Minutes from SDSI Uganda Dissemination Meeting

August 20, 2014

Hotel Africana, Kampala

NDA welcome- Helen

- Introduced ADS program, implementing districts, highlighted importance especially in rural areas, thanked Bill & Melinda Gates Foundation and MSH.

Stephen Lwanga- MSH

- Overview of MSH CPM work
    - SURE
    - SCMS
    - SDSI- Work with private sector drug sellers to improve stock, dispensing, and management of drug shops. And providing bridge in availability of drugs in private sector.
- MSH is ready and willing to be associated with initiative in Uganda. We don't see this as a closing of the door of this initiative, but it's moving from one room to another to continue to work with private sector drug supply in this country
- Sustainability of ADS initiative is important; partners with government in providing drugs to citizens and residents needing medical support in this country.
- Welcome, thanks for coming and hope by the end of the day we will know which direction we should take with this initiative

Aziz Maija- Meeting Objectives (see slides)

Lubowa Nasser- ADS background and progress (see slides)

Loi Gwoyita- Background on SDSI and summary of results (see slides)

Remarks from Guest of Honor and official opening of the workshop- by Commissioner Quality Assurance- Dr. Henry Mwebesa Representing Minister of Health; acting Director General (read MOH speech)

- Welcomed TZ and US delegate; recognize USAID and WHO support
- We need to continue to make interventions necessary to provide health for people in Uganda
- Gov't adapted public private partnerships to improve delivery of health care with an aim of increasing access to health in rural communities.
    - 80% of licensed pharmacies are located in urban populations which leaves rural populations underserved
    - Many global initiatives to improve access to treatment, including private sector
    - Having medicines available is only half the battle. A problem is delivery of these medicines

- NDA has made tremendous efforts to ensure population of UG has access to safe, efficacious, and quality medicines
- With funding from the Gates Foundation and NDA, with support from MSH, initiated ADS initiative in 2009 in Kibaale. Through additional support from the Gates Foundation and STRIDES, ADS has been implemented in 4 additional districts to help increase access. (Commissioner is from Kyenjojo, so was pleased by this)
- NDA will adapt GIS and mobile technology. Grateful for technology to advance medicines regulation
- MOH was happy to learn that NDA was recognized by NEPAD as regulatory center for excellence.
    - NDA has potential to inspire for global excellence and MOH will continue to support NDA in this endeavor.
- Implementing a new initiative presents challenges and we can learn from challenges and move forward. This is why we are all here. We want to address challenges that will bring a sustainable ADS model that will ultimately provide medicines to underserved areas.
- Hope you can open/exchange ideas for what we can do better to increase medicines and access to pharmaceuticals in Uganda.
- By end of this meeting I want you to leave here inspired, but with more than just ideas.
- I hope we'll come up with complete recommendations on maintenance and sustainability of ADS program in Uganda
    - When we look back on this day we'll say it was the beginning of the journey in this country
    - MOH will want to receive recommendations of this meeting so he can follow up and be an active participant.
- Acknowledged NDA and SDSI/MSH/Gates Foundation
- Two key objectives for the meeting:
    - Present the work from strategies
    - And discuss results and make recommendations for next steps

<u>Contractor presentations—Session 1</u>

Sustainable training of ADS sellers: a case for institutionalization of ADS Training

- Presented by Makerere University also on the behalf of PSFU
- The institutions (IIHS and FINS) also made presentations.
- Notes on presentations (highlights/information not in slides)
    - IIHS—very good presentation; principal was a dynamic presenter
        - Said overwhelming demand for the course and the waiting list is full
        - Appreciated supportive supervision from MUK and MSH.
    - FINS-
        - Reiterated that there's a lot of demand for the training—keep getting calls asking when the next training will happen (group 3)
        - Highlighted that trainees' ability to pay for the course was really a challenge

Facilitating the formation of drug seller associations and strengthening their capacity

- Presented by CIDI
- Notes on presentations (highlights/information not in slides)
    - Shops improved premises because it is a requirement for association membership
        - People want to be member of association because there are benefits/incentives of joining, so they improve shop premises
        - Highlighted DHO/DADI role in working with associations—attended association meetings and workshops/opened meetings so ADS understood they are active/approachable/trustworthy people.

ADS peer supportive supervision model to improve quality of services

- Presented by PSU
- Average time per shop was 3.4 hours
- Supervision emphasized that medicines should be dispensed rationally, so no medicines for malaria should be dispensed without RDT. However, limited availability of RDT prevented sellers from following this guidance.
- Training of peer supervisors was 3 days in classroom and 1 day in field. Should be opposite—1 day in classroom and 3 days in the field.

Session 1 Discussion

Q1- from Medicines & Health Services Monitoring Unit- There was a school that was running an institute but he wasn't accredited/recognized by Ministry of Education. Are ADS curriculum improved by Ministry of Education? MHS monitors drug shops and they find people who don't have papers or they have papers, but they hadn't actually been trained. Who makes sure everyone has the right credentials? If need minimum of nursing assistant to qualify and MOH isn't training nursing assistants, who will be qualified for training?

Q2-MSH SURE staff (Anthony)- have talked a lot about drug shops in 4 districts, but what have we done to bring on board pharmacists in these districts, especially peer supervision?

Q3-What will you do about training funding and duration? Who will pay the bill for sustainability of training. Also, how will we deal with access to drug shops in rural areas? Rural areas are less profitable for shop owners, so who will open there?

Q4- Patrick G1—G1 has been involved with marketing/branding since 2009. How are we balancing volunteerism with mandatory association membership? People join associations based on common beliefs, so in a sense it shouldn't be mandatory. However, he understands that joining an association can improve quality services, which is mandatory. Why are public gov't institutions sluggish in picking up training?

Q5—UNICEF, Flavia—If you go to very rural settings you will find drug shops. If the sellers aren't trained there will be problems. Thinks it was a good achievement that 38 trainees were willing to pay 600,000UGX at FINS, but was surprised that so many were willing to pay that high price. Private sector works based on incentives so need to emphasize benefits of acceditaiton (such as associations) so drug shops see added benefits of accreditation and seek the training. Training needs to be mandate of

owners and sellers. Also need to see how we can make the training cheaper. Drug shops are becoming like little clinics with all the services they provide, like RDTs. Can we change name from drug shops to something more like a clinic?

Session 1 Answers to Discussion Questions

MUK

- Certifying papers of nursing assistants will be responsibility of NDA
- ADS training certificate is certificate of attendance, not certificate of qualification.
- Pharmacies—during the training, we linked sellers with pharmacies in districts so they know where they can get supplies. Encouraged pharmacies to come and talk to the sellers.
- Extending training period v. affordability of training—institutions had some upfront costs. With time and experience cost may come down. Residential nature of training pushes cost up
- Profitability v. access—always emphasize that you're providing a service but you also don't want your business to run out.

PSU

- RDTs in drug shops—based on primary health care concept, we see more decentralization of health care. Good idea for drug shops to dispense medicines for malaria after testing with RDT.
- Peer approach is good because the person is from a similar setting so they have a good cultural understanding of the seller and can effectively supervise
- Engaging stakeholders—engaged all stakeholders and explained to each one what was in it for them so they understood why the activity was important and decided to support activity.
- After peer supervisors, ADS welcomed inspection visits because they were prepared.

CIDI (associations)

- Drug shop location v. access—group leadership in Kyenjojo is trying to negotiate with DHT to stop licensing many drug shops in one area and instead to identify areas that need medicines and encourage drug shops there. This would improve access in those areas.
- Trainings—might it be possible that ADS training could be given in mainstream nursing schools? Drug shops are already owned by nursing assistants, so could curriculum be integrated into those curricula so that they are prepared to be ADS sellers?

Nasser

- 90% of people dispensing medicines in drug shops are nursing assistants—they've done senior 4, studied nursing course certificate for 1 year, and some have been working in district hospitals. When training opportunity comes, they are upgrading their knowledge. Some people haven't been trained in a while, so they get updates on medicines, which is good. Also they get training on medicines handling.
- VHTs have been working in villages—they don't have any medical background, but they are utilized and handle ACTs, amoxicillin, and ZINC because that is needed to face the situation on the ground.

- NDA is doing medicines rescheduling and also revising the law. One component of new act will be new drug schedules.
- Need to balance regulatory enforcement and supervision

Session 2 Presentations

ADS-VHT Linkage Strategy

- Presented by CIDI
- Discount for family members was suggested by ADS themselves
- Need to streamline supervision by VHTs and ADS because now there are a number of supervisory agencies, which are under umbrella of MOHSW. Would also help with data reporting because we could streamline reporting/data collection

Role of Consumers in monitoring ADS performance

- Presented by HEPS—good presenter.
- Sub-county leaders didn't even know what their rights were. So it helped them as individuals but also helped them to monitor the drug shops.

Addressing ADS profitability through product diversification

- Presented by SDSI (Loi Gwoyita)

Session 2 Discussion

Q1: Health rights consumer perspective—important to caution what types of non-medical products could be sold in ADS. We don't want to open the list up to anything (e.g. cigarettes, alcohol). How do proprietors deal with expired drugs because it would be profitable to sell them?

Q2-DHO Kibaale—we used to have distribution of essential medicines by whoever, but having training of sellers and owners was really important; it was a skills development and training for service delivery. Objective was improving access and availability of medicines in the community and to minimize quacker practitioners in the community. ADS linkage to facilities has improved so that's good. Public health facilities have grown in number along with the population. Issues around sustainability—should have more players come in so that ADS are sustainable. We also need to figure out how to increase policing. Certification—there are fake trainings that happen, and these need to be prevented. There has been meaningful participation by consumers in Kibaale in the past; G1 had a big public ceremony to open the ADS and ministers came to participate. Profitability—could also look at cosmetics and fashion items to be sold in the shops. Summary—it's good work and good development, thank you.

Q3 Flavia UNICEF—before ADS sellers treated pneumonia, did they take a breath rate? For ADS-VHT linkage, how do you guard against practice that VHTs could always refer to ADS instead of treating with medicines and then share the profit? HEPS presentation—can you explain consumers' perspective that

access changed during the initiative? Regulatory authority will close shops that are unlicensed or of poor quality; is there a plan for helping these shops to improve or are we simply going to close the shops, which then decreases access?

Q4- Alex from UNICEF- good idea to link ADS to VHTs—any reservations that VHT will refer to ADS instead of health facility? Need to take this into account in guidelines for referral.

Q5- CHAI—profitability—admires the idea of diversifying sales, but bulk of drug shop revenue will still come through drug sales. Approach taken to optimize profit through selling nutritional supplements—that approach could be used with drug suppliers. Has any work been done to link associations with importers and distributors of medicines? JMS is here at the meeting—we should invite more private medicine suppliers into the conversation to facilitate pooled procurement.

Q6-Jafary—What CIDI and HEPS presented are things that we (Tanzania) are looking for to improve ADDO sustainability. What is your insight for moving initiative into a larger scale beyond just HEPS and CIDI, in a country like TZ where program is operating nationally and also in Uganda where moving beyond 4 districts?

Q7- WHO Dr. Joseph—VHT-ADS—where are VHTs being asked to refer? To public health facilities or ADS? Need to better define this. It is great that ADS are being used for public health activities. Government is desperate to get basic information from private facilities, so this is something we could leverage in terms of the linkage. Community role: want communities to participate, but perhaps some of the things that we're asking the communities to do may not be included in the role of the regulators. Diversification of products: Nutrition program in the ministry needs to know about diversification activity. A reported challenge from morning session on associations was that associations may not see themselves as relevant, but product diversification is an example of relevance.

Q8- Issue of reporting—we need better referral forms to capture the referrals and data collection. (People really agreed with this idea and asked that it be captured as a recommendation).

Session 2 Answers to Discussion Questions

CIDI- referral—we understand that VHTs are supposed to refer to government facilities. VHTs know when drugs are not delivered to the health facility. If there is a sick child, will VHT give information to go to health facility if they know there are no drugs? Or will they refer to ADS? We still need to lay down a clear referral pathway to resolve these issues. But generally, VHT mandate will be to refer to health facility. To address Flavia's question: VHTs are motivated by providing a service, not monetary incentives. So we don't think it will be a problem. Linking associations to drug suppliers—yes associations are buying drugs in bulk and sharing cost of transport and negotiate better price. Have seen this happening in groups in Kyenjojo.

Loi—associations are already doing pooled procurement as associations get strengthened. Kind of items that can be stocked in drug shops—we drew up a list of items that were allowable that could be sold

with a health message. ADS can't just sell anything. The list was approved by NDA, and this doesn't include random commodities.

HEPS—access indicator that seemed to decrease. Might be related to communities' understanding of what was allowed to be stocked. Sustainability and scaling up initiatives—rights based approach engaging users is key, but also need to involve national, district, and sub-county level government. This is critical. Regulators need to collaborate with scouts for effective monitoring.

Aziz- in terms of VHT-ADS linkage, we didn't pilot yet, but these issues are critical issues so as we finalize the strategy we need to be aware of them and make sure we figure out the issues. Maybe referral for danger signs would be to public health facility, and for medicines would be to ADS. Recommendation that has become clear is that the issue of VHT-ADS-Health facility referral flowchart needs to be further explored and decided upon.

Nasser—NDA does sensitization meetings and explains realities of licensure so that they are more encouraged to become licensed. NDA will take away medicines for unlicensed shops, but say that once you follow the regulations, you can open your shop and operate legally. Quacks can become business owners if they hire qualified sellers.

Session 3 Presentations

Role of GIS mapping in regulation of drug outlets

- Presented by Uganda Bureau of Statistics

Technological innovations to improve regulatory capacity over drug shops: Experience from Tanzania

- Presented by Jafary Liana- MSH Tanzania

Session 3 Discussion

Q1- how do you ensure the security of the tablets in the field? It could get stolen or lost; worth a lot of money. Have owners expressed any hesitations about being mapped because of taxation issues?

Q2- NDA—NDA is in the process of procuring new netbooks for all inspectors; IT person said they have necessary RAM/specifications for GIS mapping. Will have 25 new inspectors. Happy that MSH has championed GIS. NDA is taking it to a higher level—want to map all drug shops and pharmaceutical outlets. Will now think about procuring PDAs or tablets to map rather than just Garmin because they have more functions. Could technology also help pharmacovigillance?

Session 3 Answers to Discussion Questions

Jafary—experience sharing—the reason that we (Tanzania) participate in this meeting is to share experiences and see if it's applicable for your setting. This technology is ready for Uganda to be adapted. Taxation issue- with time, after explanation and engagement, owners realized that TFDA had no connection with revenue authorities. Fear is there, but it hasn't been prohibitive. Security of tablets

hasn't been a problem. They are kept at NDA offices, given out for the inspection for the day and then returned. Yes, could help with pharmacovigilance. Drug shops can report on whatever you'd like. The system is built, you just have to modify or develop the specific applications of interest.

Closing remarks—WHO Dr. Joseph—Most NDA colleagues are attending another equally important meeting so they weren't able to be here today. WHO was invited to be involved with this project. Dr. Joseph serves on steering committee of ADS project. First interacted with this similar project in Tanzania 10 years ago. ADS programming is learning from ADDO program in Tanzania. Thanks Jafary for his support. Dr. Joseph is convinced that the objectives of this initiative are noble. Central objective is to improve access to medical products in underserved areas. Last week he was in remote place, and in 2 districts he saw 1 drug shop. Situation is dire. Objective to improve access to medicines in the very remote areas is needed. Objectives of this meeting have been met. It has been a good meeting. Discussion has been well summarized and there is clear way forward. Thanks MSH for leading this efforts and making direction clear. Would like to thank MSH for providing support. In last steering committee meeting it was mentioned that the project is one of the best practices. NDA supports and we think it'll be very useful. Would like to request MSH not to leave, but to continue to work together to support this project. Called the meeting to a close.