Sustainable Drug Sellers Initiatives Uganda

Supportive Supervision Final Evaluation Report

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About SDSI

The Sustainable Drug Seller Initiatives (SDSI) is a programme that builds on MSH's Strategies for Enhancing Access to Medicines (SEAM) and East African Drug Seller Initiatives (EADSI) programs. The program's goal is to ensure the maintenance and sustainability of the public−private drug seller initiatives in Tanzania and Uganda and to introduce and roll out the initiative in Liberia.

Contents

Acronyms and Abbreviations

ADDO	Accredited Drug Dispensing Outlet
ADS	Accredited Drug Shop
ALU	artemether/lumefantrine
DADI	District Assistant Drug Inspector
EADSI	East African Drug Sellers Initiative
M&E	monitoring and evaluation
MOH	Ministry of Health
MSH	Management Sciences for Health
NDA	National Drug Authority
PHC	primary health care
RDT	rapid diagnostic test
PSU	Pharmaceutical Society of Uganda
SEAM	Strategies for Enhancing Access to Medicines
SDSI	Sustainable Drug Seller Initiatives
STG	standard treatment guideline
STI	sexually transmitted infection
WHO	World Health Organisation

Background

The Bill & Melinda Gates Foundation provided Management Sciences for Health (MSH) with a three–year grant to continue its efforts in Africa to involve private drug sellers in ensuring access to essential medicines. The Sustainable Drug Seller Initiatives (SDSI) programme builds on MSH's Strategies for Enhancing Access to Medicines (SEAM) and East African Drug Sellers' Initiatives (EADSI) programmes. Those programmes 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 new programme'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.

Through its work in the three countries, SDSI expects not only to expand access to medicines and treatment in additional geographical areas, but also to validate 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.

EADSI developed a strategy for adapting Tanzania's Accredited Drug Dispensing Outlet (ADDO) model for Uganda and the concept was introduced successfully in Kibaale district. Results from the project evaluation showed that district health officials, shop owners, and sellers embraced the Accredited Drug Shop (ADS) initiative. The objective of SDSI is to enhance the ADS's long-term sustainability, its contributions to community-based access to medicines and care, and its ability to adapt to changing health needs and health system context.

STRIDES for Family Health, a USAID-funded programme in Uganda—implemented by MSH in partnership with Jhpiego, Meridian International, and the Ugandan organisations Communication for Development Foundation and the Uganda Private Midwives Association—recognises the importance of the private sector in the delivery of reproductive health, child survival, and family planning services, and has been supporting selected private drug sellers to improve and increase access to quality essential services in remote areas. STRIDES used an adapted EADSI[1]/SDSI private-sector drug seller model package to train and promote the accreditation of the private drug sellers in STRIDES programme districts, using the ADS standards approved by the National Drug Authority (NDA).

From 2012 to 2013, SDSI, working with STRIDES, expanded the ADS programme to four other districts in Uganda. These are Kamuli, Kamwenge Kyenjonjo, and Mityana districts. To enhance sustainability, a number of quality improvement interventions were added to the ADS programme. These add-on interventions include a peer-driven supportive supervision exercise. The supportive supervision exercise was based on the use of peers to support the ADS sellers to make continual improvements. The peer strategy was chosen over the traditional forms of supervision such as inspection because of its benefits in increasing participation and involvement of the ADS sellers in identifying areas of improvement, prioritising key issues, and designing and implementing interventions to address or resolve the issues.

With regards to implementation, the ADS Association in each district selected peer supervisors, supported the peer supervisors, collected summary observations and findings from the peer supervisors, summarised the peer supervisor reports, provided feedback to the peer supervisors, monitored and assessed the performance of the peer supervisors, and then submitted their report

[1]http://www.drugsellerinitiatives.org/countries/uganda/

to Pharmaceutical Society of Uganda (PSU). In turn, peer supervisors prepared the supervision plans, communicated the supervision schedule to ADS sellers, visited the ADS to support the sellers, summarised the findings, and submitted the report to the district ADS Association.

PSU through the Regional Representative and the Central Technical Team and in consultation with the ADS Association leadership and SDSI in-country team designed the strategy, prepared the tools, reviewed the peer supervisor selection criteria, developed training materials, trained and mentored the peer supervisors, supported the ADS Association leadership, and provided regular updates on the progress of the supervision to the SDSI in-country team and the PSU Council.

Peer supervision visits to ADS were made every two to three months. Each visiting schedule was completed within one and a half weeks. Support supervision was based on physical interactions. The supportive supervision strategy was implemented as a pilot only in Mityana district. To evaluate the effect of the supportive supervision strategy, a monitoring and evaluation (M&E) strategy was put in place by the SDSI team working with Pharmaceutical Systems Africa, Uganda, Ltd. To be able to measure the effect of the supportive supervision strategy on key ADS performance, specific indicators were measured before the supportive supervision was implemented and after it had been running for 10 months. For the purpose of comparison, the same indicators were measured in Kyenjonjo, an ADS district where the supportive supervision strategy was not being implemented. Data collection in Mityana and Kyenjonjo was done simultaneously.

Measures of effectiveness were compared within the intervention district (pre/post) and in the control district (pre/post), and comparisons of changes made between the two districts. Differences between within-district pre/post changes were taken to be the change resulting from the supportive supervision intervention. This report presents the final evaluation of the supportive supervision intervention.

Objective

The objective of this exercise was to conduct an evaluation with the aim of determining the extent to which peer supportive supervision sustains the gains of the ADS programme. Pharmaceutical Systems Africa, a US- and Uganda-based organisation with expertise in pharmaceutical M&E, was contracted to conduct this evaluation. Activities related to the evaluation included baseline and endline data collection exercises in the intervention district, Mityana, where supportive supervision was implemented, and in a control district, Kyenjonjo. Specifically, evaluation engagement had the following objectives:

1. Review the supportive supervision strategy, monitoring tools, and ADS evaluation matrix to identify additional indicators necessary for evaluation of the supportive supervision strategy

2. Review and update data collection tools to be used for the endline evaluation of the supportive supervision programme

3. Pre-test and refine data collection instruments and data entry tools

4. Collect endline data

5. Analyse the data and prepare a final evaluation report

Methodology

The supportive supervision data collection exercise sought to collect data in a number of practice areas. These areas included infrastructural and vicinity cleanliness, case management practices, and availability of key medicines, including those used for reproductive health programmes.

To collect the relevant data, teams of data collectors visited 61 (60 at baseline) randomly selected drugs shops in the intervention district, Mityana, and 60 (26 at baseline) shops in the control district of Kyenjonjo. A significantly smaller number of shops was included in the data collection exercise in Kyenjonjo at baseline because a number of shops were still converting to ADS at the time of data collection.

During the data collection exercise, data collectors introduced themselves to the attendant in the shop and explained the purpose of their visit. Where there was reluctance to co-operate, a pre-prepared letter from NDA was presented. For information on product availability, the data collectors asked the attendant to show them the drugs on the list, one by one. When it was determined that a product was in stock and not expired, it would be recorded as available. In addition to collecting availability data, a general (inspection type) survey was conducted in/at each shop visited. This allowed the data collectors to gather information on various practices, services, and a shop's infrastructural characteristics. Data were collected on paper tools and entered into Excel spreadsheets at the end of each day of data collection. Copies of the tools used for the data collection exercise are presented in the annex at the end of this report.

Findings

Number of Drug Shops Visited

Sixty (60) and 26 shops were surveyed in Mityana and Kyenjonjo districts, respectively, before the supportive supervision intervention was implemented. At baseline, a number of shops in Kyenjonjo were still converting from Class C medicine stores to ADS; hence, a lower number of ADS than required could be located. After the programme had been running for 10 months, 61 and 60 shops were visited Mityana and Kyenjonjo, respectively. Table 1 gives a summary of the number of drug shops visited.

Table 1: Number of drug shops visited before and after supportive supervision

District	Number of shops visited before	Number of shops visited after
Mityana	60	61
Kyenjonjo	26	60
Total	86	121

Shop Interior and Vicinity Cleanliness and Hygiene

Table 2 shows drug shops' characteristics and the number of shops that met certain levels of cleanliness and hygiene standards.

Table 2: Percentage of drug shops that met cleanliness and hygienic standards

Shop/Location Characteristic	Percentage of shops			
	Mityana before (N=60)	Mityana after (N= 61)	Kyenjonjo before (N=26)	Kyenjonjo after (N=60)
Vicinity is free of stagnant water	97%	97%	92%	88%
Vicinity is clean	92%	100%	81%	92%
Vicinity has adequate waste disposal system	73%	97%	62%	95%
Latrine is clean	71%	98%	65%	95%
Drug shop has running water within	90%	95%	92%	98%
Walls and floors are clean	90%	95%	65%	85%
Windows and ceilings are intact	92%	85%	77%	93%

With regards to shop interior and surrounding areas' cleanliness, the percentages of shops that met expectations in Mityana, the intervention district, at baseline was encouraging. The introduction of supportive supervision could have helped shop owners and attendants to maintain (and in some instances improve standards even further). However, Kyenjonjo, the control district, recorded significant improvements in standards during the study period. Improvements in standards in Mityana could, therefore, have been the continued improvements in standards following the introduction of the ADS programme or could have resulted from the supportive supervision. Also, the fact that during the period when the supportive intervention strategy was being implemented in Mityana a number of shops were still being accredited in Kyenjonjo could have resulted in the observed improvements in Kyenjonjo. A second evaluation, perhaps after another year of

implementation of the supportive supervision strategy, could help establish whether the sustenance in standards observed in Mityana was a result of the supportive supervision.

Storage and Inventory Management Practices

With regards to storage and inventory management practices, most drug shops met the required standards before and after the intervention. In both districts, shelves were clean and tidy; the shops were free of pests and rodents, and medicines were protected from light. In addition, most shops recorded all sales in standardised dispensing logs. Most attendants also stated that their shops were staffed by trained dispensers at most times, although this could not be verified. When practices between the two districts were compared, practice standards for Kyenjonjo were generally lower than those for Mityana at baseline, and this pattern was maintained at the end of the supportive supervision intervention. In Mityana, store and inventory management practices appeared to improve marginally following the supportive supervision intervention. However, the same improvement was observed in Kyenjonjo. Table 3 presents comparative values for managing stores and inventory across shops in Mityana and Kyenjonjo before and after the implementation of supportive supervision in Mityana.

Table 3: Percentage of drug shops that met a certain level of inventory and storage management practices

Storage and Inventory management characteristic	Percentage of shops			
	Mityana before (N=60)	Mityana after (N=61)	Kyenjonjo before (N=26)	Kyenjonjo After (N=60)
Shelves were clean and tidy	93%	92%	73%	78%
The drug shop was free of insects, pests, and rodents	93%	90%	77%	68%
Food items were kept separate from medicines	91%	97%	81%	87%
There were readable labels on shelves	20%	59%	8%	3%
Shop layout allowed for free movement	93%	95%	88%	84%
Medicines were protected from direct sunlight	93%	98%)	85%	83%
Expired or damaged items were kept separate	93%	93%	50%	65%
All sales were recorded in a standard dispensing register	78%	89%	77%	68%
Shop had stock outs of tracer items in the previous month	40%	87%	50%	95%
Shop had had some expiries during the previous month	37%	23%	8%	13%
The shop was manned by a trained dispenser	88%	77%	100%	82%
The dispensing counter was clean and tidy	86%	90%	73%	87%
Dispensing envelopes were available	100%	98%	85%	85%

Case Management

Management of Uncomplicated Malaria in Children

With regards to the management of uncomplicated malaria in children, after the introduction of the ADS programme in each of the districts, every case of suspected malaria is supposed to be tested with a rapid diagnostic test (RDT). However, at baseline only 28% and 22% of suspected malaria cases were tested with an RDT in Mityana and Kyenjonjo, respectively. Following the supportive supervision intervention in Mityana, the percentage of cases tested with an RDT increased to 54%. In Kyenjonjo, the control district, the percentage of suspected malaria cases that were tested with an RDT increased from 22% at baseline to 51% at endline. It is therefore unclear whether the increase in the number of suspected malaria cases tested was the result of the supportive supervision

intervention or not. The increase in the numbers tested could well have resulted from a combination of the supportive supervision and other interventions occurring in ADS districts, which include routine inspection by relevant authorities, or the natural maturation of the ADS programme. Also, at baseline a high number of shops reported that RDTs were not available. Improved availability of RDTs at endline could have led to the improved usage of the tests rather than the intervention per se. Figure 1 shows the number of suspected malaria cases tested with an RDT.

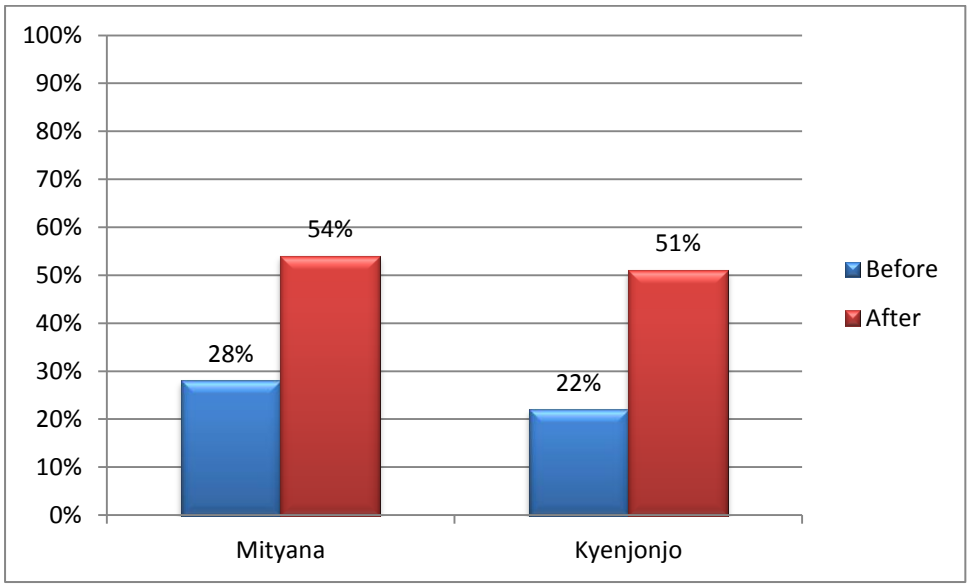

Figure 1: Percentages of suspected malaria cases tested with RDTs

At baseline, the majority of suspected malaria cases were given the appropriate first-line treatment for uncomplicated malaria, artemether/lumefantrine (ALU); 69% and 72% in Mityana and Kyenjonjo, respectively. At endline, the score increased from 69% to 92% in Mityana and from 72% to 100% in Kyenjonjo. Because improvements were observed in both districts, one cannot conclude with certainty that the improved practices in Mityana were due to the supportive supervision alone. Figure 2 summarises the management of uncomplicated malaria while Table 4 gives more information on the case management of uncomplicated malaria in both districts.

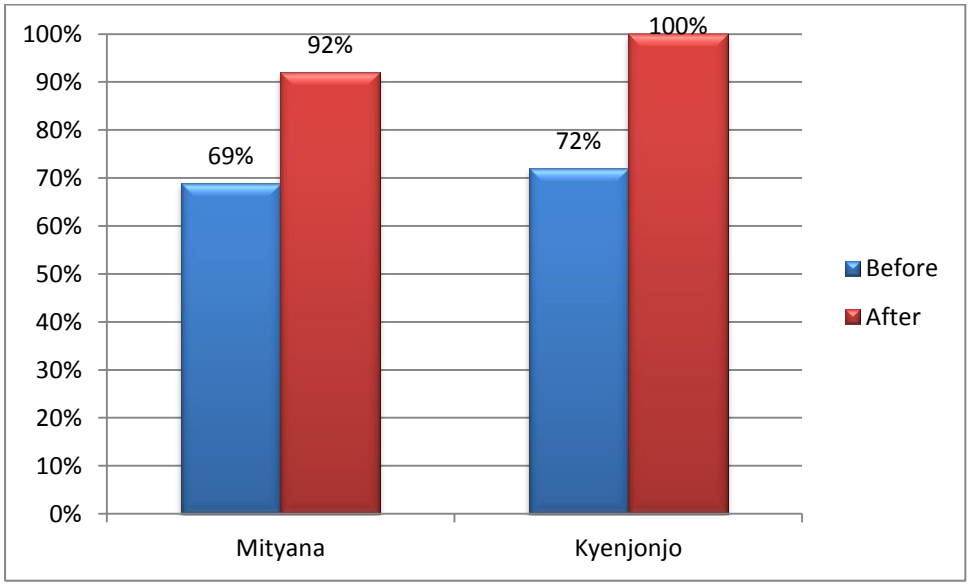

Figure 2: Percentages of suspected malaria cases treated with ALU

Table 4: Management of uncomplicated malaria in children

Category	Number			
	Mityana before	Mityana after	Kyenjonjo before	Kyenjonjo after
Number of drug shops that reported at least one suspected malaria case	45/60	61	13/26	60
Total number of suspected of malaria cases (symptomatic)	310	478	130	81
Number tested with an RDT	86/310	255/478	29/130	41/81
Number of positives (if tested)	80/86	228/255	29/29	41/41
Received artemether/lumefantrine	214/310	436	93/130	81/81
Number of clients referred	28	4	1	0

Management of Non-bloody Diarrhoea in Children

For the management of non-bloody diarrhoea in children, the recommended treatment is oral rehydration solution (ORS) plus zinc tablets. With regards to adhering to the recommended treatment at baseline, 64% of cases in Mityana and 68% in Kyenjonjo met this goal. At endline, these percentages increased to 95% and 76% in Mityana and Kyenjonjo, respectively. Clearly, the sale of zinc and ORS increased in Mityana following supportive supervision, but an increase was also observed in Kyenjonjo, although a more modest one. It is thus not conclusive whether supportive supervision alone was effective in improving dispensing practices.

Regarding the management of non-bloody diarrhoea in children, at baseline, 21% and 47% of children presenting with non-bloody diarrhoea in Mityana and Kyenjonjo, respectively, received antibiotics to manage the condition. Clinically and according to the Uganda national treatment guidelines, antibiotics are not indicated for non-bloody diarrhoea and ADS dispensers were trained on this. At endline, in Mityana, 6% of non-bloody diarrhoea cases received antibiotics, compared to 57% in Kyenjonjo. This seems to indicate that something different was happening in Mityana versus Kyenjonjo with regards to the management of non-bloody diarrhoea. Figures 3 and 4 give the percentages of the number of cases with non-bloody diarrhoea that were managed with ALU and antibiotics. Table 5 gives more information on the management of non-bloody diarrhoea in children in the two districts before and after the intervention.

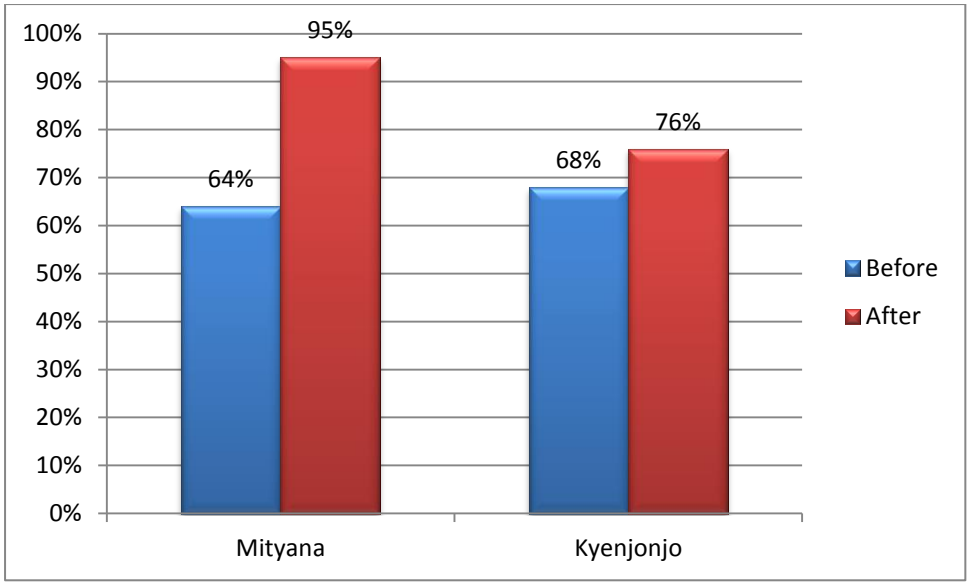

Figure 3: Percentages of diarrhoea cases that received ORS + zinc

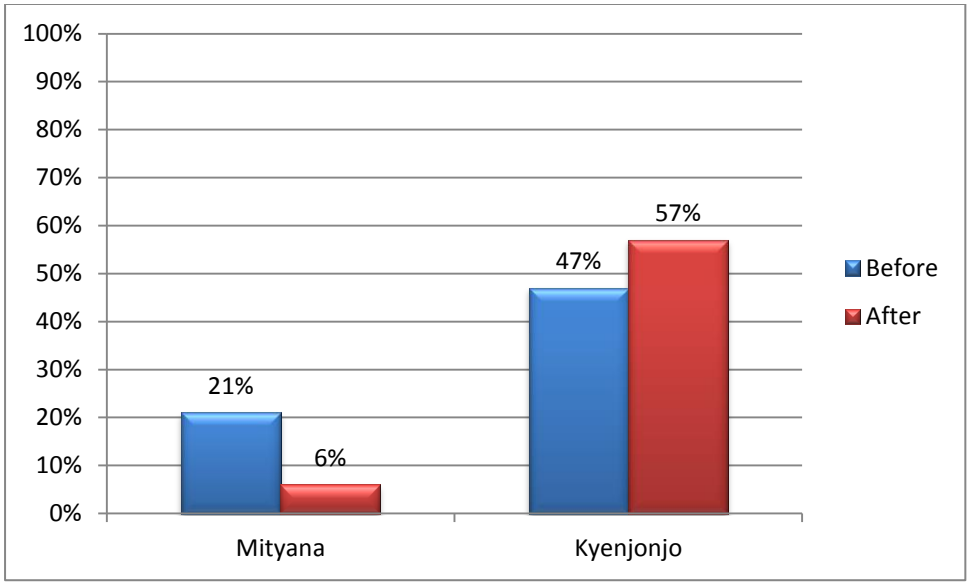

Figure 4: Percentages of diarrhoea cases that received given antibiotics

Table 5: Management of non-bloody diarrhoea in children

Category	Number			
	Mityana before	Mityana after	Kyenjonjo before	Kyenjonjo after
Presented with non-bloody diarrhoea	129	348	62	21
Received Zinc and ORS	83/129	330/348	42/62	16/21
Received oral antibiotics	27/129 (21%)	23/348	29/62	12/21
Was referred	6	1	2	0

Management of URTI in Children

Upper respiratory tract infections (URTIs) are caused by bacteria or viruses of the upper part of the respiratory system, which is above the lungs. These infections may affect the throat (pharyngitis),

nasopharynx (nasopharyngitis), sinuses (sinusitis), larynx (laryngitis), trachea (tracheitis), or bronchi (bronchitis). They usually present as cold, sore throat, flu and cough, with the most common presentation being as a common cold. A common cold is an illness that usually cures without any specific treatment except supportive management (symptomatic management). Symptoms of common colds include runny nose, sneezing, nasal and sinus blockage, headache, and sore throat. Clinically, for the management of the common cold and other minor URTIs, antibiotics should not be used. The management should involve alleviation of the cold symptoms, including analgesics for pain and fever, antihistamines and cough preparations for nasal congestion, and cough syrup and lozenges for sore throat.

Although ADS dispensers were trained on the appropriate management of the common cold, at baseline, 43% and 56% of mild URTI cases in Mityana and Kyenjonjo, respectively, were treated with an antibiotic. At endline, 79% of cases were sold an antibiotic for the management of uncomplicated URTI in Mityana, and 81% were given antibiotics in Kyenjonjo. This seems to indicate that the general management of URTI was getting worse with the maturity of the ADS programme. Supportive supervision did not appear to reduce the use of antibiotics for managing URTI. Figure 5 and Table 6 provide more information on the management of URTI in children in the two districts.

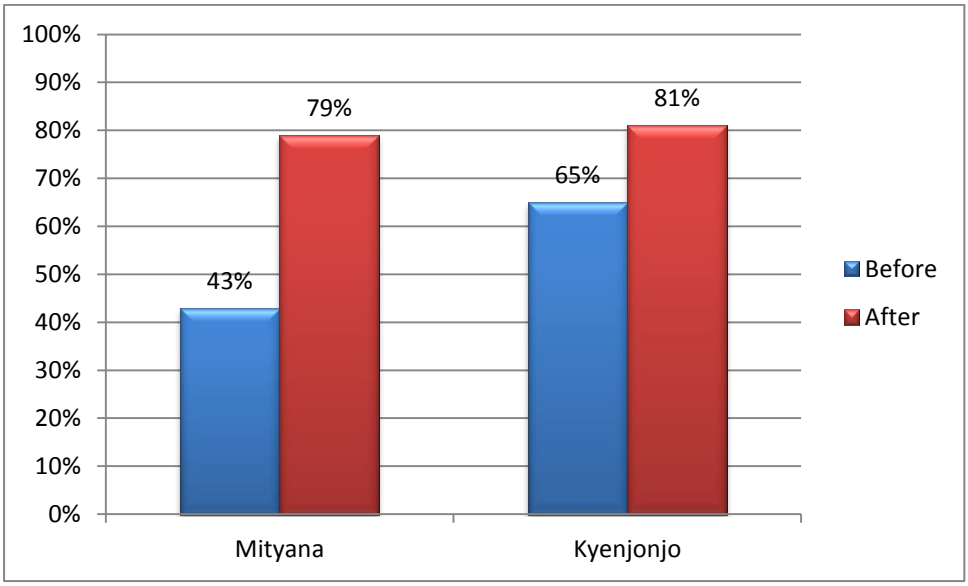

Figure 5: Percentages of URTI cases in children that received antibiotics

Table 6: Management of URTI in children

Category	Number of shops (%)			
	Mityana before	Mityana after	Kyenjonjo before	Kyenjonjo after
Presented with signs and symptoms of the common cold	464	451	132	143
Received antibiotics	199/464	258/451	74/132	117/143
Received other medicines	204 /464	148/451	80/132	116/143
Was referred	2	2	0	0

Recognition of Danger Signs

Recognition of danger signs is important to ensure that children who are in danger are referred so that they receive the critical care that they need. At baseline, approximately 60–70% of ADS dispensers in both Mityana and Kyenjonjo recognised the danger signs that would require a referral

for a child. In comparison, ADS dispensers in Kyenjonjo seemed to perform worse than those in Mityana. Supportive supervision reinforced the message that children who present with danger signs need immediate referral. In addition to this, on-site training on the danger signs ensured that only those who actually needed referral were being referred. At the project endline, more dispensers could recognise danger signs in a child. However, an improvement in this trait was also observed in the control district. It is thus not conclusive whether supportive supervision led to an improved ability to recognise danger signs among dispensers. Table 7 gives the numbers and percentages of ADS sellers who recognised specific danger signs.

Table 7: Recognition of danger signs among dispensers

Danger sign	Number (%) who recognised danger sign			
	Mityana before (N=60)	Mityana after (N=61)	Kyenjonjo before (N=26)	Kyenjonjo after (N=60)
Cough for 14 days or more	73%	64%	61%	50%
Diarrhoea for more than 7 days	73%	56%	73%	53%
Blood in stool	73%	92%	65%	90%
Convulsions	80%	95%	69%	87%
Not able to eat or drink	71%	95%	54%	92%
Vomiting everything child eats	70%	95%	62%	93%
Sucking in of the stomach when breathing	65%	98%	73%	93%
Very sleepy child or unconscious	63%	100%	65%	93%
Too thin a child	63%	92%	54%	90%
Presence of edema	63%	100%	54%	92%

Product Availability

The majority of drug shops in both districts were well stocked before and after the intervention. Key products such as ALU, ORS, and paracetamol were readily available in ADS across both districts before and after the intervention. Because the availability of key medicines was equally high in both districts, the sustenance of good stock levels of key medicines cannot be conclusively attributed to the supportive supervision alone. Table 8 presents availability figures for 40 tracer items in both districts.

Table 8: Percentage of drug shops with tracer items in stock before and after supportive supervision

Tracer medicine	Availability (%)			
	Mityana before (N=60)	Mityana after (N=61)	Kyenjonjo (N=26)	Kyenjonjo After (N=60)
Albendazole 200mg	78%)	89%	69%	80%
Amoxicillin capsules 250mg	100%	98%	96%	93%
Amoxicillin Suspension 125mg/5ml	95%	93%	96%	97%
Artemether +Lumefantrine tablets 20/120mg [24's]	97%	95%	92%	93%
Aspirin (acetylsalicylic acid) tablets 300mg	27%	16%	54%	45%
Benzyl benzoate lotion 25%	32%	36%	31%	35%

Tracer medicine	Availability (%)			
	Mityana before (N=60)	Mityana after (N=61)	Kyenjonjo (N=26)	Kyenjonjo After (N=60)
Benzyl penicillin Injection 1MU vial	2 (3%)	0%	35%	8%
Chlorhexidine gluconate solution 20%	20%	7%	23%	28%
Chlorpheniramine tablets 4mg	92%	87%	100%	97%
Chloroquine phosphate tablets 300mg base	15%	10%)	31%	22%
Ciprofloxacin tablets 500mg	98%	98%	96%	97%
Combined oral contraceptive pill {cycle}	93%	90%	100%	92%
Male condoms {3's}	98%	97%	92%	85%
Cotton wool 100 g	96%	90%	92%	62%
Co-trimoxazole tablets 480mg	100%	97%	96%	98%
Co-trimoxazole suspension 240mg/5ml	8%	75%	100%	88%
Doxycycline capsules 100mg	96%	90%	96%	95%
Erythromycin tablets 250mg	88%	97%	88%	92%
Ferrous sulphate tablets 200mg	73%	72%	65%	60%
Ferrous/folic acid tablets	35%	23%	42%	32%
Folic acid tablets	63%	49%	42%	52%
Glucose infusion 5%, 500ml bottle	0%	2%	15%	5%
Ibuprofen tablets 200mg	98%	97%	100%	100%
JIK household antiseptic 500ml	27%	18%	35%	37%
Mebendazole tablets 100mg	92%	87%	96%	92%
Metronidazole 200mg	95%	98%	100%	100%
Nitrofurantoin 100mg	43%	34%	46%	37%
Nystatin pessaries 100,000 IU {each pessary}	82%	82%	58%	70%
Nystatin suspension 100,000 IU	28%	23%	54%	75%
ORS	96%	98%	88%	93%
Paracetamol 500mg tablets	100%	100%	100%	100%
Procaine Penicillin fortified 4MU	0%	0%	38%	5%
Quinine Injection 300mg/ml	0%	0%	27%	2%
Quinine tablets 300mg	80%	80%	81%	85%
Salbutamol tablets 4mg	78%	75%	100%	90%
Sodium chloride 0.9%, 500ml bottle	3%	0%	15%	8%
Surgical gloves	83%	84%	85%	75%
Sulphadoxine + pyrimethamine	33%	26%	77%	58%

Tracer medicine	Availability (%)			
	Mityana before (N=60)	Mityana after (N=61)	Kyenjonjo (N=26)	Kyenjonjo After (N=60)
tablets 525mg				
Tetracycline eye ointment 1%, 3.5g	83%	62%	77%	82%
Zinc tablets 20mg	31.8%	93%	68%)	85%

Discussions and Recommendations

In general, ADS in Mityana appeared to have improved their practice following the introduction of peer supportive supervision. However, with the exception of the management of diarrhoea, improvements in practice were also observed in the control district. It is thus not possible to categorically state that supportive supervision was the cause of the improved or sustained performance. A longer implementation period of the strategy would allow for a more conclusive evaluation of whether supportive supervision adds value to the ADS programme.

As mentioned above, ADS in Kyenjonjo recorded improved practice between October 2013 (baseline data collection period) and August 2014. The observed improvements could have resulted from the natural maturation process of the ADS programme or other interventions such as inspections. It is also not far-fetched to suggest that improvement in practice in other ADS districts such Mityana could filter through to Kyenjonjo, leading to improved performance across the board. In hindsight, adding a qualitative component to the evaluation would have helped establish reasons why performance in Kyenjonjo seemed to improve drastically over a period of one year.

Only one indicator purported to measure dispenser knowledge: ability of the dispenser to recognise danger signs in children. At baseline, between 60% and 70% of dispensers in both districts recognised key danger signs in children. At endline, this increased to 80–90% in both districts. Since recognition of danger signs is a critical area that could save children's lives, it is important that this knowledge continue to be reinforced, either through the supportive supervision approach or other such interventions.

In both districts, most shops had the majority of key items in stock. However, this situation would need to be maintained for the population to continue to have confidence in the programme. Supportive supervision is one strategy that could ensure that owners, peers, and the community would continue to focus on the success and sustainability of the programme. Ideally, this evaluation should have added a component to evaluate the added cost to the ADS programme of including a supportive supervision component. However, due to resource and time constraints, this was not feasible.

Annex 1: Supportive Supervision Baseline Data Collection Tool

Supportive Supervision Evaluation Tool

Instructions: This tool is to be used to collect information following the implementation of supportive supervision intervention in ADS. The data collectors should note the name of the shop, the location of the shop, and the name of the person interviewed. Since the information collected will be compared to that collected at baseline, data collectors should ensure that the information collected is accurate.

Date _____

Name of drug shop _____

Name of person in charge _____

Phone # of in-charge _____

District _____

Village _____

County _____

Sub-county _____

Name of data collector _____

Shop Location and Hygiene

1.	Is the drug shop vicinity free of stagnant water?	**Yes** ☐ **No** ☐
2.	Is the drug shop vicinity clean?	**Yes** ☐ **No** ☐
3.	Does the drug shop vicinity have an adequate waste disposal system?	**Yes** ☐ **No** ☐
4.	Is the latrine for use by the drug shop clean?	**Yes** ☐ **No** ☐
5.	Is there running water within the drug shop?	**Yes** ☐ **No** ☐
6.	Are the walls and floors clean?	**Yes** ☐ **No** ☐
7.	Are windows intact and ceilings/roofs in good condition (*no leakages, etc.*)?	**Yes** ☐ **No** ☐

Storage and Inventory Management

8.	Are shelves clean and tidy?	**Yes** ☐ **No** ☐
9.	Is the drug shop free of insects, pests, and rodents?	**Yes** ☐ **No** ☐
10.	Are food items kept separate from medicines?	**Yes** ☐ **No** ☐
11.	Are labels on all shelves readable?	**Yes** ☐ **No** ☐ **N/A** ☐
12.	Does the layout in the drug shop allow free movement of staff?	**Yes** ☐ **No** ☐
13.	Are medicines arranged in a way that allows for free air circulation?	**Yes** ☐ **No** ☐
14.	Are medicines protected from direct sunlight?	**Yes** ☐ **No** ☐
15.	Are items expiring first placed in front of those expiring after? *(In situations where only one item per product is being kept, indicate N/A.)*	**Yes** ☐ **No** ☐ **N/A** ☐
16.	Are expired or damaged items kept separate from other stock?	**Yes** ☐ **No** ☐
17.	Are all sales recorded in a sales book?	**Yes** ☐ **No** ☐
18.	Are all purchases recorded in standard book?	**Yes** ☐ **No** ☐
19.	During the past month, has the drug shop had any stock outs of tracer items? (see list below)	**Yes** ☐ **No** ☐
20.	Did any products in the shop expire during the last month?	**Yes** ☐ **No** ☐

Human Resources, Dispensing Practices, and Facility Regulation

21.	During the last week was the shop staffed by a trained dispenser at all times?	**Yes**	☐
		No	☐
22.	Is the dispensing counter clean and tidy?	**Yes**	☐
		No	☐
23.	Are dispensing envelopes available in the drug shop?	**Yes**	☐
		No	☐
24.	Did the facility receive inspectors during the past six months?	**Yes**	☐
		No	☐
25.	Did the facility receive peer supervisors during the past six months?	**Yes**	☐
		No	☐
26.	Did the facility conduct at least one self-assessment during the past six months?	**Yes**	☐
		No	☐

Case Management

27. Management of Malaria *From the dispensing log, indicate the number of children under 5 years of age that fall into each of the categories on the right during the preceding 30-day period.*	**Category**	**Number**
	Suspected of malaria (symptomatic)	
	Tested with an RDT	
	Number of positives (if tested)	
	Received artemether/lumefantrine	
	Received other drugs	
	Was referred	
If testing was not done, please indicate the reason why it was not done.		

28. Management of Non-Bloody Diarrhoea *From the dispensing log, indicate the number of children under 5 years of age that fall into each of the categories on the right during the preceding 30-day period.*	**Category**	**Number**
	Presented with non-bloody diarrhoea	
	Received zinc and ORS	
	Received oral antibiotics	
	Was referred	
	Received other drugs	
If zinc and ORS were not given, please indicate the reason why.		

29. Management of URTI in Children *From the dispensing log, indicate the number of children under 12 years of age that fall into each of the categories on the right during the preceding 30-day period.*	**Category**	**Number**
	Presented with signs and symptoms of the common cold	
	Received antibiotics	
	Received other medicines	
	Was referred	

30. Were there any patients who were referred last month? **Yes** ☐ **No** ☐

31. Danger Signs

Can the seller identify danger signs in children that should be referred.

Sign	**Tick if to Be Referred**
Cough for 14 days or more	
Diarrhoea for more than 7 days	
Blood in stool	
Convulsions	
Not able to eat or drink	
Vomiting everything child eats	
Sucking in of the stomach when breathing	
Very sleepy child or unconscious	
Too thin a child	
Presence of edema	

Product Availability

32. Does the drug shop have the following products in stock?

#	Drug Name	Available		If not available, indicate why			
		Yes	No	Expired	Off market	Slow sales	Other
1	Albendazole tablet 200mg						
2	Amoxicillin capsule 250mg						
3	Amoxicillin suspension 125mg/5ml						
4	Artemether + lumefantrine tablet 20/120 mg [12 + 12]						
5	Aspirin (acetyl salicylic acid) tablet 300mg						
6	Benzyl benzoate lotion 25%						
7	Benzyl penicillin injection 1MU						
8	Chlorhexidine gluconate solution 20%						
9	Chloroquine phosphate tablet 300mg base						
10	Chlorpheniramine tablets 4mg						
11	Ciprofloxacin tablets 500mg						
12	Combined oral contraceptive pill						
13	Males condoms						
14	Cotton wool 100mg						
15	Co-trimoxazole suspension 240mg/5ml						
16	Co-trimoxazole tablet 480mg						
17	Doxycycline capsule/tablet 100mg						
18	Erythromycin tablet 250mg						
19	Ferrous sulphate tablets						
20	Ferrous/folic acid tablets						
21	Folic acid tablets						
22	Glucose infusion 5%						
23	Ibuprofen tablet 200mg						
24	JIK household antiseptic 500mL						
25	Mebendazole tablet 100mg						
26	Metronidazole tablet 200mg						
27	Nitrofurantoin tablets 100mg						
28	Nystatin pessary 100,000 IU						
29	Nystatin suspension 100,000 IU						
30	ORS						
31	Paracetamol tablet 500mg						
32	Procaine penicillin fortified 4MU						
33	Quinine injection 300mg/ml						
34	Quinine tablets 300mg						
35	Salbutamol tablets 4mg						
36	Sodium chloride infusion 0.9%						
37	Surgical gloves						
38	Sulphadoxine + pyrimethamine tablet 525 mg						
39	Tetracycline eye ointment 1%, 3.5g						
40	Zinc tablet 20mg						