sarpam

Southern African Regional Programme
on Access to Medicines and Diagnostics

tanzania

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The Tanzania Report on How Civil Society is Influencing Pharmaceutical Policies and Decisions Relating to Access to Medicines in SADC Countries.

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ABBREVIATIONS & ACRONYMS

CAF	Consumer Action Forum
CCM	Chama cha Mapinduzi
CS	Civil Society
DFID	Department for International Development (United Kingdom)
DMO	District Medical Officer
EML	Essential Medicines List
HCC	Health Centre Committee
IMF	International Monetary Fund
MOHSW	Ministry of Health and Social Welfare
MoU	Memorandum of Understanding
MSD	Medical Stores Department
NIMR	National Institute for Medical Research
NCD	Non-Communicable Disease
PACT	Partnerships for Action
PATUTA	Pamoja Tupambane wa Tanzania
PMTCT	Prevention of Mother to Child Transmission
SADC	Southern African Development Community
SARPAM	Southern African Regional Programme on Access to Medicines and Diagnostics
TENDAI	Tracking Essential National Medicines and Diagnostics Access Initiative
TFDA	Tanzania Food and Drug Authority
USAID	United States Agency for International Development
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organisation
WTO	World Trade Organisation

EXECUTIVE SUMMARY

This is the first SARPAM country case study from Tanzania using anecdotal evidence to demonstrate the influence that civil society has started to have with regards to access to essential medicines and healthcare within Southern African Development Community (SADC). The study presents stories from civil society members who live within the affected communities.

Over the past 12 months members of civil society, through the SARPAM initiated Tendai Project, have:

- Advocated for adequate staffing of healthcare facilities and helped initiate strategies to improve staff retention.
- Detected corruption and incompetence amongst officials in healthcare facilities and lobbied against them.
- Advocated for improved healthcare and basic infrastructure, such as repairing a road leading to the village clinic and installing electricity at a primary care clinic.
- Reduced medicine stock-outs by devising mechanisms that would enable healthcare facilities to have the option of selecting medicine stock suppliers and ordering medicine stock at any time required.

Through SARPAM's facilitation, networks of civil society organisations have joined up since 2011 to implement the TENDAI monitoring initiative. Using smartphones, networks of trained civil society monitors have been collecting clinic-level surveys of the availability of medicines, as well as personal stories and photographic evidence that demonstrates the everyday challenges citizens face in accessing essential medicines and healthcare. This information has been collated into monthly country-level and regional monitoring reports that the Civil Society Pact has started using to advocate for practical changes.

With the endorsement of the Ministry of Health, the Civil Society Pact has recently established a Consumer Action Forum on access to medicines (CAF) in Tanzania as a national-level mechanism to channel the public's needs and concerns to the government.

At the community level, the Civil Society Pact has participated in meetings and events organised by District Councils and engaged directly with local officials. The TENDAI monitors are generally welcomed by the staff of local health facilities monitored by the project.

Representatives of the Civil Society Pact have actively participated as key stakeholders in the SADC Pharmaceutical Advisory Committee and at official SADC regional pharmaceutical policy and technical consultations supported by SARPAM, where their voice has been recognised by government officials.

These are significant developments within the SADC region that can critically influence future policies and state responses relating to the supply and demand for essential medicines and health services.

While the evidence presented here is limited to anecdotal reports and monitoring activities, the report gives some indication of specific changes that are improving poor people's lives. This monitoring will continue through the Info-Hub platform established by SARPAM that has been demonstrated to serve this purpose well.

INTRODUCTION

The Southern African Regional Programme on Access to Medicines and Diagnostics (SARPAM), funded by the UK Department for International Development (DFID) and facilitated by Re-Action!, aims to promote a more efficient and competitive market for essential medicines to meet the health needs of poor and underprivileged people in the Southern African Development Community (SADC).

SARPAM was designed in consultation with SADC Member States, the SADC Secretariat and other stake holders, to respond to identified gaps in the pharmaceutical markets of Southern Africa, including market failures, which result in uncompetitive drug pricing and the poor availability of medicines.

SARPAM is operating through various programme components known as Partnerships for Action (Pacts) that focus on Pooled Procurement, Harmonised Regulation, Market Innovations and Investments, Trade and Intellectual Property Rights, Capacity Building and Technical Support to the SADC Secretariat.

The main focus of the Civil Society Pact is to ensure that there is strengthened institutional architecture and partnerships to improve access to medicines in the SADC region. One of the key outputs of the programme is an increased voice and influence of civil society reflected in policy. Civil society contributions will add value and support the purpose and actively participate in the pursuit of SARPAM's objectives and the principles of the SADC Pharmaceutical Business Plan.

More details about the activities of SARPAM can be found at www.sarpam.net

This case study report presents stories that illustrate some of the impact that civil society has had in Tanzania during the past 12 months. The stories outline how advocacy work by the community monitors has brought direct and indirect changes to policies, processes, attitudes and structures that have in turn improved citizens' access to medicine and healthcare in Tanzania.

THE ROLE OF CIVIL SOCIETY

Civil Society Organisations (CSOs) are critical actors in the advancement of universal values around human rights, the environment, labour standards and anti-corruption. As global development integration has advanced, the role of CSO's has gained particular importance in aligning economic activities with social and environmental priorities.

Since its inception, civil society organisations have been an integral part of SARPAM. Their local perspectives, expertise and partnership-building capabilities are indispensable in the evolution of developmental impact.

In this regard, SARPAM supports civil society advocacy initiatives that offer the potential to strengthen the capacity of regional institutions and civil society to implement joint plans that will achieve agreed results through multi-stakeholder action across countries in the region.

The Civil Society Pact has to date rolled out two major initiatives that seek to enhance consumer action and interventions in order to help improve access to medicines for citizens in the SADC region.

- The Tendai Project (Tracking Essential National Medicines and Diagnostics Access Initiative)
- The establishment of country and regional level Consumer Action Forums (CAFs).

CSO PARTNERSHIPS

The local CSO partner in Tanzania is the Southern and Eastern African Trade Information and Negotiations Institute (SEATINI), an African initiative that aims to strengthen Africa's capacity to take a more effective part in the emerging global trading system and to better manage the process of globalisation. SEATINI specifically deals with issues and debates around the relationship between the World Trade Organisation (WTO) and Africa.

More details about the activities of the SEATINI can be found at http://www.seatini.org

Apart from SEATINI, there are other two local civil society partners that are actively involved with SARPAM in Tanzania. With regards to the Tendai Project, the responsibility of national co-ordination falls under the ambit of Pamoja Tupambane wa Tanzania, (PATUTA). PATUTA is a community based health advocacy initiative that seeks to promote youth based interventions and strategies. The co-ordination of the local CAF is administered by PRAXIS. PRAXIS is a registered trust that provides a range of services across Tanzania such as research, campaigns, advocacy and lobbying especially on health related issues.

THE TENDAI PROJECT AND CONSUMER ACTION FORUMS

TENDAI, which also means "Thank-You" in one of the local languages is a civil society initiative under SARPAM that facilitates community-level collection and use of transparent information about medicines availability, price, quality and resources across Southern Africa. Initiated in 2010, TENDAI partners with local CSOs in participating countries and uses mobile smartphones to collect this information. The information is then compiled and used as evidence in advocacy campaigns to improve service delivery at those clinics.

More details about the project and its activities can be found at http://tendai.medicinesinfohub.net/

TENDAI has been implemented in three phases:

- The first phase, piloted between July 2011 and August 2012 - local health facility monitoring and mobile-based data collection processes.
- The second phase, implemented between September 2012 and August 2013 - moving beyond the monitoring and data collection process to invest in civil society led advocacy interventions.
- The third phase initiated from September 2013 - includes a more influential co-ordination role from the country level with Consumer Action Forums (CAFs) as its main focus.

The process of establishing the CAFs is currently underway. Towards the end of 2012, SARPAM assisted in the setting up of the CAFs in Malawi, Tanzania, Zambia and Zimbabwe. During 2013 more CAFs were initiated in the remaining of SADC member states. It is anticipated that by the end of December 2014 each SADC country will have a functional CAF in one form or another.

Crucially, SARPAM has stepped up efforts to formally set up the SADC regional CAF. This process was initiated at a regional civil society meeting in June 2012. In December 2013 the SADC regional CAF was formally launched in Johannesburg.

The CAFs are an essential aspect of SARPAM's exit plan to transfer ownership of civil society advocacy to the local context. The CAFs, with their intent being sustainability, are expected to be the torchbearers for advocacy action, promoting scaled-up access to essential medicines beyond SARPAM after December 2014.

TANZANIA: COUNTRY BACKGROUND

TANZANIA ECONOMIC INFORMATION	
Population:	44,928,923 (2012)
GDP:	$73.859 billion (2012)
Per Capita Income:	$1,566 (2012)
Gini co-efficient	37.6 (medium)
Unemployment	8.8% (2006)
Urban population	26.7 % (2011)

THE HEALTH SYSTEM IN TANZANIA

According to recent reports by the United Nations World Health Organisation, Tanzania has a life expectancy of 59 years for men and 62 years for women. In 2009, the United States Development Aid Agency (USAID) reported that the prevalence of the HIV/Aids epidemic in Tanzania was expected to be about 5.6% of the adult population. The Central Intelligence Agency's profile on the country indicated an estimation of 1.4 million people living with HIV and Aids during the year 2009. USAID also reported that in 2011, anti-retroviral treatment for people infected with HIV was around 30%, which was 7% below the continent average. Other major and common infection diseases in Tanzania include bacterial diarrhoea, hepatitis A, typhoid fever, Malaria, dengue fever, Rift Valley fever, Schistosomiasis, leptospirosis and rabies.

Similar to other African countries, Tanzania has committed to allocate at least 15% of its national budget on public healthcare as part of the Abuja declaration agreement. However, in 2010 The Africa Public Health Alliance reported that Tanzania had only allocated 13.7% of its national budget on healthcare. As compared to other SADC countries such as Zambia and Malawi, this was comparatively low.

For a considerable amount of time, health services delivery in Tanzania has been largely a prerogative of the state. There were a limited number of private revenue generating health services and these were only found in major towns of the country. After the country's independence health care facilities were re-directed towards rural areas and free medical health services were introduced in the country.

In 1977 private health services, with the aim of generating profit, were banned under the Private Hospitals (Regulation) Act. At the same time, the practice of medicine and dentistry were prohibited as commercial services. It then became evident with time that the Act was causing tremendous challenges for the country's health system. After a series of major economic and social changes, the Tanzanian government implemented new policies that favourably considered the role of the private sector in the country's health system.

The Private Hospitals (Regulatory) Act of 1977 was then amended resulting into the establishment of the Private Hospitals (Regulation) (Amendment) Act in 1991. Following the new Act, those qualified as medical practitioners and dentists were able to, with the approval of the Ministry of Health, establish and manage private hospitals. The private sector has thus played a major role in health services provision in Tanzania. The USAID Health System Assessment Report in 2010 indicated that approximately 40% of all health facilities in Tanzania are private entities. This includes faith-based and profit generating health service providers.

Overall, the Tanzanian health system is dependent on donors. During the period of 2004 and 2006, donor funds contributed to 44% of the total health expenditure. Over the last decade, the country's health system has seen a significant increase in donor funding, primarily as a result of an increase in the HIV/AIDS program. Development partners are key contributors to the District Health Basket, which provides funds directly to districts for health activities.

GAPS IN THE TANZANIAN HEALTH SYSTEM STRUCTURE

The Tanzania Health System Assessment Report compiled by USAID in 2010 outlined several gaps in the country's health system. This was with the intention of identifying areas where the Ministry of Health, together with the overall support of the state, would need to implement improvement measures.

- **SERVICE DELIVERY:** Although there has been a considerable improvement in the overall health service delivery in Tanzania, there are still several challenges that need to be addressed. For instance, the MOHSW has produced comprehensive policies and guidelines to guide operations within the health sector, but transcending from policy into practice is a challenge throughout the country.
- **CLINICAL SUPERVISION:** Council Health Management Teams (CHMTs) may not have adequate and qualified staff to conduct supervisory visits at health facilities properly. It is argued that health facilities would benefit from receiving more feedback and encouragement from these supervisors.
- **LEADERSHIP AND MANAGEMENT:** The Government of Tanzania (GOT) has made great strides to reform the healthcare system by developing comprehensive policies and guidelines to allow for good governance, there are nonetheless challenges in terms of accountability, community level voice, information reporting, and feedback. USAID reported that part of the problem at lower levels in the health system of the country is that many governing bodies or committees such as The Community Health Service Boards (CHSBs) that should exist do not. Others do exist but it might seem like its members do not fully fulfill or understand their roles and responsibilities.
- **FINANCING:** The Tanzanian health expenditure has increased in recent years. Nonetheless, the total government expenditure on health has not reached the Abuja target of 15% of the government's budget. With an increase on the budget that is allocated to the health system of the country, health care services will be able reach a significant number of the population. This is particularly true taking into consideration that 70% of the population that are based in rural arrears.
- **HUMAN RESOURCES WITHIN THE HEALTH SECTOR:** There is a human resource crisis within the country's health sector, along with low staff motivation, that continues to affect the ability of the health sector to cope with the heavy workload it carries. Contributing to the issue of human resource is that within the country's health system, staffing norms are identical for facilities of the same type (hospital, health canter, or dispensary). This is irrespective of the usage levels of that particular facility.
- **PHARMACEUTICAL MANAGEMENT:** Consistent availability of certain medicines and supplies in health facilities remains a challenge. Irregular and insufficient funding impacts the MSD's ability to procure sufficient volumes of medicine on a timely basis. Implementation of the Integrated Logistics System (ILS) nationally was completed in 2009, but it has become clear that facilities need additional support and supervision from the district and regional levels for the system to work well.

STORIES OF CIVIL SOCIETY INFLUENCE IN TANZANIA

The remainder of this report presents instances of impact based on the advocacy interventions of the TENDAI community monitors. The most significant stories are presented below as a collection indicative of the impact that civil society has had within the Tanzanian community. Through advocacy and lobbying, community monitors have been able to influence decision-making by key stakeholders. This has in some cases led to the implementation of innovative mechanisms that enabled a platform through which the poor in the society could access basic health care.

STORY 1

REPAIRING THE MAIN ROAD LEADING TO THE MAVURUNZA CLINIC IN THE KINONDONI DISTRICT

It was through the data collection phase of the Tendai Project and the subsequent and persistent lobbying by TENDAI monitor **Salha Uyaga** that access to the Mavurunza Clinic was improved.

Based in Kinondoni District, Dar es Salam, the Mavurunza Clinic is a village clinic that services six villages in the surrounds. The facility has a staff of four doctors and five nurses, providing treatment for a range of illnesses.Overcrowding and long queues are a common occurrence at the clinic.

While interviewing patients about the general state of Mavurunza clinic, Uyaga discovered the overwhelming concern from the community about the state of the gravel road leading to the clinic. The condition of the road was so bad that cars could not safely drive on it to reach clinic. As the only road leading to the facility, this saw patients many of whom were critically ill, walking more than four km to reach the clinic.For many it was impossible with or without assistance.

According to Uyaga, the responsibility of infrastructure maintenance falls to the village government. Due to miscommunication among those occupying the offices, there is often poor service delivery and lack of infrastructure maintenance.

In April 2013 Uyaga approached the chairman of the locality in an attempt to resolve this issue. The chairman promised Uyaga that he would escalate the issue to the local ward councillor who would be able to address the repair and maintenance of the road.

Towards the end of May 2013 Uyaga had had no response from the chairman. When following up she learnt that the chairman had communicated with the ward councillor and that he too was still waiting for a response to the matter.

Uyaga then went to the ward councillor directly, apply pressuring on him to come and visit the facility. Upon his visit and meeting with Uyaga the ward councillor escalated the issue to the District Development Committee.

Once District Development Committee received the complaint they allocated the requisite budget and organised for a Caterpillar grader to be deployed to fix the road. The repair work began in June 2013 and the repairs to the road have been successful and vehicles are able to utilise it safely

STORY 2

DISSOLUTION OF CORRUPT HEALTH FACILITY COMMITTEES AT ZINGIZIWA FACILITY IN THE ILALA DISTRICT

While monitoring access to medicines and healthcare at the Zingiziwa Clinic, TENDAI monitor **Selemani Nyonde** uncovered corruption among various officials in the village health committee and the health facility board which resulted in continual stock-outs at the clinic. Through his lobbying efforts these officials were brought to book and replaced.

The Zahanati ya Zangiziwa Clinic is a sub-village clinic that serves a population of about 700 people. One doctor and seven nurses see approximately 20 people a day.

During the monitoring process Nyonde was consistently told by the pharmacist that all medicines were available at the clinic and that they did not experience stock-outs. However the patients told a different story, they were regularly informed by the clinic that medicines were not available, particularly medicines for pregnant women, children who are under 5 years and elderly folk (over 60). According to Tanzanian health policy these groups are exempt from paying for medicines.

Initially Nyonde approached the chairman of Health Facility Board, but the meeting was fruitless and not surprisingly so, considering the stock-outs started occurring when he began his tenure as chairman. Nyonde opted to escalate the issue to the ward councillor and chairman of the Village Health Committee. The ward councillor asserted that there was enough medicine for the people at the clinic, but later ordered Nyonde to drop the investigation.

Nyonde, suspecting corruption amongst the officials, started lobbying the District Medical Officer (DMO). Along with other activists and members of his organisation, Tuamke Youth and using the lobbying training he had received from the Tendai Project, Nyonde ensured that the DMO listened and responded to his concerns and suspicions.

In June 2013, the DMO dissolved both the committees. In the same month elections took place and new committees were assembled. The community members have expressed their satisfaction with the newly elected members of both the committees.

Nyonde reports that there hasn't been a complaint about medicine stock shortages since the new committees were assembled.

STORY 3

INSTALLATION OF SOLAR POWER AT A LOCAL CLINIC AT THE ZAHANATI YA ZANGIZIWA FACILITY IN THE ILALA DISTRICT

As a TENDAI monitor **Selemani Nyonde** has used the advocacy training he has received through the project to have a solar power system installed at the clinic in Zahanati ya Zangiziwa to supply much needed electricity.

In Tanzania it is unlikely for buildings in sub-villages like Zahanati ya Zangiziwa to have access to electricity. The clinic had operated without electricity since its opening 5 years ago.

This lack of electricity caused many inconveniences for the staff as well as the patients. There was no storage place for medicine that needs to be placed in refrigerators and due to the lack of lighting, patients who needed immediate attention at night could not be attended to until the following morning.

Nyonde realised how essential electricity was to ensure greater access to medicine and healthcare in the area. In 2012, during the first phase of the Tendai Project, Nyonde took it upon himself to resolve this issue. He approached the chairman of the local district council and consulted him about the need for electricity at the clinic.

The position Nyonde holds as a ward chairman of the youth development committee gave him a lot of credibility. As a result, the chairman of the council was motivated to attend immediately to Nyonde's concern. He escalated the issue to the local Member of Parliament and after deliberations at parliament level, it was then decided that a solar power system would be installed at the clinic to supply electricity.

The solar power system was installed and since there has been a constant supply of electricity to Zahanati ya Zangiziwa Clinic.

STORY 4

IMPLEMENTING STRATEGIES TO AVOID MEDICINE STOCK-OUTS AT THE MSUMI FACILITY IN THE KINONDONI DISTRICT

Through the tenacity and forward thinking of TENDAI monitor **Alban Tesha** there have been improvements to stock shortages at the Msumi clinic facility and an important step made in decentralising the control of medicine supply.

Tesha is assigned to monitor access to medicines and healthcare at the Msumi clinic facility, a village clinic based in Kinondoni District, Dar Es Salam. Msumi is about 14 km away from the nearest town. The clinic has two doctors and four nurses and offers general health care services to patients. The clinic serves approximately 25 patients daily.

During March 2013, Tesha realised that there was a decrease in medicine stock levels at the facility. He approached the local chairperson of the Facility Board with regard to the matter, who told him that they do not receive the medicine stock in time from MSD. He also said to Tesha that when they placed an order for medicine, they usually receive less stock than the order placed.

This is an issue common to clinics within the Kinondoni district and to resolve this problem. Clinics would engage in what they refer to as the "loaning system"; a clinic would borrow medicine from another clinic with the intent of returning it after they had received the stock they had ordered from MSD. Tesha was instrumental in helping Msumi clinic build relationships with other clinics within the same ward to facilitate this process.

In May 2013 Tesha realised that the decreasing medicine stocks still existed, and that the "loaning system" was not working as expected. Tesha decided to approach the Chairperson of the local council and brought the issue of decreasing stock levels to her attention. The Chairperson arranged a meeting with Tesha and the local facility Chairman.

Following this meeting it was agreed that if there was a shortage of stock, the clinic should not wait on MSD but could use the money it generated from the paying patients to buy medicine from other service providers.

Since this measure was introduced, there has been sufficient stock at Msumi clinic. The decision was significant - in Tanzania the supply and control is typically centralized. . The permission to use funds that are generated from fee-paying patients at the clinic's discretion is an important step towards decentralising the control of medicine supply and allows the clinic the autonomy it requires to ensure adequate stock supply.

STORY 5

INTRODUCTION OF A STAFF RETENTION POLICY AT THE MSUMI FACILITY IN THE KINONDONI DISTRICT

During his time as a TENDAI monitor **Alban Tesha** has been responsible for other changes at Msumi Clinic, including identifying and taking actionable steps towards reducing staff turnover.

While monitoring the Msumi Clinic, Tesha became concerned about the high staff turnover at the clinic. Many of the nurses deployed at the clinic would not stay for long before requesting a transfer; most of them had come from more urban environments in Tanzania and were not acclimatised to the pressures of a rural village clinic.

In an attempt to resolve the staff retention problem at Msumi, Tesha brought the matter to the chairperson of the local district council. The chairperson then set up an employment policy that aimed to reduce the staff turnover. Whenever a new nurse was employed at the facility, he or she must be introduced to the chairman of the locality and when then enter into an agreement binding them to stay at the facility for at least 6 months before applying for a transfer. The nurse would only be granted a transfer should he or she present valid reasons for the transfer.

After this new system was introduced, there has not been a transfer request since July 2013.

STORY 6

RESOLVING CRITICAL HOSPITAL STAFF SHORTAGES AT THE MWANANYAMALA FACILITY IN THE KINONDONI DISTRICT

Passionate about activism, the late Tendai monitor **Juma Kambajeck**[1] enabled changes at Mwananyamala Facility that have subsequently seen increased staff and better service delivery.

The Mwananyamala facility is district hospital that has been recently upgraded to a referral regional hospital. The hospital had six doctors and is visited by approximately 2000 patients daily. There are ten doctor's rooms, but not all of these rooms were in use because of the lack of doctors at the facility. This resulted in long queues at the hospital and patients waiting a considerable amount of time before being seen by a doctor.

While monitoring the facility Kambajeck took the initiative to resolve the problem. Kambajeck's first step was to approach the Vice Chairman of the local Kinondoni district council. After listening to Kambajeck's concerns, the Vice Chairman invited him to come and take part in a municipal health committee meeting that took place in April 2013. This gave Kambajeck an opportunity to present the issue to the rest of the committee. The committee asked him to give recommendations on how this issue could be resolved.

1 Juma Kambajeck sadly passed away in November 2013

Initially, Kambajeck suggested that the municipality expands the budget allocated to the hospital and although there is a new budget allocated to the hospital following its upgrade it would only take effect the following financial year (2014).

Kambajeck then suggested approaching Project Abroad Global, an NGO based in the UK that specialises in issues surrounding access to medicine. Since donors mostly work with NGOs rather than government institutions, Kambajeck used his NGO, The Global Initiative Development Foundation to request the assistance. The request was successful and in October 2013, Project Abroad Global assigned six volunteer doctors to Mwananyamala hospital increasing the doctor complement to 12. The doctors signed a 3-year contract at the hospital. They also brought their own equipment which they promised to donate to the hospital at the end of their contracts.

Kambajeck reported that the community is happy with the volunteer doctors because they treat patients with utmost respect.

STORY 7

OVERCOMING MEDICINE STOCK PILFERAGE AT THE MWANANYAMALA FACILITY IN THE KINONDONI AREA

During his monitoring at Mwananyamala hospital, the late Juma Kambajeck became aware that the shortage of medicine stock at the hospital was directly related to the vacancy of the position of chairman of the facility. Through Kambajeck's lobbying, the position was filled and the medicine shortage resolved.

According to records kept, the hospital received stock from the suppliers on time, each time an order was placed.

However patients were complaining about a shortage of medicine stock at the hospital. Kambajeck researched this issue and discovered that it was hospital policy that the medicine stock is delivered in the presence of the local chairman of the facility's board, the District Management Officer (DMO) and the local pharmacist.

The chairman of the facility board is supposed to serve as a "watchdog" for the community and ensure that the hospital personnel do not engage in corruption or theft of any sort.

Kambajeck learnt that since the chairman of the facility board had died, the secretary of the local hospital facility board had been delaying the process of appointing a new chairman. He also discovered that the issue of medicine stock shortage started during the period when the chairman's post had been vacant. It was then that Kambajeck started advocating for the immediate appointment of a new facility board chairperson.

During his advocacy campaign, Kambajeck met with the chairman of the local district council to bring to his attention the situation at Mwananyamala hospital. The chairman reacted quickly arranging for the election of a new local facility chairman to take place.

Anyone within the community was allowed to contend for the position. Consequently, a new chairman was elected and since his appointment in June 2013, there have no more complaints regarding medicine stock shortages at the Mwananyamala hospital.

CONCLUSION

The impact stories presented in this report are not the only stories of how TENDAI monitors in Tanzania have been working to improve access to basic healthcare and essential medicines. However these examples do begin to show evidence that under the Tendai Project, civil society networks co-ordinated by SEATINI have already started to successfully engage and influence the pharmaceutical policies and decisions relating to access to medicine in Tanzania, especially at local levels.

In particular, the Civil Society Pact has been instrumental in advocating for alternative and feasible ways to ensure the procurement of medicine stock on a timely basis and avoid stock-outs in clinics. Through lobbying, civil society in Tanzania has also been able to begin combatting corruption that has been leading to the pilfering of medicine at health care facilities.

Other accomplishments by the Civil Society Pact in Tanzania include:

- influencing leadership structures within various committees responsible for the overseeing of health care facilities;
- advocating for the placement of sufficient staff levels at hospitals, and
- influencing municipalities to repair infrastructure to improve accessibility to clinics.

The success that Civil Society Pact in Tanzania has seen over the past 12 months was made possible by the professional attitude the TENDAI monitors have towards their work. The monitors' passion and commitment to their work has led them to go out of their way in an attempt to resolve various issues affecting access to medicine and healthcare services.

While the evidence presented here is limited to anecdotal reports and monitoring activities, this gives some indication of the specific changes that are improving poor people's lives. This monitoring will continue through the InfoHub platform.

As more evidence is gathered and as the movement develops further, more structured independent evaluation can be undertaken of how SARPAM has contributed to an increased voice and influence of civil society being reflected in policies on access to medicines and diagnostics in Southern Africa.