SDSI
Sustainable Drug Seller Initiatives

SUSTAINABLE DRUG SELLER INITIATIVES PROGRAM
UGANDA

COMMUNITY ENGAGEMENT IN THE USE OF MEDICINES AND DISPENSING SERVICES

A consolidated report based on research, situational and options analyses, and stakeholder input

MARCH 2013

Prepared by the Coalition for Health Promotion and Social Development (HEPS Uganda) for the Sustainable Drug Seller Initiatives Program

CONTENTS

List of Figures

List of Tables

ACKNOWLEDGMENTS

This report is a compilation of three separate reports based on the work of a research team at the Coalition for Health Promotion and Social Development (HEPS Uganda) written by Denis Kibira and Richard Hasunira.

PREFACE

The Sustainable Drug Seller Initiatives (SDSI) program continues Management Sciences for Health's efforts in Africa to involve private drug sellers in enhancing access to essential medicines. It builds on two previous MSH programs, which 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. SDSI's goals include ensuring the maintenance and sustainability of these public-private initiatives in Tanzania and Uganda, and introducing the initiative in Liberia.

In Uganda, SDSI objectives are to enhance the accredited drug shops' long-term sustainability, contributions to community-based access to medicines and care, and ability to adapt to changing health needs and health system context. In order to achieve these objectives, SDSI commissioned local organizations ("contractors") to assess various components of the Accredited Drug Shop (ADS) initiative and develop recommendations for improvements.

Annex 1 provides further information about each component and identifies the contractor and their objectives. Nine factors affecting ADSs in Uganda were examined.

1) ADS Regulatory System
2) Supportive Supervision
3) ADS Seller Training
4) Mobile Technology
5) Geographic Information Systems
6) ADS Associations
7) ADS Supply Chain
8) Engaging ADS Consumers
9) Community-Based Health Initiatives

In completing their assignments, each contractor undertook three primary activities:

- Preparing a situational analysis based on qualitative and quantitative data on their topic gathered through extensive interviews and use of questionnaires;
- Analyzing the options for future action;
- Present the data, analyses, and options to stakeholders in a workshop, followed by a plenary meeting, so they could review and comment on the analyses and conclusions and make recommendations.

The contractors submitted their findings in three reports, one on each of the above. The reports were then compiled into single reports, like this one on community engagement and use of medicines and dispensing services.

ACRONYMS AND ABBREVIATIONS

ADDO	accredited drug dispensing outlet
ADS	Accredited Drug Shop
CBO	community-based organization
DADI	District Assistant Drugs Inspector
DHO	District Health Officer
DHT	District Health Team
EADSI	East African Drug Seller Initiative
EIC	information, education, and communication
FGD	focus group discussion
HC	health center
LC	local council
MoH	Ministry of Health
MSH	Management Science for Health
NDA	National Drug Authority
NGO	nongovernmental organization
PRA	participatory reflection and action
PWD	people with disabilities
RUM	rational use of medicine
SDSI	Sustainable Drug Seller Initiatives
SEAM	Strategies for Enhancing Access to Medicines
SURE	Securing Ugandans' Right to Essential Medicines
UGX	Uganda shilling
VHT	village health team
WHO	World Health Organization

1. Executive Summary

This report presents the results of formative research, situation and option analyses, and key stakeholders' feedback on proposed activities. These activities were all undertaken by HEPS–Uganda (the acronym for the Coalition for Health Promotion and Social Development) to determine the best ways to involve communities in the Accredited Drug Shop (ADS) initiative and to enhance access to essential medicines under the Sustainable Drug Seller Initiatives (SDSI) program.

HEPS-Uganda's objective was to identify current needs, experiences, and expectations of selected consumer populations in five districts where the ADS initiative is being implemented; to facilitate the completion of an options analysis of how to engage consumers; and to develop strategies for engaging consumers in ensuring the quality, appropriateness, and affordability of ADS services provided in their communities.

The Situational Analysis

The survey targeted health consumers at the household level in Kamuli, Kamwenge, Kayunga, Kibaale, and Mityana Districts and used structured questionnaires, interview guides, and focus group discussions (annex 4) to capture data. The formative research also surveyed the experiences and expectations of selected populations of health consumers in the use of medicines. The survey field data collection was conducted between June 10 and 19, 2012.

The following conclusions and recommendations were made following analysis of the survey data.

Conclusions

- Drug shops are the most accessible and convenient private medicine outlets to households.
- The utilization of private medicine outlets by households is generally high across the survey districts.
- A majority of the private medicine outlets—about 8 out of 10—were open whenever consumers visited them to buy medicines.
- The prices of medicines across the five districts are generally high and unaffordable to the majority of people in the survey districts.
- Malaria is the biggest health challenge faced by households across all districts and most acute illnesses reported are communicable and preventable. Stomach ulcers are the leading chronic health problem.
- Private medicine outlets are handling health complaints beyond their capacity.
- Labeling of medicines is generally poor across the survey districts and is a major concern.
- Consumers are seeking medicines for health complaints not considered serious, which may be a precursor to irrational use of medicines.
- Overall, the status of consumer empowerment and advocacy on health in general, and medicines in particular, is low.

Recommendations

- Efforts to increase access to essential medicines should focus on private drug shops and build their capacity to deliver medicines designated for their level.
- Price subsidy programs are needed to make medicines affordable for the majority of people, who are primarily subsistence farmers and without a formal source of income.
- Operators of private medicine outlets should be trained in medicine handling, communication skills, and customer care.
- Consumer engagement in ADS should empower them on rational medicine use, benefits of the ADS, and the range of services and products that are recommended for that level of service.

THE OPTIONS ANALYSIS

The options analysis was carried out using a qualitative approach, participatory reflection and action (PRA), to engage stakeholders and generate the key challenges and ideas, and to identify solutions. Through ranking and scoring, participants identified the key options for community engagement to solve the challenges in their communities.

Information gathering for the options analysis was conducted in four districts: Kamuli, Kamwenge, Kayunga, and Mityana. In each of the districts, one PRA meeting was organized for 30–40 key stakeholders—local leaders, health service providers, district leadership, and representatives of civil society organizations—who worked in groups as well as in plenary sessions. The meetings took place between August 20 and 29, 2012. Kibaale District could not be included due to an outbreak of Ebola at the time planned for data collection; the government had banned public gatherings in the district.

Participants in the PRA sessions generated a range of ideas on how communities and other stakeholders can be engaged in the ADS program. These ideas fell into broad categories, as follows, and favored:

1) Mechanisms that focus on representation of different stakeholders on committees or other similar structures and bring together and engage more players, including the primary targets of the ADS program;
2) Approaches that focus on different sectors at the local government level, working together to support improvement in the services of private medicine providers;
3) A clear program for capacity-building of community stakeholders that serves as the entry point to empower consumers and other community stakeholders to meaningfully participate in the ADS program.
4) Strategies focusing on engaging communities in discussions;
5) Approaches seeking to engage communities more actively and build their capacity, such as in training health consumers and monitoring drug shops;
6) Approaches focusing on the drug shops to set their own standards and take the lead in improving the industry;
7) Using the different channels of the mass media to reach out and engage general populations.
8) Approaches that utilize local resources, including existing structures and resources (e.g., the district health teams, village health teams [VHTs]), which are likely to be more sustainable.

9) Interventions adapted to specific situations and the interests of each participating district to promote ownership and interest.
10) There should be a clear framework for coordination of the different players in the ADS program as well as of the work of engaging different stakeholders in the various options.

STAKEHOLDERS' MEETING

MSH, in partnership with the National Drug Authority (NDA), convened the October 29–30, 2012, stakeholders' meeting to give stakeholders an opportunity to review the findings and recommendations of HEPS-Uganda and other contractors.

The stakeholders' meeting included both workshops and plenary sessions. The objectives were to (1) provide a background and overview of the SDSI objectives; (2) review findings and recommendations from recent assessments and studies on various ADS components; and (3) discuss the options and agree on feasible interventions to ensure maintenance and sustainability of the ADS initiative.

The key recommendations presented to the workshop were:

- To improve access to medicines, the government should establish price subsidy programs to make medicines affordable for those without a formal source of income.
- On consumer engagement, the key options were identified as:
    - Use of multi-stakeholder committees to assist regulatory agencies in community monitoring, sensitization, and mobilization;
    - Use of multisectoral approaches to engage district-level government sectors to improve the services of private medicine providers;
    - Focus on engaging communities in discussions through community dialogues, village meetings, public rallies, etc.
- Other options for consumer engagement were:
    - Seeking to engage communities more actively, such as training health consumers to monitor drug shops;
    - Focusing on having drug shops set their own standards and take the lead in improving the industry (self-regulation through drug shop associations);
    - Using the different mass media channels, including mobile technology, to engage the general population.
- To ensure sustainability, the implementers of the ADS initiative should build the capacity of community stakeholders to empower meaningful participation in the program and establish a clear framework for coordination of roles and responsibilities.
- Tailor the mechanisms of engaging and coordinating communities and other stakeholders to existing structures and resources and to adapt each intervention to specific situations and the interests of each participating district to promote ownership and interest.

The theoretical basis for ranking was framed in order, starting with the most preferable: low effort/high impact, high effort/high impact, low effort/low impact, and high effort/low impact. On this basis, the most feasible options were ranked as: (1) consumer/community empowerment, (2) coalition building, and (3) stakeholder committees.

2. BACKGROUND

2.1 THE SUSTAINABLE DRUG SELLER INITIATIVES PROGRAM

The Sustainable Drug Seller Initiatives (SDSI) is a program that involves private drug sellers in enhancing access to essential medicines in underserved areas. The SDSI program builds on Management Science for Health's (MSH's) Strategies for Enhancing Access to Medicines (SEAM) and East African Drug Seller Initiative (EADSI) programs, which 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 SDSI 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. This work is expected not only to expand access to medicines and treatment in additional geographical areas, but to also 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 Uganda, availability and access to drugs is a problem in both the public and private sectors, especially in remote and underserved rural communities. In addition, the public cannot be assured of the quality of drugs in the Uganda market. The issues of access and quality are aggravated by a lack of communication, monitoring, supervision, and reporting tools within the health sector, which could be used to report and give feedback on the effect of accessible channels for drugs.

SDSI was successfully piloted in Uganda in Kibaale District, where 73 out of 85 Class C drug shops (86 percent) were accredited to operate as Accredited Drug Shops (ADS) in 2010. In addition, 246 drug sellers and 82 owners were trained in proper dispensing and business skills; health assistants trained as local monitors; and two microfinance institutions and several savings and credit cooperatives (SACCOs) started giving credit to private drug sellers. Results from the project evaluation showed that the initiative was well received by district health officials and shop owners and sellers.

During the launch of the Accredited Drug Shop program, stakeholders acknowledged the need to create consumer interest and ADS brand awareness as an essential component of the promotion strategy. The strategy, however, did not include mobilization of consumers to play a role in ensuring the quality, appropriateness, or affordability of the services provided in their communities. The HEPS-Uganda survey laid the groundwork for increasing community awareness of ADS products and services; encouraging the community to gain interest in broader community health issues; and engaging consumers to help ensure ADS compliance with regulatory requirements and the provision of quality products and services.

2.1.1 Key Actors in the ADS Program

The different stakeholders have different roles in the improvement of the quality of service of private medicine outlets in general, and drug shops in particular. Under the ADS program, the key players are the NDA, SDSI/MSH, the drug shop owners/proprietors, drug shop operators/attendants, district health teams (DHTs), drug sellers' associations, and level-three health center (HC III) In-charges.

NDA is the lead implementer of the ADS program. MSH/SDSI provides technical support to help build the capacity of ADS sellers and owners by training them to appropriately manage medicines and the most prevalent health conditions in the areas where they are located. MSH/SDSI also trains and mentors drug shop owners in business skills and entrepreneurship, and guides other players who contribute to the success of the entire program.

Drug shop owners are the primary targets of the ADS program; they implement the improvements that the program demands. They are expected to upgrade premises to meet the ADS standards; ensure availability of key working tools (e.g., dispensing trays, dispensing logbooks, order books, and referral forms); obtain and renew operating licenses annually; employ qualified attendants; and ensure availability of adequate stock, among other responsibilities. Together with the drug shop attendants, the owners are responsible for adhering to good dispensing practices as well as the ADS code of ethics and standards.

Another category of major players in the ADS program comprises those individuals involved in supportive supervision. A team of one HC III In-charge, one member of the DHT, and one representative of the drug sellers' association at the sub-county level conduct supportive supervision. The supervision helps drug sellers and owners to strengthen and maintain the quality of services they provide.

2.2 Assessments of Accredited Drug Shop Components

To lay ground for the rollout of the initiative to more districts, MSH contracted with organizations with different specialties to assess the various components of the ADS initiative (annex 1). Between May and October 2012, the contractors undertook situational and options analyses of these components. HEPS-Uganda analyzed the situation of, and options for, consumer mobilization and advocacy in the districts of Kibaale, Kamuli, Mityana, Kamwenge, and Kayunga. HEPS-Uganda's overall objective was to identify current needs, experiences, and expectations of selected consumer populations where the ADS initiative is being implemented; to facilitate the completion of an options analysis on how to engage consumers, and develop strategies for engaging them in ensuring the quality, appropriateness, and affordability of the ADS services provided in their communities.

MSH, in partnership with the Uganda National Drug Authority, convened a meeting on October 29–30, 2012 to give stakeholders an opportunity to review the findings and recommendations of HEPS-Uganda and other contractors.

This report provides the results of the situational analysis, options analysis, and stakeholder review regarding consumer mobilization and advocacy in five districts of Uganda.

3. INTRODUCTION TO THE SITUATIONAL ANALYSIS

3.1 OBJECTIVES

The overall objective of the situational analysis was to identify current needs, experiences, and expectations of selected consumer populations where the ADS initiative is being implemented; to facilitate the completion of an options analysis on how to engage consumers; and to develop strategies for engaging them in ensuring the quality, appropriateness, and affordability of ADS services provided in their communities.

The specific objectives were as follows:

1) Conduct formative research to identify current needs, knowledge, and expectations of consumers in Kibaale, Kamuli, Mityana, Kamwenge, and Kayunga.
2) Carry out a situational analysis to determine the status of consumer advocacy relating to health care and use of medicines, and characterize consumer advocacy work in Kibaale, Kamuli, Mityana, Kamwenge, and Kayunga.

3.2 METHODOLOGY

3.2.1 Geographic Scope of the Survey

The survey assessed current needs, experiences, and expectations of selected consumer populations in use of medicines. The districts for the survey were purposively chosen from the SDSI districts were Kamuli, Kamwenge, Kayunga, Kibaale, and Mityana (figure 1).

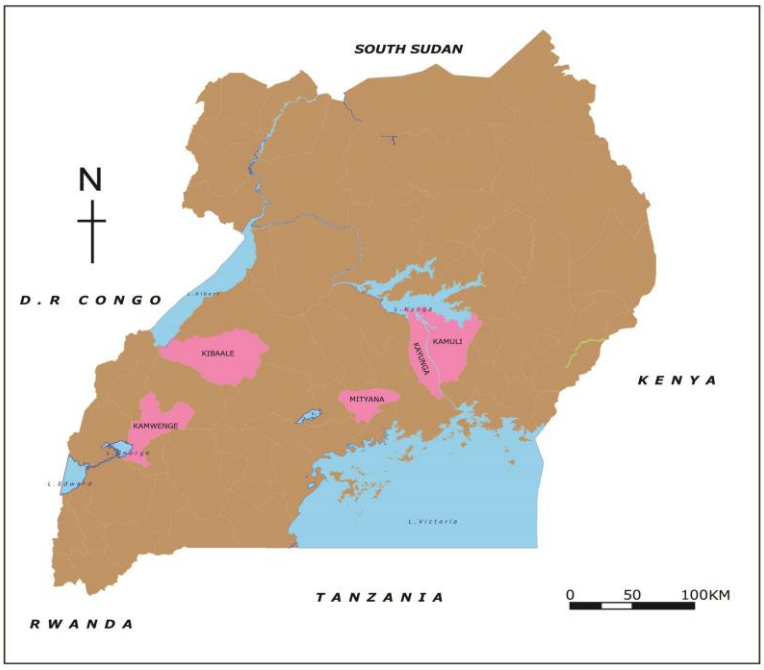

Figure 1. Geographic location of the five survey districts

3.2.2 Population of the Survey Districts

District	Population
Kamuli	554,100
Kamwenge	363,200
Kayunga	297,081
Kibaale	514,200
Mityana	354,000

Table 1. Population of the survey districts

The survey districts had a total estimated population of 2,082,581, with Kayunga District having the smallest population and Kamuli District the largest (table 1).

3.2.3 Survey Tools

A semistructured questionnaire was adapted from the HEPS-Uganda/Uganda National Health Consumers Organization (UNHCO) Community Report Card, which is designed to assess the extent to which resources allocated to the health facilities affect access to essential medicines, and from the World Health Organization's (WHO) Level II Household Questionnaire, which is designed to assess access to and use of medicines.

The interview guides for key informants and focus group discussion (FGD) guides were adapted from the Tanzania Consumer Advocacy Society (TCAS) tools for assessing consumer linkage with accredited drug dispensing outlets (ADDOs). These survey tools appear in Annex 4.

3.2.4 Selection and Size of Sample Households

The household survey measured current needs, experiences, and expectations of consumer populations in use of medicines and collected data from households located in the vicinity of reference private drug dispensing outlets. Households were purposively chosen according to their distance from the reference facility.

In each survey district, the household respondents were identified by first selecting the reference private drug dispensing outlet. A sample of 200 households per district was targeted (total 1,000 households). Private drug dispensing outlets in the community were selected to become reference facilities for the purposes of the household survey.

The households per reference drug outlet were divided into three clusters: those within a 5-kilometer radius of the outlet, those between 5 and 10 kilometers from the facility, and those more than 10 kilometers from the facility. Beginning with the reference drug outlet as a central reference point, the clusters were divided so as to be in different directions.

3.2.5 Household Sampling

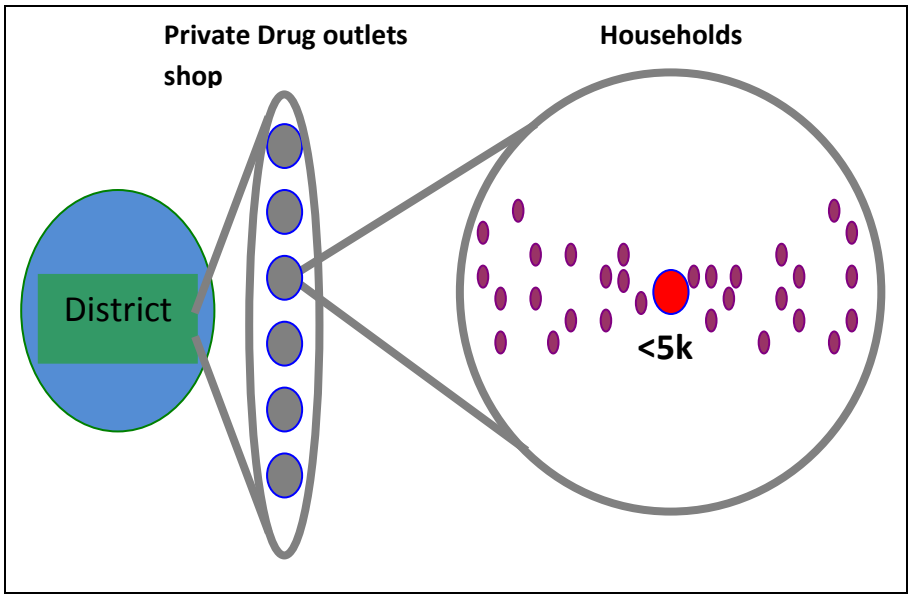

Figure 2. Identification of a cluster and households

Within each cluster, a random starting household was selected at the required distance from the reference drug outlet. After completing an interview with the respondent of this household (or scheduling one for a later time), a few households were skipped before selecting another household in the cluster. Not every household was able to participate in the survey; in such cases, the next household was chosen as a replacement.

Interviewers were trained to use judgment in selecting the households and respondents for the sample, and were asked to use the following guidelines:

- Households should not be next to each another;
- Households should not be excluded if respondents are not immediately present, but an appointment can be scheduled to interview them later in the same day;
- Households should have an economic status that is generally representative of the area in terms of dwelling condition, size, organization of the household premises, and water supply.

Respondents were selected if they met at least three of the following criteria:

- Main health care decision-maker;
- Most knowledgeable about health of household members;
- Most knowledgeable about health expenditures of the household;
- Most knowledgeable about health utilization by household members;
- Designated caregiver for sick household members.

3.2.6 Data Collection

The survey field data collection was conducted between June 10 and 19, 2012. The survey team consisted of a survey manager, five area supervisors, 20 data collectors, one statistician, and four data entry personnel. Each area had four data collectors, who were organized into two teams of two, each

comprising one pharmacist and one social scientist. All survey personnel received training in the standard survey methodology and data collection/data entry procedures at a workshop held on June 6–9, 2012. As part of the workshop, a data collection pilot test was conducted in households in Gayaza sub-county, Wakiso District, in Central Uganda. In addition, 10 FGDs and 15 key informant interviews were held.

Area supervisors checked all completed questionnaires at the end of each day of data collection. Upon completion of the survey, the survey manager conducted a quality control check of all completed questionnaires prior to data entry.

3.2.7 Data Entry and Analysis

A team of four data entry persons with experience in data entry procedures entered the survey data. The data entry team also underwent training on June 6–9, 2012. Microsoft Excel was used for the data entry. The quality of data entry was checked by comparing data records with raw data, and erroneous entries and potential outliers were verified and corrected, as necessary.

Data records were analyzed using the Microsoft Excel computer application.

3.2.8 Limitations of the Survey

The study districts were chosen purposively, and therefore the sample size of the districts and results may not provide an appropriate representation of consumer behavior regarding use of medicines across all demographic and geographical divides of the country, but only a fair picture of the situation in the SDSI districts and other districts with similar demographic and geographical characteristics.

Geographical access to some of the survey areas was a challenge, particularly those that are mountainous and difficult to reach by vehicle. The survey team was forced to resort to walking to those areas, which consumed a lot of time and effort.

4. Discussion of Survey Results

This section outlines the outcomes of the survey and discusses their implications in light of the objectives of the SDSI goal of maximizing the contribution of ADS to increased access to quality, affordable, and accessible essential medicines at the community level.

4.1 Characteristics of Household Respondents

A total of 895 households participated in the survey. This was a return rate of 89.5 percent on the target number. The survey sought to characterize the age, gender, marital status, religion, education level, and occupation of respondents. All these characteristics can have an influence on health-seeking behaviors.

District	Kibaale	Kayunga	Mityana	Kamuli	Kamwenge	TOTAL
Median age	36	30	35	36	39	36

Table 2. Median age of respondents

A majority of the respondents were middle-aged, with the median age for all districts recorded at 36 years, with a range of between 30 years in Kayunga and 39 in Kamwenge.

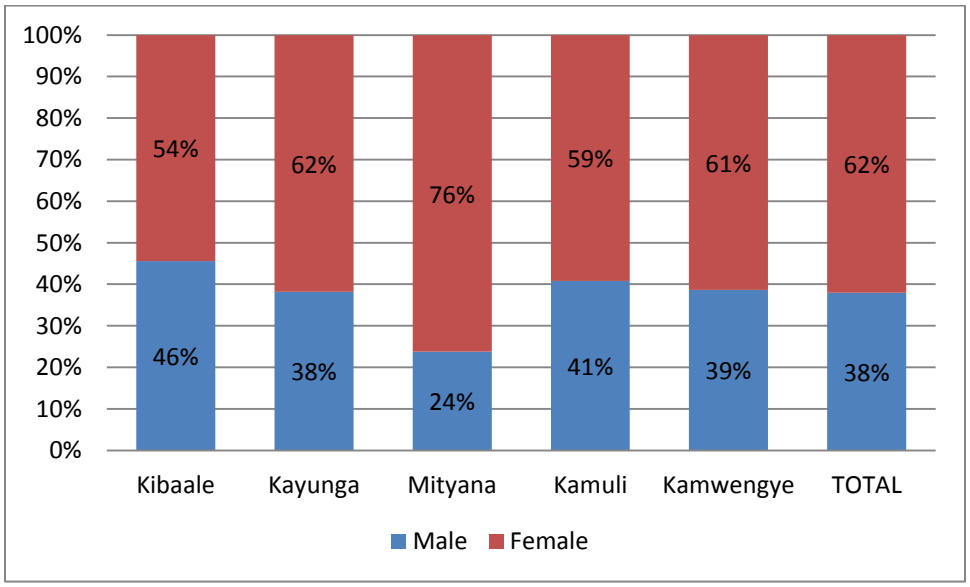

Figure 3. Gender of household respondents

A majority of the household respondents were female, with the biggest proportion of female respondents being registered in Mityana (76 percent) and the smallest in Kibaale (54 percent).

Given that the selection of the respondents was based on meeting the criteria of being decision-makers on health care; having knowledge of the health of household members, health care utilization, and health expenditures; or being designated as caregiver for sick household members, these findings suggest that women in the survey districts play a major role in health care within households.

Key points:

- Kayunga has the youngest population (30) and Kamwenge the oldest (39).
- Women are the major decision-makers on health care in households.

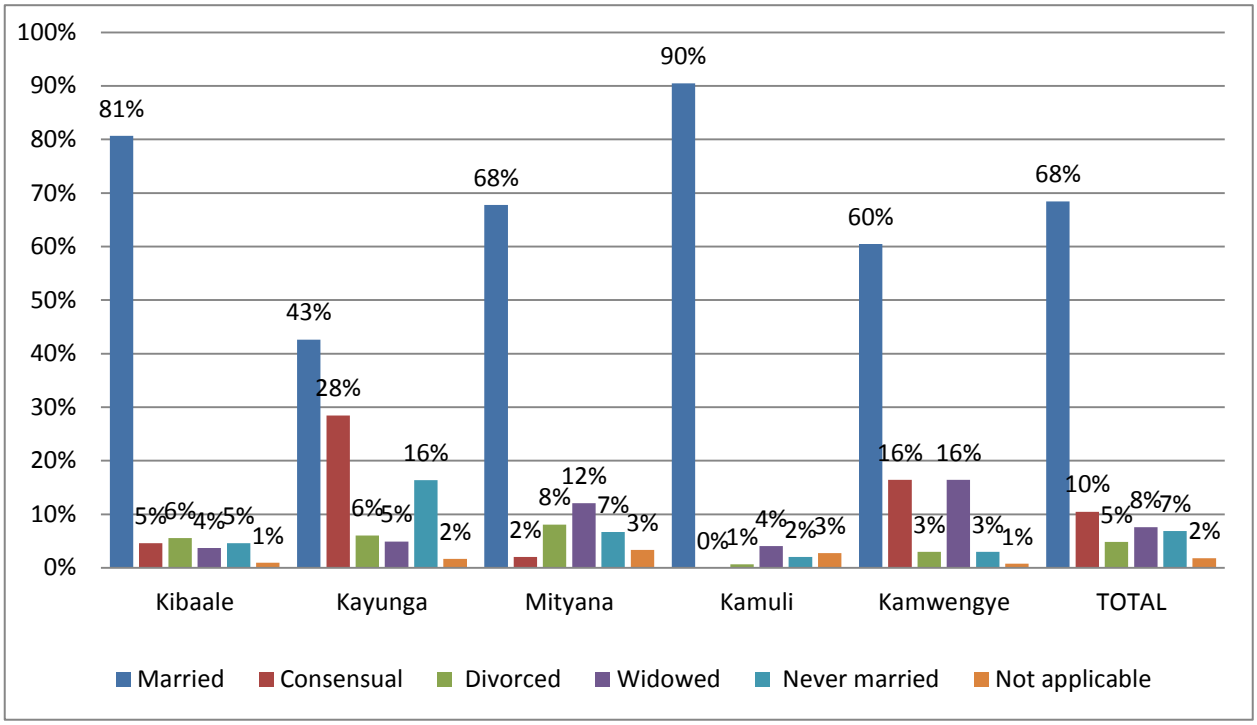

Figure 4. Marital status of respondents

The overwhelming majority of household respondents—more than two-thirds—were married. Up to 78 percent of the respondents was living as part of a couple—in either a marriage or a consensual relationship. Interventions aimed at increasing access to medicines or consumer participation in improving the services of private medicine outlets will need to take into account this "couple phenomenon" and its dynamics when dealing with households.

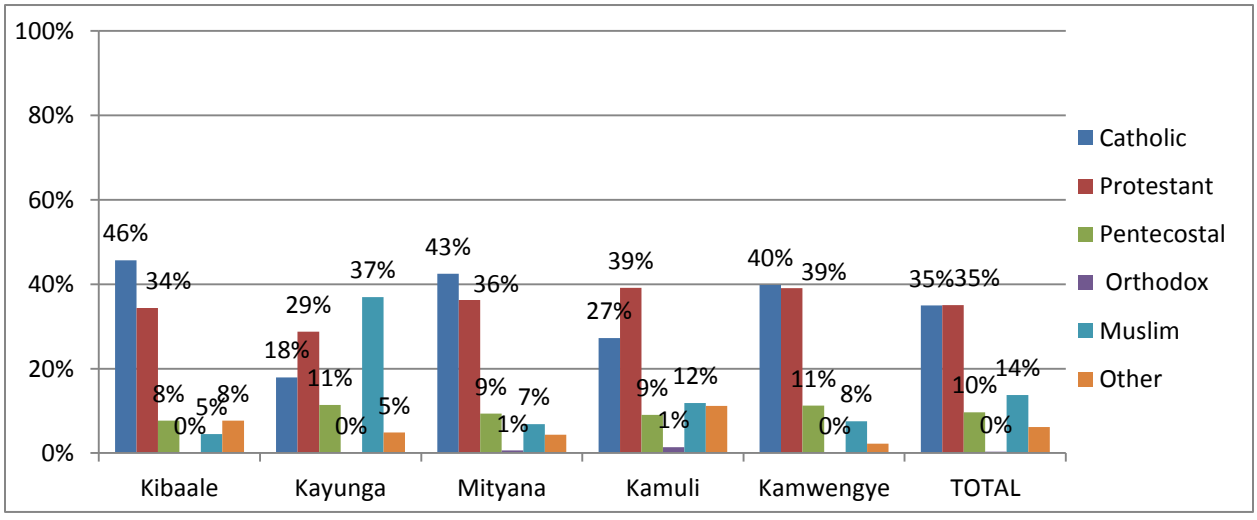

Figure 5. Religion of household respondents

A majority of the respondents (70 percent) were either Catholics or Protestants (Anglicans), with the two religions dominating in four of the five survey districts. Only in Kayunga District did Islam constitute the single biggest religion, at 37 percent. Overall, however, Muslims made up only 14 percent of the household respondents.

Interventions on access to medicines should consider the religious aspects, i.e., the large Muslim population in Kayunga and Christian populations in the other districts.

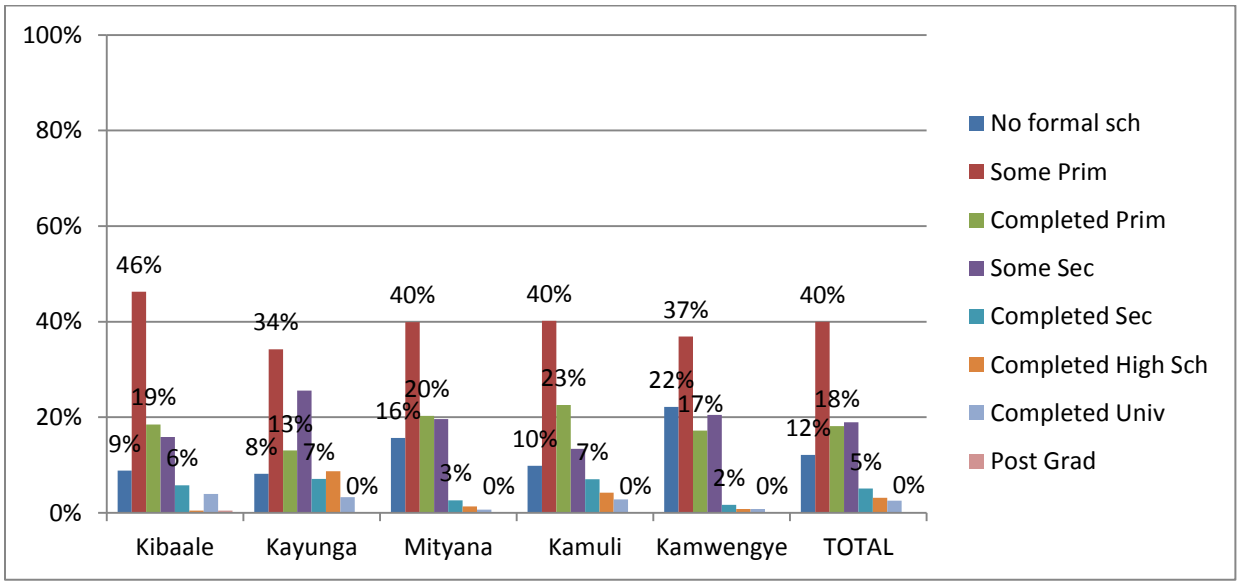

Figure 6. Education level of household respondents

Most of the household respondents reported to have only a modest education. Just over half (52 percent) of the respondents had either some elementary education or no formal education at all. Taken together with the respondents who completed primary education, the proportion of household respondents with only elementary instruction or no formal schooling at all rises to 70 percent.

Thus, less than one-third of the household respondents had attained at least some secondary education, with the least proportion being registered in Kamwenge District (24 percent) and the highest in Kayunga (45 percent). In Mityana District only 25 percent of the respondents reported to have attained at least some secondary education, even though its proximity to the capital, Kampala, is better than that of Kayunga District.

Key point:

- Promotion of access to medicines should consider visual and action material in the local language for individuals with only an elementary education level.

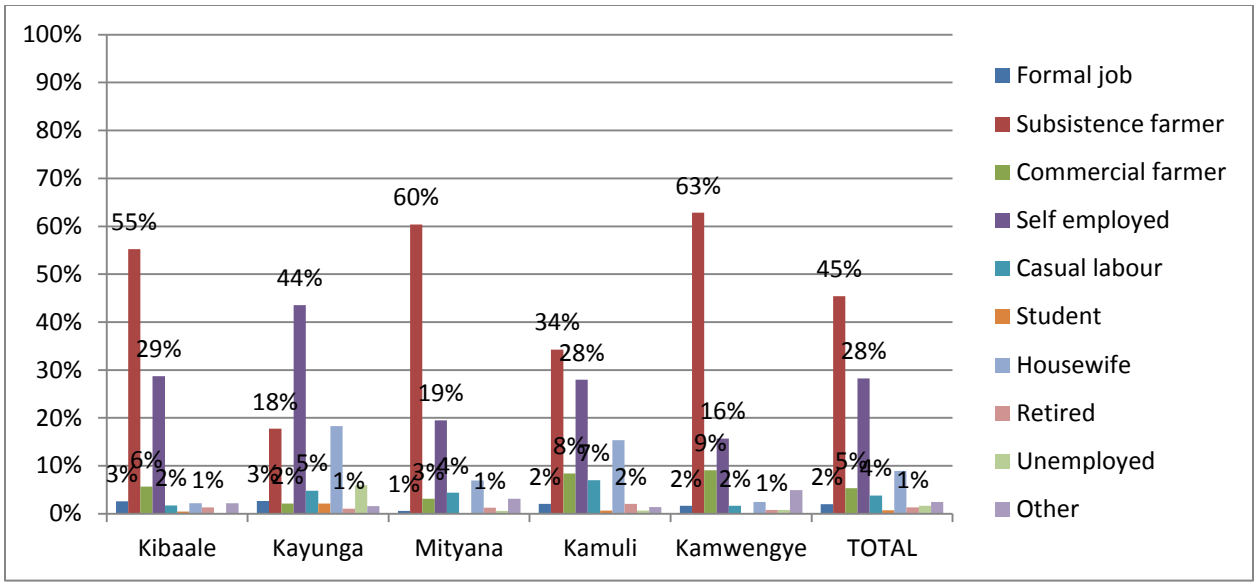

Figure 7. Occupation of household respondents

In four of the five survey districts, subsistence farming was the predominant occupation of the household respondents. Kayunga was the only district where self-employment was the leading occupation (44 percent), followed by subsistence farming (18 percent) and "housewife" (18 percent). In three of the districts (Kibaale, Mityana, and Kamwenge), at least half of the respondents were dependent on subsistence agriculture. Overall, an estimated 61 percent of the household respondents did not have a source of income as they depend on subsistence farming, or are housewives, students, or retired. This large proportion of non-income earners means that they can only buy medicines if they sell an asset or if someone else meets the cost.

Key points:

- The majority of respondents from the districts is involved in subsistence farming and has no formal income, except in Kayunga, where the majority is self-employed.
- Private sector access to medicines interventions should therefore consider income levels and how to subsidize costs for the population.

4.2 Access to Private-Sector Medicine Outlets

Access to private medicine outlets was measured in various forms, including proximity in distance and time to reach a facility, type of nearest private medicine facility, reliability in availability of all required medicine, and cost of medicine.

The World Health Organization considers medicines to be accessible if a facility is within 5 kilometers from an individual or within one hour's walk. The relative numbers of different types of private medicine outlets, their proximity to survey households and the estimated time respondents need to walk to them were used to consider respondent access to private medicine sources. The findings show that a variety of private medicine sources, including hospitals, clinics and drug shops, among others, are available at community level in the survey districts.

> *"Community members here get medicines from drug shops, local clinics that are accredited, and from public health units in Mugarama and Isunga, which are in the neighborhood. There are also other private sources, which include NGO [private-not-for-profit] health facilities as well as herbal clinics." —Community Leader in Kibaale District*

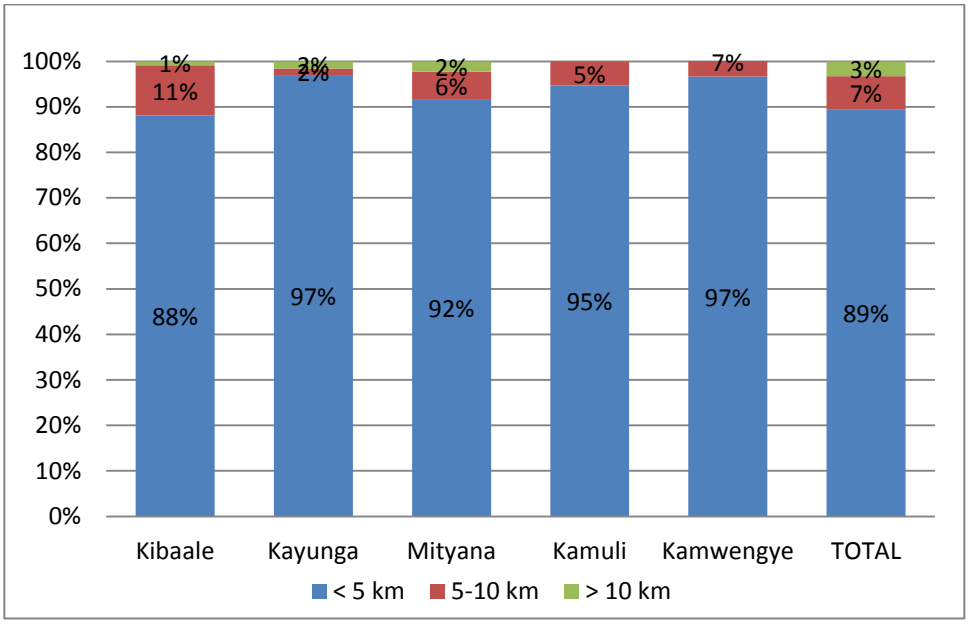

Figure 8. Distance of respondent households from private medicine outlets

Geographical access to private medicine outlets was found to be universal in the survey districts. Most of the respondents, averaging 89 percent, reported to be within just 5 kilometers of the nearest reference private medicine outlet, suggesting that private medicine outlets are convenient access points for essential medicines.

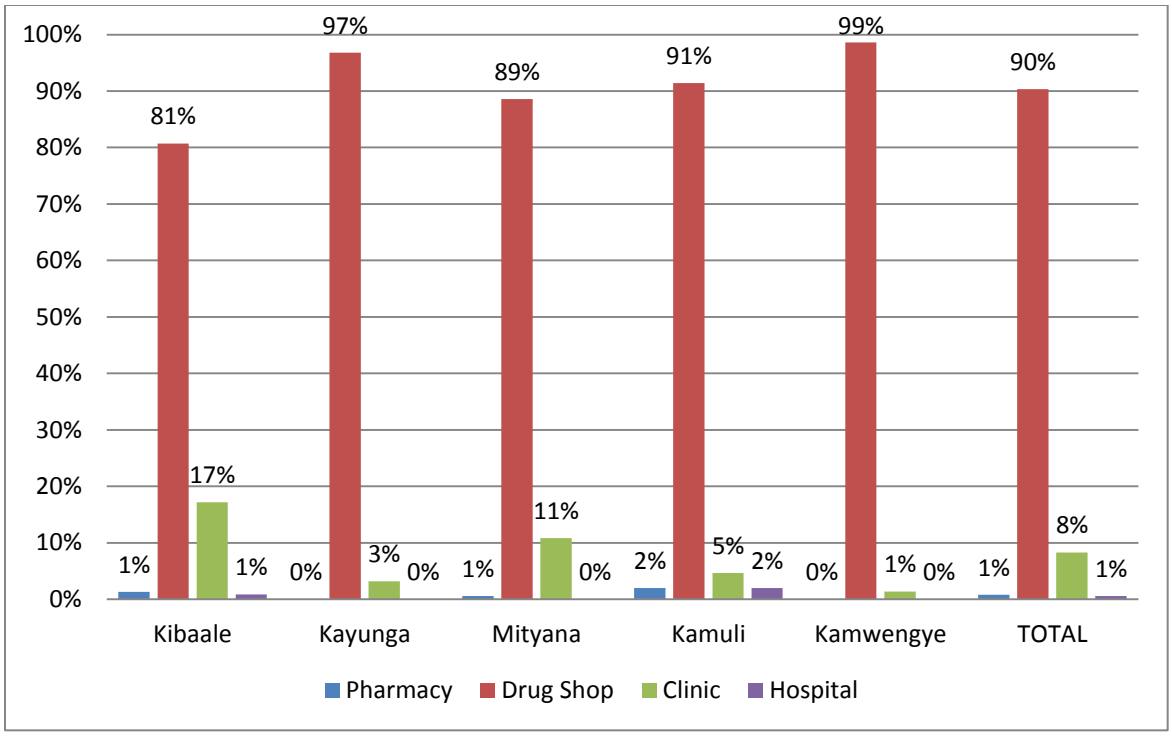

Figure 9. Types of private medicine outlets, by district

Drug shops make up the overwhelming majority—averaging 90 percent—of private units in the survey districts (figure 9). They are followed by clinics. The higher health facilities, represented by hospitals, averaged just 1 percent, and in case of Kamwenge, Kayunga, and Mityana, there was no hospital, while drug shops made up 99 percent, 97 percent, and 89 percent, respectively, of the private medicine outlets in the three districts.

> *"Drug shops are more than any other sources here because they are distributed all over the place; we don't have any hospitals, we don't have any pharmacy..."*
> *—Respondent in Kamwenge District*

In line with the relative distribution of private medicine outlets, the majority of household respondents reported sourcing medicines from drug shops. The respondents considered drug shops to be more accessible and convenient than hospitals and pharmacies.

> *"Drug shops are open from morning up to 10 pm in the night; I appreciate their efforts because there is a lot of congestion in (public) hospitals. They help to decongest hospitals. I suggest the government trains these drug shop operators so that they provide good services to the population." —FGD participant in Kamuli District*

Key point:

- Drug shops are the most accessible and convenient private medicine outlets for households.

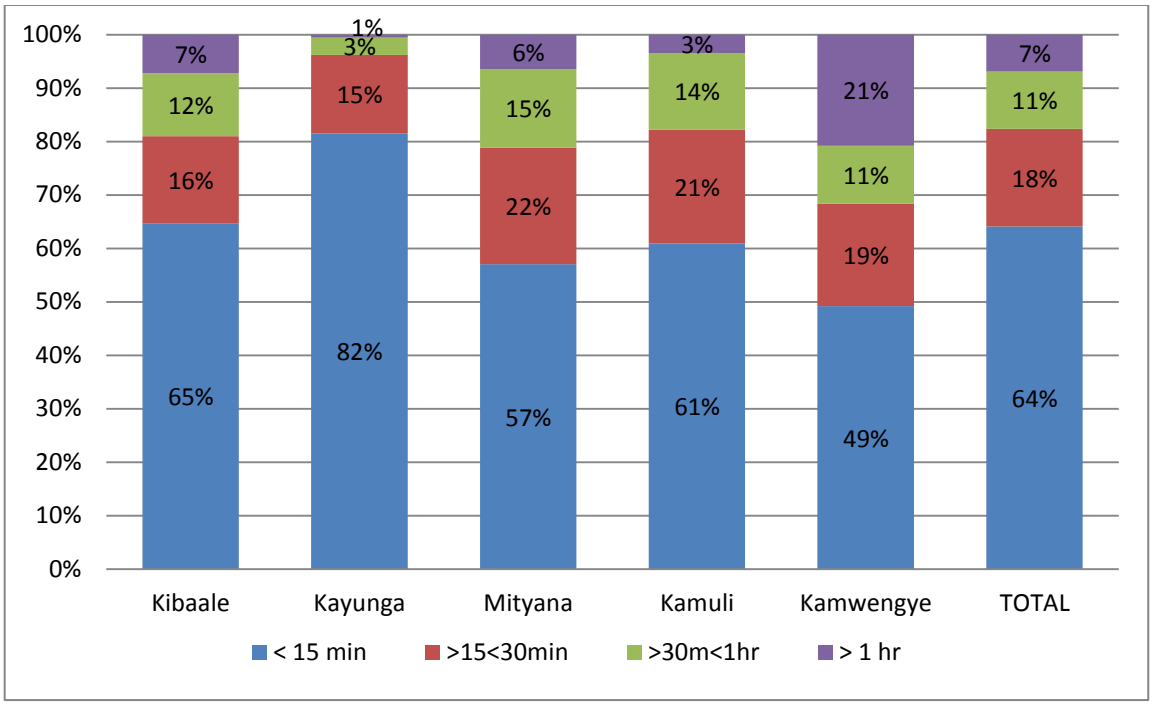

Figure 10.Time needed to walk to nearest outlet

Overall, 64 percent of the household respondents, and up to 82 percent in Kayunga, reported to be within 15 minutes walking distance of the nearest private medicine outlet. At the other extreme, only 7 percent of the respondents overall, and just 1 percent in Kayunga, reported their walking distance to exceed one hour. The results suggest that geographical access is generally not a problem in the survey districts, save Kamwenge, where barely half of the respondents were within 15 minutes walking distance.

With other private medicine sources (pharmacies, clinics, and hospitals) being relatively less distributed within communities, respondents considered drug shops to make the biggest contribution to accessibility of medicines at the grassroots level, particularly because they reduce the cost of transport to access medicines and health care.

> *"I rarely go to the hospitals because emergencies are also handled in the drug shops too and when my children and I fall sick, that is where we go and this becomes cheaper if the transport cost to the hospital is considered too." —FGD respondent in Kamuli District*

4.3 Utilization of Private Drug Outlets

Respondents were asked if they had visited the nearest private medicine outlet in the previous one year. Their responses are summarized in figure 11.

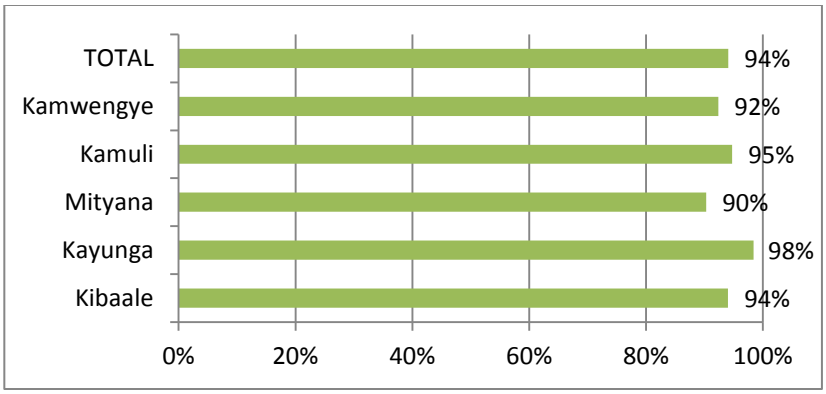

Figure 11. Household utilization of private drug outlets

An overall majority (94 percent) of households had utilized private drug outlets in the past year. The largest number was in Kayunga District, at 98 percent.

If the respondent's household had not visited the reference private outlet, the reasons were sought. The results are summarized in figure 12.

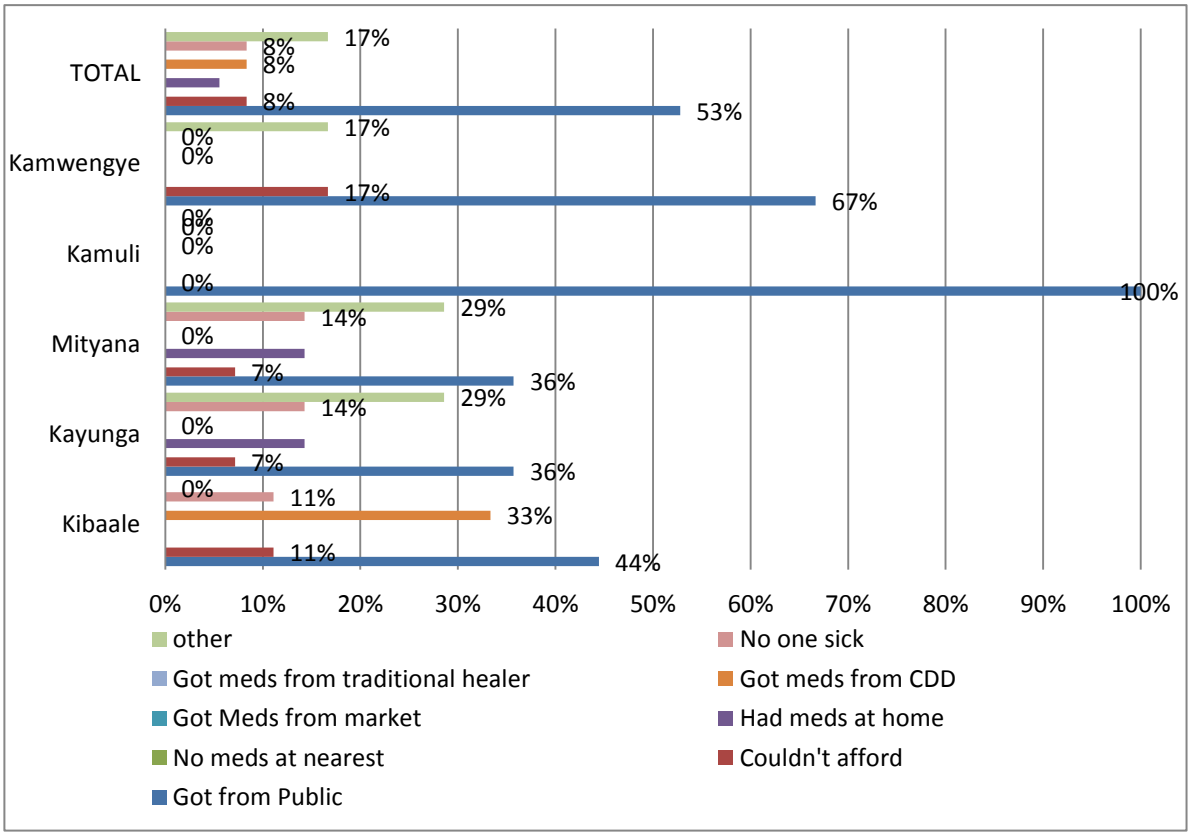

Figure 12. Reasons why households had not visited reference private medicine outlet

For those who had not visited the private medicine outlets in the previous year, the major reason was because they received medicine from the public health facilities. This was especially so in Kamuli (100 percent). Household respondents reported other reasons as well: they received medicines from

community drug distributors (CDD), particularly in Kibaale (33 percent); no one was sick in the household during the period; they already had medicines at home; or they could not afford them. Overall, 8 percent of the respondents reported that they had not utilized private medicine outlets in the previous 12 months because they could not afford to, with the problem affecting mostly health consumers in Kamwenge (17 percent) and Kibaale (11 percent).

Key point:

- Although variation in utilization of private medicine outlets is not marked across the districts, the overwhelming use in Kayunga, as compared to Mityana, may suggest a linkage between a preference for the private sector and increased education.

4.4 Reliability of Private Medicine Outlets

4.4.1 Open for Business When Needed

The reliability of private medicine outlets was assessed in terms of the likelihood of finding the closest private medicine outlet open when a health consumer visits it for medicines.

District	Kibaale	Kayunga	Mityana	Kamuli	Kamwenge	TOTAL
% of open private facilities	80	88	71	76	72	78

Table 3. Private facility is open when medicines are needed

An estimated 8 out of every 10 private medicine outlets are open when health consumers visit them to buy medicines. This proportion however, varies between 7 in 10 in Mityana and Kamwenge to about 9 in 10 in Kayunga. This creates a major access problem, especially in Kamwenge and Kibaale, where the walking distance to the next nearest outlet exceeds one hour for 64 percent and 41 percent of the respondents in the two districts, respectively.

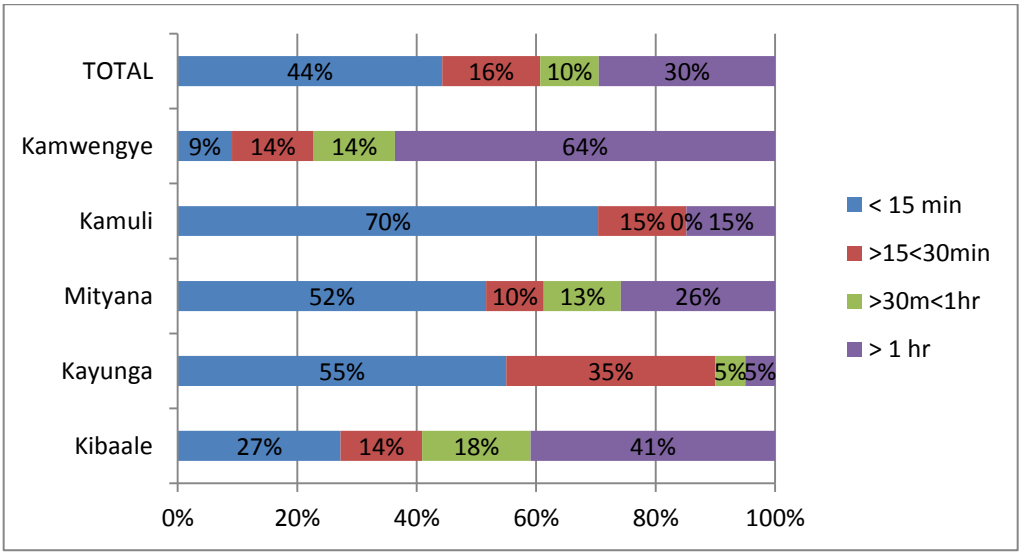

Figure 13. Distance to next facility when nearest is closed

Overall, the walking distance to the next nearest outlet exceeds a quarter of an hour for more than half of the respondents.

4.4.2 Received All Medicines Prescribed from the Same Private Facility

The reliability of the private medicine outlets in terms of medicine availability was also tested by inquiring whether all the medicines prescribed were obtained at the same facility. A large proportion of respondents—more than one-third—do not get all the prescribed medicines at the same facility. Between 35 percent and 41 percent of the household respondents in the different survey districts reported that they did not get all the prescribed medicines at the private outlet they visited. The reasons why they did not were mainly because the outlets were stocked out (83 percent) or the clients could not afford the prescribed medicines (16 percent).

Table 4 shows the reliability of medicine availability by district.

	Kibaale	Kayunga	Mityana	Kamuli	Kamwenge	TOTAL
% received all medicines at same facility	65	65	62	59	62	63

Table 4. Received all medicines prescribed from the same private facility

> *"For example, one can treat malaria and finish the treatment from a recommended hospital without realizing any improvements, then they turn to the traditional services out of desperation to get well." —Respondent in Kamuli District*

The likelihood of getting all medicines prescribed at the same private medicine facility across the five districts is 63 percent, and it is highest in Kibaale and Kayunga (65 percent) and lowest in Kamuli (59 percent).

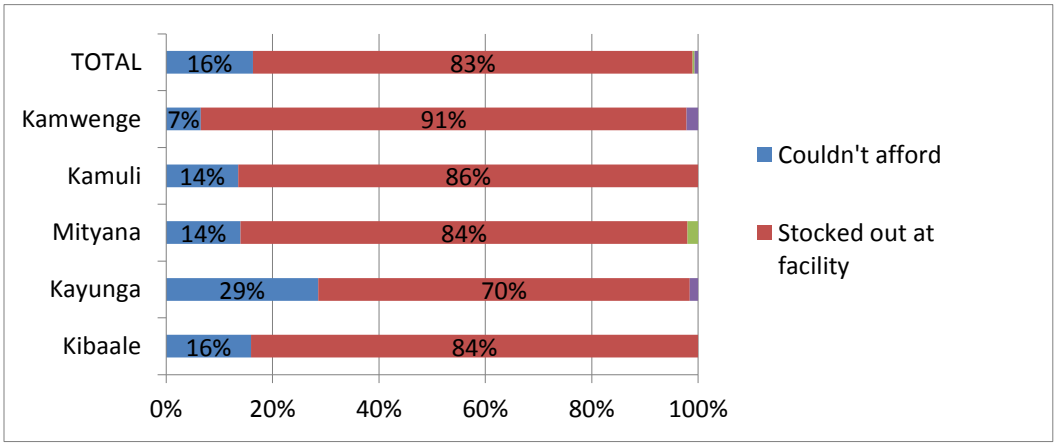

Table 5. Reasons why all medicines were not obtained from the same facility

The main reason provided for not getting all the medicine from the same private medicine outlet was because of a stock-out at the facility. It should be noted that some medicines (Class A and B drugs) are not stocked at drug shops.

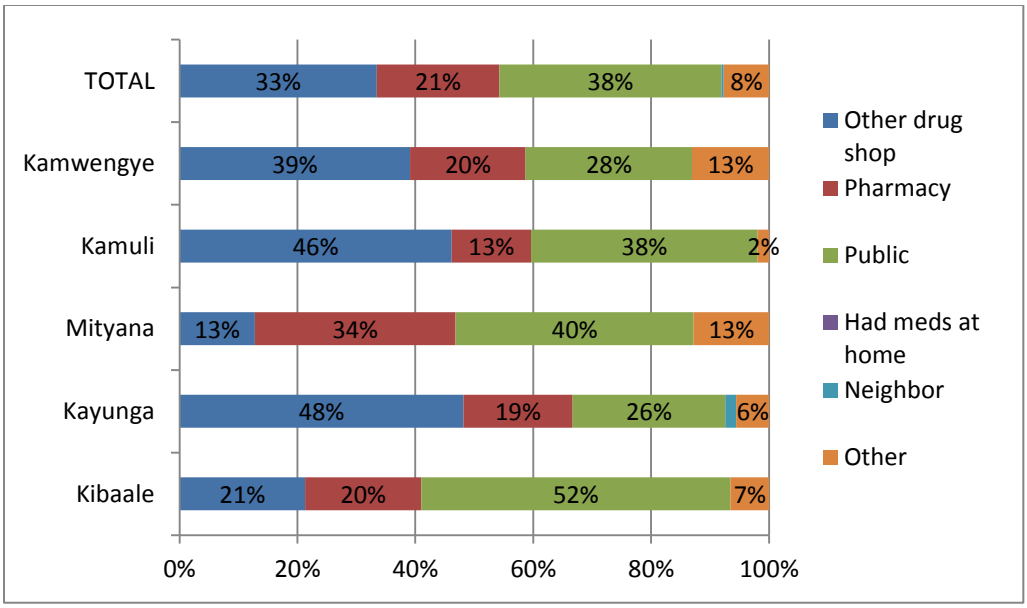

Figure 14. Source of medicines if nearby private drug outlet is stocked out

For those that could not get all the prescribed medicines at one private outlet, about 38 percent got the rest of the medicines from a public facility, one-third (33 percent) from another private drug shop, and 21 percent from a pharmacy.

> *"The common sources of medicines in Mityana are clinics, drug shops, government health centers, and traditional healers….These sources are not reliable. A case in point is the drug shops; these do not have all the medicines that the community needs and also sometimes sell expired drugs. For the government health centers, there are hardly drugs found in them, while the traditional healers are very unreliable." —Respondent in Mityana District*

Respondents identified many challenges in the utilization of private medicine outlets. At the top of the list were high medicine prices and medicine stock-outs. Other reported challenges included limited services and medicine options, unknowledgeable staff, reluctance to refer cases they cannot handle, and ineffective medicines, among others.

> *"Services like admissions are lacking in the drug shops, especially since there are no beds in the drug shops and first aid services like putting a patient on drip in times of emergencies before they are transferred to the hospitals are not available… On the contrary, sometimes after the patients go to the hospitals, they get referred back to the clinics." —Respondent in Kayunga District*

4.5 Price and Affordability of Medicines

Respondents were asked to recall the cost of medicines for the treatment of the last illness at the private medicine outlet. Their responses are summarized in table 6.

District	Median medicine cost (UGX)	Average medicine cost (UGX)
Kibaale	10,000	14,543
Kayunga	6,000	11,961
Mityana	6,000	10,890
Kamuli	6,500	19,676
Kamwenge	12,000	19,183
Total	6,500	15,251

Table 6. Median and average cost of medicines

The median price of medicines ranges between 6,000 Uganda shillings (UGX) in Kayunga and Mityana and UGX 12,000 in Kamwenge. On average, households had paid between UGX 10,890 in Mityana and UGX 19,183 in Kamwenge for medicines to treat the latest health problem. Households met this cost; none of the respondents reported that insurance fully or partially covered the cost.

Only about 40 percent of household respondents felt that prices of medicines at private outlets were fair, and about 41 percent felt that they were affordable. While 63 percent reported that they could get medicines at a private medicine outlet on credit, 64 percent reported that they had to sell an asset or a possession in order to buy a dose of medicine.

> *"The medicines at the drug shops/ADS are very expensive, and to make it worse, they lack most of the powerful medicines which the patients might need, thus forcing them to go back to the public hospitals that they ran away from." —Respondent in Kibaale District*

Key points:

- The price of medicine across the five districts is very high, considering that most of the households depend on subsistence farming and do not have a formal income.
- Medicine prices were highest in Kamwenge, followed by Kibaale.

4.6 Nature of Health Problems Clients Present to Private Medicine Outlets

Private medicine outlets handle a wide range of health problems at the community level, from minor to what respondents considered serious acute as well as chronic complaints.

The survey sought to identify the common ailments that take households to private medicine outlets. Lists for symptoms of health problems were provided that included common acute problems ranging from fevers, flu, cough, diarrhea, breathing problems, pains, burns, to bleeding and accident-related injuries, among others; and complaints related to chronic problems, including stomach ulcers, hypertension, asthma, cancer, diabetes, HIV/AIDS, epilepsy, and others.

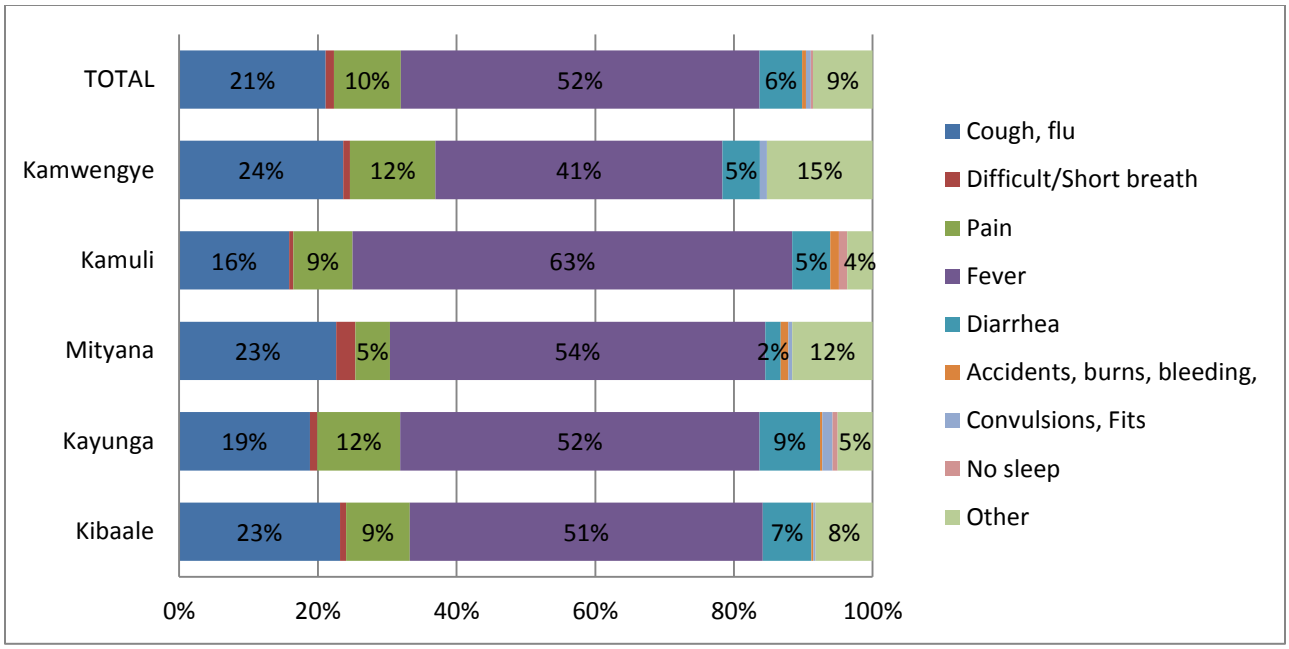

Figure 15. Common acute health problems that take households to private drug outlets

Fevers make up the biggest proportion—averaging more than half (52 percent)—of health complaints that household members present to private medicine outlets (figure 15). Fever is commonly associated with many health problems, but the most common single cause of fever in Uganda is malaria. It can therefore be inferred to that malaria is the biggest health challenge across all districts, and the pains and aches reported in third position may also be due to malaria. Across the survey districts, cough and flu constitute the second commonest acute complaint for users of private medicine outlets.

> *"Many houses do not have latrines, and the people here break into other people's latrines as others dispose of their waste as and when they wish. Another problem is we have stagnant waters that breed malaria-causing mosquitoes." —Respondent in Kamuli District*

Key points:

- Many of the acute health problems are related to environmental sanitation and hygiene.
- Malaria is the biggest health challenge faced by households across all districts, and most acute illnesses reported are communicable and preventable.

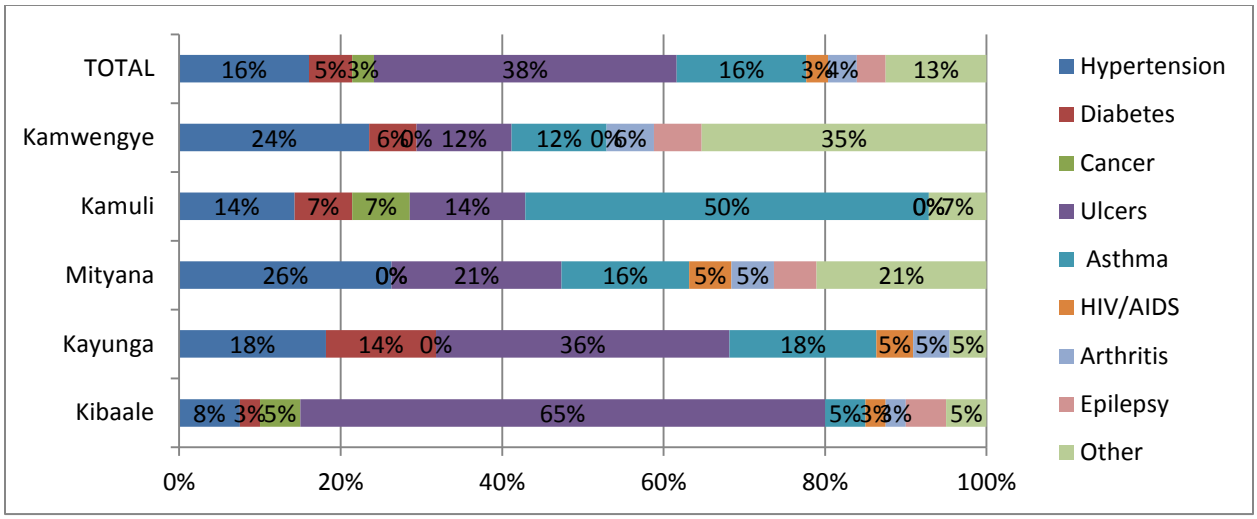

Figure 16. Common chronic health problems presented to private drug outlets

Overall, stomach ulcers are the leading chronic health problem (38 percent) that households present to private medicine outlets, followed by hypertension (16 percent) and asthma-related symptoms (16 percent) (figure 16). However, the magnitude of the stomach ulcer problem differs markedly across the survey districts, with Kibaale accounting for the highest proportion at 65 percent and Kamwenge for just 12 percent.

Asthma-related complaints are most prevalent in Kamuli (50 percent), hypertension in Kamwenge (24 percent), and diabetes in Kayunga (14 percent). Indeed, in Kamwenge, as in Mityana, the respondents reported hypertension to be the commonest chronic health problem presented to private medicine outlets.

Key points:

- Stomach ulcers are the most commonly reported problem that takes households to private medicine outlets, followed by hypertension and asthma-related symptoms.
- Ulcers are a major concern in Kibaale and Kayunga, and asthma in Kamuli.

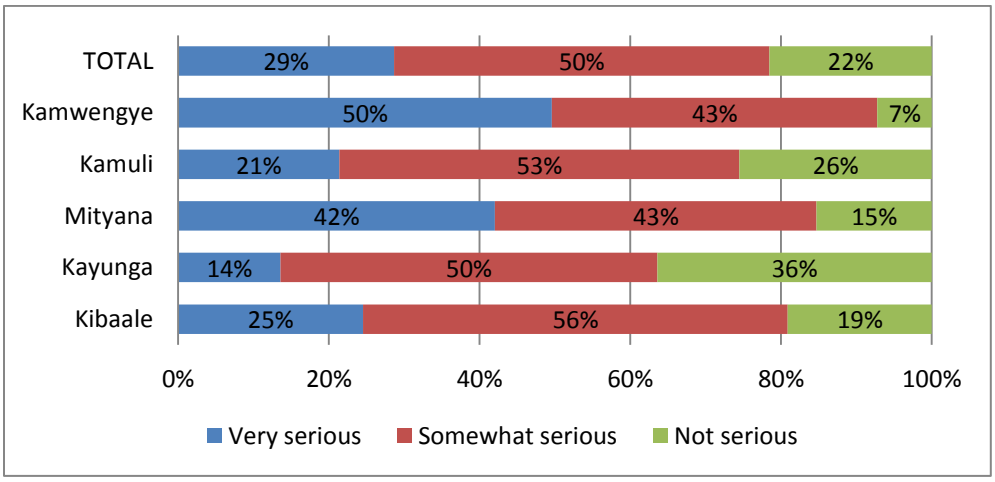

Figure 17. Seriousness of health problems presented to private drug outlets

One-half of the respondents overall presented to private medicine outlets heath complaints that they felt were "somewhat serious" (figure 17). At least one-fifth of cases presenting to private medicine outlets are considered "not serious" and could potentially lead to irrational use of medicines.

In line with the nature of problems that clients present, private medicine outlets offer a broad range of services, including many that under normal circumstances are beyond their capacity. Household respondents reported receiving mostly curative services from private medicine outlets, and their range was reported similar across the different types of outlets.

Some of the services and products offered were listed as diagnosis of diseases, dispensing medicines, administering injections, minor operations, testing blood, putting people on drip, and offering HIV testing and counseling services. Maternity services also are offered.

> *"Even drug shops offer general medical services like diagnosis, selling of medicines, and delivery services to women. These also carry out minor operations like cutting of boils, and some deliver mothers." —Respondent in Kamuli District*

Key points:

- Private medicine outlets are handling health complaints beyond their capacity.
- Options for ADS ought to consider thorough training for the medicine handlers, but also community sensitization.
- Communities are seeking medicines for ailments not considered serious, which may be a precursor to irrational use of medicines.

4.7 Rational Use of Medicines

According to WHO, rational use of medicines requires that "patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community." Rational use of medicines was measured using various aspects, including consumers' knowledge and empowerment regarding medicine issues, adequacy of labeling for medicine packages, and client adherence to prescribed guidelines.

Empowerment of consumers over knowledge areas for medicines was assessed, as shown in figure 18.

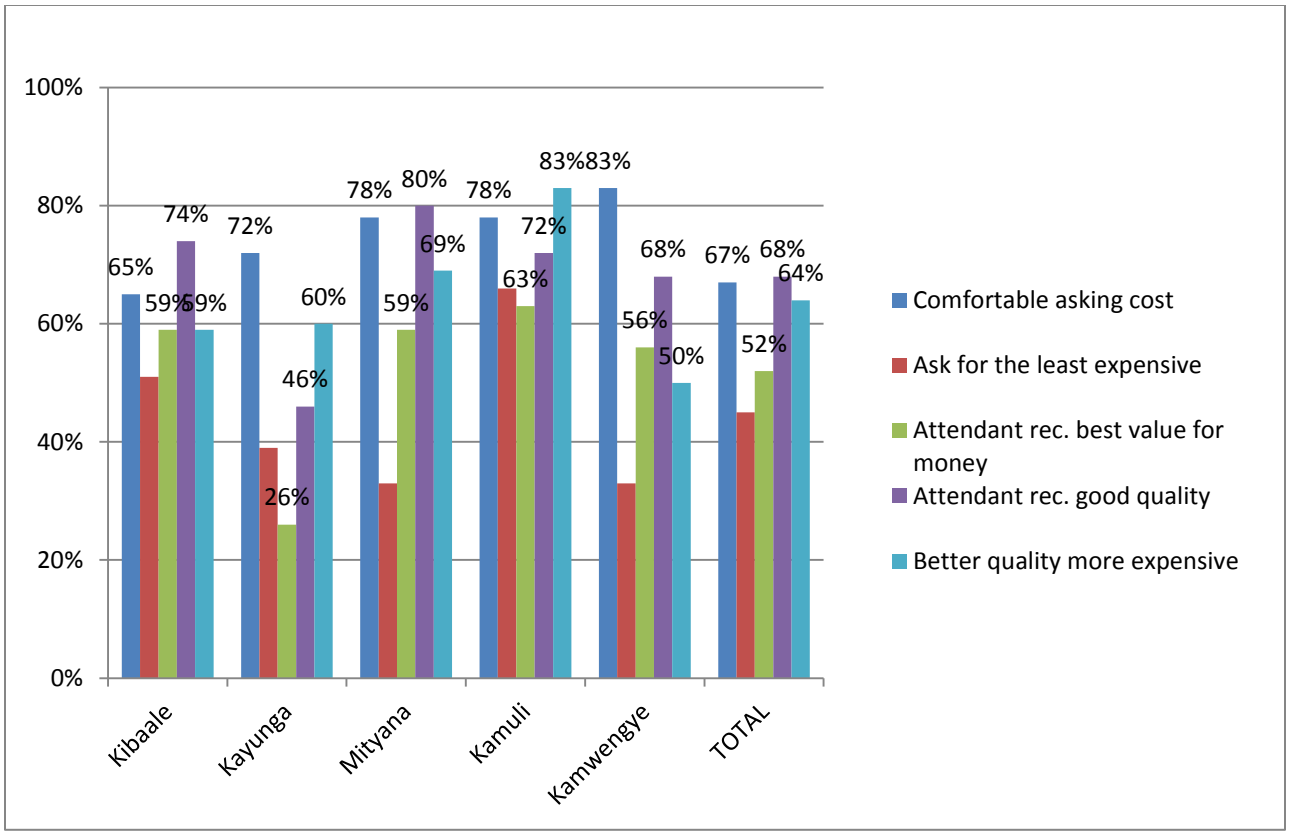

Figure 18. Consumer knowledge of medicines

On average, 67 percent of all respondents were comfortable asking drug shop attendants the price of the medicine they were to buy. Kamwenge had the highest percentage at 83 percent, followed by Kamuli and Mityana at 78 percent; and Kibaale performed least at 65 percent.

Only 45 percent of consumers were comfortable asking for the least expensive available brand of medicines. Kamuli consumers (at 66 percent) were the most empowered in this area; Kamwenge and Mityana were the least empowered at 33 percent.

Overall, about half of consumers were confident of best value for medicine recommended by drug shop attendant. Consumers in Kayunga were least confident (26 percent) on this aspect. On the other hand, 68 percent of consumers were sure of the quality of medicine when recommended by a drug shop attendant. Again, consumers in Kayunga were least confident, at 46 percent, of the quality of recommended medicine.

About two of every three of consumers associated better quality with higher price of medicines. This notion was highest in Kayunga, at 83 percent.

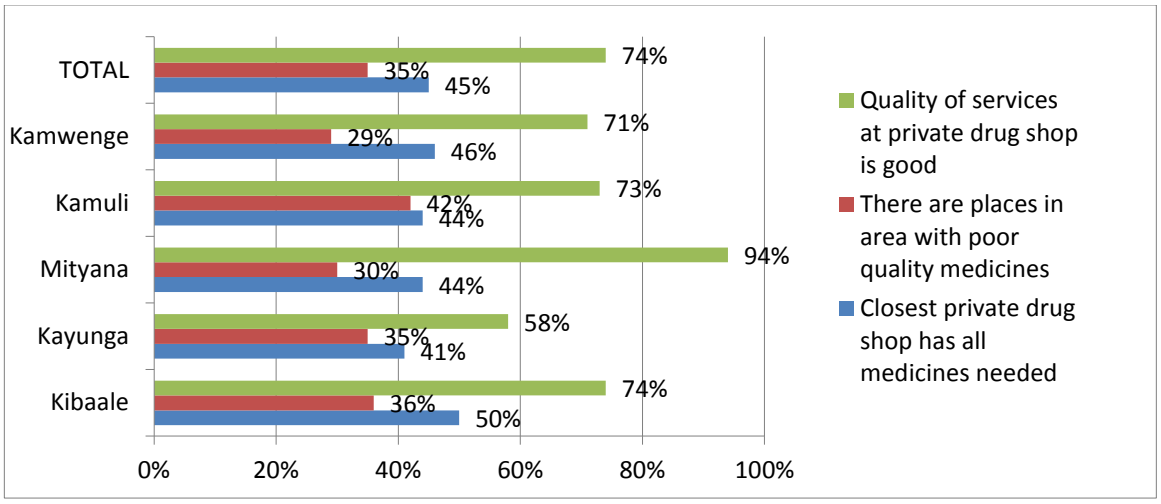

Figure 19. Perceptions of nearby private drug shops

Overall, 45 percent of respondents had drug shops closest to their households with all the medicines needed by consumers. Drug shops in Kibaale performed the best, at 50 percent (figure 19). About one in three respondents perceived that some drug shops in their area sell poor quality medicines, and they would never go to such drug shops. Also, 74 percent of respondents perceived the quality of services delivered by private drug sellers in their neighborhood to be good. Mityana performed best in this area at 94 percent, and Kayunga performed least well at 58 percent.

Key points:

- Consumers in the districts have relative trust and confidence in drug shop attendants and are comfortable asking questions.
- Consumers associate better quality with higher price of medicines. The concept of generic medicines is unknown.
- Consumer empowerment on medicine issues is low across the five study districts.
- There is a belief that some drug shops sell poor quality medicines, especially in Kamuli.

The survey sought to verify the proportion of adequately labeled medicines found in households. For this survey, minimum requirements for an adequately labeled medicine package were possession of the following: name of medicine, dose, and duration.

District	% complete label
Kibaale	13
Kayunga	18
Mityana	12
Kamuli	17
Kamwenge	3
TOTAL	13

Table 7. Proportion of medicines appropriately labeled

The standard of labeling for medicine found in respondent households was generally poor. Overall, only 13 percent of medicines found with health consumers had the name of medicine, dose, and duration written on the envelope. In Kamwenge, the proportion was as low as 3 percent.

> *"Most [drug shop] owners have a tendency of leaving their children or spouses to dispense drugs when they are away, and most times these have limited knowledge on what drugs to give in what amount." —Respondent in Mityana District*

Regarding adherence to prescribed medicines, the proportion of consumers reported to take all medicines prescribed averaged 79 percent, implying that one in five people may not be taking medicines as prescribed. The situation was more or less the same across the survey districts (table 8).

District	% that take all medicines
Kibaale	77
Kayunga	80
Mityana	79
Kamuli	85
Kamwenge	73
TOTAL	79

Table 8. Household members that take all medicines provided

The main reason why consumers are defaulting on medicines was overwhelmingly because symptoms got better (figure 20). Respondents also reported that the high cost of medicines also makes it difficult for clients to purchase full doses, and drug shops were reported to provide medicines for only the money that clients have.

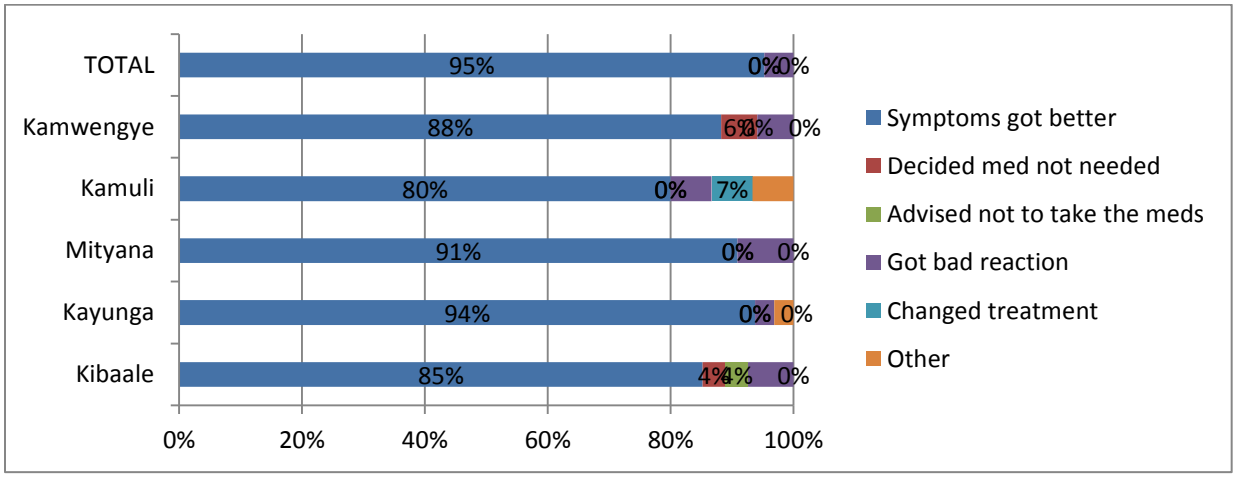

Figure 20. Reasons for not taking all the medicines provided

Key points:

- Proper labeling of medicines is an issue which drug shops owners and regulators should work on in order to improve medicine use.

- Consumers reported widely to adhere to instructions on medicine use and complete prescribed doses. However, the one in five that do not complete the prescribed dose can be a major issue.
- The main reason medicines were discontinued is due to relief from symptoms. This could be due to the fact that many consumers are taking medicines even when it is not required, as reported earlier.

4.8 Quality of Service at Private Medicine Outlets

Quality of service as perceived by a client was measured from various consumer aspects, including expectations of the consumers, experiences of the consumers when they visited the private drug shops, the behavior of drug shop attendants, consumer satisfaction with services, and comparison with services in the previous year.

	Registration/ licensing	Neat and orderly	Qualified staff	Knowledgeable staff	Hospitality	Display medicine prices	Issue receipts	Give full information on medicine use	Properly label medicines	Not handle medicine with bare hands
Kibaale	89	99	95	98	99	80	84	100	99	96
Kayunga	91	99	99	99	100	66	90	99	99	100
Mityana	92	99	98	100	98	69	86	98	95	99
Kamuli	88	100	100	100	100	61	88	100	100	100
Kamwenge	82	99	95	97	98	65	84	98	98	91
TOTAL	89	99	98	99	99	69	86	99	98	97

Table 9. Expectations of consumers from private drug sellers, in %

Consumer expectations of private medicine outlets were high in terms of registration/licensure, neat and orderly, qualified staff, knowledgeable staff, hospitality, giving full information on use of medicines, labeling medicines, and not handling medicines with bare hands (table 9). The pattern of expectations was similar across the different survey districts. The expectations were lowest in terms of displaying medicine prices. In Kibaale, consumers had relatively high expectations regarding display of medicine prices when compared to other districts.

Respondents in interviews and focus group discussions suggested that, in most cases, private medicine outlets did not meet these expectations, even though many felt their customer care was still better than what public facilities give.

> *"Some rooms are segmented with papyruses, while others are separated by the contents they are selling. For example, one corner is filled with drugs with another having shop contents." —Respondent in Kayunga District*

In terms of consumer satisfaction, three in four clients (about 77 percent) reported that they were generally happy with the services of private medicine outlets.

> *"The advantages of ADSs are that they are so welcoming and have good customer care, which is the first form of treatment a patient needs…Since these are at the neighborhood, one spends less time accessing them and accessing medicines too with manageable numbers of patients." —Respondent in Kibaale District*

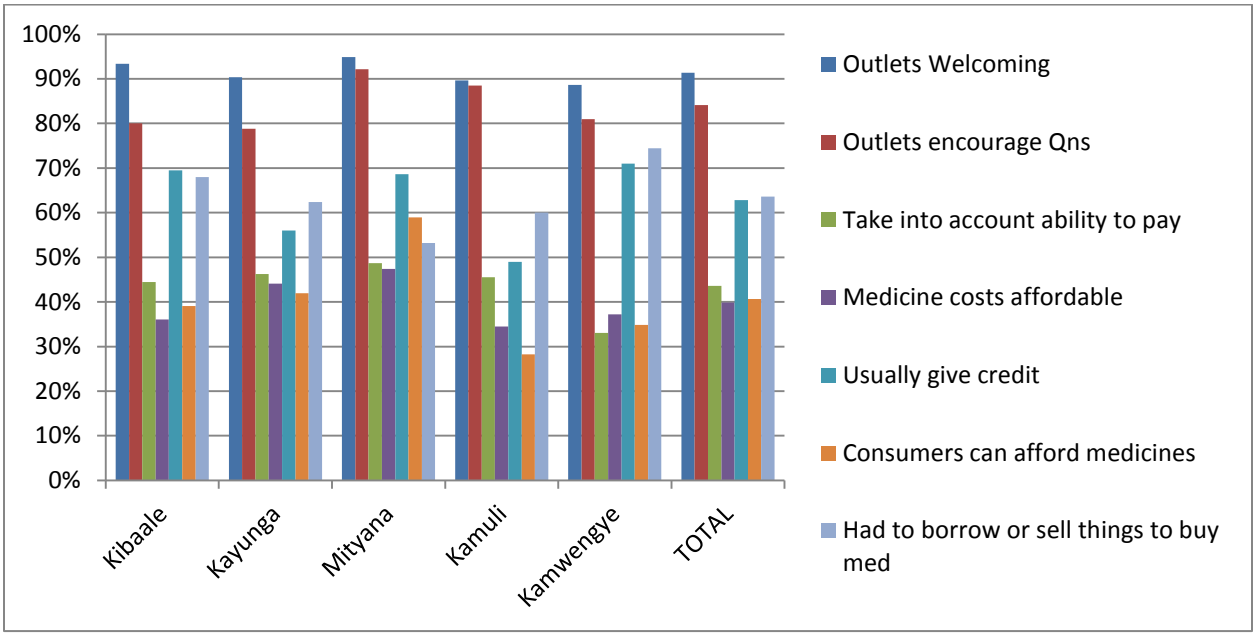

Figure 21. Consumer experiences with private medicine outlets

Nine in 10 clients of private medicine outlets in the survey districts felt that the outlets were welcoming and a comparable proportion reported that the outlets encouraged questions (figure 21). Across the survey districts, less than half of the respondents reported that the outlets took into account one's ability to pay, and yet only 40 percent felt that medicines were affordable. On the upside, more than one in two respondents reported that they were in a position to get credit from private medicine outlets.

> *"Drug shop owners can be lenient and treat before you pay their money.…We are assured of drugs because every time you get to the drug shops you do not fail to get what you have asked for." —Respondent in Kamwenge District*

Key points:

- Private medicine sellers are generally welcoming and encourage questions.
- Medicine in private outlets is, however, unaffordable to a big proportion of the population.
- Private medicine sellers should look into prices of different products when stocking medicine so as to provide products affordable to the population.

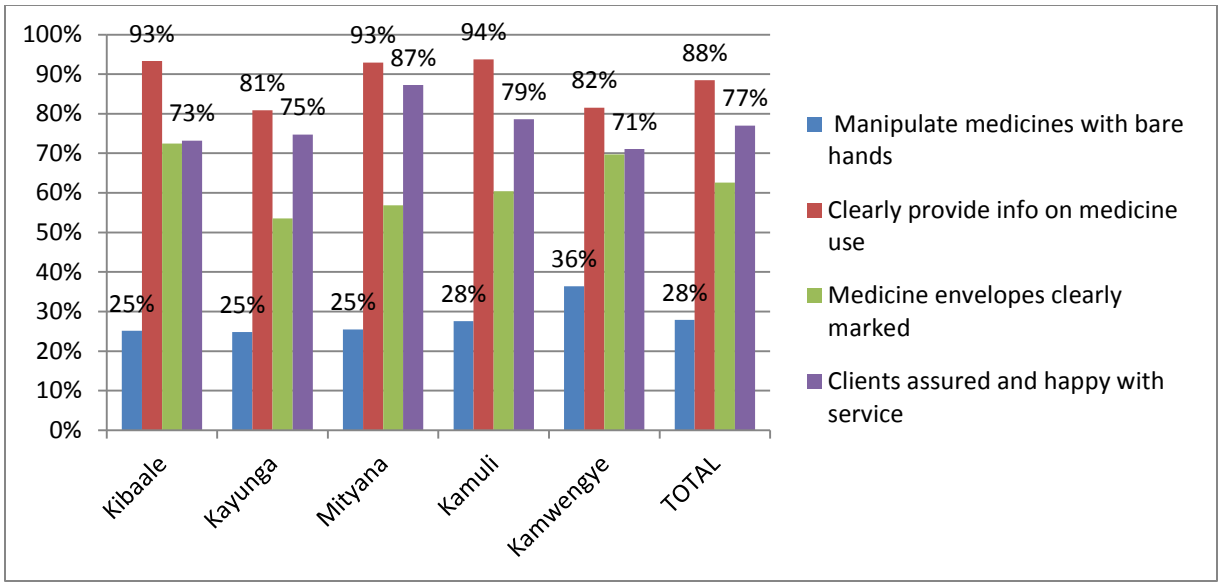

Figure 22. Behavior of medicine sellers

More than one in four respondents (28 percent) reported dispensers in private medicine outlets manipulated medicines with their bare hands. The majority of the clients were happy with the behavior of private medicine dispensers (figure 22).

In the focus group and key informant interviews, the few consumers that were not happy with the services had reasons that ranged from high medicine prices, medicine stock-outs, unqualified staff, limited equipment and services, and low levels of hygiene, among others.

> *"Drug shops have poor hygiene….Sometimes by entering you even get worried about your health other than for the sickness you want to treat. Some of them have stained walls; cups meant to serve water for patients in terms of emergencies are not pleasant for the eyes to see." —Respondent in Mityana District*

It is important to note that the inadequate consumer knowledge and empowerment on medicines may be a barrier to patient determination of a minimum expected service. As depicted in figure 22, more than three in five of the respondents felt that medicine packages were clearly marked, and yet evidence showed that only 13 percent of medicine packages met minimum label requirements.

Key points:

- The biggest behavioral challenge related to private medicine dispensers is hygiene. Manipulation of medicine with bare hands is unacceptable.
- Inadequate consumer knowledge regarding medicine is also noted to be high.

District	Distance to private drug outlet	Level of privacy	Availability of medicines	Behavior of private drug provider	Cleanliness of facility	Orderliness of facility	Quality of information for drug use	Overall health service satisfaction

Kibaale	75	69	51	80	80	80	78	71
Kayunga	82	66	49	69	74	75	57	45
Mityana	73	62	37	69	74	76	72	67
Kamuli	67	69	53	91	84	87	83	81
Kamwenge	61	70	55	82	82	84	78	71
TOTAL	72	67	49	78	79	80	74	67

Table 10. Consumer satisfaction with the quality of service provided by private drug sellers, in %

Overall service satisfaction ranged between 45 percent in Kayunga and 81 percent in Kamuli (table 10). The outlets were rated lowest in terms of availability of medicines (49 percent), with the most affected being Mityana District (37 percent). The outlets were rated best on orderliness of the facility (80 percent), closely followed by cleanliness of the facility (79 percent) and behavior of the private drug provider (78 percent).

> *"There are cases of medicine stock-outs in both drug shops and public facilities whereby people go to the hospitals after being given medical forms, they are referred to drug shops that also do not have all the drugs." —Respondent in Kamuli District*

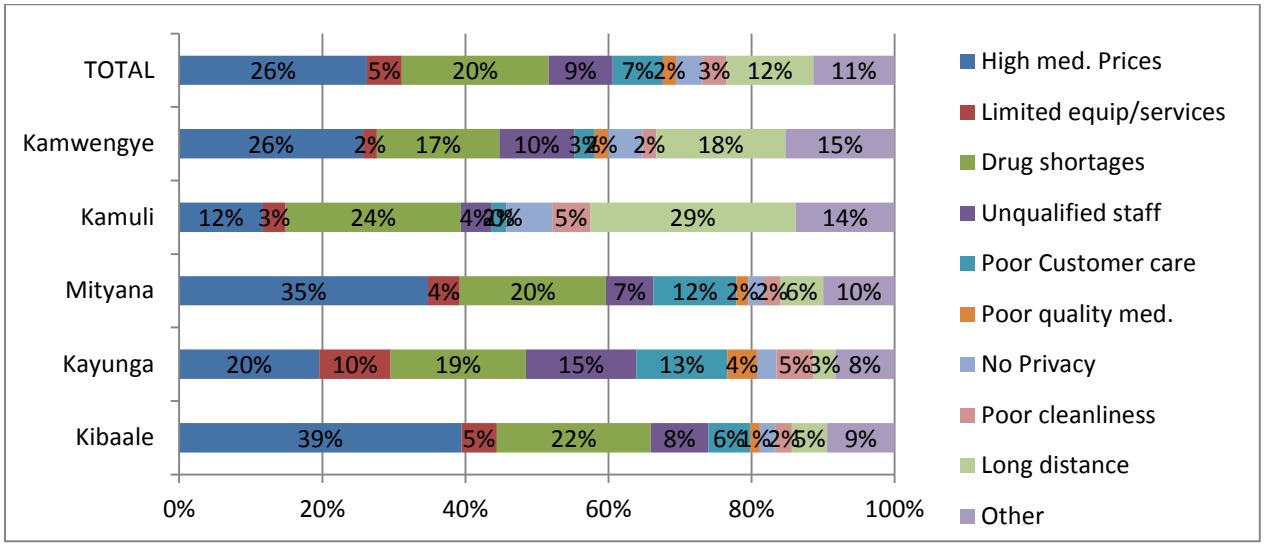

Figure 23. Reasons for dissatisfaction

As shown in figure 23, overall, those who were dissatisfied with the service were mainly concerned about high prices of medicines (26 percent) or had been unable to access medicines due to stock-outs (20 percent). High medicine prices were a bigger concern in Kibaale and Mityana, while concerns about stock-outs were greater than the average in Kamuli and Kibaale.

District	% Same	% Better	% Worse

Kibaale	42	44	15
Kayunga	49	41	10
Mityana	49	42	9
Kamuli	47	44	9
Kamwenge	37	50	13
TOTAL	45	44	11

Table 11. Service comparison of current year with the previous year

Consumers were asked to compare their satisfaction with the current level of service with their satisfaction with service in the previous year (table 11). Overall, 45 percent of the consumers felt that the service had not changed, compared to 44 percent who felt there was a change for the better and 11 percent who felt the service level had decreased. The best improvement was noted in Kamwenge (50 percent) and households felt the level of service had deteriorated most in Kibaale (15 percent).

Respondents who said the service was better/ worse than a year before were asked to provide reasons (figure 24).

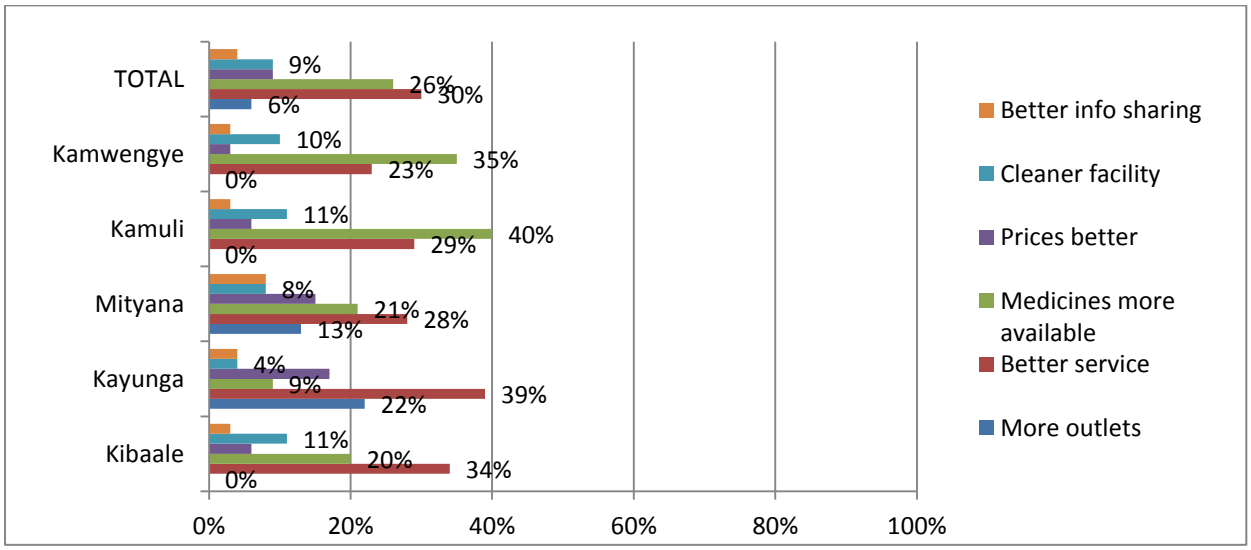

Figure 24. Reasons why service was better than a year ago

Improvement of service was most notable in Kayunga (39 percent) and Kibaale (34 percent) whereas in medicines were more available in Kamuli (40 percent) and Kamwenge (35 percent).

The most frequently given reason why consumers felt the situation was worse than a year ago was the high prices of medicines (53 percent), as shown in figure 25.

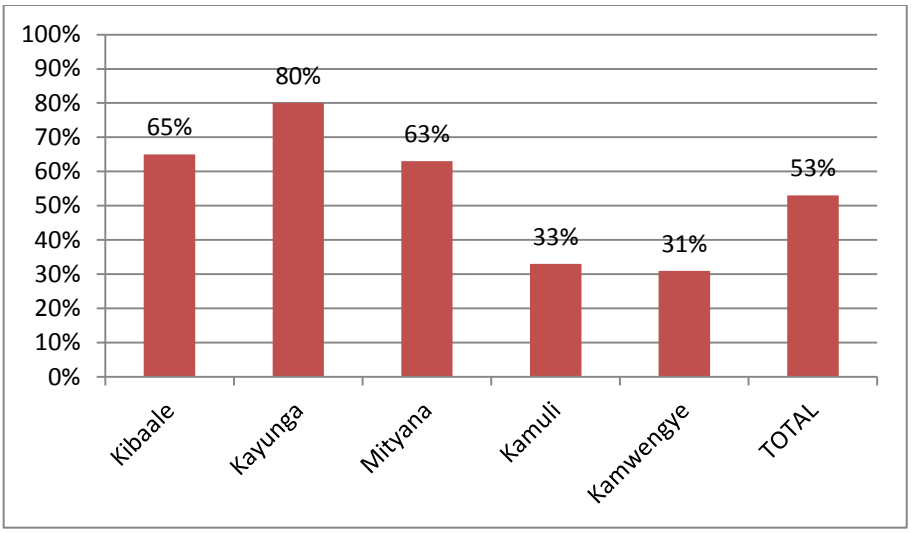

Figure 25. Level of problem of price

The price pinch was most felt in Kayunga (80 percent) and Kibaale (65 percent). It is ironic that although the highest medicine prices were experienced in Kamwenge, the respondents that mentioned the service being worse than a year before did not place price as the major concern. On the other hand, in Kayunga, where medicines were relatively cheaper than in other districts, respondents felt that the prices were high.

Key points:

- Reliable availability of medicines is a major issue with private medicine outlets
- Prices of medicines are unaffordable.
- Consumer empowerment on medicine issues is low across all districts.
- Kayunga reports the youngest population of household decision-makers, the highest education levels, highest distrust in private medicine dispensers, and the greatest dissatisfaction with the prices of medicines.
- Kayunga also reports the best prices of medicines. This could point to better empowerment of the population there.

District	Improve drug supply	Improve Infrastr. (roads, water)	Price reduction	Training & retention of attendants	Improve customer care	Improve cleanliness	Improve supervision & monitoring	More services, equipment	Provide credit	Nearer outlets
Kibaale	19	2	25	10	4	3	6	12	2	10
Kayunga	18	4	20	20	6	3	7	11	2	5
Mityana	18	5	24	11	6	2	6	7	2	12
Kamuli	19	0	11	11	7	5	1	14	0	6
Kamwenge	17	1	17	10	4	1	3	17	1	9
TOTAL	18	3	20	13	5	3	5	12	1	8

Table 12. Consumer suggestions to improve service, in %

Respondents were asked to suggest possible recommendations to improve services of private medicine dispensers. Overall, there were various recommendations made by consumers, as shown in table 12. The most frequent recommendation from all districts was reduction of the prices of medicine (20 percent), followed by improvement of drug supply (18 percent), and availability of better-trained drug shop attendants (13 percent).

Key point:

- Prices and improved availability of medicines is the major concern of consumers regarding private medicine outlets.

4.9 Status of Consumer Advocacy on Health Care and Medicines

Consumer advocacy on health care and medicines is low across all districts. Annex 3 shows the NGOs engaged in health and medicines in the five districts. The activities of the NGOs in the various districts principally relate to environmental sustainability and agriculture; HIV/AIDS awareness and care; advocacy for marginalized groups, including people with disability (PWD); women and youth; child rights and well as livelihoods; and reproductive health. Across all districts, there is limited empowerment on medicine use.

Kayunga has the highest number of NGOs, 64 in all, and Mityana does not have any NGOs involved in consumer advocacy.

NGOs can have a number of crosscutting mandates. One NGO might, for example, work on HIV/AIDS, and child and women rights. Figure 26 shows the distribution of NGOs by activity across the five districts.

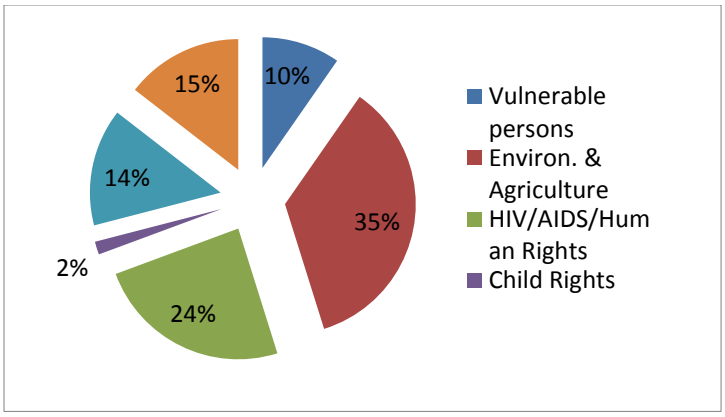

Figure 26. NGOs in the five districts by activities

Thirty-five percent of the NGOs activities are in environmental sustainability and agriculture, followed by HIV/AIDS awareness, care, and human rights (24 percent).

Key points:

- Overall, the status of consumer advocacy on health, and medicines in particular, is low. This explains the low level of empowerment on medicine issues and use.
- Kayunga District has an overwhelming number of NGOs compared to the other districts. Although the NGOs do not focus on access to medicine, this could explain the general level of awareness and empowerment of the population in the district.
- Overall, consumer engagement in ADS would require empowerment of communities on medicine use and benefits of the ADS.

5. SITUATIONAL ANALYSIS: KEY CONCLUSIONS AND RECOMMENDATIONS

5.1 CONCLUSIONS

The major conclusions from the survey results concern eight areas: accessibility of private medicine outlets, utilization of private medicine outlets, reliability of private medicine outlets, medicine price and affordability, health problems presented to private drug outlets, rational use of medicines, service quality, and empowerment and advocacy.

5.1.1 Accessibility of Private Medicine Outlets

- Nine out of 10 private medicine outlets in the survey districts are drug shops. Most of the respondents, averaging 89 percent, reported to be within just 5 kilometers of the nearest reference private medicine outlet, and nearly two-thirds (64 percent) of the household respondents reported to be within 15 minutes walking distance to the nearest private medicine outlet, with the proportion being highest in Kayunga District (82 percent). Hence, drug shops are the most accessible and convenient private medicine outlets to households.

- Nevertheless, access is a concern in Kamwenge, where barely half of the respondents can access a private drug outlet within 15 minutes walking distance.

5.1.2 Utilization of Private Medicine Outlets

- The utilization of private medicine outlets by households is generally very high across the survey districts, with at least 9 in 10 people reporting to have visited a private facility in the previous 12 months. The largest proportion of survey households reporting utilization of private medicine outlets was observed in Kayunga District (98 percent). Although variation in utilization of private medicine outlets is not marked across the different districts, the relatively higher utilization in Kayunga as compared to Mityana may suggest a linkage between preferences for the private sector with increased education.

5.1.3 Reliability of Private Medicine Outlets

- A majority of the private medicine outlets—about 8 out of 10—were reported open whenever consumers visited them to buy medicines. This proportion however, varied between 7 out of 10 in Mityana and Kamwenge and about 9 of 10 in Kayunga. This variation constitutes a major access problem, especially in Kamwenge and Kibaale, where the walking distance to the next nearest outlet exceeds one hour for 64 percent and 41 percent of the survey households in the two districts, respectively.
- About 63 percent of respondents who visited private medicine outlets reported getting all medicines prescribed at the same facility during their previous visit. A slightly higher proportion (65 percent) was observed in Kibaale and Kayunga, relative to Kamuli (59 percent). The main reason given for not getting all the prescribed medicines from the same facility was stock-out of some or all medicines at the facility. For those who could not get all the prescribed medicines at one private outlet, about 38 percent got the rest of the medicines from a public facility.

5.1.4 Price and Affordability of Medicines

- Only about 40 percent of household respondents felt that prices of medicines at private outlets were fair and about 41 percent felt that they were affordable. The prices of medicines across the five districts are generally high and unaffordable to the majority of people in the survey districts, considering that most of them depend on subsistence farming and have no formal income. Prices of medicines are a major concern of consumers over private medicine outlets.
- Responses in this survey indicated that medicine prices were highest in Kamwenge District, followed by Kibaale. Kayunga, where the majority of respondents were self-employed unlike in the rest of the survey districts, reported the lowest prices of medicines. This points to better empowerment of the population in the district.
- Consumers associate high prices to quality of the medicine. The concept of generic medicines, which delivers quality medicines at relatively lower prices, was apparently generally unknown to the respondents.

5.1.5 Health Problems Presented to Private Medicine Outlets

- Private medicine outlets handle a wide range of health problems at the community level, from minor to what respondents considered serious acute as well as chronic complaints. Fevers, a major symptom of malaria, make up the biggest proportion—averaging more than half (52 percent)—of health complaints that household members present to private medicine outlets. Malaria is the biggest health challenge faced by households across all districts, and most acute illnesses reported are communicable and preventable. Stomach ulcers are the most commonly reported chronic problem that takes households to private medicine outlets, followed by hypertension and asthma-related symptoms. Ulcers are a major concern in Kibaale and Kayunga, and asthma in Kamuli.
- Private medicine outlets are handling health complaints beyond their capacity.

5.1.6 Rational Use of Medicines

- Labeling of medicines is generally poor across the survey districts and is a major concern. Overall, only 13 percent of medicine envelopes found within respondent households was appropriately labeled, with this proportion being as low as 3 percent in Kamwenge District.
- Communities are seeking medicines for health complaints not considered serious, which may be a precursor to irrational use of medicines. This apparently undue seeking of medicines for conditions that are not serious—conditions that may for example, only require a short rest—could be increasing the demand for medicines and contributing to the stock-outs and shortages of medicines that respondents have reported in this survey.
- Consumers reported widely to adhere to instructions on medicine use and complete prescribed doses. However, one in five reported that they had not completed their previous prescribed dose, with the main reason for the discontinuation of medication being that symptoms had subsided. This incomplete dosing is a major public health danger, as it could result into the spread of resistant strains of pathogens, as has been observed with malaria parasites and quinine.

5.1.7 Quality of Service

- Respondents in interviews and focus group discussions suggested that, in most cases, private medicine outlets did not meet their expectations in areas such as licensure, orderliness, knowledgeable staff, and hygiene, even though many felt their customer care was still better than what public facilities gave.
- Three in four clients reported that they were generally satisfied with the services of private medicine outlets. The reasons consumers were not happy included high medicine prices, medicine stock-outs, unqualified staff, limited equipment and services, and low levels of hygiene, among others.
- It is important to note that the inadequate consumer knowledge of and empowerment regarding medicines may be a barrier to patient determination of a minimum expected service.

5.1.8 Empowerment and Advocacy

- Consumers in the districts have relative trust and confidence in drug shop attendants and, on average, 67 per cent of all respondents were comfortable asking a drug shop attendant the price of the medicine they were to buy. Kayunga reports the youngest population of household decision-makers, highest education levels, highest distrust in private medicine dispensers, and prices of medicines. However, consumers' empowerment on medicine issues is generally low across the survey study districts. There is widespread lack of knowledge on medicine.
- Overall, the status of consumer advocacy on health and medicines in particular is low. This explains the low level of empowerment on medicine issues and use. Kayunga District has an overwhelming number of NGOs compared to the other districts. Although the NGOs do not focus on access to medicine, this could explain the general level of awareness and empowerment of the population in the district.

- The majority of the clients were happy with the behavior of private medicine dispensers, although one in four respondents reported that dispensers in private medicine outlets manipulate medicines with their bare hands. Therefore, one major behavioral challenge related to private medicine dispensers is hygiene. Manipulation of medicine with bare hands is unacceptable.

5.2 RECOMMENDATIONS

- Since drug shops constitute the majority of private medicine outlets and are accessible to the majority of the people, it is important for efforts to increase access to essential medicines to focus on them and to build their capacity to deliver medicines designated for their level.
- Interventions to enhance the delivery of medicines through the private sector should take into consideration the income levels of the different districts and regions, through well-targeted price subsidy programs.
- Private medicine outlets should consider the ability of their clients to pay for medicines when making procurement and stocking decisions, with a view to providing products that are affordable to the majority of their potential clients.
- Options for ADS ought to include thorough training for the medicine handlers as well as consumer sensitization, to ensure that consumer expectations are in line with the standards of service prescribed for the different private medicine outlets. Operators of drug shops and other

private medicine outlets should be trained in correct labeling of medicines, communicating effectively with customers, and other skills required to enhance consumer adherence to medication.

- Consumer engagement in ADS should empower them on rational medicine use, benefits of the ADS, and the range of services and products recommended for that level of service.

6. Options Analysis Background

6.1 Objectives of the Options Analysis

The overall objective of the options analysis was to devise options for community involvement with private medicine sellers that would enhance access to essential medicines under the Sustainable Drug Seller Initiatives program. The specific objectives were to (1) carry out an options analysis on how to engage communities to enhance access to medicines in the private drug outlets in the SDSI program and (2) rank options for community engagement in the SDSI program

6.2 Options Analysis Methodology

6.2.1 Study Design

This analysis used qualitative approaches. Participatory reflection and action techniques were used to engage stakeholders at one-day stakeholder meetings. PRA was used to generate the key challenges and ideas, using a facilitated discussion to identify the solutions. And through ranking and scoring, the participants identified the key options to solve the challenges in their community. This method works on the assumption that nobody understands the community better than the community itself.

At the meetings, stakeholders reflected on the conditions of private medicine outlets in their respective communities and the role that different stakeholders, including at the grass roots, can play in improving the services of private medicine outlets. The stakeholders identified and discussed different possible strategies for community engagement with the ADS program and ranked the various options.

Stakeholders worked in three groups—local leaders, health service providers, and civil society—to identify community engagement options. The group for “local leaders” included Local Council executives, councilors, parish and sub-county chiefs, religious leaders, and drug inspectors. The groups for “service providers” included health workers, drug shop owners and operators, village health team members, program managers, and Health Unit Management Committee members. Finally, the group for “civil society” included nongovernmental players, civil society advocates, community-based organizations, and media representatives.

The working groups reported back to the plenary meeting, where long lists of all the options identified by the three groups were developed. The meetings were then facilitated to come up with short lists of options through brainstorming, and merging and eliminating some suggested options. Each meeting participant ranked the options on the short list, and then the rankings were tallied and reconciled to determine a final list of options, in order of preference.

6.2.2 Data Sources

The participants at the PRA sessions included the following categories of stakeholders:

- Local council executives
- Sub-county and parish chiefs
- Drug shop owners and attendants

- Health workers in public and private health facilities
- Members and parish-level coordinators of village health teams
- District Drug Inspectors
- Officials from the offices of the District Health Officers (DHOs)
- Members of Health Unit Management Committees
- Representatives of nongovernmental organizations
- Representatives of community-based groups
- Media practitioners/journalists

6.2.3 Scope of the Study

The survey was conducted in four districts—Mityana, Kayunga, Kamuli, and Kamwenge. In each district, one PRA meeting was organized for 30–40 key stakeholders. They worked in groups as well as in plenary meetings to identify different possible engagement options for communities and other stakeholders. The PRA meetings took place between August 20 and 29, 2012.

6.2.4 Survey Team

This survey was conducted by a team of one survey manager, a field team that was composed of three persons per district (a lead investigator, an assistant, and a recorder), two data entry personnel, one data analyst, and two report writers. A team of two resource persons with experience working with community stakeholders and the PRA methodology facilitated each meeting. One recorder working as data entrant supported them.

6.2.5 Limitation of the Study

Unlike the situational analysis, which was conducted in all five target districts, this survey was carried out in four districts, leaving out Kibaale, where there was an outbreak of Ebola epidemic at the time of data collection. The government had banned public gatherings.

6.3 Stakeholder Roles and Empowerment

6.3.1 Identifying Potential Roles of Community Stakeholders

Community stakeholders were not among the active players in the pilot phase of the ADS program, which was noted as a gap. The community stakeholders identified during the PRA sessions included medicine consumers, community leaders, civic leaders, opinion leaders, VHTs, traditional healers, community-based organizations, NGOs, schools, lower-level health centers, and the general public.

The PRA sessions identified a range of roles for community stakeholders, including seeking appropriate health care, understanding the range of medicines recommended for drug shops, knowing the regulatory requirements for drug shops, demanding quality care, monitoring drug shops, using medicines rationally, providing appropriate coaching for the younger generation, sensitizing communities, undertaking advocacy, and providing proper diagnosis and referral services to health consumers, among other roles.

6.3.2 Stakeholder Empowerment

Stakeholders participating in the PRA sessions noted the importance of building the capacity of the different community-level stakeholders to fulfill the potential roles they identified for them. The consumer situational analysis found a range of gaps at the community level that needed to be addressed through sensitization and empowerment to ensure that the ADS program delivers maximum benefit to drug shops and the communities they serve.

The situational analysis found that communities were seeking medicines for ailments not considered serious, and in the process creating fertile ground for irrational use of medicines. In addition, the situational analysis found that at least one in five consumers did not take all the medicines as prescribed. Self-prescription and self-medication were also prevalent. In regard to pricing, many respondent households associated higher prices with better quality, which is not always the case.

On the other hand, household respondents had concerns about the quality of services provided by the private drug shops, in particular the high prices of medicines, the availability of medicines, the lack of privacy, medicine labeling, and the quality of service, among other issues.

The ADS program can empower community stakeholders and spell out and promote their roles through meaningful, active involvement in addressing many of the identified gaps and concerns. An empowered community can advocate and demand good service; use medicines more rationally; and participate in monitoring medicine and service quality. It can do this by looking out for issues of low quality medicines, expired medicines on the market, medicines not recommended for Class C drug shops, inadequate hygiene, and other unacceptable practices on the part of drug sellers, based on comparison to what has been agreed are acceptable standards.

In accordance with the foregoing, the key capacity-building areas for community stakeholders center on the need to create consumer awareness of the concept of essential medicines. The activities envisaged in this approach are training and mentoring of community trainers; engaging communities to reflect on their situation and identify the most crucial challenges; and prioritizing interventions based on locally available resources through PRA mechanisms, district health promotion campaigns, community-based civil society initiatives, and other sustainable approaches.

It will be necessary to measure the impact of community trainings and participant understanding; to involve all people, including at the lowest levels of the community; mentor and coach community trainers and champions; build networks of volunteers; and ensure sustainability and community ownership. Cascade training will require expertise and resourcing and will demand a lot in terms of time and coordination—all of which will be worthwhile investments.

6.4 Options for Structured Community Engagement

Stakeholders participating in PRA sessions in Kamuli, Kamwenge, Kayunga, and Mityana Districts generated a range of ideas about how community stakeholders can be engaged in the ADS program. These ideas fall into six broad categories:

1) Mechanisms that focus on representation of different **stakeholders on committees** or other similar structures;

2) Approaches that focus on different **sectors at the local government level**, **working together** to support improvement in the services of private medicine providers;
3) Strategies focusing on **engaging communities in discussions**;
4) Approaches seeking to **engage communities more actively**, such as in training health consumers and monitoring drug shops;
5) Approaches focusing on the **drug shops setting their own standards** and taking the lead in improving the industry;
6) Using the different channels of the **mass media** to reach out and engage general populations.

Each option has advantages that are unique to it, but it would be too costly to utilize all the identified options, and no option will work in isolation. The best approach would be to utilize a synergistic combination of two or three options. However, each district is unique, and no single option or combination of options can be uniformly applied across all districts.

6.4.1 Multi-stakeholder Committees

This option envisages that separate structures in the form of committees can be established with as many different stakeholders represented as possible. These multi-stakeholder committees would be based at various levels: district, sub-county, parish, and village. At each level, the committees can be charged with assisting official regulatory agencies in community monitoring and sensitization of consumers, as well as mobilization of communities.

The rationale for this option is that there currently is not any community representative structure to oversee the functioning of drug shops and other private medicines outlets. Monitoring and regulation are done by district drug inspectors and the NDA, with little or no community involvement. Therefore, drug shop operations are taken as any other business operations that do not require any input from the community.

The range of functions of the multi-stakeholder committees can include: setting the agenda for the multi-stakeholder engagement; participating in trainings and in community forums; providing supportive supervision; coordinating the work of different stakeholders; providing feedback and linkage with communities; and participating in community sensitization. Stakeholder committees are also well-placed to serve as planning platforms that can develop and approve work plans and other materials, and provide leadership and coordination of the ADS program.

Critics of this approach, however, raised fears that it may leave off the grassroots community persons because such committees tend to be dominated by the elite in society, and their views may not be representative of the community's poor and vulnerable persons.

6.4.2 District-Level Multisectoral Approach

The participants in PRA sessions thought out a district-level, multisectoral approach as a modification to the program planning and implementation processes of the district administration, with a view to harnessing the strengths of the different sectors, with each sector making a contribution to the improvement of the services of private medicine outlets. In addition, district-level administrative

departments undertake outreach separately. This strategy calls for building community empowerment and capacity to give feedback to the outreach programs of the different departments.

The planning processes are fairly integrated at the district level, but implementation is fragmented; each department makes interventions independently. The key departments cited by participants include health, education, water, and production. The supporters of this strategy felt that the ADS program could leverage the joint planning processes and try to ensure that issues of access to essential medicines through the private sector are incorporated into the various departmental plans. At implementation, the ADS program should then seek to create synergies at the community level, where each department makes its interventions independently.

The key actors in this strategy, as identified by the participants, are heads of departments, In-charges of health facilities, school administrators and head teachers, District Heath Officers, political leaders, VHTs, operators of private medicine outlets or their representatives, and the ADS program staff.

The proponents of this strategy argued that it enables the different sectors to be represented, and it is cost-effective and sustainable because each sector has a budget for its interventions. Also, it provides a diversity of people who can talk to communities about access to essential medicines. This strategy has the added advantage of taking the issues directly to the duty bearers and having them incorporated into local government plans, which gives them a kind of official stamp.

It was also argued that the multisectoral approach utilizes the capacities of various stakeholders from different backgrounds; it is facilitated from departmental budgets and any other resources are supplementary to that. It also has the potential to bring issues that are hidden or not obvious to the surface because if one partner misses an issue, there is a chance another will notice it.

This approach has an additional strength in being sustainable, as it builds on already existing structures and processes that are already funded under the formal district funding mechanisms. Indeed, it may not cost a penny to add drug information to ongoing programs, such as immunization campaigns.

The approach's critics, however, pointed out that this strategy focuses on the district and stakeholders in government and leaves out nongovernmental actors and the targeted beneficiaries of the ADS program, including the civil society. Most important, it does not include the community, drug shop operators, and health consumers. In addition, some critics doubted the potential for sustainability, pointing out that any additional responsibility for community outreach normally comes at an extra cost in terms of energy, time, and/or money. This strategy also demands a lot in terms of coordination, and faces very difficult questions on funding messages and interventions that are not in the direct mandate of the sectors involved.

6.4.3 Community Forums

Community forums focus on engaging communities in discussions in the form of community dialogues, village meetings, public rallies, and similar forums. A similar engagement has been in the form of *bimezas or barazas*, which discuss political issues at the grassroots level. These could be organized along different community stakeholders, e.g., leaders, schools, drug sellers/operators, health workers, consumers, etc. In other words, they can be modified to cater to different constituents.

Community forums are appropriate for reaching the grassroots person as everyone is invited. In such engagements, community members can be sensitized, information shared, opinions exchanged, solutions generated, and feedback sought on the ADS program and drug shops.

Participants in the PRA sessions argued that community forums give ordinary people an opportunity to speak directly to their leaders and duty bearers, to raise issues they observe and experience in drug shops. This process promotes social accountability and helps people in key decision-making positions to make informed decisions because such forums also serve as information-sharing sessions.

The disadvantages of community forums are that they are normally short, and there is not enough time to for people to reach an appropriate level of understanding; they can be politicized; and wrong elements could come to disrupt them. It was also noted that community members, especially the poorest of the poor and other vulnerable, voiceless groups, might not attend community meetings. In addition, such meetings are too big to result in consensus on anything, as people have different levels of understanding and some could just be bent on causing confusion.

6.4.4 Engagement through Mass Media

Participants in the PRA sessions also identified mass media as an avenue for engaging community stakeholders in the ADS program. This could be through interactive talk shows, newspaper articles, etc.; a toll-free line (hotline) for consumer complaints and compliments; bulk SMS; and information, education, and communication (IEC) materials such as billboards, posters, fliers, and brochures.

Mass media reaches a wider audience than community forums, and to its advantage, there has been a proliferation of private radio stations. Participants who favored this strategy argued that 9 in 10 households in Uganda have a radio set and listen to discussion programs, and often call in to contribute to discussions. In addition, prepared messages can be aired anytime as spot advertisements or as announcements.

Those that did not favor a media strategy to community involvement in the ADS program pointed out the high cost of media, given that radio requires repetitive delivery of messages, and national newspapers and television stations have only limited coverage. It was also argued that although many households own a radio set, few people have time to listen to radios, while others are illiterate and not able to read newspapers.

6.4.5 Self-Regulation by Drug Shop Associations

Self-regulation requires that drug shops in the various districts set up associations to lead improvements in the services of their member drug shops, reward best practices, and penalize errant behavior. The self-regulation approach calls for enlisting the association of drug shop owners and operators to set standards for their industry and monitor their implementation. This calls for the ADS program to work with associations to establish disciplinary committees to which monitors, consumers, and the general public can report violations.

The participants who favored this approach believed it provided the best opportunity for drug shop operators to be heard and to participate in setting the standards of regulation. This was thought to be the best way to win maximum cooperation from drug shops.

However, this option was not widely favored. Some participants thought that the majority of the stakeholders would be left out by this approach, and some thought it was not self-sustaining and unrealistic because illegal drug shops would be unlikely to be members of the drug shops association.

6.4.6 Direct Engagement with Communities

Participants in the PRA sessions also proposed active engagement of community stakeholders aimed at building their capacity to play an active role in the ADS program. This should involve sensitization of communities on why prices could rise with the ADS program, why it is in their interest to stop protecting unqualified drug shop attendants, and the dangers of drug mismanagement.

These interventions can be targeted primarily to local leaders, VHTs, and other opinion leaders at the community level, who can be trained as community trainers and supported in utilizing accredited drug shops and monitoring their services, among other roles.

The key players in this approach are the civil society, the district health teams and SDSI/MSH; they should sensitize communities, identify community-level champions, and build a network of community trainers and promoters of the ADS program.

> *"The people in the community need serious engagement to understand their roles and responsibilities regarding drug usage. There is a lot of ignorance among the people on issues of medicines." —Community Worker, Kamwenge District.*

Community members should be sensitized at meetings so they will understand the challenges of drug mismanagement, expired drugs, and their rights as health care consumers, as well as their responsibilities regarding usage of drugs.

> *"People must understand that the drug sellers do not deal with injectables. Once they know this then most of the problems that regard drug mismanagement will be solved." —Senior Medical Officer, Kamwenge District*

7. Options Analysis: Key Conclusions and Recommendations

7.1 Conclusions and General recommendations

The following conclusions emerged from the options analysis:

- Capacity-building for community stakeholders is a key entry point for communities to appreciate the ADS program and the role they have to play to facilitate its success.
- Approaches that bring together and engage more players, including the primary targets of the ADS program, have the best chances bringing the best of community engagement.
- Approaches that utilize local resources, including existing structures and systems, are likely to be more sustainable.
- Each option has advantages that are unique to it, but it would be too costly to utilize all the identified options.
- No option will work in isolation. The best outcomes would be to utilize a combination of two or three options in synergy.
- Each district is unique. No single option or combinations of options can be uniformly applied across all districts.

The general recommendations were:

- A clear program for capacity-building of community stakeholders should implemented as the entry point to empower consumers and other community stakeholders to meaningfully participate in the ADS program.
- There should a clear framework for coordination of the different players in the ADS program as well as the work of engaging the different stakeholders using the different options as discussed.
- To make the intervention sustainable, the mechanisms of engaging communities and other stakeholders, as well as their coordination, should be tailored to existing structures and resources, such as the district health teams, VHTs, and others.
- Interventions should be adapted to specific situations and interests of each participating district to promote ownership and interest.

7.2 Community Engagement Options for Four Districts

7.2.1 Kamuli District: Community Engagement Options

Stakeholders attending the Kamuli PRA session ranked stakeholder committees and community forums as the most preferable options, followed by mass media.

Multi-stakeholder Committees

Stakeholders in Kamuli District ranked multi-stakeholder committees as the most preferred mechanism for engaging them and communities in the ADS program. This was suggested as a separate, parallel structure operating at the district, sub-county, parish, and village levels. The suggested composition of these committees at the four levels appears in table 13.

District Committee	Sub-County Committee	Parish Committee	Village Committee
• The District Health Officer (DHO) • District Health Inspector • District Drug Inspector • Secretary for Health • Chairperson drug shop operators and owners association • HC IV In-charge • Civil society	• LC III Chairperson • Sub-county Chief • Drug sellers • Community Development Officers • Secretary for Health (LC III) • HC III In-charges • Health workers (HC III) • Chair, HUMC • Community-based organizations	• LC II Chairperson • Parish Chief • Drug sellers • Parish coordinator VHTs • Councilors • Community-based organizations	• LC I chairperson • Drug sellers • VHTs • Community-based organizations • Community members

Table 13. Proposed multi-stakeholder committees (Kamuli District)

The different stakeholder categories (local leaders, health service providers, civil society representatives) ranked this mechanism ahead of the rest on the short list. Health providers argued that the proposed committees would involve all stakeholders and promote ownership of the ADS program, particularly if they used their sessions to come up with joint work plans and to create consensus around the most pressing challenges and priority interventions. This, they argued, will empower and involve many stakeholders, leading to better service delivery.

Civil society representatives were of the view that it would be easy to monitor committees and their members and assess their performance, and that the committees would involve leaders, all drug sellers, and other key stakeholders.

The local leaders felt that the committees would bring on board many stakeholders, including drug shop operators, and that members would be empowered to carry out sensitization of their respective constituents and to work as watchdogs to identify the problems in private medicine outlets.

Participants with reservations about this mechanism argued that it would leave out ordinary people at the grassroots level because only the elite in the community are likely to sit on such committees. There was a particular worry that members of the committees might not pass along the information in a timely fashion.

Local leaders expressed concerns that such committees could duplicate the work of the NDA and its inspectors; would be vulnerable to manipulation by the political elite; and could be exploited for personal gain, such as to generate money from donors or to malign political opponents who might be drug shop owners.

Community Forums

The second-ranked option for engaging communities and other stakeholders in ADS program was community forums, operating community dialogue in the form of *barazas* or *bimezas*.

Civil society advocates felt that community forums would give the ordinary person an opportunity to speak directly to their leaders and duty bearers, and to raise issue they observe and experience in drug

shops. This process promotes social accountability and helps people in key decision-making positions to make informed decisions because such forums also serve as information-sharing sessions.

> *"It's because you can really feel what is on the ground and views can easily be worked on and follow up is easy." —A representative from the civil society in Kamuli District*

Community forums were also considered to be a platform to easily disseminate information to community members and to sensitize them.

> *"This approach involves many categories of people, and different development partners have succeeded in different projects, therefore communities listen and believe in whatever they come with." —Another representative from the civil society in Kamuli District*

Engagement through the Mass Media

The mass media was ranked third as a community engagement strategy for Kamuli District. While the mass media broadly includes radio, television, newspapers, telephone, Internet, and other communication vehicles, it was observed that the most effective mode in Kamuli District would be radio since most households in the district own a radio set. Kamuli has one FM radio station based in the district, and it is within reach of radio stations based in Jinja town and neighboring districts.

In addition, participants argued that mobile telephones are widely distributed in the district and could easily be used for bulk short messaging. Large parts of the district are covered by networks of major telephone service providers.

However, Kamuli District does not have a locally based newspaper or television station, and there is no newspaper in the local language in circulation in the district. Instead, people must depend on national newspapers, which are fairly expensive and are accessible to only a limited portion of the population.

Participatory Approach/Self-Regulation

The participatory, or self-regulation approach, calls for enlisting the association of drug shop owners and operators to set standards for the industry and monitor their implementation. It was envisaged that members of the public, health consumers, and clients of drug shops would be sensitized on the ADS program, and drug shop best practices and standards, and then would report violations to a disciplinary committee of the association that would engage the errant member drug shop and demand corrective action or penalize it.

This option appealed to the least number of stakeholders in Kamuli. Many thought that the majority of the stakeholders would be left out by this approach. Some thought it was not self-sustaining and was quite unrealistic as it would be hard to achieve because many of the illegal drug shops are unlikely to be members of the professional association.

The few participants who favored this approach believed it provided the best opportunity for drug shop operators to be heard and to participate in setting the standards of regulation. This approach was thought to be the best way to win maximum cooperation from drug shops.

7.2.2 Kayunga District: Community Engagement Options

According to the DHO of Kayunga, most people who invest in drug shops are not skilled and do not employ the right dispensers. The majority of people in Kayunga (as in the rest of the country) access medicines from drug shops, in part because the district has only 20 public health facilities, which limits geographical access to health care services and commodities. And given that they are distributed throughout the communities, drug shops tend to be operated by people who are from within the community and are willing to offer friendlier payment terms. Therefore, drug shops and other private facilities play an important role in access to essential medicines in the district.

The PRA session narrowed the community engagement options to four: the multisectoral approach, community dialogues, partners forums, and mass media.

District-Level Multisectoral Approach

The planning processes are fairly integrated at the district level, but implementation is fragmented as each department makes interventions independently. This strategy was thought out as a mechanism that coordinates the work of the different departments at the district level, to ensure each incorporates activities to promote sustainable access to quality medicines and services through the private sector.

It was noted that, at the moment, departments at the district administration undertake separate community outreaches that do not feed into each other. The key departments that were cited include health, education, water, and production. This strategy calls for community empowerment to build capacity to give feedback through the outreach programs of the different departments.

Community Dialogues

The community dialogue option was ranked the second most preferred mechanism to engage community stakeholders in the ADS program in Kayunga District. Those who preferred this approach argued that it had the potential to reach "the last consumer of services," is open to everyone, and gives everyone a chance to actively participate.

> *"[With community dialogue] the community discusses its problems, and in most cases the community knows the solutions to its problems….In this case the community is very realistic." —A Local Leader, Kayunga District*

> *"Experience with community dialogues is that people just turn up to do* lugambo *(rumor monger) because of the envy they gave against health workers….If one drug shop refused to give one credit, it is possible that he or she may try use the community meeting to slur them and to try to get it closed or to lose public appeal." —A Health Provider, Kayunga District*

Partners Forum

This option was ranked third by stakeholders attending the Kayunga PRA session. It was envisaged as a platform that brings together implementing partners to share ideas, experiences, and plans, and in the process seek synergies that should promote access to essential medicines through the private sector. This forum was seen as one that convenes regularly to review progress of the ADS program, undertakes joint planning to fill any gaps, and coordinates efforts of the different players in the ADS program.

Engagement through Mass Media

Stakeholders in Kayunga District believe mass media is one of the mechanisms through which community stakeholders can be effectively engaged in the ADS program. Kayunga is within reach of most Kampala-based radio stations, television station, and national newspapers.

This strategy however, ranked lowest on the list of priority community engagement strategies that the participants in the PRA session came up with. There were particular concerns about the high cost of media campaigns, the inability of people in the remotest parts of the district to follow and actively participate in media interventions, and its potential to be dominated by the elite.

7.2.3 Mityana District: Community Engagement Options

The participants in the PRA session in Mityana District identified the strategies that might increase community involvement in the ADS program while also addressing the district's current problems with access to medicines through private drug outlets.

Direct Engagement to Empower and Work with Communities

Stakeholders in Mityana District regarded as paramount the sensitization of communities to empower them with the necessary knowledge by increasing awareness of the ADS program and its benefits and risks. This includes explaining why the prices of medicines could rise with the ADS program, why it is in their interest to stop protecting unqualified drug shop attendants, and the concept of rational drug use.

> *"If we sensitize the people that consume this medicine about the dangers of using medicines that are not fit for human consumption, it will help reduce the challenge of expired drugs." —Community Worker, Mityana District*

VHTs, community drug distributors, community leaders, and other community "gatekeepers" were suggested as primary targets that should be trained as trainers of their respective communities at the grassroots level. Participants expressed a strong need to train and empower VHTs and community-based organization (CBO) members who are more knowledgeable about their communities to be the ones to sensitize and give information to other members of the community and to receive feedback on the ADS program.

This strategy should involve working through existing community structures, for example dissemination of information to the community through local councils (secretaries of information), community radio, cultural networks, politicians, and others. It was suggested that a network of "community scouts" be put

in place to assist in the monitoring and reporting of wrongdoers and corruption. The scouts can be the VHTs, community workers, and the lower local council members (LC I chairpersons).

Participants also suggested that the ADS program should help kick-start discussions and implementation of community health insurance schemes to help secure community health and assure access to essential medicines through the private sector whenever subscribers are unable to access medicines through government hospitals.

Mass Media and IEC Materials

Participants of the PRA session in Mityana ranked engaging community stakeholders through the mass media as their second choice. In particular, they suggested holding radio talk shows and developing and circulating educational pamphlets on rational drug use, proper handling of medicines, the concept of essential medicines, health rights and responsibilities, and the ADS program and the role of the community in its success. These materials should be easy to understand and distributed widely in the community through public places, such as health centers, trading centers, places of worship, schools, and other social places.

Video documentaries and films were suggested as good visual illustrations that can be taken to the community to have the people sensitized.

> *"They used to bring for us the videos indicating the experiences in other districts. If this can be revived, then it can be a good way of reaching the community, because it had started making a difference." – VHT Mityana*

Community Forums

Dialogue meetings at grass roots emerged as a third option for the ADS program in Mityana District. The dialogues should engage the people at community level to share experiences and highlight medicine issues, as well as the performance of accredited drug shops. The key players in these discussions are the community drug monitors (earlier suggested as "community scouts"), VHTs, health assistants, and members of the community.

This was envisaged as a bottoms-up mechanism that surfaces issues of concern at the community level through dialogue engagements, then transmits them through VHTs and local government structures—depending on who is responsible for the issue at hand—and then to the health system and ultimately the central government.

7.2.4 Kamwenge District: Community Engagement Options

The options that emerged from the group of participants from Kamwenge District focused on direct community engagement and empowerment, community dialogues, using the community members and consumers to monitor drug shops, and more community involvement in the scrutiny of drug shops.

Community Sensitization on Rational Use of Medicines and Rights Issues

The most important way to get communities meaningfully engaged in the ADS program in Kamwenge District is to empower community stakeholders to understand their health rights and responsibilities, including rational use of medicines; the regulatory requirements of drug shops; the services they should expect when they visit Class C drug shops; and disclosure of their health conditions. The participants were concerned with getting consumers and other community stakeholders to understand their rights as health care consumers as well as their responsibilities regarding the use of drugs. The people should be sensitized about when it is most appropriate go to health centers before going to drug shops, and vice versa.

> *"People must understand that the drug sellers do not deal with injectables. Once they know this, then most of the problems that regard drug mismanagement will be solved." —Senior Medical Officer, Kamwenge District*

The people should also be empowered to demand for quality services, particularly to see certificates of registration and licenses of drug shops if copies of them are not displayed in the shop.

> *"The people in the community need serious engagement to understand their roles and responsibilities regarding drug usage. There is a lot of ignorance among the people on issues of medicines." — Community Worker, Kamwenge District*

This sensitization should be extended to politicians, some of whom were reported to protect illegal drug sellers. The sensitization should target the lower local government leaders right through members of Parliament. They should be empowered to participate in the inspection of drug shops, and they are well placed to undertake community sensitization and policy advocacy.

Participants recommended that drug sellers should be sensitized on best practices of handling drugs and be empowered to share vital information to the consumers regarding the drugs, especially those that insist on self-medication and under-doses.

Community Drug Committees

Stakeholder in Kamwenge District also suggested that the best way to engage communities is to engage community stakeholders as the primary monitors of the drug shops, since the drug shops are located within the community and community members provide the market for their drugs. Community members should take part in monitoring and evaluation of drug sellers and report to the officer responsible.

The participants said that this would be possible if village committees are formed to oversee the operations of the drug shop attendants and are able to report to the people as well as the district inspectors and health assistants. These committees carry out sensitization and monitoring, and comprise VHTs, opinion leaders, and cultural and religious leaders as well as health professionals in lower-level health facilities. To ensure effectiveness of these committees, training should be carried out so committee members understand their mandate.

Toll-Free Telephone Line

A toll-free telephone hotline was also suggested by stakeholders in Kamwenge District as a way of involving communities in the ADS program. Community members can be empowered to report bad practices to authorities. Some participants were however, worried that ill-intentioned people might abuse the mechanism; those in support of it felt this could be controlled through moderation and appropriate sensitization.

> *"If community is sensitized about the toll-free line, it will be very easy for them to report the cases of corruption, bribery, and the illegal drug shops." —Health Worker, Kamwenge District*

8. Stakeholders' Meeting

MSH, in partnership with the National Drug Authority, convened the October 29–30, 2012, Stakeholder's Meeting to give stakeholders an opportunity to review the findings and recommendations of HEPS-Uganda and other contractors.

8.1 Meeting Objectives

The objectives of the stakeholders' meeting were to:

1) Provide a background and overview of the SDSI objectives;
2) Review findings and recommendations from recent assessments and studies on various ADS components;
3) Discuss the options and agree on feasible interventions to ensure maintenance and sustainability of the ADS initiative.

8.2 Opening Remarks by Mr. Sematiko of the NDA

Mr. Gordon Sematiko, Executive Secretary of the Uganda National Drug Authority, welcomed delegates and thanked the Ministry of Health and MSH for the partnership to create sustainable access to quality medicines through the SDSI program.

He reported that the Bill & Melinda Gates Foundation, which funds the SDSI program, is also supporting the East African Community (EAC) to harmonize the drug registration processes in the region to ensure it is fast, uses a common standard, and improves access. The project was ending its first year and was due for review at a meeting of the steering committee in December 2012 in Arusha.

Mr. Sematiko stressed the importance of improving the handling of drugs along the supply chain, noting that even a product that is safe when it leaves the factory may become contaminated as it makes its way to the consumer. He announced that effective January 2013, the NDA has banned the importation and marketing of loose tablets and capsules for the private sector because they are open to contamination by distributors, retailers, and dispensers who do not follow the required handling standards. Only tablets and capsules packed in blisters and other consumer packs will be allowed.

Also, each drug outlet will be required to display its facility identification number (FIN), given out as of November 2012. The number will show whether the outlet is a retailer, wholesaler, or distributor, and their location, district, etc.

8.3 Remarks by Dr. Ndiramanga, Tanzania Food and Drug Authority

Dr. Ndiramanga spoke of Tanzania's experience with the ADDO program, saying that the accredited drug dispensing outlet intervention was timely for his country. Tanzania piloted the ADDO program between 2001 and 2005, and it took seven years to roll it out. He said it had not been easy because of many hurdles, and cautioned that sustaining the program was an even bigger challenge, arguing that initial implementation has a fairly clear pattern of steps, unlike sustenance. He wished Uganda success in using the ADS initiative to create and sustain a better-regulated medicines market.

8.4 Review of Contractors' Work and Recommendations

The meeting facilitator introduced the six contractor organizations and the components of the ADS program they analyzed (annex 1), and explained that each attendee would work in a group to review a contractor's findings and recommendations before reporting back to the plenary.

On the first day of the meeting, Richard Hasunira made a presentation to the group on behalf of HEPS-Uganda titled, "Engagement of the Community in Dispensing Services and Use of Medicines." He reviewed the situational and optional analyses: their scope, methodology, results, conclusions, and recommendations. He emphasized the results related to consumer needs, access to medicines, consumer experience and knowledge, and consumer advocacy.

The key recommendations presented to the workshop were:

- To improve access to medicines, the government should establish price subsidy programs to make medicines affordable for those without a formal source of income.
- On consumer engagement, the key options were identified as:
    - Use of multi-stakeholder committees to assist regulatory agencies in community monitoring, sensitization, and mobilization;
    - Use of multisectoral approaches to engage district-level government sectors to improve the services of private medicine providers;
    - Focus on engaging communities in discussions through community dialogues, village meetings, public rallies, etc.
- Other options for consumer engagement were:
    - Seeking to engage communities more actively, such as training health consumers to monitor drug shops;
    - Focusing on having drug shops set their own standards and take the lead in improving the industry (self-regulation through drug shop associations);
    - Using the different mass media channels, including mobile technology, to engage the general population.
- To ensure sustainability, the implementers of the ADS initiative should build the capacity of community stakeholders to empower meaningful participation in the program, and establish a

clear framework for coordination of roles and responsibilities in options to engage them. It will also be necessary to tailor mechanisms of engaging and coordinating communities and other stakeholders to existing structures and resources, such as the district health teams, village health teams, and others, and to adapt each intervention to the specific situations and interests of each participating district to promote ownership and interest.

8.5 Suggested Additional Options

Following discussion, the workshop participants added two options to those that resulted from the options analysis.

8.5.1 Coalition Building

The group discussed the viability of using coalitions of nongovernmental actors to promote consumer interests by engaging with drug shops, the NDA and its inspectors, health facilities, community and district leaders, and other stakeholders. The coalitions should consist of community "gate keepers," such as LCs, opinion leaders, activists, and religious leaders, as well as civil society groups and others. The group concluded that it would be better for such coalitions to focus on civil society groups that act on behalf of health consumers or vulnerable groups, or to establish consumer groups to give consumers a strong voice to engage meaningfully with other stakeholders in the ADS program. These coalitions can be based at the district level, with different member organizations working in their respective communities and jointly engaging other stakeholders. The capacity of these groups should be built to empower communities and their respective constituents in the rational use of medicines and the ADS program, as well as health rights and responsibilities.

8.5.2 Toll-Free Telephone Helpline

A toll-free telephone contact line should be established and publicized to enable health consumers to seek help and provide feedback on the ADSs and other medicine outlets. The advantage with this is that it would link consumers directly to NDA, and promoted pharmacovigilance. Brainstorming on this suggestion concluded that it was part of the broader media-based approach that had also been suggested.

8.6 Prioritization of Community Engagement Options

The group brainstormed on the feasibility of each of the suggested community engagement options, assessing its advantages and disadvantages, including the amount of effort it would require relative to the impact on the ADS program. The options were then assessed and ranked; the result of this process appears in table 14.

The theoretical basis for ranking was framed in order, starting with the most preferable: low effort/high impact; high effort/high impact; low effort/low impact; and high effort/low impact. On this basis, the most feasible options were ranked as: (1) consumer/community empowerment; (2) coalition building; and (3) stakeholder committees.

Option	Rank	Modality	Merits	Demerits	Assessment
Consumer/ community empowerment	1	MSH/community-based partners train community '*gatekeepers'* in RUM and health rights and responsibilities, to act as community trainers. Target audience: LC's, religious leaders, radio presenters, opinion leaders/elders, VHTs, etc. Communities can then monitor services of drug shops.	• Potential to use existing platforms to pass on RUM messages • Creates grassroots activists • Reaches big numbers due to multiplier effect • Beneficiaries receive same message from different people • In long run, cost is low because community trainers are volunteers	• Possibility of distorting message as the messages trickle down • Possibility of misusing the training/ information (e.g., some may pose as inspectors, etc.)	High effort High impact
Coalition building	2	Create and strengthen the voice of consumers through consumer and consumer advocacy group coalitions. Facilitate these groups to engage drug shops, drug shop associations, NDA, and other duty bearers	• There is direct engagement with consumers • Can link at different levels: community, district, national	• Sustainability is difficult; moral may wane • Potential for manipulation by political interests • Cost is high	High effort High impact
Stakeholders' committees	3	Establish committees with representation from different stakeholders at district, sub-county, and village levels. Target audience: DADI, CSOs, DHT, drug sellers, consumers, health workers, etc. These should meet regularly to review performance of ADS and stakeholder concerns and appropriate interventions	• Promotes ownership among different stakeholders • Potentially good representation of community	• High cost of sustaining new structures • It is difficult to get commitment from all stakeholder	High effort High impact
Multisectoral approaches at local government level	4*	Getting different departments at the local government level to harmonize community interventions. E.g., production, health, education, water, etc.	• Low cost because it uses existing structures • Easier to monitor and evaluate performance due to access to central data	• This would leave out key stakeholders outside the local government system • It may be difficult for departments to buy into the new line of work	Low effort Low impact
Engaging communities in discussions on rational use of medicines	5*	Conducting community dialogues; village meetings; rallies; etc.	• Gives firsthand information directly to health consumers • Promotes participation of grassroots persons • Good in generating awareness and feedback	• Difficult to reach consensus on decisions because of big numbers • Quality of discussions is low due to difficulties of sustaining focus of discussion and there is potential for disruptions	Low effort Low impact

Option	Rank	Modality	Merits	Demerits	Assessment
Self-regulation by drug shop associations	6*	Create/ strengthen associations of drug shop owners/ operators to take on regulatory roles. Members of the association are only those that are accredited as ADS	• Complements work of NDA, MOH • Promotes acceptability of new standards due to ownership • They can help weed out wrong doers in the market • Feeds back to the manufacturers on quality issues	• Leaves key stakeholders, e.g., health consumers, advocates • May promote industry interests at the cost of consumer interests • Potential for manipulation/ conflict of interest • Leaves out a section of the market that does not subscribe to association	Low effort Low impact
Mass media	7	• Work with newspapers, TVs, radios to pass on messages on RUM. • Training media practitioners in RUM • Toll-free tel. number for communities to lodge complaints. • Use of mobile technology to communicate with health consumers and get feedback • IEC materials, i.e., posters, leaflets, billboards, etc.	• The information gets to wide audience easily • Can provide feedback on services of ADS	• Cost is high • Difficult to assess impact • Lack direct contact with beneficiaries • Media is profit driven, and gives audience to messages from antagonists	High effort Low impact

* Note that the options ranked fourth, fifth, and sixth are all rated the same: low effort/low impact.

Table 14. Prioritization of options, with pros and cons

9. ANNEXES

Annex 1. SDSI Partners and Their Activity Objectives

SDSI partners and their activity objectives as related to SDSI's goal in Uganda		
Contractor	**Activity Objective**	**Period of Performance**
Pharmaceutical Systems Africa (PSA)	To document the **ADS regulatory system** and experience in Kibaale, explore options for sustainable ADS regulatory system, and recommend a strategy and needed tools to ensure regular inspection, re-accreditation and enforcement of ADS standards.	August–November 2012
Pharmaceutical Society of Uganda (PSU)	To document the experience of **supportive supervision** teams in Kibaale since the start of ADS initiative, explore options for sustainable ADS supportive supervision, and recommend a strategy and needed tools that would help ensure delivery of quality pharmaceutical services by ADS providers.	August–November 2012
Makerere University-Kampala Department of Pharmacy (MUK)	To review the current **ADS seller training** initiative and recommend short and long-term solutions that will result in the sustainable availability of trained ADS sellers.	August–November 2012
Avytel Global Systems	To assess and develop a strategy on the feasibility and utility of using **mobile technology** to strengthen ADS services in areas of product availability and quality.	August–October 2012
G1 Logistics Ltd	To develop a **geographic information system (GIS)** strategy for Uganda's National Drug Authority (NDA) in order to improve its regulatory capacity over Accredited Drug Shops.	July–October 2012
Ugandan Health Marketing Group (UHMG)	To determine the status of the **ADS associations** and develop a strategy for facilitating the establishment of ADS associations in Uganda.	May–October 2012
Pharmaceutical Systems Africa (PSA)	To assess the **ADS supply chain** deficiencies and identify possible solutions and recommendations for strengthening the ADS supply chain system.	August–November 2012
Coalition for Health Promotion and Social Development (HEPS Uganda)	To identify current needs, experiences, and expectations of selected consumer populations where ADS have been implemented and to develop strategies for **engaging consumers** in ensuring the quality, appropriateness, and affordability of the services provided in their communities.	May–October 2012
Community Integrated Development Initiatives (CIDI)	To identify and characterize **community-based health initiatives** in Uganda to determine the best options for collaboration between such initiatives and ADS in an effort to improve access to medicines.	September–November 2012

Annex 2. Survey Team

NO.	NAME	DESIGNATION	DISTRICT
Technical Team			
1	Rosette Mutambi	Executive Director	
2	Denis Kibira	Survey Manager	
3	Prima Kazoora	Monitoring & Evaluation	
Field Team			
1	Pelagia Tusiime	Soc. Scientist/ Supervisor	Kayunga
2	Mariam Akiror	Soc. Scientist	
3	Yusuf Rwakaikara	Soc. Scientist	
4	Collin Semakula	Pharmacist	
5	Nomi Ilaborot	Soc. Scientist	
6	Mangusho Joseph	Pharmacist/ Supervisor	Kamuli
7	Wycliff Kitimbo	Pharmacist	
8	Sumaiya Kanyiri	Soc. Scientist	
9	Nathan Isabirye	Soc. Scientist	
10	Buwembo Muniri	Soc. Scientist	
11	Paul Akankwasa	Soc. Scientist/ Supervisor	Kamwenge
12	Annet Beinomugisha	Soc. Scientist	
13	Osbert Twikirize	Pharmacist	
14	Cornelia Kazoora	Soc. Scientist	
15	Kenneth Mwehonge	Soc. Scientist	
16	Lubega Mohamed	Pharmacist/ Supervisor	Mityana
17	Richard Serunkuma	Soc. Scientist	
18	Winnie Wednesday	Soc. Scientist	
19	Judith Kiconco	Soc. Scientist	
20	Lawrence Bbale	Soc. Scientist	
21	Margaret Abigaba	Pharmacist/ Supervisor	Kibaale
22	Kenneth Mugumya	Soc. Scientist	
23	Richard Turyamwesimira	Soc. Scientist	
24	Annet Ariho	Soc. Scientist	
25	Clara Atuhaire	Soc. Scientist	
	Data Entry Team		
1	Lillian Mujuni	Statistician	
2	Bestason Aliyo	Data clerk	

NO.	NAME	DESIGNATION	DISTRICT
3	Guma Martin	Data clerk	
4	Julian Komuhangi	Data clerk	
5	Sylvia Kimuli	Data clerk	

Annex 3. Mapping of Status of Consumer Advocacy Related to Health Care and Medicines Use

a. Kayunga district

No	Name and address, Tel, Fax, Email and Website	Activities	Contact Person
1	Kayunga District Disability Organisation (KADIDU)	Advocate for the rights of PWDS, conduct integrated programs, mobilize	Mwanje Emmanual 0772685717
2	Nsona Development Association	Environment Conservation	Ssaku Edward 0772418843
3	Joint Action on AIDS (JAAH)	HIV/AIDS awareness	Madada 0774147767
4	Green Belt Anti-Desert Tree Planting Movement	Tree planting	Maka 0774841297
5	Kayunga Orphans Education Care and Support Organisation	Support to orphans	Tom Maxwell Ngobi
6	Kayunga Women Development Forum	Mobilise women groups for development programs	Mrs Magenzi
7	Islamic Propagation Information Orphanage Centre and Charitable Organisation International	Orphan support and Development	0784427992
8	Rural Tree planting	Tree planting	Mukooza
9	Ganyana	Savings food Security	Nakirija Robinah 0775476547
10	Talibalamu	HIV/AIDS Sensitisation	Mpagi 0782113480
11	Kukyeramu Christian Orphans Education	Rehabilitating widows	Diflex Solio
12	Kangulumilira Girl Child Education Support	Promoting Girl Child Education	Kamanya 0782089347
13	Kiwana Rural Development Association	Promoting Girl child Education	Kalinda 0778946552
14	Bbaale Tusitukirewamu		
15	Namaliiri Education and Community Development Centre	Trinity Nursery Schools	Mrs Anaba Kayonza
16	Nakabango AIDS patients Support (NAPSU)	Voluntary Counselling and testing of HIV/AIDS, care and support for PLWAs, HIV sensitisation	Yeko 0772946552
17	Kitwe Charitable Initiative	Orphanage Schools, food security	Muluuta
18	Agape Mission	Evangelism, care for AIDS patients, animal husbandry, drama, primary and secondary	

No	Name and address, Tel, Fax, Email and Website	Activities	Contact Person
		education	
19	S. T Ana Nazigo Catholic Women's Guild	Farming, Art and Crafts, banking	Parish Priest Nazigo Catholic Church
20	Kitimbwa Community Development Scheme	Training nurses, HIV/AIDS awareness	Kitimbwa
21	Centre for integrated carriers project	Vocational training, promoting human rights and Sustainable agriculture	Jemba Walugendo
22	Nakyesanja Parish Muilt purpose Development Youth Association	Production and Processing of fruits, animal husbandry	Sentogo Erismus 0782631789
23	Kuku Development Association (KUDA)	Agriculture, Loans and Credit	Busaana
24	Nkeretanyi Organic Farmers	Farming, tree planting, environmental Sanitation	Noven Igobe Balisanga-Kayonza
25	Mirembe Women's Group		Kayunga TC
26	Busaale Tukolebukozi	Credit and Savings Agriculture	Kamoga 0787443868
27	Zinununula Omunaku Care Sub Project		Bisaka Bidugala
28	Kayonza Youth Community Organisation		Kayonza
29	Bukyanagandi group		
30	Nakaseeta AIDS Care	HIV Sensitisation	Ssaku Edward 0787443868
31	Kangulumira Youth Development		
32	Kwongo Co-op Society		
33	Wabirongo Farmers Group	Pineapple and Vanilla Production	0392944218
34	Zibula Attude Women's Group		039244219
35	Namalere Tweyambe Women's Group		
36	Tuwereza Multipurpose		
37	Kimooli Farmers Association	Development Projects	0392944227
38	Kinyara Bore hole project		0392944227
39	Kayunga Women's Association		
40	Tweyambe Widows group		Ssuka
41	Nakaseeta Rural Development Association		Nakaseeta
42	Jerusalem Pipers' Association		Kayunga TC
43	Nazigo Country Meats		Ms Kiggundu Nazigo
44	Tuwereza Multipurpose		
45	Kayunga Muslim Development Association		

No	Name and address, Tel, Fax, Email and Website	Activities	Contact Person
46	Kukola Kwewayo Farmers Association		Bubajwe
47	Tender Mercies	Care for Orphans and Vulnerable Children	Charles 0752845365
48	Strides for Family Health	Health	
49	Self Help Africa	Food security, HIV/AIDS	Naikesa Dorothy 0392848143
50	Community Awareness and Response on AIDS (CARA)	HIV /AID services, orphans and vulnerable children	Kabiyamba Willy 0392960970
51	Kayunga District Farmers Association (KDFA)-Company Limited by Guarantee	Food security, biodiversity conservation, promotion of appropriate energy technologies	0312270607
52	Patience Pays Initiative	Food Value addition, orphans and widows	Jane Naluwairo 0782842528
54	Global Health	HIV/AIDS	C/O Madada
55	Women and Youth Services	Developing Youths and Women	Charles Kakooza 0772681525
56	Makerere Watereed Project	HIV/AIDS	Kayunga TC
57	Child Health Advocacy International		Kayunga TC
58	Rural Empowerment Network	Food Security	
59	Youth and People with Disability Development Association YOPIDIDA	Art and Crafts HIV/AIDS control	
60	Action for Human Rights and Civic Awareness (AHURICA)	Paralegal services, Human Rights, HIV/AIDS awareness	Bar-Chimpe Yusuf 0772576258
61	Kayunga District Union of People with Disabilities	Coordinate disability development groups	Mwanje Emmanuel 0772685717
62	Rubaga Youth Development Association (RYDA)	Youth Empowerment, HIV/AIDS awareness	Tom Maxwell Ngobi
63	Mirembe Self Help Project	Vocational Training, Environmental protection, and Sustainable agriculture	Asaf Senyonga
64	Bugerere Dairy Co-operative Association	Dairy Products	Bbaale

b. Kamwenge District NGOs

S/N	Name and address	Objectives/ Activities	Current and previous work
1	Baylor college of medicine	HIV care	HIV care
2	STRIDE for family health	Family planning	-
3	PACE	Social marketing related to sanitation, reproductive health commodities	• Health centre development • Provision of mosquito nets • Water guard • Condom and contraceptive distribution • General health education
4	CARTER CENTRE	Treat and eliminate River blindness	• Provide drugs • Train Village Health Teams • Spraying
5	WORLD VISION	Child advocacy, nutrition and good health	• Work on nutrition • Advocate for children's rights • Give medicines like, Vitamin A capsules, abendazole • Train VHT
6	SDS Strengthening Decentralized Services	Strengthening Decentralized Services	• Participate in planning at district level • Support supervision to health facilities
7	SURE	Medicines management	• Check stocks • Check expiry • Take medicines in facilities of shortage • Monitor how medicine is being utilized
8	Family International	Support family planning	• Family planning • Empower communities to use diplovera

c. Kamuli District NGOs

No.	Name and address, Tel, Fax, Email and Website	Activities
1	Uganda National Health Consumers /Users Organisation (UNHCO)	Consumer advocacy on health rights. Maternal health project
2	Integrated rural development initiatives-	Support livelihood
3	STRIDES	-Reproductive Health Services. Currently provide mosquito nets to pregnant mothers
4	PACE	-Health centre development -Sanitation at health centre's -Provides mosquito nets -Water guard -Condoms -General health education
5	Plan Uganda	Reproductive Health Services
6	Uganda Red Cross	Humanitarian, relief and disaster assistance
7	Kamuli Peoples Integral Dev't Association NGO-	HIV and income generating activities
8	Uganda Development services	Agriculture, children education and environment protection
9	VEDCO	Agricultural services and advocacy
10	Child Fund Uganda	Children affairs and livelihood programs
11	NACWOLA	Psycho-social support group of women living with HIV/AIDS
12	AEGY	HIV and discordant couples
13	NAWOU- National Association of Women Organisations in Uganda	Women empowerment and advocacy
14	KAMDIPU- Kamuli Disabled Persons' Union	Advocacy and livelihood for the disabled
15	Community Vision	Entrepreneurship Capacity building for
16	Citizen link	Sustainable agriculture and livelihoods

d. Mityana District NGOs

S/N	Name and address, Tel, Fax, Email and Website	Objectives of the organization	Current activities
1	Strides for Family Health 15 Princess Anne Drive Bugolobi P.O. Box 71419 Kampala, Uganda Telephone: 256.414.235.038/043	1. Increase the quality and provision of routine Reproductive health (RH)/Family Planning (FP) and Child survival (CS) services at facility level. 2. Improve and expand access to and demand for RH/FP and CS services at the community Level. 3. Advance the use of RH/FP and CS services through supportive systems.	-Supply contraceptives to health facilities. -Sensitizing the community about contraceptive use.
2	Securing Ugandans' Right to Essential Medicines (SURE Program) Management Sciences for Health (MSH) Uganda Office Plot 15 Princess Anne Drive, Bugolobi P. O. Box 71419, Kampala, Uganda. Tel: +256 414 235 038/43 Email: sureinfo@sure.ug Website: www.sure.ug	1. Improve Uganda's policy, legal and regulatory framework to produce pharmaceutical supply chain stability and sustainability. 2. Improve capacity and performance of central government entities, especially the National Medical Store, to carry out their supply chain management responsibilities. 3. Improve capacity and performance of districts, health and implementing partners in their supply chain management roles.	1. Working with the district and the community to strengthen health systems. 2. Monitoring the supply of essential medicines and other health supplies at every health facility in Mityana.

e. Kibaale District NGOs

S/N	Name and address, Tel, Fax, Email and Website	Objectives of the organization	Current activities	Past activities
1	World Vision	Promotion girl child education and health	-Construct schools and latrines -Well safe water -children rights -environment, train VHTs	Construct schools and latrines -Well safe water -children rights -environment, train VHTs
2	Uganda Rural Development Training Organisation(URTDT)	Construction of schools. Girl-education entrepreneurial skills development	-Health, IGAs, Land Issues - protection of water -children's rights -household sanitation	Health, IGAs, Land Issues - protection of water -children's rights -household sanitation
3	Red Cross		-Sensitization, -Emergency -Provision of materials	
4	Infectious Disease Institute(IDI)	Provision of health services to the community	▪ Curative and Preventive ▪ Save mothers, gives life ▪ Construct Health centers ▪ HIV/AIDS – counseling and testing	▪ Curative and Preventive ▪ Save mothers, gives life ▪ Construct Health centers ▪ HIV/AIDS
5	UNESCO	Provision of health facilities and services	▪ Construct Health Centers ▪ Schools and latrines ▪ Provision of safe water ▪ Training of VHTs ▪ Essential Medicines	
6	SURE	Hard to research areas	▪ Medicines Management ▪ Sensitize medical workers	

Annex 4. Survey Instruments

Household Semi-structured Questionnaire

INTRODUCTION

HEPS Uganda in collaboration with Management Sciences for Health are undertaking an assessment to identify current needs, experiences, and expectations of selected consumer populations in use of medicines. This assessment aims to increase community awareness of Accredited Drug Sellers (ADS) products and services, encourage the community to gain interest in broader community health issues, and engage consumers to help ensure drug shops/ADS compliance to regulatory requirements and the provision of quality products and services. The information collected will only be used for the above purposes and will be confidential. This interview will take about 30 minutes. We request you to kindly respond to the following questions.

Name (Respondent): _____(Optional)
Name (interviewer): _____
Date: _____ (DD/MM/YR) Start time_____ End Time_____
Checked by: _____Date: _____

The 'Household Informant' should be the person in the household who is the main health care decision maker. This person is usually the person who is knowledgeable about the health care utilization of members of the household. The survey should not be completed if this person, or appropriate substitute, is absent.

The household head can consult other household members during the interview:

Is the household head or appropriate substitute willing to participate in the survey?
1☐ Yes if yes continue ☐ 2 No if No ,stop here and go to next household

Household No…….. **Reference Private drug outlet…….**
Place of Residence: District ……Sub-county……
Parish…… Village…….

1.Distance of household from Private Drug outlet.(tick one)	**< 5km**		**5-10Km**	**>10km**
	1 ☐		2 ☐	3 ☐
2. Type of Private Drug outlet.(tick one)	Pharmacy	Drug shop	Clinic	Hospital
	1☐	2 ☐	3☐	4☐

3. Has your household visited a private drug outlet for medicines in the past 12 months?

1☐ Yes, if yes skip to Section 1 ☐ 2 No, if No, ask why and then and go to next household

Reasons why Household has not visited the reference health facility	
Code	Responses
1= Got all medical care from public facility 2= Could not afford 3= No medicines available at nearest 4= Had medicines at home 5= Got medicines from vendor/market 6= Got medicines from community drug	

	distributor 7= Got medicines from traditional healer 8= No one was sick 9=Other (specify)----------	

1.0 DEMOGRAPHICS SECTION

Instructions: Please fill in the most appropriate answer in the response column/row. This task is solely the responsibility of the interviewer. *Information provided here shall be kept confidential*					
1.01 AGE	1.02 GENDER	1.03 CURRENT MARITAL STATUS	1.04 RELIGION	1.05 HIGHEST EDUCATION LEVEL	1.06 OCCUPATION
[ ] [ ] years	1=Male 2=Female	1=Married 2=Consensual union 3=Divorced 4=Widowed 5=Never married 7=Not applicable	1= Catholic 2= Protestant 3=Pentecostal 4= Orthodox 5=Muslim 6=Other specify…..	1=No formal schooling 2=Some primary 3=Completed primary 4= some secondary 5=Completed Secondary 6=Completed high school or equivalent 7=Completed college/university 8= Post- Graduate	[1] Formal employment [2] Subsistence Farmer [3] Commercial farmer [4] Self employed [5] Casual [6] Student [7] House wife [8] Retired [9] Unemployed [10] Other Specify……

2.0 NEEDS, ACCESS AND USAGE (tick one)

Number	**Question**	**Code**	**Comments**
2.01	How much time does it take you or your household to walk to the nearest private drug outlet	1. <15 mins 2. >15 mins < 30 mins 3. >30 mins<1 hour 4. > 1 hour	
2.02	Is the private facility always open when you need medicines?	1. Yes (skip to 2.04) 2. No	
2.03	If **2.02** above how far do you have to go for medicines when it is closed?	1. <15 mins 2. >15 mins< 30 mins 3. >30 mins<1 hour 4. > 1 hour	

2.04	What type of health problem (symptoms) usually takes household members to private drug outlet?	**Acute disease** 1= Cough, runny nose, sore throat, ear ache 2= Difficulty breathing, fast breathing 3= Pain, aches 4= Fever, headache, hot body 5= Diarrhea, vomiting, nausea, could not eat 6= Bleeding, burn, accident 7= Thirst, sweating 8= Convulsions, fits 9= Could not sleep 10= Do not know 11= Other (please specify)	**Chronic disease** 1= Hypertension, high blood pressure 2= Diabetes, high blood sugar 3= Cancer 4= Ulcer, chronic stomach pain 5= Asthma, wheezing, chronic difficulty breathing 6= Tuberculosis 7= HIV /AIDS 8= Liver disease 9= Arthritis, chronic body pain 10= Depression 11= Epilepsy, seizures, fits 12= Other (please specify)
2.05	How serious is the problem in **2.04** above?	1=Very serious 2= Somewhat serious 3= Not serious	
2.06	Did you receive **ALL** the prescribed medicines from the same facility	1= Yes **(skip to 2.09)** 2=No **(continue to next)**	
2.07	If **no** in **2.06** why did you not get all the medicines	1= Could not afford 2= Medicines not available 3= Had medicines at home 4= Other (specify)	
2.08	If **no** in **2.06**, where did you get other medicines from?	1= Other Drug shop 2= Pharmacy 3= Public health facility 4= Had medicines at home 5= Neighbour 6= Others (specify)	
2.09	How much did your household pay for medicines used to treat this illness?	|__| |__||__| |__| |__| |__| *local currency*	
2.10	Was the cost covered by insurance?	1= Yes entirely 2= Part of it was covered 3 = No	
2.11	Do the household members take all the medicines given for illnesses	1 = Yes **(Skip to next section)** 2 = No **(Go to next question)**	
2.12	If **no** above why were the medicines not taken fully?	1=Symptoms got better 2=Someone in the household decided medicines were not needed 3=Someone advised not to take medicines 4=Sick person had bad reactions to medicines in the past	

		5=Someone in the household chose a different treatment 6=Other (please specify)	
2.13	Do you have any medicines in the house today? **Check label on package for**: Name of medicine, dose and duration	Label complete: 1=Yes 2=No	

3.0 EXPERIENCES (Tick correct response: **Agree, Disagree, Don't know**)

Number	Question	Code		
3.01	Private drug outlets are welcoming	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
3.02	Private drug outlets encourage to ask questions and get responses	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
3.03	Private health providers take into account our ability to pay when they decide which medicines to sell	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
3.04	Medicines costs in private drug outlets in my area are affordable	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
3.05	My household can usually get credit from the private if we need to	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
3.06	My household can usually afford to buy the medicines we need	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
3.07	In the past, my household had to borrow money or sell things to pay for medicines	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
3.08	Drug sellers usually manipulate medicines with bear hands	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
3.09	Private drug providers clearly provide information on use of medicines	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
3.10	Medicines envelops are clearly marked with name of medicine, dose and duration of treatment	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
3.11	I was assured and happy about service by private drug providers	**Agree** ☐	**Disagree** ☐	**Don't know** ☐

4.0 KNOWLEDGE (tick correct response: **Agree, Disagree, Don't know**)

Number	Question	Code		
4.01	When I receive a prescription, I am comfortable asking how much the medicines will cost	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
4.02	When I buy a medicine, I ask for the least expensive product	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
4.03	When a drug outlet attendant recommends a medicine, I can be sure that it is the best value for money	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
4.04	When a drug outlet attendant recommends a medicine, I can be sure that it is of good quality	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
4.05	Medicines of better quality are more expensive	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
4.06	The private pharmacy closest to my household usually has all the medicines my household needs	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
4.07	There are places in my neighborhood where I would never buy medicines because they sell medicines of poor quality.	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
4.08	The quality of services delivered by private health care providers in my neighborhood is good.	**Agree** ☐	**Disagree** ☐	**Don't know** ☐

5.0 EXPECTATIONS OF CONSUMERS FROM PRIVATE SELLERS (tick one)

Number	Question	Code		
5.01	Drug shops should be registered/licensed	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
5.02	Drug shops should be neat and orderly	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
5.03	Drug shops should have qualified staff	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
5.04	Staff in Drug shops should be knowledgeable	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
5.05	Staff in Drug shops should be hospitable	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
5.06	Drug shops should display prices of medicines	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
5.07	Drug shops should issue receipts of medicines paid for	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
5.08	Staff in Drug shops should give information on use of medicines	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
5.09	Staff in Drug shops should properly package and label medicines **(Name of patient, Name and strength of medicine, frequency and duration, conditions for use)**	**Agree** ☐	**Disagree** ☐	**Don't know** ☐
5.10	Staff in Drug shops should not handle medicines with bear hands	**Agree** ☐	**Disagree** ☐	**Don't know** ☐

7.0 SATISFACTION WITH THE QUALITY OF SERVICE

Instructions: ***Below are the following indicators, respondents need to respond whether they are satisfied or Dissatisfied or Neither satisfied nor Dissatisfied.. Fill in the appropriate code on the response given.***

	Indicator	Completely Satisfied	Satisfied	Partially Satisfied		
					Dissatisfied	Very dissatisfied
	Coding	**1**	**2**	**3**	**4**	**5**
7.01	Distance to the private drug outlet					
7.02	Level of privacy					
7.03	Availability of medicines					
7.04	Behavior of private drug provider					
7.05	Cleanliness of the facility					
7.08	Orderliness of facility					
7.11	Quality of information for drug use					
7.12	Overall health service satisfaction					

7.13	Reasons for dissatisfaction (list important four)	1. 2. 3. 4.		
7.14	What suggestions do you have to improve the service (give most important four)	1. 2. 3. 4.		
7.15	As compared to a year ago, how is the health service provision?	1. Same 2. Better 3. Worse	**Response**	

Focus Group Discussion Guide

INTRODUCTION

HEPS Uganda in collaboration with Management Sciences for Health are undertaking an assessment to identify current needs, experiences, and expectations of selected consumer populations in use of medicines. This assessment aims to increase community awareness of Accredited Drug Sellers (ADS) products and services, encourage the community to gain interest in broader community health issues, and engage consumers to help ensure ADS/ DRUG SHOPS compliance to regulatory requirements and the provision of quality products and services. The information obtained will be used to develop strategies for consumer advocacy and education, which will improve consumers' involvement in monitoring ADSs and eliminate inappropriate consumer use of medicines thereby reducing drug resistance. Our discussion will last approximately 1.30 hour. With me here, I have my colleagues (FGD team), moderator; notes taker and observers (mention their names) _____who will be helping me taking notes.

We would like to record these discussions to help us remember. Details of the discussions and your names will be kept confidential – so please feel free to express your opinions. Ask for concert -**Would you agree to have our discussion recorded in order to document well the process and results of our discussion? Thank you. (Take 5 minutes)**

1.1 Take names and physical addresses of all participants attended and allow for a quick self-introduction. Please say this! *''If you can tell us your name, what you do''* my colleague will prepare name tags to help us remember your names. ??CAN WE TAKE THE NAMES?? PREPARE TAGS?

(Take 10-15 min)

3.0 Key Research Questions.

The Key research questions will revolve around understanding of *knowledge, skill* and *attitudinal* gaps that respondents have about ADS/ DRUG SHOPS services and products, products affordability and reliability, appropriate use of medicines, medicine dispensing practices, consumers' counseling, compliance issues, complaints procedures and information sharing-IEC.

Key questions	**Probing Questions**
3.1 What do people understand about the "*appropriate use of*	a) What do you understand about the word medicines? b) Who is the main health care decision maker in your family? This person is who is knowledgeable about the health care utilization of

medicines"	members of the household? c) Do they know their roles on appropriate use of medicines? d) What does appropriate use of medicines involve? e) What are the advantages of appropriate use of medicines?
3.2Availability - Where do you get your medicines (human and veterinary)	a) What type of health problem (symptoms) usually affects your community? b) What are the commonly sources of medicines in this community. c) Why do you rely on these sources d) What kind of products and services are offered by these sources? e) Are the medicines you want easily available from your area? f) What are some advantages and disadvantages of these different sources? g) Why do they have these disadvantages? h) What are the existing problems and possible solutions? i) Have you ever came across or bought fake/substandard medicines? j) What makes it difficult for a person from your community to get proper medicines? k) Are you aware of health Insurance? What are the common complaints when using your Health Insurance cards to get your medicines?

3.3 How frequent do you use ADS/ DRUG SHOPS services?	a) How frequent do people buy their medicines from ADS/ DRUG SHOPS in this community? Are you comfortable/free to ask questions to ADS/ DRUG SHOPS dispensers b) What are the barriers making people not using ADS/ DRUG SHOPS services c) Are you satisfied with ADS/ DRUG SHOPS services? d) Why do people use traditional healers' services?
3.4 What information would you need about appropriate use of medicines?	~~a)~~ What information would you like to receive in order to feel more comfortable when using your medicine? b) Are you advised/counseled to use your medicines timely/appropriately? And do you follow those directives? c) Are there any IEC i.e. leaflets, calendar, posters, brochures, radio/TV programs shared on appropriate use of medicines around your community? d) Are there forums where medicine or health issues are discussed? e) What need to be done to narrow the gaps on information sharing?
3.5 What are your responsibilities when taking your medicines?	a) What are your responsibilities when using medicines? b) Do you know who is responsible if you are adversely affected with medicines? c) Do you know what your rights are?
3.6 In case you have a	a) Where do you go to lodge a complaint about medicines?

complaint about sub-standard or adverse effects of medicines, where can you go?	b) What are ~~the~~ common complaints people have about medicines in your community? c) Why do you think people commonly complain about these issues? d) What are some common complaints people have about ADSs/ drug shops in your community?
3.7 Compliance issues	a) Are you satisfied with the way ADSs/ drug shops are operating? b) Are you satisfied with ADSs/ drug shops dispensers' skills, knowledge, experience and support? If not give suggestions. - * The moderator may inquire on issues of ADS's establishment guidelines, licenses and permits – probe whether community members knows if ADS/ DRUG SHOPS are being inspected.
3.8 General overview	a) Based on your experience, what are the things need to be improved at ADS b) Any other comment you have regarding ADS/ DRUG SHOPS initiatives and appropriate use of medicines

One hour discussion (60 min)

4 Closure (3 -5 min)

Thank you. Your answers and discussion have been helpful and informative. Do you have any questions for us?

KEY INFORMANT INTERVIEW GUIDE

INTRODUCTION

HEPS Uganda in collaboration with Management Sciences for Health are undertaking an assessment to identify current needs, experiences, and expectations of selected consumer populations in use of medicines. The information obtained will be used to develop strategies for consumer advocacy and education, which will improve consumers' involvement in monitoring ADSs and eliminate inappropriate consumer use of medicines thereby reducing drug resistance. Our discussion will last approximately 30 minutes.

I would like to record the discussions to help us remember. Details of the discussions and your names will be kept confidential – so please feel free to express your opinions. Ask for consent - **Would you agree to have our discussion recorded in order to document well the process and results of our discussion? Thank you.**

1. **Key Research Questions.**

The Key research questions will revolve around *the experiences*, *knowledge*, *skill* and *attitudinal* gaps that of the community dispensing services.

Key questions	**Probing Questions**
1.1 Availability	l) What type of health problem (symptoms) usually affects your community? m) What are the commonly sources of medicines in this community. n) Are these sources reliable? o) What kind of products and services are offered by these sources? p) What are some advantages and disadvantages of these different sources? q) Why do they have these disadvantages? r) What are the existing problems and possible solutions? s) Are fake/substandard medicines a problem? t) Is health Insurance common?
3.3 How frequent do you	e) How frequent do people buy their medicines from ADS/ DRUG

use ADS/ DRUG SHOPS services?	SHOPS in this community? f) What are the barriers to usage of ADS/ DRUG SHOPS services g) Do people know the difference between ADS/ DRUG SHOPS? h) Are you satisfied with ADS/ DRUG SHOPS services? i) Why do people use traditional healers' services?
3.4 What information would you need about appropriate use of medicines?	~~f)~~ What information would you like to receive in order to feel more comfortable when using your medicine? g) Are you advised/counseled to use your medicines timely/appropriately? And do you follow those directives? h) Are there any IEC i.e. leaflets, calendar, posters, brochures, radio/TV programs shared on appropriate use of medicines around your community? i) Are there forums where medicine or health issues are discussed? j) What need to be done to narrow the gaps on information sharing?
3.5 What are your responsibilities when taking your medicines?	d) What are your responsibilities when using medicines? e) Do you know who is responsible if you are adversely affected with medicines? f) Do you know what your rights are?
3.6 In case you have a complaint about sub-standard or adverse effects of medicines, where can you	e) Where do you go to lodge a complaint about medicines? f) What are ~~–~~common complaints people have about medicines in your community? g) Why do you think people commonly complain about these issues?

go?	h) What are some common complaints people have about ADSs in your community?
4.7 Compliance issues	c) Are you satisfied with the way ADSs/ drug shops are operating? d) Are you satisfied with ADSs/ drug shops dispensers' skills, knowledge, experience and support? If not give suggestions. - * The moderator may inquire on issues of ADS's/ drug shops establishment guidelines, licenses and permits – probe whether community members knows if ADS/ DRUG SHOPS are being inspected.
3.8 General overview	c) Based on your experience, what are the things need to be improved at ADS/ drug shops d) Any other comment you have regarding ADS/ DRUG SHOPS initiatives and appropriate use of medicines

5 Closure

Thank you. Your answers and discussion have been helpful and informative. Do you have any questions for us?

NB: This tool has been adapted from Tanzania Consumer Advocacy Society (TCAS) tools for the research understand consumers linkage with ADDOs

Mapping Tool for NGOs and status of consumer advocacy related to healthcare and medicines use

S/N	Name and address, Tel, Fax, Email and Website	Objectives of the organization	Current activities	Past activities