What role can citizens play in addressing stock outs?

Key Findings

- Improving health care requires access to affordable essential medicines, yet critical shortages of those medicines persist in Tanzania.

- Shortages result not just from a lack of resources and technical challenges: local politics, accountability relationships and how information is used matter too.

- This briefing sets out four new ideas for how to address these institutional issues – and calls for a new coalition aimed at 'getting things done'.

1. Introduction

Improving health care requires access to affordable essential medicines. The Government of Tanzania has committed to a series of reforms to improve access to medicines and reduce user fees, especially for vulnerable groups. But change takes time, and a lack of access to essential medicines remains a chronic issue for many.

What else can be done to improve ordinary citizens' access to these basic medicines?

Research undertaken in September 2013 by Twaweza and the UK-based Overseas Development Institute suggests we need a better understanding of why medicine stock-outs persist and identifies a number of underlying factors that explain why recent reforms have not gone far enough. If we better understand the nature of the problem, we can identify more sustainable solutions – and, our findings suggest, these should prioritise citizens and their connections to service providers and policymakers. Our recommendations highlight four new ideas for building more sustainable and citizen-led solutions:

- Campaigns to improve transparency of medicine data at facility level
- Independent verification of facility-level data
- Using the media to highlight success and relative performance
- Looking for, connecting with and fostering positive deviance from a variety of actors

2. Why do medicine stock-outs persist?

Despite policy commitments, we know that medicine shortages persist, as shown in recent survey data. A 2013 survey by Twaweza, for instance, found that 41% of patients were not able to get the medicines they needed directly from a public health facility, while 26% of health facility heads said that a lack of medicines was the main problem facing their facility and 69% considered it to be one of the top three problems they faced (Twaweza, 2013). The 2012 Afrobarometer survey also found that 88% of Tanzanians had reported shortages of medicines at public facilities within the preceding year (Afrobarometer-REPOA, 2012).

Why do these shortages persist despite attempts to reform and improve current systems? We identify five underlying reasons, which have not been adequately addressed in the policy debate so far:

Health policies often focus on the simple, visible and politically rewarding – meaning stock-out solutions are not always a priority.

Politicians face pressures to deliver tangible and visible results to voters – whether building schools, health facilities or ambulances. This is true for most countries. In Tanzania, the ruling Chama cha Mapinduzi (CCM) has dominated the political landscape

since independence and is up for re-election in 2015. With more competition than in the past, within CCM and from outside it, these pressures have increased.

For health-related issues, this translates into a strong emphasis on expanding coverage and access to health facilities, particularly the pledge to build a dispensary in every village and a health centre in every ward (MOHSW, 2007). These reforms are popular, particularly in districts with no or limited access to health care. But there can be unintended consequences in the long run; for instance, creating more facilities without big increases in staff leads to the risk of overstretching an already understaffed health workforce. An increase in the number of facilities also makes the logistics of delivering medicines more complicated. Another visible strand of reform has been efforts to improve the Medical Stores Department (MSD), so that medicines are delivered directly to health facilities, bypassing district-level health authorities.

This short term approach, however, which focuses on very visible areas, has come at the expense of other, less visible and more complex reforms, such as the need for better performance management across the health system, including improved skills, enforcement of regulations, and better oversight of frontline staff. Another example is the need to strengthen decentralised systems, which currently operate mainly from the top down.

Resource shortages matter, but more spending alone cannot cure stock-outs.

Broader resource shortages in the health sector are frequently highlighted by the Ministry of Health and Social Welfare as the main cause of medicine stock-out problems. Estimates highlight just how big a gap still exists:

- In 2012-13 the budget for medicines and medical supplies was TZS 80 billion. Estimates for total needs were almost two and a half times larger – TZS 198 billion.
- Tanzania spends less than US$1 per capita on medicines every year compared to a national target of US$2.50 and global health initiative guidelines of US$5 (MOHSW, 2013).

This is not only a problem of financial resources: human resource gaps also contribute to medicine stock-outs. They exacerbate problems of medicine forecasting and contribute to heavy workloads, poor oversight and discipline issues and medicine wastage and leakages due to poor prescription practices.

- **Shortages of health workers:** A 2008 survey found that, looking across facility and health worker types (Sikika, 2010), on average, health facilities had 54%

fewer health workers in practice than is required by Tanzanian national standards.

- **Health worker concentration in urban areas:** A 2013 survey found that only 31% of health professionals were stationed in rural areas, despite approximately 70% of the Tanzanian population living in these areas (IHI, 2013).
- **Lack of key skills:** A 2011 report notes that only 55-60% of district pharmacists have pharmacy training, and low skill levels amongst health workers in general are noted across a range of studies (USAID, 2011).

Although severe, these resource gaps do not, on their own, explain stock-outs. They are also a reflection of policy choices. The lack of transparent and reliable data on medicine stocks means that it is hard to monitor and track availability, and as a result there is no clear consensus on what Tanzania's real medicine needs are or how much money would be needed to meet them. Poor co-ordination across government is another contributing factor here, with delays in the release of funds from the Ministry of Finance to the Ministry of Health, and then in turn to MSD, historically contributing to medicine stock-outs.

These issues are exacerbated by existing political competition and the focus on short-term policies. The drive to expand access to health facilities and dispensaries, for example, stretches the existing workforce even more thinly. However, a focus on recruiting, training and retaining health workers would only have a limited impact unless deeper issues around staff performance, discipline and oversight were also addressed.

Information and supply-chain systems have improved, but data reliability and usage is still a big problem.

Challenges with the medicine supply chain and data collection reflect in part the complex technical and logistical aspects of medicine supply chains, which have been analysed in depth by others (NAO, 2011; USAID, 2013). Few of these challenges are purely technical; they are also connected to Tanzania's political context and the incentives it creates for the various actors.

One of the major barriers to the smooth supply of medicines is that existing data on medicine orders, deliveries and consumption are not reliable. This reflects a number of factors:

There is a general culture in which data and information are seen as something to be collated and passed upwards, rather than utilised, for example, by frontline health workers or health facilities.

- Few facilities keep patient records, and recording practices for prescriptions and medicine disbursals vary significantly across facilities, despite national guidelines.

- Poor skill levels for forecasting medicine needs and ordering have been widely noted.
- The data used by the MSD to predict medicine needs excludes medicines purchased from other sources during stock-out periods and so underestimates the true level of demand.

Some of these issues may be related to weaknesses in training, but there may also be incentives for staff at the health facility and local government level to neglect or falsify records in order to cover up inadequate medicines training. A lack of transparency within the supply chain was also noted by many of those interviewed:

- Incomplete or anomalous deliveries of medicines are reported to be frequent and are often unexplained
- Health workers in facilities were often unclear about their medicine budget allocations
- Information on medicine availability is rarely transmitted formally, although there were reports of some facilities using informal contact to establish availability.

There is considerable potential to improve both the quality of information and its transparency and usage within and outside the medicine system. However, efforts to do this must pay attention to the crucial questions of who the data are generated for, how accessible the information is, and whether there are incentives within the system to use and act on information generated.

Poor oversight and unclear lines of accountability are major drivers of stock-outs.

Weak oversight and unclear lines of accountability inside the civil service and among healthcare providers create conditions in which stock-outs are made worse. They contribute to poor forecasting, lengthy procurement processes and opportunities for medicine leakages. They can also create 'cover' for those engaged in corruption and the siphoning off of funds and medicines.

District Medical Officers (DMOs) interviewed highlighted a lack of adequate resources for their oversight and supervision of health facilities. DMOs are often overburdened with a wide range of priorities and responsibilities, which can further limit their ability to oversee medicine stock issues. Interviews found few examples of officials disciplining staff for failing to follow guidelines on record- keeping. There was no evidence that thorough investigations were carried out, even where medicine leakages were suspected or uncovered. This lack of accountability partly reflects a culture within the civil service

where individuals agree not to report each other for malpractice, making corruption and misbehaviour harder to detect and act upon.

Poor accountability also reflects unclear lines of responsibility when there are multiple levels of authority and reporting at the local level. Without clear mandates and reporting lines, it can be much more difficult to identify who is responsible for what and to hold them to account when things go wrong. Officials themselves may also face pressures to act according to political priorities rather than medical best practice or official guidelines. This may exacerbate problems of the inefficient and unequal distribution of medicines and create political protection for those involved in malpractice or corruption.

Taking action on corruption and malpractice is possible, as shown by the example of the closure of 120 private pharmacies in the Mwanza region in September 2013 for selling government drugs (The Citizen, 2013). But this type of action is relatively rare. It is likely that government officials and politicians at all levels find these accountability issues to be a barrier to carrying out reforms. Roles and responsibilities need to be better defined so that it is clear who is responsible for what across the delivery chain.

The public is aware of stock-outs and does take action, but the results are not always straightforward.

Awareness of medicine stock-outs in a general sense was very high amongst the ordinary citizens and community leaders interviewed, although specific knowledge of exactly which medicines were or were not available was more mixed. Overall, medicine stock-outs seemed to be an issue of which people were aware and which they were concerned about, and this too is shown in the survey data.

Many citizens interviewed thought that even if MPs and Councillors were interested in solving the problem, there was little they could do about it in practice. In some cases, Councillors were seen as able to provide short-term solutions by purchasing medicines for individual constituents or alerting the DMO of shortages in their constituencies and requesting supplies, but these were highly individualised and reactive. Public expectations of individual politicians generally seemed to focus on providing infrastructure (e.g. building or expanding health facilities) and securing resources (e.g. ambulances and medical equipment), rather than building sustainable systems for health service delivery.

Official mechanisms for public accountability of health facilities, such as health facility committees, have often been found to be inactive or are believed to be dominated by local authorities. Our research found a mixed picture of activity, but a strong feeling among committee members interviewed was that they lacked information on the operation of the health facilities and were unable to challenge health workers.

Oversight and supportive supervision mechanisms introduced specifically for medicine deliveries were felt to have improved knowledge of supplies at the village level. However, this had not resulted in greater activism, and local leaders acknowledged that they had little information on what happened to supplies after their delivery. Much of the focus at the district and village level seemed to be on raising the enrolment levels of the Community Health Fund to generate funds for the district authorities to spend on medicine procurement rather than on reducing leakages or improving the supply of drugs from the Medical Stores Department.

Despite these complex challenges, the research did uncover some positive examples of action from the public and from local governments on stock-outs:

- Two RMOs had begun to investigate stock-out processes following pressures from the community and media.
- A community score-card programme had gathered information on local stock-outs, which was used to ensure that the elderly had better access to free medicines from private pharmacies when there were stock-outs at government facilities.

Our research found that district officials and councillors in many areas were interested in the idea of a system of citizen monitoring for medicine supplies, particularly if it could improve their ability to check on supplies and maintain oversight of facilities. However, any such system would need its information to be properly verified and regulated to ensure credibility.

3. Four Ideas

Our research found that the problem of medicine stock-outs in Tanzania results not just from a lack of resources and technical challenges: local politics, accountability relationships and how information is used also matter.

Greater transparency and improved data may help create better awareness of the problem, but on their own this will not lead to sustainable solutions unless the question of who can effectively use that data to reduce stock-out problems is addressed. Citizens are sceptical that change will happen; this is another barrier to their engagement and action on this issue. Yet our research indicates that there are people at the central, district and local levels who are all interested in the issue of stock-outs and in the potential for citizen monitoring to provide oversight. While they face considerable institutional barriers within the civil service and the political system to taking action, there is real potential for alliances and cooperation between these actors to build sustainable solutions. We suggest four new ideas that would support this.

Independent verification of facility-level data

In the course of our research, we came across many DMOs, Councillors, members of Council Health Boards and hamlet leaders who felt they lacked information about what was happening at the health facility level and expressed interest in the potential for improved monitoring. Independent, citizen-led monitoring could both help close this information gap and usefully complement and verify official administrative data collection processes. Drawing on the experience of Twaweza's Uwezo (www.uwezo.net) initiative, it may be possible to conduct annual national or more frequent local surveys of medicine stock-outs of several essential drugs. Instead of undertaking cumbersome auditing and mapping of the complex procurements and distribution of medicines, attention should be focused on the key outcome in this process: the actual availability of key medicines at local facilities. While there are different challenges involved for medicines compared to assessing basic literacy and numeracy, Uwezo demonstrates the potential for citizens to produce credible data on complex issues that can contribute to national and local debates. These could be done as simple exit surveys of patients leaving facilities, and comparing their experiences with official data to create a national sample, map a particular local area or focus on the 100 large public hospitals responsible for a significant percentage of the medicine supply. A simple health facility survey could also be added to the annual Uwezo exercise.

Greater transparency of data on medicine supply and distribution at facility-level

Schemes conducted by the Medicines Transparency Alliance (MeTA www.medicinestransparency.org) in Ghana and by the Kenyan Medical Supplies Authority (KEMSA www.kemsa.co.ke/index.php) have allowed the release of medicine data collected by governments and development partners. This could be replicated in Tanzania. Civil society and the media could then play a major role in analysing this data and transforming it into useful and popularly accessible forms. This data could form the basis for informed comparisons across districts, highlighting which areas perform better or worse, and supporting greater action.

A potentially useful model for tracking medicines through the supply chain is provided by the monitoring of 'radar' school textbooks as part of the Primary Education Support Project in Tanzania. The Government of Tanzania commissioned a private organisation to run an interactive website (www.pesptz.org) that provides clear and accessible information about how many books have been provided to schools (including what type of books, from which publisher, and so on). The radar site also provides for citizen feedback loops, allowing people to add their own inputs and react to data presented on the site, while being certain that it has been passed on to the relevant authorities. Adapting these systems to medicine distribution should be possible and is consistent with the commitment of the Government of Tanzania under the Open

Government Partnership (www.opengovpartnership.org/country/tanzania/commitment/transparency) to disclose the flow of medicines down to the facility level. However, creating conditions to foster citizen feedback and government responsiveness remain key challenges.

Fostering positive deviance

While our findings and official data show that accountability and performance are critical challenges across the country, we were also made aware of a few 'outliers' who have taken unusual actions or achieved different results despite facing constraints. These include the actions by several DMOs and RMOs to solve problems such as Iramba district's improved monitoring, Wajibika's (https://www.devex.com/en/contracts/wajibika-project-strengthening-the-capacity-of-local-government-authorities-in-tanzania) 'satellite' approach of health centres acting as hubs and monitoring dispensaries in their area, and the use of collaborative, community score-card programmes to bring problems out into the open and provide a forum for dialogue and discussion between service users, service providers and district officials (e.g. CARE in Mwanza and PADI in Songea). Systematic efforts can be mounted to identify, analyse and publicise such cases. Understanding the 'secret' to their success – the motivations and methods of the actors who have mounted successful action despite the odds – may provide useful insights and lessons for greater replication, similar to the identification of positive deviance in nutrition outcomes in Vietnam (see examples: www.positivedeviance.org/about_pd/case_studies.html). Highlighting and potentially rewarding genuine innovations and success stories could also help to counter scepticism over the ability to end medicine stock-outs. Highlighting positive cases, rewarding effort, spreading hope and creating ideas for positive innovations elsewhere may be as important as the traditional 'watchdog' role of drawing attention to corruption and pressuring for reforms.

Broker greater engagement and public dialogue

Innovations and good ideas do not travel and get traction on their own, and documentation and dissemination to policy-makers alone do not guarantee uptake. Twaweza's experience shows that mass and social media can be an important channel to stimulate and inform public debate, gain the attention of key actors and potentially realign incentives for more concerted action. Media, such as radio call-ins, TV discussions and Facebook pages, can also provide a useful platform for user feedback and discussion. That said, the media's own capacity to cover these issues in a thoughtful, evidence-driven manner is limited, as is its ability to bring actors together in a positive manner to debate differences and foster dialogue that can enable problem-solving. Organizations that can serve as brokers could therefore play particularly useful roles. These brokers could help to filter information for media houses in line with editorial standards and also to highlight cases of positive deviance in media-friendly ways. They can also play wider roles in bringing together a range of stakeholders, whether at the national, regional or

local levels, in order to facilitate dialogue, shared understanding and problem solving (for those inside and outside of government).

4. Conclusion: A 'coalition for getting things done'

Persistent medicine stock-outs across the health sector have been a cause of widespread concern in Tanzania for some time. Numerous initiatives have been established to address the problem from within and outside government, but despite several promising starts, overall they have not yet had sufficient long-term success.

Our research found that individuals at a variety of levels and in a range of positions are interested in solving the problem of medicine stock-outs. Cooperation with these actors will be crucial to any endeavour to improve the stock-out issue, and fostering these relationships is a major challenge and necessary task for civil society. The four ideas we present above seek to enable better flows of information, both about problems and potential solutions, in order to provide platforms for reformers and problem-solvers within and outside government to tell their stories and to create conditions to realign incentives to achieve change. Our aim is to spur new sets of collaborations and accountabilities between citizens, service providers and reformers within the state at both national and local levels; and to recognize and reward innovations that get things done. Put differently, the key to solving Tanzania's chronic stock-out problem may lie less with any particular set of solutions, several of which are known and likely to be useful, and more with creating the conditions in which a coalition of actors come together and work in a concerted fashion to make things move.

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