The Ghana Pharmaceutical Journal

Volume 18
Number 1

- AGM '96: Programme Review
- Pharmacy Council Makes Progress
- PSGH at World Congress of Pharmacy '96
- Ghanaians and Pharmaceuticals

Official Organ of the Pharmaceutical Society of Ghana

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The Ghana Pharmaceutical Journal

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COVER PICTURE: The leader of the co-sponsors of the Society's representative to the FIP congress in Jerusalem, Mr. Ernest Bediako-Sampong (right) presenting their contribution to Mr. Dela Ashiabor, Vice President of PSGH.

The Ghana Pharmaceutical Journal is published three times a year by the Pharmaceutical Society of Ghana in Accra. Correspondence concerning editorial contents and advertisements should be addressed to: **The Editor, Ghana Pharmaceutical Journal, P.O. Box 2133, Accra, Ghana.** All materials intended for publication should be submitted typewritten, in double spacing on one side of the paper and in duplicate. Materials accepted for publication may be subjected to editorial revision and, in case of original papers, once they are published in this journal, they cannot be published elsewhere except by agreement. Authors should conform with current style in the presentation of papers, indicating where tables and figures should be inserted. Views expressed by contributors do not necessarily reflect the opinion of the editor.

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Pharmacists Need To Educate The Public

It is well known that the vast majority of Ghanaians do not know enough about medicines in particular, and about their bodies and different disease states that they can fall victim to.

This fact is amply demonstrated on daily basis in our pharmacies where for example a patient either comes to buy two capsules of an antibiotic to treat a sore or buys a cream or soap purposely to bleach the face and body.

The consequences of such lack of knowledge could sometimes be very disastrous.

Having been educated to the level we find ourselves now with the tax payers money, should we sit by unconcerned so see our fellow countrymen go through untold hardship and suffering as a result of their inadequate knowledge about drugs and about their bodies?

The kind of education pharmacists receive at the University equips them to play roles that go beyond their traditional role as caretakers of the nation's medicines. Pharmacists are very well capable of educating the public not only on medicines but also on their health in general and this job they must take more seriously.

Engaging in this sort of public education activity will go a long way to enhancing our public image.

AGM '96: Programme Review

The month of September is just around the corner and with it is coming yet another general meeting of pharmacists.

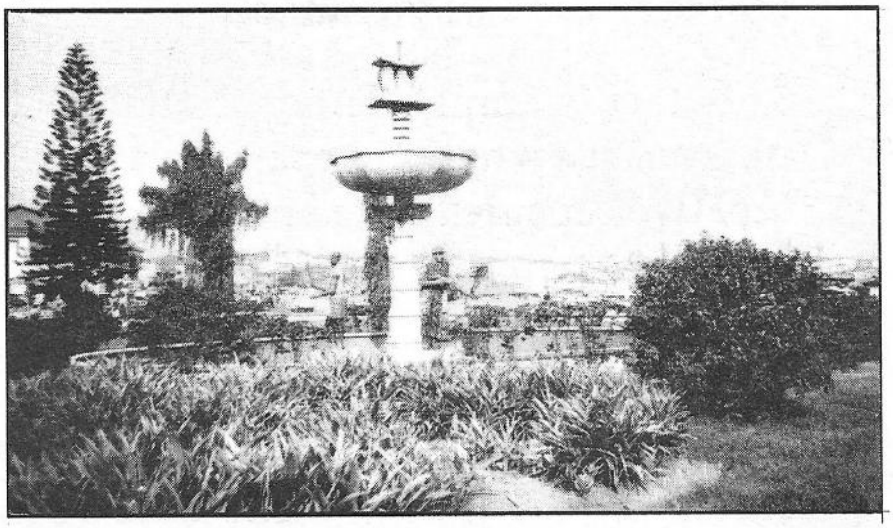
The GNAT Hall situated near the Kumasi Technical Institute (KTI) will now be the venue for this once-in-a-year thing. As you know, KTI was the original venue but circumstances beyond our control forced us to change the venue.

The main theme to be discussed as most of you are already aware, since it was stated in the invitational brochure sent to all fellows and members, is "Pharmacy Practice: The Professional and Commercial Dimensions".

Fellows and members of the society will be expected to arrive in Kumasi on Wednesday, September 11 and register at the GNAT Hall from 3.00 p.m. to 6.00p.m. The registration exercise will continue on Thursday, September 12 at the same place from 8.00a.m.

Thursday will be a very busy day since all the lectures on the various sub-themes will be delivered on that day. Of course, a time for discussion will follow each lecture. The day will end with a cocktail to be sponsored by Gokals Ltd. and Ghana Pharmaceutical Co-operative Ltd. at the Four-Aces relaxation spot, off Pine Avenue, Danyame.

Friday, September 13, will be the Official Opening Day. The ceremony will be performed by the Hon. Minister for Health, Dr. Eunice Brookman-Amissah at 10.00 a.m. She will also open the usual exhibition of drugs and other health related products but all these will be proceeded, starting from 9.00 a.m., by a period of presentations by some sponsors.



A view of a part of Kumasi from the Kejetia Round-about

An optional tour is scheduled to take place in the afternoon of the same day, and in the evening, commencing at 7.00 p.m., another cocktail, this time sponsored by our host, the Ashanti Regional Branch, will come off at the UST Senior Staff Club.

The rather "easy" Friday will give way to yet another busy day, that is, Saturday, September 14. The whole of this day will be occupied with the presentation of various reports, election of Fellows and the adoption of:

a) reviewed constitution,

b) a review welfare package for members and

c) a communique emanating from the general meeting.

The day, and indeed, the AGM will be rounded off with a special social session at the Georgia Hotel at Nhyiaeso. ❑

Companies Donate Towards Society's Participation at FIP Congress

Seven companies have contributed ¢3,720,000.00 to co-sponsor Standing Executive Committee (SEC) member to the 56th International Congress of FIP or World Congress of Pharmacy '96 to be held in Jerusalem, Israel from September 1-6.

The companies include Ernest Chemists, Gokals Pharmacy (Club Road), M&G Pharmaceuticals, Universal Chemists, Bendoz Pharmacy, Citadel Pharmacy and Bel-Team Publications Ltd all of Accra. The Co-sponsor, the Pharmaceutical Society, contributed ¢1,720,000.00.

The presentation of donations on behalf of the contributors was done at the secretariat of the Society on August 5, by Mr. Ernest Bediako-Sampong, Managing Director of Ernest Chemists.

In a short speech that preceded the presentation, Mr. Bediako-Sampong said he and his colleague decided to assist an executive member to attend the congress because they believed his attending the congress would afford him the opportunity to acquaint himself with new ideas with regard to the practice of pharmacy which he could share with other members of the Society on his return.

He regretted that because of the short notice given them, they could give assistance to only one person and assured the Society that in future more than one person shall benefit from their benevolence.

Mr. Dela Ashiabor, Vice President of

PSGH received the donations of behalf of the Society.

He thanked them for the donation and said the gesture was a testimony to their commitment to the well-being of the society. He said the Society would make up the difference on the total amount required to send a representative to Jerusalem.

Mr. Ashiabor hoped that other companies will emulate their example and sponsor future representatives of the society to such congresses.

It may be useful to know that the Federation Internationale Pharmaceutique, or the International Pharmaceutical Federation as it is better known today, was founded in the Hague, The Netherlands in 1912 to bring together pharmacists from all over the world so that they could learn from each other and thus advance the profession of pharmacy.

FIP's mission is "to represent and serve pharmacy and pharmaceutical sciences world-wide". FIP sees its principal role as one of education in and development of the practice and science of pharmacy.

The membership of FIP falls into a number of categories. It has Ordinary Members which are national organisations representing pharmacists and pharmaceutical scientists. It currently has over 80 such organisations which, in turn, represent over 250 pharmacists or pharmaceutical scientists around the world. Ordinary Members come from 59 countries ranging from highly developed, such as those found in Western Europe or America, to the developing such as Eritrea or Bangladesh. This makes FIP the largest and most representative international organisation in its field.

FIP also has 4,500 individual members from around 90 countries in six of the seven continents.

Ghana is an Ordinary Member of FIP and has been paying its dues over the years but has not been able to partake in its activities and derive maximum benefit from its membership. It is for this reason that the SEC decided that every effort must be made to send at least a delegate to this and subsequent year's congress. ❑

Pharmacy Council Makes Progress

Following its inauguration in October of last year, the Pharmacy Council has quickly settled down to serious business and has come out with a number of regulations all of which have the purpose of streamlining the operations of pharmacy business in Ghana.

With regard to licensing of premises a set of documents has now been prepared by the Council to guide prospective applicants for pharmacy and chemical sellers businesses. These documents incorporate the application forms and the procedure for applying for the siting and registration of premises.

There are four of such documents and these are:

1. Retail Pharmacy
2. Wholesale Pharmacy
3. Retail/Wholesale Pharmacy
4. Chemical Sellers shops.

Significant decisions taken by Council on registration of premises include:

1. New retail or retail/wholesale pharmacy business should be located at least 400m radius from an existing retail pharmacy; and

2. Applications are submitted by either a pharmacist or a body corporate, whose instrument of incorporation shall include dealing in pharmaceuticals, and has engaged the services of a superintendent pharmacist.

The two step application process, that is, site and final approval has been abolished to give way to a single approval.

Review of Fees

Council has reviewed the fees chargeable for renewal of Certificates and licences as follows:

Registration/Renewal of wholesale Pharmacy from ¢25,000 to ¢100,000.

Registration/Renewal of Retail Pharmacy from ¢15,000 to ¢50,000. Application/Processing fee for wholesale and retail pharmacy is ¢25,000. Chemical Sellers Registration/Renewal of Pharmaceutical Industries from ¢100,000 to 150,000. Application/Processing fees for Pharmaceutical Industries from ¢10,000 to ¢50,000. Reviewed Fees for Registration of Drugs are as follows:

Mr. K.A. Ohene-Manu, Chairman of the Pharmacy Council

Specialty

1. Application and processing from ¢10,000 to ¢20,000 [local and foreign].

2. Registration and Renewal of speciality [Foreign for 5 years] $500,00 to $250,00

3. Registration and renewal of speciality [local for 5 years] from $ 150,00 to ¢150,000

Generic

4. Registration and Renewal [foreign for 5 years] from $500.00 to $100.00

5. Registration and Renewal [local for 5 years] from $150.00 to ¢150,000

Reviewed Professional Fees are as follows:

1. Professional Qualifying Examinations from ¢25,000 to ¢50,000

Registration as Pharmacist from ¢25,000 to ¢50,000.

Regional Offices

Council has decided to set up regional offices in accordance with the Pharmacy Act 1994. For the moment plans are advanced to site an office at Sekondi for Western/Central Regions and Kumasi for Ashanti/Brong Ahafo Regions. Other plans include an office each at Koforidua for Eastern/Volta; Tamale for Northern/Upper East/Upper West Regions; and Accra for Greater Accra Region.

New Certificate

In line with Act 489, Council has now computerised the issue of certificates and licences. The new format for pharmacies now bears the name of the business, approved location, nature of business and the name and registration number for the superintendent pharmacist.

Regulation Actions The Council had taken regulatory action against a number of pharmacy and licensed chemical sellers premises which were operating without authorisation. The affected shops have since been closed by the Council.

Uncommitted Licence

Council has abolished the "uncommitted licence" and decided that Pharmacists who wish to operate pharmacies would be given permission to do so provided that they operate within the law.

This measure, in the opinion of Council, is to encourage pharmacists to start their own pharmacies.

Council also affirm that it still upholds the three year post registration requirement for pharmacists before they are eligible to register pharmacy businesses.

Between October, 1995 and May 1996, the Council received a total of 202 pharmacy applications, out of which 53 were approved. The remaining were either rejected, withdrawn or deferred. Some of the applicants whose applications are not approved have either petitioned or re-applied.

A total of 13 petitions have been considered, six (6) have been approved while the remaining (7) seven have been rejected.

Physically and Mentally Handicapped Pharmacists

Council expressed concern about some pharmacists who are physically and/or mentally incapacitated as a result of old age or illness and therefore may not be able to supervise pharmacies. A sub-committee made up of Council and PSGH members has been formed to examine the situation and come out with recommendations.

Professional Discipline

It is the aim of Council that pharmacists keep abreast with the new law, that is, Pharmacy Act 1994 (Act 489) and other related laws in order to update their knowledge on latest developments affecting the profession.

Council would also want to remind Pharmacists that its inspection activities would be stepped up and those found to contravene the rules and regulations governing the practice shall face disciplinary actions. ❑

Committees of the Pharmacy Council

In accordance with Section 7 and 22 of the Pharmacy Council law, 1994 (Act 489) a number of committees has been formed. These are:

1. Registration Committee: This shall be responsible for registration of premises ie. pharmacies and chemical sellers shops.

2. Finance Committee: This is responsible for financial matters of Council

3. Education Committee: This shall advise in the training of pharmacists from the undergraduate to graduate levels and also for professional training.

4. Drugs Committee: This shall be responsible temporarily for the registration of all drugs until the Food and Drugs Law is established.

5. General Purpose Committee: This shall advise Council on actions to be taken against defaulting chemical sellers and companies.

6. Disciplinary Committee: This is to be responsible for all disciplinary matters and recommend appropriate sanctions to Council.

Council has also formed General Purpose Committee to advise it on actions to be take against defaulting chemical sellers and body corporate. ❑

Sekyere-Marfo Back Home

The Assistant General Secretary of the Society, Mr. Daniel Sekyere-Marfo has last August, returned from the United Kingdom after an eight-week course in Effective Drug Management and Rational Drug Use. Aimed at promoting rational and effective management and utilization of pharmaceuticals in any setting so that patients receive the best care, the course took place at the School of Pharmacy of the Robert Gordon University in Aberdeen Scotland. It attracted eleven participants from various countries who were taken through topics like Drug Policy and Legislation; Selection, Estimation and Procurement of Pharmaceuticals; Store and Stock Management and Distribution; Budgeting and Financial Control; Quality Assurance, Computer assisted Dispensing Techniques; and Interpersonal Communications, among others. The picture above shows Mr. Sekyere-Marfo (standing third from left with some of his course mates. ❑

NEW ADMINISTRATIVE OFFICER FOR PSGH

Mr. A. Aggrey

Mr. Anthony Aggrey, 44, has been employed on April 1st by the Society as its Administrative officer. Selected from among 140 applicants, Mr. Aggrey holds a Diploma in Public Administration from the University of Ghana, Legon.

He has served as administrative officer in a number of institutions including the P&T Corporation and the National Vocational Training Institute. He was Assistant Administrative Manager at his last work place, that is, Masai Developers Ltd. Mr. Aggrey is computer literate, has some knowledge of accounting and has experience with Desk Top Publishing.

He will administer the secretariat under the direction of the Hon. General Secretary and also assist in the production of the Ghana Pharmaceutical Journal. ❑

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From the Secretary's Desk

Reports reaching the Secretariat point to the fact that the open forum at this year's Annual General Meeting (AGM) to take place in Kumasi will be full of 'fireworks'. For me, in particular, this is a positive signal because I usually do not feel very comfortable when I see only a couple of members doing all the talking at such fora. What amuses me is that, right after these fora, some colleagues, especially the 'young ones' complain that they are ignored when they raise their hands to make a contribution when in fact I hardly see their hands up.

I am compelled therefore to believe that these young ones lack the courage to stand up and say their minds, not trusting what they will say will be considered sensible or are afraid they will be branded disrespectful should they engage in some heated debate with 'senior' members of the Society.

If the reasons I have given above are correct, then, I hasten to urge them display boldness in those situations and disabuse their minds of the belief that arguing with a senior colleague on an issue is disrespectful.

How many ideas that have led to great things today were not laughed at when they were first advanced? And how many of these ideas were not brought forward by men and women younger than those of us who consider ourselves young?

Debates or 'contentions by words or argument', as Webster's New Collegiate Dictionary defines it are the only means intelligent people can discuss issues and come up with far-reaching results. And in the art of debate what really matters is not age or academic qualification but rather the quality of the arguments. The argument must be rational, factual and in our case, it must have at its centre the well-being of the Society.

Making our open fora heated on all issues including the handling of the Society's financial affairs, the welfare of its members, performance of officers of the society, among others, will only lead to one thing - a greater Pharmaceutical Society of Ghana. ❑

Letter to the Editor

Dear Sir,

Kindly allow me a space in the Pharmaceutical Journal to comment and suggest or recommend probable solutions on the Ministry of Health/Pharmacy Council Drug Import Permit Form.

I wish to seize this opportunity to congratulate the Pharmacy Council and Ministry of Health (Pharmacy Division) for the task of confirming and approving *authentic* Drug Import Permits without extra assistance.

Inter alia a requirement/information needed on the said Permit Form is the SIGNATURE at bottom right corner of the form. One wonders whose signature. Of course, it is that of the AUTHORISED PHARMACIST (the one whose licence covers the establishment) of the importing company/shop/institution.

However, one believes that the signature could be provided by an UNAUTHORISED PERSON(S) because everyone has one and could sign it. It is expected that other specific additional information of the authorised pharmacist (known to the approving authorities should be provided).

It is very possible that these extra information were once requested for and space provided for it on earlier forms but with time 'narrowed' to only the signature as seen today. Therefore, an assumed ideal earlier form (permit) might read:

Name of Spt. Pharmacist
Registration Number
Signature
Date

Such a form may be described as 'closed' as compared to the the new form which may be termed 'open'. One could imagine all that can happen using the 'open' form, ranging from signatures of unauthorised pharmacists, proprietors, nephews etc., to difficulty in ensuring the authenticity or otherwise of the permit.

Several solutions are possible in averting the mentioned probables above. As part of these solutions one would suggest that:

(1) The form may be redesigned to read as the assumed ideal, earlier format suggested above.

(2) All authorised pharmacists (those registering importing establishments) may submit plus their Registration Number, Names and SAMPLE SIGNATURES to the controlling bodies for cross-checking to ensure fair play.

F.K. Akarkpo
Reg. No. 1000 ❑

TRIBUTE TO THE LATE VICTOR AIDOO

by the Pharmaceutical Society of Ghana

The sad news of the sudden departure on 7th July, 1996 of the late Victor Kofi Aidoo was received with profound shock by the entire membership of the Pharmaceutical Society of Ghana. It is therefore with heavy heart and intense grief that we pay this tribute to our past leader.

First, it is relevant to pharmacists to state that Kofi's period of training and education to become a pharmacist was an important landmark in the history of the profession in this country. Why? Because when Dr. Kwame Nkrumah of blessed memory had the vision to establish the Kumasi College of Science and Technology, Pharmacy was among those profession he elevated; he instructed that the Korle-Bu Dispensing School be closed and in its stead, a School of Pharmacy be established at the College. Thus, in 1953, Victor Kofi Aidoo was one of the first batch of only 12 students to be admitted at the School of Pharmacy at the Kumasi College of Science and Technology as a Kingsway Chemists Scholar.

A great sportsman that he was and with several national and international honours and awards to his credit, Kofi graduated from the School of Pharmacy in the year 1957, becoming a registered member of the PSGH. And with instant employment by Kingsway Chemists.

Then his professional career began. Even though we know we are in a state of mourning yet we believe it is appropriate to give you a short break here with one quick anecdote. Among his classmates of 1957, Victor Kofi Aidoo was nick-named 4-FIGURES and it should interest us to know what 4-FIGURES meant Kofi was the first among his year group to receive from his employers in the private sector an annual salary of £1080 (ie. 4-Figures) when the rest being civil servants received the standard £680 (ie. 3-Figures). Of course we should not forget to add his fringe benefits like bungalow , car allowance, watchman and so on.

Very ambitious, hard working and well skilled at his job, Kofi Aidoo quickly rose to the position of Manager of Kingsway Chemists within 3 years of employment at the age of 30 and not long thereafter, was appointed Area Manager. No wonder therefore, that he became his own boss in 1970 by managing his own professional business - St. Andrews Pharmacy.

Victor Aidoo again had all the qualities of a good Christian leader: exemplary in conduct, affable, easy of address, steady and firm in principle, able and willing at any time to perform any task allotted to him with skill and assiduity.

He represented the Pharmaceutical Society of Ghana at the Constituent Assembly which ushered in the Second Republic. At the youthful age of 40 he accepted the responsibility of leadership of the Society and was elected President in the year 1971 for 2 terms, 1971-1974.

Of course, like all other mortals, Kofi was not without fault but by God's grace his other professional leadership achievements followed in rapid succession:

1. He was a Founding Father of the West African Pharmaceutical Federation under the West African Health Community,

2. He was a foundation fellow of the West Africa Postgraduate College of Pharmacists,

3. He was a fellow of the Pharmaceutical Society of Ghana,

4. He was the principal architect of the Ghana Pharmaceutical Co-operative Ltd. and past Chairman of the movement,

5. And he was a fellow of the Institute of Pharmacy Management.

And so KOFI, we say FARE THEE WELL and fervently pray that the good Lord in whose vineyard you have toiled so admirably whilst in life, will himself, now at your death, grant you safe lodging and eternal rest in perfect peace. ❑

Some Decisions of WAPF Council

The Council of the West African Pharmaceutical Federation at its 32nd meeting held during the 10th Scientific Congress of the West African Pharmaceutical Federation (WAPF) which took place in Banjul, the Gambia last March decided on a number of issues including the following:

1. Membership of national associations will be updated and used in the publication of a Directory of Pharmacists as well as a Book of Fellows of the West African Post-graduate of Pharmacists (WAPF).

2. Presidents of National Associations are to ensure payment by defaulting Fellows of WAPCP of their Establishment Fee of US$50 for academic caps and gowns.

3. It was resolved that henceforth no country should be called upon to render account of Local Funds; each country would be responsible to itself in so far as they were not receiving support from the West African Health Community.

4. It was resolved that WAPF would no longer ask for funding from WAHC which would not be forthcoming in any case and that WAPF would run the College at all cost without reference to WAHC. The implication is that member countries should continue to endeavour to organise fund-raising in pursuance of the College objective.

5. Council appealed to President of National Societies to ensure that cavitation fee of US$1.00 was collected during payment of annual retention fees, and that members should be sincere to declare the actual number on register.

❑

The Communique issued at the End of the 10th Scientific Congress of WAPF and WAPCP

The 10th Scientific Congress of the West African Pharmaceutical Federation and the West African Post-graduate College of Pharmacists has been held at the Atlantic Hotel, Banjul, The Gambia from 17th - 21st March, 1996 on the theme - Child Survial: Challenges for Pharmacy.

Participants were drawn from the member countries of the Federation namely the Republic of The Gambia, Ghana, Sierra Leone and the Federal Republic of Nigeria. The Congress noted with regret the absence of participants from Liberia.

The Congress was declared open by the Hon. Minister of Works and Communication, Mr. E. Ceesay on behalf of the Chairman of the Armed Forces Provisional Ruling Council and the Head of the State of the Republic of The Gambia, Capt. Yahya A.J.J. Jemmeh.

The keynote Address was delivered by Mr. M.M. Sesay. President of the Commonwealth Pharmaceutical Association. After exhaustive deliberation on the theme and sub-themes congress observed the following:

1. That every child has a right to live and develop to its fullest potential.

2. That a healthy child is of economic, social and political benefits to its nation and people.

3. That there is a high incidence of poverty, ignorance and even violence in the sub-region which creates situation inimical to the child's health.

4. That the increasing incidence of AIDS in the sub-region has posed a new threat to child survival initiatives.

5. That majority of the peoples in the sub-region are not accessed to good drinking water, adequate sanitation and satisfactory health care.

6. That worm infestation is equally detrimental to the child's growth and development.

7. That fewer pharmacists are involved in the Expanded Programme on Immunisation and other public health programme instituted for child survival strategy.

8. That practical progress however has been made in the Expanded Programme on Immunisation resulting in a substantial reduction in in fact and child mobidity and mortality.

The Congress therefore recommends the following:

Continued on page 12

Continued from page 11

1. That pharmacists must play a vital role in child survival strategies, (i) Through provision of drugs; (ii) Counselling; (iii) Public Health Education and (iv) By full integration of pharmacists into the Expanded Programme on Immunisation and other public health programmes.

2. That there is need for every country in the sub-region to sustain the control of diarrhoea, AIDS and childhood diseases which are controlled through EPI programmes.

3. That the congress recognises the importance of breastfeeding in any sustainable child survival effort and that breastfeeding should be encouraged.

4. That as the continued survival of the child depends on good nutrition status, all pharmacists should be involved in promoting good nutrition in the early years of life of the child.

5. That there is a compelling need to effectively design a de-worming strategy in the sub-region and give it equal emphasis as the EPI and ORS/ORT programmes.

6. That governments of member countries and NGOs should continue to assist in providing amenities that would guarantee the survival of the child.

7. That governments should enforce all international conventions on children ratified by member countries.

The congress resolved to pursue the programme of the Post-graduate College of Pharmacists in meeting the higher level man power requirements of facilitate the attainment of better quality of life for all.

Finally, the congress expressed deep appreciation to the Government and people of The Gambia, particularly, the Chairman of the Armed Forces Provisional Ruling Council and Head of State, Captain Yahya A.J.J. Jammeh. It also expressed gratitude to the West African Health Community, and other International organisations for their support and contributions. Th excellent arrangement made by the Pharmaceutical Society of The Gambia was highly appreciated. ❑

WHO Issues New International Guidelines for Drug Donation

The World Health Organisation (WHO) has released in April this year, new international Guidelines for Drug Donations, which are designed to improve the quality of drug donations both in acute emergencies as well as in development aid programmes. The guidelines were approved in an interagency meeting at WHO headquarters in Geneva.

By urging the adoption of common standards, WHO aims to better align drug donations with the needs of recipients and to reduce wastage in time and resources. The Guidelines are not an international regulation, but are intended to serve as a basis for national or institutional guidelines to be adapted and implemented by governments and organisations dealing with drug donations.

Medicines are an essential element in alleviating suffering and international humanitarian relief efforts can greatly benefit from donations of appropriate drugs. But experience in emergencies over the years has shown that drug donations often prove to be more harmful than helpful. They may not be relevant to a particular emergency situation, or may not comply with local drug policies and standard treatment guidelines. Many donated drugs arrived unsorted, or labelled in a language which is not easily understood in the recipient country.

In the former Yugoslavia, to cite one example, of all the donated drugs destined for the region that were received by WHO's Area Office in Zagreb, 15 percent were completely unusable and 30 percent were not needed. In Sarajevo, huge quantities of expired medicines took up valuable warehouse space from incoming supplies and then had to be destroyed using scarce fuel. Many similar problems have been encountered in in other large-scale emergencies over the years.

There are several underlying reasons for these problems. Probably the most important is the common but mistaken belief that in an acute emergency, any type of drug is better than none at all. Another is a general lack of communication between donor and recipient, which can lead to many unnecessary donations. Often, the total handling costs for duties, storage and transport are higher than the value of the drugs themselves, while stockpiling of unused drugs can encourage pilferage and black market sales.

The 12 articles of the Guidelines for Drug donations are bases on four core principles:

1. A drug donation should benefit the recipient to the maximum extent possible;

2. a donation should be given with full respect for the wishes and authority of the recipient and support existing government policies and administrative arrangements;

3. there should be no double standards in quality - if the quality of an item is unaccepted in the donor country, it is also unacceptable as a donation; and

4. there should be effective communication between the donor and its recipient.

The Guidelines were developed by WHO and represent the culmination of efforts to standardise drug donations which begun in the early 1980s by some major international agencies.

❑

Enhancing the Image of the Ghanaian Pharmacist

by Daniel Sekyere-Marfo

The 1995-1997 strategy of the new Council of the Pharmaceutical Society of Ghana on the 2nd of October 1995 is "Image Building and Enhancement of the Ghanaian Pharmacist and his/her Profession".

It is important for us all to see ourselves as part of the effort towards the achievement of the goals set for ourselves and our profession.

"The dinosaur is extinct today not because it was marginalised. Neither is it because it was not strong or powerful. The reason is that it REFUSED TO CHANGE -the insect kept changing and it survived".

One strategy for avoiding pharmacy going the way of the Dodo or Dinosaur way is image-building and enhancement. Professional Image is the perceived public perception of, rating of or attitude towards a profession and its practitioners, especially in terms of Social and Functional relevance, impact or influence.

Will the next generation still find pharmacist and pharmacy relevant? In other words "What Image will pharmacist and pharmacy have in the next generation in Ghana?"

A quick look at our strengths, weaknesses, opportunities and threats will offer some insight into the situation for our general consideration.

STRENGTHS

1. University Education and a unique body of knowledge functionally useful and desirable for health care.

2. Professional Association; useful for organising, regulating and promoting ethical standards amongst its members.

3. Legislation: Pharmacists and Pharmacy in Ghana are regulated and protected by the existence of an Act of Parliament where enforcement is largely in the hands of Pharmacists.

4. Socio-economic relevance: The pharmaceutical sector of every nation has real socio-economic relevance in terms of (among other things) national productivity and socio-political stability.

5. Accessibility: Pharmacists are easily accessible

WEAKNESSES

1. Lack of corporate or managerial attitudes, skill and knowledge including communication and negotiating skills, financial and accounting skills, job design and supervisory skills etc.

2. Too much reliance on credential rather than functional qualifications. Skillful hands-on job performance is more desirable than insistence on recognition on the basis of paper qualification alone.

3. Lack of knowledge, skills and performance in public health activities. The pharmacist must be knowledge able in areas such as:

a. Healthcare management eg. human and material management and identification and estimation, cost reduction/containment and wastage control.

b. Distribution and determinants of disease states.

c. Disease control, surveillance and prevention.

d. Health information management etc.

4. Perverse practices by some pharmacists.

5. Absence of a mandatory, sustained continuing education programme for career development.

6. Lack of professional or monitoring system within the profession.

7. Non-involvement of pharmacists in national politics and community-oriented activities.

8. Unwillingness of pharmacists to contribute their money, time and effort to the Pharmaceutical Society of Ghana.

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Mr. Daniel Sekyere-Marfo is the Resident Pharmacist with the Bank of Ghana Clinic and the Assistant Honorary General Secretary of the Pharmaceutical Society of Ghana.

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9. Lack of uniform guidelines and/or knowledge evaluation procedures for pre-registration Housemanship for pharmacists.

OPPORTUNITIES

1. Sustained, Mandatory, continuation education programmes as a shared responsibility between the Pharmacy Council and the Pharmaceutical Society of Ghana.

2. Publications i.e. journals and newsletters.

3. Practice research on useful common topics based on observed local issues and problems.

4. Seminars/workshops on contemporary issues.

5. Involvement in national politics.

6. Institution of useful community oriented projects.

7. Pharmacy House: Incorporating offices, conference rooms publishing unit, library and model pharmacy.

8. Modification of undergraduate course structure for practice enhancement. Teacher-practitioners will be very useful in this direction.

9 Uniform guidelines and knowledge evaluation procedures for pre-registration pharmacists doing housemanship.

10. Widening the scope of pharmacy practice in Ghana eg. Clinical Pharmacy, Pharmacy Epidemiology, Poison and Drugs Information Centres etc.

11. Organising joint pharmacy medical conferences, meetings etc. with our medical colleagues.

THREATS

1. Pharmacists and their individual attitudes and principles constitute the greatest threat to the survival of pharmacy into the next generation.

2. Non-Practitioner Pharmacy Proprietors and Licensed Chemical Shop Owners: More often than not, the sole aim of these two groups of people is profit maximisation - usually at the expense of the image of pharmacy. A strong, and reliable inspectoraite unit within the Pharmacy Council will be expected to keep a check on their activities.

3. Advertisements: they tend to confuse and compel the public to look at medicines as ordinary items of commerce.

4. Legislation, legislators and government policy, eg. Non-mandatory membership of the Pharmaceutical Society of Ghana, Cash and Carry System, National Health Policies.

5. Expectations of society: most often professionals do not know what the society really expects of them. In such a situation the professional and the society may be in constant state of conflict and mistrust.

6. Allied Health Profession: Inter-professional politics especially in times of limited funding within the public sector can pose a threat to the image of pharmacy.

7. Parallel pharmaceutical activities including smuggling by unofficial, non-registered companies and individuals.

8. Fakery and counterfeiting of medicines leading to generalised loss of confidence in the health care provider especially purveyors of medicines. ❑

New Drug Control Legislations: My Views

by Mrs. Eniton R. Gavu

Until 1992, the Pharmacy and Drugs Act (64) 1961 provided for the setting up of the Pharmacy Board to control the supply, manufacture, importation, exportation, storage, transportation and sale of Drugs as well as the regulation of the Pharmacy profession in Ghana a dual function. This Act (64) now stands repealed with the promulgation of the Food and Drugs Law 1992 (PNDC L 305B) and the enactment of the pharmacy Act (Act 489) 1994.

The two laws have consequently set up two bodies namely Food and Drugs Board (FDB) and the Pharmacy Council respectively to take over the duties of the erstwhile Pharmacy Board. The former is thus responsible for regulating and controlling drugs, food and chemicals, their manufacture, distribution, with focus on measures for protecting the health of consumers while the latter, the Pharmacy Council regulates Pharmacy Practice.

FOOD AND DRUGS LAW (PNDC LAW 30B) 1992

COMPOSITION OF THE BOARD - SHORTFALLS .

The Food and Drugs law is supposed to control manufacture, distribution, importation, registration of drugs etc. The Board has a membership of 15 and whose activities would be under the control and supervision of the Ministry in all matters relating to the administration and implementation of the law. It also has in addition to the Chairman, The Director of Fisheries, The Head of Nutrition and Food Sciences Department, University of Ghana, Veterinary Surgeon, The Director of Crop Services, Ministry of Agriculture, (all in the interest of 'Food') one Practitioner of Herbal Medicine and the Registrar of Pharmacy Board (now defunct), and representative of 5 professional interests namely Ghana Standards Board, Food Research Institute, Ghana Medical Association, The Attorney General or a lawyer, a representative from the Environmental Protection Council and two consumers. There are some obvious shortfalls which need to be addressed.

Since this is a Board under the Ministry of Health and takes over very important responsibilities of the defunct Pharmacy Board, the composition of this Board must include the following:

1. A representative from the Ministry of Health

2. A representative from the Pharmaceutical Society of Ghana

3. A representative from Faculty of Pharmacy

4. In addition to the Registrar of the Pharmacy Council, two other pharmacists to represent the interest of manufacture (production) and distribution.

It must be borne in mind that drug manufacture comprises production, packaging and quality control while distribution also has pharmaceutical interest of wholesaling and retailing.

It is obvious that decision taken by the FDB on drug issues like drug registration, importation or similar drug policies will be relevant and binding on pharmacy practice. A Board with Agriculture (or Food) bias cannot and should not be the final authority on Drug issues. If nothing is done to put things right early, a time will come when even the minister cannot easily influence their decisions. they can decide to set up new structures altogether and could allow other agents to infiltrate to take over some functions and privileges of the profession.

Similarly, even though a Drugs Division of the

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Board may have a competent technical committees, nothing prevents the Board from ignoring their recommendations.

SO WHAT DO WE DO?

1. MEMBERSHIP OF THE BOARD:

The Pharmaceutical Society of Ghana, as a matter of urgency, should send a memorandum to the Minister of Health to request for adequate representation of pharmacists on the Board since issues on drugs can be expertly dealt with by pharmacists.

2. Structures

The present Pharmacy Board Offices could house the Pharmacy Council whilst the Pharmacy Board Drug Control Laboratory can be used as the nucleus of the Food and Drugs Board. On the longer term, the piece of land on the side of the laboratory can be developed to be used as the building complex of the Food and Drugs Board. The Pharmacy Board is in the process of acquiring office and residential accommodation in all the regions of the country as part of its decentralisation programme with establishment of the FDB. It would be easier for these structures to be taken over to carry out the same responsibilities.

3. Staff

The Pharmacy Board presently has trained staff in various aspects of Drugs Control. there will however, be the need to recruit additional staff in the medium and long term. Some functions of the Pharmacy Board which must be taken over by the Drugs Division of FDB include:

a. Pharmaceutical industries and operational research which covers licensing of pharmaceutical industries, enforcing quality assurance systems and organising continuing education programmes for personnel in pharmaceutical industries.

b. Product registration, evaluation and capacity monitoring.

c. Product inspection and post marketing surveillance unit which will inspect at the ports and monitor imports.

d. Product information and public relations unit to take care of product advertisements organising of scientific seminars (for staff) etc.

e. Drug Control (Laboratory) activities.

f. Administration Unit taking care of human resource development staff recruitment and training etc. not forgetting offices and financial control facilities.

Government surely has made financial provision for this Drugs Division to build up and increase capacity and infrastructure. Since fees obtained from services like drug, cosmetic and chemical registration, manufacturing industries registration, training courses and consultancy service should be enough to make the Drugs Division self supporting.

Pharmacy Council Law 480, 1994.

This Act Provides for a Pharmacy Council which will now control professional practice including:

1. Premises licensing

2. Inspection and Enforcement involving routine inspection of all registered premises in all regions etc.

3. Pharmacy practice and ethics. Registration of pharmacists, continuing educational programmes, handling of complaint, Professional Qualifying exams etc.

4. Information Systems and Public Relations.

5. Administration.

At this juncture, I must state there is the need for Government to publish copies of the National Drug Policy, particularly on issues of drug legislation for educational purposes since three bodies, as shown below are taking up to a more or less degree functions and activities of the Pharmacy Board i.e.

Narcotics Control Law (PNDC L236) 1990

Food and Drugs Law (PNDC L305B) 1992 and Pharmacy Act 1994.

We must educate ourselves on policies regarding Drug registration, and get acquainted with the new schedules (classes) of medicinal products, among other things. ❑

Approaches to Enhancing the Quality of Drug Therapy

by The Canadian Medical and Pharmaceutical Associations

Goal of this Joint Statement

The goal of this joint statement is to promote optimal drug therapy by enhancing communication and working relationships among patients, physicians and pharmacists. It is also meant to serve as an educational resource for pharmacists and physicians so that they will have a clearer understanding of each other's responsibilities in drug therapy. In the context of this statement, "patient" may include a designated patient representative, such as a parent, spouse, other family member, patient advocate or health care provider.

Physicians and pharmacists have a responsibility to work with their patients to achieve optimal outcomes by providing high quality drug therapy. the important contribution of all members of the health care team and the need for co-operative working relationships are recognised; however, this statement focuses on the specific relationships among pharmacists, physicians and patients with respect to drug therapy.

This statement is a general guide and is not intended to describe all aspects of physicians 'or pharmacists' activities. It is not intended to be restrictive, nor should it inhibit positive developments in pharmacist-physician relationships or in their respective practices that contribute to optimal drug therapy. Furthermore, this statement should be used and interpreted in accordance with applicable legislation and other legal requirements.

This statement will be reviewed and assessed regularly to ensure its continuing applicability to medical and pharmacy practices.

This joint statement was developed by the Canadian Pharmaceutical Association and the Canadian Medical Association and includes the goal of drug therapy, strategies for collaboration to optimize drug therapy and physicians' and pharmacists' responsibilities in drug therapy. The statement recognized the importance of patients, pharmacists and physicians working in close collaboration and partnership to achieve optimal outcomes from drug therapy.

Goal of Drug Therapy

The goal of drug therapy is to improve patients' health and quality of life by preventing, eliminating or controlling diseases or symptoms. Optimal drug therapy is safe, effective, appropriate, affordable, cost-effective and tailored to meet the needs of patients, who participate, to the best of their ability, in making informed decisions about their therapy. Patients require access to necessary drug therapy and specific, unbiased drug information to meet their individual needs. Providing optimal drug therapy also requires a valid and accessible information base generated by basic, clinical, pharmaceutical and other scientific research.

Working Together for Optimal Drug Therapy

Physicians and pharmacists have complementary and supportive responsibilities in providing optimal drug therapy. To achieve this goal, and to ensure that patients receive consistent information, patients, pharmacists and physicians must work co-operatively and in partnership. This requires effective communication, respect, trust, and mutual recognition and understanding of each other's complementary responsibilities. The role of each profession in drug therapy depends on numerous factors, including the specific patient and his or her drug therapy, the prescription status of the drug concerned, the sitting and the patient-physician-pharmacist relationship. However, it is recognised that, in general, each profession may focus on certain areas more than others.

For example, when counselling patients on their drug therapy, a physician may focus on disease specific counselling, goals of therapy, risks and benefits and rare side effects, whereas a pharma-

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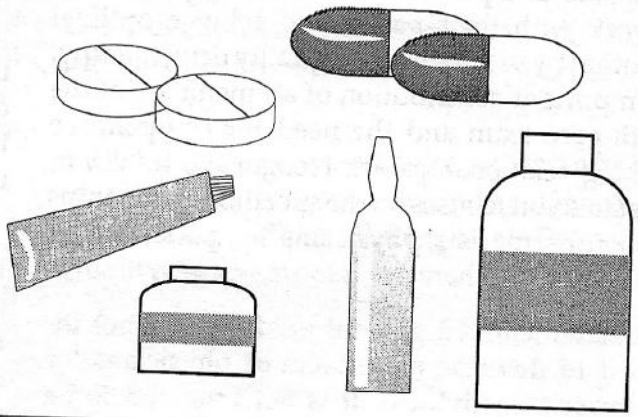

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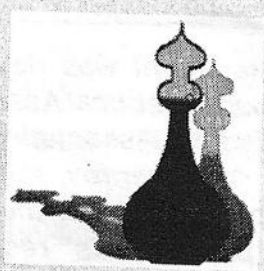

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cist may focus on correct usage, treatment adherence, dosage, precaution, dietary restrictions and storage. Areas of overlap may include purpose, common side effects and their management and warnings regarding drug interactions and lifestyle concerns. Similarly, when monitoring drug therapy, a physician would focus on clinical progress toward treatment goals, whereas a pharmacist may focus on drug effects, interactions and treatment adherence; both would monitor adverse effects.

Both professions should tailor drug therapy, including education, to meet the needs of individual patients. To provide continuity of care and to promote consistency in the information being provided, it is important that both pharmacists and physicians assess the patients knowledge and identity and reinforce the educational component provided by the other.

Strategies for Collaborating to Optimise Drug Therapy

Patients, physicians and pharmacists need to work in close collaboration and partnership to achieve optimal drug therapy.

Strategies to facilitate such teamwork include the following:

- Respecting and supporting patients rights to make informed decisions regarding their drug therapy.

- Promoting knowledge, understanding and acceptance by physicians and pharmacists of their responsibilities in drug therapy and fostering widespread communication of these responsibilities so they are clearly understood by all.

- Supporting both professions' relationship with patients, and promoting a collaborative approach to drug therapy within the health care team. Care must be taken to maintain patients' trust and their relationship with other caregivers.

- Sharing relevant patient information for the enhancement of patient care, in accordance and compliance with all of the following: ethical standards to protect patient privacy, accepted medical and pharmacy practice, and compliance with the law. Patients should inform their physicians and pharmacists of any information that may assist in providing optimal drug therapy.

- Increasing physicians' and pharmacists' awareness that it is important to make themselves readily available to each other to communicate about a patient for whom they are both providing care.

- Enhancing documentation (e.g. clearly written prescriptions and communication forms) and optimising the use of technology (e.g., e-mail, voice mail and fax) in individual practices to enhance communication, improve efficiency and support consistency in information provided to patients.

- Developing effective communication and administrative procedures between health care institutions and community-based pharmacists and physicians to support continuity of care.

- Developing local communication channels and encouraging dialogue between the professions (e.g. through joint continuing education programmes and local meetings) to promote a peer-review-based approach to local prescription and drug-use issues.

Teaching a collaborative approach to patient care as early as possible in the training of pharmacists and physicians.

- Developing effective communication channels and encouraging dialogue among patients, physicians and pharmacists at the regional, provincial, territorial and national levels to address issues such as drug-use policy, prescribing guidelines and continuing professional education.

- Collaborating in the development of technology to enhance communication in practices (e.g share patient databases relevant to drug therapy).

- Working jointly on committees and projects concerned with issues in drug therapy such as patient education, treatment adherence, formularies and practice guidelines, hospital-to-community care, cost-control strategies, sampling and other relevant policy issues concerning drug therapy.

- Fostering the development and utilisation of a high-quality clinical and scientific information base to support evidence-based decision making.

The Physician's Responsibilities in Drug Therapy

Physicians and pharmacists recognise the following responsibilities in drug therapy as being within the scope of physicians practice, on the basis of such factors as physicians' education and special-

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ised skills, relationship with patients and practice environment. Some responsibilities may overlap with those of pharmacists (see The Pharmacist's Responsibilities in Drug Therapy). In addition, it is recognised that practice environments within medicine may differ and may affect the physician's role.

Assessing health status, diagnosing diseases, assessing the need for drug therapy and providing curative, preventive, palliative and rehabilitative drug therapy in consultation with patients and in collaboration with caregivers, pharmacists and other health care professionals. When appropriate.

• Working with patients to set therapeutic goals and monitor progress toward such goals in consultation with caregivers, pharmacists and other health care providers, when appropriate.

• Monitoring and assessing response to drug therapy, progress toward therapeutic goals and patient adherence to the therapeutic plan; when necessary, revising the plan on the basis of outcomes of current therapy and progress toward goals of therapy, in consultation with patients and in collaboration with caregivers, pharmacists and other health care providers, when appropriate.

• Carrying out surveillance of and assessing patients for adverse reactions to drugs and other unanticipated problems related to drug therapy, revising therapy and, when appropriate, reporting adverse reactions and other complications to health authorities.

• Providing specific information to patients and caregivers about diagnosis, indications and treatment goals, and the action, benefits, risks, and potential side effect of drug therapy.

• Providing and sharing general and specific information and advice about disease and drugs with patients, caregiver, health care providers and the public.

• Maintaining adequate records of drug therapy for each patient, including, when applicable, goals of therapy, therapy prescribed, progress towards goals, revisions of therapy, a list of drugs (both prescriptions and over-the-counter drugs) currently taken, adverse reactions to therapy, history of known drug allergies, smoking history, occupational exposure or risk, known patterns of alcohol or substance use that may influence response to drugs, history of treatment adherence and attitudes towards drugs. Records should also document patient counselling and advice given, when appropriate.

• Ensuring safe procurement, storage, handling preparation, distribution, dispensing and record keeping of drugs (in keeping with federal and provincial regulations and the CMA policy summary "Physicians and the Pharmaceutical Industry (Update 1994)" *Can Med. Assoc. J.* 1994; 150:256A-C.) when the patient cannot reasonably receive such services from pharmacist.

• Maintaining a high level of knowledge about drug therapy through critical appraisal of the literature and continuing professional development.

Care must be provided in accordance with legislation and in an atmosphere of privacy, and patient confidentiality must be maintained. Care also should be provided in accordance with accepted scientific and ethical standards and procedures.

The Pharmacist's Responsibilities in Drug Therapy

• Pharmacists and physicians recognise the following responsibilities in drug therapy as being within the scope of pharmacists' practice, on the basis of such factors as pharmacists' education and specialised skills, relationship with patients and practice environment. Some responsibilities may overlap with those of physicians (see The Physician's Responsibilities in Drug Therapy). In addition, it is recognised that, in selected practice environments, the pharmacists' role may differ considerably.

• Evaluating the patients' drug-therapy record ("drug profile") and reviewing prescription order to ensure that a prescribed therapy is safe and to identify, solve or prevent actual or potential drug-related problems or concerns. Examples include possible contraindications, drug interactions or therapeutic duplication, allergic reactions and patient non-adherence to treatment. Significant concerns should be discussed with the prescriber.

• Ensuring safe procurement, storage, preparation, distribution and dispensing of pharmaceutical products (in keeping with federal, provincial and other applicable regulations).

• Discussing actual or potential drug-related problems or concerns and the purpose of drug therapy

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with patients, in consultation with caregiver, physicians and health care providers, when appropriate.

• Monitoring drug therapy to identify drug-related problems or concerns, such as lack of symptomatic response, lack of adherence to treatment plans and suspected adverse effects. Significant concerns should be discussed with the physician.

• Advising patients and caregivers on the selection and use of non-prescription drugs and the management of minor symptoms or ailments.

• Directing patients to consult their physician for diagnosis and treatment when required. Pharmacists may be the first contact for health advice. Through basic patient assessment (i.e. observation and interview) they should identify the need for referral to a physician or an emergency department.

• Notifying physicians of actual or suspected adverse reactions to drugs to health authorities.

• Providing specific information to patients and caregivers about drug therapy, taking into account patients' existing knowledge about their drug therapy. This information may include the name of the drug, its purpose, potential interactions or side effects, precautions, correct usage, methods to promote adherence to the treatment plan and any other health information appropriate to the needs of the patient.

• Providing and sharing general and specific drug-related information and advice with patients, caregiver, physicians, health care providers and the public.

•. Maintaining adequate records of drug therapy to facilitate the prevention, identification and management of drug-related problems or concerns. These records should contain, but are not limited to, each patient's current and past drug therapy (including both prescribed and selected over-the-counter drugs), drug-allergy history, appropriate demographic date and, if known, the purpose of therapy and progress toward treatment goals, adverse reactions to therapy, the patient's history, occupational exposure or risk, and known patterns of alcohol or substance use that may influence his or her responses to drugs. Records should also document patient counselling and advise given, when appropriate.

• Maintaining a high level of knowledge about drug therapy through critical appraisal of the literature and continuing professional development.

Care must be provided in accordance with legislation and in an atmosphere of privacy, and patient confidentiality must be maintained. Products and services should be provided in accordance with accepted scientific and ethical standards and procedures. ❑

Ghanaians and Pharmaceuticals

by K.A. Senah

The topic I have elected to speak on is: How do Ghanaians perceiver pharmaceuticals? What do they think about them? How do they use them? The research aspects of these Have already been dealt with; I will now bridge the gap with practical experience. Unfortunately in answering these questions, I can only excite your appetite given the time constraints.

One morning while conducting a research into the socio-cultural aspects of medicines in a nearby rural community, a distraught mother accosted me. Clutching what seemed like a severely malnourished child in her arms, she cried out for help saying, "May child is dying". Relating her story, the anxiety-stricken mother recounted how she had bought all manner of medicines including expensive antibiotics, blood tonics, vitamin syrups, etc. and sought diagnosis and treatment from neighbours, clinics, drugstores and hospitals. Her frantic search for cause and cure had been emotionally and financially taxing. She had given up all hope. "I have spent so much on medicine and yet my child is still sick. Now, I am penniless. What should I do" she asked.

Again in the course of the study, while discussion the undesirable aspects of medicines with a 60 year old farmer, the latter seeing nothing wrong with medicines, per se, countered my view with the following insightful statement;

The whiteman is a witch. If you are sick and you swallow two or three pills (tablets) or you take a shot of injection, your sickness vanished at once. Let us (Africans) not compete with him; rather let us pray that he will continue to produce more powerful medicines to solve our heath problems.

These two instances of health-seeking behaviour via pharmaceuticals are by no means exhaustive. However, in a way, they underscore the social, cultural, economic and political forces that have popularised pharmaceuticals and placed them at the epicentre of health drama in developing countries, including Ghana.

Illness is an inevitable factor in every social group; it has social, psychological as well as biological implications. Thus this fact of life must be explained and dealt with in some pragmatic and philosophical manner by each society.

In human evolution, perhaps the beginning of this century has been most remarkable in one significant respect. The great leaps and bounds in communication, science, and technology have accelerated the process of global villagisation. In the realm of medical science, today diseases that decimated populations of earlier civilisations have, to some considerable extent, been brought under control. It is an incontrovertible fact that the discovery of medicines has contributed in no small measure to this success. Thus, today, there is medicine for almost every disease, ache, and pain. However, as both the cause and effect of this situation modern society is virtually encapsulated in chemicals. Indeed, what is now being experienced is 'pharmaceutical invasion' or what Ivan Illich calls the 'chemicalisation of life' and its concomitant iatrogenic diseases. In short, modern medicine including pharmaceuticals, has become a sorcerer's apprentice.

In Ghana, as in most part of the developing world, modern pharmaceuticals came as part of the baggage of colonisation. However, in spite of their alien character, today they have acquired the dubious distinction of being as available as coca-cola: they are in high demand to the point where they have become political commodities. Indeed, in our own political evolution, some regimes have been over-thrown among others for lack of medicines in the system (Rawlings accused the Limann Administration of 'turning the hospitals into transit camps to our graves'). In Ghana, medicines are legally and illegally distributed by all manner of people and some of these medicines are either

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Mr. K.A. Senah is a Lecturer at the Department of Sociology, University of Ghana, Legon. This is a paper he delivered at the 43rd Conference of the Pharmaceutical Society of Ghana.

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fake, have expired or are sub-therapeutic. Clearly these situations may be explained by our weak medical infrastructure and the lack of effective control and monitoring measures. As a medical anthropologist, however, such macro-explanations do not satisfy me. The question is: Assuming our medical infrastructure is strengthened and assuming we put in place adequate control and monitoring measures can we guarantee that the drugs consumer will use drugs as prescribed by the doctor, pharmacist or the manufacturer? In other words can we guarantee that the young girl in my village will no longer use paracetamol as a contraceptive? Ladies and gentlemen, the point I am stressing is that in addition to whatever we do at the macro-level, knowledge of what is on the ground is crucial for the success of any policy that affects people.

And this brings me now to the crux of this paper: the attitude of Ghanaians towards pharmaceuticals. Given time constraints I shall touch on just a few of these attitudinal characteristics.

In our local vernaculars pharmaceuticals are described as 'whiteman's medicine': the Ga call it 'blofo tshofa' the Ewe, 'yevu tshike'; the Akan Obroni aduro'; the Nankana, 'solomi - tiim'. In this nomeuclature lies one of the charms of pharmaceuticals. In our social context medicines have both objective and symbolic characteristics - in objective terms, they are seen as technical fixes to cure and relieve pain and suffering. However in symbolic terms they are more than these: in the process of indigenization, they are often impregnated with qualities not intended by the manufacturer.

Generally, there is the belief among Ghanaians that whatever comes from overseas (USA, UK etc.) must be of high quality: there seems to be a widespread belief in cultures throughout the world that extraordinary knowledge can be found elsewhere. Thus the Ghanaian " been-to" is more likely to be given preference in competition for a job and in promotion and in any case, he receives added respect from colleagues, friends and kins. Clearly, then blofo tshofa has an added charm over indigenous medicines merely because it has "foreignness" around it.

Another charm of pharmaceuticals is that they are quicker at dealing with infectious and parasitic diseases. In this regard, among adults injection is usually the preferred mode of administration of medicines. Injection is said to work faster because it is said to go straight into the blood. However it appears that it is the psychological aspect which makes injections popular. Injections are painful; this pain is an indication that the disease is being "attacked" in more empirical terms. Thus the more pain injection inflicts, the more the psychological satisfaction that something is being done. Thus the doctor, nurse, or chemical seller must learn to give injection, however unnecessary to be able to stay in business.

The colour, taste and size of medicines are points for attraction also. Among Ghanaians, reddish or brownish medicines - liquid or tablet are by their colour, easily associated with blood-tonic while yellowish or greenish ones are associated with anti-malarial medicines. Is it any wonder then that very often women ask for guiness stout beer ostensibly to cope with blood lost through menstruation?

With regard to taste, it is generally believed that sweet medicines are for children and bitter ones for adults. Indeed, the more bitter the medicine, the more it is credited with efficacy. Bitterness, like injection-pain, gives psychological assurance that the disease is being attacked, something positive is being done.

In times of ill-health, the size of medicine prescribed communicates a lot of message: very small tablet, especially, are regarded with awe. In their smallness lies the whiteman's 'witchcraft' to effect cure; to the patient their smallnes is an indication that his condition is very serious.

As special case however must be made for capsules popularly known as 'tupaye', 'abombelt'. For a good number of Ghanaians, abombelt is for the treatment of sores or wounds. Characteristically, their contents may be emptied onto open wounds or these are mixed with palm oil or palm kernel oil and administered onto wounds. Similarly, adults and children who are suspected to have sores in their stomach are made to take capsules. In the case of children the contents of a capsule may be poured into a spoon diluted with water and administered to the sick child. Finally, one characteristic or charm of medicine is that as objects they permit individuation. In cultures where illhealth is a group affair and where witchcraft accusations are rife, medicines disengage the sick individual from the group and affords him

the privacy of dealing one-on-one with a provider who may be interested in nothing but his money.

Ghanaians have acquired such perceptions of medicines not only through folk knowledge, but also through advertisement and prescribing habit of doctors, pharmacists and chemical sellers. Polypharmacy makes economic sense because it rakes in more money. However, there is this view among Ghanaians that a good doctor or pharmacist must prescribe many and expensive medicines. Indeed, I have often overheard patients say: "Doctor X likes me very much. Look at the number of drugs he has given me". In the village where I am conducting my study, one health care provider is popularly known as "Doctor Para" because as the villagers allege, every consultation ends invariably with the patient taking home some paracetamol tablets which are regarded as cheap. In the same vein, mothers desire 'strong' medicines for their diarrhoea - afflicted children and not ORS which they regard as cheap and by extension ineffective.

For the doctor, however, medicines are an important tool in his armamentarium: through prescription, he reduces his workload while maintaining his authority and control in the encounter. This way, the patient is also satisfied because to him, a successful end to a doctor-patient encounter must result in a prescription. A doctor or pharmacist who merely offers advice at the end of such encounters would soon lose some of his patients. Beside these, for the doctor there is one more power in medicines: they enable him to guess, to do trial-and-error or to hide his ignorance about or his incompetence to deal with a situation. It must be noted that in the doctors-patient game politics, it is often *infra dignitatem* for a doctor to openly admit failure: there is the psychological pressure to do something and in medicines he finds this 'something'.

At the other end of the spectrum, pharmacists are constantly confronted with prescription forms which list various drugs in strange combinations. They are consulted daily by patients who want to avoid the social and economic costs of hospital attendance; they must take quick decision in a situation where out of say, five prescriptive medicines, the patient can afford just one or two which used on their own is sub-therapuetic. The pharmaceutical drama in Ghana is indeed very complex. No doubt as far back as 1975 one Josephine Adusu wrote is the Ghana Pharmaceutical Journal: "I have found that one cannot practise pharmacy in Ghana and be completely ethical. In fact, sometimes one has to behave like a doctor in order to let your patients have confidence in you". This view is still true today.

In brief then we may say that the attitude of Ghanaians towards pharmaceuticals cannot be encapsulated in one word. It is indeed influenced by macro factors such as lack of adequate health care facilities and personnel and mechanism for effectively policing drugs production and distribution. At the micro-level we have to contend with folk knowledge expressed through indigenization or creolization of western pharmaceuticals and though perception of the body and its dynamism and disease processes.

Very often attempts to correct these popular conceptions have led to massive public education campaigns. And where such educational efforts fail to yield the desired dividends, we blame the people for being ignorant, difficult or upright stupid. I submit that we the so-called educators are rather ignorant, difficult and stupid. I say this because our mode of education is very wrong: we assume that we know everything and the people know nothing; what we know is the truth, the most "scientific" and what the people know are "misconceptions" with no empirical validity. Thus we "educate" the people as if they know nothing and in the process we fail. This is the problem of contraceptives and family planning in Ghana today. This 'banking mode' of education must be reconsidered. I submit that we can effectively educate only when we the educators are first educated in the usages and nuance of the people. It is now time to listen to the 'other' side of the story. This way we can easily build upon what exists already. And we can do this only through painstaking and systematic research.

Short of this, any talk about 'essential drugs', 'rational drug use', 'patient compliance' and all the other cliches that index the authority relationship between the health care provider and consumer, will be meaningless to the man on the street as long as these cliches have no local warranty.

I wish to conclude with a piece of advice Benjamin Paul, a malariologist who worked on the Panama Canal, bequeathed to disciples in public health. He says: "If you want to know why mosquitoes bite, then think like one". ❑

Remuneration for Locum Pharmacists

by J.Y. Adu

INTRODUCTION

Who is a Locum Pharmacist? The new edition of the Longman Dictionary of contemporary English defines locum as "someone, especially, a person in health care work, who does another person's job for a limited time". The purport of this definition in the context of "locum pharmacist" is that, a locum pharmacist is someone who acts on behalf of a superintendent Pharmacist in the absence of the superintendent pharmacist in a Pharmacy. This helps to ensure continuous and smooth operation of the Pharmacy in the absence of the superintendent pharmacist, since by law, a Pharmacy cannot operate without a pharmacist. Within the purview of our discussion therefore, the importance of locum pharmacists need no further emphasis.

It was discovered recently that locum pharmacists in Accra and elsewhere in the country are not adequately rewarded financially. Consequently, a survey was conducted to determine the real situation on the ground. the survey was basically meant to find out how much locum pharmacists receive per hour and also, whether a pharmacist or a non-pharmacist owned the pharmacy they work in.

METHOD

Twenty-two locum pharmacists were randomly selected from various locations in Accra. They were asked to provide information according to the criteria below:

1. The number of hours they work per day
2. The number of days they work per week
3. The owner of the Pharmacy; a Pharmacist or a Non-Pharmacist
4. Whether they are satisfied with the remuneration they receive

RESULTS AND DISCUSSION

Of the twenty-two locum pharmacists interviewed 64% were found to be working at Pharmacies owned by a pharmacist while 36% work at no-pharmacist owned shops. The highest paid locum pharmacist works at a non-pharmacist Pharmacy ¢3,333.00 per hour as compared to the lowest paid locum pharmacist. receiving ¢350.00 per hour. The average wage of locum pharmacists in a non-pharmacist owned Pharmacy is ¢1,263.84 per hour whilst the average wage of locum pharmacists in a pharmacist-owned pharmacy shop is ¢874.73 per hour.

It could be deduced from the results that locum pharmacists who are at non-pharmacist shops are paid 31% higher than that of their colleagues at Pharmacies belonging to pharmacists. Of the twenty-two locum pharmacists interviewed, 95% indicated they were not satisfied with what they receive per hour at their place of work. The big question we must ask ourselves is, why are locum pharmacists not being paid well by our colleagues whom we expect to make locum pharmacists more financially comfortable? While there may by several good reasons for this which may include the level of activity in the shop, the size of the Pharmacy, the size of the business, the bottom line is, can we sincerely say that we are truly committed towards promoting the interest of our locum pharmacists who are also our colleagues in the profession?

The role of the Society on this issue cannot be over-emphasized. As our Society continues to grow in size not only should the responsibilities of its members be of utmost interest to the Society but also the economic status of its members. It is true to say that the Society cannot satisfactorily cater for all the needs of each individual member. Nonetheless, as health care delivery expands in size and becomes more complex with increasing responsibilities for pharmacists, collective effort may by necessary to solve group economic problems. With this view, the Society can meet the aspirations of its financially disadvantaged members by embarking on a broad economic status programme. Needless to say pharmacists, in this regard locum pharmacists, could perform their professional roles with enthusiasm and proper motivation at their places of work if they are well paid. The relationship between work output and remuneration of a professional is summed up beautifully by the American Society of Hospital Pharmacists (ASHP), now named America Society of Health System Pharmacists as follows: "The professional and economic goals of the professional person are closely interelated. Only in attainment of this goals can he assume the leadership role expected of him in the community, by his colleagues and by the other health professionals. When satisfactory economic status is achieved, the professional can realize his maximum potential and apply his full energies to the needs of society".

This drives home the point that even not only locum pharmacists but all pharmacists deserve remuneration which must necessarily be commensurate with their professional status. But since this paper is particularly concerned with remuneration of locum pharmacists, we will limit our discussion to locum pharmacists. If better remuneration is given to locum pharmacists, some pharmacists could even earn their living by practising solely as locum pharmacists without having to use their licenses to register a pharmacy. This will go a long way to improve the efficiency of our Pharmaceutical Service and also maintain high standard of pharmacy practice as obtains in Europe or in the U.S. Time is ripe for the Society to appraise and analyse the remuneration of locum pharmacists so that a much more realistic amount could be determine a minimum amount per hour which every locum pharmacist must receive. ❑

Mr. J.Y. Adu is a pharmacist with the Ridge Hospital in Accra.

REFERENCE

1. *Practice Standard of ASHP 1992-93*, ASHP Statement on its economic status program p 7.

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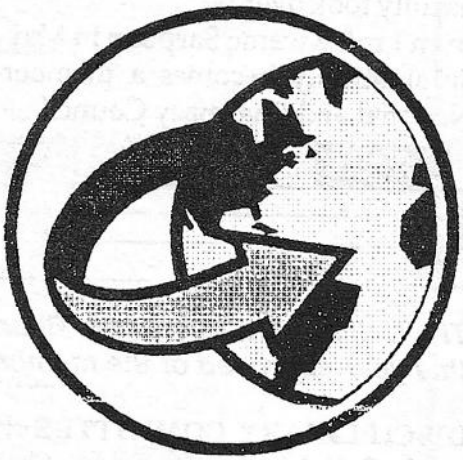

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PROF. J.S.K. AYIM

Prof. J.S.K. Ayim is the new Dean of the Faculty of Pharmacy at the University of Science and Technology. Prof. Ayim who is also the Head of the Chemistry Department of the Faculty took over from Prof. Kwame Sarpong in May this year. He automatically becomes a member of both the National and Pharmacy Council.

MR. CHARLES DONTOH

Mr. Charles Dontoh has been named by his employers, Pharmacia and Upjohn, as the new Regional and Sales Training Manager for the West and Southern Regions of the Company's Africa market. He will be responsible for 12 African countries. These are Cape Verde, The Gambia, Guinea Bissau, Sierra Leone, Liberia, Ghana, Nigeria, Sao Tome and Principe, Equatorial Guinea, Zimbabwe, Zambia and Malawi.

The National Council of the Pharmaceutical Society of Ghana at its meeting held on March 8, this year approved of the membership of the committees listed below as follows:

DISCIPLINARY COMMITTEE

1. Mr. Dela Ashiabor	- Chairman
2. Mr. Oscar Bruce	- Secretary
3. Mr. J.K. Arthur	- Member
4. Mr. A.K. Kokukokor	- Member
5. Mr. Rudolf Mensah	- Member
6. Mr N. Akuetteh	- Member
7. Prof. K. Boakye-Yiadom	- Member

FINANCE COMMITTEE

1. Mr David Anim-Addo	- Chairman
2. Mrs J. Addo-Atuah	- Member
3. Mr Oscar Bruce	- Secretary
4. Mr Isaac Mensah	- Member
5. Ms M. Korri	- Member
6. Mr. Dela Ashiabor	- Member

EDITORIAL COMMITTEE

1. Mr Oscar Bruce	- Chairman
2. Dr M.L.K. Mensah	- Secretary
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4. Mr D. Sekyere-Marfo	- Member
5. Mr Louis Nortey	- Member
6. Mrs J. Addo-Atuah	- Member
7. Mrs E. Bruce	- Member

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1. Prof. Kwame Sarpong	- Chairman
2. Ms Nancy Owusu	- Secretary
3. Mrs C. Ribeiro	- Member
4. Mr E. Osei-Tutu	- Member
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4. Prof. J.S.K. Ayim	- Member
5. Dr Manama Duwiejua	- Member
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PROPERTY ACQUISITION COMMITTEE

1. Mr. D. Ashiabor	- Chairman
2. Mr D. Sekyere-Marfo	- Secretary
3. Mr H. abutiate	- Member
4. Mr James Binka	- Member
5. Ms M. Korri	- Member

A new committee, the Property Acquisition Committee, which shall see to the acquisition of properties such as land and building, among other things, for the society has been set up with the following membership: Mr. D. Ashiabor (Chairman), Mr. D. Sekyere-Marfo (Secretary), Mr. Harry Abutiate, Mr. J. Binka and Ms. Marigold Kori. ❑

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