GIC Limited

Uganda's Accredited Drug Shops
Business Analysis and Recommendations

June 2011

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Summary of Key Findings and Recommendations

This summary highlights our key findings and recommendations. The summary follows the same structure of the report, which is arranged in three parts. Part One is the review of the Profitability and Sustainability of the Accredited Drug Shop business model with recommendations for how it can be strengthened and developed. Part Two contains a brief numerical model for the successful operation of Drug Shops. Part Three contains options for the implementation of a nationwide scale up of the ADS model, recommendations for steps to be taken in advance of the scale up and a business model for the scale up implementation.

This report was prepared by GIC Limited (www.giclimited.com).for Management Sciences for Health in June 2011. The report is based upon a review of documentation and field trips to Tanzania and Uganda. During the field trips a series of dialogues were conducted with key stakeholders and trading data was collected to enable a review of the profitability and sustainability of the businesses taking part in a pilot regulation of Accredited Drug Shops in Kibaale District, Western Uganda. A total of 12 ADS owners were met representing about 20% of the total currently registered in the Kibaale pilot. The owners' shops were spread geographically around the District in seven different villages from five sub counties.

Part One: Profitability and Sustainability of Accredited Drug Shops

There are currently an estimated 21,000 Drug Shops (out of which only about 5000 are licensed by NDA) engaged in supplying the market for pharmaceuticals in Uganda, an average of one shop for every 1,620 people. It is probable that the majority of these shops trade illegally in some Class "B" drugs which are currently restricted for sale through pharmacies. This level of business activity demonstrates a vibrant demand for pharmaceuticals.

The demographics of Uganda's population and the health profile of the country suggest that demand for pharmaceutical supply is likely to remain strong and grow substantially in the coming years.

The ADS model in Kibaale shows that owners are able to operate a mark up multiplier of around 2.4 times wholesale prices with a gross margin of around 50%. We found that the business model is therefore capable of generating sustainable profits through a range of operating costs.

There are several options available to improve ADS profitability and sustainability through:

- broadening the product range to reduce over-reliance on pharmaceutical sales;

- developing pharmaceutical product sales in the future with the addition of more permitted items;
- participate in social welfare programmes;
- respond to developments that may occur in health insurance.

The principal threats to the ADS business model would appear to be a dramatic and sustained improvement in government pharmaceutical supply to hospitals and clinics, which are the ADS' main competitor, or an unstable regulatory regime.

Access to loan finance was not perceived as a problem by the ADS owners whom we met and access to trade credit terms had been improved significantly in the pilot by the inclusion of the drugs previously supplied illicitly.

We have recommended that ADS owners should be encouraged to add permitted non-pharmaceutical product to their range in order to reduce dependence on only one product type; to receive support to implement the good management practices discussed during their training such as stock management practice to avoid stock outs; to work together through the establishment of trade associations; to participate in social welfare campaigns.

The additional costs of complying with the new regulation piloted in Kibaale do not seem to present any fundamental difficulty for Drug Shop owners.

Part Two – A Brief Numerical Model

The numerical model takes the form of a Trading Profit & Loss account for which three alternative versions were prepared to illustrate the break even point of the businesses across a range of the costs and sales figures that we were given.

Data was collected from the ADS owners about their most popular selling items, their daily sales and operating costs. Wholesale prices were obtained for the best selling items and the margin between buying and selling prices calculated. The result shows that the ADS model operates at around 50% gross margin which is a good basis for making net profits providing the owners are able to control their operating costs.

The most significant operating costs were rent, wages and transport. A few ADS owners owned their premises, but most rented. Rents varied with the size of village and the shop location within it. Wages were determined largely by the manning levels required for the pilot, which included an "in charge" post between the owner and the dispenser. We did not meet anyone holding this post during the field trip, although most owners

said that they did employ someone in this role. We recommend that the need for this role should be reviewed before a nationwide scale up. A similar post was removed in the ADDO model in Tanzania before the nationwide scale up.

The transport costs were incurred travelling to and from Kampala to purchase stock. Although a number of wholesale pharmacists had opened in the District most ADS owners used them to buy small top up stocks, buying their main supplies from Kampala.

Part Three – Options and Recommendations for a Nationwide Scale Up and a Business Plan.

We recommend a District-led rather than a centrally driven approach to implementation based on the Tanzanian experience and Uganda's established preference approach to government.

The National Drug Authority of Uganda is the most appropriate body to lead the nationwide scale up. However, it lacks resources and expertise needed for this type of large scale project and we recommend that its structure and resources should be reviewed to identify the gaps that need to be filled and the additional resources in finance and people that it will need to carry through the scale up successfully.

The Ministry of Health and the NDA should together identify sources of national and international funding to support the scale up.

The NDA will need to complete the report, which we understand is currently being prepared, on the outcome of the Kibaale pilot, with a recommendation to the Ministry of Health for its adoption across the country. The NDA will also need to draft the new regulation policy for the Ministry of Health and to accompany this with a fully costed scale up implementation plan.

The NDA should run the nationwide scale up through five regional offices each of which should be provided with two teams of three trainers to carry out the training.

It is proposed that the Districts with the highest number of registered Drug Shops should be selected to be the first to be invited to engage in the new regulatory regime as the number of Drug Shops serves as a reasonable proxy for the demand for pharmaceutical product.

District stakeholders from the community, government, business and healthcare providers should be targeted first to inform them of the impending change in pharmaceutical retail regulation, to explain the benefits of the new approach and the steps that will be needed to move to it. Districts should then be encouraged to apply to the Regional NDA offices to join the process.

We recommend that the sensitisation process for the general public in the pilot scheme should be reviewed. We suggest that the use of radio advertising should continue to be the main communication channel whilst the use of painting the exterior of buildings in the colour scheme and logo of the ADS should be confined to the building of ADS owners who successfully obtain accreditation under the new scheme, thus improving relevance and visibility.

The staffing of ADS should be reviewed, in particular the post of "In charge", the purpose of which is unclear, but which adds considerably to an ADS owner's staff costs and appears to add around $2 million to the cost of the scale up training.

The qualification requirement of ADS staff should be reviewed to assess if sole reliance on UCE is appropriate. It appears to us possible that good candidates who possess the necessary reading, writing and arithmetic skills may not hold UCE qualification, in which case it may be preferable to have a simple test to administer to candidates.

We propose several alternative approaches to the scale up training. We suggest that forty trainers should be employed by the NDA in teams of three for fixed term contracts of two years and trained at Makerere University Department of Pharmacy.

We suggest that the number of trainees per course should be expanded to forty from the current thirty. If this were combined with the elimination of the "in charge" post and in consequence the training programme reduced to a four week cycle from five, then it should be possible to provide a capacity of 10,400 places in a two year period which should enable 48 ADS to be registered in each District.

A permanent residual training capacity will have to remain after the scale up is complete to cater for replacements and additions to be trained.

There is some evidence from Tanzania to suggest that owners are willing to spend more money than they are currently being asked to pay on acquiring the accreditation by contributing towards the cost of training staff. We explored this idea in our dialogue with owners and we received a very positive response, most owners were quite willing to make a contribution to the training costs.

The possibility of owners making a contribution towards training costs should be considered in developing the scale up plans. It might be possible to offer a tapering charge scheme with a number of the first DS owners applying for participation being offered free training and then a sliding scale being applied for later joiners.

1. Introduction

The contents of this report are based upon an analysis of the pilot of a new regulatory regime for pharmaceutical retailers known as Accredited Drug Shops (ADS) following a one year pilot in Uganda's Kibaale District, supported by the East African Drug Seller Initiative. This report was undertaken to determine if the ADS business model is profitable and sustainable for its owners, with recommendations for its strengthening or improvement, before a decision is taken to scale up nationwide. A numerical model of the business and plans for the scale up were also requested.

The analysis was undertaken by GIC Limited of London, on behalf of Management Sciences for Health (MSH) of Arlington Virginia, according to the Scope of Works (SoW) reproduced in Appendix One.

The analysis was undertaken in three stages. Stage One was a thorough review of all the reports, information and data provided by MSH to GIC, from the parent Accredited Drug Distribution Outlet (ADDO) model developed in Tanzania and the preparations for the establishment of the pilot ADS initiative in Uganda. Stage Two was a three-day visit to Tanzania for familiarisation with the operation of the ADDO model. The third Stage was a field trip to Uganda to conduct a series of dialogues with national stakeholders and data collection, specified in the SoW, upon which the analysis and recommendations contained in this report rest.

This report is set out in three parts. Part One reports our findings into the profitability and sustainability of the ADS business model. Part Two is the brief numerical business model of the ADS that was required as deliverable three of the SoW. Part Three contains the Options and Recommendations for implementing a nationwide scale up of the ADS initiative and a Business and Implementation Plan for the scale up, which were required as the fifth and sixth deliverables in the SoW. Finally, there are four Appendices.

2. Acknowledgements

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3. Background

The purpose of the East African Drug Seller Initiative (EADSI) is to find ways to improve access to good quality pharmaceutical products that are affordable, with reliable availability, and with informed services for the rural poor.

A significant obstacle to improving access has been a shortage of trained pharmacists, with a particularly acute shortage in rural areas. This shortage of pharmacists, coupled with a regulatory regime which restricted the sale to the public of some of the most popular pharmaceutical products to pharmacies, has seen the emergence of an illicit supply to meet the demand that could not be satisfied legally.

There are several problems with the illicit trade in pharmaceuticals:

- product quality is often poor with counterfeit or expired items in the supply chain;
- the quality of advice and knowledge of product use is often poor leading to inappropriate product being supplied and taken in incorrect dosages;
- the price of product tends to be high with no open competition available to customers;
- it proves to be nearly impossible to regulate effectively because of a lack of resources on one hand and the moral hazard of, in some cases, withdrawing the only source of medication to isolated populations.

EADSI has worked to address these problems through the development of amended regulatory regimes, which permit the retail of a wider range of pharmaceuticals, coupled with providing training to the vendors and an improvement in the hygiene of the premises and practices of drug sellers.

In 2003 the Government of Tanzania developed a new retail pharmaceutical regulatory regime through the ADDO programme. This model has proved to be successful and self-sustainable.

In 2009 the Government of Uganda launched a pilot Accredited Drug Shop (ADS) programme in Kibaale District based upon the ADDO model but with some differences.

The pilot in Kibaale district has been run under the auspices of the National Drug Authority of Uganda with advice and support provided by Management Sciences for Health (MSH).

The National Drug Authority reports to the Ministry of Health, and has responsibility for regulating the supply chain of pharmaceutical products to the market. This responsibility

extends from inspecting the quality of pharmaceutical products imported into the country down through the supply chain to the retail outlets supplying the general population.

Pharmaceutical products are classified into one of three categories "A", "B" or "C" depending upon their nature and the care needed in prescribing or taking them. The "A" category is the most tightly restricted. The "B" list contains most of the antibiotics and other items such as injectables which are restricted to be sold only in pharmacies. The "C" category drugs are the least tightly restricted. The largest number of outlets regulated by the NDA is the Class "C" Drug Shops, which under the current regulation can be owned and operated by anyone without any particular medical knowledge or training. It is the "C" Class Drug Shops which have become illicit suppliers of "B" list products, particularly the antibiotics.

The Accredited Drug Shop pilot in Kibaale District has been testing the practicality of a new regulatory regime under which Class "C" Drug Shop owners have been invited to become Accredited under the new regulation to sell items from the "Extended List that includes a list of products which were formerly restricted to approved "B" list retailers" in addition to the existing "C" list . The Accreditation process under the new regulation requires the owners to improve their retail premises, and for them and their dispensers to attend and pass a training programme.

This report has been commissioned by Management Sciences for Health (MSH) to determine if the additional costs of conforming to the requirements of the new regulation regime of the ADS pilot can be supported by the participating Drug Shops in terms of their profitability and sustainability.

4. Methodology

Following the requirement of the SoW for this project, interview and data collection tools were designed and then discussed with EADSI staff. Modifications were made as a result of the observations received. These tools provided the framework around which the dialogue and data collection for the Business Analysis and Recommendations has been carried out. Dialogues were held with key stakeholders in Uganda such as the National Drug Authority, the Ministry of Health, the Pharmaceutical Society of Uganda, Makerere University, ADS owners, Kibaale District officials, the Kibaale ADS Owners Association, micro finance organisations and the professional staff of Management Sciences for Health in Uganda. Relevant trading data has been collected and analysed. Reports and presentations compiled during the earlier design and implementation of the ADS initiative in Uganda were reviewed.

By way of comparative background a short visit was paid to Tanzania and reports and presentations from the establishment of the ADDO network there were reviewed

together with a one day field visit to a small sample of ADDOs in the Morogoro District to meet their owners.

PART ONE
Accredited Drug Shop Profitability and Sustainability

1.0 Existing Business Opportunities for Drug Shops in Relation to Profitability and Sustainability

1.1 Existing Opportunities

The size of the commercial market for the supply of "C" list pharmaceuticals in Uganda is indicated by the number of drug shops currently active in supplying the market. The NDA experience of the Kibaale District trial suggests that there may be around 21,000 drug shops currently operating in the country about half of which may not be registered.

> The Real Number of Drug Shops – Evidence from the Kibaale Pilot
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> At the start of the pilot in Kibaale the NDA had 70 Class "C" Drug shops registered in the District. During the pilot, drug shops that had not previously been registered, came forward to join the pilot scheme. The District Assistant Drug Inspector (DADI) expects that by the end of the current year there will be a total of nearly 200 registered Class C drug shops (either accredited or unaccredited) in Kibaale District, the majority of which had previously been trading. If this pattern is repeated nationally it suggests that there could be a network of up to 21,000 retail outlets selling pharmaceutical products, about half of which might be currently registered as Class C drug shops under the existing regulation. With a population approaching 34 million this suggest that one drug shop is serving an average of 1,620 people.

This statistic provides evidence that there is a very active retail market in pharmaceutical products in Uganda. It is very probable that many, if not all, of these outlets may be engaged to some degree in the illicit supply of some Class "B" products.

We do not know if all these drug shops are providing their owners with a sustainable income but the evidence of their probable numbers suggests that they most probably are.

1.2 Future Demand

The demographic statistics of Uganda, life expectancy, health profile and so forth, clearly demonstrate the need for pharmaceutical products. It is also clear that the future likely need for remedies and preventative products of a population with 17 million people (50%) between the ages of 0 and 14, in the absence of conflict, and given normal patterns of reproduction, is going to grow enormously. These future health related needs will translate into demands in the market place.

1.3 Profitability

The results of our dialogues with 12 ADS owners during our field trip to Kibaale indicate that all the owners that we met were making profits. The numerical models that appear in Part Two of this report show that this sample of ADS was able to average a mark up multiplier of 2.4 times the wholesale price that they paid their suppliers to the retail price they charged their customers, producing a gross profit margin of around 50%. This is a good working margin for the basis of a sustainable business, providing the retailer is able to manage their operating costs. The numerical models' range shows that to generate net profits (i.e. after meeting operating expenses) the necessary average daily sales ranges from US$0.79 cents at the lowest operating cost option to US$9.17 cents at the highest operating cost option. In interviews, owners revealed that their average daily sales ranged between US$5 and US$61 with an average of US$ 24.80 per day.

Owners expected that a good day's sales would be twice the daily average. Although owners were understandably hesitant to reveal the extent of the profits that they are currently making, all claimed that they were making profits. The numerical data supports their assertions and indicates that on the basis of the data collected profits may range between US$50 and US$4 per day or US$18,000 and US$1,440 per annum. This can be compared to the annual salary for a government employed pharmacist, which is in the region of US$ 3,400.

1.4 Profit Maximisation

Our dialogue with ADS owners showed that they were pleased with the level of profits that they were making. However we noted that none of these owners relied solely on the ADS for their income, they all had at least one and sometimes two or more alternative sources of income. For some owners, other income came from employment, as many were employed in government hospitals or health centres. Several owners had other businesses, some were agricultural and some in general trading or shop keeping. In our view, this spread of income generating activity and the lack of dependence on any one source means that it is unlikely that owners focus on maximising profits from their ADS. For example, although all the premises that we visited had unused space that could have been used for selling ancillary items to pharmaceuticals, such as cosmetics or health food supplements, none of the owners had seriously investigated the possibility of adding to the range of product that they stocked in order to generate more sales and increase profits.

Having multiple sources of income spreads the risk of any one source failing but it also reduces the need to develop any one source fully. At present, based on the small sample of ADS owners that we met in the Kibaale District, it would appear that the ADS model is profitable and at levels of profit that are sustainable.

2.0 Potential Business Opportunities in Relation to Profitability and Sustainability

We have identified four types of potential business opportunities to increase sales based on existing operating costs and reducing reliance on one category of product or service to improve sustainability.

2.1 Product Range Diversification

Product diversification is the process of adding products to the range currently offered for sale. The guidance that we received from the NDA is that ADS can offer other products for sale apart from pharmaceuticals as long as the products do not compromise the standards required for the sale of pharmaceuticals. So for example, ADS owners could offer products such as cosmetics, personal hygiene or food supplements as long as they were stored and displayed separately from the pharmaceuticals.

In our dialogue with ADS owners, most of them were interested in the idea of extending the range of products they offered for sale and a couple had vague plans to do so in the future. However, the immediate focus for all of them has been to meet the accreditation standard and to settle their business into the new regulatory regime. From our dialogues, it appears that ADS owners are not yet ready to extend their business model as they want to make sure that the new model is working well. A couple were also unsure on the type of product that would be permitted and said that they would welcome guidance on this.

In Part Three of this report we have made recommendations, to prepare for the nationwide scale up, to review the guidance given to ADS owners during their business training about the permitted scope for diversifying the product range.

2.2 Extensions to Pharmaceutical Product Range

In our dialogue with the ADS owners and with the DADI, it became clear that consideration is being given to make further changes to the list of drugs that ADS are permitted to sell. Some ADS owners wanted to sell injectables, whilst the DADI thought that the inclusion of some medication for chronic conditions to meet repeat prescriptions such as hypertension merited consideration for inclusion.

Clearly extensions to the list of permitted drugs will create a broader base for sales and profits. Equally the ADS can provide useful insights for the NDA into new patterns of demand that are emerging in the market. Our dialogues showed that a new relationship based on mutual respect and a two way flow of information can be established between

the regulator and the regulated to the benefit of both sides. This new positive and open relationship was clearly valued by both the ADS owners and the DADI.

2.3 Service Diversification

It is probable that the growth in the ADS network that would follow a national scale up will offer opportunities for government community healthcare initiatives to begin to engage the ADS with service or equipment distribution. In Tanzania, a trend of engagement with ADDOs as a natural distribution channel for healthcare campaign information or product is becoming established, with ADDO owners being paid a small fee or allowance for their services. An example is the recent distribution of subsidised treated mosquito nets, where the ADDO network was called on to receive and distribute nets to their local populations. In Uganda, a recent distribution of treated nets used village health teams, requiring the government to mobilise its own distribution network.

2.4 Health Insurance

There may be opportunities for ADS to engage with insurers or other providers of medical cover to provide pharmaceuticals to their members. For example, Tanzanian civil servants are provided with government financed health insurance cover to meet the cost of treatment and medication. A number of ADDOs, regulated by the National Health Insurance Fund, have been given the opportunity to register as providers under the scheme. Under this scheme a civil servant with a prescription to fill from the list of drugs that ADDOs can sell can have it filled free by the participating ADDO, which is then re-imbursed from the government scheme. We understand that there is currently discussion in Uganda about extending such a benefit to national civil servants, which could provide a new opportunity for ADS owners to participate.

3.0 Potential Problem Areas that May Affect Profitability and Sustainability

3.1 Sustained Improvement in Government Supply of Pharmaceuticals to Hospitals and Clinics

ADS and government health facilities supply the same market with pharmaceuticals. Sales at ADS rise as the availability of drugs in government hospitals and health centres falls. In our dialogues, it was reported that sales in the ADS were currently depressed because the government supply was buoyant.

Owners we spoke to were phlegmatic about this situation because, as we have commented above, none of them relied solely on their ADS for their livelihood, and they expected sales to improve in the coming months as government supplies dwindled.

Because the operating costs of a business are usually fixed in the short term, any reduction in sales will reduce profits. A long term or sustained reduction in sales will lead owners to take action to reduce operating costs, such as a reduction in staff. If the level of sales remains depressed and reduces profits to low levels or the business begins to incur losses, the business cannot be sustained for long and/or quality of services provided will decrease.

This situation is significant because if the government supply becomes consistently effective ADS owners will suffer.

3.2 Increase in Free Pharmaceutical Product Supply

Donors sometimes give quantities of drugs for free distribution to support a particular health objective. Whilst the distribution of free drugs may benefit those in need whilst they are available, they can cause considerable damage to the commercial supply chain and to the interest of those who operate businesses in that market.

3.3 Changes in Regulatory Regime

A change in regulation can often result in additional expense for business owners. This is usually regarded as an acceptable business risk providing that the changes are not too frequent, are consistent and are well thought out. A regulatory regime which is unstable or haphazard and requires business owners continually to make large and unplanned investments in their business, will deter businessmen from engaging in that business because the effort and expense of meeting the regulatory requirement takes so much profit out of the business that continuing the business becomes unsustainable.

In the preparations for the national scale up we have recommended in Part Three of this report that the regulatory requirement should be reviewed to ensure that it is robust, sensible and is unlikely to need change during the lifetime of the scale up.

The Specification for the ADS model needs to be finally agreed upon (either accepting the pilot model or making revisions to that model based on what was learned during the pilot) by all the regulatory and policy stakeholders (Ministry of Health and the National Drugs Authority) with the engagement of the Pharmaceutical Society of Uganda, before the scale up is given the go ahead. This includes such elements as the:

- facilities specification – floor area, surface finishes, roof material, storage media etc;
- name to be given to the reformed Drug Shops;
- future of the Drug Shops that do not migrate to the new model – will they be closed or regulated separately?
- educational requirements of the people who will be accepted for dispensing training;
- curricula for dispensing training;
- content, nature and scope of commercial training of owners.

In addition, the Kibaale pilot has only been permitted under a time limited exemption from current regulation. Unless permanent changes in legislation and regulations are made soon, an extension of the exemption from current regulations for Kibaale will be required. If a decision is made to go ahead with a nationwide scale up without legislative change, other districts will also have to receive exemptions.

3.4 Evolving Market Developments

The Kibaale pilot has shown that the new regulatory regime has encouraged new entrants to join the market - including the arrival of more pharmacies (from 1 to 4) with combined retail and wholesale operations - and for some pre-existing, covert, DS operators to appear to join the licit retail market.

When the ADS model is scaled up nationwide, we expect this finding to be replicated to some degree. This lesson from the Kibaale trial is leading the NDA to revise its initial estimate of the number of ADS outlets that may be expected to provide national coverage from 30 per District to around 120 per District or 10,000 nationally.

The response of businesses to new market opportunities follows a series of phases, which we expect will be followed in Uganda as the new regulatory regime is scaled up nationally. These phases are as follows:

- Over supply

The result of the first year or two of national ADS accreditation we would expect to lead to an over supply of outlets as many business owners strive to secure a section of the newly opened market.

- Price Competition

This oversupply can be expected to lead to strong competition on prices as the owners compete to secure market share. It is probable that some of these owners will find their profits squeezed so much by the competition that they will decide to close their ADS and leave the market.

- Consolidation

The next phase will be a degree of consolidation in ownership as some outlets purchase others. It is also likely that in a period of 2-5 years after ADS rollout some chains of ADS will begin to emerge with the general development of a more sophisticated retail sector. This pattern has already been demonstrated in the pharmacy market with the emergence of the Vine chain of pharmacies.

- Maturity or Equilibrium

The last stage is when the market supply and demand are matched in a stable balance. There will still be new entrants, although fewer in number and the larger and more successful businesses will extend their reach through acquisition or by opening new shops to the extent that regulation, the logistics of control and their ambition dictate.

These are the usual phases of a market's development. The Regulatory authorities should not be tempted to intervene in this process other than to ensure that the supply of pharmaceuticals offered still meets the necessary standards of hygiene, efficacy and rational dispensing that they are required to support and that the interests of the consumer and supplier are balanced.

3.5 Access to Loan Finance

During our dialogue with MSH staff in Kampala, we were asked to consider the issue of access to finance as a possible factor affecting the sustainability of ADS.

In our dialogues with ADS owners, we were impressed that no owners whom we spoke to had borrowed money to finance their investment in the shops. All the owners had financed the upgrading of their premises themselves from savings. Some had reached agreements with their landlords for rent free periods to offset partially or fully the investment in improving the premises. Some had agreement with landlords that they would renovate the interior whilst the landlord should renovate the exterior. Most owners

appear to have shouldered the cost of the premises improvements themselves without any offset arrangements or borrowing.

All the owners whom we spoke to believed that they would be able to obtain loan finance if needed. They thought that they would be able to do so on the basis of the previous trading record of their Drug Shop or other businesses. They also believed that their record of saving with a bank or micro-finance institution or against their employment in salaried government posts would enable them to obtain loans.

Some of the owners told us that they believed from the briefings given to introduce the concept of the new regulation and the pilot accreditation programme in Kibaale that finance would be made available through the accreditation process. This was not the case or the intention of the pilot. We have recommended in Part Three of this report that additional care must be taken in a nationwide scale up to ensure that an accurate presentation is given of this topic.

In dialogue with the General Manager of the EDF Microfinance organisation in Kibaale, we learned that loans were usually granted against trading records or employment/salary. We understand that because Kibaale District had been subject to a considerable inward migration and recent civil unrest, land titles are often not available or could not be proved in order to provide collateral security. EDF had several customers who had been operating Drug Shops for some years and their trading records and personal references would be strong enough to support loan applications if they were made. Where someone with no previous business experience, regular employment or savings history applied for a loan, EDF was prepared to offer advice and guidance about forming self-help groups for setting up joint savings accounts for self-financing members loans.

In summary, it appears that access to finance was not an issue among the Drug Shop owners whom we spoke to. However, we only met owners who had made a success of applying for and obtaining accreditation, we did not meet any who had failed. The drug shop owners we met in Kibaale were either in government health service employment or had a number of other established businesses. If this pattern is repeated nationwide, then it is unlikely that access to finance will be a problem for most of them. Those who are likely to face a problem with finance are unemployed people with no business track record, no savings and no assets to offer as security. This however is an international phenomenon not confined to Uganda. As the purpose of the new regulatory regime is primarily to bring existing drug shop owners, who appear to be numerous, within the new accreditation framework, a lack of access to finance does not appear to offer a material obstacle to a nationwide scale up.

3.6 Access to Trade Credit

Most of the ADS owners whom we met told us that they were able to obtain credit terms from their wholesale suppliers once they had established a good trading record with them. Typically, the credit period would extend to 30 days. The value of trade credit has been extended considerably for the ADS because a significant element of their purchases are now legitimate, whereas before they were illicit – off the record - and had to be paid for in cash. The new regulatory model supporting ADS has improved the finance available to the business through extended credit and has thereby increased its sustainability.

4.0 Recommendations on Actions Needed to Strengthen Drug Shops and their Resulting Profitability and Sustainability

Our recommendations are designed to strengthen drug shops by:

4.1 Improve Current Management Practices

Our dialogue with owners revealed a concern to avoid stock outs which resulted in lost sales. None of the owners whom we spoke to identified expired stock as a problem. As they are now able to purchase all their stock legitimately, owners are able to select long expiry date stock and to manage their purchasing to ensure quick rotation of stock. However a couple identified stock outs as a concern because they lost the immediate sale as a result and, if it happened often enough, they thought that they would get a poor reputation for holding stock among customers.

We reviewed the business training material provided to owners and noted there the recommendation for the use of stock cards to help to control stock levels to avoid both over and under stocking. However we did not observe the use of stock cards in any of the shops that we visited. One of the owners who mentioned the stock out problem was the Secretary of the Trade Association to which most ADS owners belonged. We discussed with him the use of stock cards and mentioned that we had not observed them in use. He agreed that it was a point that many, including him, had not taken on board and he decided that he would raise this as a topic for discussion and possibly a refresher training session at the next meeting of the Association.

The training offered to owners offers a good grounding in retail management, however it is not surprising if not every technique or practice is taken up immediately. Providing refresher training or supporting trade associations in their delivery of training will be an important part of ensuring that all the lessons given are eventually applied rather than forgotten.

4.2 Increase Sales through Developing the Product Range

As we have pointed out above in Business Opportunities, it makes sense for the owners to broaden their product range to include non pharmaceuticals. This will not only open up the possibility of increasing sales and profits but also by introducing items that are not subject to competition from other sources – such as the distribution of pharmaceuticals by the government – it insulates the business from dependence on sales of one product type alone.

This development should be encouraged and the possibilities examined in the business training given to the owners as they prepare for accreditation.

4.3 Engagement in Social Welfare Projects

A well regulated ADS network will offer the government opportunities to engage it in social welfare projects such as health promotion actions, free or subsidised net distribution, vaccination campaigns or disease reporting. Engagement in these types of projects will bind the ADS network into the fabric of public health improvement as well as save the government money.

4.4 Acting Collectively for Mutual Support

The Kibaale District Private Medicine Sellers Association is a trade membership body set up with the encouragement of the NDA, by the ADS owners.

Trade Associations (TAs) are a common and widespread phenomenon in Uganda. Reference to the experience of Tanzania is not helpful in this instance as the history of the role and acceptability of civil, non-government, institutions is very different in the two countries.

Trade Associations can be viewed differently depending upon standpoint of the observer. For example, the NDA welcomes and supports the development of TAs as they are viewed as providing an extension of the regulation system by encouraging members to abide by the rules or possibly expelling (or reporting to the NDA) those that break them. The Ministry of Health is more ambivalent as it sees the emergence of an ADS Trade Association as posing a possible challenge to its policy setting by campaigning and gathering political support for change in the regulatory regime. The Pharmaceutical Society of Uganda (PSU) welcomes Trade Associations on one hand but is also concerned that they may pose a challenge to the professional dominance of the PSU in the future.

In our dialogues with owners, it was clear that all of them supported the establishment of an Association and were either members of it or had applied to join. Many said that it if there had not already been an association in existence they would be keen to help establish one. Owners view the association as a source of guidance, training and support as well as a forum through which they could make suggestions for regulatory change. Owners told us that they thought that the Association had an important role to play in ensuring that members maintained standards and in developing the ADS reputation and standing in the community.

PART TWO
A Brief (numerically based) Business Model/Plan for the Successful Operation of Accredited Drug Shops

5.0 Notes to Accompany a Brief Numerical Business Model for Successful Operation of ADS

5.1 Introduction

The data upon which the numerical model is based was collected during the field trip to Kibaale District between 30th May and 2nd June 2011 during which 12 ADS owners were interviewed.

The numerical model that appears in the accompanying pages* takes the form of a Trading and Profit and Loss Account presented in an Excel spreadsheet. The model is designed to find the break-even point for the different cost structures. This means identifying the value of sales at which the business covers its operating costs; sales above the break-even value will result in profits; sales below the break-even value will result in trading losses. The attached model therefore shows the minimum level of sales needed to meet the operating costs and at which profits will start to be generated i.e. the level of sales at which the business begins to be commercially successful.

Page 1 of the model uses a Trading / Profit and Loss account format to show the sales, the cost of the goods sold and the Gross Profit figure. Below these the Operating Costs are set out and the resulting Net Profit figure. The sales figures in the model have been set to make the Net Profit equal to zero by making Gross Profit equal to the Operating Expenses; which is the point at which the business "breaks even". The model is designed to allow higher or lower sales figures to be inserted to observe the resulting effect on the Net Profit. The model shows values in Ugandan Shillings (UGX) and US Dollars ($). The exchange rate used for the conversion was obtained from www.oanda.com.

Page 2 of the model sets out the data that was gathered during the field visit on the 10 best selling items and the selling price at which the items were offered for sale by each of the 12 ADS visited. The wholesale prices for the same items, in the same pack sizes, were obtained from Abacus Pharma Limited in Kampala, a popular wholesale supplier used by many of the ADS visited. The resulting average mark up multiplier was derived by calculating the factor by which the wholesale price is multiplied to achieve the retail price across the range of products offered by all the ADS. The average mark up multiplier is used in sheet 1 to determine the Cost of Goods Sold (COGS) and hence the Gross Profit from any chosen value of sales that is fed into the model.

The data collected revealed very different cost structures between the ADS visited. The most significant of these costs were rent and wages. Some ADS owners owned their

* The version of the spread sheet that appears in this printed report is only an extract. The full, interactive version is available in the electronic version of this report.

own premises and therefore paid no rent. Some of those ADS owners employed no staff but operated their ADS themselves. Meanwhile other owners rented property and employed up to two staff, an "in charge" and a dispenser. To demonstrate the effect of these different cost structures in the numerical model we have developed three variations:

- A = High operating costs with rent and staff wages.
- B = Median operating costs between A and C.
- C = Low operating costs with no rent and no staff wages.

Further notes on the Gross and Net Profit margins and Operating Costs appear below.

5.2 Mark up Multiplier

The mark up multiplier is the amount by which the seller multiplies the purchase cost of the stock to obtain the selling price.

5.3 Gross Profit Margin

The Gross Profit Margin is the percentage of the selling price which is profit. The ADS owners were each asked to identify the ten best selling items that sold in their shops, the unit in which the item was sold (bottle, course of tablets, pack size etc) and the price at which it was sold. They were also asked to estimate what proportion of their shop's daily sales was accounted for by the top ten sellers. The reply to the last question ranged upwards from 40% to 80%. A total of 31 different items made up the list of top ten sellers amongst the 12 ADS visited. This list was reduced to 28 items during the analysis (sheet 2 of the spreadsheet) as distorting anomalies were identified in the data of three items. The wholesalers selling price for the list of 31 items was obtained from a popular wholesaler in Kampala used by several of the ADS (Abacus Pharma Ltd). The difference between the two prices represents the mark up multiplier used by the ADS shops.

5.4 Net Profit

The Net Profit is the sum of money that is left to the ADS owner after the costs of operating the shop have been deducted from the Gross Profit. Net Profit is the money available to the owner to be used to meet their living expenses, saving and investment. In the accompanying model the Net Profit has been brought to zero by setting the monthly sales figure to a level where the resulting Gross Profits are equal to the Operating Costs i.e. the break even point of the business.

6.0 Operating Costs

6.1 Rent

Some ADS owners own their premises and therefore pay no rent; the rest rent their premises. In the sample visited, it appears that the owners living in remoter areas tend to own their premises whilst those with shops in the larger villages and towns rent. The difference between renting and owning makes a considerable difference to the operating costs of the business. Option A in the attached numerical model is based upon the higher reported rents. Option C is based upon ownership with no rent paid. Option B represents the cost of an average rent.

6.2 Staff

Staff costs were the other major cost variable in the ADS visited. Some ADS were effectively owner managed with the owner spending all their time selling from the shop. Where the owner has the required health care background (Nursing Assistant certificate or higher) there was no need to employ anyone else to sell or to act as "In Charge". The effective staff costs in this set up was effectively nil. In other cases where the owner was not active in the business they are required by the NDA to employ an "In charge" and a drug seller who have been through the necessary training. Option A in the attached numerical model is based upon the employment of two staff. Option C is based upon self-employment. Option B is between the two when one person may be employed in addition to the owner or someone is paid for cleaning.

6.3 Lighting

Lighting methods varied from mains electricity, paraffin lamp or candle to lighting provided by solar panel.

6.4 Water

All the ADS used water drawn from wells or bore holes and bought by the "Jerry Can". Usage was calculated by the number of cans used per day. The cost of each can if fetched by the owner was UGX 300 or UGX 500 if brought to the shop by someone else. It was notable that the use of rainwater capture was not observed anywhere during the field study and yet the use of corrugated iron roofs and the frequent rainfall suggests that this could be a viable option to reduce water costs and incidentally to reduce ground erosion around the exterior walls of the shops and the consequent weakening of their concrete floor pads.

6.5 Cleaning Materials

This item is the cost of the materials used in cleaning the ADS premises but excludes the cost of paying for someone to do the cleaning, which is recorded under Staff costs.

6.6 Transport

This is largely the cost of travel to Kampala to purchase and collect supplies. Most of the ADS met, bought the majority of their supplies from Kampala, whilst purchasing locally when necessary for top up items.

6.7 Telephone

None of the ADS owners was including the costs of their airtime used for the business into their operating costs. However they all used their phones for the business and so they were asked to estimate the amount of airtime that they bought for this purpose.

6.8 Stationery

This heading contains such items as the paper bags that some drugs are dispensed in, patient record books, referral forms, purchase ledgers and so forth. All the ADS visited were still using the books of record that they received during training, but we understand that they will be required to purchase replacements when these are full. We have allowed a nominal sum against this heading with rather higher amounts for the "A" cost model stores as a higher turnover will result in faster usage of these items.

6.9 Fixture and Fittings

This is the cost of adding new fittings or furniture to the business. We have allowed a nominal sum against this heading because few of the ADS owners had added any fittings since being accredited and were not budgeting for this. However if additional display cabinets are added to hold new lines, for instance cosmetics, this should be allowed for. We have allowed for a higher cost under this heading for the A model as with the need for higher sales and more customers, it seems more likely that ADS owners operating with a higher cost model are more likely to spend under this heading.

6.10 Repairs and Renewals

ADS owners were not identifying costs under this heading, although they were spending money on items such as floor covering and may need to replace chairs, benches or glass in the future. We have allowed a nominal amount for this purpose in the model. We have allowed for a higher cost under this heading for the A model as with the need for higher sales and more customers it seems more likely that these ADS owners are likely to spend more under this heading.

6.11 Taxes

There appear to be two local taxes that were common to all ADS. They are the annual licence for a retail premises (UGX 30,000) and a local service tax (UGX 10,000).

6.12 Accreditation

Each ADS pays an annual accreditation renewal fee to the NDA of UGX 60,000.

6.13 Subscription

There is an annual subscription fee of UGX10,000 for the trade association – The Kibaale District private Medicine Sellers Association – to which most ADS belong or intend to join.

There is also an annual fee paid to the PSU of UGX 12,000. This fee was questioned by several ADS owners as they were unsure of the purpose behind such a fee or what benefit they gained from paying it. As our earlier conversations with the PSU had not revealed this fee and the PSU had indicated that the ADS were not, and could not be, members of the PSU it is unclear whether this fee has been properly levied or to what organisation it goes.

EADSI Uganda: Accredited Drug Shop (ADS) Brief Numerical Business Model for Successful Operation of ADS

Figures shown are monthly	Uganda Shillings			US Dollars 1UGX=0.00041USD**		
	A	B	C	A	B	C
Sales per month*	670,857.00	352,000.00	58,000.00	275.05	144.32	23.78
Cost of Goods Sold (Sales / Mark up Multiplier)	279,523.75	146,666.67	24,166.67	114.60	60.13	9.91
Gross Profit	391,333.25	205,333.33	33,833.33	160.45	84.19	13.87
Gross Profit Margin	58.33%	58.33%	58.33%	58.33%	58.33%	58.33%
Operating Expenses						
Rent	80,000.00	40,000.00	nil	32.80	16.40	nil
Wages	90,000.00	45,000.00	nil	36.90	18.45	nil
Lighting	20,000.00	10,000.00	2,000.00	8.20	4.10	0.82
Water	12,000.00	5,000.00	500.00	4.92	2.05	0.21
Cleaning	30,000.00	15,000.00	2,000.00	12.30	6.15	nil
Transport	120,000.00	60,000.00	10,000.00	49.20	24.60	4.10
Telephone	15,000.00	10,000.00	5,000.00	6.15	4.10	2.05
Stationery	5,000.00	3,000.00	1,000.00	2.05	1.23	0.41
Fixtures and Fittings	5,000.00	4,000.00	2,000.00	2.05	1.64	0.82
Repairs and Renewals	5,000.00	4,000.00	2,000.00	2.05	1.64	0.82
Taxes: Shop License	2,500.00	2,500.00	2,500.00	1.03	1.03	1.03
Local Service Tax	833.00	833.00	833.00	0.34	0.34	0.34
Accreditation Fees (renewal)	5,000.00	5,000.00	5,000.00	2.05	2.05	2.05
Subscriptions PSU and ADS Association - Annual	1,000.00	1,000.00	1,000.00	0.41	0.41	0.41
Total Operating Expenses	391,333.00	205,333.00	33,833.00	160.45	84.19	13.87
Net Profit	0.25	0.33	0.33	0.00	0.00	0.00
Sales needed per day*** to break even	UGX 22,361.90	UGX 11,733.33	UGX 1,933.33	$9.17	$4.81	$0.79

See accompanying notes for fuller explanation

EADSI Uganda: Accredited Drug Shop (ADS) Numerical Model for Successful ADS Operation

Sales Analysis

		Retail Price												
Product Name	**Sales Unit**	**ADS 1**	**ADS2**	**ADS3**	**ADS4**	**ADS5**	**ADS6**	**ADS7**	**ADS8**	**ADS9**	**ADS10**	**ADS11**	**ADS12**	**Total**
		UGX												
Paracetemol	18	1,000.00	400.00	300.00	300.00		300.00	360.00	360.00		450.00		225.00	3,695.00
Amoxycillin Cap	30	3,000.00	3,000.00	2,000.00			1,500.00	2,250.00	1,500.00	1,500.00	2,000.00	3,000.00	3,000.00	22,750.00
Amoxycillin Syrup	100ml			2,000.00		2,000.00	2,000.00	2,000.00	2,500.00		2,500.00	2,000.00		15,000.00
Cotrimoxole / Septrine Tab	20	1,000.00	1,000.00	600.00	1,000.00	1,000.00		600.00	1,000.00		1,000.00	1,000.00	1,000.00	9,200.00
Zinc Tab	10	2,000.00			1,500.00			1,000.00			2,500.00		3,000.00	10,000.00
Metroniolazole Syrup	100ml										2,500.00			2,500.00
Metroniolazole Tab	30		1,000.00		1,500.00	1,000.00		600.00					1,500.00	5,600.00
Ciproflaxacin tab	10	2,000.00			2,000.00			1,000.00	4,000.00	1,500.00	2,500.00			13,000.00
Erythromycin Syrup	100ml		3,000.00								3,000.00			6,000.00
Erythromycin Tab	10				4,000.00	1,500.00	1,500.00		1,000.00			1,000.00		9,000.00
Artemether/Lumefantrica Tab	24					6,000.00			6,000.00		6,500.00	7,000.00		25,500.00
Doxycycline Caps	14							1,400.00	1,400.00		1,500.00			4,300.00
Always Pads Packet	1											3,000.00	3,000.00	6,000.00
Pampers Packet	1												6,500.00	6,500.00
Coartem Original Tab	24	6,000.00		6,000.00			6,000.00						6,000.00	24,000.00
Chloramphenical Syrup	100ml											2,500.00		2,500.00
Haemoforte Syrup	250ml											4,500.00		4,500.00
Quinine Tab	42					10,500.00	8,000.00			6,300.00				24,800.00
Quinine Syrup	100ml		3,000.00									3,000.00		6,000.00
Lonart Tab	24		6,000.00		6,000.00									12,000.00
Cotton Wool	500gm		9,500.00											9,500.00
Vitaglobin Syrup	250ml		5,000.00				7,000.00							12,000.00
Mebendazole Tab	15		500.00											500.00
Diclofenac Tab	30			1,500.00	1,500.00	1,500.00		1,500.00						6,000.00
Cough Linctus Syrup	200ml	1,000.00			1,500.00			1,000.00						3,500.00
Kabuti Syrup	200ml					2,000.00								2,000.00
Flucap Cap	10	1,000.00				1,000.00				1,000.00				3,000.00
Nystatin Pessaries	14						4,000.00							4,000.00

PART THREE

National Scale up Plan for ADS Initiative

7.0 Options for Implementing a Nationwide Scale up of the ADS Initiative.

7.1 Alternative Approaches

There are two alternative approaches to implement a nationwide scale up:

- centrally driven and managed: "supply led" ;
- devolved, District level: "demand led"

7.2 Our Recommendation

We recommend the demand led District level approach following:

- a thorough review and report by the National Drug Authority (NDA) of the results of the Kibaale pilot to incorporate any changes into the regulatory model such as: training requirement, building specification, qualification requirements of participants and the structure and roles of employed posts in Accredited Drug Shops (ADS);
- the preparations of a draft Policy Document for the Ministry of Health by the NDA, based on the report and findings of the Kibaale pilot, outlining the new regulation regime it is proposing for the retail of pharmaceuticals. The draft policy should cover such issues as; the future status of "C" List Drug Sellers under the new regime, the amendments to "B" and "C" list pharmaceuticals and the classification of those who can sell the items listed;
- the preparation by the NDA of a programme of sensitisation of the District stakeholders to explain the shortcomings of the current regulation regime, the proposed changes and the benefits that this will bring to all local stakeholders with illustrations drawn from the Kibaale Pilot.

There are three reasons for choosing a decentralised District "demand led" approach:

- the central management of the Tanzanian scale up programme failed because the centre was soon overwhelmed though insufficient resources in people and funding. Tanzania abandoned the centrally driven approach and successfully adopted a devolved approach with Districts following the policy and guidelines prepared by the centre;
- Uganda already has a devolved approach to government so a centralised approach would go against the flow of current government policy;
- the lessons learned during the Kibaale pilot indicate the paramount importance of bringing the local interest groups on side so that their enthusiasm for the new

regime becomes a powerful force in driving and enabling the changes to happen on the ground. The local stakeholders include:

- Politicians;
- Health service professionals in hospitals and clinics;
- National Drug Authority staff;
- Local Government officers;
- Community leaders;
- "C" List drug sellers.

8.0 Recommendations for Implementing a Nationwide Scale Up of the ADS Initiative

8.1 Approach

We recommend that the implementation of a nationwide scale up of the ADS initiative should be based on an approach which creates and then responds to local District level support and demand for a change to the new regulation.

We recommend that the implementation of the new regulation should be carried out through five NDA Regional offices (North, based on Gulu; Central based on Kyambogo; South Central based on Makerere; South East based on Busitema; South West based on Mbarara) each of which would be supported by two, three person training teams. Each Region would be responsible for the scale up in around 20 Districts.

8.2 Leadership

We recommend the National Drug Authority is the body best placed to lead this scale up, with external advice and support as necessary. The NDA is the natural choice to lead this scale up as it is the body responsible for the regulation of pharmaceutical sales in Uganda and the local source of pharmaceutical technical expertise; it has responded to the shortcomings of the current regime by developing and conducting the pilot of a new regime in Kibaale; and it will be responsible for preparing the policy recommendation to the Ministry of Health to amend the current regulation in the light of the positive outcomes of the pilot. The NDA will be required to prepare and execute a scale up plan to establish a number of ADS in each rural District within a given time period.

The need to move forward from the pilot in Kibaale is gathering momentum. The regulatory exemption for the ADS in Kibaale will have to be extended. The pressure for change from the Drug Shop owners in Districts neighbouring Kibaale will grow as they see their customers moving over the District border to access the ADS. The pressure on the NDA to scale up around the country will grow quickly as awareness of the benefits of the new regulation regime become apparent to the public and to Drug Shop owners.

Nevertheless, the NDA has no previous experience of project managing a national scale up of this size and complexity. An institutional review of the NDA lies outside the scope of our work, so we recommend that the NDA's requirements in terms of manpower and the financial resources to implement a national scale up should be reviewed. In the light of that review we recommend that the NDA should be provided with the necessary specialist support, guidance and project management expertise to prepare the plans and manage their execution. We recommend that the NDA and the Ministry of Health

should jointly seek sources of external and government funding to support implementation.

8.3 Preparing the Policy

The NDA must provide the technical recommendations to the Ministry of Health, based upon the lessons and experience of the Kibaale pilot, as the basis for the preparation of the new regulations for the control of pharmaceutical retailers. The work of the NDA will comprise three steps below.

The first step must therefore be for the NDA to prepare a report on the Kibaale pilot with recommendations for the introduction of changes to the regulation of the retail of pharmaceutical supplies, to be ratified by its senior management Board and then for submission to the Ministry of Health.

The second step is for the NDA to prepare a policy paper setting out the framework of the new regulatory regime that it will recommend to the MoH based upon the outcome of the Kibaale pilot.

The third step will be for the NDA to prepare a detailed and costed implementation plan to be followed if the change in regulation policy that it will propose is accepted. The plan should set out the answers to such questions as:

- What criteria will be used to guide the implementation of the new regulation by the Districts?
- How will the Districts be sensitised to the issue of the failure of the current regulations regime and how will those failures be addressed in the new regulations?
- Who will conduct the training required for the accreditation of sellers and owners in the new regulation?
- How will the training be organised and how will the programme of training and inspection be planned, managed and financed?

In the section 9.0 "Business and Implementation Plan" we set out our suggestions to address these questions.

8.4 The Basis for Prioritising Districts

We recommend that the Districts with the highest number of registered Class "C" Drug Shops should be the first to be targeted for conversion to the new regulation scheme. We suggest that the number of Drug Shops currently registered in a District should be used as a good indicator of where the demand for pharmaceutical supply is highest; the

higher the number of Drug Shops, the greater the number of people seeking access to pharmaceuticals and therefore the place where the illicit sale of B list products is likely to be most prevalent.

8.5 The Sensitisation Task

We recommend that a clearer distinction should be drawn between raising awareness among the general population and among the health care and politician / local government cadres:

Awareness among the local healthcare and political / local government cadres

This is the process of spreading awareness among Districts of the new policy of changing the regulation of pharmaceutical sales through Drug Shops and what this will mean for the local population and those involved in health care.

We recommend that the sensitisation process should be led by the District Assistant Drug Inspectors (DADIs) with support from members of the NDA Regional training teams.

Awareness among the general population

We recommend that the approach to sensitisation should be reviewed in the light of the experience of the Kibaale pilot. The need and the techniques that were appropriate for the pilot scheme are unlikely to be the same for a national roll out. For example, the spray painting of building frontages with the ADS colour and logo seems to have followed the example used by the mobile phone companies, which have applied this technique widely to raise local peoples' awareness. The result in the pilot seems to have been that expectations were raised before the ADS had been accredited and in several instances the buildings that received the painted frontages did not actually contain an ADS, which was confusing and misleading. The properly accredited shops fronts were not painted and the signage for them to display their accreditation was small and unremarkable.

We recommend that the timing of the awareness raising among the general population should coincide with the accreditation of the new ADS, through radio advertising. Displaying the new logo and painting the exterior of the accredited shops in the new colour scheme will raise their profile.

8.6 Access to Finance

We recommend that during the sensitisation process that no suggestion should be made that accreditation to the new regulation will lead to, or improve, the chances of owners accessing loans. During our meetings with ADS owners in Kibaale, it became

clear that several owners believed that they had been told that accreditation would improve their access to loans or that the ADS scheme would actually provide access to loans. Neither of these claims is true. In the national scale up, it should be made quite clear that access to loans from a bank or micro-financing organisation will depend solely upon the collateral that can be offered or the businesses' established trading history.

8.7 Inspection of Premises

We recommend that the building specification of the retail facility for selling pharmaceuticals should be reviewed in the light of the Kibaale pilot. The specification should be clear, simple and unambiguous for the building so that business owners know exactly the minimum standards that they are being required to provide. The specification should not allow for a wide degree of interpretation, so that it can be applied evenly between different Districts.

We understand that there are differences in the building specification required between the Tanzanian ADDO shops and the Uganda ADS shops. For example, in Tanzania a separate room at the rear of the shop is required for the storage of stock and a window is required for light and ventilation at the side of the building. These differences may be appropriate, but we recommend that the building specification is reviewed before a scale up to ensure that no changes have to be made during or after the scale up.

8.8 Staffing of Accredited Drug Shops

We recommend that the requirement for an "in charge" post, specified for the shops participating in the pilot scheme should be reviewed to ensure that it is appropriate and affordable before the national scale up. As we have noted elsewhere in the numerical business model, rent and wages are the two major costs of the ADS business.

We understand that the staffing of shops for the pilot recognised three roles: owner, supervisor or "in charge" and dispenser. It appears possible that these roles may be condensed into one, in the case of an owner who is a trained dispenser with some health care background. During our field trip it became clear that several owners who did not dispense themselves were employing an "in charge" who was not actually present – or necessarily expected to be present, in the shop. In some cases, this appeared to be a relative who had some health care training but who, because of family relations, would not expect to be paid very much.

It is not clear to us what the role of the "in charge" is supposed to be, or how important it is, particularly if they are not required to be present in the shop. A similar role was originally specified in the Tanzanian ADDO model but was dropped from the requirement before the scale up started.

The inclusion of the "in charge" post adds substantially to the operating costs and may affect the sustainability of the business.

The cost of providing training for one "in charge" for each of the 11,000 ADS required to achieve a national scale up is about $2.2 million in per diem expenses alone ($20 per day X 10 days of training X 11,000 trainees) and accounts for one week of the five week training cycle used for the Kibaale pilot.

The cost of the "in charge" post in the scale up is significant. The operating costs of the ADS shop are significantly increased when an "in charge" is employed and the sustainability adversely affected. The post has been abolished in the original ADDO model.

The current process of harmonising the regulations governing business practice in the East African Association trade area also suggests that a review of the Ugandan requirement for an "in charge" in the ADS makes sense.

8.9 Qualifications of ADS Staff

We recommend that the assessment of staff to be employed in ADS is reviewed in the light of the pilot and its suitability for the national scale up. We understand that the dispensers are required to demonstrate competence in reading English, arithmetic and in writing either English or a local dialect. We understand that holding a Ugandan Certificate of Education (UCE) alone is taken as sufficient evidence of the required standard. We think that Uganda's history of civil turmoil in various parts of the country, may have affected attendance in formal education with the result that some people who have the necessary skills for ADS employment may not hold the formal UCE. We suggest that it would be prudent to devise a simple test of the reading, writing and arithmetic skills required to supplement or replace the holding of formal certificates of education and provide a more immediate test of skill attainment.

8.10 The Training Task

Training is the most expensive element of the implementation of the scale up. We show below three alternative approaches to the training of staff for the ADS which range in the cost per shop between $481 and $739.

Our recommended approach to the provision of ADS national scale up training is based upon the following calculations.

World Bank figures show that of the current country population of around 34 million, 13% or 4.5 million live in urban areas with 87% or 29.5 million living in rural areas. Although the proposed changes in Drug Shop regulation are intended to apply only to rural areas, we think that it will prove very hard in practice to enforce such a distinction.

Therefore we think it practical to plan the national scale up on the basis of eventually having Accredited Shops in all 108 Districts.

We estimate that each of Uganda's 108 administrative Districts will be able to support between 100 and 200 ADS, depending upon population density, or between 10,000 and 20,000 nationally. The Kibaale pilot revealed that the number of "C List" ADS under the previous regulation was about 60; but that with new registrations of previously unknown Drug Shops, the DADI is expecting to register a total of 200 ADS in the current year. As the Kibaale District population is 600,000 this indicates an average 3000 people in the population as potential customers for each ADS.

Given a national population of 34 million, the Kibaale proportion of ADS to population suggests a national requirement of 11,330 ADS could be expected. If the shop manning requirements in Kibaale of between one and three staff are maintained, this translates into a national training requirement of between 11,330 and 34,000 people.

The Tanzanian experience has shown that the effect of training dispensers in the ADDOS increases their marketability with the result that some of these trained dispensers move on to work outside the ADDOs or move more frequently within the network. The loss of dispensers to the ADDO network results in demand for more to be trained; so a degree of replacement and the continued provision of a training capacity should be factored into the scale up plan.

The illustrative training scheme that follows is based upon a target of establishing an average of around 90 licensed drug shops in each District within a two year period. This represents a target of around 9,000 dispensers. The target can be increased or decreased depending upon financial and political constraints.

The training scheme is based upon employing 40 trainers as fulltime staff of the NDA for two years. The PSU has indicated to us that it believes that it is realistic to expect to attract suitable candidates to fill this number of posts. The salary chosen to illustrate the cost is, we understand, the salary that would be paid to a fully qualified Pharmacist employed by government.

8.11 Scale Up Training Costs

We show below two alternative models for the employment and use of trainers and three alternative models for the delivery of the training.

We recommend that the trainers should be employed full time on two year fixed contracts and when not actively delivering training they should be used to supplement DADI and local Health Inspector roles in visiting and inspecting premises for ADS applicants. At the end of the two year contract, the trainers could be considered for

posts to provide continuing training activity or for other drug regulatory support activities..

We understand that the course and materials for the training of trainers for the pilot was devised and undertaken by the Pharmacy Department of Makerere University in conjunction with the Pharmaceutical Society of Uganda (PSU). Both organisations have indicated they are keen to support the further training that would be needed for the national scale up.

The first model for the trainers is based upon the five week training cycle followed during the Kibaale pilot, when the maximum number of courses that the two man training teams could be expected to deliver would be ten per year. The second model for trainers is based upon a four week course which would allow each team to deliver 13 courses per year.

The three alternative models for the trainees are as follows:

The first is based upon the five week cycle with 30 trainees used in the Kibaale pilot and includes the "in charge" post. The second shows the effect of removing the "In charge" post and reducing the course to four weeks. The third shows the effect of the four week course with trainee numbers increased to 40 per course.

The per diem costs are, in every case, the same as those used during the Kibaale pilot.

8.12 Trainers

8.12.1 Option 1

Salary:

Employ 40 trainers at US$3,500 per annum each $140,000.

(Approximate annual salary of a pharmacist employed by the Govt.)

Form these into 10 teams of 3 trainers with 10 on standby rotation.

Per Diems:

Each Team to deliver 10 X 5 week courses per annum at 5 days per week.

10courses X 5weeks X 5days = 250 active training days per annum per trainer

Pay each active trainer a per diem of $30 for each active training day

$30 X 250 training days X 30 Trainers = $225,000

========

Total Cost of Training staff provision **$365,000**

OR

8.12.2 Option 2

If the course is reduced to four weeks duration and the number of courses delivered per team is increased to 13 per annum:

13 courses X 4 weeks X 5 Days = 260 active training days per trainer

Paying each trainer a per diem of $30 for each active training day

$30 X 260 training days X 30 trainers = $234,000

========

Total Cost of Training Staff provision **$374,000**

8.13 Trainees

8.13.1 Alternative One: The Kibaale Pilot training model: Five week course:

Week One	Week Two	Week Three	Week Four	Week Five
Dispensers 30 trainees	Dispensers 30 trainees	"In Charge" 30 trainees	Dispensers 30 trainees	Owners + "in charge"

30 ADS' staff trainees per course (30 dispensers + 30 "In charges" + 30 owners)

10 trainer teams delivering 10 courses a year each = 100 courses

100 Courses X 30 ADS units' staff = 3,000 ADS' unit trainees per annum

Living expenses for trainees $20 per day per trainee for accommodation and food

3,000 dispensers X 15 training days X $20 per training day = $ 900,000

3,000 "in charges" X 10 training days X $20 per training day = $ 600,000

3,000 owners X 5 training days x $20 per training day = $ 300,000

Total **$1, 800,000**

Materials and equipment per trainee (notepad, manual, pencils etc) $5.00 **$ 45,000**

Total Cost for Trainers and Trainees **$2, 219,000**

Cost per trainee $2,219,000 / 9000 trainees = **$246.55**

Total capacity for training ADS for Accreditation per year: 3,000 ADS or $739.66 training cost per shop.

OR

8.13.2 Alternative Two: Four week course without the "In charge" post:

Week One	Week Two	Week Three	Week Four
Dispensers 30 Trainees	Dispensers 30 Trainees	Business Owners 30 Trainees	Dispensers 30 Trainees

30 ADS' staff = 30 dispensers + 30 owners

130 courses per annum X 30 ADS unit's staff = 3,900 ADS' unit trainees per annum

Living expenses for trainees $20 per day per trainee for accommodation and food

3900 dispensers X 15 training days X $ 20 per training day = $1,170,000

3900 owners X 5 training days X $20 per training day = $ 390,000

$1, 560,000

Materials and equipment per trainee (notepad, manual, pencils etc) $5.00 **$ 39,000**

Total Cost for Trainers and Trainees **$1, 973,000**

Cost per trainee $1,973,000 / 7800 trainees = **$252.94**

Total capacity for training ADS for Accreditation per year: 3,900 ADS or $505.89 training cost per shop.

OR

8.13.3 Alternative Three: Four week course with 40 trainees per course

Week One	Week Two	Week Three	Week Four
Dispensers 40 trainees	Dispensers 40 trainees	Business Owners 40 trainees	Dispensers 40 trainees

40 ADS staff = 40 dispensers + 40 owners

130 course per annum X 40 ADS unit staff = 5,200 ADS' trainees per annum

Living expenses for trainees $20 per day per trainee for accommodation and food

5,200 dispensers X 15 training days X $ 20 per training day =	$1,560,000
5,200 owners X 5 training days X $20 per training day =	$ 520,000
	$2,080,000
Materials and equipment per trainee (notepad, manual, pencils etc) $5.00	**$ 52,000**
Total Cost for Trainers and Trainees	**$2,506,000**

Cost per trainee $2,506,000 / 10,400 trainees =**$240.96**

Total capacity for training ADS for Accreditation per year: 5,200 ADS or $481.92 training cost per shop.

8.14 Charging Owners for Training

We recommend that the possibility of charging Drug Shop owners for part of the cost of the training should be reviewed. The experience in Tanzania has been that drug shop owners have proved willing to contribute towards the cost of the training. Recently this has extended to owners pre-paying the full cost of training courses when the central training budget ran out of funds in order to ensure that there would be no delay in their staff receiving the training needed to gain accreditation.

During our field trip each of the shop owners whom we met expressed a willingness to contribute something towards the cost of training up to a figure of US$100.

We recommend that consideration is given to offer a mixture of fixed or sliding scale of fees for the national scale up. For example, the first 50 Drug Shop owners in each District to enrol could be exempt a charge for training, whilst the charge could rise to $75 for the next 50 Drug shop owners. Charges should also be considered for follow up training requirement – for example the cost of training a replacement dispenser after the first one leaves could be $100.

The value to owners of joining the new accreditation scheme by bringing drug shop owners within the law in exchange for improvements to premises and staff being trained should not be underestimated. Although the primary purpose of the new regulation scheme is not to generate revenue for the government there is no reason why a contribution towards the cost of the training should not be considered. The revenue from an average charge of $50 per shop could be around $500,000 over a possible two year national scale up to 11,000 shops.

9.0 Business and Implementation Plan for the NDA to manage the nationwide scale up of the ADS initiative.

9.1 Implementing Authority: National Drug Authority of Uganda

9.2 Objectives

To introduce a new regulation framework for the control of the retail of pharmaceutical supplies in categories "B" and "C".

To provide new guidelines for the quality, size and amenity of the premises in which the retail sales of pharmaceutical products are to be made.

To provide a framework and curriculum of training that owners and sellers of retail pharmaceutical shops, that are to be licensed under the new regulation, will be required to attend and to pass.

The above objectives are to be achieved within a two year period from the date at which the new regulation scheme is gazetted.

9.3 Strategy

The implementation of the new Retail Drug Regulations for Class "B" and "C" list drugs is to be achieved in a three phase approach:

- Preparation
- Implementation
- Monitoring, Evaluation and Control

9.4 Preparation Phase

The Preparation phase is composed of three steps:

9.4.1 Step One: Report on the Outcomes of the Pilot

The completion of the report, currently being prepared by the NDA, setting out the findings of the pilot regulation scheme conducted in Kibaale District. The report will describe the problems of the original regulation regime and the purpose of testing a new regime in one District to assess its impact and feasibility. The report will set out the parameters of the pilot; its aims and objectives and will report on the extent to which the original aims and objectives have been realised. The outcome of the pilot will form the basis on which the recommendation for a change of policy is to be based.

9.4.2 Step Two: Preparation of the Policy

The preparation of a policy paper for consideration by the senior management of the NDA and, if approved, for transmission to the Ministry of Health.

9.4.3 Step Three: Prepare the Costed Implementation Plan

The preparation of a detailed and costed implementation plan to accompany the Policy Paper, which sets out how it is proposed for the new regulation regime to be implemented.

9.5 Implementation Phase

The Implementation Phase is composed of eight steps.

9.5.1 Step One: NDA Briefing

NDA Briefing: Once the new Policy has been approved a briefing document should be prepared and distributed as part of briefing sessions to all NDA staff to inform them of the changes in the regulation regime:

- how they are to be introduced;
- how these changes will affect them in their work;
- the time frame against which this will happen.

9.5.2 Step Two: Recruitment of Trainers

Recruitment of trainers: the recruitment of 40 trainers on two year contracts will take place. They will be formed into ten teams of three with ten trainers held in reserve at any one time to provide rotational cover for courses and additional support for NDA inspection duties, holiday absence or sickness.

9.5.3 Step Three: Establishment of Regional Training Teams

Regional Delivery Teams: the NDA trainers and implementation teams should be organised into five regions of about 22 Districts each. Two trainer teams will be assigned per region.

9.5.4 Step Four: Training Programme

Training Programme: The training materials and curricula for the shop owners will be revised and agreed in its final format with the PSU and the Training of the Trainers (ToT) (recruited above) take place under the auspices of the School of Pharmacy at Makerere University. Following the completion of the ToT scheme the training teams

will disperse to their allotted Regions to work with the NDA teams on the sensitisation programme.

9.5.5 Step Five: Sensation Programme

Sensitisation Programme: The NDA Regional teams will work through the prioritised list of Districts to visit and to explain to local stakeholders the purpose of the new regulation and how it will be implemented in their District, when the District signals its readiness by requesting a programme of premises inspection and staff training. Districts will be prioritised by the number of registered Class C Drug shops listed with the NDA; those with the highest number of registered drug shops will be chosen first.

9.5.6 Step Six: Training and Inspection Programme

Training and Inspection programme: As the NDA Regional teams receive requests from Districts for conversion to the new regulation scheme they will prepare a schedule of training courses for the Shop owners and the dispensers and of premises inspections and carry these through. The outcome of this process will be the admission of the newly qualifying drug shops into the accredited scheme.

9.5.7 Step Seven: Public Support Programme

Publicity Support programme: the NDA will undertake a programme of public information and support for the newly accredited shops. The information programme will use mass media, such as radio, to raise and spread awareness of the new regulation and accreditation system and the benefits to the public of choosing to use one of the newly registered shops. Newly accredited shops will also have the outside of their premises repainted in a distinctive colour scheme and be provided with an external shop sign identifying them as being one of the newly accredited pharmaceutical shops.

9.5.8 Step Eight: Milestones and Control

Time based targets/milestones/goals for the achievement of each of the stages of the national scale up should be set out to enable progress of the scale up to be monitored and, if necessary, action taken to return the plan to the timetable to be determined and costed.

9.6 Monitoring, Evaluation and Control Phase

The last phase is the NDA monitoring the implementation of the national scale up plan outputs as the new regulation regime spreads and becomes established. The effectiveness of the new regulation scheme will be assessed and further changes to the scheme or to the drugs lists will be proposed from time to time.

APPENDICES

Appendix One: Scope of Work

ARTICLE I: SCOPE OF WORK

A. OBJECTIVE

The objective of this contract is to: (1) identify existing and potential business opportunities for drug shops in relation to profitability and sustainability, (2) identify potential problem areas that may affect profitability and sustainability of the drug shops, (3) make recommendations on actions needed to strengthen the drug shops and their resulting profitability and sustainability, and (4) develop a business plan for implementing a nationwide scale up of the ADS initiative in Uganda. To achieve this objective the Contractor shall perform the activities described below in paragraph C.

B. BACKGROUND

MSH is undertaking collaborative efforts with the Government of Uganda, funded by the Bill & Melinda Gates Foundation, to design and pilot an accredited drug seller initiative in Uganda with the ultimate goal of national scale up and long-term sustainability without the need for continuing donor support. The Ugandan initiative builds on the earlier Accredited Drug Dispensing Outlet (ADDO) program which was piloted in Tanzania and is now being rolled out nationwide in Tanzania. The ADDO initiative in Tanzania has been in place since 2003 when the pilot activity was initiated in Ruvuma region. Over 200 shops in Ruvuma region are now open, with most approaching eight years of successful operation. Reports on these efforts, as well as implementation in other regions of Tanzania as part of the nationwide scale up, are available.

C. ACTIVITIES

This contract is from May 2, 2011 through June 30, 2011. The Contractor at a minimum shall perform the following activities:

1. Thoroughly review all the reports, information and data previously prepared on the ADS initiative (and, as needed, information from the parent ADDO initiative in Tanzania).

2. Contact the MSH-appointed administrative officer and in-country technical support leads in Uganda and Tanzania to coordinate activities with them.

3. Prepare a program of work and timetable of activities for review by and approval of EADSI staff administrative and technical leads and gain approval of proposed timing for work in-country.

4. Develop any interview or data collection tools necessary to collect needed data from the field that will help identify potential problems relating to ADS profitability and sustainability and nationwide scale up.

5. In conjunction with the MSH-appointed administrative officer and/or technical advisory staff, undertake a visit of 3 to 5 days to Kampala for central level data collection and 5 to 7 days to Kibaale district to collect data from district health officials, ADS owners and sellers, and others as deemed appropriate.

6. Undertake a visit to collect relevant data from the Tanzania ADDO program (assume no more than 5 days total LOE).

7. Formulate a brief (numerically based) business model/plan for the operation of an Accredited Drug Shop, using the previously generated operational figures as a base to indicate their potential profitability and sustainability.

8. Identify potential solutions to problems relating to profitability and sustainability and engage local businesses and organization to identify what levels of support might be available to contribute to the profitability and sustainability of the ADS initiative.

9. Present a short debriefing of activities and achievements to the central and district level stakeholders at the end of the field visits, clearly specifying any further information which the group is to supply or activity which they are to undertake.

10. Develop a business plan for implementing the ADS initiative nationwide.

11. Draft and finalize report for submission to EADSI.

Appendix Two: Background Information about Kibaale District

Mission and Vision of Kibaale District and Geographical Maps– extracted from the Kibaale District website.

Kibaale District is one of the 112 Districts of Uganda located in the Mid-Western part of the country. The District is bordered by Lake Albert to the West, Hoima District to the North, Kiboga District to the East, and Mubende District to the South where as the South-West lies Kyegegwa, Kyenjojo, Kabarole, Toronko and Bundibugyo Districts.

The district was created in 1991 from Hoima District and is made up of 5 counties namely: Buyanja, Buyaga West, Buyaga East and Bugangaizi West and Bugangaizi East. The District has a total of 31 sub counties and Two Town Councils namely Kibaale and Kagadi town council, 135 approved parishes, and 1201 villages.

It is approximately 215 Kms from Kampala, the Capital City of Uganda. The District covers a total area of approximately 4,400 sq. kms, while 319 sq kms is covered by water bodies. The major wetlands cover 536 sq. km. The district perimeter is 360.7 km. The average rainfall range is 1000 – 1500 mm with two peak rain seasons in march – May and August – October. The average temperature range is 15 – 30 degrees centigrade. The lowest Altitude is 2040ft above sea level and the highest are Magoma hills, 5100 ft, in Kasambya Sub County.

Our Vision: Is having a healthy population with functional skills, improved household income and sustainable development by the year 2025.

Our Mission: Is to serve the community through coordinated delivery services which focus on national priorities and significant local needs in order to promote sustainable development in Kibaale District.

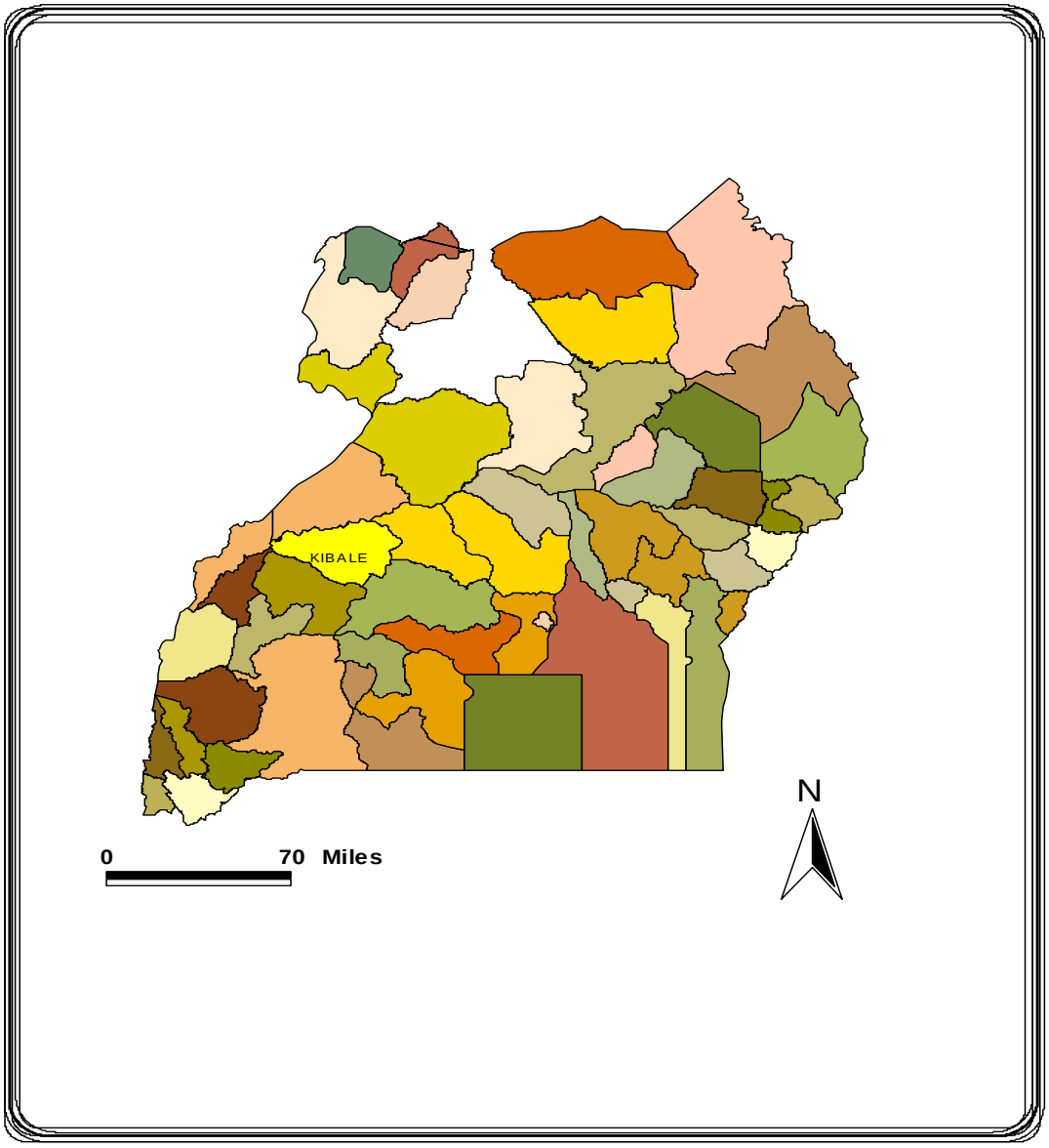
This website is established as way of ensuring transparence, accountability and a channel of getting feedback from our people.

We encourage all stakeholders in the development of Kibaale district to utilize the website as a channel of communication.

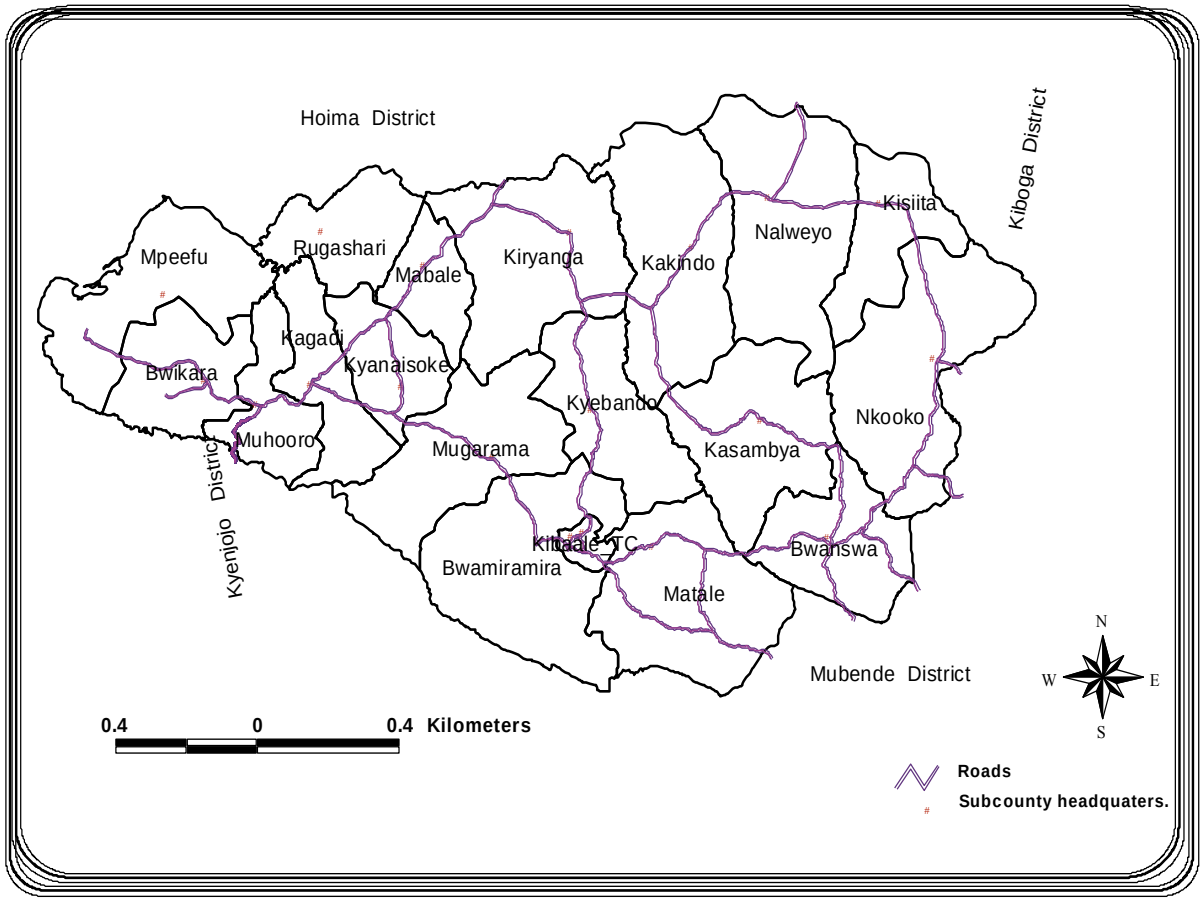
George William Namyaka

District Chairperson – Kibaale District

Map of Uganda Showing Location of Kibaale District



Map of Kibaale District by Sub Counties



Appendix Three: Meetings Held

Tanzania

Michael Gabra	Head of Party	EADSI	MSH
Jafary Liana	Senior Programme Associate	EADSI	MSH
Dr. Suleiman Kimatta	Senior Programme Associate	EADSI	MSH
Elizabeth Shekalaghe	Manager Accredited Drugs Dispensing Outlet Programme Co-ordinator. Tanzanian Food and Drug Authority		
Dunoo Mousa	District Officer	Morogoro District	
Mahabara Wholesale Pharmacist		Morogoro District	
Mwana Howa Mzee	ADDO Owner	Morogoro District	
Asinath B Mhando	ADDO Owner	Morogoro District	

Uganda

Saul Kidde	Technical Adviser Supply Chain Operations		MSH
Aziz Maija	Senior Programme Associate		MSH
Kate Kikule	Head of Drug Inspectorate	National Drug Authority	
Dennis Mwesigwa	Senior Inspector	National Drugs Authority	
Phillip Asiimwe	General Manager	EDF Micro Finance Kibaale	
Hussein Oria	Head of Department of Pharmacy – Makerere University		
Yusuf Sembatya	Current Secretary Pharmaceutical Society of Uganda (PSU)		
Swaib Mukubi	Previous Secretary PSU		
Morris Seru	Principal Pharmacist	Ministry of Health (MoH)	
Martin Oteba	Assistant Commissioner Pharmaceuticals (MoH)		
Tom Makumbi	Trainer for the ADS Accreditation Course (PSU)		

Dr. Dan Kyamanywa	District Medical Officer – Kibaale District
George William Bizibu	Kibaale District Health Secretary
George Okrut	Kibaale District Drug Inspector NDA
Vivienne Tebwiliggwa	Kibaale ADS Owner
Pamela Twinomugisha	Kibaale ADS Owner
Rosemary Kitone	Kibaale ADS Owner
Jackiline Atecieka	Kibaale ADS Owner
Mary Kisembo	Kibaale ADS Owner
Grace Tumusiime	Kibaale ADS Owner
Bedrma Tibasuurioa	Kibaale ADS Owner
Karim Bahemuka	Kibaale ADS Owner
Winifred Kiggundu Nakigudde	Kibaale ADS Owner
Jose Tusuubira	Kibaale ADS Owner
Adela Kaizire	Kibaale ADS Owner
Robert Augustine Senteza	Kibaale ADS Owner and Secretary of the Kibaale District Private Medicine Sellers Association

Appendix Four: Interview and Data Collection Tools

Introduction:

The following interview and data collection tools provide a framework within which the dialogue with the Key Stakeholders of the ADS initiative can take place. The dialogue required in the SoW is to be the means by which the business operations of the ADS are to be reviewed to:

1) Identify existing and potential business opportunities for drug shops in relation to profitability and sustainability;

2) Identify potential problem areas that may affect profitability and sustainability of the drug shops.

The identification of opportunities and threats in the dialogue process is then to result in the other two objectives of the project:

3) Make recommendations on actions needed to strengthen the drug shops and their resulting profitability and sustainability;

4) Develop a business plan for implementing a nationwide scale up of the ADS initiative in Uganda.

The Key Stakeholders of the ADS initiative can be collected into three groups:

Group One: ADS Business owners.

Group Two: Professional Bodies (Pharmaceutical Society).

Group Three: Bodies responsible for Regulation (District Staff, National Drugs Authority, Ministry of Health).

As the interests of each in relation to the ADS initiative are different the interview tools vary accordingly.

An interview/data collection tool for each group appears in the following pages.

ADS Owners.

Personal Details (If the interviews are conducted in group settings then this information will be collected through a circulated attendance list):

Name: Age: Sex: M/F

Qualifications:

Occupation (in addition to ADS owner):

Number of ADS currently owned:

Do you own or rent the premises used for your ADS?

If you rent your premises are you responsible for the maintenance of the building or is that done by the landlord?

Role in your ADS: Owner Dispenser Both

Business Objectives

When did you first become a DS owner?

Is your ADS your only source of income?

Is your ADS your main source of income?

What other source of income do you have?

Why did you become a DS owner?

Increase income: Improve Community health: To complement other business/professional interests:

Other:

Purpose of Accreditation

Why did you decide to take part in the Accreditation scheme?

The prospect of:
Increasing sales Increasing profits Retaining market share

Improve profits by reducing stock wastage/write offs? Formal endorsement of your business.

Does Accreditation give you access to better supply chains considering:

Price? Yes/No

Or Quality of product? Yes/No

Or supply lead time and frequency? Yes/No

Training

Have you or your staff received business management training as part of the accreditation process? Yes/No

If Yes what topics were covered?

What additional business training would help you?

Outcome of Accreditation

Have the results of being accredited been positive i.e. good for your business or negative i.e. bad for your business?

If positive; how and how much i.e. change in sales, change in profits.

Would you consider opening another ADS as a result of your experience so far?

Would you recommend opening an ADS to a friend?

What changes would you like to see to make your ADS more profitable?

Greater range of product? If so, what?

Better sources of supply?

Access to credit or Loans?

Additional service lines? If so, what?

Changes to the regulation regime? If so what?

If negative; how and how much i.e. higher costs, lower sales, restrictions on goods that can be offered.

Will you continue to operate your current ADS or will you try to close or sell it?

What would need to change for you to consider your investment in ADS a success?

Greater range of product? If so what?

Change in the regulation regime? If so what? Being allowed to sell more pharmaceutical products? Being allowed to sell non pharmaceutical products?

Other.

Regulation

Which organisations regulate you business?

National Drugs Authority?

District Government Staff?

Ministry of Health?

Other?

Do those who regulate your business help you to understand the regulations and make positive suggestions for improvement?

Is the effect of the current arrangement for regulating your business positive or negative?

Why?

How could the regulation regime be improved from your point of view?

Trade Associations

Are you a member of a trade association?

Which one?

Why?

Are you aware of any Association for ADS being formed?

Would you be in favour of joining an Association for ADS ?

Why?

What should an Association for ADS be for?

- Regulation?
- Marketing?
- Training?
- Advocacy?
- Financial Support?

Would you be prepared to pay to join an ADS Association?

Would you be prepared to assist in starting an ADS Association?

Aspirations

What do you want your financial situation to be in the future?

In 5 years do you expect to be better off than you are now? Yes/No

If YES what part do you expect your ADS to have played in this? Major part; Minor part: No part at all.

What do you expect to be the most important activity that you are doing today that will have helped to improve your financial situation?

Future Roll Out

From your experience of the ADS initiative which organisation(s) do you think are going to be best placed to organise the roll out of the ADS across the rest of the country?

National Government?

District Government?

National Drugs Authority?

NGOs?

A mixture of the above?

Others?

Data Sheet for ADS Owners

This information is supplied in confidence. Do not write your name on this page.

Sales

Average total daily sales of your ADS in Ugandan Shillings

Average Extended Medicines List product daily sales of your ADS

Average Non EML product daily sales of your ADS (By subtraction)

Best Selling Products

Please list the 10 items that sell best in your shop, the usual quantity in which you sell them and the price at which you sell them:

	Product Name	Selling quantity (e.g. ml, no. of tablets)	Selling Price
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

What is your estimate for how much of your total sales are accounted for by these ten items e.g. 10% or 20% or 30% etc.

Profit

Calculating Gross Profit as the sales revenue minus the cost of the goods you sell.

Does your ADS make a Gross profit? Yes / No

Total Sales - minus Cost of Goods = Gross Profit

Costs

What do you have to pay for apart from the goods that you sell? e.g.

Electricity: phone bill; water: rent: tax, Staff wages

repaying loans

Stock write offs (e.g. damaged stock or expired stock handed over for destruction which you have paid for)

Adding the cost of all these items together; how much do you pay out each week on average? UGS.

Income

After you have paid for the goods that you sell in your ADS and the costs listed above for electricity, phone etc: Do you have anything left over for yourself? Yes / No

Income for You: Approximately how much money do you have each week for yourself UGS:

What do you use this money for?

- Family expenses
- Saving
- Financing / expanding the Business

Professional Bodies: (Pharmaceutical Society of Uganda)

Name of interviewee

Position:

Role:

Professional Qualification:

Does the PSU think that the introduction of the ADS initiative represents a step towards improved access to better quality medicines for the rural population of Uganda?

What do you think are the main achievements of the ADS initiative so far?

What do you think are the main failings or weaknesses of the ADS initiative so far?

What are the main concerns of the PSU towards the ADS?

Do you think that the Extended List of items which ADS can sell includes everything that should be included for promoting better access to good quality medicines by the rural poor?

Are there items that the PSU would wish to see removed from the Extended List list? Why?

Are there items that the PSU would like to see added to the Extended List list? Why?

Do you think that there should be limitations to the products that the ADS can sell apart from Extended List items? Why?

What role does the PSU currently play in supporting or encouraging the ADS initiative?

What changes would the PSU like to see in its current role in supporting or encouraging the ADS? WHY?

Does the PSU think that a trade association for ADS would be beneficial?

Does the PSU offer training relevant to the needs of ADS owners or dispensers?

Does the PSU consider that the right to sell Extended List medicines should be controlled or guided by a professional body or could it be left to general retailers to organise the sale of these items?

Organisations Charged with Regulation (National Drugs Authority, Ministry of Health, District Officials)

Name of Interviewee:

Organisation:

Position:

Role:

Professional Qualifications:

Length of time in Post:

Does your organisation think that so far the introduction of the ADS initiative represents a step towards improved access to better quality medicines for the rural population of Uganda?

What do you think are the main achievements of the ADS initiative so far?

What do you think are the main failings or weaknesses of the ADS initiative so far?

What are the main concerns of your organisation towards the ADS?

Have the legislative changes been made (e.g. to Extended List lists) that are necessary to prepare for a National Roll out of the ADS? Yes/No

If No: If there are still legislative changes required before the national roll out of ADS can take place when would you expect these to be complete?

Do you think that the Extended List of items which ADS can sell includes everything that should be included for promoting better access to good quality medicines by the rural poor?

Are there items that your organisation would wish to see removed from the Extended List list? Why?

Are there items that your organisation would like to see added to the Extended List list? Why?

Does your organisation think that the selling of Extended List items should be done separately from other businesses – like retailing food or cosmetics? Or do you think that it does not matter how Extended List items reach the rural public as long as they are of good quality and sold responsibly?

Do you think it matters what the business or professional interests are of the people who own ADS? If yes, why?

What other types of product apart from Extended List items does your organisation think that ADS should be able to sell?

Do you think it possible/desirable for ADS to offer for sale medicines for the treatment of animals?

Does your organisation think that the sale of medicines or services through ADS should allow the owner to make a profit?

Does your organisation think that the sale of medicines or services through ADS should be subsidised to reduce costs to the rural population?

Do you think that a Trade Association for ADS would strengthen the ADS initiative?

Would your organisation welcome or oppose the establishment of a Trade Association?

- Welcome/Oppose?
- Why?

Future Roll Out

Does your organisation think that the ADS model that has been trialled in Kibaale is ready to be rolled out to the rest of the country? Yes / No

If No: What changes need to be made to the ADS model before it is ready for a national roll-out?

If Yes: By whom do you think that such a roll-out ought to be managed?

By central control of the government? Why?

By the local District governments? Why?

Others (e.g. an NGO)? Why?

Do you have personal experience of rolling out such programmes?