Local production and access to medicines: Tanzanian evidence, and research gaps

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Can local production of medicines improve access to essential treatment?

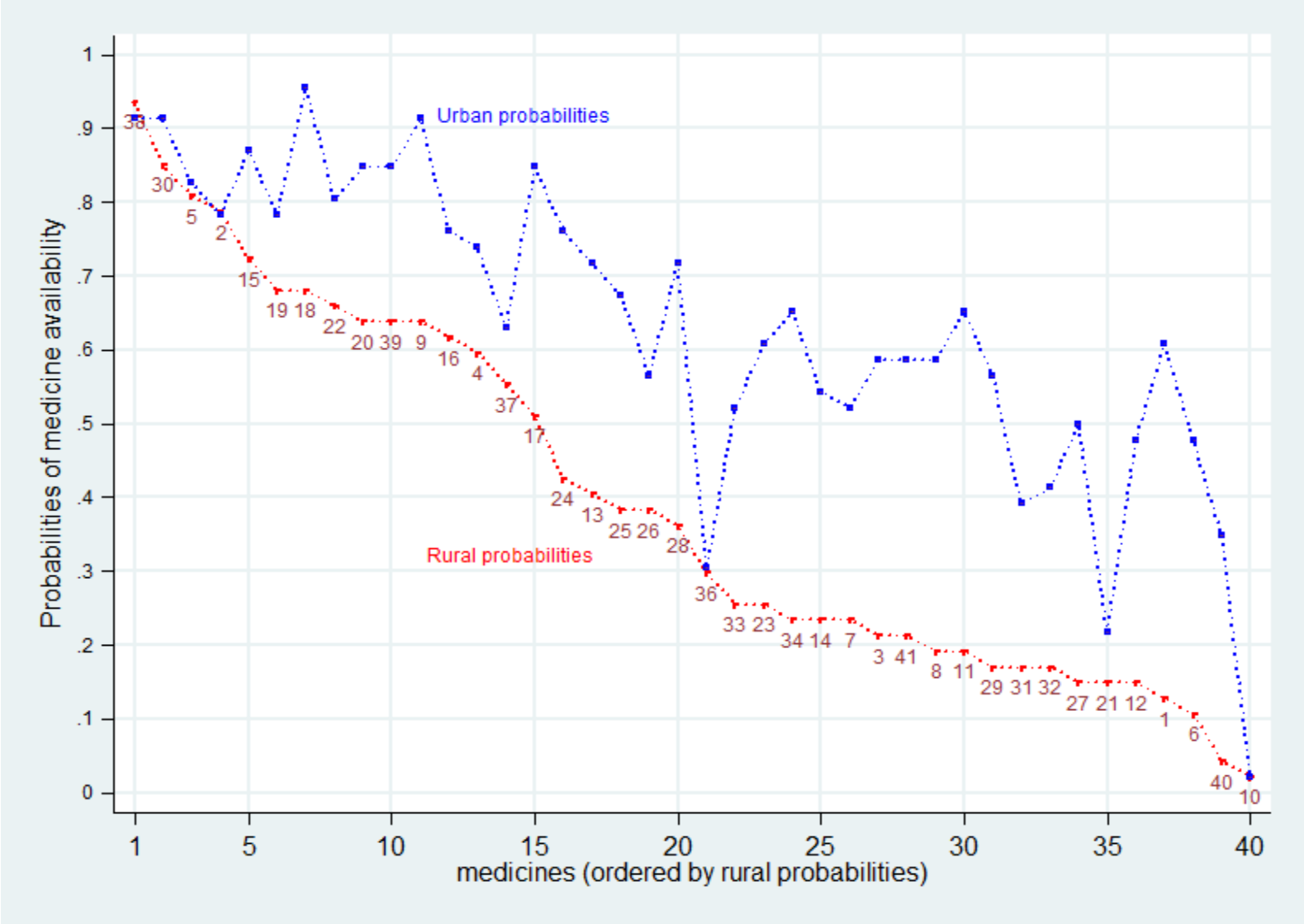
Tanzanian evidence:

1. ‘Urban bias’ in medicines distribution : drugs produced in Tanzania are more likely than imports to reach rural areas;
2. Local producers can compete with imports across a wide range;
3. Users find local products acceptable;
4. Imports into East Africa from India may not be sustainable.

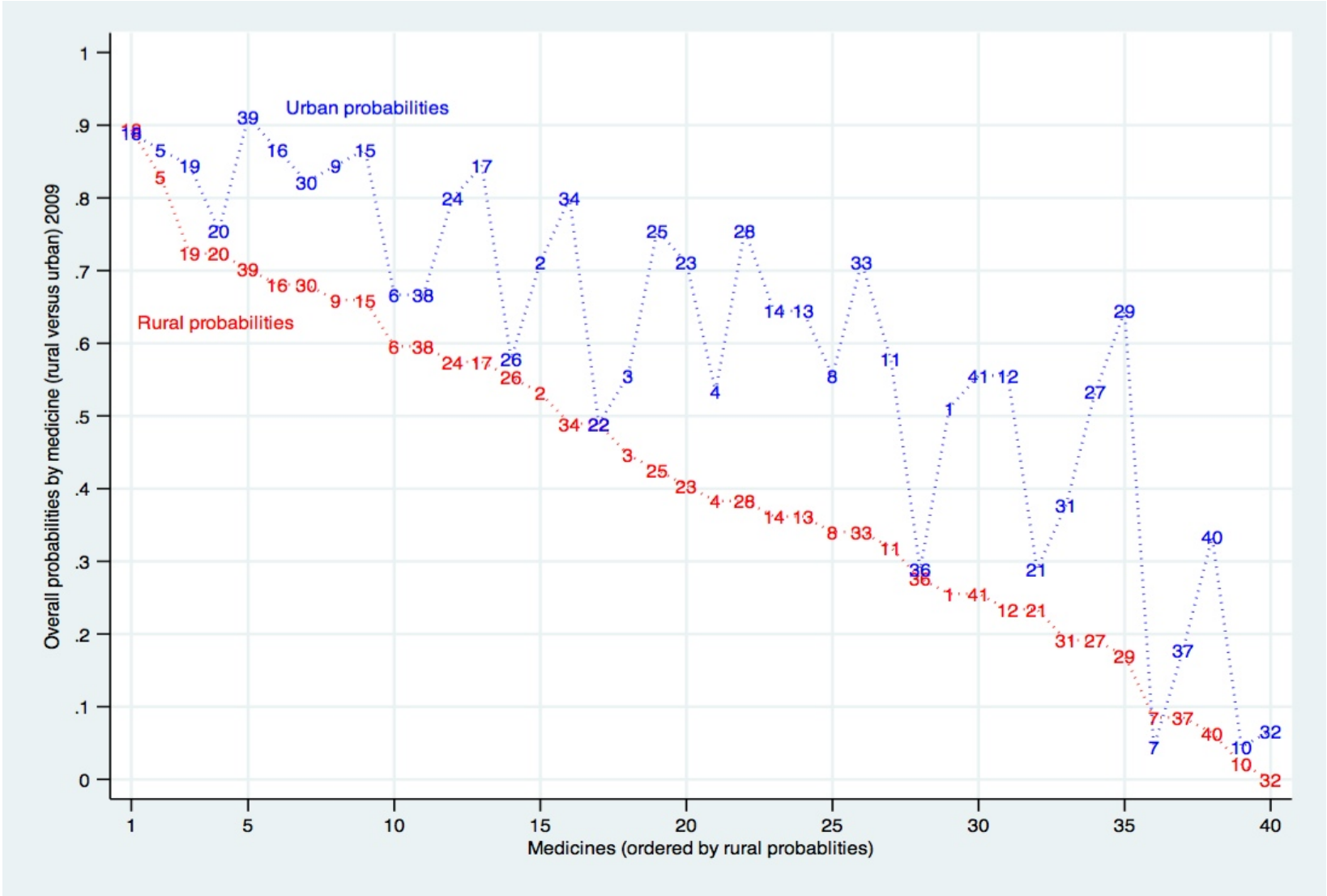
1.**Urban bias in access and distribution**

- The availability of medicines is lower in rural than urban areas.
- Much of the rural availability is locally produced.
- Tanzanian medicines are more likely than imported medicines to reach rural areas.

Access to essential medicines is lower in rural than urban areas: 2006: 41 tracer medicines



2009: same medicines and outlets : similar, rather narrower rural/urban gap

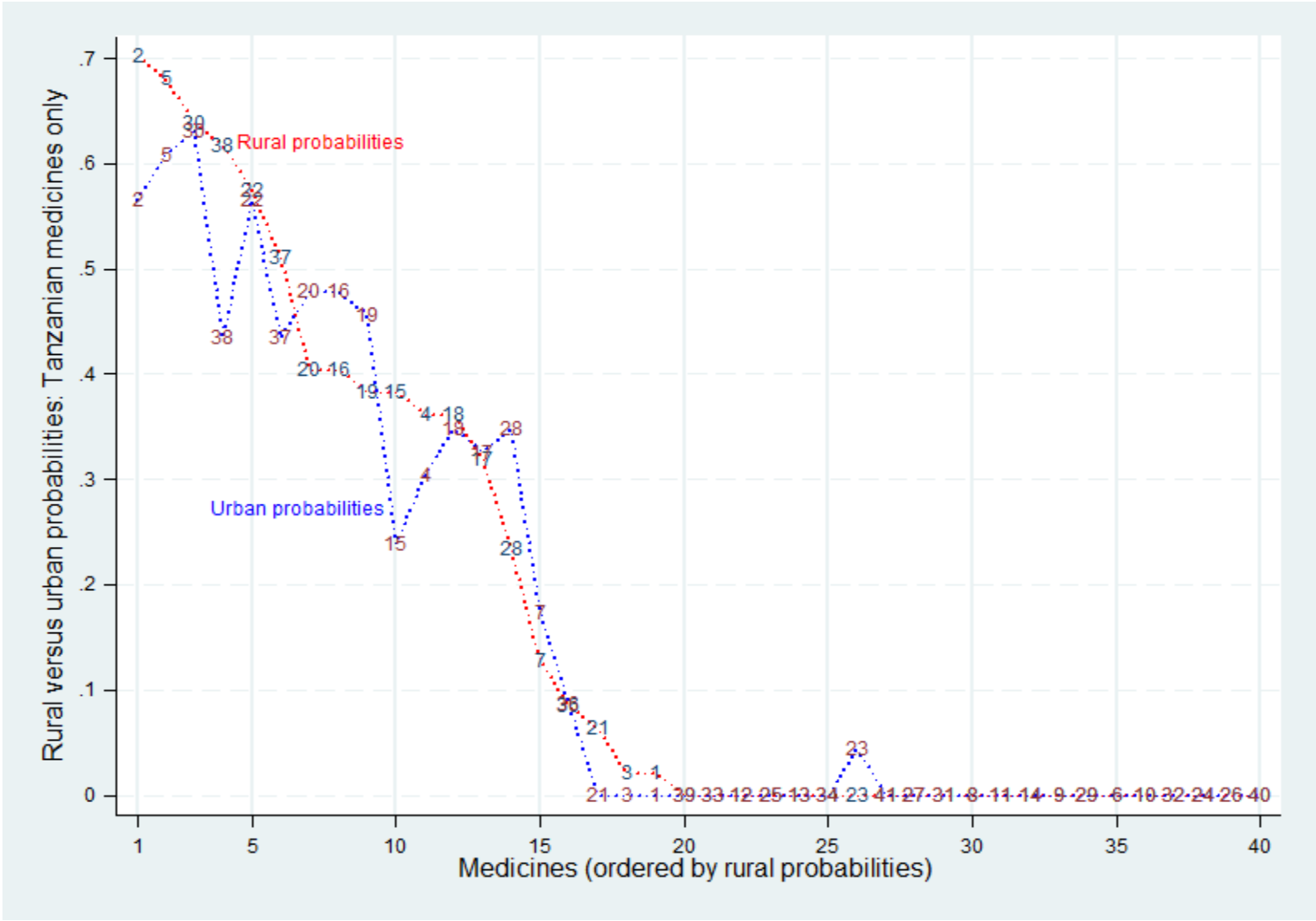


In 4 rural districts in 2006, in 69 private & NGO shops / facilities, Tanzanian and Kenyan drugs predominated

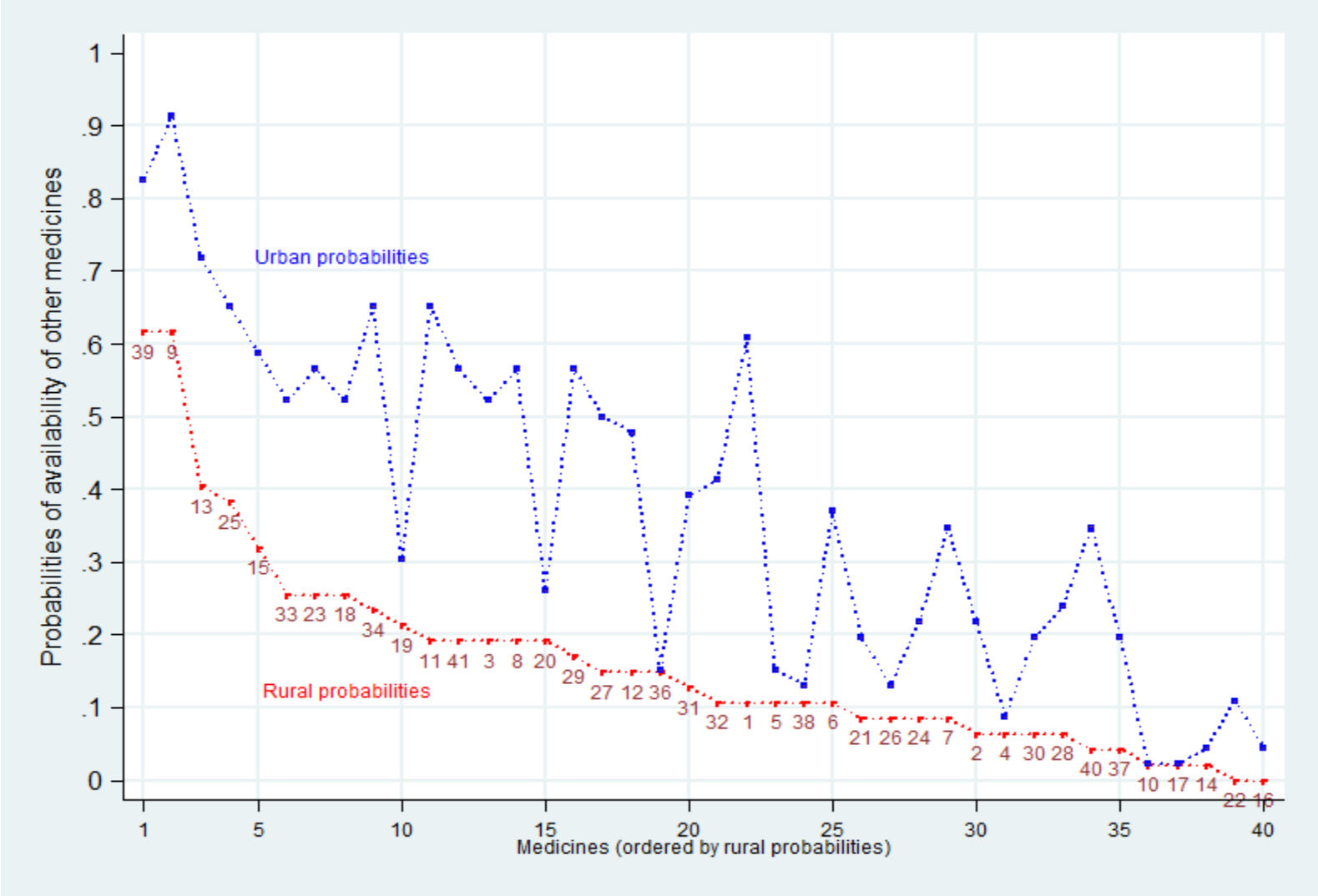
Mean proportions of medicines from each country of origin by type of outlet 2006

	Tanzania	Kenya	India	Other	Number of medicines
Drug shops	0.56	0.14	0.24	0.05	27
Private facilities	0.33	0.22	0.36	0.08	28
FBO/NGO facilities	0.42	0.15	0.31	0.11	31

Probability of finding a Tanzanian medicine was similar in rural and urban areas: 2006



..while the probability of finding a non-Kenyan imported medicine was higher in urban areas:



Comparison of probability of finding a medicine manufactured in Tanzania, Kenya, and elsewhere in a sample outlet, by rural and urban location 2006 and 2009 (41 medicines)

2006	Tanzanian manufactures	Kenyan imports	Other imports
Rural	0.17	0.05	**0.16**
Urban	0.16	0.09	**0.38**

2009	Tanzanian manufactures	Kenyan imports	Other imports
Rural	0.11	0.05	**0.25**
Urban	0.10	0.08	**0.41**

2. Local production can compete with imports: mean prices did not differ significantly by country of origin (2006)

Stated selling prices for 17 tracer medicines : 69 rural private and NGO outlets, by country of origin (TShs)

Statistic	Tanzania	Kenya	India	Europe
17 tracer medicines (1 case by main countries)				
Robust mean price	92.5	110.94	153.75	n/a
Median price	45	40	45	n/a

3. Users find local products acceptable:

Expressed preferences for country of origin of their medicines by exit interviewees, 69 rural outlets: % of those who expressed a view, by illness (2006)

Preferred country of origin of medicine/ illness	Tanzania	Kenya	India	Europe
Malaria	38	13	12	37
Pneumonia	55	9	7	29
Diarrhoea	59	9	5	26

4. Imports into East Africa from Asia may not be sustainable, while local and regional suppliers can develop further

2006 evidence:

- Indian suppliers tended to be second-tier firms; interviews in India showed leading firms losing interest
- India: 38 manufacturers including (observations): Intas (7), Simrone (6), Aurochem, Lincoln, Medopharm and Emcure (5 each).
- Several Tanzanian suppliers : Shelys (20 of the 31 tracer medicines), TPI, Interchem, Keko
- Kenyan suppliers: Elys (14 of the tracer medicines), then Lab. & Allied, Regal, and Cosmos.

Research and policy gaps

1. Why does the urban bias exist?
2. How can local producers build on their observed ability to supply rural areas?
3. How can the health sector improve its ability to buy from and support competent local manufacturing?
4. Are the donors by-passing local production for the health sector; if so, can that be changed?
5. Are there particular disadvantaged sectors in health care, such as maternal health, that could be supported by targeted local production?
6. How can quality of local production be both sustained and demonstrated?