



GHANA PHARMACEUTICAL JOURNAL

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IN THIS ISSUE

- *The 44th Conference of the Pharmaceutical Society of Ghana*
- *Importation of drugs from the West African Sub-Region*
- *Ghana Federation for Traditional Healers meet Pharmaceutical Society of Ghana*
- *Pharmacy Council on the distribution of Pharmacies*
- *The role of Pharmacist in the fight against the HIV-AIDS pandemic*
- *Pill for Impotence wins approval*
- *The 11th Scientific Congress of the West African Pharmaceutical Federation (WAPF)*
- *Malaria treatment, new drugs, new problems*
- *Our prescribing & dispensing habits*
- *Professional bodies and changing National Development demands - A Pharmacist view*

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CONTENTS

EDITORIAL
 RAISING EXISTING PROFESSIONAL STANDARDS 1

NEWS
 ADDRESS BY THE PRESIDENT OF THE PHARMACEUTICAL SOCIETY OF GHANA, 2
 BREAKTHROUGH IN HEALTH RESEARCH 3
 IMPORTATION OF DRUGS FROM WEST AFRICAN SUB-REGION 3
 DISGRACED PHARMACIST IGNORED BAN 3
 LATTER DAY SAINTS DONATE BOOKS TO FACULTY 4
 LOUISA HANSON RETURNS FROM COURSE 4
 NEWLY REGISTERED PHARMACISTS INDUCTED 5
 THE GHANA NATIONAL DRUGS PROGRAMME 6
 DOTS: A FIVE-POINT STRATEGY 6
 TOP SEED 6
 GHANA FEDERATION FOR TRADITIONAL HEALERS MEET PHARMACEUTICAL SOCIETY OF GHANA 7

SOCIETY NEWS
 REPORT - 44TH CONFERENCE OF CONFERENCE OF PHARMACEUTICAL SOCIETY OF GHANA 8
 44TH CONFERENCE OF PHARMACEUTICAL SOCIETY OF GHANA DECISIONS OF BUSINESS SESSION 9
 COMPUTER SYSTEMS START'S NETWORK 10
 PHARMACY COUNCIL ON THE DISTRIBUTION OF PHARMACIES 11
 KEYNOTE ADDRESS 44TH CONFERENCE OF PSGH 12

FIP NEWS
 THE ROLE OF THE PHARMACIST IN THE FIGHT AGAINST THE HIV-AIDS PANDEMIC 17
 WORLD'S PHARMACISTS URGED TO REACH FOR THE STARS 18
 PILL FOR IMPOTENCE WINS APPROVAL 19

WAPF NEWS
 THE 11TH SCIENTIFIC CONGRESS OF THE WEST AFRICAN PHARMACEUTICAL FEDERATION (WAPF) 20

PHARMACARE
 ASTHMA PATIENTS SHOULD RENEW TOOTHBRUSH OFTEN 25
 CAUTION ON STEROID DROPS 25
 OTC CONTRACEPTION 25
 CASH AND CARRY AFFECT PML MICE 25

CONTINUING EDUCATION
 SKIN BLEACHING, DEPIGMENTATION, HYDROQUINONE & OTHER 26
 MALARIA TREATMENT NEW DRUGS, NEW PROBLEMS 27
 TREATMENT OF SCABIES 29
 CALCIUM CHANNEL BLOCKER SAFETY - THE DEBATE CONTINUES 30

FEATURE
 OUR PRESCRIBING & DISPENSING 31
 ESSENTIAL DRUG LISTS AND THE USE OF GENERIC DRUGS 33
 QUIZ - UPDATE YOUR KNOWLEDGE 35
 KORLE - BU LAUNCHES MONTHLY BULLETIN 36
 GHANA HEART FOUNDATION APPEAL TO RAISE FUNDS TO SUPPORT THE NATIONAL CARDIOTHORACIC CENTRE (NCTC) KORLE-BU TEACHING HOSPITAL, ACCRA 36
 MAGNESIUM AND THE LUNG 36
 PROFESSIONAL BODIES AND CHANGING NATIONAL DEVELOPMENT DEMANDS - A PHARMACIST'S VIEW 37
 CALENDAR
 PUBLIC HEALTH AND THE PHARMACIST 40
 NOTICE BOARD 43
 LETTERS TO THE EDITOR 44

Raising Existing Professional Standards

The noble aspirations of the profession towards new age initiatives and roles such as those relating to health promotion have gained world-wide acceptance.

In every profession, there is always a positive action to improve the existing standards. New horizons for the practice of pharmacy have been discovered. These include:

- Managing prescribed medicines
- Managing chronic conditions (asthma, hypertension, etc.)
- Managing common ailments (headaches, diarrhoea)
- Counselling on healthy lifestyles (e.g. for diabetics)
- Good relationship between members of the healthcare team.

A number of pharmacists are doing all these activities already. However, there should be measures to ensure that, every pharmacist adopt the "new age" practice of pharmacy.

Pharmaceutical Care should be introduced to community pharmacies since that is the first point of contact for patients. There should be a training programme for all community pharmacy workers, including those who are not pharmacists; to improve their communication skills which help to improve the standard of pharmacy in the community.

Pharmacy premises should be improved and made more receptive. Pharmacists should also work in teams to help spread their knowledge on new trends of the practice of pharmacy. As team work is encouraged individual pharmacists should also strive to develop themselves to be able to impart current information.

The Pharmaceutical Society of Ghana has a clear role in working in partnership with all relevant authorities like Ministry of Health, Pharmacy Council, Food and Drugs Board to address legitimate concerns, especially those of the Ghana Hospital Pharmacists Association (GHOSPA); and to incorporate the changing standards of the practice of pharmacy into the course structure of the degree in Pharmacy in Kumasi. This will ensure that the new breed of pharmacists know what to do immediately after they complete their course of study in Pharmacy at the University of Science and Technology, in Ghana.

The already existing practice of pharmacy in Ghana is of acceptable standard, however, it has to be more patient - focused to measure up to the new trend in pharmacy which is pharmaceutical care. Globally, there is a move towards a new vision for pharmacy into the 21st Century and Pharmacy in Ghana cannot afford to be left behind. The first of such calls to come is the call for the raising of existing professional standards. ▀

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ADDRESS BY THE PRESIDENT OF THE PHARMACEUTICAL SOCIETY OF GHANA

MR DELA C. ASHIAGBOR, AT THE 1998 INDUCTION OF NEWLY REGISTERED PHARMACISTS

Chairman, Honourable Minister of Health, Fellow New Colleagues, etc...

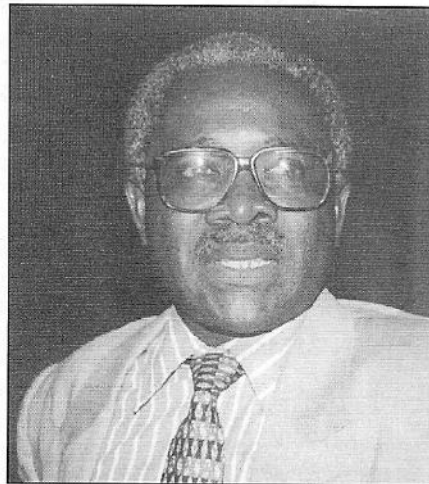
These young ladies and gentlemen are entitled to be called "Colleagues", having been inducted into our noble profession of Pharmacy. I am sure you are deservingly full of pride and expectations.

Distinguished Guests, Ladies and Gentlemen, these young ones entering the profession at a very crucial moment - This is the time when our profession is at its evolutionary and revolutionary peak, the transformation of the profession from the historical stages of store keepers, pseudo-accountants, dosage auditors, ward stock inspectors and manipulative dispensers to patient care practitioners. The call now is for pharmacy to be practised for the patient. This is what is now conceptualised as pharmaceutical care.

Pharmaceutical Care is based on the principle that wherever possible and practicable all interests and actions must focus on the patient; the patients' values, the patients' preferences, the patients' perceptions and what is important to the patients' well-being. It is expected that the pharmacist plays an integral role in the cost effective management of drug therapy in the prevention and treatment of diseases. In other words, the pharmacist critically evaluates a patient's drug related needs, determines whether the patient needs one or more drugs and works with other members of the healthcare team to implement and monitor drug therapy. Through this concept of Pharmaceutical Care, a pharmacist therefore:

1. Ensures the appropriate use of a drug and its correct dosage to meet individual health needs of a patient.
2. Reduces the potential for a drug interactions and adverse drug reactions.
3. Eliminates duplication or unnecessary drug therapy.

To do these properly, a pharmacist must be highly qualified and trained, have good communication skills, accept changes in the practice environment and above all have mutual respect for each member of the health care team. The ideal pharmacist for the future - that is you - has been described as a 7-Star



Mr. Charles Dela Ashiabor, President of PSGH delivery his address at the Induction of newly registered Pharmacists

pharmacist i.e. a pharmacist who is equal in excellence to a 5-Star hotel yet accessible to everyone from the rich to the poor. It is a professional challenge to you to evolve with the health services so as to respond to the needs of the future.

SO WHAT MUST YOU DO TO EVOLVE INTO A 7-STAR PHARMACIST?

1. **Be a Care Giver** - With your knowledge of drugs selection, safety, consequences etc. assume the role of a Care Giver. You must ensure treatment of the highest quality and cost effectiveness through patient focused therapy.
2. **Be a Decision Maker** - You will have to make decisions that you can justify in terms of efficacy and cost. While exercising your professional ethics and limits, you should explore and evaluate solutions and implement them with professional confidence.
3. **Be a Good Communicator** - Be a good listener, understanding and persuading patients, family and community for effective implementation of drug therapy.
4. **Be a Leader** - You must assume the role of a leader. By your understanding of the healthcare services and by appreciating the

breadth of each problem in health risks, you cannot simply dispense medication but must take a positive interest in the community health activities which will benefit large number of people.

5. Be a Manager - To fulfil the functions mentioned above you have to acquire managerial skills. Since you have to work in a team, in close co-operation with other members of the health care team, managerial skills are essential. Even as a subordinate you must learn how to manage your boss.

6. Be a Life Long Learner - Pharmacy and Pharmaceutical Sciences are changing fast. New drugs, strategies of drug therapy, technology and awareness are constantly changing. You have to update yourself constantly if you want to be in the front line of the health care team. Continuing Pharmaceutical Education must be your life long pursuit.

7. Be a Role Model - A 7-Star pharmacist with all the above attitudes has to be a role model - both in the profession and in your community. You must have vision for the future and be an effective and influential activist in your community. Go the extra mile in demonstrating the qualities of an ethical pharmacist.

This is not a dream I am relating. These are attitudes you have to develop and actions you have to take to make yourselves indispensable partners in the healthcare system of our dear country, Ghana.

Have you asked yourself the question - "What will I do for Pharmacy?". Are you just going to be an ordinary pharmacist - go to work, close, get remunerated well or poorly and that is all? I believe we must all together develop meaningful and appropriate strategies as we move towards the 21st Century. It is my hope that each and everyone of you will be part of the progress in fulfilling our roles in healthcare delivery through active participation and meaningful interaction supported by needed action in practice.

May I on behalf of the Pharmaceutical Society of Ghana welcome you to our fold as friends of the human race as our motto says "AMICUS HUMANI GENERIS"

BREAKTHROUGH IN HEALTH RESEARCH

The Kumasi Centre for Collaborative Research (ICCR) of the Kwame Nkrumah University of Science and Technology (KNUST) has been able to identify the gene responsible for hearing impairment and deafness.

Professor George Wereko-Brobby, Dean of the School of Medical Science (SMS) of KNUST made this known at the commissioning of a \$500 million Kumasi Centre for Collaborative Research in Tropical Medicine (KCCR) in Kumasi last February.

He said the gene was identified last year after extensive research carried out by the Kumasi Centre for Collaborative Research of the SMS at Adamorebe known as the deaf village, in Eastern Region.

The Adamorebe village is often described as "deaf village" because of the high incidence of deafness and hearing impairment in that community.

The discovery will make for the reduction of deafness in the village to the barest minimum.

The centre is a collaborative venture between the School of Medical Sciences and Bernhard Nocht Institute of Germany.

Professor Wereko-Brobby said the gene can be likened to the one responsible for the sickle cell disease which is hereditary. ▀

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IMPORTATION OF DRUGS FROM WEST AFRICAN SUB-REGION

In 1989, a suspension was placed on the importation of pharmaceuticals from the West African Sub-Region, in particular Nigeria, to prevent the influx of fake and substandard drugs into the country.

The Pharmacy Council in its 1996 Annual report has stated that, the government has lifted this suspension upon a recommendation to the Ministry of Health that the conditions that warranted the ban no longer existed.

The report further said that the decision to lift the suspension was to conform to ECOWAS protocols on inter-country trade in goods and services and also tell in line with the government's trade in goods and services and also fell in line with the government's trade liberalisation policy.

Special checks are however to be made on all pharmaceuticals coming from Nigeria; and initially only Nigerian companies reputed for their good manufacturing practices will be allowed to export pharmaceutical products to Ghana, the report concluded. ▀

DISGRACED PHARMACIST IGNORED BAN

The disciplinary committee of South Africa's Pharmacy Council is once again preparing to deal with rogue pharmacist Desmond Brown, who was struck off the register in August 1996 for selling drugs not registered with the Medicine's Control Council.

His twin-tablet concoction for arthritis, which he called "Tweeling Pille", is **potentially fatal**. He had mixed an over-the-counter pain killer, Dolqrol Forte, with out-of-date stock of a highly toxic, prescription only phenylbutazone (Inflazone), licensed only to be used for ankylosing spondylitis as it has so many dangerous side-effects.

Brown, who had been found guilty of disgraceful conduct, continued selling his remedy by mail order despite his year's suspension, until February when MCC Investigators and drug squad detectives unearthed a horde of drugs - including 155,000 Inflazone tablets - plus bottles and paperwork from the mail order business.

The MCC says the illegal repackaging and renaming of medicine is a growth industry, and is determined to clamp down. Brown, who already faces criminal charges for supplying an unregistered scheduled drug and for carrying out business as a pharmacist without being registered, is likely to be given a rough ride by the disciplinary committee. ▀

• **Editor's Comment:** *Business by all means? Some concoctions! Some marketing ways! We cannot fail our gullible and highly vulnerable public!*

QUIZ ANSWERS

1. B, C.
2. B? D
(Whether *H vaginalis* can cause the non-specific vaginitis with which it is often associated is disputed).
3. A, C
4. D
5. A
6. C, D (Chlorpromazine may promote it)
7. A
8. C
9. False
10. True

References

- a. Ledward RS, Hawkins D; *Drugs in pregnancy. To be published by Chapman and Hall, London*
- b. Tuchman - Duplessis H. *Drug effects on fetus* P. 202 Adis Press 1975

LATTER DAY SAINTS DONATE BOOKS TO FACULTY

The Faculty of Pharmacy, Kwame Nkrumah University of Science and Technology, was among a number of institutions that benefited from massive book donations by the Charities of The Church of Jesus Christ of Latter Day Saints. Two separate donations were made on the 9th December last year and recently on the 10th February 1998. A total of sixty-one schools and institutions received various assortment of much needed books to assist in meeting their research and training requirements.

Making the last presentation, Mr. Kwegir Aggrey of the Local Church said that the gesture was in response to requests received earlier from the immediate past President of Pharmaceutical Society of Ghana (PSGh), Mr. David Anim-Addo on behalf of the Faculty of Pharmacy. He expressed his delight and that of the church in playing a meaningful role in pharmacy education in the country and assured that future requests will be given due consideration. ▶



Mr. Kwegir Aggrey making the book presentation to Mr. Dan. Sekyere-Marfo, the General Secretary of PSGh. Also in the picture is President Bodhaine, head of the Africa Area of the Church.

LOUISA RETURNS FROM COURSE

Mrs Louisa Hanson recently returned from Aberdeen, Scotland after attending a nine-week course in Essential Drug Management and Rational Drug Use. The course was organised by The Robert Gordon University in collaboration with the World Health Organisation (WHO) and recommended by the Commonwealth Pharmaceutical Association (CPA). It sought to assist health personnel and policy makers in the government and private sectors (especially in the developing countries) to make essential drugs available to all by the year 2000; and also to assist in rational use of drugs by health workers for the benefit of the patient.

The aim of the course, therefore, was to promote rational, cost-effective management of drugs by highlighting on key areas that could be examined and adapted by individual countries.

Giving an overview of the course, Mrs Hanson said the facilitators explained individual topics in the

context of current trends in drug management and rational use with emphasis on the use of cost-effective and safe alternatives for existing treatment regimens. The use of appropriate generic substitutions were discussed and given a very important attention.

Mrs. Hanson was very pleased with the outcome of the course and hopes to bring the benefit so gained to bear on her output at the Trust Hospital, her place of work.

She aims to provide quality service by developing systems for efficient running of the pharmacy department. She believes her performance will be enhanced by establishing a drug information centre, developing a manual for drug procurement, providing a system for clinical pharmacy practice and by helping to develop an in-house standard treatment guidelines using the hospital's drug list and morbidity record. These initiatives according to her will help to maximize drug efficacy and promote individualised patient care - all in line with Clinical Pharmacy Concepts. ▶

NEWLY REGISTERED PHARMACISTS INDUCTED

An impressive induction ceremony was held in Accra on the 18th March 1998, to usher one hundred and twenty-nine newly registered pharmacists into the pharmacy profession. It was the second in the series to be organised by the Pharmacy Council which took over from the Pharmacy Board in 1996. This is an annual function for new pharmacists who have completed the prescribed internship and have been duly registered with the Pharmacy Council after proving successful in the professional qualifying examinations.

In his welcome address the Acting Registrar of the Pharmacy Council stated that by their education and the two-year post-qualification training offered them, the new pharmacists have been prepared for the challenging opportunities open to them in the various areas of practice. These include regulatory control and management, Community Pharmacy, Hospital Pharmacy, Industry, the Academia - teaching and research in the various pharmaceutical sciences, and medical representation among others. He stated that pharmacy is dynamic, and today's practitioners are faced with new and expanding roles, adding that today's practice is clinical and patient oriented. "The future they say belongs to dreamers. You need a broad vision of the direction in which you wish to steer your profession, and what you can contribute to make pharmacy greater as a service to humanity", he admonished.

Whilst urging the inductees to keep abreast with the modern trends and developments in their fields of expertise by continuous education, he said professional excellence and unflinching devotion to the cause of pharmacy are sine quo non for the elevation of the professional image and social stature of pharmacy. He advised the new pharmacists not to yield to the pressures and temptations that could be brought to bear on them by the present economic situation. "You must realise as a professional that the ethical obligation you owe to the community makes you distinct from an ordinary businessman. Your attitude is not just to make or earn a living but rather to provide honest service; you must be trustworthy and of course competent; these are among the qualities that determine the dignity and prestige of your profession", he concluded.

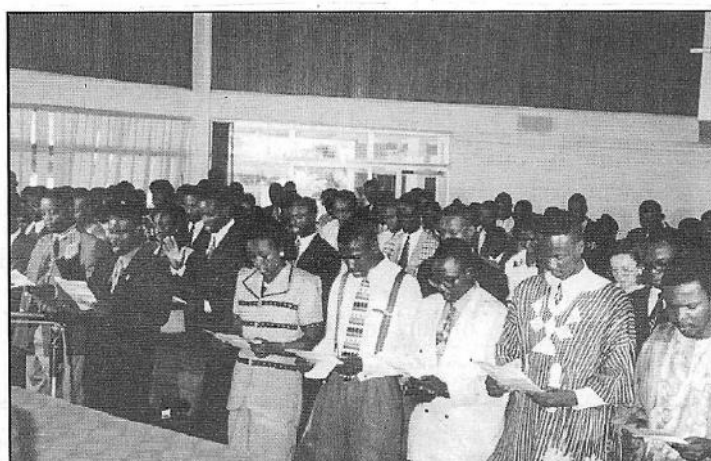
In her keynote address, the Minister of Health, Dr. Mrs. Eunice Brookman-Amissah called on the Pharmacy Council to work out incentives that would encourage the setting up of pharmacies in deprived areas. She also urged the council to critically examine and review the current criteria for locating pharmacies to complement the efforts of the Ministry to bring health services closer to the majority of Ghanaians.

Giving the statistics on the distribution of pharmacies in the country, Dr. Brookman-Amissah said as at last year, while Greater Accra Region alone had about 502 community pharmacies, the whole of the Northern, Upper East and Upper West Regions combined had only 12 of such facilities.

The Minister suggested that to reduce the number of applicants



Dr. Mrs. Brookman-Amissah - Minister For Health, delivering her Keynote Address.



Induction Ceremony for Newly Registered Pharmacist

for areas already well served, the Pharmacy Council should set standards which will include the population each facility is expected to serve. The prospective applicant, she said, should also have identified the need for locating the facility at the proposed location.

The Minister said arrangements are underway for attachment training courses in some selected hospitals in the United Kingdom for pharmacists as a means of improving their competence and also encouraging them to stay in the public sector.

She further urged the Pharmacy Council and the Food and Drugs Board to protect the public from unscrupulous drug peddlers especially in areas where drug regulatory activities are minimal. The President of the Pharmaceutical Society of Ghana, Mr. Dela Ashiagbor advised the new pharmacists to focus on providing healthcare for their patients and not on monetary gains.

Mr. Gideon Buernor Addo received the John Ocran Award of ₵500,000.00 for coming out as the best student in the professional examinations. ▀

THE GHANA NATIONAL DRUGS PROGRAMME

The MOH has instituted a number of programmes and actions aimed at solving the problems plaguing the drug supply system in the country. Among the problems identified by the Ministry is the increasing lack of qualified and experienced management and technical personnel and inefficient procedures for drug management.

Others are inadequate storage and inefficient distribution system coupled with an ineffective regulatory control of drugs. These were stated by the Minister of Health, Dr (Mrs) Eunice Brookman-Amisshah when she addressed a two-day consensus meeting on the draft National Drug Programme in Accra on 3rd March, 1998.

She said the **Ghana National Drugs Programme** is a five-year action plan aimed at comprehensively improving the pharmaceutical sector in the country. The ultimate goal is to ensure that all Ghanaians have access to effective, safe and affordable drugs of good quality in

both the public and private sectors and that these are rationally used.

Other actions of the Ministry have been the publication and distribution of a National Essential Drugs List and Formulary with Therapeutic guidelines for use at all levels of health delivery system and the organisation of various workshops and meetings on rational drug use for health practitioners.

The promulgation of the Food and Drugs Law 1992, (PNDCL 305 B) and the Pharmacy Act, 1994 (Act 489) have led to the establishment of the Food and Drugs Board and Pharmacy Council respectively. These provide the legal authority for the control of pharmaceutical activities in the country.

The National Drug Policy has already undergone a far reaching review process. And the Minister believed critical analysis were made on all aspects of our health resource and requirements before coming out with the draft document. ▀

TOP SEED

Credit: News Week Feb. 23, 1998-04-17

America gave the World Disney and Base Ball. Now it's supplying the world with its sperm. Would-be parents worldwide are logging on to Web sites of US - based fertility clinics in search of the perfect dad. Unlike other countries, American clinics are less regulated and have plenty of supplies.

Many also have on-line catalogues where it's easy to search by race, education levels and looks. Select the sperm, pay a fee and it's way - by male carrier, not stork. But not everyone is glowing about the sperm. Last month (January) the British government warned that online specimens may not be as "rigorously" screened as native varieties. ▀

DOTS: A Five-Point Strategy

WHO'S recommended approach for treating TB is DOTS - directly observed treatment short course - and a major campaign run by WHO'S Global TB Programme is actively promoting its use. Yet, worldwide, only some 10% of TB patients are receiving DOTS. It is quite possible that some of the health workers who read this journal still do not know what DOTS entails. It involves the use of anti-TB drugs given in combination but that is only part of the story.

The following summary explains the five elements of the SOTS strategy. WHO stresses that all five elements are required before any DOTS programme can reach the target cure rate of 85%.

1. The first priority for every programme, according to WHO, must be to direct resources towards identifying sputum smear-positive cases of TB, as these are the sources of infection. Until high cure rates are being achieved with these patients, active searches for other cases in the community would only divert resources away for the priority cases. Adequately resourced laboratories are of course essential for this aspect of DOTS.
2. Patients must be observed swallowing each dose of their medicines by a health worker or trained volunteer. This is especially important during the first two months of treatment when the patient may be seriously ill, at risk of acquiring drug resistance, and an

infectious threat to others. Patients who fail to keep their appointments for treatment must be contacted immediately and helped to resume treatment.

3. The progress of each patient must be monitored. In this case of contagious patients, sputum must be examined after two months and on completion of treatment to ensure the patient is free of TB bacilli. A rigorous recording and reporting system is also essential; as well as making it possible to evaluate the progress of individual patients, this enables health services to identify districts and communities which are failing to meet the 85% target. ▀

GHANA FEDERATION FOR TRADITIONAL HEALERS MEET PHARMACEUTICAL SOCIETY OF GHANA

A Consultant Committee of the Ghana Federation of Traditional Healers (GFTH) held a collaborative meeting with the standing Executive Committee of the Pharmaceutical Society of Ghana on the 5th of March, 1998 at the Society's Secretariat.

The meeting was at the request of the GFTH. The delegation was led by Togbaega Dabra VI a.k.a. Mr. P.K.K. Aloka, a pharmacist and traditional healer. In his introductory address Togbaega Dabra stated that the Federation has charged the consultative committee to seek a working relationship with the PSGH and the Ghana Medical Association (GMA) with the ultimate aim of promoting the integration of traditional the pharmacist in this drive by virtue of his training, according to him, was considered crucial. Also on the agenda was the marketing of herbal products.

Recounting the role of traditional medicines in the healthcare delivery system, Togbaega Dabra said the WHO estimates that 80% of Third World Population depend on herbal medicine. *"In Ghana, especially in rural areas with no clinics or such healthcare facilities, traditional healers are readily available to provide their much needed services"*, he added. He further stated that there is an urgent need for progress in such areas as the production, quality control and utilization of herbal medicines and called for the involvement of pharmacists.

Togbaega Dabra asked all the stake holders in the drug delivery system to ensure that the needed support was given to traditional medicine to enable it redeem the image it had held since olden times.

ENEMIES

"Dr. Ransford Appiah-Kubi of Apico Herbal Clinic at Madina in Accra said until the meeting, he regarded pharmacists as enemies who always wanted to destroy traditional medicine to the public. He asked the PSGH to let the meeting mark the beginning of a collaborative effort towards ensuring sanity in the administration of drugs in the country.

The President of PSGH, Mr. Dela C. Ashiagbor acknowledged the importance of the meeting and said the pharmacist and the traditional healer were colleagues seeking the utmost interest of the public. They are not enemies. He said the PSGH was not in any way controlling the traditional healers and welcomed the idea of setting up an autonomous body to handle traditional medicine.

He explained that it was the duty of the Food and Drugs

Board (FDB) control and regulate all drug related bodies in the country and not the PSGH as was being held by members of the GFTH.

The Editor of the Ghana Pharmaceutical Journal, Mr. S.N. Tenkorang, responding to questions relating to the production, marketing and safe use of herbal medicines in the country, said the consensus meeting on the formulation of a National Drug Policy recently held in Accra addressed most of the issues raised, especially the establishment of an autonomous body to co-ordinate the affairs of herbal medical practitioners.

The general secretary of the PSGH, Mr. Dan. Sekyere-Marfo, urged the GFTH to ensure some degree of standardisation to make their products acceptable on the international market. ▶



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THE 44TH CONFERENCE OF PSGH

The 44th Conference of the Pharmaceutical Society of Ghana was held last year in Accra from 24th to 27th September under the theme "The Pharmacist in Health Education and Health Promotion.

The Opening Ceremony took place at the Accra International Conference Centre (AICC). Mr. John K. Arthur, the then Greater Accra Regional Chairman of PSGH welcomed all participants to the Opening Ceremony and wish them, successful deliberations and a happy stay in the capital City during the four-day conference period.

PRESIDENTIAL ADDRESS

In his presidential address, Mr. David Anim-Addo said that the theme for the conference emanated from the WHO philosophy behind primary Health Care (PHC). according to him, PHC concepts by the WHO calls for an extended role for the pharmacist, a role which require devolvement of power from other health care professionals. He noted that this concept constitutes a "boundary encroachment" by the pharmacist on general Practice medicine. Mr. Anim-Addo, who was at the end of his second and last term stated that the pharmacist could only fit into this new role if he acquired the requisite knowledge derived through training in appropriate vocational skills.

He observed that health promotion is a relatively new discipline which brings together concepts from a number of other disciplines like psychology, epidemiology, economics and education. All these subjects, he declared, are no longer the exclusive preserve of any particular group of health professional.

The President emphasized the need for change of attitude by health professionals in order to accomodate the status and directions in the form of various declarations given by the WHO concerning PHC.

Touching on the government of Ghana's medium Term Health Strategy, he said that raising the standards of care and improving the quality of service are the most important objectives set out in the document.

But he noted that good health care needed good teamwork and collaboration among professionals and agencies with the aim of using their different skills to the full benefit of the patient. He emphasized that it only makes

economic sense to ensure that the skills of all health personnel who have been trained at great cost to the tax payer are optimally utilized.

In order to promote better health and alleviate human suffering and disability.

OFFICIAL OPENING

The official opening of the conference was done by Deputy Minister Nana Paddy Acheampong on behalf of the Honourable Minister of Health Dr, Eunice Brookman-Amissah. In her speech, she expressed great delight on the Society's departure over the past few years from drug-centredness to patient and people focused approaches in examining the role of the pharmacist in the overall performance of the health sector. She noted that the role of the pharmaist in health education and health promotion is an area which the health sector had neglected for too long.

Dr. Brookman-Amissah observed that the pharmacist occupies a strategic position in the provision of health care and that in most cases the pharmacy is the last place the patient visits after accessing a health facility. She said the imput of the pharmacist is of such crucial importance that to the patient it is the most tangible contribution that will ensure that he/she recovers from the ailment. And to the service provider this imput will to a large extent determine his/her performance. The health minister noted further that imforming the public and educating specific groups on health matters will create increased public awareness on health issues, disease control against indoctrination and any form of propaganda exercises which may affect people's reasoned choices and in the wider context cause distortions to the seals of the national strategies for health for all.

The Honourable Minister of Health observed that the empahasis on health promotion is usually viewed as an attack on curative services. According to her for those of us for whom curative services have a direct financial impact, health education has the tendency of taking on a different motive and meaning. She, therefore, reminded pharmacists that the issue involved is not that of commerce, but it is a moral and legal imposition on us by virtue of the profession we have chosen to pursue and for which we have pledged our lives.

The need for the observation of ethics

regarding health information in pharmacies and dispensaries was brought to the fore by the Minister. She hoped that pharmacists will be provided with practical opportunities to join the debate on health issues as we seek to improve individual capacities to manage and provide information.

On the ultimate goal of health education, the Minister advocated the replacement of blind obedience of instructions when dealing with our clients with informed conversation resulting in personal choice for the patient. she cautioned against professional dictatorship which is very popular among health workers.

HEALTH SECTOR REFORMS

Dr. Brookman-Amissah noted that the credibility of health messages depended on the track record of performance by health professionals. And this has to do with our ability to provide efficient and effective services to our clients. She said the Ministry of Health, is recognising this fact, has embarked on very extensive and ambitious reform programmes designed to ensure enhanced professionalism and create the right environment for the provision of high quality, effective and efficient services. And she urged pharmacists and all health workers to educate themselves and identify with the changes in the ministry, which deal with institutional and operational reforms as well as the development of the human resource potential for high performance. She mentioned that work was ongoing to develop the appropriate conditions for workers to be able to give off their maximum, and added that opportunities for career development has become wider and more open in the public sector to pharmacists then before.

As part of the ministry's Essential Drug Policy, Dr. Brookman Amissah said that a National Drugs Programme has been developed with the aim of promoting rational drug us, strengthening quality assurance, improving drug financing and improving the overall supply of drugs in the public health sector. She also mentioned structural proposals to reorient the Central Medical Stores within the framework of five year National Drugs Program to ensure total pharmaceutical sector improvement. She stated that this reorientation will require the support of all prescribers and pharmacists alike in complying with the

provisions of the Essential Drugs Policy (EDP). She, therefore, called on the manufactures to so fashion their activities in the public health sector as not to compromise the provisions of the EDP.

The Minister urged pharmacists to re-examine their role with other professionals in the bid to encourage a much more rational use of drugs in our health facilities. Drawing attention to the prevailing epidemic of self-medication among our people, she noted that whilst the International Pharmaceutical Federation and the WHO call on pharmacist to play a bigger role in ensuring that responsible self medication is practised, there was the need for instituting some form of professional control and guidance. This initiative should be aimed at assisting members of the general public and where appropriate referring them to seek medical attention.

On the task ahead as healthcare providers, Dr. Brookman-Amissah said it is as big as it is rewarding. And to achieve our objectives in health education and health promotion, the

Minister expressed the need for a reappraisal of pre and post - qualification and continuing education programmes so as to adequately address our communication needs. She urged practising pharmacists to show interest in and acquire skills in public health issues like health resource management epidemiology, child survival and population control, In this regard she called for clear-cut definition of roles for the Faculty of Pharmacy, the Pharmacy Council and the Pharmaceutical society of Ghana.

In conclusion the Minister said the services provided by pharmacists are needed in every corner of the country and will require the development of strategies for reaching every community and every outlet. Health education and health promotion, she said, are public health issues which require proactive strategies with economic as well as moral dimensions.

Among the topics treated during the Serial Lectures included the following:

Serial Lecture I

- Public Health and Pharmacy

- Nutrition, diarrhoeal Diseases and Child Development.
- Worm Infestation Control as a component of child survival Programmes.

Serial Lectures II

- The pharmacist in TB Control.
- Oral Health Promotion and the Pharmacist.

The last Lecture was on Pharmaceutical care of AIDS/STDS Management.

The Business Sessions were held on the 26th and 27th. Important decisions were taken culminating in the conference communique and the election of officers for the 1997/1999 term.

The end of Conference dinner/dance took place at the Nogahil Hotel, Accra.

The 44th Conference chalked a great success due mainly to good organisation. It was well-attended and sponsorship was encouraging with some seventeen Companies making generous contributions towards its organisation.

44TH CONFERENCE OF PHARMACEUTICAL SOCIETY OF GHANA

**HELD IN ACCRA ON 24TH - 27TH SEPTEMBER 1997
DECISIONS OF BUSINESS SESSION**

1. FROM PHARMACY COUNCIL

Procedures for licensing of Pharmacies: Re-affirmation of 24 sq.m - Retail Pharmacy Business 48 sq.m - Wholesale Pharmacy Business as requirement for new Pharmacy operation; 400m radius from existing facility as minimum requirement for licensing new Retail as well as wholesale Pharmacy business.

2. EDUCATION

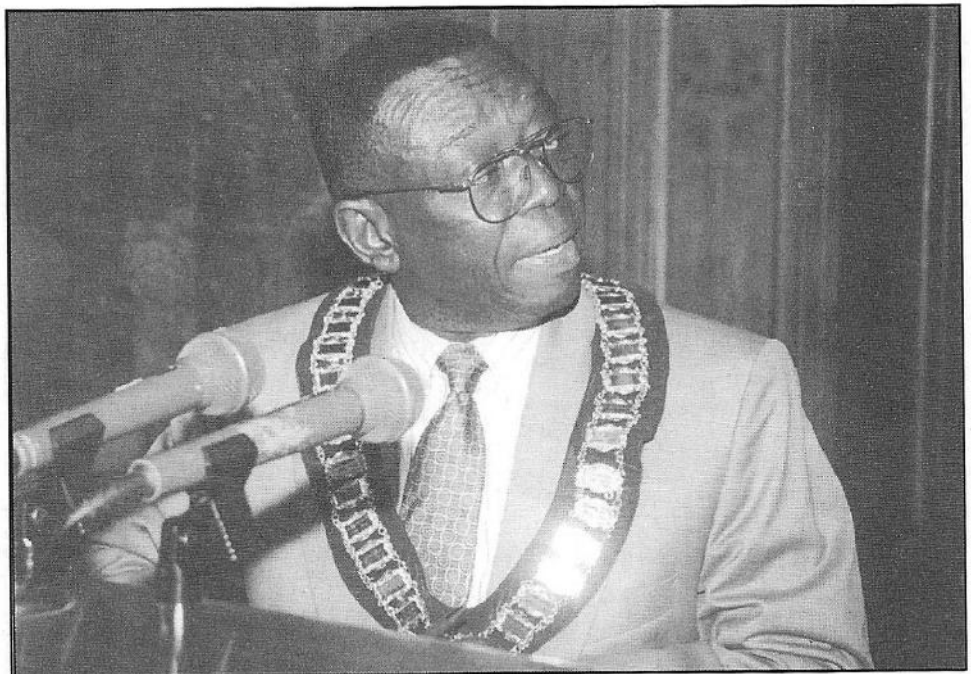
Need for changes in Basic as well as Continuing Education curricula was generally recognised in view of changing public health and Pharmicare concepts and demands.

Pharmacy Council and National Council were mandated to liaise with Faculty of Pharmacy to effect necessary curricula reforms - structured to enhance fitting into MOH establishment.

3. PHARMACY PRACTICE

Need for long term and short term plans by all concerned to control distribution of Pharmacies and Pharmacists recognised

Rising number of Chemical Sellers' Shops



Mr. David Anim-Addo delivering the Presidential Address at the 44th Conference of the Pharmaceutical Society of Ghana.

to be curbed. Need for re-consideration of Pharmacy Council's "400m radius" rule generally expressed.

Pharmacy Council stressed the require-

ment that the names of Superintendent Pharmacists be submitted at the very first stages of consideration for pharmacy business registration.



Some of the 44th Pharmaceutical Society of Ghana Conference guests at the Opening Ceremony. Seated 3rd right (front) is Mr. Sam Okudzeto, President of the Association of Recognised Professional Bodies.

4. EMPLOYMENT

Safeguarding Profession:

- (I) Aspects of Pharmacy practice which deprive Pharmacists full control of own business and profession to be checked:
 - (a) Need for demanding signed orders to regulate/control purchases,
 - (b) Pilfering and stealing, including activities of itinerants
 - (c) Dispensing Doctors

Need for Pharmacists to do what is expected of them in order to curb activities and proliferation of interest groups was generally supported.

(II) Postings: Activities of Pharmacy Council in the use of PRECEPTORS and the expansion of postings of Housemen generally approved.

Council is engaged in identifying suitable PRECEPTORS in Community, Hospital, and Industrial Pharmacy practice.

5. HUMAN RESOURCE DEVELOPMENT

Initiative from PSGh Council to encourage young Pharmacists to expand qualifications both horizontally and vertically was generally accepted and applauded.

To fit into new MOH Establishment such post-graduate fields of study as the following were recommended to the youth:

- (a) Clinical Pharmacy
- (b) Law
- (c) MPH
- (d) MBA

6. SOURCES OF FUNDING

(a) Faculty Endowment Fund:

Response to fund so far was observed to be discouraging PSGh to take initiative to make fund enjoy Alumni patronage

(b) Retention Fees:

To ensure that all registered Pharmacists fully meet their obligations towards Society, it was recognised that there is the need to redefine "Retention Fees" to encompass all aspects of funding.



Mr. David Anim-Addo hands over the Chair of Office to in-coming President of PSGH, Mr. Dela C. Ashiagbor

Council's proposal that retention fees be raised from ₵40,000.00 to ₵50,000.00 effective from 1998 was carried by majority decision.

Retention fees is to include Building Fund contributions.

7. PHARMACY HOUSE

The activities of the Fund Raising Committee was applauded

Donors in support of special fund appeal were acknowledged and awarded certificates of honour.

Seriousness from Council towards the Pharmacy House was asserted and Year Groups challenged to respond positively.

8. WELFARE FUND

Need to make fund beneficial to the living sick and or the distressed was recognised. Fund was observed to be skewed in disbursement towards funerals. Council mandated to decide appropriately.

9. CLOSING REMARKS FROM CPA PRESIDENT - Mr. M. SESAY

- (a) He advised authorities concerned to use planning to arrange and implement Continuing Education Programmes.
- (b) He expressed the need to initiate action to curb proliferation of interest groups into Pharmacy practice.
- (c) He encouraged Pharmacists to attend the CPA's next conference in Melbourne, Australia slated for March 1999.
- (d) He informed the Society of the formation of an FIP Council - African Group. An African Pharmacists' Forum will immediately precede future FIP meeting.

- (e) He informed the Society of a UN Special Initiative to support Africa's health sector with 25million USD.
- (f) He entreated Pharmacists to have a say in the use of this money. His remarks were highly applauded.

10. 44TH BAC CORRECTED AS 44TH CONFERENCE

It was accepted that the conference be appropriately named either 62nd Annual General Meeting or 44th Conference (and not 44th Biennial Conference) since the Society has been in existence for 62 years (and not 88 years).

Future conferences will take this fact into account and effect the necessary corrections. ▀

COMPUTER SYSTEMS STARTS NETWORK

Network Computer Systems (NCS) Limited has started an Electronic Data Interchange (EDI). A RELEASE ISSUED IN Accra on 10/3/98 by NCS explained that EDI facilitates the electronic exchange of business documents in standard formats such as invoices, purchase orders and bills of lading.

The release said in today's fast-paced business world, businessmen can enter the world of EDI and take advantages of the speed and economy of electronic commerce.

NCS, a leader in network services, was the first in West Africa to introduce the SWIFT financial network. NCS was also the first in the sub-region to introduce the INTERNET. ▀



*PHARMACEUTICAL
SOCIETY OF GHANA
(PSGH)*

**1998 ANNUAL
GENERAL MEETING
(AGM)**

*THE PRESIDENT AND THE
NATIONAL COUNCIL OF THE
PHARMACEUTICAL SOCIETY OF
GHANA WISH TO ANNOUNCE
FOR THE INFORMATION OF ALL
REGISTERED PHARMACISTS
THAT THE 1998 ANNUAL
GENERAL MEETING (AGM) OF
THE SOCIETY COMES OFF AT
THE UNIVERSITY OF CAPE
COAST, AS FOLLOWS:*

THEME: *TOWARDS A NEW
VISION FOR
PHARMACY INTO THE
21ST CENTURY*

VENUE: *UNIVERSITY OF CAPE
COAST AUDITORIUM,
CAPE COAST*

DATE: *WED. 16TH - SAT. 19TH
SEPT. 1998*

*THE CONFERENCE FEE IS
¢80,000.00 PER PHARMACIST.
HOWEVER MEMBERS WHO PAY
BY AUGUST 30TH, 1998 WOULD
ENJOY A REBATE OF 10% AND
HENCE PAY ¢72,000.00.*

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PHARMACY COUNCIL ON THE DISTRIBUTION OF PHARMACIES

As part of its functions, the Pharmacy Council regulates the distribution of Pharmaceutical Services in the country. A recent decision of the council to apply a 400meter- rule to new pharmacies has not been well received by pharmacists and businessmen alike.

Under the rule, new retail/wholesale pharmacy business application may be considered only if they do not fall within at least 400 meter radius of existing facilities.

The council explained during the 1998 induction Ceremony for newly registered Pharmacists that her recent decisions regarding citing of facilities, are meant to ensure equitable distribution of pharmacies and chemical sellers, shops throughout the country in order that pharmaceutical services are brought as close as possible to members of the public.

With the new move of Council abolishing the provision that newly registered pharmacists are not permitted to superintend pharmacies until at least two years after registration, the acting Registrar of the Council stated that these pharmacists now have the rare opportunity to offer their professional services to the generality of the rural communities who need their services most.

He declared that Council is more akin to consider applications for the districts and towns rather than the cities which are already relatively adequately served the registrar said that of the 165 new pharmacy applications received and considered in 1997, 107 came from Greater Accra (ie 65%) and 28 from Ashanti Region (ie 17%); most of the applications were from the regional capitals. He added that the present skewed distribution of pharmaceutical services in the cities cannot and must not be allowed to continue. ▽

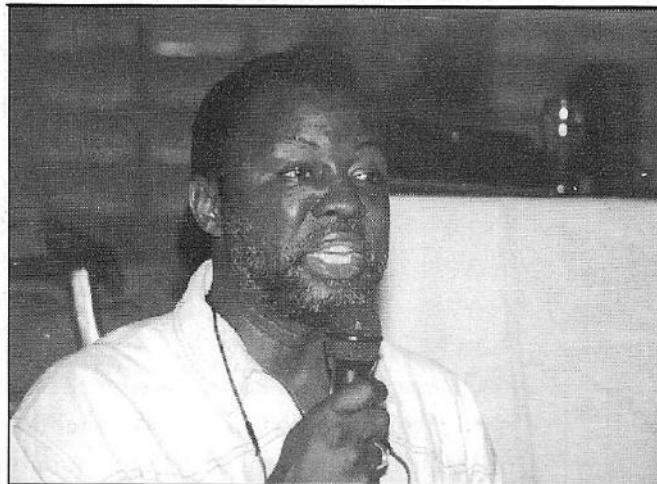
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KEYNOTE ADDRESS 44TH CONFERENCE OF PSGH

THEME: "THE PHARMACIST IN HEALTH EDUCATION AND HEALTH PROMOTION"

DELIVERED BY MR. MURTADA M. SESAY, PRESIDENT OF THE COMMONWEALTH PHARMACEUTICAL ASSOCIATION (CPA) AND PRESIDENT OF THE PHARMACEUTICAL SOCIETY OF SIERRA LEONE

The cornerstone of the foundation and platform of my thoughts on the theme is made of the fact that throughout my career, I have considered myself as a pharmacist - the individual, a pharmacist - an active member of my family, the community and then a pharmacist - citizen of my country. If you share with me this vision of your professional self, then I assume that you will also agree with me that our role in Health Care Provision will vary from context to context. I shall return to this apparent complexity later.



Mr. M. Sesay Murtada delivery the Keynote address at the 44th Conference of the Pharmaceutical Society of Ghana

We also need to be on the same platform when we speak of Health Education and Health Promotion, so let us get the semantics agreed, at least for the duration of my talk today!

HEALTH EDUCATION

In organising this address, I came across two definitions of Health Education which I would like to quote as food for thought:

Health Education is any designed combination of methods to facilitate voluntary adaptations to behaviour conducive to health.

As you reflect on this definition, let me share with you some questions that ran through my mind:

- Whose design of whose method?
- Whose behaviour is targeted for adaptation?
- Whose health are we concerned about?
- In fact, what is health any way?

In 1973, the committee on Health Education set up by the President of the United States of America offered the following definition:

"Health Education is a process which bridges the gap between health information and health practices. Health Education motivates the person to take the information and do something with it to keep himself healthier, by avoiding actions that are harmful and by forming habits that are beneficial"

This definition suggests, as does the first, that Health Education is related to health behaviour, either in helping people to maintain their life styles or in helping them to develop their lifestyles in health enhancing directions.

Ethical and political issues are raised right away when one begins to consider altering peoples' behaviour.

It is only in the last two decades that there has been a profound shift in public health focus to the importance of behaviour in reducing the burden of unnecessary illness.

At the 11th World Conference on Health education. In Helsinki in June 1991, Dr. Hiroshi Nakajima, Director - General of the World Health Organisation said and I quote "Society must make it possible for people to live healthy lives. A grand alliance of people, policy makers and health professionals is necessary". This public health approach has its roots in the WHO/UNICEF - sponsored global conference on public health held at Alma Mata in 1978, where the vision of Health For All was born.

What about Health Promotion? Dillon and Philip, in their book

"Health Promotion and Community Action for help in developing countries" state as follows:

"Health promotion can be described as social, educational and political action that enhances public awareness of health, fosters healthy lifestyles and community action in support of health and empowers people to exercise their rights and responsibilities in shaping environments, systems and policies that are conducive to health and well-being. Health Promotion is in fact enlightened health activism"

The Department of Health and Human Nutrition of the United States publishes a book called "Healthy People 2000-National Health Promotion and Prevention Objectives" which sets up priorities for preventive action, organised in three basic categories. Health Promotion, Health Protection and Preventive services. It addresses specific behavioural risks, disease conditions and health outcomes that must be effectively addressed in the coming years, if the American People are to take advantage of the opportunities for better health.

Health Promotion strategies are those related to individual lifestyles - personal choices made in a social context - that can have a powerful influence over one's health prospect. These priorities include

- Physical activity and fitness,
- Nutrition, tobacco, alcohol and other drugs,
- Family planning,
- Mental health and mental disorders and
- Violent and abusive behaviour

Health Protection strategies are those related to environmental or regulatory measures that confer protection on large groups. These strategies address issues such as:

- un-intentional injuries
- occupational safety and environmental health
- food and drug safety and
- oral health.

Preventive services include

- counselling**
- screening**
- immunization or chemoprophylactic interventions for individuals in clinical settings**

Priority areas for the strategies include

- maternal and infant health,**
- heart disease and stroke,**
- cancer,**
- diabetes and chronic disabling conditions**
- HIV infection,**
- Sexually transmitted diseases and infectious diseases**

These definitions immediately indicate that the capacity of Pharmacists, either individually or as professional groups to influence lifestyle and health behavioural change would indeed be limited if not carried out within an overall national framework of Health Care.

HEALTH EDUCATION METHODOLOGY

The emergence of public and professional interest in the subject was fuelled by national and international trends converging on the issues of self help, prevention and health promotion. In the United States of America, this moved from rhetoric and sentiment with the enactment of the Health Maintenance Organisation Law in 1973 which specified that preventive and educational services were mandatory for HMOs receiving federal certification. In that year, the President's Committee on Health Education advocated for the establishment of a bureau of Health Education in the Department of Health, Education and Welfare and in the private sector, a National Centre for Health Education. The National Health Planning and Resource Development Act of 1974 specified Public Health as one of the priorities of the nation.

"Health Education in Europe," a report published in 1976, provides an overview of Health Education policies, trends and practices in twenty-eight countries. In summarizing the report Schocks states:

Everywhere in Europe today, Health Education is perceived as an integral dimension of health care and an essential prerequisite to effective legislative action aimed at protecting people from health hazards ..."

Several interesting examples of health

education innovations are cited in the report including a 25-year prospective study in Sweden designed to curb smoking by means of selected social influences.

D.N. Laransky, Director of the then USSR's Central Institute for Scientific Research in Health Education explained that the Presidium of the Academy of Medical Sciences of the USSR identified Health Education as a factor of national significance and established a special health education problem commission in 1976, calling it a decision and "heralds a new and important period in the development of health education in the country". From now on, he said, "all the medical departments and institutes located in the various republics and regions will participate in educational activities on a regular and planned basis".

HEALTH EDUCATION PLANNING

If Health Education is a process, it means that health education activities have a common basis no matter where they occur, whether in clinical, community, school, home or work setting. Emphasizing process makes it possible to avoid being diverted by dissimilarities of settings and of education contents and methods and to keep goals more clearly in focus.

Pharmacists involved in Health Education must be prepared for a systematic programme planning and evaluation if the outcome is to attain validity and effect in the eyes of the public. Unless they have well-defined schemes for health education planning in which long range outcomes and behavioural objectives and program inputs are clearly defined in relation to each other, our well-intended actions and efforts run the risk of straying into ritualistic and questionable health education practices called "traps". Then there is also the technology trap in which health education practices seem to be based on a series of fallacies, the sum of which suggests that the answer to effective health educational technology. One of this is referred to as "the empty vessel fallacy". In this, health educators behave as if all they have to do to ensure the success of their programme is to pour health information into the empty minds of an eagerly awaiting target population.

Organised health education activity must be based on the desire of pharmacists to intervene in the process of development and change in such a way as to maintain positive health behaviour or to interrupt a behaviour pattern that is linked to increased

risks for illness, injury, disability or death. The behaviour is usually of the people whose health is in question but often it may be the behaviour of those who control resources or rewards, such as community leaders, parents, employees, peers, teachers and health professionals as well. (This is why our concept of the multi-context pharmacist is important.)

FRAMEWORK

Let us briefly look at one framework for Health Education Planning called PRECEDE. (An acronym for Predisposing, Reinforcing and Enabling Causes in Educational Diagnosis and Evaluation). The framework directs the health educator's initial attention to outcomes rather than to inputs, forcing him or her to begin the health education planning process from the outcome end. It encourages the asking of "why" questions before "how" questions. Stated another way, the factors important to an outcome must be diagnosed before the intervention is designed.

Once the behavioural diagnosis has been completed and the health behaviour analyzed in terms of its predisposing, reinforcing and enabling strategy most suitable and configured to the target group and the health problem.

There are three broad educational strategies that could be identified:

1. **Communication methods:**
 - Lecture/discussion**
 - Individual counselling or instruction**
 - The four media techniques of mass media, audio visual aids, television and programmed learning**
2. **Training Methods:**
 - Skills development**
 - Stimulations and games**
 - Inquiry learning**
 - Small group discussions**
 - Modelling**
 - Behaviour modification**
3. **Organisation methods:**
 - Community development**
 - Social action**
 - Social planning**
 - Organisational development**

Obviously the delineation will not be as clear and there is bound to be overlap none the less I think it is useful to have a feel of the possibilities.

An important aspect of health education methodology which needs to be borne in mind is that it can be approached from three levels:

- Primary - Hygiene
- Secondary - Early detection
- Tertiary - Therapeutic

Whether a Health Education Programme is operative at the primary (hygiene), secondary (early detection), tertiary (Therapeutic) stage of prevention, it may accurately be seen as an intervention, the purpose of which is to short-circuit illness or to enhance the quality of life through change or development of health-related behaviour.

It is clear that the intervention and hence strategy will have to be sensitive to which level we wish as pharmacist to and can sensibly influence.

COMMUNICATION

Because of the critical importance of communication as a strategic element of Health Education and Promotion and the fact that there is nothing automatic about the communication and application of health information, it is worth spending some moments on issues in health communication and common causes of breakdown in such communication.

- Communication involves the sharing of ideas, knowledge, attitudes and feelings. But efforts to communicate health messages do not always achieve the results intended for a number of reasons:
- The message may reach only some of the target audience because only one or two communication channels are used.
For example, some health programmes rely on printed materials such as posters and leaflets to reach illiterate people, or on radio and television to reach people who have no access to these media.
- The people may receive the message but not understand it.
For example, the message may be expressed in the wrong language or dialect, or using highly technical terminology.
- The people may receive the message but misinterpret it and apply it incorrectly
For example, mothers who are taught to use oral re-hydration therapy (ORT) may use too much water, which makes the solution ineffective, or too little, making the solution potentially dangerous.
- The people may receive and understand the information, and learn a new health action correctly. But the new knowledge may conflict with existing attitudes and beliefs and is discontinued or not put into practice at all.

For example, mothers who are taught to continue feeding a child with diarrhoea may not act on this information because it conflicts with a traditional belief that the stomach needs to be 'rested' during diarrhoea.

- The people may receive and understand the new information but be unable to act upon it because of poverty or because basic services are not available.
For example, mass media campaigns can increase community demand for packets are too expensive or unavailable from the health services or private pharmacies, the money spent on such campaigns is wasted.
- The people may receive the information but change their behaviour only temporarily because of disappointment with the results.
For example, mothers may learn to prepare and administer ORT correctly but lose faith in the therapy because what they want is a treatment to stop diarrhoea quickly rather than prevent dehydration.

Communication breakdowns of this kind are not inevitable. They can usually be avoided if communicators first try to understand the attitudes, beliefs and social factors that determine people's health behaviour.

STEPS

In many countries, the following steps have been found to be useful in communicating new health knowledge and skills:

1. Define clearly what health behaviour you are trying to formulate.
 - *Example, a child with cough should be kept warm*
 - *Everyone should wash hands with soap after contact with faeces and before handling food*
2. Deciding exactly who in the population you are trying to influence.
3. Ask whether the new health behaviour requires skills
 - *Preparation of a safe and effective drink for a child with diarrhoea*
- 4 Learn about the present health knowledge, beliefs and behaviour of the target audience
- 5 Enquire whether the health behaviour you are trying to promote has already been introduced to the community
- 6 Investigate the target audiences present

sources of information about health

7. Select the communication channels and media which are most capable of reaching and influencing the target audience

Interpersonal channels - such as takes place in a community pharmacy
Mass Media - radio, television, newspapers, magazines.
Small Media - posters, cassettes, video

It is always more effective to use a mix of channels.

8. Design health messages which are:
 - Easily understandable
 - Culturally and socially appropriate
 - Practical
 - Brief
 - Relevant
 - Technically correct
 - Positive
 9. Develop and test your education materials
 10. Synchronize your educational programme with other health and development services
For example, a health education programme encouraging the use of ORS in the home should not start unless there is already an adequate supply of ORS packets available through the health services and commercial networks
 11. Evaluate whether the intended behaviour is being carried out (step 4)
 12. Repeat and adjust messages at intervals over several years
- As I indicated earlier, the goal is not to turn us into professional health educators but rather to develop a philosophy of practice in which we focus our attitudes, behaviours, commitments, concerns, ethics, functions, knowledge, responsibilities and skills on the provision of drug therapy, with the goal of achieving definite therapeutic outcomes. In fact I have just defined Pharmaceutical care, as envisioned by Professor Helper and his colleagues in the USA in 1990. Although this definition focuses on drug therapy in the individual patient, this could be extended to the public as a whole. It recognises the pharmacist as a health care provider who can actively participate in illness prevention and health promotion, along with other members of the health care team. We have the advantage of an extensive and frequent interface with the general public, added to our acknowledged credibility, to influence

health behavioural change.

Under the WHO's revised drug strategy adopted by the World Assembly in 1986, WHO has organised two meetings on the role of the Pharmacist in Delhi in 1988 and in Tokyo 1993 (WHO/PHARM./94-5.69). This was followed by the adoption of resolving WHA 47.12 on the role of the Pharmacist in support of the WHO revised drug strategy in May 1994.

The report of the work group spelt out various actions that comprise the application of pharmaceutical care to the individual, which if undertaken in whole or in part, will result in added value to drug therapy by making a positive contribution to the safe and effective use of drugs, tending to positive outcomes and improved health care. I encourage all of you to read that report (WHO/Pharm/94.569) because it encourages Pharmacists individually and as a profession to participate in health promotion and education such as:

- *The proper use of medication*
- *Smoking cessation*
- *Immunization*
- *Prevention of drug abuse*
- *Hygiene*
- *Family Planning*
- *Aids Prevention*

In 1992, the International Pharmaceutical Federation (FIP) developed standards for Pharmaceutical services under the heading "Good Pharmacy Practice" in Community and Hospital Pharmacy settings. The document was intended to focus the attention of Pharmacists in the community and hospital pharmacy sector on developing the elements of service that seek to meet changing circumstances.

The first of the four main elements of Good Pharmacy Practice has to do with activities associated with promotion of good health, avoidance of ill health and the achievement of health objectives. In addition to the four main elements, Good Pharmacy Practice also encompasses the establishment of arrangements with other health professional communities for health promotion activities at a population level, including the minimization of the abuse and misuse of medicines.

For each of the four main elements of GPP, national standards covering processes and necessary facilities should be established and promoted to the profession. For Health Promotion and Ill Health Prevention, standards are needed for:

- *Facilities for confidential conversation that cannot be overheard by others*

- *Provision of general advice on health matters.*

Involvement of personnel in briefings for specific campaigns to ensure coordination of effort and consistency of advice

Quality assurance of equipment used and advice given in diagnostic testing

I have spent some time raising issues of history and methodology including the identification of a strategy for health education and promotion. However, as is often the case, the translation of this into real life is bound to be fraught with practical problems. I will therefore spend the remainder of my time raising a few questions for our reflection:

COST

Clearly, Health education carries with it a price tag. Who picks up the tab? The individual pharmacist, the Pharmaceutical Society, The Government or indeed should be the target beneficiaries contribute towards the cost of an activity that can be shown to improve their quality of life?

TIME

How much time does the practising pharmacist have for the additional functions inherent in our involvement in health education activities? By the way, do we know how much time is involved?

REWARD

Should the participation of pharmacists in these activities be voluntary? If so why should one pharmacist spend time giving useful advice for which no remuneration is given? There are of course the more optimistic among us who would argue that this service brings financial rewards in the form of expanded goodwill.

EVALUATION

What indicators can we use to monitor whether or not Health Education is being carried out in a particular setting? Do we as pharmacists have the knowledge and training in specific health education issues? Well, I have just skimmed some of the concepts, so you can imagine the answer to this question. Let our colleagues in academia assess the weight of further investment in health education, from a point of view of their current curriculum. I however recall that some years ago the Nuffield Committee pharmacy in the UK stated in paragraph 3.62 of its report - "The pharmacist is well qualified to give advice on matters relating to health

education that may obviate the need for future treatment of disease."

LIABILITIES

In the very extreme case, does the provision of health education and promotion carry with it any liability in a similar way to the dispensing of medicinal products?

CREDIT

How will credit for a successful programme involving other professionals be apportioned?

These are issues for necessary debate which I do not intend to open now. Perhaps, during our deliberations this week, we shall do so.

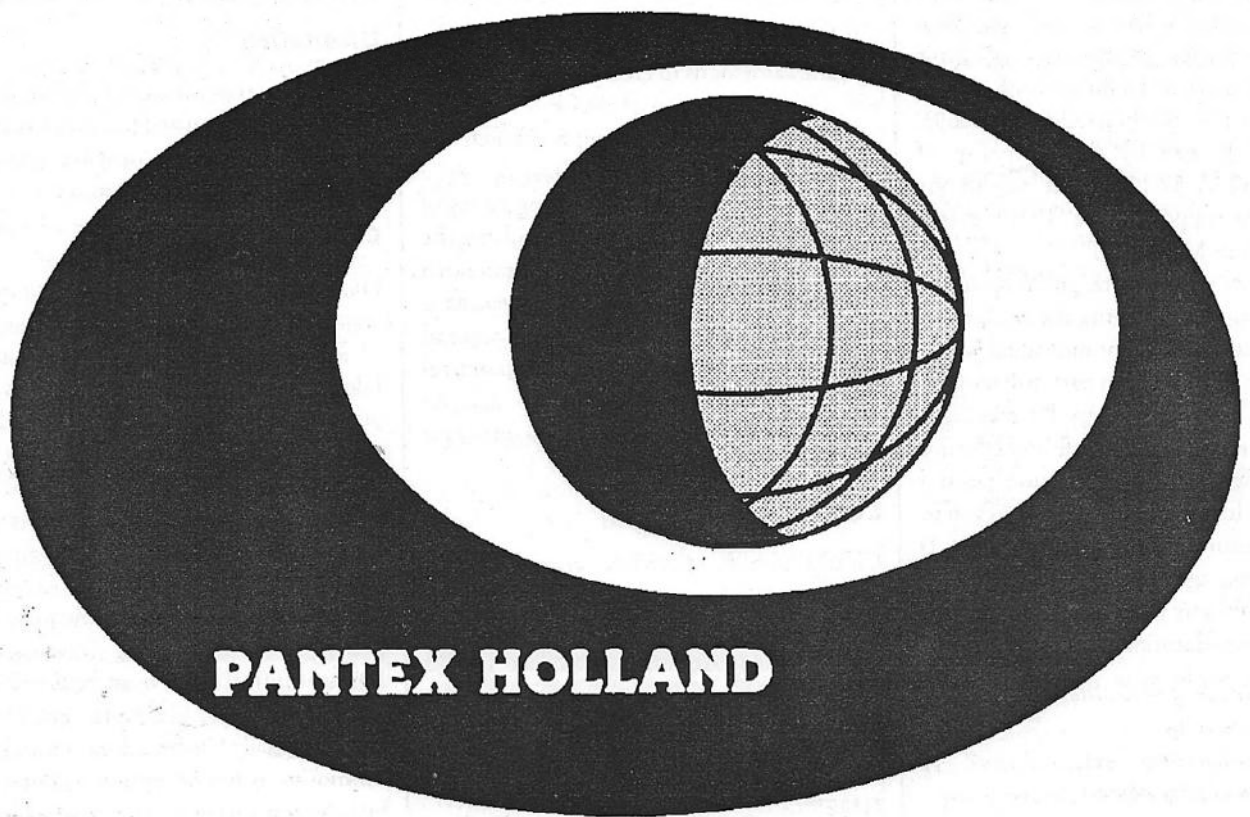
In closing, I want to just say that the bottom line of all this in my view, is that Pharmacy practice today, whatever the speciality, must be tuned to the frequency of providing affordable and accessible health care to all the peoples of our communities. Such practice, within the framework of Pharmaceutical Care, must be devoid of any mystiques, plain and simple. Public Health Care, especially Health Education and Health Promotion is not an option to Pharmacists, but a vision and opportunity which must be followed, for professional survival into the new millennium.

It is at this point very opportune for me, being a UNICEF person, to recall a statement by our former Executive Director, James P Grant, in one of his many child survival encounters with the medical profession.

"The basic determinants of a child's health are in the hands of the parents, not doctors. Only if medical professionals see their task as demystifying medical knowledge and empowering others to use it will they make their potential contribution to the advance of child health 'which is now possible'"

I now want to take this opportunity to publicly thank the Government and People of Ghana, particularly those dedicated men, Professors Gyang, Ansa-Ansamoah, Dwuma-Badu and Ocran of blessed memory, Sackeyfio, Gyane, Boakye-Yiadom, Sarpong, Ayim, Korning, to name a few, for giving me the opportunity to benefit from their own careers, and finally to all my colleague and mates who made my UST days in Kumasi memorable in many ways.

Once again I thank you all for having me here it has been a great privilege for me to be with you on this occasion.



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SUPERIOR QUALITY IN VETERINARY MEDICINE

The role of the Pharmacist in the fight against the HIV-AIDS pandemic

A joint declaration of the World Health Organisation (WHO) and the International Pharmaceutical Federation (FIP)

Whereas there are today 1.6 million reported AIDS cases, but the unofficial estimate stands at over 8 million; this means that the pandemic is the most life-threatening challenge our society has had to face since the beginning of the 20th century;

- The majority of cases are in sub-Saharan Africa and in some developed countries, but extensive spread in South East and South Asia indicates that this area could become the next epicentre of the pandemic;
- People with clinical AIDS are by far outnumbered by those who have been infected by the virus but who have not yet actually developed the disease WHO estimates that the infected population will amount to about 40 million by the year 2000;
- As it is the case for many diseases behavioural factors and lifestyles are known determinants of HIV infection;
- All individuals concerned by the disease - whether clinically ill, HIV-positive or relatives of those infected - are confronted with problems of a medical, social and economic nature, and they may also face discrimination.

Now therefore:

WHO and FIP intend to work actively to prevent the further spread of the HIV-AIDS virus, to seek to improve patient care and to fight against discrimination in all its forms. This joint commitment is based on the Organisation's mandate in public health and the worldwide presence and vocation of pharmacists in the field of health:

- Pharmacists all over the world are the most numerous and easily accessible "health outlets" for the general public;
- Trained in public health questions, with long experience of entering into dialogue with, and providing education of the information to the general public, pharmacists are well-placed to participate in health education and prevention campaigns;
- As health professionals, they are in permanent contact with decision-makers in the

epidemiological, diagnostic and therapeutic fields; they participate in the actual treatment and follow-up of patients, and they make a major contribution to the collection, analysis and communication of health data.

Thus: In co-operation with WHO, FIP has drawn up a set of guiding principles for pharmacists and pharmaceutical scientists on the approaches they can take in the fight against the spread of HIV-AIDS. In this way, WHO and FIP believe that pharmacists and pharmaceutical scientists, working with all interested parties, can help in the fight against the HIV-AIDS pandemic and against any other factors which contributes to its spread - in particular injectable drug abuse.

WHO undertakes to promote these principles in all relevant for a in which the organisation participates. FIP undertakes to promote the principle to national associations of pharmacists and pharmaceutical scientists and to individual pharmacists worldwide; and to encourage national associations to transmit the declaration to the health authorities of their country.

Guiding principles:

WHO and FIP urge pharmacists and pharmaceutical scientists, together with their national and international associations for federations to draw up individual plans, within an overall national strategy wherever possible committing them to the following guiding principles:

- Encourage and promote better support networks for people with HIV-AIDS, and even more determined action against discrimination;
- Participate in the global struggle against the HIV-AIDS pandemic, on the basis of the commitments made by heads of state and governments at the summits in London, 1992, and Paris, 1994;
- Fight to ensure that all proven treatments be made accessible in all countries to all who could benefit from them without discrimination;

- Co-ordinate with all those working in public health education, and seek closer ties with other individuals and community groups who could be usefully involved in the effort to combat the disease, in terms of prevention, treatment and patient-care and support-teachers, family associations, politicians, etc. - and through community involvement of pharmacists;
- Provide information on Sexually Transmitted Diseases (STD) prevention and treatment in order to promote "health awareness behaviour" with regard to STD's;
- Develop specific training programmes for professionals, whether initial training or continuing education;
- Motivate pharmacists and pharmaceutical scientists to get involved at national level in the making of public policies related to HIV-control;
- Initiate a dialogue between health professionals, financing, bodies and patient associations; such a pooling of talents will ensure the comprehensive care of the greatest number of patients, fully respecting both ethical and cost-effectiveness requirements;
- Participate, together with the relevant health professionals - doctors nurses, social workers, etc; - in the evaluation of clinical treatment and in the provision and follow-up of treatment;
- Encourage national and international pharmaceutical associations or federations to enter into dialogue with international organisations representing the pharmaceutical industry, in order to identify all possible means permitting an improvement in access to treatment programmes;
- Develop, implement and evaluate activities within national field programmes: e.g. drug substitution programmes, needle and syringe exchange programmes and condom availability;
- Promote and set up interprofessional networks to collect, analyse and disseminate data at both national and international levels;
- Participate in scientific research involving drug trials with a view to ensuring that internationally agreed ethical principles are respected.

WORLD'S PHARMACISTS URGED TO REACH FOR THE STARS

The 57th World Congress of Pharmacy and Pharmaceutical Sciences took place in Vancouver Canada, from September 1 to 5. Held in conjunction with the Canadian Pharmacists Association's annual conference, it was officially opened by Mr Garde B. Gardom, Lieutenant-Governor of British Columbia. It attracted almost 3,000 participants from more than 80 countries. The congress theme was "Taking responsibility for the future". This report of the congress opening session begins a series of reports from the congress which will be published over the coming weeks.

Ideals are like stars: we may not be able to reach them but we must keep trying. That was the message that Dr Dieter Steinbach (president of the International Pharmaceutical Federation) urged the world's pharmacists to take on board when he addressed the FIP congress at its opening session. By using new concepts and making greater efforts, pharmacists would cross barriers and the future of their profession would grow to new horizons, he said. Pharmacy, like other health care professions, was ready to meet the need to adapt to a rapidly changing world. By the end of this century, health care systems, and with them pharmacy, would face an unprecedented number of problems. Examples were a demographic change in industrial countries, an increasing scarcity of resources and an explosive increase in the population of developing countries. Added to this were continuing advances in medicine and pharmacy as well as a steady increase in the number of patients with chronic diseases. Such advance themselves increased economic problems. Pharmacists' goal should be to turn those problems into new opportunities.

WINDS OF CHANGE

Dr Steinbach went on to say that the winds of change were blowing throughout the pharmaceutical sector - in national drug policy, in global trade, in drug regulation and in approaches to evidence-based drug

information. Countries were reviewing their sometimes long-established national drug policies to evaluate their functionality and relevance in the new environment. They faced the challenge of retaining the focus on equity and public interest that had to underlie any health policy, while building on experience and new opportunities.

In some countries, the winds of change had at times been more like hurricanes. Central and Eastern Europe countries and newly independent states were facing acute problems. In the pharmaceutical sector, hasty privatisation combined with a lack of proper control and regulation and created the paradox of improved drug availability but decreased affordability.

Turning to pharmaceutical care, Dr Steinbach reminded the congress of a European Council resolution which read: "Primary care should be conceived in such a way that medical therapy, whether prescribed or not, should be integrated into the community pharmacist's work. He or she should take part with other health professionals in the planning, the rationalisation and the administration of treatments." Those words described pharmaceutical care. Pharmacists' growing influence in prescribing issues was particularly significant and encouraging. Today, physicians and the pharmaceutical industry were beginning to acknowledge the importance of the pharmacist in product selection and patient management. The pharmacist's role in selecting an appropriate drug therapy, while observing the cost factor, would no doubt be expanded.

THREE PROPOSITIONS

Dr Steinbach believed that this was essential because an expanding body of literature on preventable, drug-related morbidity had suggested three propositions about medicine use, especially in North America and Europe. The first was that drug treatment involved significant amounts of preventable injury to patients.

In many existing community-based inpatient and outpatient practices, risks of drug therapy were not properly controlled. The second proposition was that the cost of preventable, drug-related disease and treatment failure might be substantially greater than the costs of the drug treatment itself. The third was that appropriate systems could reduce preventable, drug-related disease, improve outcomes and reduce costs of care. The pharmacist's role was to take care that medicines were used in accordance with regard to quality, safety and efficacy, he said.

Dr Steinbach said that a pharmacist's duty, besides selling medicines was to consult and inform patients. A drug only became a medicine once information had been added. Policies on over-the-counter drugs varied around the world. In most of the continental European countries, most if not all OTC drugs were available only through pharmacies, whereas in the United States all those drugs could be sold in general retail outlets, leaving patients dependent for information on advertising only. Advertising of medicines had always been a sensitive issue, but it was generally recognised that it was important for the public to learn about the availability of non-prescription medicines. Advertising was, therefore, an important part of the information system. "But it is important, too, that advertising of drugs should be carefully controlled not least as a means of demonstrating to the public that medicines are not ordinary articles of commerce but something special," he said.

MEDICINES MARKETING

In that context, said Dr Steinbach, the FIP and the World Medical Association had drafted a joint statement on treating medicines with respect, stating that both organisations held the firm

view that medicines should not be promoted to the public on price or by any marketing technique designed to stimulate an impulse purchase or to persuade a person to buy more of a medicine than was

needed at the time of purchase. Such techniques might be suitable for increasing sales of general goods but both organisations insisted that they were quite inappropriate for application to medicines.

Dr Steinbach said: "It is not only FIP's policy that pharmacists have a key role to play in providing assistance, information and advice to members of the public about drugs available without prescription - and especially the circumstances in which self-medication is not appropriate and a physician should be consulted - it is also the common position of the health ministers of the European Union. Nevertheless, we recognised that today there are some countries where the sale of non-prescription medicines is not restricted to pharmacies, but we believe it is evident that public health would be better served if there were professional advice attached to every sale."

INTERNET BLUES

MEMORIES....

A medical student was visiting his elderly grandfather and was asking him about the various medications that he was currently taking. "So, I understand that you're taking Ginkoba. Have you noticed any improvement with your memory?"

"How the Hell am I supposed to know," the grandfather replied. "I never remember to take it!"

LOVE ENGLISH STYLE

A bloke goes to the doctor.

"I've got a problem," he says.

"Well?" asks the doc.

"Well, I wake at 5 in the morning and the wife is quite horny, so we have sex. Then, she makes breakfast, and she looks so great while she's bending over the cooker, that I can't resist and we have sex again. Then, after I take my shower and just before I go to work, I make love to her again. On my way to work, I call in at the lonely widow's home and give her a seeing to. When I get to work, I have sex with the secretary, then the tea lady, then the barmaid at the local pub at lunch time, then with the secretary again when I get back to work, and finally, with the tea lady again. Then, when I get home, my wife and I make love all night until 2 in the morning"

"What's the problem?" asks the doc.

"Well, the bloke explains, "My dick hurts whenever I play with myself!"
JS

SPICE GIRLS ROBOTS

A young boy was watching TV with his father while his mother prepared the dinner in the kitchen. After a while, the kid wanders into the kitchen and asks, "Mummy, are the Spice Girls Robots?" "Well daddy just said that he'd like to screw the arse off the black one."

INDIANS RIDE BARE BACK

An attractive woman from New York was driving through a remote part of Texas when her car broke down. An Indian on horseback came along and offered her a ride to a nearby town. She climbed up behind him on the horse and they rode off. The ride was uneventful except that every few minutes the Indian would let a whoop so loud that it would echo from the surrounding hills. When they arrived in town, he let her off at the local service station, yelled one final "Yahoo!" and rode off. "What did you do to get the Indian so excited?" asked the service station attendant. "Nothing. I merely sat behind him on the horse, put my arms around his waist, and held onto his saddle horn so I wouldn't fall off." "Lady," the attendant said, "Indian ride bareback"

PILL FOR IMPOTENCE WINS APPROVAL

The first pill that men can take for impotence has won approval from the US Food and Drug Administration.

Viagra, made by New York drug giant Pfizer Pharmaceuticals, could become one of the top-selling drugs of all time, according to pharmaceutical analysts.

Known generically as sildenafil, Viagra will cost \$7 a pill, wholesale.

The FDA said a man must be sexually aroused before the drug will work. But unlike mechanical devices that engorge the penis, it mimics the natural effects of arousal.

"It's an erection enhancer," said Dr. Drogo Montague of the Cleveland Clinic in Cleveland, Ohio.

Tests on more than 3,000 men showed Viagra could help impotence associated with diabetes, spinal cord injuries, prostate surgery, and even impotence with mysterious causes.

"I think it will help a lot of men for a couple of reasons," said Dr James Barada, a urologist in Albany, New York who helped draw up erectile dysfunction guidelines for the American Urological Association (AUA).

"The most important thing that this does is place erectile dysfunction on the radar screen for patients and partners," Barada said in a telephone interview.

Also, it was the first oral therapy. Other treatments include injections, pellets that must be inserted into the end of the penis and mechanical pumps.

For example, Pharmacia & Upjohn's Caverject involves an injection into the penis and Vivus Inc's MUSE system is a pellet. There are vacuum pumps, and surgical implants.

Such therapies can be off-putting, for obvious reasons. "People will prefer a pill," said Montague, who headed the AUA guidelines panel.

Barada and Montague said all of these systems worked. "The vast majority of men who have a problem, the only thing they are missing is erections," Montague said. "Many men maintain a good interest in sex, or libido."

They can still have orgasms and ejaculate with a flaccid penis. There are drawbacks to any impotence treatment - especially the lack of spontaneity.

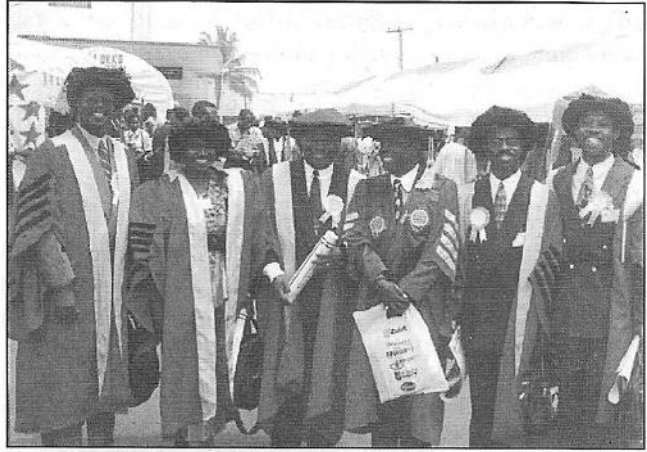
"Even this oral medication will require some planning unless men take it daily," he said. "You sort of have to plan, 'Am I going to have intercourse this evening?' and if so at what time." Barada and Montague said they hoped approval of Viagra would get men into their doctors' offices to talk about their problems.

"What we hope is that doctors will learn how to take sexual history and understand that sexual dysfunction doesn't occur of no reason," - Montague.

The 11th Scientific Congress of the West African Pharmaceutical Federation (WAPF)

WAS HELD IN LAGOS, NIGERIA FROM THE 22ND - 26TH FEBRUARY, 1998. THE THEME WAS "DRUG PRODUCTION STRATEGIES TO MEET THE MEDIUM TERM NEEDS OF THE SUB-REGION". EIGHTEEN GHANAIAN PHARMACISTS ATTENDED THE CONGRESS.

Among the highlights of the Congress was the first Fellowship awards by examination conferred on eighteen (18) pharmacists of the Federation's Post Graduate College including six Ghanaians. They were Messrs Louis Nortey, Samuel Nkansah, Anthony Duncan, Derx Baffour, Baffour Kwakye and Mrs Louisa Hanson.



WAPF Fellowship Awards at Lagos, Nigeria, West-Africa

The next Congress slated for Liberia will take place in February/March 1999. Liberia has been given up to July this year to indicate her preparedness to host the Congress failing which Ghana will have the honour to step in.

We publish below two of the papers presented at the Congress - "Recent Advances in Malaria Chemotherapy" and "Faking and Counterfeiting of Drugs." Others will be serialised in subsequent issues of the Ghana Pharmaceutical Journal.

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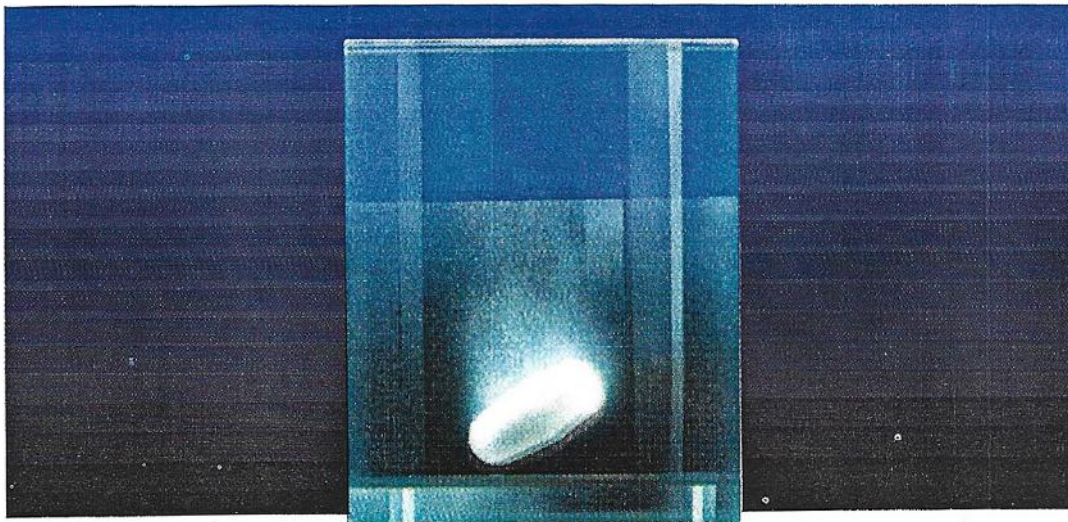
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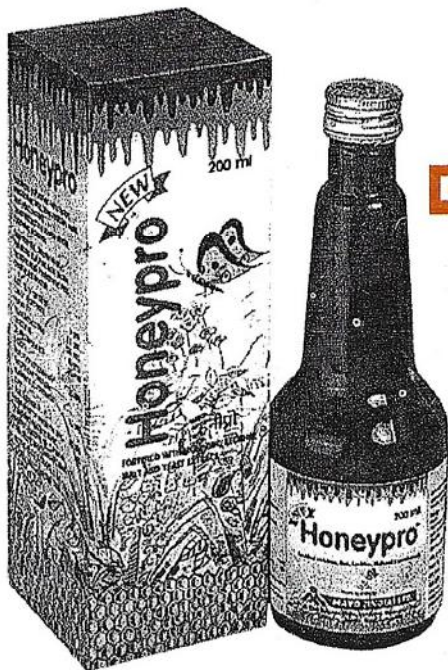
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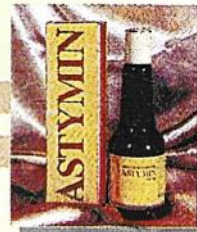
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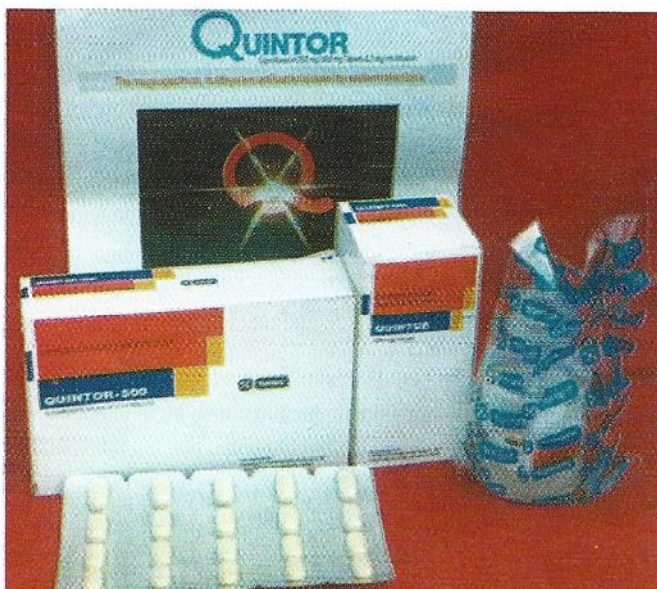


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ASTHMA PATIENTS SHOULD RENEW TOOTHBRUSH OFTEN

Patients with asthma and chronic obstructive airways disease who use inhaled steroids should renew their toothbrush regularly to reduce the risk of oral candidiasis. Colonised toothbrushes may act as a source of candidal re-infection, respiratory specialists have reported.

Research from Nottingham City Hospital studied 17 hospital patients who received inhaled steroids to see whether a toothbrush or the plastic inhaler body could act as a source for oral candidiasis. *Candida* was cultured in heavy growth from the toothbrush of six patients (35 percent), all of whom also had positive throat swab cultures. Five of the patients had a sore mouth. Only one inhaler body was infected.

Patients should be advised to rinse their mouth or brush their teeth after using inhaled steroids to reduce the risk of oral candidiasis. Such patients may sterilise their toothbrush (by rinsing in Milton) or use a new one if they developed a sore throat which lasted for more than one day.

Using a new toothbrush was probably preferable to sterilising as the latter did not guarantee removal of all fungal growth at the base of individual bristles, the researchers suggested

CAUTION ON STEROID DROPS

Patients receiving steroid eye-drops for more than three weeks should be referred to an ophthalmologist.

There has been a reported case of steroid induced glaucoma and cataracts (with irreversible visual loss) in a 47-year-old woman following unsupervised use of topical steroids. The patient had used betamethasone 0.1 percent eye-drops and dexamethasone 0.1 percent eye-drops three times daily over three years. The steroids had been prescribed by her general practitioner on a repeat prescription basis and had been started for the treatment of an uncomfortable eye.

The patient's intraocular pressure and visual acuity had not been monitored. Doctors say this case emphasises the dangers of the unsupervised and inappropriate use of topical steroids.

OTC CONTRACEPTION

With the increasing contraceptive options available over-the-counter, there is the need for full counselling and follow-up. Pharmacists must prepare themselves adequately to offer contraceptive counselling and advice on wider aspects of sexual health.

Pharmacists would have to liaise with general practitioners and family planning clinics so that further advice could be given to the patient on future contraception and on the action to take in the instances where a particular contraceptive method may not have worked. In this direction the Ghana Social Marketing Foundation (GSMF) must do more than marketing to ensure that their methods and others would be to the undisputed benefit of potential users.

CASH AND CARRY AFFECT PML MICE

When I spotted a fat mouse roaming leisurely and earlessly at the OPD of Princess Marie Louis Children's Hospital in Accra during one of my detailing rounds I literally screamed at my discovery thinking that this was a big one. But my nurse acquaintance was quick to inform me about what turned out to be an important revelation about the fall-outs of the Cash and Carry System of drug supplies in our public health institutions.

According to her, the mice which grew in population and sizes and were a popular sight some years back are suffering these days because of the Cash and Carry. I asked her why, and your response would not have been any different, I guess. I was told that in earlier times patients had access to good and abundant food and could afford left overs which served to fatten these fearless mice.

These rodents could even help themselves with dextrose drink as desserts "but now because of the cash and carry the patients find it difficult to buy their drugs and provide themselves with rich plentiful food enough to leave any scrums for the mice, so they (the mice) are also suffering in numbers and weight" she explained. That's for you to ponder.

Editor

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SKIN BLEACHING, DEPIGMENTATION, HYDROQUINONE & OTHER

BY JOHN ARTHUR MIDLAND PHARMACY LIMITED.

Skin bleaching is a cosmetic practice present in Ghana with delayed disfiguring skin reactions¹. It is interesting to note that while bleaching agents may be used therapeutically², the reason for their use is purely cosmetic as far as bleaching is concerned.

This kind of practice is common among those with lower education achievement³. However a general observation in the West African Sub-region as represented by Ghana & Nigeria, reveals that a lot more fairly well educated men and women have resorted to this kind of practice.

A group of 30 women who were randomly selected were interviewed on their views on bleaching. About 50% (15) of them did not see why women or men for that matter should bleach their skins. However, the other 50% (15) also had their views; in short they were of the opinion that it makes them look lovelier. Therefore the women were equally divided in their views. One thing however came up with the later group; to quote one of them "If my husband goes after "fair" complexion ladies; I have to look the same". Another had this to say: "It is because of you men that we bleach, so we can look attractive to you".

Another group of 30 men were also interviewed on their views on bleaching. Majority of the men 25 i.e., (83%) did not subscribe to bleaching at all; the remaining 5 (16%) did not find anything wrong with it. Ironically 5 (20%) of the former group were asked about their known* relationship with ladies who have bleached. They found nothing wrong if the lady is a girlfriend and not a wife. In other words if you are the wife no bleaching for you; if you are the girlfriend, there is nothing wrong with it.

The bleaching agents used were either

soaps and or creams. The soaps are usually 'Asepso', 'Crusader', 'Roberts', 'Neko', 'Medi-Soft' and 'Anago Soap', a local preparation made from burnt plantain peels and pounded with palm oil.

The predominant bleaching agent is however **HYDROQUINONE**. Incidentally hydroquinone is an ingredient in several film development formulations, e.g. metol-hydroquinone development film⁵. Hydroquinone is 1,4-Benzendiol, hydrochinonum. $C_6H_6O_2 = 110.1$. Hydroquinone may cause transient erythema and a mild burning sensation. High concentrations or prolonged use may produce hyperpigmentation especially in area of the skin exposed to sunlight. Occasionally hypersensitivity has occurred and some authorities recommend skin testing before use.

Alternatively, it may be suggested that the incorporation of sunscreens within the hydroquinone preparations would prevent the occurrence of such reactions¹, but as reported experience with such preparations has not been successful³.

Hydroquinone should not be applied to the abraded or sunburnt skin. It should not be used to bleach eye lashes or eyebrows and contact with the eyes should be avoided; as it may produce staining or corneal opacities. The systemic effect of hydroquinone and their treatment are similar to that of phenol, i.e. removal of the phenol contaminant; blotting off the excess phenol, washing of the skin with copious amount of water, then applying a vegetable oil. Macrofol 300 and eucalyptus oil have been used⁴.

In Great Britain the occupational exposure of hydroquinone is 2mg per m³ (long term) and 4mg per m³ (short term).

In the United States, the permissible and recommended limits are 2mg per m³ (long term) and 2mg per m³ (maximum, short term) respectively.

The incidence of exogenous onychosis is in a survey of black South African patients was found to be 15% in males and 42% in females with 69% of affected individuals admitting to using hydroquinone containing preparations⁵.

Addo H.A.1 reported incidence of morphological changes in subjects with bleached skin as follows:

<i>Colloid milia</i>	-	86.6% (31/35)
<i>Onychosis</i>	-	100% (35/35)
<i>Atrophy</i>	-	25.7% (9/35)
<i>Telangiectasia</i>	-	5.7% (2/35)
<i>Modules & Tumors</i>	-	8.6% (3/35)

This was considered to be more consistent with a toxic/side effect of a drug with a low therapeutic index rather than an idiosyncratic reaction. Onychosis usually becomes apparent after about six months application of hydroquinone and once established was irreversible.

Patients may initially use skin lighteners for cosmetic purposes but once onychosis develops they fall into the "Skin lightener trap" as they use other hydroquinone preparations to remove the disfigurement⁵. Reversible brown discoloration of the nails has also been reported following the use of skin lighteners containing hydroquinone⁶.

MECHANISM OF ACTION

Chemically induced depigmentation results from a selective melanocytotoxic action in functional melanocytes.

The potent depigmenters here are structures similar to tyrosine, which is probably relevant. The competitive inhibition of the enzyme tyrosinase has been suggested. These compounds are incorporated into melanogenic cell culture initiating lipid Peroxidation which is a chain reaction leading to the

destruction of lipoprotein membranes of the melanocytes and its subsequent death.

THE COUNT DOWN

The Sun is one of the most important factors that sustain life on earth, and many of our daily rhythms are dependent on the cycles of Sunlight.

The Sun is also one of the most potent carcinogens present in the environment.

To survive the insults of photons, humans have evolved a group of defence mechanism. These include Keratinization (thickening of the stratum corneum); production of melanin (the most important protective pigment in skin) and synthesis of urocanic acid (an absorber of UV).

The dietary carotenoids also provide some protection by absorbing the visible region and quenching singlet oxygen and various active radical species. The protective mechanism evolved against the detrimental effects of the sun are in a growing number of cases inadequate due to modern life styles⁷.

As pharmacists we must continue to educate our people on the dangers and hazards of skin bleaching.

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MALARIA TREATMENT - NEW DRUGS, NEW PROBLEMS

Dr. Geoff Gill of Walton Hospital and Liverpool School of Tropical School of Tropical Medicine, UK discusses drug problems in Malaria treatment.

A lot is happening on the malaria scene at present. Firstly, the search for new drugs effective against chloroquine-resistant malaria continues. The latest is pyronaridine, trials of which have recently been reported. Pyronaridine has been used in China for some time, and appears effective, well-tolerated and relatively inexpensive. A trial from Cameroon compared it with chloroquine in which 81 patients were treated with chloroquine 25mg/kg orally for three days, and 40 patients with pyronaridine 32mg/kg also orally for three days. The patients were followed for 14 days, and parasite clearance from the blood was 44% for chloroquine and 100% for pyronaridine. Looking at the pyronaridine group in more detail, they were all afebrile by day three, and parasitaemia cleared in all by day four. No significant side-effects were noted.

This all looks very promising. To be fair, the trial was perhaps a little biased in that the comparative drug with pyronaridine was chloroquine - now notoriously ineffective in Africa. Perhaps mefloquine or Fansidar (pyrimethamine-sulfadoxine) would have been more realistic, though these preparations are extremely expensive. Despite these quibbles, pyronaridine comes out very well and larger trials are eagerly awaited. In particular, experience will need to be much greater, to be sure there are no adverse effects. One is reminded here of the situation with amodiaquine - a very cheap and effective antimalarial, but one whose serious bone marrow and liver side-effects did not become apparent until experience was greatly widened from initial clinical trials.

The question of antimalarial drug side-effects has been raised by the media in Britain recently. Potentially severe neuropsychiatric side-effects of mefloquine have been known for some time, but have been thought to be rare. Mefloquine, has become generally adopted as the recommended malarial

prophylactic drug for most of Africa. Reports of side-effects on television and in newspapers have, therefore, caused considerable disquiet, especially as it became apparent that at least some leading UK tropical physicians would not themselves use mefloquine for prophylaxis, preferring the more traditional regime of chloroquine and proguanil. The problem is one of weighing up benefits and risks; the occurrence of mefloquine-induced neuropsychiatric side-effects is generally thought to be low. Estimates include 1:20 000, 1:15 000, 1:13 000, 1:10 000 and 1:6 000 travellers. Part of this variation may be due to greatly varying duration of tropical exposure (and hence mefloquine treatment). Though mefloquine side-effects seem to be uncommon, when they occur they can be severe. Perhaps this drug achieved its status as "UK favourite" prophylactic rather too soon and too uncritically. As for myself, I have always taken chloroquine and proguanil, and for the present I will continue to do so!

Two final brief items on the malaria scene should be mentioned. London workers have described a case of what they believe is "needlestick malaria". The patient was a health care worker in the UK who had no relevant foreign travel, and fell ill with proven P.falciparum malaria (successfully treated). Ten days prior to presentation he had been involved in the resuscitation of an African child with falciparum malaria and had sustained a definite needlestick injury with a needle contaminated with the child's blood. The second report concerns American workers who have reported malaria in a non-endemic area, contracted by unusual modes of spread. The three New York cases of falciparum malaria appeared to have been caught from local anopheline mosquitoes which had presumably fed on infected hosts. As far as possible 'harbour' and 'airport' malaria was excluded. These two reports serve to remind us just how clever the Plasmodium parasite is!



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ROUND THE GLOBE

GREAT BRITAIN Negotiations of a merger between the two pharmaceutical giants GlaxoWellcome and SmithKline Beecham have been called off. Had these negotiations been successful, the merger company would have been the second largest company in the world after General Electric. According to SmithKline Beecham, the merger plans failed because of disagreements on director level second to the two top bosses Jan Leschly and Sir Sykes, who already were in agreement. SKB, the two now look for another partner to merge with and will possibly begin re-negotiating with American Home Products.

GREAT BRITAIN The use of drug combinations has been a watershed for HIV therapy. Trials have demonstrated results never previously achieved in this area and have all but ended the era of monotherapy. Such progress has been integral to the optimism that AIDS may ultimately become a manageable disease. According to new report by Datamonitor the market for anti-HIV drugs is currently worth USD 2,500 million and is predicted to be in excess of USD 5 billion by 2005.

FINLAND The International Pharmaceutical Students' Federation (IPSF) and the Pharmaceutical Students in Finland (PsiF) will co-host the 44th IPSF Congress in Helsinki, Finland from 16 - 25 August 1998. The programme includes a symposium on 'The role of the pharmacist in self-care and self-medication' and various workshops. Approximately 160 pharmacy students and recent pharmacy graduates from around the world are expected to participate in this Congress. For further information contact: ipsf98@dlc.fi

CANADA An evaluation of the Continuing Education Programme arranged by the Community Pharmacy Section at the FIP Congress in Vancouver, Canada in 1997, received both positive and negative comments. For some participants, the programme exceeded their expectations and gave an interesting international view on Continuing Education. For others, the programme was not clear and included basic information. Suggestions have been made that this programme should be on a higher level.

PORTUGAL The Portuguese market serves a population of just under 10 million people, but it is the fastest growing market for self-medication products in Europe. A recent study by James Dudley Management and Compete, a Portuguese consultancy, shows that the market for non-prescription bound products is estimated at USD 194 million dollars in 1997, which is a growth of 351% since 1992.

USA A new vaccine designed to prevent cystitis in women, a major public health problem has proved effective in the laboratory and is promising say researchers. The vaccine is based on an 'adhesion', a sticky protein found at the end of each of the hair-like pili used by bacteria to attach to targets on host cells. This approach may represent a means of preventing recurrent and acute infections of the urogenital mucosa and it is hoped that the new technology will also help prevent other infections.

TREATMENT OF SCABIES

BY S.N. TENKORANG

Scabies is a condition caused by the 'itch' mite, *Sarcoptes scabiei hominis*, which most commonly affects children and is transmitted by direct contact. It causes an intensely pruritic linear eruption corresponding to the tracks of the burrowing beasts; the pruritus results in excoriation and secondary pyoderma, often located in the head and neck with sparing of the palmoplantar regions. It is a worrisome condition requiring competence in management.

Lindane 1% in a lotion basis, Malathion 0.5% in an aqueous/alcoholic basis and Permethrin 5% dermal cream are indicated for scabies. Lindane causes skin irritation and should be avoided during pregnancy or breast-feeding in young children, and in patients with low body-weight or a history of epilepsy.

Aqueous preparations are preferable to alcoholic lotions, which are not recommended owing to irritation of excoriated skin and the genitalia.

Older preparations include benzyl benzoate (25% in an emulsion basis) which is an irritant and should be avoided in children; monosultiram, which was liable to induce disultiram-like reactions with alcohol has been discontinued.

APPLICATION

Although acaricides have traditionally been applied after a hot bath, this is not necessary and there is not even evidence that a hot bath may increase absorption into the bloodstream, removing them from their site of action on the skin.

All members of the affected household should be treated. Treatment should be applied to the whole body paying particular attention to the webs of the fingers and toes and brushing lotion under the ends of the nails. It must be complemented by improved personal hygiene:

1. Bathe the person with soap, water and brush before applying the treatment;
2. the patient should put on clean clothes which have been washed, in boiling water if possible, and then ironed or dried in the sun;

3. bedding should similarly be washed and should be changed regularly to prevent re-infection. These measures are necessary to ensure complete treatment of scabies.

In the case of infants and young children (up to the age of about 2 years) application should be extended to the scalp, neck, face and ears. Application may also need to be extended to the scalp, neck, face and ears in the elderly, immuno-compromised and those who have experienced treatment failure. Providing application is done properly, lindane, malathion and permethrin need only be applied once; in the case of benzylbenzoate (effective, but not a first - choice) up to three applications on consecutive days may be needed - apply 25% application of benzyl benzoate over the whole body; repeat without bathing on the following day and wash off 24 hours later. It should be noted that dilution of this application to reduce irritant effect also reduces its efficacy.

It is important to warn users of scabies applications not to wash their hands, since this will require reapplication. Patients with hyperkeratotic (crusted or 'Norwegian') scabies may require two or three applications of acaricide on consecutive days to ensure that enough penetrates the skin crusts to kill all the mites

ITCHING

The itching of scabies persists for some weeks after the infestation has been eliminated and antipruritic treatment may be required. Application of crotamiton (Eurax) can be used to control itching after treatment with more effective acaricides, but caution is necessary in its use near the eyes and broken skin - calamine is probably more suitable. Oral administration of a sedative antihistamine at night may also be useful. w

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Calcium channel blocker safety - the debate continues

Recent, favourable results from studies of calcium channel blockers have moved some way to counter the negative image of the drugs' safety, researchers suggested at the congress.

On such trial, the **SYST-EUR** study examined the effects of the calcium channel blocker nitrendipine in the prevention of stroke in 4,695 elderly patients with isolated systolic hypertension. The trial, which included nine UK centres, was halted early because of a significant reduction (42 per cent) in the number of strokes in treated patients.

There was also a downward trend in the number of adverse cardiac events (eg, myocardial infarction) and in cardiovascular mortality. All cause mortality was not significantly lower. There was no difference in the number of cancer cases.

When asked at a Bayer press briefing whether the results would "end the safety debate" on the calcium channel blockers, Professor Lawrence Ramsay (Royal Hallamshire hospital, Sheffield) said that the trial "*will not completely end the debate, but it does provide some answers*".

It was not a new thing, he said, for a widely used drug to be "attacked". The **SYST-EUR** trial at least went some way to providing a similar quality of evidence on the safety of these drugs as, for example, was available for the beta-blockers, he suggested.

The trial provided valuable safety data, probably transferable to a class effect. This should allay concerns when calcium channel blockers needed to be used, he said.

The safety of calcium channel blockers was the subject of presentations made by several other groups of researchers. Two groups discussed suspicions that there was a risk of cancer associated with the agents.

In a 10-year follow-up study of 4,808 patients after myocardial infarction, a group from the Neufeld Cardiac Research institute in Israel found no evidence of an increased risk of cancer from nifedipine. Some of the patients monitored were included in the Sprint study, in which 1,606 patients (out of 2,138) received nifedipine for one year. After 10 years deaths directly related to cancer were seen in 3.7 per cent of nifedipine patients compared with 4.3 per cent in the placebo group.

A second study, led by the Danish Cancer Society, failed to find any indication of an excess risk of cancer among 17,911 patients who had received at least one prescription for a calcium channel blocker.

The authors of the study acknowledged that the reassuring result might have arisen from the short period of follow up; continued monitoring is planned.

A third group, led by Dr William Boden, (SUNY health science centre, Syracuse, New York) found that use of heart rate lowering calcium channel blockers (eg, diltiazem, verapamil) was not associated with increased cardiac death or non-fatal myocardial infarction in 5,677 post-infarction patients. *PJ*

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OUR PRESCRIBING & DISPENSING HABITS

In dispensing, supply or sale of drugs the pharmacist acknowledges two major classes:

- I Prescription drugs and
- II Over the Counter (OTC) drugs.

Drugs in the first category are dispensed or supplied on valid prescription. For the sake of us all here but especially the doctors, I shall remind you what a valid prescription is under Section 22(2) of the Pharmacy and Drugs Act 1991 (Act 64) as this area seems to be the problem area between doctors and pharmacists

VALID PRESCRIPTION

Must have:-

- i. the usual signature of the prescriber
- ii. the date on which the prescription is given
- iii. the name, qualification and address of the prescriber
- iv. the name and address of the patient and if for veterinary treatment, the name and address of the person whom the drug prescribed is to be delivered
- v. if given by a dentist the words "for dental treatment only" or if given by a veterinary surgeon the words "for animal treatment only."
- vi. An indication of the total amount of the drug to be supplied and the dose to be taken except in the case of ointment, cream and liniments
- vii. The prescription must not have been previously dispensed fully.

The pharmacist is required by law to fill valid prescription in accordance with the directives given by the prescriber. If he detects an error in the prescription, his training enjoins him to contact the prescriber. There should be no attempt to cast doubt on the professional competence of the prescriber to the patient. May be by contacting the

prescriber you will know why a particular dosage was prescribed. The training of the pharmacist must also help him to determine the types of OTC products that a patient can safely take, taking into consideration drugs he is already taking, e.g. an asthmatic who wants to buy a cough suppressant etc.

Summary of dispensing responsibilities that we as pharmacists have towards patients and doctors are:-

A) PATIENTS

Interaction Guide:-

1. CONSIDER POSSIBLE DRUG INTERACTIONS

- Before recommending or dispensing any drug
- When control on long term medication changes
- When side effects seem out of proportion or unusual

2. ASK ABOUT OTHER MEDICATIONS

- Has a doctor already prescribed medication for the current complaint?
- Is the patient taking any medication for a chronic condition? E.g. hypertension, diabetes, asthma
- Is the patient taking any medication bought over the counter? E.g. painkillers, antacids, cough mixtures, laxatives, antihistamines. What effects have these on patient's current medications?

3. WHEN CO-DISPENSING 2(TWO) OR MORE DRUGS, CONSIDER

- Do the preparations contain similar active ingredients?
- Do doses need to be adjusted?
- Can interaction be avoided by adjusting time administration of various preparations?

- Do you need to alert patient to possible adverse reactions.

4. TYPES OF DRUG INTERACTIONS

- Additive - combined effect = sum of each drug alone
- Synergistic - combined effect sum of singles effect Potentiation

5. HOW THE DRUG SHOULD BE TAKEN OR ADMINISTERED

- Before meals, after meals, no alcohol, no smoking, at what hourly intervals? Avoid TDS, BD and QID as these can be confusing.

B) DOCTOR

- We must foster closer relation by being up to date with knowledge of drugs and fostering close co-operation as professional partners
- We must make available a range of as many prescription products to the doctor as possible so that doctors do not operate pharmacies in the clinics!
- We should advise on routes of administration oral, IV, IM, SC, etc and dosages.
- Side effects
- Help in patient monitoring (non-compliance or over dosages, side effects, and counselling)
- Drug interactions
- Cost effectiveness
- Types of products available, Inj, Susp., Tabs., Powders, Creams, Ointments
- We should arrange proper storage, packaging and labelling of drugs supplied.

The advise that we give doctors has a

Cont'd on page 33



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Cont'd from page 31

central elements i.e. KEEPING UP TO DATE with current knowledge in our profession. In the case of General Practice Pharmacist, who is in constant contact with the public and doctors prescriptions, he is duty bound to take reasonable care to warn customers of any potential dangers S/E, C/I and drug interactions arising from drugs they buy or take. There is also a special relationship between the pharmacist and customer. Reliance is placed upon the special skill and knowledge of the pharmacist when selling, prescribing or dispensing drugs. The law expects that he exercises that degree of competence which the average members of the profession is required to possess. He should be alert at all times when he is giving any drug to a patient, as drugs are poisons and not ordinary items of commerce. I quote two cases to illustrate this from The Pharmaceutical Journal.

CASE 1:

February 20th 1982 page 205 in a decision of the High Court of England A woman who suffered gangrene in both feet after receiving over dose of migril (ergotamine tartrate, cyclizene HCl, caffeine) prescribed for migraine, was awarded £100,000.00 damages the pharmacist admitted negligence and was punished with 45% of the damages awarded. The judge in making the award said the pharmacist should have found the doctor's error and queried the prescription with the prescriber.

CASE 2:

In another case 1988, Page 404 of the same journal, a diabetic patient went to his doctor for his regular prescription for inhaler and tablets. At the same time he was given a prescription for AMOXIL capsules for his chest infection. When he took the prescription to the pharmacy, the pharmacist misread the Amoxil as DAONIL and when the patient took the dispensed dose, he suffered irreversible brain damage. The Court awarded

£139,000.00 damages (75% against the pharmacist and 25% against the doctor).

The Judge, Mr. Justice Auld in awarding the damages against the pharmacist, said that even assuming that the prescription was unclear, the pharmacist should have been alerted by the fact that DAONIL was being recommended in the wrong dosage and quantity. It was not enough for the pharmacist to BLINDLY dispense drugs without giving thought to what he is doing! The Judge held that the doctor has a duty to his patient to write his prescription sufficiently legibly so as to reduce the likelihood of it being misread by a busy, careless Pharmacist. But the pharmacist was duty bound to give some thought to the prescription that he is dispensing. If there is ambiguity in the prescription he should not dispense the drugs without first satisfying himself that the drug is the correct one" Unquote.

In the light of this decisions and the trend which is emerging "Pharmacists must consistently and with good reason press for recognition as experts on drugs and medicines, and for the right to take a greater part in the health services. Every right has its correlative duty, and pharmacists, as they achieve greater recognition must expect the law (and doctors) to require from them a higher degree of skill, as they are probably more liable to actions for professional negligence."

If I have stimulated some interest by this presentation for further discussion, then I think it has been worth serving on this panel.

This paper was presented by Mr. H. K Abutiata, MD, Paracelsus Pharmacy & Mkt Co. Ltd and National Chairman of GPPA on the 5th November 1996 at the British Council Auditorium on the occasion of the Medical / Pharmaceutical Dialogue 1996 organised by Pharma Info Consult.

ESSENTIAL DRUG LISTS AND THE USE OF GENERIC DRUGS

HALF of world's population lacks access to essential drugs. Essential drugs are those most needed for the health care of the majority of the population. They should be available at all times in adequate amounts and in proper dosage forms.

From the practical experience of hospital therapeutic committees, and of countries like Mozambique and Sri Lanka, it has been established that concentrating on a selection of a few key drugs leads to better therapy, lower costs and easier management of drug storage and supply. The concept of essential drugs is fundamental to the rationalisation of limited financial resources for drug use, drug procurement and supply. In 1975, a report to the World Health Assembly noted that developing countries were wasting their limited resources on expensive drugs that were irrelevant to their main health problems. The Assembly requested WHO to implement the proposals of the report -in particular, to advise member states in the selection and procurement of low-cost, effective and safe essential drugs. The selection of essential drugs is one of the basic components of a national drug policy (NDP) whose main objective is to make safe, effective, low-cost drugs available and affordable to all and to ensure that drugs are of good quality and used rationally. Essential drugs are also among the eight components of PHC as adopted in the Alma Ata conference in 1978.

Drug Selection

Essentials drugs should be chosen on the basis of the actual health problems of each specific country. WHO issued the first model essential drugs list (EDL) in 1977. It is currently updated every two years by WHO's expert committee on the use of essential drugs. The purpose of the regular review is to keep pace with the development of useful new medicines and new information on existing substances. The model list is a guideline and serves as a starting point for individual countries, which should adjust it to local health needs. WHO suggested criteria for selecting essential drugs are: the pattern of the prevalent diseases, treatment facilities, training and experience of personnel, financial resources, genetic, demographic and environmental factors, efficacy, safety and quality of the drugs, their availability, their stability under anticipated conditions, and the relative cost-effectiveness of alternative treatments.

National EDLs are established and regularly updated by national committees of experts in PHC, public health, medicine, pharmacology, pharmacy and drug management. The selection process has three steps: identification of health problems, definition of standard treatments, and selection of drugs based on the selection process to increase their adherence to the list in drug procurement and prescribing practices. This involvement is achieved by requesting comments on the list developed by the national drug committee, and by discussing and adopting the list in a national workshop. For instance, the revision of the EDL in Kenya and Benin involved professionals from all levels of the health system including university teaching hospitals.

EDLs in Africa

The WHO Action Programmes on Essential Drugs (DAP) provides technical and financial support to many

member states to develop national drug policies and essential drugs lists. More than 100 countries have EDLs, including the 46 member states in WHO's African Region. The EDLs vary from a simple drug list to a more elaborate formulary or a standard treatment guide, which provides the name of each drug and information on its better and safer use. The EDL must reach, and should be used by, a large number of professionals to rationalise drug procurement, prescribing and dispensing practices. In Kenya for instance, the EDL is widely distributed and used for a wide range of purposes: public education and information, procurement prescribing and dispensing in the public sector, medical/paramedical education, in-service training of health professionals, preferential import duties and drug taxation, local production, pricing policies and drug donations. In most African countries the use of an EDL is limited to the public sector though the private sector is often encouraged to use the list, as in Tanzania. The effect of using EDLs should be measured. DAP has developed tools to monitor the impact of different components of national drug policies (NDPs) including drug selection and rational use.

The EDLs of most countries are established by the level of health care. The number of levels varies with the national health structure; for instance the essential drugs lists of Benin, Guinea, Kenya and Malawi have respectively five, three, seven and three levels. Lower levels of health care have a more limited range of drugs which their staff can safely prescribe.

Use of generic drug in Africa

Essential drugs lists should use international non-proprietary (generic) names for easy identification of active ingredients. International non-proprietary names (INNs) have been adopted by WHO to facilitate

communication among professionals at international level and to harmonise the activities of existing national nomenclature commissions. Prescribers should use INNs to avoid the confusion created by the existence of several names for the same product. Health professionals should be provided with a cross-index on non-proprietary and proprietary (brand) names in all essential drugs manuals.

Generic drugs are pharmaceutical products marketed under generic names after the product patent has expired. The trade marks do not expire and cannot be used by other manufacturers without licence or other arrangements. Pharmaceutical products can only be manufactured by other companies at the expiration of the patent period, until which time the innovators have the monopoly to exploit their invention either directly or through the activities of a licensee. Sometimes, during the patent period, the product is manufactured by other companies through licensing and other arrangements.) When the patent period has expired, the product can be marketed under three kinds of name: the original trade mark, the INN or generic name, and other commercial names given by other manufacturers (so-called 'branded generics'). Generic drugs are thus multi-source pharmaceutical products. The WHO expert committee on specifications for pharmaceutical equivalence and therapeutic equivalence. A generic drug may be pharmaceutically equivalent (same amount of the same active substance) to the original product, but in order to be interchangeable, it should be therapeutically equivalent.

The distinction between essential drugs and generics should be clarified. A drug under a generic name is not always an essential drug. To be an essential drug, a generic product should be included in the national EDL. Essential drugs are procured under either brand names or under generic names. Essential drugs procured under

under their generic names cost, in general, much less than the therapeutically equivalent brand drugs. In Africa, anglophone countries generally use more generics than francophone countries. The devaluation of the CFA by 50% in January 1994 has positively influenced the procurement of generics in Francophone African countries. Countries throughout Africa now base government procurement on EDLs using generic names, leading to competitive drug prices. The shift to use of generic drugs in Africa is increasing in both public and private sectors. However, promotional activities for branded drugs, low margins for generics, and negative public perception of the quality and packaging of generics, constitute crucial issues facing the introduction of generic drugs in the private sector, which represents 80% of drug market..

Policies favouring the use of generic drugs are being implemented throughout Africa as part of comprehensive national drug policies. These policies include: informational/educational activities for

prescribers, dispensers and consumers; generic procurement, prescribing and dispensing; generic substitution; the same margin for brands and generics; lower registration fees for generic essential drugs; specific registration procedures for generic drugs; and local production of generic essential drugs. In Tanzania, for instance, the minister of health has declared, 'All prescribing, purchasing, labelling and dispensing should be by generic names as far as possible'.

Quality Assurance.

The quality of all pharmaceutical products should be guaranteed. In order to ensure the quality of drugs moving in the pharmaceutical market in Africa, DAP provides technical and financial support to countries to strengthen their national quality assurance systems and national drug regulatory authorities. In addition, WHO recommends the use of its certification scheme which offers, to importing countries, information on the status of the product and of its manufacturer, the quality of individual

batches of exported pharmaceuticals and product information as approved by the exporting country. The use of the scheme and other quality assurance activities can contribute to the control of fake and substandard drugs.

Conclusion

The use of carefully selected effective, safe and good quality essential drugs under generic names, efficient drug management systems, rational prescribing/dispensing, and the implementation of sound national drug policies are key elements to ensuring the availability and the accessibility of essential drugs to all needy people in Africa.

The Ghana Pharmaceutical Journal is grateful to Dr. Vincent Habiyambere of WHO Action Programme on Essential Drugs, Geneva for this article. He was in the country as a facilitator during the consensus meeting on the draft National Drug Policy on 3rd to 4th March, 1998.

QUIZ

UPDATE YOUR KNOWLEDGE

It is suggested that you try to answer the following questions before checking with answers on page. (NB: In multiple choice questions more than one may be correct).

1. Which of the following drugs are contraindicated in pregnancy?
a. Penicillins b. tetracyclines c. thiazides d. methyllopa
2. Which of the following may cause vaginitis in females of reproductive age?
a. *N. gonorrhoeae* b. *T. vaginalis* c. *E. coli* d. *H. vaginalis*
3. *Trichomonas vaginalis* is
a. a protozoan b. a metazoan c. a flagellate d. a dinoflagellate
4. *Balantidium coli* normally live in
a. small rodents b. dogs c. cows d. pigs
5. *Hymenolepis diminuta* normally live in
a. cows b. small rodents c. pigs d. dogs
6. Which of the following drugs would not be likely to suppress lactation?
a. bromocriptine b. pyridoxine c. Amoloxin
d. chlorpromazine
7. In how many months might a normal fertile woman expect to become pregnancy after removal of an IUD?
a. 4 b. 8 c. 16 d. 24
8. Which of the following is not commonly responsible for septic complications in patients who have had a splenectomy?
a. *Strept.pneumoniae* b. *N.meningitidis*
c. *Ps.aeruginosa* d. *H. influenzae*
9. There is no advantage in giving steroids on alternate days if double the once-daily dose is used. True or False
10. Endogenous steroid secretions will be suppressed if more than 7.5mg prednisolone is given daily. True or False

KORLE - BU LAUNCHES MONTHLY BULLETIN

THE Korle-Bu Teaching Hospital Administration has launched a monthly bulletin to inform and educate staff as well as the general public about the operations of the hospital.

The bulletin will also provide a mouth piece for the staff and members of the general public to air their grievances and make suggestions towards improving the quality of services provided at the hospital.

Dr. Henry Holdbrook-Smith, Chief Executive of the Hospital, said in an interview that the bulletin, which will be distributed freely, will be circulated to the staff, especially nurses, who have greater contact with the public to keep them up-to-date with developments in all departments and the public expectation of them among others.

He said public institutions will also be supplied with copies in a bid to demystify some of the misconceptions held about the hospital in the hope that their staff and the public would be better informed about its operations and contribute meaningfully to its maintenance.

Dr. Holdbrook-Smith expressed the hope that many people will patronise and contribute to the bulletin so that it can be expanded.

The maiden edition carries publications about replacement work at the accident and emergency centres, installation of telephones, budget and management centres to man the various departments, new appointments at the hospital and on-going projects.

GHANA HEART FOUNDATION

APPEAL TO RAISE FUNDS TO SUPPORT THE NATIONAL CARDIOTHORACIC CENTRE (NCTC) KORLE-BU TEACHING HOSPITAL, ACCRA

The National Cardiothoracic Centre at Korle-Bu Teaching Hospital offers treatment for people suffering from heart, lung, and related diseases. The Centre is equipped with all the major medical equipment, instruments, laboratories and operating rooms and is manned by specialist men and women. It is comparable to the best health facility available anywhere in the world.

We are making an appeal to raise funds through the Ghana Heart Foundation to support the Centre so that it is maintained at the highest level of readiness and efficiency.

The NCTC has promised that if Ghanaians can contribute ₵200.00 a month regularly to the Ghana Heart Foundation, heart patients who cannot afford it would receive world class surgery free of all charges.

If you are so moved, and would want to make a donation, please obtain a form from the Ghana Heart Foundation, fill this Pledge Form and forward it to the Ghana Heart Foundation. You may pay your contribution to any Branch of the Ghana Commercial Bank and send a copy of the pay-in-slip to the Foundation through the Post (free of postage charges).

MAGNESIUM AND THE LUNG

A HIGH dietary intake of magnesium is associated with higher lung function, researchers in Nottingham have found.

At the British Thoracic Society's summer meeting on July 1, the researchers pointed out that magnesium was involved in many biological activities, including some that might protect against the development of asthma and chronic airflow obstruction.

In a randomised population sample of 2,633 adults with a mean daily dietary magnesium intake of

380mg/day, a 100mg/day higher magnesium intake was found to be associated with a higher force expiratory volume and a reduction in body hyper-reactivity and self-reported wheezing within the past 12 months (after adjustments had been made for age, sex and for the effects of atopy, total kilocalorie intake and smoking).

The researchers suggested that low magnesium intake might, therefore, be involved in aetiology of asthma and chronic obstructive airways disease.

THE JOURNAL WILL NOW BE PUBLISHED
REGULARLY EVERY QUARTERLY BEGINNING
WITH THIS ISSUE - IE MARCH,
JUNE, SEPTEMBER AND DECEMBER.

PROFESSIONAL BODIES AND CHANGING NATIONAL DEVELOPMENT DEMANDS

A PHARMACIST'S VIEW

INTRODUCTION

Mr. Chairman, I wish to believe that in choosing the theme for this AGM of GIP, our planners sought to define the role of professional bodies in national development.

This is because I observe that the objective of defending and promoting citizens rights as well as ensuring national development must be at the heart of every professional institute such as ours.

Having acquired the requisite advanced education and special training at the expense of our people and nation for that matter, it is only a matter of duty for us to live up to their expectations.

As professionals therefore we are poised towards the provision of training, research, technical assistance, information and documentation services.

The major implications of these services should be mapped out in strategic thinking and planning activities. These will lay the foundations for the viability and credibility of our professional bodies in the eyes of the civil society.

It is said that responsible fathers PLAN their families if this is true for the basic unit of society, then it should equally hold good for all aspects of social development.

Planning is virtually important for national development and I see professional bodies as engaged in helping to PLAN for systematic and constructive responses to the expectations and requirements of stakeholders in National development by assisting in providing a clear vision, mandate, structure and directions for development planning and management.

The diagram below is a schematic

representation of the major player in national development. If this is so, then the need for co-ordination of approaches by all involved cannot be over emphasised and the professional bodies should assume responsibility for ensuring this kind of co-ordination and collaboration.



STAKE HOLDERS IN NATIONAL DEVELOPMENT

NATIONAL DEVELOPMENT

National development, which imply increasing and improving the availability of goods, services and opportunities, depend no doubt, on the state of technological advancement and a commonly shared vision of good life in any country.

Following from this, the applicability or suitability of any development strategy must be mainly related to the way and manner available technology and its application ENHANCE the attainment of societal goals. When technology, its application and the cost of application, either become a constraint to or do not aid the attainment of such goals, it is then time for a re-consideration of existing development strategies.

Mr. Chairman when the above preamble is viewed against our present

circumstances as a nation, then it becomes quite evident that our nation is in dire need of alternative paths for development.

CHALLENGES

Population growth and Urbanisation with their attendant complex problems and implications for PUBLIC HEALTH, present a formidable challenge to modern development planning. The rate of population growth still outstrips the availability of resources, the distribution and access to wealth, the benefits of development including the provision of health care services are skewed towards the urban dweller. As a consequence, there is the unstoppable rural-urban migration, and the price we pay for neglecting the rural areas is the filth and environmental hazards we have to contend with in the cities.

Our major challenge is in the implementation of policies and programmes. This suffers greatly from lack of PRIORITY, limited funding and severe constraints of personnel and resources quality of development projects is another dimension to the challenges.

Programmes and services must of necessity be appropriate and acceptable to cater for needs and total involvement of stakeholders.

HEALTH PLANNING

Mr. Chairman Healthcare and what it stands for in Ghana these days is a big puzzle. This is because the question defies an easy and simple answer.

Almost everything being done to provide the health needs of the people seems to be falling apart. The health landscape is very frightening. In fact

healthcare in our part of the world is yet to evolve as part of a wide network of social and welfare improvement, including public infrastructure, housing, education and the like.

Our health systems cannot support the WHO targeted Health programme by the year 2000. Barely 2 years to the year 2000 Ghana's health edifice cannot submit to the outbreak of the diseases - Buruli ulcers, Guinea-worm, Yaws, TB, Malaria and not forgetting HIV/AIDS etc. the poor economic position of the country account for the pathetic dedication on the part of health authorities according to Lewis (1968) the basic reason why African countries remain poor is unquestionably because they lack knowledge. By this he meant that chosen direction were absent from the internal system the internal application of foreign technologies.

That the health sector could be oblivious of the existence of certain diseases in certain parts of the country ('93 Buruli Ulcer in Tontokrom - Amansie West District of Ashanti; Buruli Ulcer has been reported in certain parts of the Greater Accra and Central Regions for some years now) is seen as an indictment on the country's health system.

The fact is, contrary to widespread panic among Ghanaians about the debilitating and deforming nature of the disease, unlike AIDS for which no cure has been found yet, Buruli Ulcer can be managed if the medical profession is provided with the necessary resources. Deficiencies in health planning monitoring and evaluation against the backdrop of our scarce national resources cannot be permitted.

PRIMARY HEALTH CARE INITIATIVES (PHC)

PHC, which is an WHO initiative, seeks to provide health care that is affordable, accessible and acceptable to our people and also involve their participation. The obvious outcome of this approach is government's efforts at providing adequate healthcare centres, but these

facilities are ill-equipped to provide the necessary service and encourage our people to seek medical care in their own localities.

PHARMACEUTICAL SERVICES

Mr. Chairman, the need to improve quality as well as distribution of pharmaceutical services in the country has long been identified; and as far back as 1986, the task of extending qualified pharmaceutical services to the rural areas was the focus of the AGM of the Pharmaceutical society of Ghana held in Koforidua that year. Among the steps initiated jointly by the ministry of Health/pharmacy Council / Pharmaceutical Society of Ghana towards the Health institutions are:

- a) "Cash and Carry" system of drug supply
- b) In-house production of some medicines
- c) Quality control measures at CEPS, medical stores, Pharmacy Council
- d) Pharmacare concepts - patient oriented care; clinical pharmacy
- e) Rural Care approaches emphasised - re - distribution of facilities (Pharmacies, Chemical Sellar Shops and other health facilities)
- f) Legislation: food and Drugs Law 1992 (PNDC 305B) and Pharmacy ACT 1994 (ACT 489)
- g) Herbal Medicine Control.
- h) Health Education and Promotion.

Others:

- 1) initiatives - Control and proper management Malaria, Malnutrition, Infections (also STD, HIV/AIDS, Substance/Drug Abuse and misuse)
- 2) family Planning Services
- 3) Iodization of Salt, etc.

FINANCING HEALTH CARE DELIVERY

Health Insurance Schemes, under consideration.

Revolving Drug Fund (Cash & Carry)

OTHER SUGGESTIONS:

- a) Money following patients (financial incentives provided to patients and Regional Hospitals to use/apply primary care facilities appropriately)
- b) Contracts (Health Services purchased as a product by local authorities e.g District Assemblies)

National Drug Policy - A health care development initiative. In attempting to ensure the availability of essential drugs to the populations as one of the major approaches to the development of the health services, the MOH has initiated the formulation of a National Drug policy a draft is currently in circulation for study.

The manifold problems plaguing the health sector include the following:

- a) the increasing cost of drugs and medical supplies with the expanding provision of health services leading to significant increased constraint on the overall health budget.
- b) Lack of qualified and experienced management and technical personnel, inadequate supply management procedures, unsuitable and insufficient distribution and storage facilities, often resulting in increased procurement cost and losses.
- c) Poor patient management practices including diagnosis, prescribing and dispensing resulting in irrational drug use,
- d) Inadequate manpower requirements and lack of systematic and continuing in-service training or refresher and upgrading courses coupled with inadequate reference and learning materials for various areas of drug utilisation sectors of the healthcare delivery leading to low staff morale and inefficiency.
- e) Lack of the machinery and regulation to ensure adequate enforcement of

legislation to control drug manufacture, distribution and use resulting in poor compliance with the laws. Recognising these problems, the MOH in consultations with all health professionals of Ghana has taken a number of steps in an attempt to solve them.

These include:

- 1) the publication and distribution of a National Essential Drugs list and Formulary with therapeutic guidelines for use at all levels of the healthcare system. The organisation of various workshops and meetings on rational drug use for all levels of healthcare practitioners.
- 2) The present process to develop a 5 year Ghana National Drug Programme.
- 3) The promulgation of the Food & Drugs Law 1992 and the Pharmacy Act, 1994 which have provided the legal instruments for control of Pharmaceutical activities in the country (food, cosmetics, herbal medicines inclusive).

Already some components of the drug policy are in place and are operational and efforts are being made to set up additional structures for the other components to make it complete. The Ministry of Health has therefore put in place the drug policy document to ensure better co-ordination and to serve as a reference guide for all future national pharmaceutical developments.

The various elements examined in the drug policy include legislation and regulatory control, local manufacture, therapeutic needs, herbal medicines/drug registration selection of essential drugs, quantification of drug requirements, drug supply management, quality assurance, co-ordination, technical co-operation and policy monitoring and evaluation.

All this is aimed at identifying and developing necessary strategies to accomplish the required objectives

against the backdrop of available resources, potential of drugs in disease management and the socio-economic environment.

CONCLUSION

Mr. Chairman, the status and mood of the majority of our people is that of despair and great responsibility rests on our shoulders as professionals to help turn their fortunes around. One of the major strategic thrusts in achieving desirable goals in being responsive to changing development demands is CAPACITY BUILDING for effective national development programmes.

In this direction we are expected to:-

- be proactive as professional bodies
- strengthen co-operation and business relations with public, collaborators and sponsors for better strategic and development planning, contracting, feedback and evaluation.
- Develop and institutionalise continuous quality improvement and monitoring, evaluation and feedback systems to support development and improvement of high quality products and services.
- Develop and strengthen mutually beneficial collaborative agreements, coalitions, endorsements and memoranda of understanding to reinforce and build a unified approach to problem-solving.

This paper was presented on the 28/11/97 by SAM N. TENKORANG at the Ghana Institute of Planners Annual General Meeting/Workshop,

Theme: "CITIZENS RIGHTS & NATIONAL DEVELOPMENTS" 27 - 28 November, 1997 At Wangara Hotel, Accra.

CALENDER

LAPAG MONTHLY MEETINGS

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Dates: April 6-8, 1998

Venue: New Orleans, LA, USA.

OUTCOME FROM : FIP CONGRESS AND CONFERENCES ANDRIES BICKERWEG 5, 2517 JP THE HAGUE, THE NETHERLANDS.

STD MANAGEMENT TRAINING FOR PHARMACISTS

The West African Project to Combat AIDS is pleased to announce the following dates for pharmacists in Accra - Tema for 1998.

April 14th
May 12th
June 23rd
July 28th
August 13th
September 29th
October 1st
November 24th
December 10th

Venue: Videomart Ltd. at Ringway Estate, Accra
Time: 9.30 - 4.30 pm

Please call us on Tel. No. 241452 to confirm the date of your participation if you have not as yet received the training. It is important that your notice of participation is received early to enable the project make adequate preparation for all participants.

FIP -BPP CONFERENCE ON SUBSTITUTION

Rome, Italy 10-12 June, 1998

FOR OUTCOME CONTACT THE SECRETARIAT OF THE GHANA PHARMACEUTICAL SOCIETY, ACCRA. OR WRITE TO FIP CONGRESSES AND CONFERENCES Andries Bickerweg 5, 2517 JP THE HAGUE, The Netherlands.

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PHARMACY WORLD CONGRESS, 58TH INTERNATIONAL CONGRESS OF FIP

Dates: August 30 - 4 September, 1998.
Venue: The Hague, The Netherlands.

PUBLIC HEALTH AND THE PHARMACIST

Prof. S. Ofosu-Amaah

School of Public Health, University of Ghana, Legon

INTRODUCTION

Public health is the study of factors affecting the health of communities and of measures for reducing the disease burden. Fraser Brockington put it very succinctly as "The application of scientific and medical knowledge to the protection and improvement of the health of the group". (B) it is a body of knowledge and a set of technologies with the objective of sustaining or even optimising man's well being the term public health is used in several different senses these include the notions that public health is

1. The equivalent to governmental or public sector health services, sometimes this is broadened to include actions by the community;
2. "Non-personal" services, eg. Sanitation and water supply; often expanded to include preventive services for vulnerable groups such as for children and women in MCH, Immunisation, and family planning programmes.
3. There is also the concept of "public health problems", referring to dangerous disease problems usually of an epidemic nature, eg. HIV/AIDS, "Drugs", pollution, etc.

DEFINING PUBLIC HEALTH

The field and the scope of public health are linked "population" or "community" as in the first definitions quoted the population is its reference point for analysis. Its tools are epidemiology, social science and the study and management of "patients" with a disease problem.

In public health the focus is on the "population at risk", or the denominator in the health equation in this sense

therefore simplistically clinical medicine is the study or analysis of the "numerator" or of the individuals on the population who actually are suffering from a disease hence "patients" it should be obvious that in attempting to understand the health of man, the logical connection between the numerator and the denominator is not forgotten in summary one could envisage analysis and programme responses in human health within the following framework:

1. Molecular/sub-molecular levels/individual:- *Clinical medicine*
2. Population:- *Epidemiology*

it is therefore the reference point for analysis that leads either to clinical medicine or to public health. Human well being is indivisible and we curtail progress by not comprehending this fact K White lamented in his book - "Healing the schism -epidemiology, medicine and the public's health" on what he thought was the serious dichotomy between clinical medicine and public health if this dichotomy is real one could be concerned that Pharmacy might be tempted to be on the clinical side. Fortunately the theme for this 44th Annual meeting of the Pharmaceutical Association, "The Pharmacist in Health Education and Health Promotion" is a good indication that this association does not see the "schism"

Public health concerns itself very much with the measurement of health or more correctly the absence of health using measures such as in morbidity and mortality rates such as Crude Mortality, infant Mortality, Maternal Mortality rates, life expectancy, incidence and prevalence the newer conceptualisation of health is the estimation of the burden

or DALYS. This measure aggregates years of life lost due to all diseases that might lead to immediate fatality or to disability either short term or of long duration. It is estimated that the global burden of disease is highest in sub-Saharan Africa in 1991 it was estimated that sub-Saharan Africa lost 574 DALYS per 1,000 of the population, whereas the industrial countries lost only 117 DALYS; in other words our burden of disease is five times as great.

The prevention of disease is classically regarded as Primary or Secondary Prevention.

1. **Primary Prevention** - which includes health promotion, improving water supply, health education, interventions such as immunisation, prophylaxes against malaria or pregnancy (family planning) etc; technologies to ensure the non-occurrence of disease.
2. **Secondary Prevention** - which attempts to arrest the progression of disease through curative means and other forms of management. Pharmacy obviously has a role in both areas, although the discipline might see its key role in curative efforts.

THE METHODS OF PUBLIC HEALTH

The major tool for the study of public health is Epidemiology; that is the use of scientific method for understanding the occurrence of disease in populations linked to it are the tools of the social and behavioural sciences. Epidemiology established logical links between patients with diseases and the susceptible population it often points to the area from which the "cause" of disease can be determined. It uses descriptive, analytic

and experimental methods, in arriving at its conclusions or inferences, upon which programmes can be designed. Epidemiology is a precise science and depends upon measurement hence its twin sister - biostatistics the concepts of sampling, probability, relative risk, odds ratio and hypothesis testing are very much at the heart of the discipline. Public health also relies upon the social sciences and on the science of human behaviour, the management of resources, the concept of concept of cost-effectiveness etc.

These methods can be and should be applied to any aspect of health and the health system, and most certainly to the field of pharmacy.

RE-DEFINING THE FIELD OF PHARMACY

Drugs are defined as the chemicals and biological substances used in health practice. Could one be permitted to extend "health" to include the well-being of animals and plants, useful to man? This immediately enlarges the scope of those like you whose expertise is drugs. Could one therefore include in the definition of "drugs" substances such as domestic, agro - and industrial chemicals that without a doubt effect human health, especially when used with little understanding? What about radiation? Who will study these areas in a country with very few scientists working on the environment and chemicals?

This is my point about the inevitable extension of the role of the profession of pharmacy in Ghana the Promotion of health the mobilisation of communities and their interaction with some of the most powerful chemicals and biologicals ever devised y man are matters of concern in real sense there is a crisis in Ghana, not only about the cost and availability of drugs and their rational use but also about the beliefs, attitudes and behaviour of communities.

You are the best trained of all the health professions to understand these substances your scientific allies and few indeed, and therefore have to fulfil more needs than in countries that has a good

supply of trained personal in fields allied to your profession. My suggestion therefore is a new appraisal of the role of pharmacy in public health, and to suggest a much more inclusive set of concerns not only with drugs and biological. The plea is for a expansion of the role of pharmacy in the national efforts to reduce and burden of disease in Ghana.

THE "EPIDEMIOLOGICAL SITUATION".

The population of Ghana has a large proportion of illiterates, 30% of men and 40% of women. This also implies that these illiterates and even some who can read are pre-scientific in their way of life. It is really hard to live a scientifically based life in many of our communities: Unfortunately the powerful chemicals and substances of modern living are fairly easily within their reach.

The resultant problems are many and worrying.

a. Therapeutic Substances

There is the lack of understanding of the basis of drug chemistry and action. Yet their disease burden is great and so is their need for drugs and for treatment. They cannot read and understand labels. Their understanding of the concept of dosage is likely to be "the more potent the better". This stems from a prior culture of herbal use side effects are not recognised or even "welcomed", as a sign that the drug is effective.

Unless well instructed, their tendency would be to use drugs inappropriately and possible fail to comply with hurriedly given instructions shelf life concept not understood, and most unfortunately poverty might restrict quantity purchased.

b. Other Chemicals

There is ready access to other chemicals especially in agriculture/fishing, "galamsey" mining, "battery harvesting". Mishandling of common chemicals -woodwork, minor technical work in workshops and in households.

Dangerous storage of household chemicals in inappropriate containers.

- c. There is an increasing use of Recreational and habit forming drugs/chemicals
- d. The pharmaceutical system has obviously many problems, that this meeting I am sure will address. I am discouraged by the laxity in the observance of the regulation. There recording of drugs dispensed seem very relaxed. When drugs are dispensed there are usually no lot numbers, not dates of manufacture, expired drugs and patients usually do not receive all the information that they need I believe that things were better in the 1960s.

These observations are striking because I have been impressed in the past few years by the rigour of the adherence to regulations in the United States.

SUGGESTIONS

The problems enumerated above call for some urgent action; but one individual's observations or mere anecdote are not a sufficient basis for public policy formulation the need for careful, population based research on drugs and chemicals and their uses by Ghanaians with the objective of enhancing health and well-being is abundantly clear the rational use of drugs has been recognised as a problem everywhere. All I am suggesting is the broadening of the concept of "drugs".

There is an urgent need for members of the pharmacy profession to learn and to use public health methods to the problems enumerated above-epidemiological, social and behavioural science methods this I believe will enhance the expertise of the profession in population base research.

The key suggestions would be that:-

- a. Pharmacists in training should have their studies emphasise knowledge about all the substances that either enhance man's health or reduce it in our environment, they should also be introduced to public health techniques and concepts of surveillance and research.

b. Some pharmacists should choose to train in public health. It is good to state that your president has been very keen on this. Last year the school trained one pharmacist at the MPH level this year we have just admitted two pharmacists to the new MPH class. I hope is that they will enrich the field of pharmacy with the training that they will get from school.

c. As the School of Public Health at Legon expands and its faculty is enlarged it should be possible to arrange for part time teaching for busy practitioners.

As the profession increases its appreciation of public health in relation to pharmacy, we expect that this field will attract the coming generation of pharmacists to be trained and to join in the training of other health professions, and in the dissemination of knowledge and in the refinement of public policy.

Might one suggest that the Association sets up a small group to fully examine your strategies in research, in training and dealing with some of these issues of major national concern. This association is best placed to do this. I am sure experts in the field of public health will be eager to work with your association with you long history and dedication to improving health in this country I am certain you will rise to the challenge.

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The Gold Coast Motors Limited has made an offer to supply cars for Pharmacists under a special finance and supply arrangement.

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The Finance package includes a **minimum of 15% down payment with the balance paid in 36 - 60** equal monthly instalments. Payments will be in the local currency at the rate of exchange prevailing on the date of payment.

All pharmacists willing to take advantage of this attractive and exclusive offer should contact the PSGh Secretariat for details.



THE PHARMACEUTICAL SOCIETY OF GHANA

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6. Mr. F. Aboagye-Nyame	"

NOTE

The Pharmaceutical Society of Ghana regards all bodies in the country charged with various responsibilities associated with pharmaceutical activities and concerns as her AFFILIATES.

These bodies hold vital offices and news items that are of interest to all pharmacists.

The Society requests that the heads of such affiliated bodies/offices releases on regular basis to the Secretariat their programmes and new items for publication in the Ghana Pharmaceutical Journal every quarterly (**March, June, September, December**) for the wider information of all pharmacists. The following are particularly to take due notice: All regional Branches of PSGH,

- INDUSTRIAL PHARMACISTS ASSOCIATION
- LAPAG
- AREPI
- GPPA
- FACULTY OF PHARMACY
- GHOSPA
- NATIONAL DRUG COMMITTEE
- WAPF
- FOOD AND DRUGS BOARD
- PHARMACY COUNCIL
- MOH-PHARMACY DIVISION
- ETC.

All must Co-operate to improve reader interest for the GHANA PHARMACEUTICAL JOURNAL.

PEOPLE + ACTION + READER INTEREST = NEWS

We are the people in action. Report the News promptly, and we the people will read and the Journal will endure.

PUBLICATION OF THE GHANA
PHARMACEUTICAL JOURNAL.
ANNUAL REWARD FOR
CONTRIBUTORS.
COUNCIL DECIDED TO REWARD
ANNUALLY, PERSONS WHO
CONTRIBUTE ARTICLES TO THE
GHANA PHARMACEUTICAL JOURNAL

NEW APPOINTMENTS

The National Council has made the following appointments at the Society's secretariat:

1. Mr. Dominic Owusu-Sekyere - BA, LLB (London), BL as Counsel for the Society on retainer basis.
2. Mr. William Abaka Mensah - Dip Business Studies as Accounts Officer.

PERSONAL

This column is intended for social announcements. The charge for an insertion under the heading is \$50,000.00 for not more than 25 words, and \$25,000.00 for every additional 10 or few words. Payment (in the form of personal cheques only, payable "The Pharmaceutical Society of Ghana") should be forwarded with the notice, which should be authenticated by the name and address of the sender, to: **The Editor, The Ghana Pharmaceutical Journal, P.O. Box 2133, Accra, Ghana.**



LETTERS TO THE EDITOR

Opening & Closing Prayers

Dear Sir,

I wish to congratulate you on your election to the highly esteemed office of the Editor of The Ghana Pharmaceutical Journal.

Once again, I would be very grateful to be allowed some space on our mouth piece, the journal for a view regarding the above topic.

I have observed that opening/closing prayers at all meetings within the Society, are said by Christians only. The probable reason I sometimes settle with is the fact that the PSGH is dominated by Christians. Well, you may correct me if the observations is wrong, but for how long can this be a burden if not exposed to all concerned.

Undisputedly, PSGH like all societies other than religious ones in interdenominational and includes Christians, Moslems, Buddhists, African Traditional Religion, Resocruicians, Lamists etc., and only little is know about the members but Christians. It is also well known that these groups have their own DOCTRINAL way of praying, which may not be shown in public or open to all.

One would wish to see a member of any so such groups where applicable, at a time or the other say prayers at meetings. Hopefully, these expressions should neither construe ANTI-CHRISTIAN sentiments nor smack of FUNDAMENTALISM, but rather viewed as an attempt to inform if not remind ourselves of the importance of acknowledging religious groupsother than Christians within the Society.

The modern and tolerable societal adoption all over world interdenominational gatherings is "ASKING ALL PRESENT/GATHERED TO OBSERVE A MINUTE'S SILENCE IN PRAYER WITHIN ONE'S FAITH". This approach has been considered a more collective way of thinking and living a "family" within societies.

I strongly uphold this way of living and thinking in the interest of principles of freedom of worship maintaining diverse interests of members, thereby enhancing the PSGH "family" concept.

One hopes that, this view is shared by all, especially those who are working hard in diverse ways to keep the unity in the Society into the next century, those who cherish family concept of societies in general and PSGH in particular and indeed all members as "brothers".

Francis Akakpo
ACCRA.

EDITOR'S NOTE

It is not a philosophy of PSGH to so order meetings as to subordinate any religious faith or their faithfuls for that matter. We remain one united and solid

Reading The Journal

Dear Sir,

Officialdom is clearly concerned about the poor patronage accorded by members of the Society to the Journal in terms of readership and contributions of articles.

It is definitely good to read, but reading may have to be facilitated and encouraged to be made easier/attractive. Research shows the most effective way to increase the amount of responsive undertaken by any group of people is to improve the available materials which interests them. It is against this background that I think it will be worth the Society's while to improve the general content and quality of the Journal at whatever cost; and I was pleased to hear the new Editor talk about introducing variety to promote reader interest during his electioneering message.

The journal must be published on schedule and its materials must enjoy readership, supported by good contributions to meet the objectives for setting up the organ.

Benedicta Nana Ama Asafu-Adjaye (Mrs.)

Expiry Date

Dear Editor,

The fact that most drugs do not suddenly become ineffective or toxic on their expiry date is generally accepted.

It is common knowledge that for several reasons some drugs are used months after their expiry date with the claim that they were still effective.

However it would be unethical to administer such drugs to patients (without due expiry proof of efficacy/safety unless they were informed).

It may be true that drug manufacturers use expiry dates to promote sales and to enable their products to be marketed promptly but the fact remains that after their expiry date some drugs are ineffective and/or toxic. The use of expired drugs should therefore not be encouraged, the practice is as bad if not worse as administering fake or substandard products.

Obeng Paul K.

ARE YOU A PAID UP MEMBER? PAY YOUR RETENTION FEES TO SUPPORT THE SOCIETY.

INTERNET BLUES

THE GANG IS GREEN

During my first six months as a student nurse, we didn't know very much about anything yet. The senior students would amuse themselves by sending us nurses on all sorts of fool errands. On one such occasion, my friend and I were sent to get fallopian tubes from the men's medical ward. Needless to say everybody had a good laugh.

LIZ

The Self-Diagnosis of Sanity

One busy evening as an RN on a psych ward, one of our patients came rushing up to the nursing station. He grabbed the counter with both hands and loudly declared, "I'M CURED! I am ready to go home!" One of doctors inquired, "What makes you feel you are ready to go home?" The patient looked straight at him and said, "I'm no longer mentally deaf! I'm hearing voices!"

MARY

BIRTH CONTROL SOUTH OF THE MASON DIXON LINE

Being a pharmacist, we hear intimate details of our patients' lives on a daily basis. One evening, a lady approached the counter and said she needed help with choosing a birth control method. The pharmacist asked her what method she had used in the past and she said, "Oh, we've been using the rhythm section for the past year, but I'm afraid it won't work." We kept our composure until she left, but we could just visualize the couple next to a band (the rhythm section).

Anonymous

A True Stamp of Approval

Years ago, a young woman was hurrying to get ready for her OB/Gyn appointment. She made a habit of always using the restroom before the visit to empty her bladder. When she was in the bathroom stall, she realized that there was no toilet paper.

So, since she was in a hurry, she grabbed in her purse for a tissue. She used the tissue, and then left for her appointment. She went for her appointment with the doctor and was placed in the stirrups for the exam. The physician came into the exam room and after a brief exam, smiled, and said, "Gee, you give stamps too!!!"

This was during the time that merchants gave out "green stamps" with purchases. The stamps had evidently been stuck inside the tissue used in the bathroom.

CT



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