512/2450751/ 2452108, Fax: +255-22-2450793, Website: **www.tfda.or.tz**, Email: info@tfda.or.tz, adr@tfda.or.tz | | | | | | | | | | | | | | | | |
| **CRITERIA FOR ISSUE OF A PATIENT ALERT CARD** *Rear side* | | | | | | | | | | | | | | | | |
| **The alert card is to be given to:**  Patients who are hypersensitive/allergic/intolerant to a particular drug,  Patients who developed a 'near-fatal' reaction to any particular drug,  Patients who had a drug-induced morbidity to any drug,  Patients who had hospital admission due to an AR to any drug. | | | | | | | | | | | | | | | | |

1. *PC - Head, Education and Training Department* [↑](#footnote-ref-1)
2. *Members of the households/family were involved in FGDs* [↑](#footnote-ref-2)
3. *Like Mama Lishe, selling of used cloths, selling of raw food stuff like fish and Maandazi.* [↑](#footnote-ref-3)
4. *(63-were ADDOs’ dispensers; 298- were FGDs discussants, 228 were F2F respondents; and 22 WEOs)* [↑](#footnote-ref-4)
5. *’’Consumer Expectation’’ referred to as their needs and interests on goods and services* [↑](#footnote-ref-5)
6. Each household has six family members: Family members include; father, mother, children including in school and out of school and any other family dependent i.e. grand children and the like [↑](#footnote-ref-6)
7. In-school and out of school youth [↑](#footnote-ref-7)
8. Like Mama Lishe, selling of used cloths, selling of raw food stuff like fish and Maandazi. [↑](#footnote-ref-8)
9. *Do analysis whether service or product performance exceeds expectations*. [↑](#footnote-ref-9)
10. Referred to as the science and activities relating to the detection, assessment, understanding and prevention of adverse effects or any other possible medicine-related problems [↑](#footnote-ref-10)
11. According to WHO standard’s everyone has the right to complain about health care services (including pharmaceutical products and services) and to have such complaints investigated and to receive a full response on such investigation. [↑](#footnote-ref-11)
12. Tanzania Bureau of Standards Act; 1975 with it amendment of 2010; Weight and measures Act; 1982; Energy and Water Utility Regulatory Authority Act, 2001; The Surface and Marine Transport Regulatory Authority Act, 2001; Animal Diseases Act No.17 of 2003; Seed Act No 18 of 2003; The Merchant Shipping Act, 2003; The Industrial and Consumer Chemicals (Management and Control) Act, 2003; The Environmental Management Act No 20 of 2004; The Fisheries Act (2003); The Fair Competition Act, 2003; The Tanzania Communications Regulatory Authority Act, 2003; The Tanzania Civil Aviation Authority Act, 2003; Tanzania Food and Drug Authority Act 2003; The Bank of Tanzania Act, 2006 ; The Fertilizer Act No 9 2009; Pharmacy Council Act. 2011 and many other [↑](#footnote-ref-12)
13. *Clinton Foundation, Global Fund, USAID and others* [↑](#footnote-ref-13)
14. *Ensure that malaria treatment and prevention commodities and services are used effectively by Tanzanian households, particularly rural households* [↑](#footnote-ref-14)
15. Notable TV stations include; Star TV, ITV, TBC1, channel ten, others Mlimani TV. Tumaini TV, Capital TV, DTV, Capital TV, ATN, Cloud TV, TV Sibuka, just to mention some few. [↑](#footnote-ref-15)
16. Recommendations – establishment of new ADDOs must heavily focus to the rural population as more than 70% of the population lives in rural areas. [↑](#footnote-ref-16)
17. Masai is a tribe found in Tanzania and Kenya, their main activities is cattle keeping and they do migrate from one point to another for greener pasture [↑](#footnote-ref-17)
18. But the herbal medicines referred here aren’t labeled or prepared in pharmaceutical dosage form but they are believed to contain herbal active ingredients. [↑](#footnote-ref-18)
19. Usually rely on medicines’ efficacy [↑](#footnote-ref-19)
20. Buy medicines at ADDOs without consulting a medical practitioners [↑](#footnote-ref-20)
21. One of the rights of consumer is the right to basic needs (essential medicines); regardless of ability to pay. [↑](#footnote-ref-21)
22. Consumers, dispensers, local leaders including WEO and VEO [↑](#footnote-ref-22)
23. A member of a health insurance or medical aid scheme is entitled to information about that insurance or medical aid scheme and to challenge, where necessary, the decisions of such health insurance or medical aid scheme relating to the member. [↑](#footnote-ref-23)
24. The government committed to give ‘’a top-up backup fund’ of a similar amount contributed for CHF at every ward. [↑](#footnote-ref-24)
25. Access to a minimum pharmaceutical service all consumers [↑](#footnote-ref-25)
26. TFDA - ADDO Establishment Guideline 1st.Edition - Oct.2012 pg 46-49 shows a list of 127 different types of medicines which don’t require prescriptions [↑](#footnote-ref-26)
27. TFDA – Swahili-ADDO Establishment Guideline 1st.Edition - Oct.2012 pg 45-46 shows a list of 49 types of prescription medicines [↑](#footnote-ref-27)
28. Some ADDOs are performing abortion, injecting clients, dressing wounds [↑](#footnote-ref-28)
29. Comprise of VEO /WEO being a committee chairperson, clinician at dispensary, health officer and veterinary officer [↑](#footnote-ref-29)
30. Please note there is ADDOs’ technical team at village, ward, district, regional and National level. To be more specific on the two village and ward levels the ‘’Council Food and Drugs Committees’’ (CFDC), is under the chairmanship of the VEO and WEO respectively other committee members are medical officer in-charge, veterinary officer and health officer. [↑](#footnote-ref-30)
31. Though It was difficult to establish which one started first, was it a bar or an ADDO [↑](#footnote-ref-31)
32. *Consumers are responsible to provide to health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or/and counseling purposes.* [↑](#footnote-ref-32)
33. *This group is 16% of the respondents.* [↑](#footnote-ref-33)
34. This is Tanzania music [↑](#footnote-ref-34)
35. *(63-were ADDOs’ dispensers; 298- were FGDs discussants, 228 were F2F respondents; and 22 WEOs)* [↑](#footnote-ref-35)
36. Consumers have the perception of getting healed immediately after using medicines also have the habit of Over Using Antibiotics, the habit of using pain killers to cure diseases, the habit of not sharing information, and some don’t associate medicines used with side effects [↑](#footnote-ref-36)
37. 48% of respondents agreed that they don’t finish their medication. [↑](#footnote-ref-37)