SUSTAINABLE DRUG SELLER INITIATIVES PROGRAM

UGANDA

ESTABLISHING COLLABORATION BETWEEN ACCREDITED DRUG SHOPS AND COMMUNITY-BASED HEALTH INITIATIVES

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

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Prepared by Community Integrated Development Initiatives for the Sustainable Drug Seller Initiatives Program

CONTENTS

List of Tables

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FOREWORD

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 situation analysis based on qualitative and quantitative data on their topic gathered through extensive interviews and use of questionnaires;
- Analyzing the options for future action;
- Conducting a workshop, followed by a larger meeting, with shareholders so they could review and comment on the analyses and conclusions.

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 establishing collaboration between the ADS and community-based health initiatives.

ACRONYMS AND ABBREVIATIONS

ADS	Accredited Drug Shop
AIDS	acquired immune deficiency syndrome
ASPR	Annual Sector Performance Report
CBHI	community-based health initiative
CBO	community-based organization
CIDI	Community Integrated Development Initiatives
DADI	District Assistant Drugs Inspector
DHI	District Health Inspector
DHO	District Health Office
DHT	District Health Team
EADSI	East African Drug Seller Initiative
FGD	focus group discussion
FP	family planning
GoU	Government of Uganda
HIV	human immunodeficiency virus
HSSP	Health Sector Strategic Plan
HUMC	Health Unit Management Committee
ICCM	Integrated Community Case Management
JMS	Joint Medical Store
MDG	Millennium Development Goal
MoH	Ministry of Health
MSH	Management Science for Health
NDA	National Drug Authority

NGO	nongovernmental organization
PFP	private for-profit
PHA	people living with HIV/AIDS
PHC	primary health care
PNFP	private not-for-profit
RRH	Regional Referral Hospital
SDSI	Sustainable Drug Seller Initiatives
SEAM	Strategies for Enhancing Access to Medicines
SURE	Securing Ugandans' Right to Essential Medicines
SWAp	sector wide approach
TBA	Traditional Birth Attendant
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UHMG	Uganda Health Marketing Group
UNMHCP	Uganda National Minimum Health Care Package
USAID	US Agency for International Development
VHT	Village Health Team

1. EXECUTIVE SUMMARY

The Sustainable Drug Seller Initiatives (SDSI) program builds on MSH's Strategies for Enhancing Access to Medicines (SEAM) and East African Drug Seller Initiative (EADSI) programs with support from the Bill & Melinda Gates Foundation. The programs focused on creating and implementing public-private partnerships using government accreditation to increase access to quality pharmaceutical products and services in underserved areas.

The primary focus of the programs is 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 project's objectives are to:

- Enhance accredited drug seller initiatives' long-term sustainability, contributions to community-based access to medicines and care, and ability to adapt to changing health needs and health system context.
- Facilitate the spread of private-sector drug seller initiatives.
- Define and characterize information related to consumer access to and use of medicines and facilitate its use in developing public health policy, regulatory standards, and treatment guidelines.

The sustainability of the successes achievable would depend highly on the availability of well-trained and competent sellers who can provide services in the established outlets.

Among other objectives SDSI program aims to build capacity of existing drug shops in Uganda through training and mentoring of the shop owners and attendants or dispensers. This has led to accreditation of some drug shops as Accredited Drug Shops (ADS). In Uganda, drug shops play an important role in community health care by acting as the first and most accessible point for medicines and services for common conditions, including childhood illnesses. Among the various efforts to ensure sustainability, the SDSI program aims to involve ADS in community-based activities. In Uganda these activities are currently carried out for the most part by primary health care facilities (both public and private) and a system of community health workers (CHWs) or Village Health Teams (VHTs).

The situational analysis therefore aimed at identifying and characterizing community-based health initiatives (CBHIs) in Uganda and determining the best options for collaboration between primary health care facilities, CHWs, VHTs, and ADS in an effort to improve access to medicines.

The study adopted both qualitative and quantitative approaches to characterize the CBHIs in the four target districts of Kamuli, Kamwenge, Kyenjojo, and Mityana. Primary data were collected using key informant interviews, focus group discussions, and two sets of survey questions. Thematic and content analysis approaches were applied to qualitative data, while frequencies, percentages, medians, and means summarize the quantitative data.

The study found that the most common CBHIs working with different partners to extend health services to the community in the four target districts were VHTs, the Health Unit Management Committees

(HUMCs), Traditional Birth Attendants (TBAs), drug shops, and the Traditional Healers or Herbalists. Other CBHIs included, but were not limited to, spiritualists; churches; local tooth extractors, most especially among young children when they extract abnormal teeth; and local specialists who deal with tonsillitis and headaches. Common among these initiatives is the use of sharp instruments, leading to excessive bleeding and administration of pain relief to patients.

The study also noted that among a number of drug shops in the four target districts, their scopes of work were overwhelmingly inconsistent and often not in accord with expected standards. The shops were mainly class C shops, or part of a clinic or *duka* (retail shop). In the four districts, drug shops prescribe drugs, sell drugs that they are not licensed to sell, and carry out other health-related activities. For example, at least 75 percent of the drug shops (ADS, class C, and *dukas*) were involved in family planning counseling, clinical diagnosis and treatment, health education talks, and provision of referrals to the health units in the past three months.

Notable partners supporting CBHIs included the following: Baylor Uganda works with a set of trained VHTs to undertake maternal health programs; the Malaria Consortium works with VHTs on malaria control among children, a Plan project works with VHTs to mobilize for HIV counseling and testing, Strides and Marie Stopes also work with VHTs on maternal and child health, while the Ministry of Health, through the Community Health Department, is also working with VHTs to undertake the Integrated Community Case Management (ICCM) project in all four study districts.

The study also found major problems facing the CBHIs, such as lack of transport facilitation, insufficient drug stocks and delayed drug delivery, lack of regular refresher training, and drug abuse in the communities. The VHTs also cited high staff turnover and lack of any remuneration, means of transport, and field gear as other key challenges.

There was some collaboration, although at a minimal level, between VHTs, HUMCs, health units, and the drug shops. For example, the drug shops work with the health centers (HCs) only when they have organized some specialized trainings where resource persons are needed. For the case of the VHTs, drug shops support community mobilization and immunization programs. The drug shops also do family planning counseling in addition to the screening of some minor conditions. In general, there is no mechanism (formal or informal) that brings together the VHTs and the drug sellers at a common forum. The drug sellers are exclusively involved in business, and VHTs are on a voluntary basis across all the study districts.

Although, there are no streamlined referral services between drug shops and the HCs , there was a common practice of health workers in the health centers writing prescriptions and advising the patients to access the drugs from drug shops, especially when drugs are out of stock at the HU.

The key CBHIs and other stakeholders that have potential to collaborate with the drug shops include the HC s, VHTs, HUMCs, and the Herbalists. Both the drug shops and the CBHIs acknowledge that because most of the shops are staffed by attendants who have at least a certificate in nursing and are currently involved in running other health-related activities, ADS provide an opportunity to support the CBHIs. Many shops are attended by personnel who are more educated than the VHT members, and with some

training they can act as mentors for them. This is most useful in settings where the HCs are located far from the community.

Based on both the qualitative interviews and quantitative data, the CBHIs are willing to collaborate with the drug shops on delivery of various health services. The VHTs, HUMCs, and HC staff favorably rated the competence and willingness of the drug shops to run some health activities, for example mentoring the VHTs, screening for some diseases, and acting as a hub for information on health issues. Similarly, the VHTs and HC staff strongly believe that the engagement of the drug shops in such activities will considerably ease their work.

The drug shop attendants were willing to collaborate with the VHTs and the HC s. Over 50 percent observed that it will be easy to incorporate various health-related activities into their drug shop businesses. However, they requested that the government sell drugs at a discount. This would ease their provision of drugs to the VHTs on credit whenever necessary.

The potential areas of collaboration between the drug shops, VHTs, and HC s include the provision of family planning services, community sensitization, immunization and education, streamlining the referral system, mentoring of the VHTs, and provision of drugs on credit.

2. BACKGROUND

2.1 ACCREDITED DRUG SHOPS AND COMMUNITY-BASED HEALTH INITIATIVES IN UGANDA

The Sustainable Drug Seller Initiatives 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. The SEAM and EADSI programs focused on creating and implementing public-private partnerships using government accreditation to increase access to quality pharmaceutical products and services in underserved areas of Tanzania and Uganda. The 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, EADSI determined what it would take to successfully adapt Tanzania's accredited drug dispensing outlet (ADDO) model for Uganda, and the concept was introduced successfully in Kibaale district when the Accredited Drug Shops (ADS) were launched there in 2009.

In Uganda, drug shops play an important role in community health care by acting as the first and most accessible point for delivery of medicines and services for common conditions, including childhood illnesses. Among its various efforts to ensure sustainability, the SDSI program aims to involve drug shops

in community-level activities. Currently, these activities are mainly carried out by primary health care facilities (both public and private), and a system of community health workers or VHTs.

Studies have shown that VHTs are difficult to sustain and motivate over a long period (Katureebe 2007; Haines and Sanders 2007). The major shortcoming of the VHT strategy is its "voluntary" nature; the VHT strategy does not provide financial payment to community members, which may adversely impact participation (MoH 2010a) and lead to high attrition rates. In addition, there is no consistent training for VHTs to enable them to provide a basic standard set of prevention and care interventions. Training appears to vary in quality and has not been planned or delivered in a coherent or efficient way. Another concern is inadequate supervision and monitoring by health facilities, largely due to the low staffing levels at most of the facilities. Furthermore, the VHT system has not been scaled up in every district in Uganda due to inadequate funding (MoH 2010b). As of June 2010, only 84 of the 112 districts had fully implemented the VHT Strategy (table 1).

Table 1. Village Health Team establishment

VHT district coverage	No. of districts	Districts
100% coverage	84	
50–99% coverage	6	Kalangala, Kanungu, Kisoro, Mukono, Nakasongola, Ngora
Below 50%	19	Buikwe, Bulambuli, Busia, Buvuma, Buyende, Iganga, Jinja, Kabale, Kampala, Kayunga, Manafwa, Mityana, Namayingo, Pallisa, Rakai, Sembabule, Sheema, Sironko, Tororo

Source: MOH, ASPR 2012

VHTs also frequently lack stocks of medicines, and although there is a linkage between the VHT and the health facility, there is no direct linkage with drug shops within the communities where the VHTs are located. Furthermore, despite serving the same populace, there is no coordination between the drug shops and the VHTs or between the drug shops and the health facilities in the communities.

Therefore, the SDSI program envisions that collaboration and linkages among the three entities—the drug shops, the VHTs, and the health facility—would increase utilization of services in both health facilities and the ADS, increase community participation in facilitating referrals of sick people to health facilities, and increase promotion of healthy behavior and proper use of medicines by the community. This will benefit the communities and also to enable the accredited drug shops' long-term maintenance and sustainability.

2.2 Objectives of the Study

To create collaboration and linkages between the ADS and community-based health initiatives, including the VHTs, it is necessary to establish the current situation of the CBHIs and drug shops. The overall objective of the current study, therefore, was to identify and characterize community-based health initiatives in Uganda through a situational analysis and to use the findings to determine the best options for collaboration between such initiatives and ADS.

Specifically, the primary activities of the Community Integrated Development Initiatives (CIDI) study team were as follows:

1) Conduct a situational analysis of community-based health initiatives in the four districts of Kamuli, Kamwenge, Kyenjojo, and Mityana and assess them by type, geographical coverage, potential impact, and the partners supporting the initiatives;
2) Identify feasible activities to link community-based health initiatives with ADS, such as providing supplies; acting as a hub for information; screening for selected diseases; and monitoring, mentoring, and supervising community health workers;
3) Develop an options analysis, including opportunities and challenges, regarding potential collaborative efforts;
4) In collaboration with key stakeholders and MSH/SDSI, facilitate a consensus-generating workshop to finalize strategy for linking ADS with community-based initiatives.

2.3 Overview of the Ugandan Health Sector

Health service delivery is the backbone of any health system. Historically, Uganda provided the majority of health services through a vast infrastructure. However this public-sector only delivery system has changed dramatically in the last 20 years. The Ugandan health service delivery system now includes a wide array of public and private health care providers working in many different clinical settings.

The delivery of the Uganda National Minimum Health Care Package is central to the implementation of the Health Sector Strategic Plan 2010/11–2014/15 and attainment of the sector goals and objectives. The Minimum Health Care Package is aligned with the Second National Health Policy and National Development Plan 2010/11–2014/15, the overarching national policy and strategic framework governing the health sector in Uganda.

Additionally, the Minimum Health Care Package core strategies are aligned with the Millennium Development Goals, to which Uganda is a signatory. The National Development Plan (through sector plans) and the Health Sector Strategic Plan 2010/11–2014/15 are being implemented in a sector-wide approach, which addresses the health sector as a whole in planning and management, and in resource mobilization and allocation. However, delivery of the minimum health care package is constrained by the structure of Uganda's population. Not only does the population grow annually by 3.2 percent (MOH 2010), which requires increased investments in the health sector, there is also a challenge of a high dependence ratio, as evidenced by the country's demographic strata (table 2).

Table 2. Uganda demographics

Demographic Variables	Proportion	Population
Total population	100%	32,939,800
Children <18 years	56%	18,446,288
Adolescents and youth (10–24 years)	34.7%	11,430,111
Orphans (for children <18 years)	10.9%	3,590,438
Infants <1 year	4.3%	1,416,411
Children <5 years	19.5%	6,423,261
Women of reproductive age (15–49 years)	23%	7,576,154
Expected number of pregnancies	5%	1,646,990

2.3.1 Selected Health Indicators

In Uganda, mortality indicators improved significantly between 2000 and 2010, but they remain relatively high. For example, although there was a decline in the infant mortality rate from 89 deaths per 1,000 live births in 2001 to 63 deaths per 1,000 live births in 2010 (UBOS 2010; World Bank 2011), this is very high, even in comparison with other African countries. Indeed, the country is still a long way from achieving its MDG.

There are still high levels of maternal mortality due to high fertility, the high incidence of infectious diseases, poverty, and poor health services for pregnant mothers (MoH and Macro International 2008). There is also a high unmet need for family planning (UDHS 2010). Other challenges women face accessing health care include lack of money for treatment, long travel distances, unavailability of medication, and reluctance to go without support from relatives.

There are also inequities in accessing health care across the regions, with Kampala (the capital city) having fewer women reporting access problems, and women in the southwestern and the northern parts of the country (the areas with highest infant and under-five mortality rates) reporting the greatest access challenges (UBOS and ORC Macro 2006; Okwero et al. 2010). Specific challenges in addressing maternal health problems in Uganda include inadequate funding; lack of adequate health workers, medicines, and supplies; inappropriate infrastructure; inadequate transport; and lack of communication equipment for referrals (GoU, 2010).

2.3.2 Organization of Service Delivery

The public health care system under the Ministry of Health (MoH) is organized in a tiered structure. The numbers and types of facilities, distribution of care, the expected population served by a facility, and the level of facility that offers the expected care are shown in table 4.

Health Center IVs (HC IVs) were introduced as a strategy to address poor access to health care services. The introduction of a HC IV to an area can be seen as indication of an area with poor access to hospital services, as HC IVs were designed to be able to handle some emergencies, such as emergency obstetric

care, that were normally handled at the hospital level. So, in the absence of easy access to a hospital, HC IVs are supposed to provide at least some emergency services normally provided by a hospital.

There are 13 Regional Referral Hospitals (RRHs) in the country, but for the annual reporting exercise, four large private not-for-profit (PNFP) hospitals (Lacor, Mengo, Nsambya, and Rubaga) with the scale and scope of RRHs are included, making a total of 17 RRHs (MoH 2011e). There are two National Referral Hospitals (Butabika and Mulago). Both the public and private sectors play an important role in supporting communities to improve their health.

The private sector is composed of the private not-for-profit (PNFP) and the private for-profit (PFP) health providers. The PNFPs are divided into two groups: the facility-based PNFPs (FB-PNFP) which offer preventive and curative care; and the non-facility-based PNFPs (NFB-PNFP), which offer preventive, rehabilitative, and palliative care. About 41 percent of the hospitals and 22 percent of the lower-level facilities belong to FB-PNFPs. More than three-quarters of the FB-PNFPs belong to the faith-based umbrella organizations of the Uganda Catholic Medical Bureau, Uganda Protestant Medical Bureau, Uganda Muslim Medical Bureau, and Uganda Orthodox Medical Bureau.

There has been a recent increase in the number of practitioners of non-indigenous traditional or complementary medicine, such as Chinese and Ayurvedic medicine (MoH 2010f). These TCMPs include Herbalists, traditional bonesetters, Traditional Birth Attendants, hydrotherapists, spiritualists, and traditional dentists. TCMPs are present in both rural and urban areas (GoU 2010b). The definition of private facilities does not stringently follow the definitions in table 3, nor do referrals between the public and private sectors, while functioning, follow a hierarchical structure in all cases.

Table 3. Structure, characteristics, and size of the health care service delivery systems

Type of Facility	Physical structure and services	Clinical personnel	Location	Population served		Number of facilities			
				Standard	Current	Government	Private not-for-profit	Private for-profit	Total
Health Center I (Village Health Team)	None	N/A	Village	1,000	N/A	N/A	N/A	N/A	N/A
Health Center II	Stand-alone facility, outpatient services	Nurse	Parish	5,000	14,940	1,562	480	964	3,006
Health Center III	Inpatient and facilities (maternity and general ward) and laboratory/microscopy	Clinical officer	Subcounty	20,000	84,507	832	226	24	1,082
Health Center IV	Outpatient and inpatient services, wards, operating theatre, laboratory and blood transfusion services	Doctor	County	100,000	187,500	12	1	177	190
General Hospital	Hospital, laboratory, and X-ray	Doctor	District	500,000	263,157	64	56	9	129
Regional Referral Hospital	Specialist services	Doctor, Specialists	Region	3,000,000	2,307,692	13	4	0	17
National Referral Hospital	Advanced tertiary care	Doctor, Specialists	National	10,000,000	30,000,000	2	0	0	2
Totals						2,485	767	1,174	4,426

2.3.3 Referral System

In Uganda, the system for referral of patients from the lower levels of health care to tertiary levels is largely ineffective. Lack of ambulances, fuel, or both prevent patients from quickly transferring from one facility to another. The referral mechanism also faces the challenges of poor road networks or terrain, as well as lack of referral forms; relevant emergency medicines; and supplies, including blood for transfusion at the referral facility (MoH and Macro International 2008; GoU 2010). In addition, people often have to pay for emergency care, and their inability to pay for the services might delay access to or provision of referred services.

A critical challenge for the referral system is the inadequate capacity of the health facilities, especially the Health Center IVs, to handle emergency cases such as caesarean sections or blood transfusion. A common practice is that patients, particularly those with more money than the average patient, bypass the lower-level facilities and self-refer themselves to whatever higher-level facility they perceive as good for them. This leads to congestion of high-level hospitals (or example, Mulago teaching hospital) with patients with minor ailments that could have been treated at lower levels.

2.3.4 Coverage and Availability of Services

The government of Uganda is committed to universal coverage through the Uganda National Minimum Health Care Package. Availability of services is impacted by the location of facilities and the degree to which the facilities are functional, i.e., their hours of operation and adequacy of human resources, equipment, and supplies. About 72 percent of the population in Uganda lives within a 5-kilometer radius of a health facility (MoH 2010b). However, this measures only geographical accessibility. Clients face many challenges, even when they are close to the facilities.

Many health facilities lack an adequate health workforce, especially in the rural areas. For example, many of the HC IVs are not functional because of lack of medical officers, inadequate infrastructure, and lack of local supervision (MoH 2010b). The percentage of HC IVs that provide emergency services like minor operations, caesarean sections, and blood transfusion did not improve much between the 2006/07 and 2009/10 fiscal years. This is partly due to the concentration of health workers in urban areas, with few HC IVs having full-time doctors. The challenges of service delivery are compounded not only by inadequate numbers of public health workers but also the lack of the right cadre mix at the facilities and the unavailability of the health workers who are supposed to be at the health facility in the public system.

Medicines are a major component of service delivery. In order to ensure that the public health facilities have drugs for common illnesses, the MoH monitors five tracer medicines for health facilities. During the course of implementing HSSP II, through 2010, the proportion of public health facilities without stock-outs of the five tracer medicines and supplies was a dismal 41 percent. With the push system, some public facilities are given drugs that they do not need, and eventually these drugs expire.

Insufficient stock in the public sector has created a boom in the private sector, with many clients seeking clinical consultation in the public sector and then purchasing their drugs in the private sector. In many

cases, some health consumers are bypassing the public sector entirely and going to the private sector for services and medicines.

Rehabilitation of buildings and maintenance of medical equipment is not done regularly, and consequently most facilities and equipment are in a state of disrepair.

2.3.5 Service Utilization

Outpatient department utilization can be used as a proxy for measuring utilization of health services in an area. The outpatient department utilization in government and PNFP facilities ranged between 0.8 and 0.9 visits per person per year during 2004/05 and 2009/10. Inadequate personnel and frequent stock-outs at health facilities contribute to this low utilization of government and PNFP facilities.

Health service utilization varies across the public and private providers and for different types of services. The removal of user fees in 2001 pressured the government to increase the drug budget to effectively deal with increased utilization of government facilities (Burnham et al. 2004; Xu et al. 2006; Nabyonga-Orem et al. 2008). Private health facilities, especially the drug shops and small private clinics, are mostly utilized for outpatient care, while PNFPs and government facilities are utilized for severe illnesses (Konde-Lule et al. 2006). Overall, the choice of provider is based on proximity, cost, and provider skills.

Table 5. Reasons for choosing a health care provider among households, by type of provider in Uganda

Type of Provider Visited	Number	Reason for Choice of Provider		
		Proximity	Provider Skills	Cost
Public	251	41%	45%	12%
PNFP	80	56%	41%	10%
PFP	269	59%	26%	11%
Traditional Practitioner	73	23%	34%	19%
General Merchandise Shop	6	83%	00%	17%
Totals	679	52%	29%	14%

Source: Konde-Lule et al., Private and public health care in rural areas of Uganda (2010)

Comparison of reasons among persons that visited different providers indicates cost is the least frequently cited determinant for choice of provider, which is likely because there is a cost incurred to the patient for every type of provider, even public providers, including transport costs and out-of-pocket payments (formal and informal). The main factor driving consumer choice is proximity. Because PFP providers (including the drug shops) are more convenient—more accessibly located and with shorter waiting times and longer hours of operation, the majority of clients interviewed preferred PFP, followed by PNFP.

2.3.6 Quality Assurance

One of the functions of the MoH is to set standards and ensure quality for the entire health sector (MoH 2010c). The MoH has a Quality Assurance unit, headed by a commissioner, to help lead this very vital function of the Ministry. The maintenance of professional standards is the responsibility of health professionals' councils. Professional councils are charged with enforcing ethics and professional standards.

In medical practice (GoU 2010b), the National Drug Authority is charged with ensuring the safety of pharmaceuticals, equipment, and medical supplies. The maintenance of standards is beset with challenges in terms of inadequate human, logistical, and financial resources for supervision, monitoring, and enforcement. The government's ability to enforce quality standards among the private-for-profit providers is affected greatly by the lack of sufficient resources.

The health sector supportive supervision mechanism was another intervention aimed at improving quality. It was arranged in a cascading manner such that the national-level agencies and institutions supervised the district offices, while the district offices supervised the district-level public providers.

2.3.7 Community Participation

According to the National Health Policy, individuals and communities are supposed to play an active role in health care. Communities should participate in decision-making through Health Unit Management Committees and Village Health Teams (MoH 2010c). In a facility like an HC IV, for example, the membership of this committee is drawn from the subcounties that fall within the facility's catchment area. An equivalent of a HUMC in a PNFP is a facility or hospital management board. Health Unit Management Committees were established in many health facilities, but some have not been functioning well. Whereas the HUMCs are supposed to be avenues through which the health facilities receive feedback from the community, oftentimes the communities are not consulted. In addition, HUMCs often do not relay information from the HC s to the community (Rutebemberwa et al. 2009).

The Village Health Teams have been instituted in the country to act as the first level of care (HC I). They are charged with facilitating the process of community mobilization and empowerment for health actions. Each VHT comprises about five people selected by the village. One-third of the team members should be women (MoH and Macro International 2008). The VHT strategy is expected to harmonize various programs at the community level. The VHTs are also expected to facilitate community data collection.

Uganda has significantly improved access to maternal and child health care as well as the country's response to the HIV/AIDS epidemic. Further, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the US Agency for International Development (USAID), and other donor programming has led to increased availability of HIV prevention, outreach, and treatment services. Most Ugandans now live within 5 kilometers of a health center. Despite this progress in service availability, significant challenges remain to improve the quality of service delivery and address continuing health status issues, such as high infant and maternal mortality.

Primary health care remains difficult for some to access, and the quality of care is inconsistent. The referral system is not functional, and patients often ignore secondary or tertiary care due to the high costs involved with travel. Stock-outs of drugs and supplies and inadequate human resources for health impact service delivery. Lack of financial and human resources adversely impacts regulation and quality control. Many services, including those related to HIV and tuberculosis, are not well integrated into the general health delivery system and continue to be provided vertically. Evidence-based medicine is not consistently followed, and facility-based quality improvement initiatives, while they exist, have not been institutionalized uniformly. The system also does not invest sufficiently in prevention and public health services to minimize unhealthy behaviors that lead to increases in both noncommunicable and infectious diseases.

3. Methodology and Approach

3.1 Geographic Study Area and Participant Sampling

The study covered four districts in Uganda: Kamuli, Kamwenge, Kyenjojo, and Mityana. The districts were preselected and determined by SDSI as potential areas of future intervention. Within each district, two parishes within two subcounties were randomly selected and stratified on the rural and urban divide. In each parish, a total of 2 TBAs, 5 VHTs, 2 health center staff members, 2 Health Unit Management Committee members, and 6 drug shops were randomly selected using a stratified random sampling technique.

Other study participants (mainly for the qualitative survey) were purposely selected based on their level of knowledge and involvement in a particular service. These included the District Health Officer, District Inspector of Drugs, Health Center in-charges, Medical Bureau representatives, Ministry of Health officials, and representatives of national-level health partners like the Malaria Consortium, Pace, Ugandan Health Marketing Group (UHMG), and the National Drug Authority (NDA), to mention a few.

Primary data were gathered using key informant interview (KII) and focus group discussion (FGD) guides. For the mini-survey, the data were collected through questionnaires (annex 2). Secondary data were obtained through document review and data extraction.

3.2 Data Analysis

Qualitative data were translated and analyzed thematically to generate conclusions and recommendations. Quantitative data were entered into a predesigned Microsoft Access database, and then summarized using percentages, frequencies, medians, and means.

3.3 Study Limitations

The study was conducted in four rural districts of Uganda with a very wide geographical coverage. The time allocated to this study was relatively short and, as a result, not all CBHIs could be reached or

exhaustively traced. However, most of these CBHIs are not of key importance in collaborations with the ADS.

Other related challenges included lack of records, for example for all the drug shops and CBHIs at the district or the subcounty level, from which the study team could easily draw its sample of respondents. Instead, the team used the incomplete records and enumeration of the CBHIs and then obtained the sample afterwards, which took more time than anticipated. Nevertheless, the study team feels that the sampling strategy and the triangulation of the data collection methods and sources were able to give a balanced and thorough study of the CBHI in the target districts.

4. KEY FINDINGS

4.1 CHARACTERISTICS OF CBHIS

The most common community-based health initiatives included the Village Health Team, the Health Unit Management Committees, Traditional Birth Attendants (TBAs), and the Traditional Healers or Herbalists. However, there are also community-level-based projects and programs that are run by nongovernmental organizations (NGOs) and organizations such as STRIDES Uganda, Baylor, STAR, PLAN International, the Malaria Consortium, Catholic Relief Services, Uganda Health Marketing Group, AFRICOM, Mildmay, and the National Forum of PLHA Networks in Uganda.

Most of the projects and programs work directly (e.g., support, train, supply some drugs) with the VHTs and HUMC members as their community contacts. For example, Baylor Uganda works with a set of trained VHTs to undertake maternal health programs; the Malaria Consortium works with VHTs on malaria control among children; STRIDES and Marie Stopes also work with VHTs on maternal and child health; while the Ministry of Health, through the Community Health Department, is also working with VHTs to undertake the ICCM project in all four study districts. Since most of these projects are transient, this report focuses on the VHTs, HUMCs, TBAs, and Herbalists, in addition to HCs II and III (government or private). The people living with HIV/AIDS network (set up by National Forum of PLHA Networks in Uganda) is also set up at the district level.

In addition to the mainstream CHBHI, Kamwenge and Kyenjojo had some other local community initiatives, which were instrumental in health-related activities. These included spiritualist, churches, and local tooth extractors, most especially for young children when they extract abnormal teeth; and local specialists who deal with tonsillitis and headaches. Common among these initiatives is use of sharp instruments, leading to excessive bleeding and administration of pain relief. Some VHTs have also reported that these initiatives, especially the Herbalists, have a habit of making concoctions with conventional medicines mixed with herbs. Table 6 presents a snapshot of these characteristics and the CBHIs current situation in the study districts.

Table 6. Summary of some key characteristics and current operational situation among the CBHIs

	VHTs	HUMCs	Herbalists and TBAs	Other CBHIs
Set-up and operational structure	Mandated by MoH and supervised by the DHO and HC II and III through a VHT focal person.	Mandated by MoH. Work in collaboration with the DHO, CAO, HC II and III staff, and local leaders	Set up and run by individual Herbalists, sometimes are affiliated with an association.	Individually set up and basically rely on knowledge acquired through experience.
Geographical coverage	About four VHT members per village.	Members of HC II and III management team and are operational whenever HC II and III exist	• Their operations are often beyond the village level. • Individual business that can be executed wherever needed, often within same subcounty.	Operate at the village level and with no clear boundary
Roles in community-based health	• Health Center I: in charge of drug distribution, maternal health, hygiene and sanitation, and community mobilization for health, such as immunization. • The HC staff identified the early referrals of patients, follow-up of patients after HC treatments, management of common ill health conditions, and community sensitization as some of the impacts of the VHT on the health system.	Planning for the HC , verify drugs at delivery, inform community about the availability of drugs, management of the health center.	Claim to treat illness and minor complications in the community	Claim to treat illness and minor complications in the community
Partners	MoH; NMS; JMS; religious organizations; project- or program-based support by organizations such as STRIDES Uganda, Baylor, STAR, PLAN International, Malaria Consortium, AIC, JCRC, CRS, ICOBI, SCHPA, FLEP, PREFA, UHMG, AFRICOM, Mildmay, PACE, Marie Stopes, FHI	MoH, local councils, HCs	MoH; medical and professional associations and councils, National Association of Herbalists. However, most of the Herbalists have no support at all.	Local associations
Collaborations	Collaborate with partners listed in previous section; collaborate with TBAs (80%), HUMCs (86%), and Herbalists (60%). Currently 33% (27% in rural and 33% in semi-urban areas) collaborate with drug shops.	VHTs, TBAs, drug shops, through information sharing	VHTs, TBAs, drug shops through information sharing	HC through referrals
Potential impact on community health	Have led to improved service delivery to the local communities, most especially among children in control of diarrhea, malaria, anemia (through ICCM), maternal health, and FP services	Have led to improved service delivery to the local communities, especially through drug accountability and reduced stock-outs	Close spiritual gap and psychological healing of the local community	Accidentally manage some health cases
Challenges	• Run out of drugs often • High staff turnover • Lack of facilitation • Drug shop owners view VHT as inspectors in some instances • Limited and nonstandard training	Lack of facilitation	• Lack of facilitation • Lack of training • Mechanism of treatment by Herbalist is not known and therefore even where it works is difficult to replicate with certainty.	

4.2 Characteristics of Respondents Representing CBHIs and Current Operational Challenges

4.2.1 General Characteristics of Respondents Representing CBHIs

The 178 study respondents representing CBHIs included 86 VHT members, 29 health center (government or private) health workers, and 24 members of Health Unit Management Committees, among other players in the community health-based services (table 7). Other community-based stakeholders not interviewed include some NGOs and community-based organizations (CBOs), such as Saving Mothers Giving Life, PHA networks in Mityana, and Forum for PLHAs in Kamwenge, the Youth Alliance in Kamwenge, and other project-based initiatives, such as those set up by PLAN International, STRIDES, etc.

Table 7. Characteristics of the respondents representing CBHIs (*N* = 178)

	N	Percent
Sex		
Female	107	60.1
Male	71	39.9
Age group		
20–29	35	19.3
30–39	57	31.8
40–49	38	21.6
50+	48	27.3
Residence		
Semi-urban	89	50.0
Rural	89	50.0
Type of CBHI or stakeholder		
VHT	86	48.3
HC II/III staff	29	16.3
HUMC	24	13.5
TBA	23	12.9
Others (e.g., Herbalists)	16	9.0
Highest education-level attained		
None	8	4.5
Primary	36	20.2
Secondary	69	38.8
Tertiary	65	36.5
Received specialized training		
No	22	12.5
Yes	156	87.5
Total	178	100.0

About 30 percent of the TBAs had no formal education, while 50 percent of the HUMC members and 15 percent of the VHT members had attained tertiary education. Compared to the drug shop attendants, therefore, most of the VHTs attained the same level of education, at best. Drug shop attendants, therefore, have potential to participate in mentoring the VHTs.

4.2.2 Challenges Facing CBHIs in Executing Their Duties

Challenges or problems mentioned by over 40 percent of the respondents representing the VHTs, HCs, and HUMCs included lack of transport facilitation, insufficient drug stocks and delayed drug delivery, lack of regular refresher training, and the problem of drug abuse in the communities. The VHTs also cited high staff turnover, lack of any remuneration, and lack of field gear as other key challenges. The HC staff cited lack of well-trained staff, low staff remuneration, lack of transport to effect referrals to higher-level HCs or hospitals, and late referrals to the HCs as challenges. Late referrals might be due to lack of transport for the client or their inclination to self-diagnose, the buying of drugs from the drug shops, or patient ignorance and misperceptions, or drug shops failing to refer patients they cannot help. The HUMCs cited lack of guidelines and lack of routine meetings as other factors impeding their operations.

Some challenges were also mentioned during the key informant interviews and focus group discussions. These include:

- Resources (supplies) such as drugs, gloves, and family planning kits are in short supply, and this is one of the biggest problems.

> *"Lack of medicines disturbs patients. They lose trust in us, and whenever we tell them to go to the health centers, they switch off and instead decide to go to places like drug shops where they get some of the medicines, but unfortunately they get exploited from there in most cases. This has discouraged many from seeking treatment." (VHT Member from Kamwenge)*

- The health facilities are not adequately staffed. One staff does immunization, checks women, and does all the other work.

> *"At the end of the day, it becomes quite strenuous for health workers, and when you come late in the afternoon, they are all tired and therefore can't attend to you in the best way they can." (FGD Participant in Kyenjojo)*

Another respondent noted that the drug shops consider VHTs to be people who spy on them and report to the health centers.

> *"Drug shop operators see us as spies but this is not true. Our intention is to work with them to improve health care in our community. I don't know how we are going to change this thinking, but we are constantly talking to them about the importance of working with the health facilities." (VHT member)*

Some patients prefer going to drug shops even after they are advised to go the health facilities, as one VHT member noted:

> *"This is an uphill battle for us VHTs and other community leaders to convince our people to always seek health services from the qualified health service providers." (VHT member)*

4.3 Characteristics of Respondents Representing Drug Shops and Operational Challenges

4.3.1 General Characteristics of the Respondents

A total of 96 drug shop attendants or owners were interviewed, of which 78 percent were female. About 66 percent of the respondents were employed by the shop owner. The majority (76 percent) of the shops have been selling drugs for at least one year. Eighty-five percent of the drug shops are registered by the NDA. Many of the shops are class C drug shops, with only 13 percent being *dukas*.

Table 8. Characteristics of respondents representing drug shops (*N* = 96)

	N	Percent
Age group		
20–29	58	60.4
30–39	25	26.0
40–49	9	9.4
50+	4	4.2
Drug shop type		
ADS	7	7.4
Class C	65	68.4
Clinic plus shop	11	11.6
Duka	12	12.6
Highest education level		
Secondary	30	31.6
Tertiary	65	68.4
Who owns the shop?		
Employer	63	66.3
Family business	26	27.4
Other	6	6.3
Duration in business (years)		
< 1	22	23.2
1–2	33	34.7
2.5+	40	42.1
Collaboration with VHTS		
Yes	11	20.8
No	42	79.3
No. of people operating the shop		
1	44	47.8
2	34	37.0
3+	14	15.2
Licensed?		
No	13	15.1
Yes	73	84.9
Qualifications of key staff member		
O Level certificate holder	12	12.5
Nursing aide	13	13.5
Nursing assistant	42	43.8
Nurse and above	29	30.2
Total	96	100.0

4.3.2 Challenges the Respondents Face in Executing Their Duties

Key challenges mentioned by over 40 percent of the drug shop attendants and owners included that many patients can afford only half a dose; the high prices of drugs; competition from other drug shops; poor therapy management by clients (e.g., poor adherence, poor storage); lack of adequate training of many shop attendants, leading to poor dispensing practices; and community members blaming of all the drug shops.

4.4 Existing Collaboration between VHTs, HUMCs, HC Staff, and the Drug Shops

4.4.1 Areas of Collaboration between CBHIs and Drug Shops

The VHTs, HUMCs, and HCs work together, with HCs providing planning and guidance for the VHTs. The HUMCs have a monitoring role over the HCs, in addition to working with them to support the VHTs. Over 85 percent of the VHT members reported having worked closely with HUMC members in the recent past. However, only 33 percent (27 percent in rural and 37 percent in semi-urban areas) of the VHT members have ever worked closely with any class C drug shop or ADS. This is despite the fact that over 77 percent of the VHT members live nearer to a drug shop than to the health center supervising them. Some areas of collaboration include provision of drugs when the health center is out of stock and provision of information on drug use (table 9).

Areas of collaboration	*N*	*%*
Family planning counseling	4	15.4
Mass immunization support	3	11.5
Provide drugs when HC stocks are out	5	19.2
Provide information on drug use	6	23.1
Consult on available drugs	5	19.2
Other	8	30.8

Table 9. Areas of collaboration between VHTs and drug shops

However, there are no streamlined referral services between drug shops and the HCs; the common practice for the health workers in the health centers, especially in public facilities that are always out of stock, is to write prescriptions and advise the patients to access the drugs from private drug shops.

Only 6 (20 percent) of HC staff have ever worked closely with the drug shops on mass immunizations and provision of drugs. Facilitating activities enlisted include the availability of drugs when HCs have run out of stock or when some essential drugs are not available, and selling drugs to the patients on credit.

Collaboration between the project-based CBHIs—such as the Youth Alliance to Combat HIV/AIDS, Kamwenge District Forum of People Living with HIV/AIDS, and PHA networks in Mityana—and drug shops is almost nonexistent. In addition, collaboration between them and the health centers exists only when they have organized some specialized trainings on specialized areas, which may require the support or resource person from the health center level.

4.4.2 Challenges to Collaboration

There is a poor relationship between HC staff and the drug shops. For example, over 60 percent of HC staff respondents observed that the drug shops are responsible for drug abuse, as they allow for selling of half doses and advise the patients incorrectly. Some HC staff also accused drug shop attendants of late presentation of complicated cases at the health center.

Of the few HC staff who have managed to collaborate with the drug shops, some have been accused by community members of conniving to sell the public HC drugs and other commodities. Interestingly, however, anecdotal evidence from FGDs and VHT key informants from Kyenjojo indicated that most of the drug shops belong to health workers at government health centers, and others are owned by absent owners who don't participate in management of the drugs shops.

There is no mechanism (formal or informal) that brings together the VHTs and the drug sellers at a common forum. The drug sellers are exclusively involved in their businesses, and so are the VHTs, across all the study districts. However, in rural subcounties, especially in Kyenjojo and Kamwenge, there were unsubstantiated reports from TBAs and Herbalists of VHTs selling drugs, especially antimalarial medicines, to community members, claiming to be transport facilitation for drug distribution, and to drugs shops at a very low price.

Drug shops are profit oriented, while the VHTs aim to help the community free of charge. This difference in priority has affected the collaboration.

4.5 Potential Areas for Collaboration between the VHTs, HUMCs, HC Staff, and the Drug Shops

The drug shops not only sell drugs but also offer a wide range of services, including filling prescriptions, drug dispensing, and minor surgery. In addition to all the clinics that sell drugs, at least 75 percent of the other drug shops (ADS, class C, and *dukas*) were involved in family planning counseling, clinical diagnosis and treatment, health education talks, and provision of referral to the HCs in the past three months (table 10).

Table 10. Involvement of drug shops in other health-related activities in the past 3 months

	Involved shops		
	N	**%**	**Freq. last 3 months**
Family planning counseling	55	64.0	12
Clinical diagnosis	26	30.2	15
Health education talks to clients	66	76.7	12
Do treatment follow-up of clients	47	54.7	10
Provide referral to HC	65	75.6	11
Involved in community case management	12	14.0	2
Supervise or mentor other drug shops	2	2.3	2

The drug shop attendants cited that they can support the VHTs on provision of information on the latest drugs, capacity-building, and supportive supervision, among other activities (table 11).

Table 11. Activities that the drug shops spontaneously identified as a support to the VHTs

Supportive Activities	*N*	%
Provide information on health-related issues	22	25.9
Provide information on drugs	38	44.7
Train or advise them	23	26.4
Provide them with drugs they do not have	58	68.2
Support them in running community activities (e.g., immunization, health talks)	21	24.7

Similarly, when the VHTs, HUMCs, and HC staff were asked about how the drug shops can better support them, many mentioned supplying drugs to the VHTs on credit and participation in community mobilization and sensitization (table 12).

Table 12. How can shops better support the CBHIs?

	HUMC members *(N = 22)*		HC staff *(N = 27)*		VHTs *(N = 63)*	
Support activity	*N*	%	*N*	%	*N*	%
Actively do FP counseling	4	18.2	6	22.2	9	14.3
Do community mobilization and sensitization	5	22.7	6	22.2	16	25.4
Provide first aid services	3	13.6	2	7.4	11	17.5
Mentor VHTs	3	13.6	2	7.4	0	0.0
Provide drugs on credit to VHTs	8	36.4	9	33.3	29	46.0
Act as hubs for information about drugs	2	9.1	4	14.8	41	65.1
Attend to patients with minor incidents	0	0.0	0	0.0	8	12.7

Over 70 percent of the respondents agreed that the drug shops can act as hubs for information on general health and as a resource for community medicines.

In conclusion, the potential areas of collaboration include the following, among others:

- Provision of family planning services;
- Provision of drugs on credit on short notice;
- Community-level health education, sensitization, and mobilization;
- Community-level outreach activities involving trainings and immunization;
- Distribution of simple drugs such as Panadol, Coartem, and other associated painkillers;
- Education about community/household hygiene and sanitation;
- Follow-up and continued support and monitoring of patients, including expectant mothers.

These are the same areas that were identified by the key informants and the FGDs participants.

> *"CHBIs like VHTs can work with the ADS once they are well trained to counsel women on family planning, and they can also distribute some of the family planning supplies apart from injections. They can work hand in hand with the ADS and the health centers to do this." (ADS Operator)*

> *"In my area, I keep family planning supplies for about four women in our area because they fear their husbands will find out that they are using family planning methods. If we can work well with these drug shops, such family planning supplies can be kept there, and the women can find ways of going there to get them." (VHT Member)*

> *"Some health workers invite us to move with them when they are going for outreaches in the community. This gives all of us an opportunity to advise, especially on issues like handling medicines, family planning, and general reproductive health for mothers. We can make a contribution there if we do joint support supervision." (Class C Drug Shop Operator)*

When asked of the potential, willingness, and competence to run some health-related activities, the drug shop attendants or owners rated themselves as competent (median score of 3) and willing (median score of 4), and that most activities will fit in well with their business (table 13).

Table 13. Rating the competence and willingness of the drug shop attendants and owners

Potential impact	Competence		Willingness		Potential impact	
	N	Median	*N*	Median	*N*	Median
Provide supplies to VHTs, TBAs, small drug shops on credit	83	3	84	4	80	2
Act as a hub for information for community members, VHTs, small drug shops, TBAs, clinics, etc.	95	3	96	4	95	3
Screening for some diseases	96	2	96	4	93	3
Help the HCs in supervising and monitoring the VHTs	96	3	96	4	94	3
Help the HCs in supervising and monitoring the other community health-workers	94	3	94	4	92	3
Help the HCs in mentoring the VHTs, etc.	96	3	96	4	93	3

4.6 HC Staff Perceptions of the Drug Shops' Competencies and Willingness To Undertake Potential Activities

Although the HC staff members are collaborating with the drug shops, the majority (71 percent) feel that if the drug shop attendants are trained, they can help to deliver various health-related activities, including the handling of simple cases. This would avoid crowding at the HCs.

Table 14. Rating competencies of the drug shops for the listed activities by VHT, HUMC, and HC staff

Competence	VHT		HUMC		HC staff		Overall	
	N	Median	*N*	Median	*N*	Median	*N*	Median
Provide supplies to VHTs, TBAs, small drug shops on credit	85	2	24	2.5	29	2	175	2
Act as a hub for information for the community members, VHTs, small drug shops, TBAs, clinics, etc.	85	3	24	3	29	3	175	3
Screen for some diseases	85	2	24	3	29	1	175	2
Help the HCs in supervising and monitoring the VHTs	85	2	24	2.5	29	2	174	2
Help the HCs in supervising and monitoring the other community health workers	85	2	24	2.5	29	1	174	2
Help the HCs in mentoring the VHTs, etc.	85	2	24	3	29	1	174	2

Table 15. Rating the willingness of the drug shops to run the listed activities

Willingness	VHT		HUMC		HC staff		Overall	
	N	Median	*N*	Median	*N*	Median	*N*	Median
Provide supplies to VHTs, TBAs, small drug shops on credit	85	3	24	4	29	4	175	4
Act as a hub for information for the community members, VHTs, small drug shops, TBAs, clinics, etc.	85	4	24	4.5	29	4	175	4
Screen for some diseases	85	4	24	4	29	4	175	4
Help the HCs in supervising and monitoring the VHTs	85	3	24	4	29	4	174	4
Help the HCs in supervising and monitoring the other community health workers	85	3	24	3.5	29	3	174	3
Help the HCs in mentoring the VHTs, etc.	85	3	24	4	29	3	174	3

Table 16. Rating the potential impact on the activities of VHT, HUMCs, and HC staff if drug shops run the listed activities

Potential impact	VHT		HUMC		HC staff		Overall	
	N	Median	*N*	Median	*N*	Median	*N*	Median
Provide supplies to VHTs, TBAs, small drug shops on credit	85	3	23	3	29	2	174	3
Act as a hub for information for the community members, VHTs, small drug shops, TBAs, clinics, etc.	85	3	23	3	29	3	174	3
Screening for some diseases	85	3	24	2.5	29	3	174	3
Help the HCs in supervising and monitoring the VHTs	85	3	23	3	29	3	174	3
Help the HCs in supervising and monitoring the other community health-workers	85	3	23	3	29	3	174	3
Help the HCs in mentoring the VHTs, etc.	85	3	23	3	29	3	174	3

Overall, the VHTs, HUMCs, and HC staff had favorable opinion of the drug shops running some activities.

4.7 National-Level Stakeholders' Perceptions on Collaboration between the Drug Shops and CBHIs

4.7.1 Perceptions from the Uganda Catholic Medical Bureau

The Uganda Catholic Medical Bureau (UCMB) is mainly concerned with supportive supervision, coordination, policy issues, and provision of technical support on issues of health care initiatives in collaboration with national-level stakeholders. The UCMB implements these activities in collaboration with the Ministry of Health, 30 hospitals, and 260 health centers. The activities of UCMB are not in any way linked with the activities of the CBHI, although they are aware that some of their partnering institutions, for example the Catholic health centers, have some collaborative arrangements, since the majority of these have a public health component as part of their health service delivery system.

The UCMB observed that under the current situation there are no possibilities of collaboration with CBHIs as this is not in line with their mandate. However, the interviewee contends that the CBHIs, such as the VHTs, have a critical role to play as in improving the delivery of health services to local communities. The interviewee added that there has been credible evidence to indicate that the recorded reduction in morbidity levels nationwide has been a result of the additional efforts and works of the CBHIs. The representative of the UCMB had both positive and negative sentiments regarding whether these initiatives can be supported more to further enhance their capacities to deliver some kind of minimum health services to local communities.

On a positive note, the UCBM regards the CBHIs as important in bridging the gap that currently exists between the formal and public health service provision centers. These were the issues cited:

- If the CBHIs are well developed and guided, they can play a critical role in the Ugandan health system. For example, the CBHIs are good in community mobilization and sensitization and hence can be used to create behavioral change.
- In Uganda today, the well-known and popular primary health care delivery system has collapsed. This means the CBHIs can be reverted to as a temporary and short-term measure as a better alternative is sought.

On a negative note, the UCBM views the CBHIs with a high level of reservation. The major concerns are as follows:

- The CBHIs are operating on a purely voluntary basis to deliver a basic and critical health service. In principle, they are not compelled to deliver this service and their supervisors will not have the moral authority to reprimand them if they fail to deliver the service.
- It is hard to find someone (in the case of a VHT) whose level of education is above the secondary school level and who will accept to undertake such voluntary services. With the reliance on individuals with the lowest level of education, the system is rendered shaky and susceptible to abuse and eventual failure
- The concept of administration of drugs must be understood to be a more complex aspect of service delivery than it might appear to the layman. It requires some level of discipline and commitment, which can come only with some requisite professional training. However, this training is not possessed by the majority of the CBHI personnel.
- Other very important necessities for effective health service provision and drug administration, such as storage and maintenance facilities, are practically nonexistent. This is likely to lead to the failure of the VHT strategy.

4.7.2 Perceptions from the Ministry of Health: Assistant Commissioner, Pharmacy Division

The Assistant Commissioner thinks there is no evidence that the collaboration will work. He would prefer that an evaluation be presented of the model implemented in Tanzania, where such collaboration has been in place for some time.

There is a need to strengthen VHTs being rolled out at every village in preventive health measures and basic information on medicines and their uses. However, according to the Assistant Commissioner, this should be a temporary strategy because in the long term it will create a problem of half-trained, quasi-health workers, potentially leading to widespread drug abuse and all its associated ills.

4.7.3 Perceptions from the National Drug Authority: Executive Director

The biggest challenge is lack of personnel along the health continuum, and the most common health centers are manned by only nurses and midwives. Similarly, many of the drug shop owners are just nursing assistants. The Executive Director thinks there should be a system to develop mid-level health cadres and get them comprehensively trained so that they can know what to do. Then they can be

phased out after a given period. The policies can be drafted to ensure that, and the training effort should be geared toward adherence to drug therapy.

4.7.4 Perceptions from the Joint Medical Stores: Head of Sales

The Joint Medical Store (JMS) is a private not-for-profit organization that was established by the two sister church denominations of the Church of Uganda and the Roman Catholic Church. The organization was established in 1979 with an aim of channeling medical items and supplies to their accredited institutions, especially the Roman Catholic– and Church of Uganda–based health centers, which are spread all over the country.

JMS currently works closely with major government hospitals such as Mulago and projects supported by UN agencies (e.g., WHO, the United Nations Development Programme) and (e.g., MSH, SURE), as well as private pharmacies. Linkage to small dispensaries, clinics, and drug shops is mainly through their accredited units, such as their health centers. Currently, there is no direct link with the VHTs and drug shops at local community levels.

In order to ensure that there is a direct collaboration between JMS and the ADS, the Head of Sales proposed the following:

- Undertake a study (a consultant has already been hired) to assess what it would take JMS to have direct collaboration with some of the CBHIs, such as the ADS. This is partly because JMS is so far still a cash-and-carry organization—in other words, they do not transport the supplies to the clients' premises.
- JMS must have a quality assurance mechanism to ensure the supplies and items for the CBHIs will remain of the same quality and standards as are dispatched and expected by JMS.
- There will be need to establish some satellite centers at either district level or, if possible, at subcounty level that can act as distribution centers from which the CBHIs can access the same supplies at much less expense on their part.

Currently the major obstacles and fears of JMS regarding dealing directly with the CBHIs is based on the following:

- The capacity of the CBHIs to hold a substantial amount of drugs is limited, and the majority do not have adequate resources to procure them from JMS, not to mention the means of transporting them to their areas of operation, since JMS does not offer transport except on very exceptional terms and with huge procurements.
- The question of quality standards for all the JMS supplies and how this is guaranteed on the part of the partner is a priority matter in JMS operations, and under the prevailing circumstances of the majority of the CBHIs, the expectation is that quality is likely to be compromised.
- In most cases the CBHIs, such as drug shop sellers, are exclusively profit motivated, with some of them extorting abnormal profit. This is very contrary to the mission of JMS. Until there is a more practical system that enables JMS to have controls against such tendencies, it will be difficult to guarantee that collaboration with CBHIs will meet the intended objectives.

5. SITUATIONAL ANALYSIS CONCLUSIONS

5.1 SUMMARY OF SITUATIONAL ANALYSIS FINDINGS

The list that follows summarizes the key findings described earlier in detail.

Activities performed by the drug shops

Out of 96 drug shop attendants, 74 percent were at the least nursing assistants. In addition to selling drugs, they perform other health-related activities, including family planning counseling, clinical diagnosis, information about drugs and health, health education talks, etc.

Existing collaborations between drug shops, VHTs, and HC staff

- Only 33 percent (27% in rural areas; 37% in semi-urban parishes) VHT members ever worked with ADS on FP counselling, mass immunization, provision of drugs, and information about drugs.
- Only 20 percent of HC staff ever worked with ADS on mass immunization and drug provision.
- Referral of patients for treatment at the HC or to buy medication at the drug shop is one general area of collaboration. However, all the referrals are informal and without any facilitation, documentation, or requests except by the patients themselves.

Challenges to existing linkages

- Over 60 percent of HC staff observed that drug shops are responsible for drug abuse in communities. Some cited selling half-doses of drugs.
- Some HC staff believed that shops and some CBHIs are responsible for delayed presentation of some patients at HCs .
- Some community members accuse HC staff and VHTs of selling HC drugs through shops.
- Unlike CBHIs, drug shops aim at maximizing profits and hence have limited collaboration.

Willingness and potential areas for collaborations

Drug shop attendants (employees and owners) were very willing to participate in activities, including:

- Provision of supplies to VHTs on credit;
- Act as hubs for health-related information;
- Mentor VHTs;
- Screen for some diseases;
- Support community activities and mobilization, including mobilizing mothers for maternal and child health interventions;
- Offer FP services.

HC staff, HUMCs, and VHTs rated the current competence of the shop attendant as wanting. However, over 70 percent of the HC staff, VHTs, and HUMCs observed that with some training the drug shop attendants could ably run these activities

5.2 Observations Based on the Situational Analysis

First, we note that the definition of the drug shops in the four districts is inaccurate in that these shops do prescribe drugs, sell drugs that they are not licensed to sell, and carry out other health-related activities, for example, family planning counseling and screening of some diseases.

Secondly, there are possibly many CBHIs and institutions that are involved in the delivery of health services to the community that we did not reach. However, most of these are project based, focus mainly on HIV/AIDS, and are potentially transient.

The CBHIs that have the greatest potential to collaborate with the drug shops include the HCs , VHTs, HUMCs, and the Herbalists. Most of the shops are manned by attendants who have at least a certificate in nursing. They are thus, more educated than the majority of the VHTs, and if they are trained further they can act as mentors to the VHT members. This is most useful in settings where the HCs are far from the community. Some drug shop attendants are already carrying out some health services beyond selling drugs, including the diagnosis and treatment of some simple illness. Additional training of the attendants will put them in a better position to deliver these services effectively.

Both the qualitative and quantitative information gathered indicate that the CBHIs are willing to collaborate with the drug shops on delivery of various health services. The VHTs, HUMCs, and HC staff favorably rated the competence and willingness of the drug shops to run health activities such as mentoring the VHTs, screening for some diseases, and acting as a hub for information on health issues. Similarly, the VHTs and HC staff strongly believe that the engagement of the drug shops in such activities will considerably ease their work.

The drug shop attendants were willing to collaborate with the VHTs and the HCs . Over 50 percent observed that it will be easy to incorporate various health-related activities into their drug shop businesses. However, they requested that the government sell drugs at a discount. This would ease their provision of drugs to the VHTs on credit whenever necessary.

The potential areas of collaboration between the drug shops, VHTs, and HCs include the provision of family planning services, community sensitization and education, streamlining the referral system, mentoring of the VHTs, and provision of drugs on credit.

6. Options Analysis Outcome

Based on analysis of the data and input gathered during the situational analysis, three options for collaboration between the drug shops and the VHTs were identified. (Note that collaboration with VHTs automatically implies collaboration with the HCs .) These options are differentiated by the number and nature of the roles to be supported by the ADS to support the VHTs, HCs , and possibly other project-based initiatives located in their communities. They appear in table 17 in the order of complexity and

the running costs on the part of the Government of Uganda (GoU) and the partners. All the options listed have similar strengths as embedded in the findings: that the drug shops are already performing most of the roles listed. All the options require the continuous training of the ADS owners and dispensers, supervision and monitoring by the DADI and possibly HC in-charges, and regular meetings convened by the HC in-charge (or designee) for the VHTs and ADS, and HC staff.

Table 17 summarizes the three options.

Table 17. Summary description of three options for collaboration

Description	Activities by the ADS	Some requirements	Opportunities	Cost implications	Threats	Risks
Option 1: **Information hub and community mobilization**	• ADS act as hubs for health-related information, including distribution of IEC materials (see community mobilization role) • Mentor VHTs • Mobilization and support community activities such as mobilization of mothers for maternal and child health interventions (e.g., immunizations & deworming, attendance of ANC & delivery at HCs, newborn care, malaria treatment, child nutrition & diarrheal treatment), health promotion, etc. • Active referral of patients	• Regular trainings of the attendants & owners • Regular meetings of the attendants & VHTs (facilitated by the HC in-charge) • Availability of IEC materials • Continuous inspection by DID (supported by HC in-charges for regular checks)	• Takes advantage of the roles already being played by the drug shops • Both the CBHIs, HC staff and drug shops are willing to collaborate • Proximal location to the clients in the community, including ADS being nearer to the VHTs than the HCs	• Relatively inexpensive option • Involves no added costs to be met by the ADS	• Lack of monetary incentives • Poor coordination of activities • Limited capacity of the ADS to perform the tasks	Low risk of failure
Option 2: **FP services and community mobilization**	• Run FP services (excluding the surgical methods) • ADS act as hubs for health-related information, as in Option 1 • Mentor VHTs, as in Option 1 • Mobilization and support community activities, as in Option 1 • Active referral of patients, as in Option 1	• Same requirements as in Option 1. In addition, an improved supply chain of the contraceptives is required, e.g., through HCs to the ADS or directly from government designated (collaborating) wholesale pharmacies	Same as above	• Relatively expensive option • Involves some costs for storage and handling	• Same as above. • In addition, it may-be limited by poor storage facilities	Relatively high risk
Option 3: **Information hub, community mobilization, and drug supply**	• Provide first aid services • Provide drugs to VHTs on credit • Distribute some drugs, such as ACTs, and other health commodities for free to the community • Mentor VHTs, as in Options 1 & 2 • ADS act as hubs for health-related information, as in Options 1 & 2 • Mobilization and support community activities, as in Options 1 & 2 • Active referral of patients, as in Options 1 & 2	• Same requirements as in Option 2 (replacing contraceptives with ACTs, ITNs, common first aid consumables) • Need improved infrastructure to enable storage • Set-up of ADS associations	Same as above	Relatively expensive option	• Same as above. • In addition, it may-be limited by poor storage facilities. • Community miss-perceptions about sale of public drugs • The ADS might sell the freely acquired drugs.	Relatively high risk

7. THE PREFERRED OPTION FOR COLLABORATION

A two-day stakeholders' meeting was organized by the National Drug Authority and Management Sciences for Health on October 29 and 30, 2012, in Entebbe, with the objective of discussing in detail the research findings and available options to support the maintenance and sustainability of the ADS initiative. Stakeholders reviewed and considered the research findings and options that were available from the formative research for discussion at the first day's workshop, and the outcome of their deliberations presented the following day at the plenary meeting for final action.

At the meeting, the stakeholders determined that the best option was that the ADS collaborate with CBHIs as an information hub, community mobilization resource, and drug supply. Table 18 summarizes the preferred option.

Table 18. Best option for ADS collaboration

Activities by the ADS	Threats	Risk of failure
• Mentor VHTs • Provide first aid services • Distribute some drugs such as ACTs and other health commodities at no cost to the community • Act as hubs for information for education and health promotion • Mobilization and support community activities • Active referral of patients • Offer FP services (except surgical ones)	• Might be limited by poor storage facilities • Community misconception about sale of public drugs • The ADS might sell the freely acquired drugs	Relatively high risk

In the current set-up, the VHTs are mainly mentored and monitored by some HC staff. As noted earlier, most of the attendants in the drug shops (particularly in the ADS) have some medical background and are more educated than the VHTs. Therefore, they can support the HC staff in mentoring the VHTs and helping them to handle some cases in the community.

The mobilization and support of the community activities include health education to the community, active involvement by the nurses (the ADAS shop attendants) in management of some cases, for example maternal and child illnesses and mass immunization.

8. RECOMMENDATIONS

The stakeholders also made the following five recommendations:

1) The MoH, NDA, and professional associations should recognize the potential of ADS and support their activities related to accessing drugs in the community.
2) Advocacy activities should target the revision and expansion of the extended medicines list for drug shops to support proposed collaborations.
3) The district health team (DHO, DADI, etc.) should work together with project-based implementing partners to train, support, and supervise drug shops and other CBHIs.
4) ADS sellers should receive regular updates of their functional skills to effectively undertake the proposed roles of mentoring, treatment, patient referrals, dispensing, and health promotion in the community.
5) Community sensitization should include roles and responsibilities of the ADS, HCs, and CBHIs.

9. CONCLUSIONS

- Currently, there is limited collaboration between ADS and VHTs and HCs.
- Key CBHIs that have a potential to collaborate with the ADS include the HCs, VHTs, HUMCs, and the Herbalists.
- Among the drug shops in the four target districts, their scope of services were inconsistent and often not in accord with expected standards.
- CBHIs are willing to collaborate with the drug shops on delivery of various health services.
- Drug shop attendants are also willing to collaborate with the VHTs and the HCs, and over 50 percent observed that it would be easy to integrate this collaboration into their businesses.

10. 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 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

SDSI partners and their activity objectives as related to SDSI's goal in Uganda		
Contractor	**Activity Objective**	**Period of Performance**
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. Data collection tools

A.1: KEY INFORMANT INTERVIEW GUIDE: COMMUNITY-BASED HEALTH INITIATIVES (CBHIs)

Situational Analysis of CBHI in four Districts of Kamwenge, Kyenjojo, Kamuli and Mityana

Target: ADS, Pharmaceutical stores, Drug shops, CBHI and ADS, Dukas

September 2012

A. ARRIVAL, INTRODUCTION AND GROUND RULES (5 MINUTES):

a) Objective – to characterize Community Based Health Initiatives (CBHIs) in the district
b) Duration – 1 ½ hours

Ask for their consent to the interview – and explain that the information provided will not be identified as having come from the participant (confidentiality).

Introduction: Greet the respondent: **(Good morning, Good afternoon, or Good evening).** My name is _____ and I'm gathering information on the Situational Analysis of Community-Based Health Initiatives in this district. Introduce yourself by name and state: I'm here on behalf of the Sustainable Drug Sellers Initiatives (SDSI) project to collect information on the CBHI. Give me a few minutes of your time to ask you some questions.

Please be honest and tell me what is true for you. The information you provide will help us to compile a report whose findings will help the SDSI to understand the CBHI in this area. This discussion/ interview will last not more than 1 ½ hours and I will be recording and writing down your responses and the key points from this discussion to enable me capture the key issues properly. The information you provide will be treated with utmost confidentiality. If you are willing to participate, please let's proceed with the discussion.

B. DEMOGRAPHIC CHARACTERISTICS (20 MINUTES):

a) Could you please share with us a brief history of your business/ organization/group?
b) What are the key activities/ services you offer? *For the district staff **probe** for supervision and quality assurance of CBHIs*
c) Who are the key customers of your business/organization/group?
d) How do you get the supplies/services (drugs) to your customers?
e) What are the payment arrangements for your supplies/services?
f) Can you please share with us your management arrangements in this organization/ group or business?
g) Please share with us the staffing arrangements of your organization/ business/group and qualification of the key staff?
h) How many hours do you operate per day and how many days do you operate in a week?

C. LEGALITY AND OWNERSHIP (15 MINUTES)

a) Please share with us your legal status/registration with the relevant authority? (Ask to see certificate if available)
b) Please share with us the process and key requirements of registration with the above mentioned relevant authority if registered?
c) How often is this registration done? Is it compulsory and are there penalties in case of non-compliance?
d) If not registered what are some of the challenges for your registration?
e) Do you think there are some advantages to registration with the above authority?
f) If yes, please share with us some of these advantages?

D. COLLABORATION AND COORDINATION IN SERVICE DELIVERY (15 MINUTES)

a) What are some of the different ways your business/organization/ group could collaborate and coordinate with other organizations dealing in similar services?
b) What challenges do you expect to encounter in this kind of collaboration and coordination?
c) How can such challenges be resolved?
d) Which other organizations/individuals, etc. in this area or elsewhere do you collaborate/co-operate with in carrying out your activities?
e) Please share with us the different ways how you could support and improve the services and operations of other community based health initiatives in this district/ Uganda.
f) Do you have a reliable source of information on medical issues or drugs in your group/organization or business?
g) If yes, please share with us your sources of accurate information and which kind of information is offered by this source?
h) Do you usually offer specialized information/ services/counseling to your customers/ clients
i) Which kind of information do you usually offer?
j) What are some of the opportunities do you see that you could harness through collaboration with ADS/CBHI in your community?

E. CHALLENGES AND RECOMMENDATIONS (10 MINUTES)

a. What are some of the challenges you usually face while conducting your business/ activities/ service delivery?
b. How can such challenges be resolved in order to improve your service delivery and generally the operations of community based health initiative
c.

THANK YOU AND GOOD-BYE

A.2: KEY INFORMANT INTERVIEW GUIDE: MOH AND NDA

Situational Analysis of CBHI in four Districts of Kamwenge, Kyenjojo, Kamuli and Mityana

Target: National level partners: Ministry of Health (MoH), Districts (DDHS) and NDA.

September 2012

A. ARRIVAL, INTRODUCTION AND GROUND RULES (5 MINUTES):

a) Objective – to characterize Community Based Health Initiatives (CBHIs) in Uganda, understand their legal and operational environment as well as opportunities for collaboration to improve service delivery.
b) Duration – 1 ½ hours
c) Ask for their consent to the interview – and explain that the information provided will not be identified as having come from the participant (confidentiality).

Introduction: Greet the respondent: **(Good morning, Good afternoon, or Good evening).** My name is _____ and I'm gathering information on the Situational Analysis of Community-Based Health Initiatives in Uganda. Introduce yourself by name and state: I'm here on behalf of the Sustainable Drug Sellers Initiatives (SDSI) project to collect information on the CBHI. Give me a few minutes of your time to ask you some questions.

Please be honest and tell me what is true for you. The information you provide will help us to compile a report whose findings will help the SDSI to understand the CBHI in this area. This discussion/ interview will last not more than 1 ½ hours and I will be recording and writing down your responses and the key points from this discussion to enable me capture the key issues properly. The information you provide will be treated with utmost confidentiality. If you are willing to participate, please let's proceed with the discussion.

B. BASIC CHARACTERISTICS :

a) What are some of the community based health initiatives in Uganda/District?
b) What kind of work are they involved in?
c) What are some of the organizations that support CBHI in doing their work?
d) What linkages exist/ do you foresee between CBHIs, health facilities and drug shops?
e) How can ADS be involved in community work?
f) What are some of the challenges that the CBHIs face while undertaking these particular roles?

C. COLLABORATION AND PARTNERSHIPS

a) In your view could you please share with us the role of CBHI in facilitating community access to drugs/health care services in Uganda/District?
b) How are these roles mentioned above supported by the Ministry of Health/ NDA/District?
c) Do you see any opportunities on how these roles could be supported by the ministry/ NDA/District?
d) In your view, is there potential for collaboration between the CBHIs, the Ministry and any other partners? If so, what are some of these collaborations and with which partners?

D. POLICY REGULATIONS AND OPERATIONAL FRAMEWORK

a) What are the operational legal and policy framework guiding the operation of these CBHI in Uganda/District?
b) How does this policy framework support or constrain the work of CBHI especially with regard to use of community medicines in the country/District?

c) What are the roles of the Ministry /NDA/District in the operation of the CBHI?
d)
e) What can be done to improve the operations of the CBHI for effective service delivery in Uganda/District
f) What are some of the policies/ regulations that are most likely to affect the operation of the ADS and any other CBHI?

THANK YOU AND GOOD-BYE

A.3: KEY INFORMANT INTERVIEW GUIDE: NATIONAL LEVEL PARTNERS: PACE, MC, JMS , UHMG, MEDICAL BUREAUS AND OTHER NGOS

Situational Analysis of CBHI in four Districts of Kamwenge, Kyenjojo, Kamuli and Mityana

TARGET: NATIONAL LEVEL PARTNERS: NATIONAL LEVEL PARTNERS: PACE, MC, JMS , UHMG, MEDICAL BUREAUS AND OTHER NGOS

September 2012

A. ARRIVAL, INTRODUCTION AND GROUND RULES (5 MINUTES):

d) Objective – to characterize Community Based Health Initiatives (CBHIs) in Uganda, understand their operational environment as well as opportunities for collaboration to improve service delivery.
e) Duration – 1 ½ hours
f) Ask for their consent to the interview – and explain that the information provided will not be identified as having come from the participant (confidentiality).

Introduction: Greet the respondent: **(Good morning, Good afternoon, or Good evening).** My name is _____ and I'm gathering information on the Situational Analysis of Community-Based Health Initiatives in Uganda. Introduce yourself by name and state: I'm here on behalf of the Sustainable Drug Sellers Initiatives (SDSI) project to collect information on the CBHI. Give me a few minutes of your time to ask you some questions.

Please be honest and tell me what is true for you. The information you provide will help us to compile a report whose findings will help the SDSI to understand the CBHI in this area. This discussion/ interview will last not more than 1 ½ hours and I will be recording and writing down your responses and the key points from this discussion to enable me capture the key issues properly. The information you provide will be treated with utmost confidentiality. If you are willing to participate, please let's proceed with the discussion.

B. BASIC CHARACTERISTICS

a) Could you please share with us a brief history of your organization?
b) What are the key activities/ services you offer?
c) Who are the key groups/clients your organization serves?

C. COLLABORATION AND COORDINATION IN SERVICE DELIVERY

a) What are some of the key community based health initiatives you are aware of in your operational areas?
b) What are the key activities of these CBHI that are being provided in your area of operation?
c) Is there any Community Based Initiative that your organization/institution supports or partners with in Uganda?
d) If yes, what kind of community based initiatives does your organization/ institution support/ partner with in Uganda?
e) Have there been any health related initiatives that your organization/institution has been supporting?
f) If yes, what are they?
g) Where and when have they been implemented?
h) What is the status of the implementation/ activities of these initiatives to-date?

i) Please share with us the key collaborative arrangements that exist between your organization and the stated CBHI in your operational areas
j) What are some of the challenges do you face while collaborating with these CBHI
k) How can these CBHI be supported to improve on their service delivery and health care in general?
l) In your view are there opportunities for collaboration between the ADS and these CBHIs? If yes in which areas can the CBHI and ADS collaborate with each other?

THANK YOU AND GOOD-BYE

10.1 KEY INFORMANT INTERVIEW GUIDE: HEALTH CENTRES

Situational Analysis of CBHI in four Districts of Kamwenge, Kyenjojo, Kamuli and Mityana

Target: Health Centre In-charges:

September 2012

A. ARRIVAL, INTRODUCTION AND GROUND RULES (5 MINUTES):

c) Objective – to characterize Community Based Health Initiatives (CBHIs) in the district
d) Duration – 1 ½ hours
e) Ask for their consent to the interview – and explain that the information provided will not be identified as having come from the participant (confidentiality).

Introduction: Greet the respondent: **(Good morning, Good afternoon, or Good evening).** My name is _____ and I'm gathering information on the Situational Analysis of Community-Based Health Initiatives in this district. Introduce yourself by name and state: I'm here on behalf of the Sustainable Drug Sellers Initiatives (SDSI) project in your district to collect information on the CBHI. Give me a few minutes of your time to ask you some questions.

Please be honest and tell me what is true for you. The information you provide will help us to compile a report whose findings will help the SDSI to understand the CBHI in this area. This discussion/ interview will last not more than 1 ½ hours and I will be recording and writing down your responses and the key points from this discussion to enable me capture the key issues properly. The information you provide will be treated with utmost confidentiality. If you are willing to participate, please let's proceed with the discussion.

B. COLLABORATION AND COORDINATION IN SERVICE DELIVERY

a) What is the current situation regarding community access to medicines in your facility? (***Probe on****: availability of medicines with the focus on sources and accessibility in the catchment area*
b) Are there any Community Based Organizations implementing health initiatives in your catchment area? If yes, what are they?
c) For each of the mentioned CBOs, please ask for its status (i.e. whether it is operating/active or not), nature of activities, geographical coverage, achievements so far, and partners supporting the initiative
d) In your view, what is the role of ADS/Drug Shops in facilitating the community access to health? If there is any role mentioned, then probe for benefits brought by ADS and any possible negative consequences
e) Is there any collaboration between ADS/Drug shops and your health facility in health service delivery in this community? If yes, what kind of collaboration? ***(Probe on specific issues like health education, vaccination, family planning, supervision, updating, training, reporting etc.)***.

f) What are the benefits observed from this collaboration? Any challenges observed? How can this collaboration be improved?

g)

h) If there is **no** collaboration between ADS and CBOs, ask: In your view, is there any need for creating collaboration between ADS and CBOs? If there is a need, ask why? And, what would be the areas for this collaboration? (***Probe on specific issues like health education, vaccination, family planning, supervision, updating, training, reporting, etc.)***

i) Is there any link between CBOs and your health facility? If yes, what are the linkages about?

j) Is there any collaboration between CBO(s) and your health facility in the delivery of health services in this community? If yes, what kind of collaboration?

k) What are the benefits that have been observed from this collaboration? Any challenges observed?

l) If there is **no** collaboration between CBOs and a health facility, ask: In your view, is there any need for creating collaboration between CBOs and your health facility? If **there is** a need, ask why and how?

m) Is there any link between ADS/Drug shops, health facility and CBO? If yes, what are the linkages about? If there **are no** linkages, is there any possibility of creating the linkages between ADS, health facility and CBO?

n) If there is no collaboration between ADS, health facility and CBO, ask: In your view, is there any need for creating collaboration between ADS/Drug shops health facility and CBO? If there is a need, ask why?

o) And, what would be the best and potentially sustainable approach for this collaboration? *(Probe on specific issues like health education, vaccination, family planning, supervision, updating, training, reporting, etc.)*

THANK YOU AND GOOD-BYE

A.3: Tool 5: Focus Group Discussion Guide.

A. SELECTION AND INSTRUCTIONS:

a) Arrange focus groups of village leaders/ local leaders, opinion leaders and local community members (facilitated by two research assistants where one will facilitate the discussion and another take notes)
b) Make sure that the group is mixed i.e. different categories of community leaders e.g. Village chief, PDC Chairperson, local counselors, different CBO leaders, extension workers, health volunteers, teachers, etc.
c) Ensure the number of people is between 8 and 12 people in each group: more will be very difficult to manage and give little chance for everybody to participate.

B. ARRIVAL, INTRODUCTION AND GROUND RULES – 10 minutes

a) Ask members to introduce themselves by job or organizational position.
b) Pass around a sheet of paper for people to record their names and positions.
c) Explain objective – to find characterize the different Community based health initiatives in their community b) to understand their levels of awareness about the community based health initiatives, their experiences with the initiatives and also provide recommendation for linkages and improvement.
d) Duration – 1 ½ hours
e) Ground rules - we want to hear from everyone

Introduction: Greet the respondents: **(Good morning, Good afternoon, or Good evening).** Our names are_____ and we are gathering information on the Situational Analysis of Community-Based Health Initiatives in this district. Introduce yourselves by name and state: We are here on behalf of the Sustainable Drug Sellers Initiatives (SDSI) project in Uganda to collect information on the CBHI. Give us a few minutes of your time to ask you some questions.

Please be honest and tell us what is true for you. The information you provide will help us to compile a report whose findings will help the SDSI project to understand the CBHIs in this area. This discussion/ interview will last not more than 1 ½ hours and we will be recording and writing down your responses and the key points from this discussion to enable us capture the key issues properly. We ask you introduce yourselves and write down your names on this piece of paper. We want all of you to contribute and the information you provide will be treated with utmost confidentiality. If you are willing to participate, please let's proceed with the discussion.

C. CBHI CHARACTERIZATION (25 MINUTES)

Introduction – *Our aim is to understand their levels of awareness about the community based health initiatives, their experiences with the initiatives and also provide recommendation for linkages and improvement.*

a) Ask about any knowledge of drug shops, and the services they offer
b) Introduce the ADS initiative and how it is working towards improving the shops
c) What are some of the community based health initiatives that you know of in this community?

d) How do these initiatives in your community mentioned above operate?
e) Please share with us some of the major services these CBHI offer to your community
f) What are the major differences between the above mentioned communities based initiatives and the main stream health centres?
g) Ask about linkage/ relationship with the health centres
h) Ask about any existing collaboration with drug shops
i) Ask about possibility of linking with drug shops and potential for collaboration
j) As about any for any foreseen challenges with the collaboration
k) What are some of the advantages and disadvantages of going to those CBHIs than going to the health centres in your community?

D. LEGALITY AND REGISTRATION (25 MINUTES)

a) Do you think these CBHI are legal in your perspective? Do they display their registration certificates in their premises?
b) Do you feel secure going to these CBHI in your community?
c) Please share with us the qualification and capacity of personnel who offer services in these CBHI
d) Do you know some of the legal requirements/regulations for the CHBI to operate in your area? (**Probe** for compliance with these legal requirements by CBHI operators)
e) What can be done to support these CBHI to legally exist and be recognized in your community?

E. CHALLENGES AND RECOMMENDATIONS (30 MINUTES)

a) Please share with us the major challenges faced by the CBHI in in this community
b) Please share with us some of the challenges faced by the community while accessing services from CBHI in your community
c) Please share with us the different ways in which these CBHI can be supported to better offer you service in your community

THANK YOU AND GOOD-BYE