

flourish

A Publication of Pharmalliance, Africa's Premier Retail Pharmacy Business Support Network

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Also in the Edition

Managing primary
dysmenorrhea

Get out of the box

Dealing with the
menace of Codeine
addiction

A better approach to
customer service

A portrait of Mrs. Yetunde Aromiwura, CEO of Precious Pharmacies. She is a Black woman with her hair pulled back, wearing large black-rimmed glasses, a pearl necklace, and a black top with a pink and black striped scarf. She is resting her chin on her hand and smiling slightly.

BEHOLD THE PRECIOUS ONE,
Pharm (Mrs) YETUNDE AROMIWURA,
CEO, Precious Pharmacies, Abeokuta



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IT IS HERE AGAIN! Your treasured publication, FLOURISH is back on the newsstands. This is the 7th edition and as you know 7 is the number of perfection. While this may not be the perfect edition, I can assure you it is a precious one. This edition is the ACPN Conference edition and it promises to give you the best of clinical, business and lifestyle information.

This edition has your usual features which keeps you spell bound from cover page to back page. Our cover interview takes us all the way to the rocky city of Abeokuta in search of a precious gem. After a rigorous expedition, we found the precious jewel we were looking for. I must say that the search was indeed worth it. We never knew that such an amazing amazon was safely tucked away in the rock city. The interview with Pharm Yetunde Aromiwura, CEO of Precious Pharmacies, Abeokuta is an eye opener as she takes us through her inspiring life story. The second is an interview with an indomitable and resilient Pharmacist and a staunch member of Pharmalliance, Pharm. Uma Ndukwe, CEO of Greenvive Pharmacy. Don't miss the stimulating discussion. This edition also highlights some of the activities of Pharmalliance, both local and international.

The clinical section of this edition focuses on Primary Dysmenorrhea culled from a wonderful resource - 'Community Pharmacy' by Paul Rutter. It's a must have for every practicing Community Pharmacist. Other articles stem from our regular columnists like Ayomipo Adegaye and Anuoluwapo Ademuyiwa. We also have a few new contributors in this edition

As you peruse this fine mix of clinical, business and lifestyle articles, we wish to inform you that the two Pharmalliance titles released recently are still very much on sale. These are **BEAT THE TAX MAN** and **COUNTER EXCELLENCE**.

Lest I forget, **Panel 8 is here!** It promises to be the highest energy event ever to hold in The Nigerian Pharma Industry. Keynote address speaker will be Mr Fola Adeola, Founder of GTBank. The 2 day event will take place at Sheraton hotel and towers, Ikeja from August 17th-18th 2016. Don't miss it!

As you digest the contents of this edition of flourish, we pray you continue to flourish in spite of the prevailing economic realities.



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FEATURING



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GET OUT OF THE BOX!

Pharm, Adeshina **Opanubi**



Depending on the side of the divide you belong to, you may not like the tone of this piece. If you belong to the old school conservative party, then this piece could at worst be described as blasphemy. This is because you most likely believe ours is a hallowed profession where we sit and wait for the patients to walk into hallowed chambers of our pharmacy seeking to see the almighty Rabbi. However, if you belong to the new school aggressive and progressive party, then your heart would be leaping for joy as you read, because you will see that at last someone is speaking your mind.

As project catalyst of Pharmalliance, Africa's premier Retail Pharmacy business network with more than 50 Retail businesses as members and a combined annual turnover of over N5billion, I have seen a lot of subtle and radical things happen in the retail sector of the Nigerian pharmaceutical industry. I have seen businesses rise and fall at different speeds and velocities. Some aborted before their first breath of life; others die in infancy while a few manage to die in old age without any leaving any inheritance behind.

However in the same space, I have seen some aged and ailing pharmacies bounce back to life after adopting some guerilla business resuscitation strategies. A few other have started strong and are still firing on all cylinders.

Having looked at all these players, I see that the real game changer is in the mindset. The bible says that as a man thinketh in his heart so is he. For a few of the older ailing businesses I would recommend that they read the book, WHO MOVED MY CHEESE. This is because their cheese has since moved and they are stuck on the same spot waiting for it to come back. In all this, I have found out that there are some who are really willing but don't seem to have the requisite resources to move ahead. It is for this group of people that we published our first 2 titles. These are BEAT THE TAXMAN and COUNTER EXCELLENCE. These books seek to address what I consider one of the biggest needs in the retail pharmacy space which is human capital development. We would be releasing a few more titles in the very near future.

However, one major limitation I find is that many pharmacists have is that of the BOX! We all seem to have caged and confined ourselves into this imaginary box which spells out limits and boundaries for us. This more than anything else has keep us bound for ages and unless there is a conscious move to emancipate the Nigerian Pharmacist, we may remain locked away for ages to come. The average community pharmacist is satisfied to sit in his pharmacy and wait for customers to walk in and give them what they ask for hoping that he has it in stock. This is IN -THE- BOX mentality. Unfortunately, world over, the picture has changed.

In the light of the current economic realities in Nigeria, the community Pharmacist that will thrive will be one that will look beyond the pedestrian practice of old and begin to carve out new frontiers of practice.

He needs to break the mould and create new realities for himself. He needs to think OUT-OF - BOX. However, there is a new school of thought which suggests that you THROW-AWAY-THE-BOX so that you can see clearly the limitless opportunities available to you. While a lot of pharmacists don't like to hear this, I am not an avid fan of the 200m space principle. While it may have served its purpose in the past, I think we need to be more creative to solve the problems of the present. The 200m space has succeeded in promoting mediocrity in the retail pharmacy space. It has empowered the pharmacist with a territorial mindset that shields him from competition yet the discerning business mind knows that competition is what every business needs to bring out its best. It is not usual to see 3 doctors practicing in the same building. That's basically because of the issue of specialization. Each one caters for a specialized target market. E.g Ophthalmology, dentistry, dermatology, cardiology e.t.c

Unfortunately, in Pharmacy, most of us do one thing only, sell drugs, shikena! Operating at this level, we are all but traders. We need to throw away the box and begin to add value to the lives of our customers by meeting their stated and unstated needs. Community Pharmacies need to increase their bouquet of service offerings so that they can clearly be differentiated from the crowd.

Some expanded pharmacy services could include:

Compounding: Most pharmacists have never bothered to look back once they secured the necessary 60% to pass the dispensing course in pharmaceuticals during their undergraduate training.

A few continued when they found themselves in pediatric units of teaching hospital where there was need to compound digoxin, frusemide etc for children with cardiac conditions or quinine syrup for children. The question is whether there is room for compounding in community pharmacy and the answer is a big yes. Imagine being able to extemporaneously prepare these pediatric formulations for hospitals around your pharmacy. Will it make a difference in the way your pharmacy is perceived? Among the doctors and even the patients. However, compounding goes a long way beyond that. There is a large market in dermatological compounding where high concentration creams are diluted with a base or even unique blends of creams and ointments created to suit a patient's unique need. We also have flavoring compounding, where unique flavors such as bubble gum, strawberry and pineapple flavors are added to existing formulations. This helps to enhance the palatability of the medication and would also increase the profitability of the business.

Nutrition services: There is a thin line between Nutrition and medicine hence the Pharmacist should be well equipped to counsel and give support to patients on nutritional issues. The pharmacist should clearly understand how to calculate calories, how to plan basic diets especially for children and patients with special medical conditions such as diabetes and hypercholesterolemia. The Pharmacist should also have competent dieticians to refer cases to. The concept of drug induced nutrient depletion should also be properly understood by the Pharmacist. All these help in differentiating the Pharmacy from others in the locality.

Weight Management service:

The Pharmacist should be able to work with patients who have a need to manage their weight. The service of the Pharmacist should go beyond checking weight and BMI but also should be able help the Patient attain the right parameters through a counseling mix of diet and exercise.

Home/Office delivery: The community pharmacy should be able to build a delivery service into its value offering such that it can deliver medication to its registered customers at their convenience. This should however be done within the ambits of the law.

Medication therapy Management:

Building loyalty with customers is easier when dealing with patients with chronic ailments. These are patients using medications that require periodic refills. These conditions include asthma, hypertension, diabetes, hypercholesterolemia, glaucoma etc. Community Pharmacists can set up an MTM service where patients can sign up to enjoy this service.

These are just a few of the very many options open to a community Pharmacists. The opportunities are only as wild and numerous as you dare to dream. Open your mind and your hearts and receive inspiration

from the most high to do great and amazing things in your business. Let me end with this quote which I find to be very profound. It says that 'we fail in life, not because we aim too high and miss but rather because we aim too low and we hit our goal'

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PRIMARY DYSMENORRHOEA

(PERIOD PAIN)



Menstruation spans the years between menarche to menopause. Typically, this will last 30 to 40 years, starting around the age of 12 and ceasing around the age of 50. The menstrual cycle usually lasts 28 days but varies and it can last anything between 21-45 days. Menstruation itself lasts between 3-7 days. Individuals can also exhibit differences in menstrual cycle length and blood flow. Dysmenorrhoea is usually categorized as primary or secondary; Primary Dysmenorrhoea (PD) is defined as menstrual pain without organic pathology, whereas in Secondary Dysmenorrhoea, an identifiable pathologic condition can be identified.

Prevalence and epidemiology

PD is very common in adolescents but exact prevalence rates vary due to differing definitions of dysmenorrhoea used in studies. However, it is likely to affect over 50% of women, and 7 to 15% of these women report symptoms severe enough to cause school/work absence.

Aetiology

Overproduction of uterine prostaglandins E_2 and F_2 are major contributory factors in causing painful cramps. Prostaglandin production is controlled by progesterone and before menstruation starts, progesterone levels decrease allowing prostaglandin production to increase, and if overproduced, cramps occur. Ovulation inhibition can also improve symptoms (by using the oral contraceptive pill) as it lessens the endometrial lining of the uterus reducing menstrual fluid volume and reducing prostaglandin production.

Arriving at a differential diagnosis

The main consideration of the Community Pharmacist is to exclude conditions that have a pathologic cause (Secondary Dysmenorrhoea). Fortunately, by far and away, the most likely problem seen in primary care is PD. **Table 1.**

It is essential to take a detailed history of the patient's menstrual history as PD is a diagnosis based on exclusion. The frequency, severity and relationship of symptoms to the menstrual cycle need to be established. Asking symptom-specific questions will help the Pharmacist to determine if referral is needed. Table 2.

Table 1
Causes of period pain and their relative incidence in community pharmacy

Incidence	Cause
Most likely	Primary dysmenorrhea
Likely	Secondary dysmenorrhoea
Unlikely	Pelvic inflammatory disease, dysfunctional uterine bleeding

Table 2
Specific questions to ask the patient: Primary dysmenorrhoea

Question	Relevance
Age	PD is most common in adolescents and women in their early twenties. Secondary Dysmenorrhoea usually affects women many years after the menarche, typically after the age of thirty
Nature of pain	A great deal of overlap exists between PD and secondary dysmenorrhoea but generally PD results in cramping whereas secondary causes are usually described as dull, continuous diffuse pain.
Severity of pain	Pain is rarely severe in PD; the severity decreases with the onset of menses. Any patient presenting with severe lower abdominal pain should be referred.
Onset of pain	PD starts very shortly before or within 24 hours of the onset of menses are rarely lasts for more than 3 days. Pain associated with secondary dysmenorrhoea typically starts

Clinical features of PD

A typical presentation of PD is of lower abdominal cramping pains shortly before (6 hours) and for 2 or possibly 3 days after the onset of bleeding. Commonly associated symptoms include fatigue, back pain, nausea and/or vomiting and diarrhoea. It is classically associated with young women who have recently (6-12 months) started having regular periods.

However, there may be a gap of months or years between menarche and onset of symptoms. This is due to as many as 50% of women being anovulatory (ovulatory failure) in the first year (and still in 10% of women 8 years after the menarche). This is important to know, as anovulatory cycles are usually pain free.

Conditions to eliminate

Likely causes

Secondary dysmenorrhoea (e.g. endometriosis)

Endometriosis simply means presence of endometrial tissue outside of the uterus.

The exact incidence of endometriosis is unclear; it is the most common cause of secondary dysmenorrhoea. Reports suggest it may occur in up to 50% of menstruating women but many are asymptomatic.

Any person over the age of 30 either presenting for the first time with dysmenorrhoea or has noticed worsening symptoms should be viewed with caution. Patients experience lower abdominal pain

(aching rather than cramping), that usually starts 5 to 7 days before menstruation begins and can be constant and severe. The pain often peaks at the onset of menstruation. Referred pain into the back and down the thighs is also possible.

Unlikely causes

Pelvic inflammatory disease (PID)

PID is an important cause of infertility and ectopic pregnancy with many women being asymptomatic and only diagnosed during infertility investigation. It most commonly occurs in sexually active women aged between 15 and 24 years old. Symptomatic cases show variable clinical presentation but it is associated with dull bilateral lower abdominal pain and dysmenorrhoea (with pain greatest premenstrually). Other symptoms such as fever, malaise, vaginal discharge, irregular menses and dyspareunia (painful menstruation) are often present.

Dysfunctional uterine bleeding

Dysfunctional uterine bleeding is a non-specific medical term defined as abnormal uterine bleeding that is not due to structural or systematic disease and includes conditions such as amenorrhoea (lack of menstruation) and menorrhagia (heavy periods); with the majority of cases attributable to menorrhagia. The Pharmacist should ask the patient if their periods are different than usual.

Fig.1**TRIGGER POINTS Indicative of referral: Primary dysmenorrhea**

- Heavy or unexplained bleeding
- Pain experienced before menses
- Pain that increases at the onset of menses
- Signs of systematic infection (e.g. fever, malaise)
- Vaginal bleeding in postmenopausal women
- Women over the age of 30 with new or worsening symptoms

Evidence base for over-the-counter medication***Non-steroidal anti-inflammatories***

The use of NSAIDs would be a logical choice because raised prostaglandin levels cause PD. In multiple clinical trials they have been shown to be effective in 80 to 85% of women. A Cochrane review by in Marjoribanks et al (2010) concluded that NSAIDs were significantly more effective in relieving moderate to severe pain associated with compared to placebo. However, there was little evidence of superiority of any individual NSAID.

Hyoscine butylbromide (Buscopan)

In one study, Buscopan was given to 17 patients in a double-blind placebo-crossover trial. The study failed to demonstrate a significant effect compared to placebo or the comparator drug – aspirin, although in the authors' opinion, Buscopan was a good alternative to NSAIDs.

Alverine (Spasmonal) is licensed for

the treatment of dysmenorrhoea. It is an anticholinergic antispasmodic that relaxes the uterine smooth muscle; however, there is a lack of published evidence regarding its efficacy.

Low-dose combined oral contraceptive

Although not available OTC, oral contraceptives have been reported to be beneficial in treating PD. A Cochrane review (Wong et al 2009) identified 10 trials, and found improvements in pain compared to placebo (OR = 2.01; 95% CI 1.32 – 3.08). Therefore, if standard OTC treatment is not controlling symptoms adequately, the patient is best referred as contraceptives provide an alternative treatment option.

Other treatment options

A number of alternative treatments have been tested in PD, most notably transcutaneous electrical nerve stimulation (TENS), acupuncture, exercise and dietary supplements. Of these, high Acupuncture appears promising and

the evidence for exercise is uncertain. A wide range of dietary intervention is frequently recommended and includes vitamins B and E, fish oils and magnesium. Most trials were conducted on low patient numbers and have reported limited or no benefit except vitamin B1 (thiamine – 100 mg), which saw a significant proportion of women with no pain compared with placebo. The Chinese herbal remedy tokishakuyaku-san, taken for at least 6 months, may also reduce dysmenorrhoea.

Summary

NSAIDs (ibuprofen or naproxen) should be used as first-line therapy unless the patient is contraindicated from using an NSAID. A trial of two to three cycles should be long enough to determine if NSAID therapy is successful.

Practical prescribing and product selection

Prescribing information relating to the medicines reviewed in the section 'Evidence base for over-the-counter medication' is discussed

Fig.2

HINTS AND TIPS BOX PRIMARY DYSMENORRHOEA

Hot water bottles

The application of warmth to the lower abdomen may confer some relief of the pain

and summarized in Table 3; useful tips relating to patients presenting with PD are given in Hint and Tips box Fig. 2

Ibuprofen

There are a plethora of marketed ibuprofen products (e.g. Nurofen and Cuprofen) all of which have a standard dose for the relief of PD. Adult should take 200 to 400 mg (one to two tablets) three times a day, although most patients will need the higher dose of 400 mg three times a day. Because ibuprofen is only used for a few days, each cycle it is generally well tolerated. However, gastric irritation is possible and ibuprofen can cause peptic ulcers or bronchospasm in asthmatics who have a history of hypersensitivity to aspirin or NSAIDs. Ibuprofen can interact with many medicines although the vast majority is not clinically significant (see Table 3).

Naproxen

Naproxen is indicated for primary dysmenorrhoea for women aged between 15 and 50 years old. The dose is two tablets (500 mg) initially, followed 6 to 8 hours later by a second tablet (250 mg) if needed. No more than three tablets should be taken in a 24-hour period. The same side effects, cautions and contraindications with ibuprofen apply to naproxen.

Diclofenac Potassium

Diclofenac Potassium is indicated for the relief of period pain. It can be given to people aged over 14 years

Practical prescribing: Summary of medicines for primary dysmenorrhoea

Name of medicine	Use in children	Likely side effects	Drug interactions of note	Patients in which care exercised	Pregnancy & breastfeeding
Ibuprofen Naproxen Diclofenac	Not Recommend ed	GI discomfort, nausea and diarrhoea	Lithium, anticoagulant s, methotrexate	Elderly (increase risk of side effects)	Not applicable in pregnancy as patients do not menstruate when pregnant. NSAIDs OK in breastfeeding but avoid hyoscine if possible due to lack of data
Hyoscine		Dry mouth, sedation and constipation	Other anticholinergi cs, e.g. TCAs	Glaucoma	

old. The dose is two tablets initially, followed by one or two tablets every 4 to 6 hours as needed. No more than six tablets (75 mg) should be taken in any 24-hour period. The same side effects, cautions and contraindications with ibuprofen apply to diclofenac.

tricyclic antidepressants, antihistamines, butyrophenones, phenothiazines and disopyramide.

Hyoscine hydrobromide

The dosage frequency for adults is two tablets four times a day. It is contraindicated in patients with narrow-angle glaucoma and myasthenia gravis and care should be exercised in patients whose conditions are characterized by tachycardia (for example, hyperthyroidism and cardiac problems). Anticholinergic side effects such as dry mouth, visual disturbances and constipation can be experienced but are generally mild and self-limiting. Side effects are potentiated if it is given with

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A BETTER APPROACH TO CUSTOMER SERVICE

Pharm. Olaoluwa **Mamora**



Every organization is in business to sell a product, render a service, make profit and edge out competition thus maintaining a sizeable market share.

At whatever level of operation or performance (local, international, global) or in whatever aspect of human endeavour (science, art, commerce etc.), all organizations must strive to provide quality customer service that not only meets but exceeds the clients expectations. This will lead to customer loyalty and profitability for the organization.

Every organization, in principle, is aware of the important roles their

clients play in their sustainability and this translates to different practices and tactics for different organizations (various approaches and different forms of customer service delivery).

Pharmacists and many other employers in various fields of practice are being formally and informally educated on the importance of placing premium on their clients. Phrases like “Customers are always right”, “Customer is king” are often chorused in the customer service environment. This philosophy, most often than not, has made employers and business owners focus customer service delivery solely on only one set of customers (external customers), forgetting that their employees are also customers (internal customers) who provide the service.

I believe every organization should rather engage in “employee-first” philosophy or approach to customer service delivery. When the employee is happy, the customer will be happy, and when the customers are happy, the shareholders or the employer is happy. The “customer-centric” approach discussed in the previous paragraphs builds a system where pressure is placed on the employee to make a customer happy or satisfied even when he or she is not.

Really, you cannot give what you don't have. Employers and organizations are encouraged to come up with ways to ensure that employees are happy and satisfied. This however may not be about a pay rise or something capital intensive; the following techniques can be put in place to ensure employee satisfaction;

LOVE AND CONCERN:

Employees are happy when they know that the employer is not only concerned about their performance at work but also concerned about other psycho-social factors (family, health) that may affect their performance at work.

They appreciate a level of personal attention from top management. They are happy when the boss asks after the welfare of their sick child and so on. This sense of love they have received will make them reciprocate the love to the company and ultimately to the clients first-hand. 'The truth is that the customers will never love a company until the employees love it first'- Simon. This is not something tedious. Systems could be put in place to ensure good employee welfare scheme and an atmosphere of love and care can be created when the leader (manager) leads by example. As much as we talk about building a relationship with your clients, I believe we should also talk about building one with your employee.

ADEQUATE JOB DESCRIPTION:

Every member of the organization should be given proper education on

how significant their job or the process they supervise is to the delivery of service to the customer. This makes them feel very important and gives them an improved confidence at what they do. Many people complain that they don't enjoy what they do simply because of inadequate understanding of the potential the work holds for self-actualization and/or its significance to customer service delivery (either directly or indirectly). Top management should continually remind employees of why their offices exist and how the clients benefit directly from them giving their best on the job. When workers understand this, they will look forward to giving their best at work every day rather than having a "Thank God Its Friday" syndrome, thus improving the customer experience. This will also make the employee have an ownership mindset and develop initiative about how to make his or her work better.

APPRECIATION AND RECOGNITION SCHEMES:

Employees should be appreciated, appraised and rewarded. Schemes that reward the employees should be set up in place. Personal words of affirmation and acknowledgement of employees' performance will also help the employee to give in their best. They are aware someone recognizes their effort at getting better and would be motivated to do more.

TRAINING:

As employees give their best to customer service delivery,

the employer should also be interested in the career growth of the employee.

They should organize or sponsor employees to go for seminars, trainings and workshops, as this will help them become better. Skills learnt at such seminars will be used on the job as employees would love to give their best when they see that they are also growing and achieving their career goals.

“We believe that if we treat our employees right, they will treat our customers right, and in turn, results in increased business and profits that make everyone happy.” – UK Business Insider, July 29, 2015



A major airline always say that there's something it values more than its customers and there's a good reason why. At Southwest Airlines, employees come first. The airline puts employee happiness above customer satisfaction. The approach may seem unconventional but it makes perfect sense and seems to be working fine for the Dallas-based airline that employs about 47,000 people and serves more than 100 million customers annually. In 2013, Southwest was named No.1 in customer satisfaction by the U.S. Department of Transportation; earned No. 2 spot on Consumer Satisfaction Survey; and ranked second on Business Insiders list of best airlines in the U.S.

The 44-year-old airline is known for its friendly (and often witty) flight attendants, as well as top notch customer service. This stems from its employees-first mantra, which plays out in a trickle-down effect. In order of importance, Southwest ranks employees first, customers second and shareholders third.

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PRECIOUS PHARMACY, BUILT TO LAST

With a strong drive to establish a front-line Pharmaceutical outfit centered on 'service to the community', Pharm (Mrs.) Yetunde Aromiwura took the bold leap to set up a business brand that will outlive her generation. She represents the quintessential figure of an industrious Lady Pharmacist and hardworking mother. Flourish Crew reports.



Can we meet you ma?

I am Pharm (Mrs) Esther Yetunde Aromiwura FPSN; providence named me as "Precious". I am in my mid-fifties. I was born to Late Pa Adegbesan and Madam S. T. Adegbesan in Ikala Ijebu-Imusin in Ijebu-East Local Government Area of Ogun State. I attained Primary and Secondary education at Ajebo United Primary School, Ikala Ijebu-Imusin and Rev. Kuti Memorial Grammar School, Abeokuta respectively. I proceeded to Sombor for Serbian Language programme and later attended Center for Educational Cadres in Medical Branch for foundation programme in Pharmacy.

I later secured admission to study Pharmacy at Faculty of Pharmacy, University of Belgrade in Europe where I obtained a B. Pharm in 1986.

Share with us your work experience.

My sojourn in Pharmacy practice began when I completed my foundation programme in Sombor and returned to Nigeria. I worked briefly "Service to Mankind" as our motto and goal. The high quality was driven by sincerity of purpose, passion and due diligence. Starting from a renovated old building in the corner of the town at Adatan, it took some time before the community could recognize that something new was in town. But when

they did, they did not look back even up till now. My landlord, then of blessed memory, once drew my attention to his observation that the patronage was low compared to a nearby reference. In reply, I told him that as a professional, I couldn't afford to join the bandwagon and that with time, the community would recognize and appreciate the service.

Our customers are key as we pay detailed attention to service satisfaction and outcome. All classes of our clients are treated with courtesy and honesty that we gained their confidence with time. Our expansion to other areas in town was fuelled by our client's demand and, in some cases, on invitation. We believe that a satisfied customer will recommend your services to others. Our clients are the strength of the organization and are much appreciated for they stand by us through thick and thin.

What challenges have you faced in business considering the business/political climate we have in Nigeria?

Without challenges, one cannot move forward nor do things in a different way. There is need to always pray that the Almighty God should make us not to encounter challenges that will submerge our efforts.

I have learnt and realized that anything can happen to anyone in life. When the present administration came on board in Ogun State and focused on road construction, Precious Pharmacy was grossly affected; all our three (3) branches were affected with two outrightly demolished. Nevertheless, we have all

cause to be grateful to God for mobilizing the Heaven for us and resources to save us from going under. Unfortunately, no compensation has been paid till this moment on these properties.

Also to mention the series of robbery attacks when there were lapses in the security network in the state, high turnover of personnel and, of course, the general challenges of lack of regular power supply to run business, unpredictable fuel scarcity and to lastly affirm that business is not easy to run in Nigeria.

What are your dreams for Precious Pharmacy?

In which areas of healthcare are you likely to expand?

I wish Precious Pharmacy is better structured so that we can take bigger and bolder steps in areas that are of interest. Whatever does not grow will die, one has to keep on growing.

How would you describe the kind of service Precious Pharmacy offers and what is the quality that sets it apart from the rest?

Precious Pharmacy is committed to providing quality services and products at affordable prices in a conducive environment without compromising standards and our clients benefit from this just as our slogan now says **“Live better everyday”**. Our watchword is: **Good Pharmacy Practice** as defined by FLP – “The practice of Pharmacy that responds to the needs of the people and health facilities who use the Pharmacist's services to provide optimal evidence-based care.” We are also concerned about health outcomes i.e. the impact of healthcare activities on our clients.



You have set your eyes on new frontiers of pharmacy and clinical services to be offered to your customers/clients. Can you share some of them and the motivation behind these laudable objectives?

More robust activities geared towards improved Pharmaceutical care as well as health education and promotion to impact positively on the health of the people we serve are dear to our organization. We set out to assist our clients to live better every day.

Do you have any role-model in the industry?

I am grateful to the following people who are my role-models in the industry. Many Lady Pharmacists have made their mark in both their roles as mothers and in their career. I'd like to mention Pharm. Mrs. Solanke of Queens Pharmacy now in Lekki, Lagos. She supported and encouraged me right from the beginning. I understudied Community Practice in her premises in the evenings; she also guided me in the choice of products to

stock at the beginning when she was still in Abeokuta. Pharm. Mrs. O. I. Lewis, former Permanent Secretary in Ogun State, for her penchant for details and protocol; Pharm. Mrs. Ogunseinde of A-Z Pharmacy, a pride of Pharmacy in Ogun State and a household name; Pharm. Mrs. Bisi Ogunbayo, who taught me how to balance career and home affairs; Pharm. Mrs. Dupe Olurin, also a former Permanent Secretary in Ogun State government, a friend and senior colleague, for her humility despite her advantaged background.

I also wish to mention Pharm. Alhaji Bola Adeyemi FPSN, our elder, indefatigable and passionate Pharmacist with exemplary leadership qualities. It is my delight to also mention Pharm. Rotimi Ogunbade FPSN of Fontana Pharmacy, Ijebu Ode; a dear brother and friend who will stick out his neck for the truth when others chicken out.

Are you currently mentoring anyone in the industry?

I have been doing that knowingly and unknowingly. By the grace of God, some of our colleagues have been inspired that you can render services without cutting corners and be fulfilled and this has encouraged them to set up their practice and believe in it. Some Pharmacy students have also realized that community can be an option, and are already in community practice contributing their own quota. NYSC Pharmacists that served under me after working for some time have set up their own practice and send appreciation for the privilege of learning through Precious Pharmacy.

How have you managed to combine the daunting roles of a mother and a business woman to build a formidable pharmacy enterprise?

My home comes first in all my endeavours and I give God all the Glory. When I was growing in community practice and my children were much younger, I cook meals for the following day in the night after they had gone to bed and even do my laundries. Let me share my experience of one of my children. I make sure they compulsorily eat breakfast before they go to school, but on this day, my son got angry and refused the breakfast and said that he won't die before midday meal. Surprisingly when he came back home, he was full of smiles and demanded for lunch. While eating, he offered to share a joke and said "Mum, I experienced how they count ceilings in the class this morning; I couldn't concentrate in class because I was very hungry. We then laughed it off. In brief, I won't trade my role as a mother and wife for anything.

How do you relax?

I love arranging and nurturing plants in a beautiful environment, so I feel much relaxed doing this. I also enjoy reading and when I get in the mood with good music, I like dancing.

What advice do you have for Pharmacists willing to tow your path in business?

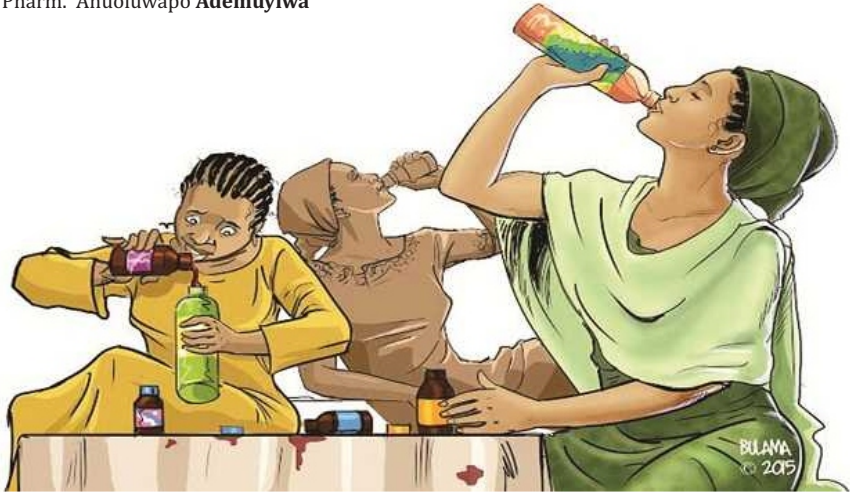
There is need to locate your area of passion and be determined to play the game according to the rules. If you don't have passion for something, you will burn out fast. You must be flexible and prepared to face challenges. If you don't stand for something, you will fall for anything. Also commit your ways to the Lord. It is only God that can direct one's step and intervene when difficulty rears its head. Seek counsel from people who can mentor you. Finally, be patient as Rome was not built in a day. Be happy when you see people doing well; rejoice with them because for you to receive, you need to accept it first. Read books to learn from those who have gone ahead or fought and conquered.

Do you think there is hope in the profession?

I believe there is hope if we have the WILL. Charity begins at home; if we desire sanity and we are sincere about it, then we can achieve it. Pharmacy profession is as dynamic as we have been so diversely and extensively trained. Let's change our attitude and imbibe microwave approach to positive development. In whichever area you are, strive to practice well.

THE MENACE OF CODEINE ADDICTION

Pharm. Anuoluwapo Ademuyiwa



These days, it has become rather easy identifying codeine addicts, as their dependency on this substance has become the driving force and major reason for their appearance at the pharmacy. Almost every single day, someone comes into the pharmacy asking for "Codeine" (not even Benylin with Codeine again but "Codeine"). My response usually goes thus;

"Sorry dear, we don't sell Codeine here..."
He is soon aware that he has come in contact with a Pharmacist, so he rephrases his question saying;

"Do you have Benylin or Parkalin with Codeine?" At that point, I often burst his bubble with... *"Oh sure we do, but you need a Doctor's prescription."*

That usually works and the inexperienced codeine-controlled freak walks away peacefully or, he

doesn't...and yells at me for denying him his right to getting high, wishing he could tear me apart.

However, there is another class of codeine addicts I call the "experienced codeine-controlled freaks". These guys have been in the game for quite a while, unlike their inexperienced counterparts; they don't come asking for "Codeine"...they know better than that. They usually avoid any contact with the Pharmacist and gun for the Sales Assistants and tell them they have been having this dry and persistent cough for the past three weeks or so and really need Benylin with Codeine.

God bless their hustle if the pharmacy they approach is owned by a non-Pharmacist who got a Pharmacist to register the premises (R&G), only to be manned by Sales Assistants who gladly hands over the bottle of Benylin with Codeine to them without questions...as long as they are making sales.

Whilst most people take codeine to get high, they are unaware of the fact that chronic use can actually cause the brain to slow or even stop endorphin production (such as the feel good hormone-Dopamine, and the happy hormone- Serotonin) causing a myriad of mental health problems, ranging from mild to severely debilitating. These effects can even include cognitive and mental conditions like difficulty concentrating, depression, disorientation, and insomnia.

In addition, other long term side effects of codeine use includes sexual dysfunction, chronic constipation, seizures, tremors and shakes, convulsions, a constant state of agitation or confusion, hallucinations, inability to drive, stomach bleeding, nausea, blurred vision, skin nodules and itching, as well as kidney and liver damage which can take months to reverse, making for a very unpleasant recovery time.

Just half way through this writing, a young lady walked into the pharmacy asking for Benylin with Codeine. From the way she was dressed, with her numerous ear rings, one could suspect that she was sent by one of her boyfriends who needed to get high. Unfortunately for her, we didn't have Benylin with Codeine brand, so I told her we had Neofylin and Masedyl with Codeinebrands. It was then that she gave in to my suspicion, as she said;

"These ones don't work as good as Benylin with Codeine". "Oh really?" I replied, and all she did was smile.

Substance abuse (codeine, tranquilizers, opiate analgesics etc) has become common place in our society, and without strict adherence to ethical conducts, community pharmacies might

just be a major contributor to this menace. The fact that a patient has the financial capacity to purchase a controlled or prescription medication shouldn't be a license for indiscriminate dispensing nor should the drive to push for sales become a misleading motivation for such act. We have a much higher calling and it is our responsibility to prevent further substance abuse and dependence amongst the populace by:

1. Educating our patients about the long term dangers of substance abuse.
2. Ensuring that medications likely to be abused such as codeine-containing cough suppressants or Tramadol are only dispensed with a Doctor's prescription or given to patients who sincerely and justifiably needs it based on the Pharmacist's discretion after careful consideration.
3. Ensuring that such requests for these medications are handled by Pharmacists and not Sales Assistants. This can only be achieved by ensuring that a Pharmacist is always on call at all times in the Pharmacy.

Fellow Men of Honour, please don't be deceived by the deceitful smile of innocent-posing beautiful ladies requesting for Codeine containing cough products; she is only an agent of an experienced codeine-controlled freak. And to my fellow Pharmacists who only registers a premise and care about nothing that is being done there (R&G), I will leave you with the former First Lady's counsel... "There is God ooo!"





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FROM THE HEART TO THE BEDROOM: A JOURNEY IN SERENDIPITY

Pharm Tokunbo Ayegun



In 1896, Alfred Nobel – the inventor of dynamite – suffered from angina. He was prescribed glyceryl trinitrate (called Trinitrin) to relieve the pain of the attacks. Alfred Nobel had earlier used glyceryl trinitrate as a component of dynamite which when mixed together with diatomaceous earth (kieselghur) forms the explosive. Glyceryl trinitrate (nitroglycerin) exerts its effects by being converted to nitric oxide (NO) in the body.

Over a century later, the works of Robert Furchgott, Louis Ignarro and Ferid Murad showed that nitric oxide (NO) was an important signalling molecule in the [cardiovascular](#) system. It is released from nerve endings and cells lining the walls of blood vessels. The effect is to make the blood vessel relax or dilate. It is also involved in the prevention of blood clots. In 1998, they received the Nobel Prize in

Physiology. The Nobel Prize was set up by the same Alfred Nobel who had earlier been treated with glyceryl trinitrate. Building on this knowledge, research by other groups was undertaken to develop new medicines which moderate the actions of nitric oxide for the treatment of cardiovascular disorders and other disorders. In 1985, scientists at Pfizer decided to develop a medicine to treat heart failure and hypertension. They were looking for a medicine that would [vasodilate](#) arteries, lower blood pressure and reduce strain on the heart.

In the year 1991, pharmaceutical chemists of Pfizer at Sandwich, Kent in England discovered that chemical compounds belonging to the pyrazolopyrimidinone class were useful in treating heart problems like angina or chest pain. During human clinical trials, it was found that the compound UK-92,480, which earlier showed promise, had insignificant effect on angina. But during the trials, an unexpected side effect was observed which made male patients on trial refuse to return the drug (it could improve and sustain a man's penile erection). An extraordinary "side effect" for an ordinary drug candidate.

A cure for male impotence – a solution which had eluded man for centuries, affecting about forty percent of men, and so depressing that as far back as 1677 in France, laws had to be passed that declared offensive the practice that considered male impotence a crime and a legal ground for divorce. Pfizer then stopped the research on sildenafil (compound UK-92,480) as a heart medication and initiated investigation on it for erectile dysfunction.

On March 27, 1998, the FDA approved the patent name Viagra (sildenafil 25mg, 50mg and 100mg) as the first prescription tablet for the treatment of erectile dysfunction. During the 13 years it took to bring Viagra to the market, Pfizer's scientists screened over 1500 compounds and spent an estimated 600 million pounds. Viagra is a name that reminds one of "VI-tality," "VI-rility," "VI-gor," and also of the powerful Niagara Falls in North America. In its first ten years (1998-2008), Viagra revolutionized the sex lives of millions and became one of the most commercially successful drugs in the world, with over 1.8 billion tablets used by about 35 million people. The early reports of cardiovascular side effects was mainly due to its interaction with co-administered nitric oxide donors, such as [glyceryl trinitrate](#) (nitroglycerine), [sodium nitroprusside](#) and [amyl nitrite](#), which can produce an acute drop in blood pressure. And when combined with the increased oxygen required during sex, it could become detrimental in men with heart disease. Other drugs that interfere with the metabolism of sildenafil include [erythromycin](#), protease inhibitors and [cimetidine](#).

Sildenafil is not effective for treating sexual dysfunction in women. The first drug to treat sexual dysfunction in premenopausal women – dubbed the "female Viagra" – was approved by the FDA on August 18, 2015. This Sprout Pharmaceuticals patent is called Addyi (Flibanserin).

Pfizer also markets Revatio (sildenafil 20mg) for use in adult pulmonary arterial hypertension as it improves patients' ability to exercise and slow down changes in physical condition.

Sildenafil is a selective phosphodiesterase type 5 inhibitor (PDE5i) that dilates blood vessels supplying the [corpus cavernosum](#) of the [penis](#) by acting on cyclic-GMP. The smooth relaxation of the muscle in the penis facilitates higher rate of blood flow and helps in producing an erection.

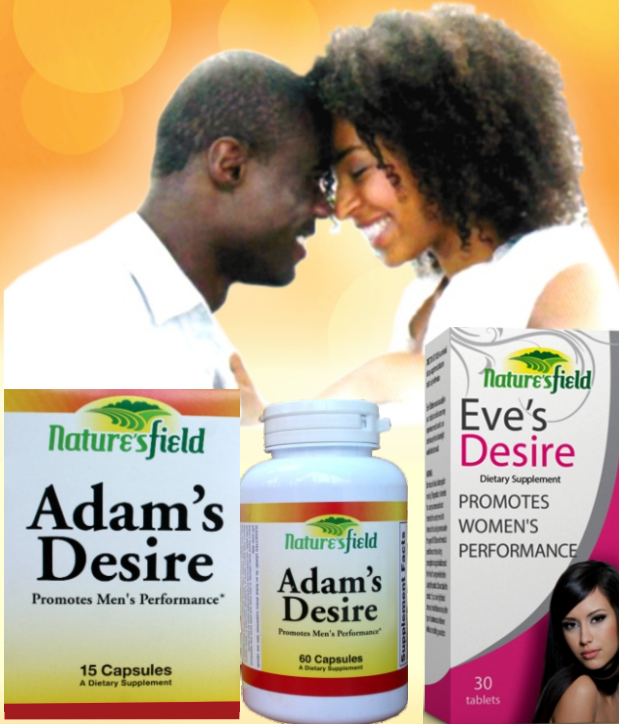
Without sexual stimulation though, and therefore lack of activation of the NO/cGMP system, sildenafil should not cause an erection. Other drugs that operate by the same mechanism include [tadalafil](#) (Cialis) and vardenafil (Levitra) – drugs whose prime ancestor (sildenafil) evolved from an intercourse between accident and intellect.

Louis Pasteur (1822-1896) once said, "Chance favours the prepared mind." It is hard to think of a better expression than "serendipity" as one reviews the incredible concatenation of intentional and chance events in medicine's relentless history. From Potassium bromide to Chloral hydrate; from Lithium to Lysergic acid diethylamide (LSD-25); from Imipramine to Penicillin; and from Chlorpromazine to our darling Sildenafil; medicine has been blessed with an array of discoveries more sagacious than those of the Three Princes of Serendip.

Serendip is the old Arabic name for Ceylon, now known as Sri Lanka. The origin of the word "serendipity" is in a Persian fairy tale. The Three Princes of Serendip travelled the world, always "making discoveries, by accidents and sagacity, of things they were not in quest of."

The Oxford English Dictionary defines serendipity as "the faculty of making happy and unexpected discoveries by accident." Serendipity is one of the many roads down to drug discovery. It has certainly played a role in the discovery of sildenafil (Viagra) as an erectile dysfunction agent. The discovery process includes the recognition of the potential for an unplanned matrimony between one's knowledge and past experiences. For sildenafil, it was a journey that started in an attempt to fashion a drug for some heart conditions that serendipitously metamorphosed into a drug for use in the bedroom.

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THE SOCIAL HABITS

OF THE AVERAGE NIGERIAN CLIENT

Pharm. Ayomipo Adegeye



As a Pharmacist, you might want to know what the most commonly used drug in Nigeria is. The answer might be a bit of a surprise because it is usually not purchased, sold or prescribed by us. Funny right? Yes! Yet Nigerians love to self-medicate on this drug to an extent that it has become the most commonly abused drug in Nigeria. Worse still, it holds a potential for interaction with our commonly prescribed drugs which could undermine their therapeutic efficacy. We thus have to be well informed about the consequences of its abuse and potential for interaction so that we can consider it when taking a medication history, filling a prescription order or prescribing drugs to our patients. The drug in question is alcohol (ethanol). Is alcohol a drug?

This article is a follow up to my last article in which I highlighted 10 common drugs of abuse in the Nigerian pharmacy (you can try to lay your hands on the previous editions in hard print or check on rxrevolution.com.ng). It could sound pretty absurd to say that alcohol is a drug. This is perhaps because we, as pharmacists, do not prescribe it or hardly have any clinical information regarding its use (indications, contra-indications, dose, side-effects, pharmacokinetics, mechanism of action etc). The closest we come is its use in formulation of liquid preparations as solvents or vehicles. Also, because of widespread consumption of alcohol as any other regular beverage (Coke, Fanta, Coffee, Tea, Apple Juice), we fail to make the necessary connection. But let's not be deceived, alcohol is as drug as any

other regular drug we know and prescribe (it is a CNS depressant). Infact, years of research have labelled alcohol (ethanol) as not only a drug, but a poison to the human body. It is a potent neurotoxin and has been classed as “Group 1 Carcinogen” by the International Agency for Research on Cancer (IARC) making it as carcinogenic as HIV, asbestos, plutonium, and mustard gas. But I am not here to spoil market for Beer Parlour Association of Nigeria (BPAN); I am simply here to inform you that alcohol is a drug which you must take into consideration when prescribing drugs to your clients (much of whom are members of the above named association) so as to reduce the incidence of drug-drug interactions. Well said!

According to a research carried out by Adamson et al in 2010, it was found out that the most widely used drug in Nigeria is neither paracetamol, nor antibiotics, nor any other drug commonly prescribed by the physician, but alcohol and cannabis. Alcohol has a rich history in the customs and traditions of our people and has been enjoyed as beverage since time immemorial. Alcoholic beverages are typically divided into three classes—beers, wines, and spirits—and typically contain between 3% and 40% alcohol by volume.

I did a good thing to dig up volumes of research academics have done in this country (which unfortunately is languishing and perishing on their shelves and not being translated into problem-solving models) on the prevalence of alcohol use & abuse and I was able to synthesize a disturbing trend among various age groups of Nigerians. The summary, according to studies conducted in various secondary and tertiary institutions and

communities in different geo-political regions, has it that in people of ages 15-25 years, 7 out of every 10 of them have been exposed to drinking alcohol. For adults above 30 years, about 6 out of every 10 persons are alcohol drinkers. There is therefore need to take this into consideration when prescribing drugs. **Due to potential drug interactions, it is extremely important to always obtain a drinking history at the first patient encounter regardless of the patient's age.**

It is likely that many people will use both prescription medications and alcohol, creating the potential for drug/ethanol interactions. It is, therefore, advisable for pharmacists to review medications that may interact with ethanol to enhance patient counselling and to avoid untoward effects. Mechanisms of interaction may involve ethanol metabolism. Once ingested, about 20% of ethanol is metabolized in the stomach to acetaldehyde by the oxidative enzyme alcohol dehydrogenase (ADH). The majority of ethanol is metabolized in the liver by ADH and the cytochrome P450 isoenzyme 2E1. Ethanol is a substrate of isoenzyme 2E1 and an inducer; primarily with long-term use (short-term use paradoxically produces enzyme inhibition). **Potential mechanisms for drug interactions include changes in enzyme activity, changes in gastric emptying, and additive toxicities.**

Pain Medications/Muscle Relaxants:

The concomitant use of ethanol and narcotics causes additive depression of the CNS, with impairment of speech, sedation, and lethargy. Non-narcotic pain relievers, such as tramadol, also may produce additive CNS depression. The interaction of acetaminophen with

ethanol is likely due to the induction of CYP2E1 in chronic alcohol users. Enzyme induction increases production of the toxic metabolite N-acetyl-p-benzoquinoneimine (NAPQI) and may result in hepatic injury or failure. The combination of NSAIDs and ethanol may cause gastritis or GI bleeding through additive irritation. Acute renal failure also is possible, secondary to volume contraction with ethanol coupled with NSAID-induced changes in renal blood flow. An increase in bleeding time (BT) also can be seen. Muscle relaxants such as tizanidine and chlorzoxazone have additive CNS depression with ethanol.

Sedatives: The combined use of sedatives and ethanol causes additive CNS depression and possibly fatal respiratory depression. Barbiturate metabolism in the liver also may be inhibited in the presence of alcohol, potentiating the pharmacologic effect.

Antianxiety/Antidepressant Drugs: Ethanol inhibits benzodiazepine metabolism, although not all agents are equally affected. For example, agents metabolized by conjugation reactions (e.g. lorazepam) have unchanged blood levels, whereas levels for agents metabolized by oxidation (e.g. diazepam) are increased. The use of ethanol and benzodiazepines results in additive CNS depression. The use of ethanol and TCAs is likely to cause alterations in psychomotor function, including "blackouts." Reduced metabolism of imipramine and amitriptyline has been shown with chronic ethanol use. Although data are lacking, product manufacturers warn against the use of ethanol with SSRIs as well as with venlafaxine and nefazodone.

Antihypertensive Agents: Ethanol causes additive vasodilation with such

agents as nitroglycerin, methyldopa, and hydralazine. In addition, verapamil has been shown to increase blood alcohol levels/concentration (BAC), presumably by interfering with metabolism. High concentrations of ethanol may reduce the rate of gastric emptying and increase propranolol absorption.

Anticoagulants: Both ethanol and aspirin have GI irritant effects, which may contribute to GI bleeding. Additive prolongation of BT is likely. Aspirin also may inhibit ADH in the stomach, reducing the first-pass metabolism (FPM) of ethanol.

Antidiabetic Agents: Ethanol is thought to reduce gluconeogenesis and may affect the safety of antidiabetic medications. Ethanol can cause prolonged hypoglycemia or disulfiram-like reactions (flushing, sweating, palpitations, headache) when used in conjunction with sulfonylureas (e.g. glyburide, glipizide). Hypoglycemic reactions also are possible in patients treated with insulin. Ethanol can enhance the inhibition of lactate metabolism by metformin.

Gastrointestinal Agents: In some studies, the H₂-receptor antagonists cimetidine and ranitidine produced slightly elevated blood alcohol levels. Cisapride and erythromycin may increase the rate of ethanol absorption by reducing the gastric emptying time and FPM by ADH.

Antimicrobial Agents: Many antifungals and antibiotics including cotrimoxazole, ketoconazole, and griseofulvin have the potential to produce a disulfiram-like reaction (DLR) with ethanol through an unknown mechanism. The combination of isoniazid and ethanol may cause DLR, a

reduced half-life with acute ethanol ingestion, and increased isoniazid metabolism with chronic ethanol ingestion. The potential for liver injury with isoniazid also is increased with ethanol use. Metronidazole combined with ethanol may cause a DLR, although this interaction has been questioned.

Antihyperlipidemics: Ethanol consumption can increase lipid levels, causing a pharmacodynamic interaction with HMG-CoA reductase inhibitors and other cholesterol-lowering drugs. Liver impairment as a result of chronic ethanol use can contribute to reduced metabolism and increased toxicity with these agents. At least one study involving moderate alcohol consumption with fluvastatin found that fluvastatin metabolism and kinetics were altered, although no adverse effects were reported and efficacy was maintained. Alcohol use during adolescence and young adulthood remains a prominent public health problem. Although the minimum drinking age in Nigeria remains 18 years, young people buy and drink alcohol freely in public places. It has been found out that among users of alcohol in Nigeria, heavy episodic drinking rather than moderate drinking is very common. Excessive alcohol consumption is associated with myriad of acute and chronic complications which include; cancers of the oesophagus, liver, stomach and colon, liver cirrhosis, alcoholic encephalopathy, alcoholic dementia, hypertension etc. Moreover, heavy alcohol consumption impacts on the relationship between those who do so and their close relatives and friends. It breeds disharmony in their family, and on many occasions, leads to collapse of their marriages. Moderate drinking is known to significantly reduce the risk of a number of health problems, such as heart

disease, stroke, dementia and gall stones. The ideal amount of alcohol to drink to achieve this health benefit for women is one (1) drink per day, and for men one to two drinks per day. A drink may be standard-sized can or bottle (330ml) of beer (5% alc.), 145ml glass of wine (12.5% alc.), or one standard shot (45ml) of spirits (40% alc.).

As Pharmacists, especially at the community level, we need to take responsibility for the health of our patients and be equipped with the requisite knowledge on alcohol related information. We need to advocate for 'responsible drinking' among our alcohol consuming clients which comprise moderate drinking and zero consumption for drivers and pregnant women. We must also insist on abstinence for minors (less than 18 years). We can also advise those who take alcohol not to do so on an empty stomach. The presence of food in the stomach leads to slower alcohol absorption, hence more efficient FPM and a lower peak BAC.

The latest American dietary guidelines make it clear that no one should begin drinking or drink more frequently on the basis of potential health benefits. So don't feel pressured to drink alcohol. But if you do drink alcohol and you're healthy, there's probably no need to stop as long as you drink responsibly and in moderation.

PHARMALLIANCE IN PICTURES



Pharmalliance members at Pharmacy Development conference Orlando USA



Pharmalliance members at PDS conference in Orlando USA



Founder of Pharmalliance meets Founder of Pharmacy Development Services USA



Armed robbery insurance pay out to Totem Pharmacy



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Childbirth celebration with Pharm Kemi Idowu of Giotos Pharmacy



Childbirth celebration with Pharm Henry Adioha of Totem Pharmacy



Childbirth celebration with Pharm Ada Okorie of Julie Harrison Pharmacy

PHARMALLIANCE INTERVIEW WITH MD/CEO OF GREENVIVE PHARMACY, LAGOS

Dubbed the 'Harvard' of learning the ropes of Pharmacy business in the Nigerian landscape, Pharm Ndukwe makes us understand why Pharmalliance represents the enterprising future of Pharmacy Practice in Nigeria. **Flourish Crew reports.**



Can we meet you sir?

I am Pharm Ndukwe Uma Ndukwe, an alumnus of the Faculty of Pharmacy, Ahmadu Bello University, Zaria. I hail from Asaga Ohafia in Abia state. I am married and blessed with children.

Share with us your work history.

I had my early work experience with Bernados Pharmacy, Ojuelegba/Idi-Araba, Lagos, first as an industrial training (IT) student and then on Internship before proceeding to serve at the State Hospital, Shokenu, Abeokuta between 1999-2000. My professional practice started with Cosmos Pharmacy, Ebute-Meta/Apapa and further

High overhead on power generation, taxes etc Today, I am superintending over Greenvive Pharmacy Ltd.

What attracted you to retail pharmacy business?

The student-day practice and exposure/experience with Bernados Pharmacy was of major influence. Having related first-hand with Pharm. Anthony Akhimien, FPSN at his practice – a uniquely sized premise – greatly enhanced my impetus. It even became more imperative to be a Community Pharmacist having witnessed the less than human treatment patients receive in hospitals.

What challenges do you face in this business?

There are quite a number of challenges experienced which includes:

- Lack of vision and focused foundation for the profession
- Lack of structure and process at every level of administration of practice.
- Absence of government support for practice
- Funding issues and credit facilities from suppliers etc
- Bad pricing competition and clustering of pharmacies.
- Man-power challenges with pharmacists and support staff
- Stocking issues. Sizeable man-hours lost monthly in search of stock
- High overhead on power generation, taxes etc

- Expiry issues without compensation policy with suppliers and manufacturers.
- Wholesalers retailing to the public and drug hawkers.
- Un-ethical practices by colleagues who employ the services of nurses in their pharmacy
- Sizeable business lost to dispensing hospitals without pharmacy departments, trade-medical practitioners, 'cure all' network marketing companies, freelance consulting and dispensing nurses and operators of open drug stores in the community.
- Super markets regulating the prices of many, if not all, medicated creams.

Why did you join Pharmalliance?

Because I needed to expand my business and practice horizon and leave my comfort zone as we know it.

Can you describe how the experience has been so far?

There is renewed assurance that practice and business will thrive. I have been more determined to take proactive steps at achieving good corporate governance, putting to practice personal and group opinions. I am every day becoming more adaptable to changes.

Do you get value for your investment in Pharmalliance?

The answer is a big YES. All expectations may not have been met, nevertheless the mutation laws have manifested in the diverse adjustments made apparent by my participation in Pharmalliance.

Can you say that Pharmalliance has impacted on Greenvive Pharmacy?

Certainly, it has. Our business outlook has improved since the last audit and in many other general aspects of business.

What do you like most about Pharmalliance?

Essentially, it's the group work/discussion/learning aspect and our improved ability to prepare monthly report of our business standing. The extra income-earning challenges are also thrilling.

What advice do you have for Pharmacists interested in joining Pharmalliance?

Colleagues are highly encouraged to join Pharmalliance. A picture of what the bigger Pharmacy society should be is mimicked at Pharmalliance. Colleagues should not be deterred by the subscription fee; it is the "Harvard" for starters in practice and the model continuous education centre for already existing practices.

What is the next frontier for Greenvive Pharmacy?

We are consolidating on our market share of the retail space by strengthening our presence and service profile.

Do you think there is hope in this profession?

There is hope for our profession. We have identified the challenges long before now and 50% of it has been resolved so far. It is the complementary aspect of summing-up courage and will to work the solutions that are left undone. Pharmalliance offers a platform to groom colleagues who, through the transformation of their person and practice, may offer the next-level motivation for change in the profession. Mind set for leadership must change.

A focus-driven profession must be built. The vision must be shared by a large majority. The conscience must again be united with practice and business. That hope rests on all of us.

If you weren't a Pharmacist, what would you have been?

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AREDS2
Eye Antioxidant



Lutein & Zeaxanthin
Double the levels of other leading brands

2X

MaxiVISION®, your exceptionally well researched brand of Eye Antioxidant Formula, has been reformulated to meet the AREDS-2 research findings.

MaxiVISION delivers a comprehensive array of highly potent antioxidants, vitamins and minerals targeted at slowing down aging, improving eye health and brain function among our aging population.

Doctors recommend **MaxiVISION®** as a standard of care in the nutritional management of age related eye diseases.



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