28. Juni 1994

The Ghana Pharmaceutical Journal

Official Organ of the
Pharmaceutical Society of Ghana

- Council for 1993-95 Inaugurated
- Endowment Fund for Pharmacy Faculty
- Marketing Practices in Public Pharmacies
- Prof. Albert Tackie in Profile.

Vol. 16 No. 1

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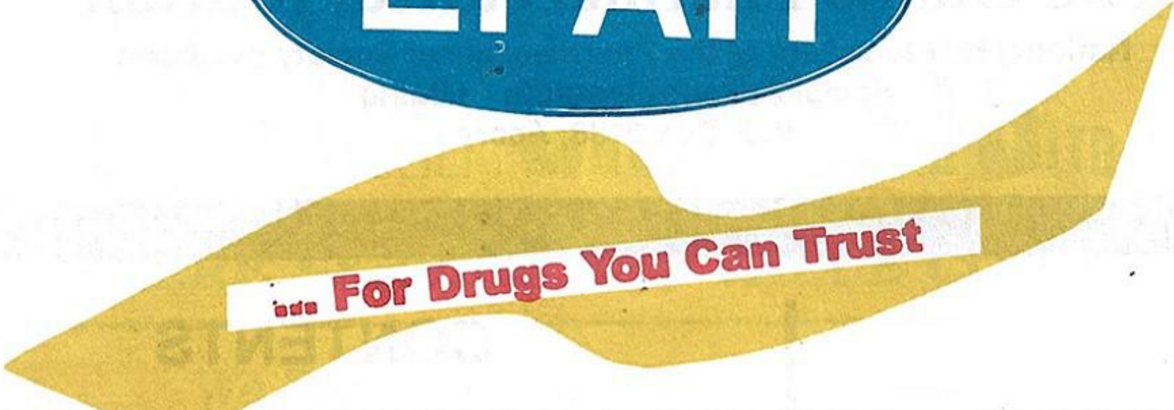

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EDITORIAL

Taking Pharmacy Practice into the 21st Century

As Pharmacists we are recognised as professionals for three main reasons. Firstly, we received academic training designed to stimulate our intellects especially in the area of drug science. Secondly, we acquired skills through the practical training we undertook. Thirdly, we are bound by a code of ethics to which we subscribe as guide to responsible conduct.

Because of our professional competence we provide services to the general public for which we receive remuneration which we do not or should not regard as a measure of our success no matter what people say.

The acquisition of a certificate of competence, however, does not end the process of learning. Knowledge is dynamic and ensures productivity. This is especially obvious in this latter part of the century characterised by a rapid growth in the science and technology of communication. We need to build up our stores of knowledge and communicate the relevant facts to our colleagues and all recipients of our services in a language they understand to enable us be effective.

It is for these reasons that we enjoin all of us to avail ourselves to the opportunity offered to participate in continuing education. It is the prerogative of us all to share experiences—even our mistakes—which we may be uniquely placed to have had. We need to stand together and speak with a common voice. It is in this vein that we endorse the President's call to strengthen our internal relations and to be involved in the affairs of the society. We wish to recap the concluding portion of the editorial of the Journal, September 1992, Vol. 14 No.1, which said "no member of our esteemed profession should regard his contribution too small towards the group effort in uplifting our professional image in the society".

We must also as professionals be adaptive to new situations. Currently, in the country and indeed all over the world, the wind of privatisation is blowing. How do we handle this? Do we allow ourselves to be blown off course or do we anchor ourselves to modern and efficient practices? We believe our strength lies in our collective effort to tackle this challenge in a meaningful and pragmatic way. Let us allow our voices to be heard on this and other pressing issues.

In less than a decade, the year 2000 AD will be with us. Then we shall be able to pronounce on our collective achievements as members of the Healthcare Team in the fulfilment of the WHO 1978 "Declaration of Health for All by the year 2000". But dare we wait till that time? The answer obviously must be no! We should evolve a strategy to evaluate our performance to date, plan and execute programmes that will enable us fulfil our calling to be "friends of the human race" through the efficient administration of drugs in the 21st century.

SOCIETY NEWS

New Council for 1993-95 Inaugurated

The new council of the Ghana Pharmaceutical Society was inaugurated at a ceremony held on the morning of 11th December, 1993, at the conference room of the Pharmacy Board. This ceremony followed the swearing into office of Mr. David Anim-Addo, the newly elected President and his team of officers whose election took place at the 1993 AGM held at Christ the King Church Hall in Accra.

The swearing-in ceremony was performed by Mr. Osei-Tutu, a Fellow of the Society who swore in the new President for a two year term of office. The President also swore into office all new Council members except Mrs. Joyce Addo-Atuah, Mr. J.K. Obeng, Mr. S.L.K. Akorlor and Mr. S. Bentum.

The ceremony was attended by representatives of the various wings of the society namely: Industrial Pharmacy, General Practice Pharmacy AREPI, LAPAG, and GHOSPA. Also in attendance were the Head of the Dispensing Department of Kumasi Polytechnic, Mrs. E. Anima-Appiah; the Deputy Director of Pharmaceutical Services at Korle-Bu Teaching Hospital, Miss Constance Allotey; a representative of the Ghana Co-operative Pharmaceutical Co. Ltd., Mr. I.D. Mensah; the WAPF Secretary (Ghana Branch), Mr. Eric Aheto; and the GPSA President, Mr. Ben Debrah.

The full list of Council Members for the 1993-95 year is as follows:

Mr. David Anim - Addo —President
Mr. Dela Ashiabor — Vice President
Mrs. Czarina Ribeiro — Hon. Gen. Secretary
Mr. Samuel Nkansah — Asst. Hon. Gen. Secretary
Miss Nancy Owusu—Hon.Treasurer
Dr. M.L.K. Mensah — Editor
Prof. J.S.K. Ayim — Member
Mrs. Joyce Addo-Atuah — Member
Prof. K. Boakye-Yiadom — Immediate Past President
Prof. K. Sarpong — The Dean, Faculty of Pharmacy
Mr. T.C. Corquaye — The Registrar, Pharmacy Board
Mr. S.A. Botchway — Ag. Dir. Pharm. Services, M.O.H., Accra
Mr. Julius Berdie — Greater Accra Reg. Rep.
Mr. F. Aboagye-Nyame — Greater Accra Reg. Rep.
Mr. J.K. Obeng — Central Reg. Rep.
Mr. S. Adu-Ayeh Offei — Ashanti Reg. Rep
Mr. M.K. Aboagye — Eastern Reg. Rep.
Mr. E.S. King—UE/UW/N Reg Rep.
Mr. Sam Oppong Asare-Dua— Brong Ahafo Reg. Rep.

In his inaugural address, the N President thanked all members of Conference for the trust imposed in Council Members elected into offic serve the Society. He urged memb to congratulate themselves for hav merited the esteem of our colleagu He also encouraged members to h in mind that they have been elec into office to serve. In that sense, vowed to be an exemplary Serva Leader and asked members of Cour to give him their support in direction of an ACTION PLAN was to unfold until Conference ti September 1995.

Earlier on, the Immediate P President of the Society, Prof. Boakye-Yiadom thanked members the Society for the support given h during his term of office and appea to all to give the new President same support.

The President's '93 Confab Dinner Speech

At the Dinner to crown the very successful Conference held in Accra, the newly-elected President of the Society, Mr. David Anim-Addo, gave a well-received speech which centred on 'professionalism' and 'Commercialism'. He noted that these are but two sides of the same coin which will enhance pharmacy practice as, by doing things generally well in the interest of the patient, sales will optimised by the patronage customers and profitability sustain

The President pledged himself be a servant-leader and he hop other elected officers would beco volunteer servants worki voluntarily, willingly, zealously a assiduously with time, energy a financial support availing.

The Committees Of Council

Listed below are members of the various Committees of Council as well as the Society's representatives at some National and Foreign bodies for the 1993-1995 period:

Disciplinary Committee

1. The President — Chairman
2. The IPP — Member
3. Hon. Gen. Secretary — Member /Secretary
4. Mr. K.A. Ohene-Manu — Member
5. Prof. J.S.K. Ayim — Member
6. Lt. Col. Joseph Appiah — Member
7. Charles Dontoh — Member

Finance Committee

1. The President — Chairman
2. The Vice President — Member
3. Hon. Gen. Secretary — Member
4. Hon. Treasurer — Member /Secretary
5. Assist. Hon. Secretary — Member

Editorial Committee

1. Hon. Gen. Secretary — Chairman
2. The Editor — Member/Secretary
3. Mr. E.N. Aheto — Member
4. Mrs. Joyce Addo-Atuah — Member
5. Mr. Oscar Bruce — Member
6. Mr. Louis Nortey — Member
7. Mr. Bediako-Donkor — Member

Fellowships Awards Committee

1. Prof. K. Sarpong — Chairman
2. Mr. K. A. Ohene-Manu — Member
3. Mr. E. Osei-Tutu — Member / Secretary
4. Mrs. Esther Amedzro — Member
5. Mr. Eric Aheto — Member

Education Committee

1. Continuing Education Co-ordinator (Prof. J.S.K. Ayim) —Chairman
2. Pharmacy Board Registrar (Mr. T.C. Corquaye)—Member
3. Clinical Pharmacist (Dr. Yaw Gyamfi) — Member
4. Faculty of Pharmacy/UST Rep. (Dr. Yaw D. Fokuo)— Member
5. Mr. Michael A. Addo — Member
6. Head of Dispensing Technicians Dept. (Mrs. E. Anima-Appiah)— Member
7. Charles Dontoh (Med. Reps. Chairman)— Member

Representation on the Pharmacy Board

1. Mr. James Pearce-Biney
2. Mrs. Eunice Ansa-Asamoah
3. Miss Nancy Owusu

Steering Committee on the Training of Dispensing Technicians

Prof. J.S.K. Ayim

International Pharmaceutical Federation(FIP)

The President

Representation on the Association of Recognised Professional Bodies

Vice President
Hon. Gen. Secretary

Commonwealth Pharmaceutical Federation (CPA)

The President

West African Pharmaceutical Federation(WAPF)

The President

Centre for Research into Plant Medicine

Mr. S. Offei Adu-Ayeh

Drug Information and Formulary Committee

1. Head of Pharmacology Dept/UST (Prof. R. Ansa-Asamoah)— Chairman
2. Clinical Pharmacist (Mrs. Esther Osei)— Member
3. Head of Pharmacy, Korle-Bu Teaching Hospital (Miss C. Allotey) — Member
4. Head of Pharmacy, KATH (Rexford Sarfo-Mensah) — Member
5. Pharmacy Board Registrar — Member
6. Faculty of Pharmacy/UST Rep. (Dr. N.I.Y. Fiagbe)— Member
7. Asst. Hon. Gen. Secretary — Member/Secretary

The President is Ex-Officio member on all committees where he does not feature.

Attention, all Pharmacists

The Pharmaceutical Society of Ghana (PSGH) is compiling a list of its members residing abroad and would be grateful if anyone who knows the address of such a member could forward it to the Secretariat of the Society at his or her earliest convenience.

Endowment Fund for the Pharmacy Faculty

The President of the Pharmaceutical Society of Ghana, Mr. David Anim-Addo, has proposed the setting up of a Foundation for the Faculty of Pharmacy, U.S.T., Kumasi with a minimum amount of ¢20 million to be realised by September 1995. The foundation to be known as the Pharmacy Faculty/UST Alumni Foundation has as its objectives:

1. the provision of research grants to Faculty members and
2. the provision of inputs such as equipment and consumables as determined by the Faculty Board.

It is hoped that the fund would be raised through contributions by benevolent members of the society, non-pharmacists, corporate bodies and organisations. It is expected contribution would average ¢180,000.

In the proposal, the President hinted on the introduction of a new bye-law for the governance of the Foundation.

As a motivation for others, the President has pledged a generous donation of £2,000 to the Foundation. As a further boost to the establishment of the Foundation, the President has also proposed two awards to be made in the name of the Foundation. These are (1) the Allman Fellowship Award and Albert Tackie Medal.

Mr. Eric Allman, a British Druggist was the head of the first Dispensary School set up in 1943 under the auspices of the Ministry of Health. Prof. Albert Tackie was the first Ghanaian Dean of the Faculty of Pharmacy, U.S.T., Kumasi.

The proposed terms for the two awards are as follows:

Allman Fellow:

This would be awarded to t contributor to the Foundation w makes a minimum grant of ¢500,0 paid locally or its equivalent convertible foreign currency paid in an external account.

To encourage part-paying cont butors reach the minimum target, designation, "Allman Fellow susta ing member" shall be used. Cont butors reaching the minimum targ shall be awarded a gold breast meda

Albert Tackie Medal:

This medal would be awarded to Faculty member completing a use research work in pharmacy with t support of funds provided by t Foundation.

Read the Ghana Pharmaceutical Journal and be informed on local as well as foreign Pharmaceutical matters.

Journal Distribution

The Editorial Committee wishes to inform members of the Society that henceforth, distribution of the journal will be done through Chairmen of the Branches.

Members should therefore contact them for their copies. ◆

The President's Action Plan for 1993-1995

Following his swearing into office, the New President, Mr. David Anim-Addo, presented a 12 point *Action Plan* to be pursued during his term of office. We bring you highlights of the *Plan* which received favourable comments from Council.

1. Strengthening of Internal Relations: — Efforts will be made to foster co-operation among the society, Pharmacy Board and the Pharmacy Division of the Ministry of Health for the benefit of pharmacists and to ensure promotion of the profession.

2. Promotion of Public Awareness of the Use of Pharmacists and their Expertise: — In summary the President drew attention to the communique issued at the end of the 42nd Conference held from September 14 to 17, 1993.

He was of the view that the special interest groups/wings and committees of the society must be encouraged to function under Council's supervision.

3. Permanent Support for the Faculty of Pharmacy: — The President lamented the absence of formal support for the "hen that lays the golden egg", referring to the Faculty of Pharmacy. He plans to move Council to make bye-laws to bring this to fruition.

4. Attention to the Ghana Pharmaceutical Students Association (GPSA): — In spite of the provision in the Society's constitution providing associate membership status for students, there is no formal co-operation with the student association. It is hoped bye-laws to promote fruitful interaction, monitoring and sponsoring of student activities will be enacted.

5. Revisiting the Ghana Pharmaceutical Journal: — It is hoped that innovative methods will be used to promote the journal with regard to:

(a) regular publication
(b) be self supporting.

It is hoped a media man/woman can be employed to support this approach and also assist the office.

6. Making a New-Bye-Law to establish a Contingency Fund: — This proposal though not new is planned to allow a percentage of members retention fees to be lodged in a fund for investment. Interests accruing from such a fund will be used to facilitate members on special assignments to meet hospitality costs.

Indeed, at Council meeting held on 14th September, 1993, a "Pressure Group" comprising Messrs K.A. Ohene-Manu, J. Pearce-Biney, D. Anim-Addo, and Professors Kwame Sarpong and K. Boakye-Yiadom was formed to pursue pharmacists interests in the Society at large.

7. Continuing Education: — As currency of knowledge is the bed rock of our profession it is incumbent upon Council to facilitate access to educational material. In the light of this, the President hopes to travel to the UK at his own expense to consolidate previous contacts in the area of Continuing Education. Other sources of assistance will also be tapped .

8. Induction of Newly Registered Pharmacists: — Following the rather negative comments made on previous induction ceremonies at the 42nd AGM, it was hoped that a more high profile ceremony will be planned to allow parents or guardians, relations to partake. It is also hoped that the necessary legislative procedures will be put in place.

9. International Relations: — Although we are in association with bodies like the FIP, CPA, WAPF our poor financial position has not kept us in active membership. It is hoped that some fruitful business projects can be started to enable us derive some benefit for payment of dues.

10. Establishing Relations with Medical Doctors: — Following a visit to the Royal Pharmaceutical Society (UK) Head Office in No. 1 Lambeth St., London, it was recommended that a relationship be forged with our colleagues in the medical profession as is the case in both the United Kingdom and Zimbabwe.

The President hopes to broach the subject with Dr. Kwaku Kankam, the President of the Society of Private Medical and Dental Practitioners.

11. 1994 Annual General Meeting (AGM) and 1995 Conference: — The President in his presentation stated that planning for both events had begun. The dates proposed for the AGM were Thursday, 22nd — Saturday, 24th September, 1994.

12. Reporting to and Gathering Information for the Society: — It was being suggested that as a professional body, reporting at all levels of the Society should be in the form of written reports — promoting a "cultures of information gathering". It is hoped that this will not only put the Society on a sound scientific base but also provide accurate records on the profession to the benefit of all.

Upgrading of Dispensing Technician Certificate Course at Kumasi Polytechnic

A further elevation has been given to the training of middle level pharmacy personnel in the industry. After the inception of a certificate course at the Kumasi Polytechnic under the Dispensing Technicians Department, nearly two decades ago, a new programme, the Higher National Diploma (Dispensing Technology) has been started. This is in line with Government's new educational programme with consequent upgrading of the Polytechnics to tertiary level institutions. This was stated in a report to Council at its inaugural meeting by the Head of the Dispensing Technicians Department, Mrs. Elizabeth Anima-Appiah.

Giving a background to the setting up of the Department in the early 1970's, Mrs. Anima-Appiah stated that it was a decision by the Ministry of Health to raise the level of training of it's Dispensing Assistants that led to it. It was also to supply middle level personnel to the clinics and pharmaceutical industries in Ghana.

The curriculum development at the initiation of the course was done by staff of the Faculty of Pharmacy namely: Professors K. Boakye-Yiadom and Kwame Sarpong and the late Dr. John Ocran in collaboration with the Head of the Science Department of the Kumasi Polytechnic, Mr. J.G.W. Essah-Hienwo. The late Dr. John Ocra[n] served as co-ordinator. The classe[s] which began in 1975 was handled b[y] National Service Personnel from th[e] Faculty of Pharmacy, Miss Josephin[e] Adusa and Mr. Adotey. Subsequentl[y] in 1976, Miss Elizabeth Anima Donkor now Mrs. Appiah, the curren[t] Head of Department, Messrs Michae[l] Simpson and Kofi Effah also joine[d] the staff. By 1978 the course ha[d] developed to its full structure.

In the 1976/77 academic year, [a] Canadian volunteer pharmacist, Mis[s] Alice Doel, joined the staff as [a] teacher. In 1978, representation wa[s] made to the British Council for sta[ff] assistance by the then Principal, M[r.] E.O. Beleve and Mr. Hienwo. Thi[s] resulted in Mrs. Pat Carless joining th[e] staff. The course was accepted as [a] programme under a new departme[nt] headed by Mrs. Carless. Mr[s.] Elizabeth Appiah and Miss Comfo[rt] Obeng were given awards by th[e] British Council to train as lecturers [at] the Garnest College for furthe[r] education in the UK.

The course, has served othe[r] nationals in the West African sub[-] region, especially the Gambia. [A] recent evaluation tour undertaken b[y] the Head of Department and Mrs. P[at] Carless who visited showed [a] considerable contribution to pha[r]macy practice by the trained Dispe[n]sing Technicians.

The course has an Examiners Boa[rd] and a Steering Committee made up [of] mainly national personalities in th[e] pharmacy sector and education. T[he] Committee is responsible for polici[es] for the proper running of the cour[se] and placement of students.

PHARMACISTS AT LARGE?

It has come to the notice of Council that some registered members of the profession are at large as a result of:

*(a) **non-payment of retention fees***
*(b) **non-registration of premises***
*(c) **in communicado***
*(d) **death***

Except for those in category (d), all other pharmacists are requested to kindly contact their Chairpersons in the regions for validation.

Action may be taken if this kind of advice is ignored.

OBITUARY

The Late Prof. Ansa-Asamoah

The death is reported of Associate Prof. Reginald Tetteh Ansa-Asamoah, Pro Vice-chancellor of the University of Science and Technology (UST) Kumasi. He died on 13th April, 1994, aged 56. Prof. Ansa-Asamoah who was a fellow of the Pharmaceutical Society of Ghana and a Founding Fellow of the West African Post Graduate College of Pharmacists was born on 28th July, 1938, at Mampong-Akwapim.

He was educated at Odorgonno Secondary School, Accra Academy and then Kwame Nkrumah University of Science and Technology. He was enroled in the latter institution to pursue the B.Pharm programme in 1961 and graduated in 1964. He undertook graduate studies leading to the award of the degrees: M.Pharm (Kumasi - 1967) and Ph.D (Sydney, Australia - 1983).

The late Prof. Ansa-Asamoah spent almost all of his working life in pharmaceutical research and teaching mainly at the UST. He worked as a Research Assistant (1964-65) with the then Alkaloidal Unit of the CSIR based at the UST and later joined the staff of the Pharmacology Department of the Faculty of Pharmacy as a Lecturer in 1968. He rose to the position of Associate Professor of Pharmacology in 1985. His research and teaching activities won him awards to enable him carry on further research in foreign lands. He undertook research in Manchester University in 1969/70 as a Commonwealth Academic Staff and under a similar fellowship, undertook research at the University of Sydney, Australia (1976-80) which earned him his PhD. Also as a Fulbright African Senior Research Scholar he worked as a Visiting Scientist at the College of Medicine, Howard University, Washington DC, USA. His research interests covered especially the pharmacology of local medicinal plant products used for analgesia, anti-inflammation, cardiovascular, anti-diabetic and H_2-receptor blocking activities. He also had interests in rational drug use and drug abuse in Ghana and the mechanisms involved in the acute and chronic effects of narcotic drugs, among other interests.

He was a member of several professional bodies including: West African Society for Pharmacology, Ghana Science Association, Ghana Animal Science Association and Associate member of the West African Pharmaceutical Federation. In addition, he held several administrative positions both in the University of Science and Technology and on several external bodies. He had been Head of Department of Pharmacology (UST) since 1982 and was Deputy Vice-Dean (1983-84) and Vice-Dean (1985-88) in the Faculty of Pharmacy. He was a member of the Executive Committee of the University (1990-92) and chaired it's Labour Rationalisation Committee in 1990. He was also associated with the administration of the Halls of Residence of the University and was the Chairman of the Committee of Hall Masters in 1974-76 having held office in Unity Hall as Senior Tutor (1972-74) and Hall Master (1974-76). He held the penultimate administrative headship of the University of Science and Technology as Pro-Vice-Chancellor for nearly two (2) terms and was in the second year of his second term (1993-94) when he suddenly took ill and died.

His teaching, research and administrative activities took him to several meetings, conferences, seminars, workshops, etc., (both local and international) as a representative of the University and/or the nation. He visited Nigeria, Sierra Leone, Benin, Kenya, Tanzania, Spain, USA and Australia either on his own or as part of official delegations. As a teacher and researcher he was outstanding. He examined several students at various levels. He attended several academic meetings where he read many papers and published about twenty papers in journals of repute both local and international.

The late Prof. Ansa-Asamoah, since becoming a member of the Ghana Pharmaceutical Society in 1967, remained active both at the branch (Ashanti) and national levels. He offered devoted service in various positions and rose to the office of Vice President in 1987-89. He served as the Society's representative on the Council of the Centre for Scientific Research Into Plant Medicine for the period 1984-88 during which time he was also its Chairman. He served as a member of the Education Committee (1985-89) and became it's Chairman in 1989-91. He was a member of the Drug Information Committee 1987-91 and represented the Society on the Steering Committee of the Dispensing Technicians' Course at Kumasi Polytechnic in the period 1989-93.

Prof. had a warm personality, helpful and devoted both to his family and work. He was survived by a loving wife, Eunice, a colleague pharmacist, and six children. He was buried on the 14th of May, 1994, at Mampong-Akwapim.

NEWS FROM THE BRANCHES AND WINGS

Greater Accra Region

The Branch holds a bimonthly meeting on the 3rd Thursday beginning from February at the Social Advance Institute. Meetings planned for the year include seminars for April 22 (Topic — Herbal medicine), June 16 and October 20. There will be a business meeting on August 18 and a party on December 16.

Various Committees including Finance and Welfare, have been formed to enable more members become involved in branch activities. Also, the British Council has been contacted to enable members use their facility to stimulate continuing education through reading.

Eastern Region

The Branch meets bimonthly beginning from January. Meetings have been scheduled for March 26, May and July. Activities planned include continuing education for members, lectures to institutions of education, prisons, etc.

The major activity planned is the hosting of this year's Annual General Meeting in September.

Central Region

The Branch has as its main objective, the pursuance of continuing education for the members. It hopes to delve into topics such as asthma and its management, as well as hypertension. The Branch will also educate the schools, the chemical sellers and the general public on topics of current interest.

Ashanti Region

Members meet every last Thursday of the month at the Assembly Hall of the Nurses Training College, KATH, Kumasi.

Activities planned include talks on "The formation of a Credit Union" in March, "Contracts" in April, "Drug Importation" in May"and in October, "Acupuncture". There will be a Dinner in December.

Brong Ahafo Region

The branch meets at the Sunyani Central Hospital. It hopes to pursue vigorous programmes of continuing education.

Contact Branch chairman for further details:

Address: Mr. Sam Oppong Asare-Duah
OPSA Health Services,
P.O.Box 23, Sunyani

Other Regional Branch reports were unavailable at the time of going to press.

Industrial Pharmacists

The group meets bimonthly in Accra. As part of its ongoing activities it has planned to update its constitution and elect a new executive committee. It has planned also to engage in continuing education programmes through film and video shows on Good Manufacturing Practice (GMP) and Good Laboratory Practice (GLP).

Association of Representatives of Ethical Pharmaceutical Industries (AREPI)

The AREPI was inaugurated in December 1992, has set itself an ambitious goal of encouraging continuing education among its members and also the entire membership of the Healthcare Team. It also hopes to bridge the gap between pharmacists and other healthcare professionals.

The group hopes to liaise vigorously with the student association in its work.

Lady Pharmacists Association of Ghana (LAPAG)

The baby group of the mother society was inaugurated on 19th November 1993 by Dr. (Mrs.) Mary Grant, a member of the Council of State.

The group has as its broad aim the education of the public in proper drug use and on matters affecting public health with women as the primary target. Topics such as the "hazards associated with excessive use of enemas", "inappropriate use of drugs during pregnancy" and "lactation" have already been dealt with. Other topics including AIDS and family planning will be dealt with in the programme for the year.

Ghana Pharmaceutical Students Association (GPSA)

The Association is based in the only national institution for pharmacy education, the Faculty of Pharmacy at U.S.T.

The student body continues to make an impact on the public through its annual National Drug Safety Week which it celebrated in April with a launching ceremony at Juabeng, Ashanti.

The Association hopes to host the International Pharmaceutical Student Federation (IPSF) 41st Congress in August 1995. In line with this the GPSA hopes to send at least 2 students to participate in the 40th Congress in Honduras for which it is asking for sponsors. It also hopes to launch a magazine "The Student Pharmacist" as part of its preparations for the IPSF 41st Congress.

NOTICE BOARD

Council Regional Visitations 1994

Eastern Region: Saturday March 16
Western Region: May 17
Central Region: May 18
Brong Ahafo Region: July 14
Ashanti Region: July 15
Northern, Upper East, Upper West Region visits are not fixed, but will be before the AGM.

Induction Ceremony for New Pharmacists 1994

A new high profile induction ceremony for newly registered pharmacists comes off at Novotel Hotel in Accra on Friday, June 3, at 10.00a.m.

PSGH A.G.M. 1994

The venue for this year's AGM is Koforidua
Theme: Impact of Pharmaceutical Services on Primary Healthcare in Ghana
Dates: Thursday, September 15— Saturday, September 17
Further details will be announced later.

WAPF General Assembly 1995

Venue: Accra
Date: February, 1995
Theme: Will be announced later.

It is hoped that an endowment fund for WAPF would be launched, and Clavendar-Parker Awards presented for Outstanding achievement.

CPA Silver Jubilee Conference 1995

Venue: Harare, Zimbabwe
Dates: Monday April 24 - Friday, April 28
Theme: Quality of Service

FIP 54th World Congress of Pharmacy, 1994

Venue: Lisbon, Portugal
Dates: Sunday, September 4 — Friday, September 9
There will be various symposia on different aspects of Pharmacy. There will be Awards in recognition of excellence.

FIP 55th Congress of Pharmacy 1995

Venue: Stockholm, Sweden
Dates will be announced later
Contact FIP Congress Department
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Challenges to the Image of Pharmacy Practice in Ghana

As part of the 1993 conference of the Pharmaceutical Society of Ghana held in Accra last September, a symposium on the theme of the conference "Challenges to the Image of Pharmacy Practice in Ghana" took place at the Christ the King Hall. We have reproduced here, the contributions from panelists who participated in the symposium. Preceding these contributions, however, we have found it appropriate to bring to you the keynote address read by Mr. K.A. Ohene-Manu, Managing Director of Oyster Healthcare Ltd., Accra, and Past President of the Society.

Keynote Address

Introduction

The theme of this year's Conference is "Challenges to the Image of Pharmacy Practice in Ghana" and to me the key words in the Theme are "Challenges", "Image" and "Pharmacy Practice".

Challenge is defined in the Collins Cobuild English Language Dictionary in various ways but the definition which I think is relevant to us reads:

"Something new and exciting or difficult which you have the opportunity of doing and which requires great effort and determination if you are going to succeed".

The Oxford English Dictionary defines *Image* as "general impression of some person or institution", or perhaps the Collins Cobuild English Language Dictionary puts it more aptly: "Image of a person, group, or organisation is the way they appear to other people".

Pharmacy Practice is pure and simply the professional activities of that creature called "Pharmacist" several of whom are gathered here this afternoon. With these key words defined, if I may be permitted to paraphrase then the theme of this year's Conference would read as follows:

The new and exciting or difficult things which we Pharmacists in Ghana have the opportunity of doing to enhance the way we appear to other people. These new and exciting things we have to do will require great effort and determination if we are to succeed.

In my presentation, I will give an outline of Pharmacy Practice as we have in Ghana today and then identify some of those new and exciting things which we have the opportunity of doing to provide a comprehensive and up-to-date pharmacy service to the people of this nation so as to enhance or improve the general impressions the public has of us. No doubt we need to constantly bear in mind the fact that to succeed we need great effort and determination.

The practice of Pharmacy, as a caring and dynamic profession, must of necessity be tailored to meet the needs of the community it serves. If this is well done, then an image that will elicit public respect and confidence emanates.

The Conference theme presupposes that we have some image but it does not say whether this image is good or bad. Let me say emphatically that the pharmacy profession in Ghana has had a good image for a considerable period of time. I believe pharmacy is now one of the most sought-after courses of study by University entrants. Although it may be assumed that all pharmacists would strive to create a good image for pharmacy it has not always been found so. There are legal requirements for the practice of pharmacy; and we also have a Code of Ethics to which we must insist adherence. The Code of Ethics of the profession guides the pharmacist in the general performance of his duties and in his relationship with the public, fellow practitioners and other health professionals. I must emphasize that although Ethics is moral rather than legal, adherence to them are essential in moulding a good image of any profession. In this respect, permit me to quote Elliot, E.C.:

"After all has been said and done, it may be concluded that the outstanding factor determining the future of the profession of pharmacy is fundamentally moral in nature. The profession must contain greater proportion of members who are ever sharply jealous of the high reputation of the profession and who, by energetic co-operation, are determined ever to protect that reputation".

In essence, for pharmacy practice to move forward and successfully face current and future challenges, a greater number of us, if not all, should strive to protect the reasonably good image or reputation which pharmacy practice has carved for itself in this country.

Pharmacy Practice

Traditional pharmacy practice encompasses compounding, manufacture, storage and supply of medicines and allied products, and this is the face of pharmacy practice that is best known to the public. Pharmacy practice requires certain basic training and education to enable the pharmacist acquire the knowledge, skills, experience, dedication and integrity with which to perform his professional duties. To ensure that whoever practises pharmacy has all these attributes, laws exist for the registration or licensing of such persons as pharmacists. The traditional pharmacy practice mentioned earlier also requires the pharmacist to provide information on the proper use of medicines to patients and clinicians: and offer help to members of the public who seek advice on common ailments, and on health promotion.

Although there are several areas of pharmacy practice, for our present purpose, I wish to dwell only on two - Hospital Pharmacy and Community Pharmacy. My reason simply is that it is these two practices which come into direct contact with patients and other members of the public, the ultimate recipients of our services. The performance of the pharmacist in these areas, no doubt, has a profound, and indeed, a make-or-break effect on the image of pharmacy.

Hospital Pharmacy Practice

The hospital pharmacist has the training and ability to co-ordinate the various functions within the hospital pharmacy to ensure that a meaningful service is provided. This service will include the procurement of supplies, issuing supplies to the wards for use by in-patients, out-patient dispensing, monitoring drug usage in the hospital, keeping and providing drug information for the benefit of clinicians and others. With current advances in health care delivery this type of service is no longer enough. The hospital pharmacist needs further training which will enable him co-ordinate the total pharmaceutical service with the needs of the entire institution and which will provide him advanced level of knowledge creating in him the ability to conceptualize new and improved pharmaceutical services including all aspects of clinical pharmacy.

Clinical Pharmacy Services in the hospital include all those patient-related activities undertaken by the pharmacist aimed at optimizing drug therapy and minimising the risks associated with drug therapy. Central to this definition is the philosophy that being the custodians of drugs, pharmacists have a fundamental professional responsibility to promote safe and effective drug therapy. Some components of Clinical Pharmacy activities are:

* providing drug information to clinicians
* preparing medication histories for patient records
* monitoring drug therapy by direct involvement with patients
* educating and counselling of patients
* participating in management of medical emergencies, such as adverse drug reactions
* participating in drug therapy selection for special patients or those at risk such as pregnant women and nursing mothers, the obese patient, the geriatric patient, the neonatal and paediatric patient.
* evaluating the nutritional state of the patient and how this affects drug therapy.

These are all critical areas for the Hospital Pharmacist and to be able to meet all these challenges, he requires continued post-graduate education not only to keep him up-to-date with medicines and drug therapy but also to be aware of the total pharmaceutical service needs of the institution so that he can evolve appropriate strategies to improve his services.

Unfortunately, unlike other health professionals, the pharmacists in the Ministry of Health hospitals — the largest group of hospital pharmacy practitioners in Ghana — have not been encouraged to undergo postgraduate training to enable them better perform this important and challenging role.

I remember some 15 years ago when a possible re-structuring of the Ministry of Health was being discussed at an Open Forum and it got to Health Manpower Development, a very top health professional at the Ministry of Health was completely flabbergasted when we talked of the need for postgraduate training for pharmacists in the Ministry. He asked with candour: "Postgraduate training for pharmacists? To enable them count tablets better or what?" I could only pity his lack of understanding of the role of the pharmacist.

Unlike the Ministry of Health, the Police Hospital Administrators saw the need in providing postgraduate training for their pharmacists, and I am sure the doctors of the Police Hospital will testify as to how effective and cordial Doctor-Pharmacist relationship has been in the hospital and the tremendous improvement they have obtained in patient-care as far as drug therapy is concerned.

It is not too late to correct this anomaly in the Ministry of Health, since the Pharmaceutical Society of Ghana runs several continuing education seminars, workshops and lectures which the Ministry's pharmacists could be sponsored to attend. Indeed, it is to meet this crucial need for postgraduate training for pharmacists in the member countries of the West African Health Community that the West African Postgraduate College of Pharmacists was

founded 3 years ago with the active support and encouragement of the Health Ministers of the Community. This College is actively functioning and there is absolutely no reason why hospital pharmacists in the country should not be sponsored by their employers to register as students and benefit from the College's lectures and training. It is sad to note that although the Ministry of Health is the single largest employer of Hospital Pharmacists, of the Ghana Chapter of the Postgraduate College's current enrolment of 33 students only 3 are from the Ministry of Health, while 7 are Hospital Pharmacists from quasi-government institutions such as Bank of Ghana, Ghana Commercial Bank, SSNIT and the Military Hospital. Let the Ministry of Health do something about this because patients deserve the best possible pharmaceutical service that can be made available.

Cash & Carry Scheme

Hospital Pharmacy Practice in Ghana will not be complete without mentioning the "Cash and Carry" scheme. To my mind the scheme itself was a good one but got poorly implemented. On the face of it, it was a big challenge to the Hospital Pharmacist who was required by the scheme to determine the total drug needs of his institution, procure them, sell them to patients, monitor their usage, determine lead times, minimum stock levels, viz, total stock management to ensure availability of drugs at all times. Unfortunately, the scheme never really worked; not because the pharmacist did not play his role but simply because:

1) there was inadequate initial capitalization;
2) Hospital Managements did not allow the pharmacist to do his work; and
3) proceeds from sale of drugs were not under the control of the pharmacist, and funds were diverted into other areas.

I believe the Cash and Carry Scheme as it is, cannot sustain itself and must be re-organised allowing the pharmacist to be in full control, of course working within agreed and business-like guide-lines; failing which perhaps the Scheme should be abandoned altogether.

Community Pharmacy Practice

Community Pharmacy is undoubtedly the most active area of pharmacy practice. It is the practice of the profession variously referred to as Chemist's Shop, Pharmacy Shop, Retail Chemist's, or Pharmacy. The Community Pharmacy practitioner is in constant and direct contact with the general public. For this reason his activities could greatly mar or enhance the public image of pharmacy.

Distribution of Pharmacies

There are some 436 registered community pharmacies in the country but of this number 265 (or 60% of the national total) are located in the Accra/Tema Metropolis alone. The Ashanti Region has 108 pharmacies with 101 of them located in Kumasi. This means that Accra/Tema and Kumasi alone have 366 of them (about 84% of all community pharmacies in Ghana). To complete this lop-sided distribution pattern, let me add that the Eastern Region has 16 pharmacies (7 in Koforidua); the Western Region, 15 (14 in Takoradi); Brong Ahafo, 10; Central Region, 8; Volta Region, 7; Northern Region, 4; Upper West, 3. The Upper East has no pharmacy at all.

This pattern of distribution obviously places our rural populations, and indeed most of our compatriots who live outside Accra/Tema, Kumasi, Takoradi and Koforidua, at a great disadvantage as far as qualified pharmaceutical service is concerned. We owe it a duty to them to correct this imbalance by extending our services to the rural areas. I am not unaware of the factors which need to be taken into account when opening a community pharmacy practice:

(a) the availability of capital and pharmaceutical manpower;
(b) the availability of utilities — potable water and electricity;
(c) the size of population the pharmacy is to serve and their health needs; and
(d) the availability and number of hospitals, clinics and/or medical practitioners within the community or its environs.

If we should for the moment leave out the availability of capital, there are several district capitals which qualify to have profitable pharmacies established in them and yet we are not doing anything about them. A Regional capital like Bolgatanga is without a pharmacy and so are large District Centres like Berekum, Bechem, Wenchi, Dormaa Ahenkro, Duayaw Nkwanta, Kintampo and Hwidiem in the Brong Ahafo Region; Bekwai, Konongo, Agogo and Tepa in Ashanti Region; Bawku and Navrongo in Upper East; Salaga and Yendi in Northern Region; Peki, Worawora, Keta and Kete Krachi in the Volta Region; Kibi, Mpraeso, Akosombo, Mampong-Akwapim, and Asamankese in the Eastern Region; Winneba, Apam and Saltpond in Central Region; Sekondi, Axim, Tarkwa and Sefwi-Wiaso in Western Region; and Dodowa and Ada in the Greater Accra Region.

All these centres meet the criteria required for setting up viable businesses, and not only that, they have been crying for help!!! What is required to extend qualified pharmaceutical service to the rural populations in the immediate future is, therefore, not lack of infrastructural

facilities and supporting health institutions but rather capital funding, manpower and determination.

Fake Drugs

Of late, there has been several reports of increasing availability of fake drugs on the Ghanaian market. Of course, the area of pharmacy practice where this problem is encountered most is Community Pharmacy. A fake drug is a drug whose appearance will make one believe that it is a particular product manufactured by a certain company while infact it is not that particular product. In effect, a fake drug is a counterfeit of the real product and it is usually sold very cheaply. Fake drugs may contain substantially less of the declared active constituents, or may not contain any active ingredient at all; or worse still they may contain potentially harmful substances.

It is a fact that it is usually the once popular but officially discontinued products which become the targets for faking. It is also a fact that the more expensive drugs are also attractive to fakers. Like bank notes' fakers, nobody fakes one dollar note when there is 100 dollar note. Although the proliferation of fake drugs in the West African sub-region is a by-product of our deteriorated economies, the problem has been exacerbated by those who will make relentless attempts to do anything to make a living; and the work of others who have the misguided view that by illegally importing cheap and spurious drugs, they are making affordable drugs available to the public. Whichever way you look at it, it is our duty as custodians and experts on drugs to protect the public from the activities of fake drug peddlers, bearing in mind that drugs by their very nature are potentially lethal products and fake drugs are certain killers.

I believe if all of us in Community Pharmacy will refuse to buy drugs from unauthorised persons, the market for fake drugs will be significantly reduced and become less lucrative for the traders who will then switch their energies to other less dangerous economic activities.

National Health Policy

The National Health Policy has identified the Primary Health Care strategy as its bedrock. The emphasis here is centred on health promotion and disease prevention, and of course when these fail, effective and appropriate treatment, including drug therapy, and rehabilitation is envisaged. As indicated earlier, one of the major components of the policy is health promotion and disease prevention. As a health professional, the community pharmacist is perhaps better placed to offer health education, than most other people. It is no secret that most often members of the public seek advice on health, first from the community pharmacist. If for no other reason, one can walk into a pharmacy and seek the pharmacist's advice or opinion and walk away without paying any consultation fee or buying anything. This situation has even been compounded in recent times because of personal economic hardship which makes some members of the public want to rely on us for everything pharmaceutical and medical.

This situation should be used by us not to exploit or endanger their health but rather to educate them on the proper things to do to maintain good health or the need for them to see a qualified medical practitioner when their health fail. Health education and counselling have, therefore, become integral part of the community pharmacist's portfolio.

Family Planning

Family Planning and Population Control have become part of the National Health Policy and we need to be involved in this programme. Most Family Planning Products are distributed from the pharmacy and it is imperative that we get accustomed to the various methods and products to enable us advise the public appropriately. Of course allied with Family Planning is the need for the Pharmacist to participate in the war on how to prevent and check the spread of AIDS.

Herbal Medicine

The Alma Ata Declaration defined Primary Health Care as "essential health care based on practical, scientific, sound and socially acceptable methods and the technology made universally acceptable to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain in the spirit of self-reliance and self-determination."

It is very clear that the majority of our people have no access to, or cannot afford, orthodox drugs if disease prevention fails. Without doubt, such people have to rely on herbs for treatment. Scientifically, some of the claims made by herbal practitioners on the effectiveness of certain herbs have been confirmed. Since Herbology is practical, scientific and socially acceptable and affordable to a large percentage of our people, there is no reason why we should not, in consonance with the Alma Ata Declaration, be involved in its promotion as alternative treatment.

Permit me to quote Prof. Kwame Sarpong, the Dean of the Faculty of Pharmacy, U.S.T. Kumasi, and himself an eminent Pharmacognosist:

"While pharmacists in the scientifically advanced countries of the world are contributing to the production of herbal pharmacopoeias, adding herbal preparations to their array of drugs and even setting up herbal shops, those of us

in West Africa take this rich heritage for granted or look down on herbs. Herbal medicine taken up in the right perspective and properly regulated will offer the pharmacist a new and fertile area of practice."

Let us re-examine our attitudes and start doing something about it now.

National Health Insurance Scheme

There has been a lot of reports on the introduction of a National Health Insurance Scheme. Although no final decisions appear to have been made for its implementation, we should keep ourselves in readiness for this Scheme so that it is not thrust on us unprepared. The biggest component of every Health Insurance Scheme is the provision of medication and this is the domain of the pharmacist, especially the community pharmacist. It will invariably require the supply of drugs against prescriptions, maintaining records of the supplies and submitting monthly bills to the Insurance Company for reimbursement. Contracts will have to be entered into in respect of prices to be charged for the products which qualify to be supplied against a particular insurance policy. All these will require an improvement in the Community Pharmacist's financial management capability, his accurate record keeping methods and his understanding of good accounting procedures while at the same time ensuring regular and reliable supplies.

Recommendations

I think I have been able to identify some of the challenges to the Image of Pharmacy Practice in Ghana. That is, "those new and exciting or difficult things which we have the opportunity of doing and which require great effort and determination if we are to succeed":

*1. **Hospital Pharmacy Practice***

The need for patient-oriented or patient-related pharmacy service can no longer be over-emphasized. In clinical pharmacy we have all the ingredients to provide first class professional service for the benefit of the patient. Let us resolve to enrol in the West African Postgraduate College of Pharmacists so that we can acquire the requisite knowledge to enable us perform better. It is our hope and prayer the Hon. Minister of Health will give a sympathetic hearing to any requests from his pharmacists for sponsorship.

*2. **Community Pharmacy Practice***

The biggest problem here is the irrational distribution of pharmacies in the country. Our rural populations need qualified pharmaceutical service so let us go over and help them. I have already mentioned some of the large towns where we can go. Let us resolve at this conference that:

(a) The Pharmacy Board must freeze registration of all new pharmacy premises in Accra/Tema, Kumasi, Koforidua and Takoradi except within newly developed residential areas which have no existing pharmacy service.

(b) The Pharmacy Board should be seen to be actively encouraging entrepreneurs who desire to set up pharmacies to go into the mentioned areas where services are needed most.

(c) Pharmacists who intend to start their own practices should understand clearly that with careful planning they can still make it without setting up in Accra/Tema, Kumasi, Takoradi or Koforidua.

(d) Through the Ministry of Health and the Ministry of Finance and Economic Planning we should negotiate for Tax Holiday for pharmacies which open in the deprived areas just the same way that the Investment Centre grants concessions to new investments.

(e) Negotiations should commence with the Ministry of Finance and the Bank of Ghana so that the Commercial Banks and Rural Banks will grant loans at concessionary rates to new pharmacies in the rural areas just like loans for Agricultural Ventures.

Fake Drugs

Let us face up squarely to this challenge because I believe although it is a difficult problem, with determination, we can easily succeed. So, firstly, let no pharmacist sign any application for Import Permit for Drugs unless he has absolute faith in the manufacturer and/or supplier and he is fully prepared to face the full rigours of the Law, if the drugs which are permitted entry under his hand are found to be fake. Secondly, true to his professional ethics, let no pharmacist buy or accept to sell or dispense any drug he knows to be fake. We must be vigilant and caring. Thirdly, let the members of the public obtain their drug supplies from only registered premises where pharmacists are available (if possible) because every pharmacist can identify a fake drug on sight; and when they have cause to believe they have been supplied a spurious drug, let them report officially to the Pharmacy Board or the Pharmaceutical Society. Fourthly, let the Pharmacy Board ensure that the Laws restricting the practice of pharmacy are fully enforced so as to exclude effectively all untrained and unqualified persons from importing drugs. Finally, let the officials of Customs Excise & Preventive Service ensure that nobody imports any drug into the country without Ministry of Health Import Permit and Certificates of Analysis. The law requires them to do this, and they owe

it a duty to the nation to so act.

General

It is my belief that with these new developments in health care delivery and anticipated changes in the National Health Policy, as far as Drug distribution and therapy are concerned, the time has come for the authorities of the University of Science and Technology, Kumasi, to review the curriculum of the Faculty of Pharmacy to enable them take up at the undergraduate level, some of the things we are grappling with now.

I am sure that some of my colleagues will not entirely agree with, or like, all that I have said but to paraphrase what a late and famous professor once wrote to his vice-chancellor:

"It has to be done whether you like it or not, because what you like is not so important as what is important for the image of Pharmacy Practice and the interests of our beloved nation".

I submit that we should all critically examine the issues raised, and together let us select some of the new, exciting and difficult things we have the opportunity of doing in our practices and together let us move on with great effort and determination to implement them so as to provide a better pharmacy service to the public and in the process enhance the reputation and good image of Pharmacy Practice in Ghana even further.

Contributions to the Symposium

The Contribution on the theme from the viewpoint of a Hospital Pharmacist

by Mrs Eunice Ansa-Asamoah, Ashanti Regional Pharmacist

The training of Pharmacists in Ghana has undergone a tremendous metamorphosis progressing from the training of Dispensers at the Military Hospital under Sergeant Hart in 1923 to the training of Pharmacists with Masters Degree at the University of Science and Technology in Kumasi to date. In the same vein there has been a lot of improvement in the practice of Hospital Pharmacy and pharmacy in general in Ghana. Until after 1966, almost all the pharmacists trained were for the Ministry of Health dispensaries or pharmacies.

First, there was the Dispenser with his "spectacle on nose" in khaki trousers and white overall struggling with his pestle and mortar in the dispensary making extemporaneous preparations.

Gradually as more sophisticated drugs appeared on the market the training programme of the pharmacist changed; the prescribing habits of the clinician changed; so did the practice of pharmacy.

Generally in the hospital, the Pharmacist has the following duties among other duties to perform:

1. Evaluation of prescriptions
2. Monitoring drug therapy
3. Prescription preparation
4. Compounding of extemporaneous preparations
5. Counselling
6. Provision of information to other health professionals
7. Provision of information on potential toxicity of drugs and other products and handling of poisons
8. Pharmacy management, involving:
   a) Operations management;
   b) Human resource management;
   c) Financial management; and
   d) Drug distribution systems

The above list of duties which is not exhaustive involves a minimum of about 5 steps each for their performance. There is currently an acute shortage of pharmacists in the Ministry of Health (M.O.H.) due to mass resignations (as a result of poor conditions of service).

There is, however, an increase in hospital attendance and this has increased the work load on the few pharmacists at post.

In the Ashanti Region for example (excluding Komfo Anokye Teaching Hospital, KATH) there are 58 health institutions and 71 Maternal and Child Health (MCH) Centres with only 16 pharmacists at post. Despite the fact that there are 18 Health Districts in the Ashanti Region each with a District Medical Officer, only 5 Districts have pharmacists. The remaining pharmacists have each been assigned to a District in addition to their normal duties. I am sure similar situations exist in other regions.

This arrangement increases the work load on the pharmacist bearing in mind the operation of the Cash and Carry scheme. These pharmacists have accepted the challenge and are doing their best until more pharmacists and District pharmacists are appointed to the region.

The University of Science and Technology turns out about 50 pharmacists a year.

The Pharmacy Board insists that these graduate pharmacists, after one year National Service should work with the Ministry of Health (M.O.H.) for additional 3 years before they can work elsewhere. Unfortunately most of them leave the M.O.H. after the 3 years service due to some of the following reasons:

a) It takes more than one year to get appointed to the MOH;
b) No one appreciates or recognises the service these pharmacists render;
c) Those who stay in M.O.H. may have to work for about 5-6 years or more as Assistant Pharmacist when they are in fact registered pharmacists and are recognised as such elsewhere;
d) The current restructuring of the M.O.H. has marginalised hospital pharmacy so one cannot see any future for pharmacists in the M.O.H.; and
e) The Director-General of Medical Services is advocating for privatisation of pharmacy in M.O.H. which does not improve the situation;

The present state of affairs is even being worsened by the re-deployment of Dispensary Attendants in the system who are the supporting staff in most dispensaries in the periphery.

Cash and Carry

The revolving drug fund scheme (Cash & Carry) introduced by the Government in January 1992, for drug supply in the Health Care Delivery system is a big challenge to the Hospital Pharmacy profession. It is a Revolving Fund Scheme where funds from the sale of drugs are used to procure more drugs and resold to patients.

The management of an efficient Cash & Carry Scheme in an institution or Region requires extra business and managerial skills from the pharmacist in the areas of:

1. Procurement
2. Monitoring, supervision and evaluation
3. Efficient stores management
4. Record keeping
5. Financial resource management
6. Human resource management

The guide-lines for the Cash and Carry Scheme issued by the M.O.H. stipulate that the funds from the sale of drugs should be put in a special Institutional Account and used solely for drug procurement. Unfortunately this directive has not been strictly adhered to in some Institutions, Drug Funds have been used for other Institutional expenditure. This is misapplication of Cash and Carry Funds. I believe the Cash and Carry Scheme is laudable and would be viable if:

(a) The pharmacist is made a mandatory signatory to the Drug Accounts in the Institution.
(b) The pharmacist is provided with means of transportation at least in each Regional Centre/Administration for Monitoring, Supervision and Evaluation of the Cash and Carry project.
(c) The pharmacist is given a free hand, within limits, in the operation of the scheme.

The Restructuring of the M. O. H.

In the recent restructuring proposals of the M.O.H., the Pharmacy profession has been marginalised. Pharmacy Division is under the Technical Co-ordination and Research Division (TCRD) and Stores and Supplies.

Personally, I believe the M.O.H. does not recognise pharmacy as a profession any more. It is, therefore, not surprising to find members of other health professionals invading pharmacy, for example a seminar on Drug Rationalisation being organised by a Medical Officer; Chairman, Essential Drugs Committee, M.O.H. is a Medical Officer, when this country has knowledgeable pharmacists some with Ph.D.s in most disciplines of pharmacy.

This invasion goes down the ladder to the institutional levels where one finds Medical Officers/Prescribers selling drugs in consulting rooms and operating theatres or directing patients to where their prescriptions should be filled outside the institution; Nurses selling drugs in the wards, dressing rooms and injection rooms; Administrators misapplying the Cash and Carry Funds. This is all calculated (may be not intentionally) to prove that the Hospital Pharmacist is inefficient.

Training

Most officers in the M.O.H. are usually considered for postgraduate training programmes except pharmacists. Most pharmacists with any postgraduate qualification in the M.O.H. were self or privately sponsored. Until recently, pharmacists with postgraduate qualifications have not been encouraged to work with the M.O.H. They have had to find employment elsewhere.

With the current trends in the profession the hospital pharmacist will work better if given postgraduate training in some of these areas: Management, Planning, Public Health, Clinical Pharmacy, Supply Management, among others.

Conclusion

The Hospital Pharmacist has always been plagued with perennial problems of lack of facilities, accommodation, transport, recognition and poor remuneration. The current problems brought about by the Cash and Carry, the restructuring of M.O.H. and the wholesale handling of drugs by non-pharmacists in the Ministry of Health threatens the very existence of the Hospital Pharmacy profession in Ghana.

The challenge is for hospital pharmacists themselves to refuse to be sidelined or marginalised in their institutions, to rise above themselves despite the work load and prove

their professionalism. Opportunities offered by continuing education programmes under the West African Postgraduate College of Pharmacists should be seized without hesitation.

GHOSPA which is the mouthpiece of Hospital Pharmacists should be revitalised with a new dynamic leadership to help solve the current marginalisation problem. In this regard, we need all the support of the leadership of the Pharmaceutical Society of Ghana.

The Contribution from the viewpoint of a Community Pharmacist by Mr. R. B. Fynn Jr. of Atlantic Chemists, Takoradi

Three separate papers are being presented by three other colleagues on the challenges to the image of Pharmacy practice in Ghana. In my contribution, I propose to fuse the end-products from two angles: The academic in relation to professional pharmacists and the industrial, in terms of pharmaceutical products. These two essential tools considered together make hospital or the community pharmacy practice possible. This approach will enable us to identify both the positive and the negative factors in the growth process which can effectively be utilised to develop the kind of perceptions and concepts useful for our understanding of what the future holds for us as pharmacists in terms of present day challenges and perhaps our own aspirations. This is because ultimately, it is the hospital or the community pharmacists who by and large are in constant touch with the public.

In principle, we have to construct bridges and create linkages with the past, the present and the future. That is to say we should review the role of the pharmacist in the past, and the future role we expect of him in community practice. Our concepts and perceptions of pharmacy practice of the future should identify our past and present weaknesses, assemble and analyse all the relevant packages of data in a manner that should ensure acceptability in operation and in management. In the end our function should aim at giving maximum job satisfaction to our good selves as well as beneficial service to our numerous customers. Our future concepts must, therefore, be very dynamic, imaginative and directed to creating satisfaction.

Operational Framework

To put into operation the concepts referred to above, the following specifics are presented as indicators of my ideas for the constructive enhancement of community pharmacy practice.

It is very important for us, as pharmacists, to encourage roles through seminars, symposia, workshops, including the tapping of experience, maturity and goodwill from those who have acquired such long and sustained knowledge in the field. Strategy at such scales should encourage cross fertilisation of ideas at both horizontal and vertical levels of operation between the participants and the resource persons.

Public Image

The pharmacist is admittedly a highly qualified expert on drugs but it is a misconception to consider him merely as a professional person who trades in medicines like paracetamol or cough mixture over the counter and dispenses prescription from doctors. The community pharmacist, in my view, fulfils a role as the front line contact with the public in any shop performing counselling functions to the public including patients, and medical personnel, e.g. doctors and nurses. He, furthermore, disseminates information on drugs. One must condemn the practice of relegating some pharmacists to the non-performing functions commonly observed in some pharmacies where the pharmacist is merely present in the background with very insignificant roles save the provision of legal cover for the outfit. In recent times, the influx of fake and spurious drugs into the country is rampant. To ensure that fake drugs in the system do not get to the consumer through the retail shop, the sourcing of all drugs should be left to the pharmacist and not to the uninitiated person who may not be able to discern between genuine and fake drugs.

Education

The pharmacist by this training is the most important and key figure in the successful operation of a pharmacy shop. He should, therefore, endeavour to educate by example those with whom he works on the ethics of the profession to ensure his meaningful contribution to the successful operation of the venture. Indeed, the manner in which some staff or personnel comport themselves and consequently dispense prescriptions leaves much to be desired. For example, instead of giving very clear and concise directions like "take one tablet three times a day" or "one capsule to be taken four times a day", there are instances where dispensed medicines leave some pharmacy shops with the following inscription "1 x 3" or "1 x 4" as if a mathematics class is in session. This practice is undesirable and must not be encouraged.

There are other occasions where previous labels are not removed from containers but new ones are simply pasted onto the old label. Let us make sure that dispensed

medicines leave our shops in clean and presentable containers like plastic or glass bottles, paper or plastic envelops with very clear directions. In addition, let us ensure that such prescriptions are duly recorded in the prescriptions book as demanded by law to save ourselves the embarrassment sometimes encountered when such an important function is overlooked. Our business premises must be neat, clean and consequently attractive. This calls for clean environment by way of clean shelves and attractive counters, orderly arrangement of goods in the shop with well attired, pleasant looking staff in attendance preferably in uniforms. Congestion and the storage of unprofessional items like empty beer cartons, crates of empty soft drink bottles on the sales floor should be avoided. The practice of some staff sitting or idling on the counter in the shop should be discouraged. Above all the facade of the shop must always be clean and attractive.

In the public health delivery, the pharmacist is an important cog in the system. How often do we not see quacks hopping from place to place, seven days a week and on market days displaying an array of drugs accompanied by very sweet, sweet sermons which are often very deceptive in content. Public education in the local languages on FM. Stations as well as T.V. programmes in English and the local languages or vernacular should be organised by the society from time to time for the purpose of educating and directing public attention to the wrong information fed to them by the quacks.

The pharmacist in community pharmacy it appears, has been marginalised in the Primary Health Care (PHC) programme currently in practice. The Ministry of Health should be made to recognise the almost indispensable role of the community pharmacist, the drug expert, to help achieve the aim of the PHC programme. Previously, the Pharmacy and Poisons Ordinance of the Gold Coast Revised edition (1957), section 48 Subsection 1a, b, and c and now also Section 20 of the Pharmacy and Drugs Act 64 of 1961 empowered the Pharmacy Board to direct the Registrar to issue to suitable persons Poisonous Chemical Licences to operate under specified conditions. In 1961, there were not many pharmacists in the country; indeed there were at the best only 306 registered pharmacists and the majority of them were in Government Hospitals and in industry; some were academics and a few were in General Practice. The need to get drugs to reach out and be available to all parts of the country could best be accomplished by the chemical sellers in the circumstances. Their existence being of very vital importance and could not consequently be over-emphasised.

Are the services of chemical sellers still needed as at now? The answer, it seems to me, is an emphatic yes. As at June this year there were 672 pharmacists. About 202 these were in Government Hospitals, 10 were in Regulatory Institutions, i.e. Pharmacy Board, Standa Board and Customs & Excise, 21 were Academics, were in Industry and the remainder, some 413, were General Practice. A study of the distribution of pharmac in the country as at December 1992 shows an o concentration in the two regions: namely Greater Accra Ashanti Regional capitals. Of the 413 registe pharmacies, Greater Accra and Ashanti have between th 365 making a total of 88% (65% for Greater Accra 23% for Ashanti). Upper West and Upper East havi regrettably, not a single pharmacy in their two regio Why is this so? There might be other reasons but reason is this: some pharmacies that have tried to establ themselves outside the regional capitals or principal tov have been frustrated by the stiff competition fr Chemical sellers in the localities. We need not pretend t we and the authorities are unaware of the mode operation of these chemical sellers. They sell every drug the knowledge of everybody, whether the drugs are Class or B or C. They do so with impunity and without a inhibition whatsoever. Indeed, they virtually practise pharmacists.

To encourage Pharmacies to be sited in the areas wh they do not exist, the following proposals are reco mended:

(a) All chemical sellers should be restricted to selling o the class C and the exempted drugs. This calls regular visits to both pharmacies and chemical sho by the authorities to ensure that they operate within law.
(b) In an area where a chemical seller's shop alrea existed before the setting up of a pharmacy, chemical seller should be allowed to function side side but of course confining his operations to the s of exempted and class C drugs. On the death of chemical seller or where he is unable to man the sho and unless the shop is converted into a pharmacy, licence should be revoked or alternatively not renew
(c) No new chemical sellers licence should be issued places already served by a pharmacy.
(d) The well established pharmacies in the capitals a other principal towns should be persuaded a encouraged by both Government and the Society open branches in the rural areas.
(e) Co-operative pharmacy shops should be encourag and sited in various parts of the country so that a apparent losses sustained by the less profitable outl are absorbed by the bigger ones in the cities.

The pharmacy profession is a respectable one and und

section 14 of Act 64, 1961, the pharmacist in community practice may be visited by someone for medical or dental advice or for assistance by way of first aid in cases of accident, etc. He must, therefore, be impressively attired preferably in a lab coat.

Community Pharmacy has a bright future if we accept some of these challenges and aspirations. We should aim at creating the tradition which obtains in the francophone countries in the West African sub-region where the sale of drugs outside hospitals is exclusively the function of the pharmacist. In this sense there is the need to reach out to the remotest parts of the country with our services, through the encouragement of the Pharmacy Board and the Government. There is the need for dialogue on a continuing basis amongst ourselves as pharmacists. This will enable us to plan statistics which should allow us to supervise the drug retail business. Every pharmacist no matter his area or sphere of activity should be involved and should lend support in the dialogue for at the end of the day, almost all pharmacists end up in community pharmacy of some sort.

Discipline must be the watch-word of everybody connected with community pharmacy. Finally let me say that it is important to sustain community pharmacy achievements so far made in order to link them up with our aspirations and challenges for the future. This is our chosen profession and all our efforts towards its enhancement must be genuine and continuing.

The Contribution from the viewpoint of an academic pharmacist by Mrs Elizabeth Anima Appiah, Head of Dispensing Technicians Department, Kumasi Polytechnic

Before we think about what we can do to improve upon the image of the Pharmacy profession, I would like to dwell a little on the role of the harmacist as a health care professional.

Much thought and debate has been devoted to defining the true professional role of the pharmacist, and deciding what special aspect only the pharmacist can contribute to the health care team.

Professional practice, sometime ago, consisted purely of compounding and dispensing. At that time, the role of the pharmacist was clearly perceived by both the public and fellow health care professionals. The traditional skills have become less important to most pharmacists now although their spirit lives on in modern pharmaceutical production and formulation techniques. Apart from the traditional role, the pharmacist is now seen as an adviser on the correct and effective use of medicines. The pharmacist is, therefore, expected to ensure that medicines are prescribed, dispensed, stored and used as safely and as effectively as possible. This means that the pharmacist's role is not confined only to the dispensaries but to the homes of patients as well. The Pharmacy Profession is, therefore, not static but dynamic.

To be able to perform our role effectively, there is the need to constantly update and upgrade our knowledge and professional skills. We should have the ability to manage situations as changes occur. Relevant skills which will take care of modern trends in the profession must, therefore, be incorporated into the curriculum of pharmacy education.

Clinical Pharmacy has now been introduced into our educational programmes which is laudable. I believe that if the pharmacist is able to understand the patient and his disease, and if he is able to recognise and monitor adverse effects should they occur in their patients, it will enhance the image of the profession.

It is also a laudable idea that continuing education programmes have now been made compulsory for all pharmacists. When the pharmacist is academically sound, he is able to give the right information at the right time when the need arises. Such educational programmes may be in various forms, e.g. workshops, seminars, etc. If they are organised on regional basis, the method will serve as motivating force to attract more pharmacists, since the pharmacist would not have to leave his work place for a long period.

It will also be economical to the pharmacist because, only the resource persons may have to travel from their regions to the various regions.

In addition to clinical pharmacy the following subject areas, if tackled, will help in improving our professional competence.

1. Social Pharmacy which should include patient counselling, Psychology (Human behaviour).
2. Communication skills which should include:
   (a) Basic computer studies
   (b) Report writing
   (c) Production of aids for effective communication
   (d) How to translate the priesthood language of medicine into a form that is accessible to the patient through verbal and non-verbal form of communication.
3. Drug Information Services.
4. Personnel Management Training.
5. Basic First Aid Techniques.
6. Management of Poisoning.
7. Family Planning and Population Control.

The need for the establishment of small libraries in our

work places cannot be over-emphasised if we want to improve our services to the community, and hence improve our professional image. Such libraries should be stocked with reference books and journals. A book such as "Drug Treatment" edited by Avery would be useful for both the hospital and community pharmacist. Pharmacists should be encouraged to read our own journals, published by our society. The pharmaceutical journal must be seen to contain a lot of information on modern pharmacy practices. The quality of materials in the journal is alright but I think that there is the need to broaden the scope.

Members of the profession should also be encouraged to register with the West African Post-Graduate College of Pharmacists. I believe that the courses which they are currently running will lead to an improvement in the professional competence of the pharmacists.

One aspect which some of us over-look and which does not augur well for the profession is the training of our subordinate staff. Since some of them come into direc contact with our patients or customers, their competenc and behaviour have reflections on the type of services th we render to our community.

We should be able to train our subordinates so that the will acquire the necessary skills which will enable them t handle the job at hand efficiently.

In conclusion, if the Pharmacist must be seen as a adviser on the correct and effective use of medicines, a rol which may even be carried out in the patient's home i necessary, and if we are to perform our duties as partner in the prevention of disease and maintenance of health the we will have to take a second look at our educationa curricula and make the necessary changes. This will hel the members of the profession to play their part effectivel to enhance our image in the eyes of the public. A lot c challenges face us but with hard work and determinatio we shall succeed.

The Contribution from the viewpoint of an Industrial Pharmacist by S. Y. Bediako-Donkor of Pharmadex Ltd

To put it simply, Industrial Pharmacy is a practice which involves the design of a dosage form, its formulation, production, evaluation, quality control, packaging and storage of pharmaceuticals. I wish to limit this definition for the time-being to products intended for human consumption, though it also involves veterinary products and cosmetics.

You may also wish to know that the procedures mentioned can only take place in well-established pharmaceutical industries under the control and supervision of an Industrial Pharmacist, who by his special training, decides on the appropriate dosage form be it *Tablets, Capsules, Suspensions, Powders, Suppositories, Creams* and *Ointments* or the *Parenterals* which includes *Vaccines.*

In Ghana at the moment, there are approximately seventeen (17) such establishments engaged in the practice of *Industrial Pharmacy.*

These Industries have been established to manufacture approximately 76 different products all tailored to "meet" the Nation's Drugs requirements. Incidentally the National drug list has 236 different products. The mathematicians among you may do well to strike the shortfall in coverage.

Objectives

I believe all Pharmaceutical Industries in Ghana have common objectives. I am being presumptuous about this anyway. These objectives can be summed up as follows:

1. To provide health care services to the people of Ghana in quality and quantity.
2. To meet the Nation's Drugs requirements which according to the Essential Drugs List, comprise 23 different preparations.
3. To provide jobs and training facilities to th professionals and other auxiliary personnel.

There may be other objectives but let us limit ourselve to these.

If these are the objectives, then as the saying goes th Industry stands to be judged by its own assertions.

The question is, has the Industry lived up to thes expectations? My answer is *YES* and *NO*. Yes, in the sens that Ghana is still a developing country, its resources ar scanty but despite these setbacks the Industry can still prid itself to have been able to live up to some of it expectations. One can find quality made-in Ghana drugs though short of the Essential Drugs List requirements, an the Industry has provided some amount of employmen prospects.

I also say no, because after many decades of existence many drugs and preparations continue to be imported int the country to augment the local output, not to mention th gradual reduction in the Industry's products profile to onl 40 products instead of the original figure of about 76.

Not surprisingly too, almost all these Industrie virtually produce the same types of drugs — certainly th fast moving and profitable lines.

At this point in time, when a lot of restructuring seem to be taking place in our dear Country, what do we se stagnation and lack of growth in the sector of Industria Pharmacy, and I believe if nothing is done now to arres

this trend, we may find it difficult to justify the continued existence of the Industry in the total health delivery system.

Is it not a known fact that imported drugs are cheaper than those manufactured locally? I cannot see any reason why this should be the case if the proper things are being done, because with the present set-up in the Industry it is possible for the Industry to deliver to the Nation its total drugs requirements as listed in the Essential Drugs List at affordable prices.

I have a strong reason for saying this. We have the infrastructure and technical know-how. For instance why do we continue to import the various life-saving *Vaccines* when these can be manufactured locally? What about the *Antisnake Serum?* The nation has a fair population of some of the most venomous snakes whose "milk" can be harvested and used for preparing these sera. Why has the Industry avoided this area? All that we need, is some amount of training for the technical men at reputable organisations known to have these production facilities. The initial cost may be high, but there are future benefits to be gained.

Someone said not long ago that "people must be seen to be seen". Has the Industry painted a good image enough to be seen or have we made ourselves available to be seen to be doing what we say we are capable of doing, that is, quality production of medicaments in the right quantity.

It is true that unlike Hospital Pharmacy or Community Pharmacy whose presence cannot be hidden from people because of the peculiar position they occupy in the Society and by their method of interaction, the story is very different with the practitioners of Industrial Pharmacy. They practice within the confines of their premises and the only direct contact with the outside world is through the presentation of the products manufactured and the silent or unspoken words of the labels affixed to these products. Therefore, the products placed at the disposal of the people or dispensed to them must of necessity speak for themselves.

Let me cite some examples of how products manufactured by the Industry can make all the difference to the image of the profession or its practitioners:

1. Manufactured tablets should remain as tablets and not turn into powder in their containers before they are dispensed and should continue to remain as tablets even long after being dispensed. The reverse has been reported in some instances.
2. Tablets should be able to dissolve and be absorbed in the gut and not come out the other way intact. The reverse, again has been reported in some instances.
3. It should be possible to dispense suspensions with minimum effort of shaking; we have seen the reverse of this.
4. Syrups have shown crystallisation both on the caps and in the body of the syrups when this should not be so.
5. Labels cannot be easily read on containers because of leakage and in some cases the labels are detached from the containers.
6. The production and sale of sub-potent drugs, evidenced by the persistence of symptoms presented despite medication.

All these lead to the tarnishing of the image of the Industry with the subsequent loss of confidence from the public in the service it provides.

We have heard about what Industrial Pharmacy is all about, its aims, its contribution in the total health delivery system with its attendant deficiencies in its image and practice.

Let us now look at the challenges that must be met to enhance the effectiveness of the role of the practice of Industrial Pharmacy in the total economic set-up of the Nation that will accord it a greater recognition of its usefulness in the Health Delivery System:

1. First of all, the Industry should do everything possible to win back the confidence of the people it serves; it must show that it can deliver its chosen service in quality, quantity and at affordable prices.
2. Considering the present number of pharmaceutical industries, it is possible to avert the type of drug shortages sometimes experienced. Drug production should be a sustainable operation and not the erratic way some Industries operate.
3. The Industry should expand its scope of activity and create more job openings to absorb the trained personnel.
4. The Government's interest and assistance in the affairs of the Industry must receive equal attention as in other sectors.

Suggestions

(a) To be able to deliver the said service in quality and quantity, postgraduate training should be offered to deserving students who show practical qualities in the field of Industrial Pharmacy to study at reputable foreign organisations in areas of the profession not already covered locally, for instance the production of all classes of *Vaccines* and other *Sera*. The cost may be high but in the long run the benefits will certainly outweigh the cost.

(b) In view of the aforesaid, favourable or good incentives should be put in place to draw these young professionals into the field to motivate them to stay on instead of looking towards the more lucrative areas of

the profession.

(c) What I am going to say may not be the panacea, and I know that my colleagues and drug manufacturers may be uncomfortable with it. To remedy the problem of drugs shortage and meet the requirements of the Essential Drug List, not more than three Industries should be allowed to produce the same lines of drugs. The Government of the day should provide the needed financial support to back these Industries and shou fully patronize the activities of these Industries.

A kind of policy to safeguard the system and make workable would be necessary. This policy should take in consideration the local manufacture of all classes of dru as embodied in the Essential Drug List towards realisi the goal of Health for all by the year 2,000.

The Communique

The conference was declared open by the Honourable Minister of Health Commodore (Rtd.) Steve Obimpeh on Wednesday, September 14th 1993 at the Christ the King Hall, Accra.

The theme of the conference was "Challenges to the Image and Practice of Pharmacy in Ghana". The keynote address on the theme was delivered by Mr. K.A. Ohene-Manu, Managing Director of Oyster Healthcare Ltd., Fellow and Past President of the Society.

At the end of the conference the Society issued the following Communique:

A. Affirming the role of the Pharmacist as a Health Counsellor and Educator;

Recognising the important role of the pharmacist in the Healthcare Delivery System;

Recognising the high public expectation for improved Pharmaceutical Services; and

Recognising the increasing importance of herbal medicine, the conference recommends that:

1. The Continuing Education Programmes of the Society be vigorously pursued by every member of the Society.
2. Clinical Pharmacy Practice be promoted in all Health Institutions, whether government, missionary or private.
3. Pharmacists should participate actively in Family Planning (FP) activities with a view to increasing the usage of FP methods and devices.
4. Pharmacists should strive to apply their professional expertise towards the standardisation and use of herbal preparations.

B. Realising the unacceptably poor distribution of Pharmaceutical Care in deprived areas of the community, the conference recommends that:

5. The government empowers the Ministry of Finance and Economic Planning, Financial Institutions, Internal Revenue Service and District Assemblies to grant concessionary loans and tax holidays to new pharmacies in such deprived areas and thereby encourage extension of quality Pharmaceutical Service to the unfortunate majority.

C. Recognising the marginalisation of the Pharma Division under the current Reorganisation Exercise of t Ministry of Health, the conference recommends that:

6. It is in the best interest of the nation to re-establish t post of Director of Pharmaceutical Service as Advis to the Director-General of Health Services, pharmaceut-ical matters.

D. Recognising the outweighing benefits of the Cash a Carry System (CCS) over previous uneconomic arrang ments by government, the conference recommends that:

7. The original policy guideline of the Cash and Car System (CCS) of the Ministry of Health whi recognised the pharmacist as kingpin in the operati of CCS and thus required him/her as mandato signatory to the Revolving Drug Account of the CC be adhered to; and this Revolving Drug Account operated solely for the purpose it was intended serve, that is, the procurement of drugs and medic supplies only.

E. Considering the publication of the Food and Drugs La (PNDC Law 305B) as incomplete without the complemen tary Pharmacy Council Law, the conference recommend that:

8. The government should expedite action on th promulgation of the Pharmacy Council Law.

F. Recognising the serious health hazard posed by th increased influx of FAKE and SUBSTANDARD DRUG across the borders of the country, the conferenc recommends that:

9. Drug regulatory and law enforcing bodies, that is, th Pharmacy Board, CEPS and the Police shoul intensify their activities in a co-ordinated manner t curb this menace and thereby protect the population.

The conference further recommends that:

10. Pharmacists and/or pharmacy proprietors should als lend their support to this anti-fake drugs campaign b reporting such peddlers and refusing to deal with them

G. Finally, considering the undue hardships experienced b

pre-registration pharmacy graduates and post-registration pharmacists both of whom have not been paid for periods up to eighteen months by the Ministry of Health after their National Service, the conference recommends that:

11. The Ministry of Health
    (i) Should act now without further delay to effect payment of all such arrears, and
    (ii) Should in the future, rectify this unfortunate and painful situation by taking up the responsibility to pay the salaries of the graduate pharmacists during the mandatory twelve-month pre-registration training period.

At the close of the conference the following officers were elected for the period 1993-1995:

Mr. David Anim-Addo — President
Mr. Dela Ashiabor — Vice President
Mrs. Czarina Ribeiro — Hon. General Secretary
Miss Nancy M. Owusu — Hon. Treasurer
Dr. M.L.K. Mensah — Editor
Prof. J.S.K. Ayim — Council Member
Mrs. Joyce Addo-Atuah — Council Member

The Conference is most grateful to the Honourable Minister of Health, members of the Pharmaceutical Society of Ghana and all those who actively contributed to its success.

ATTENTION

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CPA's Principles for a Code of Ethics

The Council of the Commonwealth Pharmaceutical Association(CPA) has accepted the revised ethical principles that were prepared by its Executive Committee almost two years ago. They are recommended as the basis for national codes of ethics:

1. A pharmacist's prime concern shall be for the welfare of both patients and public.
2. A pharmacist shall uphold the honour and dignity of the profession and not engage in any activity which may bring the profession into disrepute.
3. A pharmacist shall at all times have regard to the laws and regulations applicable to pharmaceutical practice and maintain a high standard of professional conduct. A pharmacist shall avoid any act or omission which would impair confidence in the pharmaceutical profession. When a pharmaceutical service is provided, a pharmacist shall ensure that it is efficient.
4. A pharmacist must respect the confidentiality of information acquired in the course of professional practice relating to a patient and the patient's family. Such information must not be disclosed to anyone without the consent of the patient or appropriate guardian unless the interest of the patient or the pu requires such disclosure.
5. A pharmacist shall keep abreast of the progres pharmaceutical knowledge in order to maintain a l standard of professional competence relative to sphere of activity.
6. A pharmacist shall neither agree to practise under conditions of service which prevent his professic independence nor impose such conditions on ot pharmacists.
7. A pharmacist should, in the public interest, prov information about available professional servic Publicity must not claim or imply any superiority c the professional service provided by other pharmac or pharmacies, must be dignified and must not br the profession into disrepute.
8. A pharmacist offering services directly to the pul shall do so in premises which reflect the professio character of pharmacy.
9. A pharmacist shall at all times endeavour to co-oper with professional colleagues and members of otl health professions so that patients and the public m benefit.

Halofantrine: Change in Recommendations for Use

Halofantrine is a phenantrenemethanol anti malarial which is effective against the asexual erythrocytic stage of malaria parasites. It is indicated for the treatment of acute malaria caused by single or mixed infections of *Plasmodium falciparum* or *P. vivax*. It is administered in a total dosage of 24 mg/kg given as 8 mg/kg 3 times at 6-hourly intervals. The majority of patients who have been treated with halofantrine have been infected with *P. falciparum* in areas where chloroquine or multidrug resistant strains are common.

Recent research reports have alerted that the administration of halofantrine can result in prolongation of the Q-T intervals and ventricular dysrythmias in susceptible individuals. There have also been some spontaneous reports of serious ventricular dysrythmias, rarely associated with death. In total, 8 cardiac arrests have been reported to the pharmaceutical company, leading to 6 deaths, some of which may have been associated with ventricular dysrythmias. These cases have occurred particularly under certain conditions which include the use of doses higher than recommended, recent or concomita treatment with mefloquine, the presence of pre-existi prolongation of Q-T interval or in patients with thiami deficiency.

An analysis of available ECG data in patients with *falciparum* malaria and in healthy volunteers indicat that:

1. halofantrine causes an increase in the Q-T interval recommended doses;
2. the absorption of halofantrine is increased approx mately six-fold when taken with a fatty meal, wi additional increases in the Q-T interval.

The pharmaceutical company is consequently revisir the data sheet for this product. In advance of this revisic WHO has been advised by the pharmaceutical compar that halofantrine:

- is contraindicated in patients with a family history c congenital Q-T prolongation;
- is not recommended for usage in combination wit drugs or clinical conditions known to prolong the Q-T interval or in patients who may suffer from thiamir

deficiency;

* should not be administered to patients with severe electrolyte imbalance;
* treatment should not exceed the recommended total dosage of 24 mg/kg given as 8 mg/kg 3 times at 6-hourly intervals;
* should be administered on an empty stomach (i.e. not given in association with food);
* should only be used as an emergency self-medication for presumptive therapy in those patients known to have normal Q-T intervals.

The pharmaceutical company recommends a second therapeutic course 1 week following the initial treatment of patients who have no previous exposure to malaria, such as travellers from non-endemic areas. — *WHO's Weekly Epidemiological Record No. 37.*

PHARMACEUTICAL SOCIETY OF GHANA JOURNAL

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Marketing Practices in Public Pharmacies

By Louis Nortey, MPSGH

According to the maiden newsletter (Vol. 1 No. 1, April 94) of the Greater Accra branch of the Pharmaceutical Society of Ghana, "Pharmacy is.... the most commercialised of the health professions"; and this was a comment from the public.

For the pharmaceutical industry, except hospital pharmacy practice, this is particularly true. Pharmacists are involved in the provision of services from which they make profit from their clients.

Therefore, it is important for pharmacies, i.e. hospital and community, to adopt modern marketing practices to satisfy their numerous clients. Public (Hospitals) pharmacies are often found wanting in showing any orientation towards their clients: hence it is not surprising that whenever a private modern pharmacy springs up near a public hospital, the patients sway to the private pharmacy despite the relatively higher cost of drugs in the latter.

Any modern pharmacy should adopt the marketing mix or 4P's, namely: price, promotion, products and place. Recent researches have expanded the marketing mix to include: people and processes. If one considers, the public dispensaries vis a vis the marketing mix, one would realise that the designers of the buildings as well as the management of these dispensaries have a long way to go to satisfy their clients, especially psychologically.

Public dispensaries have been praised often by the quality of drugs that they produce and their relatively cheap prices. But is that enough? Since man has both physical as well as psychological needs. That is, clients have both tangible and intangible needs.

As it were, most public dispensaries give a good product and a good price of their drugs but the premises look unkempt and unpainted, the dispensing assistance get irritated on the least provocation and the dispensaries are poorly designed. That is, there is no communication (non-verbal) or transparency between the time that the patient hands in the prescription, till the prescriptions are filled. Thus, the concepts of place, promotion, people and processes are totally ignored in the outlook of public dispensaries Why would clients not get angry, for waiting at the dispensary, despite the fact that the dispensary staffs are genuinely working to satisfy them.

It is, therefore, amusing that the authorities in Korle-Bu are trying to set up a private pharmacy owned by the hospital on the premises. Now, if the Korle-Bu management board does not change their attitude to the pharmacy and promote the 6P's then they wou beating about the bush: they are not likely to attract patronage than the existing dispensaries there. Whe looks at the dispensaries at the Paediatric and Obst and Gynaecology departments they look like an thought - the dispensaries were not part of the or design of the block. The dispensaries do not radiat confidence in patients despite the high quality of pro and cheaper prices that they provide.From the a analysis, it is clear that for the public dispensaries to any meaningful patronage and march competition must take the marketing mix seriously in order to pac an augmented product for their clients, to ensure lo and to beat competition.

An augmented product translates to mean: the quality must be right; the environment for dispensin drug must be right; the people dispensing must be and the price must be right.

The dispensaries must preferrably be of (transparent) glass for the patients to see what goes there. This would reduce patient frustration during wa and hence irritation.

When the 6P's are adequately satisfied in pharmacy's business relationships, there is likel develop:

i. a core of loyal clients;
ii. a promotion of the pharmacy;
iii. a maintenance of goodwill with the clients
iv. a desire for the pharmacy to behave like a good citizen in the community — and contribute tow social welfare (emergencies, natural disasters, e

Regarding the fourth (iv) point of good citizenshi pharmacies, there are two schools of thought on the is One school, believes that it is not necessary fo enterprise to be socially responsible, once the comp fulfils its legal and tax obligations faithfully. maintain that, by using the company's resources in s activities, it deprives the shareholders of their divide and if anything at all it should be the shareholders should decide how the resources must be used.

However, in the case of public pharmacies, the shareholder is the government, who incidentally responsible for most social welfare programmes. public pharmacies are automatic contributors to so welfare programmes.

The other school teaches that, since enterprises are based in communities, it is prudent for them to contribute towards the communities activities. Again, since enterprises are made of people, it is just right for the employers of the people to contribute to the societies which "harbour" their human resources.

Let us move from the old ways we do things in the public pharmacies, so that we can align these pharmacies to benefit from the current trade liberation which is taking place in the country.

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PROFILE

of

Professor Albert Nee Tackie

Compiled by: Louis Nortey, MPSGH

If it is true that hard work pays, then the life and works of Prof. Albert Nee Tackie, epitomises that assertion. As a child without any vision or role model, he started from scratch to blossom into the first Ghanaian PhD pharmacist, the pillar of pharmacy and scientific research in Ghana.

He was rewarded and recognized in 1994 with the naming of an alkaloid, cryptotakieine, after him. Not only that, but the Liberians also acknowledged him with the institution of Tackie Lecture Series in March 1994, at the University of Liberia, School of Pharmacy. As it were, if Prof. Allotey (UST) could claim "Allotey's Constant" in nuclear physics, then Prof. Tackie also formerly of UST could also claim "cryptotakieine" in medicinal chemistry, as their contribution to the advancement of scientific knowledge in the world. Cryptotakieine is one of the alkaloids found in *Cryptolepis sanguinolata*: the plant has anti-malarial and antitumour properties.

It is very difficult to overlook such a giant and hardworking character when it comes to sharing awards. Thus, in 1979, he was made a member of the order of the Volta (M.O.V.) by the Ghana government for his contributions in research and public administration. He is also a fellow of the Pharmaceutical Society of Ghana, the West African Pharmaceutical Federation, Ghana Academy of Arts and Sciences, The Royal Pharmaceutical Society of Great Britain(having been the first Ghanaian member) and the Royal Institute of Chemistry.

Prof. Tackie was born on 3rd November, 1922 in Accra; was educated at the Methodist school at Accra and Nsawam; Achimota College(1942) and the Dispensing School, Korle-Bu, Accra in 1947.

Prof. Tackie holds that he went into Pharmacy by chance. He recalls: "after completing Achimota College, I took up a teaching appointment at Korle Gonno Royal School, and one day on my way to school, I met Mr E.K. Bensah, a family friend who recommended that I join the Dispensing School because it was more challenging". Little did he know that he was going to begin an illustrious and distinguished career in Pharmacy. Mr. E.K. Bensah, later became the Minister of Health in the First Republic.

On completion of the three-year course at the Dispensing School, he was appointed a demonstrator and later sent to Northern Polytechnic for his Inter and B.Sc, the London University School of Pharmacy at Bloomsbury Square for his B.Pharm. Degree.

Prof. A. N. Tackie

Nee Tackie returned to the Gold Coast in 1954 and was appointed a Principal Pharmacist in the Health Services. Here, he recounts his encounter with former President Kamuzu Banda of Malawi — then a medical officer in Kumasi. The two became great professional pals after some initial differences betweem them.

In line with Dr. Kwame Nkrumh's accelerat development programme after independence, t Dispensing School was relocated at the then Kwar Nkrumah College of Technology (KCT), as t Department of Pharmacy under the Science Faculty. Albe Tackie was invited by Mr. Allman, Head of the Dispensi School and later the Department of Pharmacy to join t teaching staff.

Great things they say have humble beginnings and lecturer in the Department of Pharmacy in 1957, Albe Tackie was sent to the Chelsea College of Advance Science and Technology, University of London, for h doctorate programme. Since then, the distinguished care of Albert Tackie has seen no end.

A turning point in his life was reached in 1964, whe Nee Tackie was appointed a professor of Pharmaceutic Chemistry, Head of Department of Pharmaceutica Chemistry and Dean of the Faculty of Pharmacy all c UST. What a co-incidence.

As Dean, his vision was to replace the expatriate sta with locals because the former did not often stay for lon and that disrupted the faculty's programmes. Again, h introduced a postgraduate masters programme in all th disciplines of the faculty.

On several occasions, Prof. Tackie attempted t introduce a Ph.D programme in the faculty but was neve successful; one of the reasons being that the bigges department in the University (Engineering) did not have

similar programme. This he regrets till today, and instead of singing in his retirement: "I came, I saw, I conquered", Prof. Tackie is rather humming: "I came, I saw, but I could not finish".

Almost all the important committees of UST benefited from the patronage of Prof. Tackie. Some of these included: the Academic Board, Executive, Conference, Scholarship, and Health Services Committees and the Domestic Services Organisation. He represented or joined the Vice-Chancellor at many meetings

"Scientific research is noted to involve a collaborative effort", thus he was involved in the training of the following: Prof. Ayittey-Smith (College of Medicine and Allied Health Sciences, Sierra Leone); Prof. Mingle (Ghana Medical School); Prof. K. Sarpong (Dean, Faculty of Pharmacy, UST); the late Prof. R. Ansah-Asamoah (Pro-Vice-Chancellor, UST); Doctors Fiagbe and Abaitey all of UST; to help him in his works. He also combined the efforts of Pharmacists and Engineers to run a Masters Programme in Sanitary Engineering at the School of Engineering, UST. Having found an ally in the School of Engineering, Prof. Tackie collaborated with them to set up the Technology Transfer Centre (TCC), with an initial effort in a successful soap making venture.

The towering stature of Prof. Tackie was in the area of scientific research, thus when he left the UST in June 1973, he took up the executive chairmanship of the Council for Scientific and Industrial Research (CSIR), the following month of July, till he retired voluntarily in May, 1980.

One institution which has benefited greatly from the hard work of Prof. Tackie is the Centre for Scientific Research into Plant Medicine (CSRPM) at Mampong-Akwapim. Prof Tackie was involved in the setting up of the centre and has always been on its scientific committee. He recently retired from there as a consultant.

According to Prof. Tackie, "Scientific research is best done as a team work" hence he co-operated with many research units in various capacities. He was an external examiner at the Universities of Nairobi, Lagos, Nsukka and Ahmadu Bello. At 72 years, he is still an external examiner at the Faculty of Pharmacy, UST. In 1971, a British Council bursary took him to tour six Pharmacy Research Schools in the UK; and was the first Fulbright Professor at the School of Pharmacy, Duquesne University, Pittsburgh, USA.

The vast experience of Prof. Tackie enabled him to shape policies in research, technology transfer, education, state enterprises, pharmaceutical industries and public management in Ghana. For instance, he served as the chairman for the Technical Committee on Drugs, Ghana Standards Board (1969-73); chairman, Board of the Forest Products Research Institute (1969-73); chairman, Board of Directors of the Ghana Pharmaceutical Corporation—now GIHOC Pharmaceuticals (1965-66)

Other public international organisations were not left out, as UNIDO found him to discuss in 1977, the development of technological and managerial skills in Ghana. Other organisations such as UNCTAD, USAID, ECA, UNCSTD, and Commonwealth Science Council have used the services of the industrious and ingenious son of Ghana before. In his retirement, Prof. Tackie still contributes to postgraduate programmes at the University of Pittsburgh, USA.

The West African Pharmaceutical Federation, contracted him in 1985 to set up a school of pharmacy in Liberia , which he did with zeal and excellence but for the deteriorating economy, he had to leave for Ghana. Currently, one of his former students, Prof. E. Ayittey-Smith, has also been contracted to open a Department of Pharmacy in Sierra Leone.

The magic about Prof. Tackie which I have discovered so far after chatting with him and reading about him, is his commitment and hard work which he attaches to any endeavour which engages his attention. Thus, the success of Astek Industries Company and Vatsons Industries had something to do with him when he worked there.

Currently, Prof Tackie is on retirement, resting, but since the "tiger's claws do not grow old", he is associated with "Malaherb" production—an antimalarial herb and working on its patent in the USA.

What would please Prof. Tackie now, is to see the Pharmacy Council Law passed. He would also like pharmacists to engage the old pharmacists in their deliberations more often.

Prof. Tackie is married to Esther with four children: Michael, Cynthia, Reginald and Edith. Incidentally, Reginald is also a Pharmacist and the challenges facing him from his house are just enormous.

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The varied interests of Prof. Tackie extended him to Ghana's industrial, [illegible] technology transfer [illegible] [illegible] [illegible] and public [illegible] [illegible]. He served as the [illegible] for the Technical Committee on Drugs, Ghana Standards Board (1969-73), chairman, Board of the [illegible] Products Research Institute (1968-73), chairman, Board of Directors of the Ghana Pharmaceutical [illegible] now [illegible] (1983-1988).

Other public international organisations which made [illegible] use of his [illegible] to advise on [illegible] development of [illegible] and [illegible] in Ghana. Other organisations such as UNCTAD, UNIDO, ECA, UNCSTD and Commonwealth Science Council have used the services of his institutions and [illegible] of Ghana [illegible] Prof. Tackie still [illegible] to postgraduate programmes at the University of Pittsburgh, USA.

The Kenya [illegible] Pharmaceutical Federation contracted him in 1993 to set up a school of pharmacy in [illegible] which he did [illegible] and [illegible] for the [illegible] [illegible] had to leave his Ghana. Currently, one of his former [illegible] Prof. [illegible] Sarpong, has now been [illegible] a [illegible] of Pharmacy in [illegible].

The image that Prof. Tackie has [illegible] [illegible] [illegible] and [illegible] about him is his commitment and hard work which he attaches to any endeavour which [illegible] his attention. Thus, the success of [illegible] Industries Company and [illegible] has [illegible] to [illegible] and [illegible].

Currently, Prof. Tackie is [illegible] [illegible] [illegible] [illegible] with "Malanco" [illegible] [illegible] and working [illegible] in the USA.

What would please Prof. Tackie now is to see the Pharmacy Council Law passed. He would also like pharmacists to [illegible] the aid of pharmacists in their [illegible].

Prof. Tackie is married to [illegible] with four children: Michael, [illegible], Reginald and Edith. [illegible] Reginald is also a Pharmacist and the [illegible] him from his [illegible] just next door.

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