The Ghana Pharmaceutical Journal

Official Organ Of The Pharmaceutical Society Of Ghana

- Patient Counselling
- Inappropriate Drug Use
- Product News
- Uplifting Our Image
- Challenge To Pharmacists
- Good Manufacturing Practice (GMP)

Vol. 14 No. 1 September, 1992

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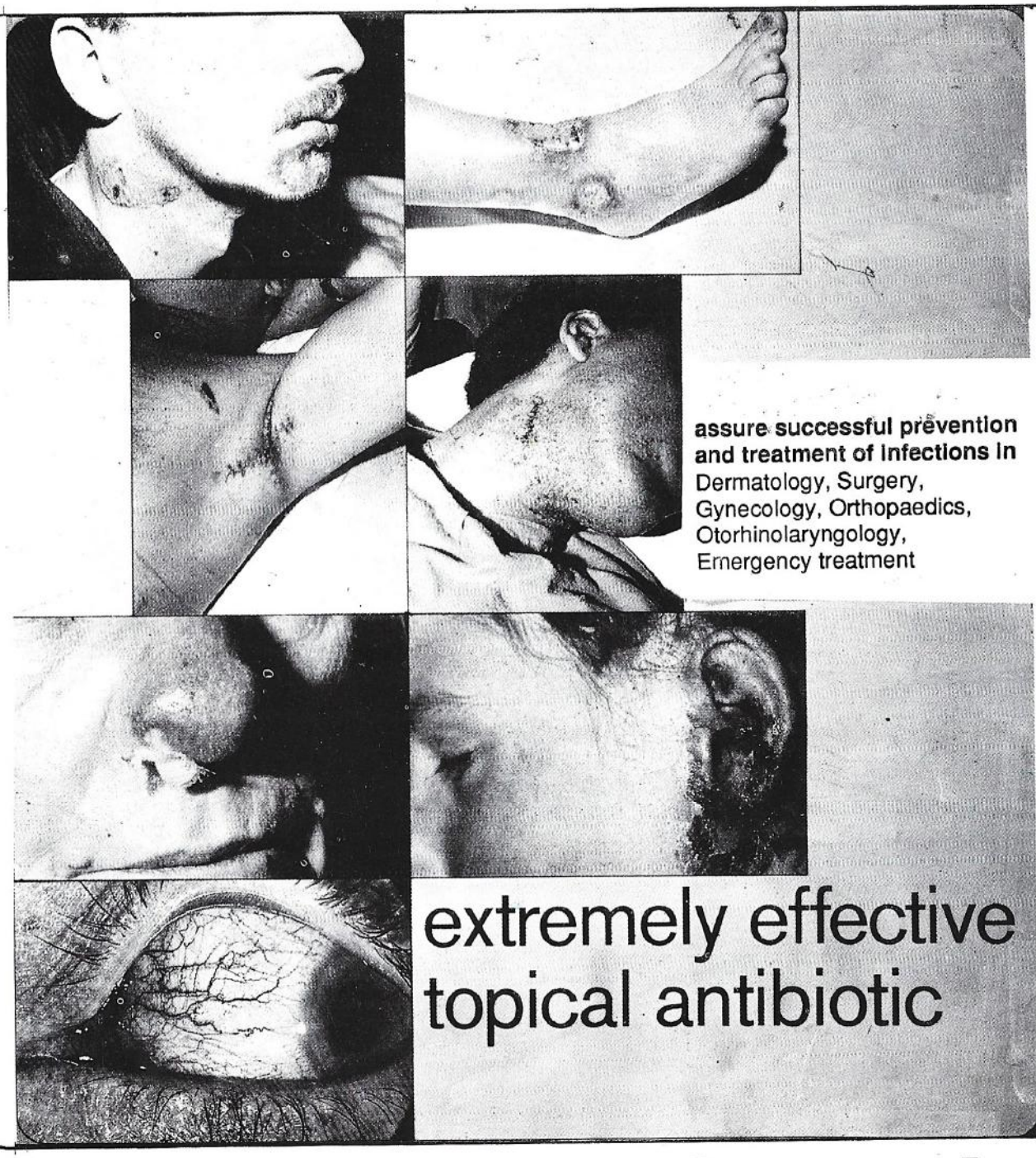

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The Ghana Pharmaceutical Journal

Naional Headquarters of the Pharmaceutical Society of Ghana
Social Advance Institute Building
P.O. Box 2138, Accra

Vol. 14 No. 1 **September, 1992**

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Uplifting The Image Of Our Profession

In as much as we desire to receive recognition as a profession from our community, we must realize that the image that we portray is first and foremost, our responsibility. As such the editorial Committee is of the opinion that it is about time we encouraged some self criticism amongst ourselves, as a first step in dealing with those obstacles that militate against the upliftment of our profession.

To start with, an assessment of our activities so far this year portrays an apparent disinterestedness in the current health needs of our community. The World Health Day has passed by without any organized activities by the society or its branches to highlight the importance that we as pharmacists attach to the day.

June 10th, a day set aside since 1982 by the Commonwealth Pharmaceutical Association (CPA) for member pharmacy Associations to make special efforts to promote the profession to other health professions, Government departments and to the public has passed without any effort being made by the P.S.G. or any of its branches.

Similarly, the International Day against Drug Abuse and Illicit Drug Trafficking which falls on the 26th of June passed without even a comment by the Pharmaceutical Society of Ghana or any of its branches apart from a solitary feature article in the national dailies by the singular effort of a member of the society.

The fact that national health authorities no longer seek our opinions on most relevant health matters and the fact that our community does not even question our apparent lack of interest in current health issues may be indicative that they no longer expect much from us. The time is past when a profession receives recognition by just sitting on the fence. These days recognition only comes through service.

Our lack of concern is demonstrated even in our attitude towards our society. It is surprising that some members do not make the requisite effort to pay our dismally low retention fees. It was a shock to learn that such a vital wing of the society as the Community pharmacists' group (GPPA) collects ¢2,000.00 per member as annual dues. With this level of dues, one cannot realistically expect anything more than a cosmetic impact on our community. It is again of little wonder that neither the society nor its branches has been able to establish a fitting reference library or a Newsletter or any other structures indicative of progress. Many interest groups within the society, like the Industrial wing have sadly seen their demise rather than growth.

Secondly, we would want to mention that recognition of a professional group is always linked to educational status. Long after obtaining his first degree in Pharmacy, when most of his colleagues in other professions have gone ahead to further their education, the pharmacist in most cases has remained stagnant in his original level, because unlike his colleagues, he has not made the attainment of further educational laurels his prime objective.

There is the need for us to be a self motivating profession, organizing frequent continuing education programmes, seizing opportunities to serve in every position that turns up in an effort to exert our influence in the health delivery system.

Thirdly, we would want members to add their voices to the few already raised on the need for a substantive Director of Pharmaceutical Services. We of the Editorial Committee of the Society are of the view that the Confidence, boldness and firmness that this position demands cannot be fully exercised by anyone whose appointment has not been confirmed. We must show our concern in more concrete ways regarding this issue which affects all of us so dearly.

In concluding, we would want to stress that no member of our esteemed profession should regard his contribution too small towards the group effort in uplifting our professional image in the society, in as much as any small negligent professional behaviour may have significant repercussions on the society at large. ■

New Developments In This Edition

Viewpoint
A forum for discussing issues of current importance to the society.

Continuing Education
A column devoted to articles on continuing education for pharmacists.

Focus
An interview with pharmacists striving to perform roles outside the traditional pharmaceutical roles.

Highlights For Next Edition Of The Journal

Viewpoint discusses the Relationship between P.S.G. and its branches, Ministry of Health, Pharmacy Board and other related institutions

Focus will be on The Editor of the Health Courier.

Send your articles, letters, and contributions as soon as you can.

Letters to the Editor

The Need For A Substantive Director

Pharmacy is one of the professions within the Ministry of Health (M.O.H.) which deserves to be accorded its due recognition and respect. For the past ten (10) years the pharmacy division within the M>O.H. has been without a substantive director Cum adequate deputies. The head of the division who just went on retirement was an acting director for about ten (10) years without being confirmed as director.

In the light of the aforementioned problem, certain anomalies have been identified within the M.O.H. in relation to Pharmacy.

(1) Promotional Stagnation.

(2) Importation of fake drugs into the system.

(3) Poor conditions of service for Pharmacists.

(4) Discrimination and antagonism against Pharmacists by other allied professionals.

(5) Infiltration into pharmacy activities and practice by people without the professional know-how both in the M.O.H. and from the private sector.

(6) Production of Sub-Standard drugs by some of the Local manufacturers which are sold to the Ministry.

(7) Abusive use of drugs

(8) Young Pharmacists leaving M.O.H. for the private sector or Leaving for abroad in search of greener Pastures.

During the latter part of 1991, there were a series of advertisements both in the dailies and on the television for the post of a substantive director of the Pharmaceutical Services of the M.O.H. Interview dates were later announced but surprisingly enough the call for the interviews was suspended indefinitely without any apparent reasons.

At this point, one may ask what are the functions of the Pharmaceutical Director in the Ghanaian Society?

(i) He is the Principal adviser of the M.O.H. on all pharmaceutical matters.

(ii) He is also the Chairman of the Pharmacy Board

(iii) He is responsible for making recommendations for the promotion of all categories of pharmacists in the M.O.H.

(iv) He controls the supply of drugs, dressings in the Ministry with respect to the Importation, Storage and Distribution of drugs in all government stores.

He is a member of the drugs Sub-Committee which deals with the buying of pharmaceutical products and dressing. He also interviews representatives of drug Manufactures to find out qualities of drugs which are suitable for the use of our hospitals.

(v) He is responsible for reporting on adequacy of supplies, misuse of drugs and inadequate storage facilities in all Hospitals. He also advices on the nature, storage, quality cost and availability of drugs sin all Hospitals.

(vi) He is responsible for the preparation of statistical returns on all categories of drugs including narcotics and deals directly with Narcotic Commission of the United Nations in Geneva. He also controls all narcotic drugs and the regulations that trade in them in this Country.

(vii) He is responsible for preparation of the portion of the M.O.H. annual report which deals with narcotic circulation of drugs in the Country.

(viii) He advices on the establishment of Pharmaceutical industries through the Pharmacy Board.

(ix) On the international level he is a member of the drug advisory Committee that advises the Health Ministry on all issues pertaining to drug supply and Management in the sub Region including supply, Manufacture, quality control etc.

Looking at the functions of the Director of Pharmaceutical Services as outlined above, the appointment of a substantive director of pharmaceutical services is in the national interest and should be done without undue delay.

The government through the Ministry of Health should ensure adequate staffing at the pharmacy division of the M.O.H. and the appointment of a Substantiative Director of Pharmaceutical Services. Also the Government should ensure that the grading of posts within the Pharmaceutical Services be reviewed so as to restore moral among pharmacists in the government service and also to ensure that conditions of service of Government pharmacists are improved to prevent the drain of Pharmacists from government service for abroad as well as to the private sector.

HOSPITAL PHARMACISTS
(ASHANTI REGION)

Urgently Needed -
A Substantive Director

It is without question that much of our efforts at improvement as a profession have produced very little results because we have not had a substantive director for pharmaceutical services (Chief Pharmacist) for a very long time.

Quite recently, we were all very relieved when it was announced that the position was being advertised, only to be informed that the interview for a choice to be made to the position had been suspended indefinitely.

Quite strangely, we have all been very quiet about it. What are we doing? Are we waiting till the pharmacy section of the Ministry of Health (M.O.H.) collapses completely before we react?

REGINA KOTEY (Mrs)
(B PHARM MPSGH)
KORLE BU TEACHING HOSPITAL
ACCRA

Reaction Of Dispensing Technicians

I heard with much disappointment, the stand of the dispensing technicians during the recent industrial action by pharmacists of the Korle-Bu Teaching Hospital.

The technicians are free to dissociate themselves from whatever action the pharmacists take, but for them to go further to notify the authorities of their stand is very sad indeed.

What did they hope to achieve? Were they hoping to cause the action by the pharmacists to backfire?

What these technicians must realise is that as their seniors, we may not always be right, but we will always be their seniors. If we do not progress, neither will they, because we determine the pace in this sector of the health ministry.

They must also realise that their service conditions are determined by us and it serves them no good to fight against us.

MR. SEKYERE MARFO
(B PHARM (HONS) MPSGH)
BANK OF GHANA CLINIC
ACCRA

The Three-Year Compulsory Service

In the mid 1980's when it was realised that there was a dearth of Pharmacists in governments hospitals and also to avoid over-exploitation of newly qualified Pharmacists by non-pharmacist pharmacy proprietors, thehe Pharmaceutical Society of Ghana (P.S.GH) suggested, and The Ministry of Health (M.O.H.) acting through the Pharmacy Board made it a mandatory policy that all newly qualified Pharmacists should serve the government for a minimum period of three years before having the option of going into private practice. Such

a directive is very welcome for at least, it will ensure that the requisite pharmaceutical expertise will be made available to the populace at all government hospitals. One would have expected that after four or five years of implementation, some monitoring would have been done to find out how effective the policy is going and most importantly, how the newly qualified Pharmacist is faring. However, this has not been done.

It must be emphasised that the largest user organisation, M.O.H. has so handled the programme that it has become worse than the National Service and there is therefore, an urgent need for a thorough review of the policy to avoid the untold hardship that newly qualified pharmacists are exposed to.

To begin with, the issue of who pays the pharmacy graduate in M.O.H. between the period of completion of National service and the writing of his professional examinations has not been solved, yet he is supposed to be doing his Housemanship like the newly qualified medical officer. There is no laid down policy at M.O.H. to that effect. Filing PSC forms for the position of Houseman Pharmacist is a waste of paper, money and effort, for nothing comes out of it. At best, it only serves as a sedative. The ordeal that those who did their service/housemanship at M.O.H. had to go through before their establishment warrants were approved is very trying indeed . The writer had to work and wait for over seventeen months before enjoying his first salary. The general attitude of M.O.H. to pharmacists is not encouraging and we should not be sold cheaply to them. The salary itself is one of the worst you can think of. There is no significant difference between his salary and that of the newly qualified SRN midwife.

The government herself, realising her inability to employ all graduates is encouraging entrepreneurship among graduates. No wonder series of lectures are currently being organized to inculcate private entrepreneurship in young graduates. It is, therefore, regrettable that employable professional skills should be rendered unemployable in the private sector by this policy. After all, what sort of exclusive privileges did the pharmacist enjoy on campus or is it a crime to read Pharmacy, such that after 4 years' hard and strenuous course, one has to be kept in suspense and bondage for another 4 years (National Service Inclusive)?

And by the way, if the newly qualified pharmacist is not considered competent enough to manage a private Pharmacy, what is the guarantee that he can do same for a government hospital?

It is my considered opinion that the policy should be scraped all together or at worst, be reduced to one year. Pharmacists should be given the option to decide where they would like to work for Trade liberalization also calls for labour liberalization.

MOSES A. ADJEI
(B PHARM (HONS) MPSGH)

P.S.G. & GHOSPA

At a crucial time such as this when members of GHOSPA are fighting for salary adjustments and improved conditions of service, it is paradoxical that no national meetings of GHOSPA have been called for the past 3 years. GHOSPA appears to have lost direction apparently due to lack of a proper leadership. For example, issues which should have been dealt with many months ago have not been addressed because the General Secretary of GHOSPA was at the Consultative Assembly.

It also appears the P.S.G. has adopted an apathetic attitude to GHOSPA problems. This *lasses-ci attitude* seems to have originated as a result of an unfortunate and unguarded statement by a previous GHOSPA executive that, hospital pharmacists can handle their own problems.

Consequently, we in GHOSPA have failed to enjoy the full support of the P.S.G. as has been demonstrated when other pharmacist groups are concerned. For example, when the AMA increased premise fees for stores, an issue that placed on the importation of certain drugs, an issue that again affected the GPPA

An Invitation

The Ghana Pharmaceutical Journal would like to ask all readers to express their views on continuing education for pharmacists, to help determine what actions the society should take in this direction.

Send your contributions:
THE EDITOR
PHARMACEUTICAL
SOCIETY OF GHANA
P. O. BOX 2133
ACCRA.

65TH ANNUAL NATIONAL CONFERENCE OF THE PHARMACEUTICAL SOCIETY OF NIGERIA

The 65th Annual National Conference of the Pharmaceutical Society of Nigeria (PNS) comes on at Durbar Hotel, Kaduna from 10th to 14th November 1991.

The theme for the conference is;

"PHARMACEUTICAL EDUCATION AND PRACTICE IN THE THIRD REPUBLIC"

Members of PSG wishing to attend should contact:

The National Secretary
Pharmaceutical Society of Nigeria
52A IKORODU ROAD (3RD FLOOR) FADEYI
P.O. BOX 531 MUSHIN
LAGOS STATE NIGERIA
OR ON TELEPHONE (01) 864267

directly, the Society once again took it up as her own problem.

We need to be reminded, however, that the image of GHOSPA in relation to that of other professionals in the M.O.H. and other government set-ups, determines the national image of pharmacists, irrespective of their areas of operation.

It is, therefore, imperative that the P.S.G. throw all its weight behind GHOSPA, especially in these times, until all our aspirations are fully realised.

JOHN AMENYAH
(B PHARM (Hons) MPSGH)
KORLE-BU TEACHING HOSPITAL
ACCRA

Drug Purchase And Supply System

With the advent of the revised cash and carry programme within the M.O.H., effective January, 19992, we in the polyclinics of Accra were asked to pay a 33.3% deposit from our accumulated drug revolving fund to generate a revolving capital for the Regional Medical Store or the Regional Purchasing Team.

Much to our surprise, spurious drugs with obnoxious labelling were finding their way to the Regional Medical Stores. With such drugs at the medical Stores, pharmacists in the region are obliged to purchase them without alternatives or questioning.

One really wonders who actually does these purchases and whether pharmacists are seriously involved in this abnormal practise.

It is rather sad that as pharmacists and professionals in the Pharmacy fraternity we are by dubious manipulations from above subjected to take drugs and other pharmaceuticals with no proper labelling, or expiry dates, into our stores and to dispense same to patients.

These same drugs and pharmaceuticals are found in reputable drug houses where the practise is purely industrial, eg. GIHOC, Pharmadex, Phemerco, Danafco, Major & Co etc.

Pharmacies within the Greater Accra Regional M.O.H. need to be re-organised and we are calling on GHOSPA and other authorities that matter to look here.

PHILIP ANUM
(B PHARM (Hons), MPSGH)
MAMPROBI POLYCLINIC
MAMPROBI

Resolutions: How Far ?

Each year, after the Annual General Conference and other very important meetings, Resolutions/Communiques are issued by the Pharmaceutical Society and presented to government; but how far are these laudable ideas and proposals carried out? This is a big question that confronts most Pharmacists in Ghana today. The writer is not intoning that the Society should not come out with resolutions or communiques, far from that.

What then, is the essence of Resolutions or Communiques issued at the end or Conferences? What are these supposed to achieve? Are these statements issued out just to impress upon governments that the Society is doing something, when in actual fact nothing is being done? I know some people will argue that for these proposals to take off, certain conditions need to be fulfilled on the part of government.

The question to ask him is that why place that big responsibility at the doors of government when we as a group want something done in our favour.

Why do we not start with something that is within the powers of the society to effect, rather than wait for the powers that be for implementation? With this initiative from the Society, something can be achieved and from there, forge ahead with other major issues. Also, this will go a long way to boost the image of the profession by rejuvenating the confidence the public holds in us as Friends of the Human Race.

REBECCA NORDOR
Principal Pharmacist
Central Hospital
Koforidua

Office Accommodation

I am of the view that the Pharmaceutical Society of Ghana is one of the most articulate and very well organized societies in this country.

I am, however, very uncomfortable about our office accommodation. I simply believe that the office does not befit our status.

I am not too sure about the office accommodation of the other professional bodies, but I can point a finger at the Institute of chartered Accountants and also the Ghana Medical Association and say that these are very suitably accommodated.

I am aware that there have been moves in the past to acquire an office building, but to date this has not materialized. However, in the interim, I sincerely believe that as a progressive society, we should be able to rent a much more decent office accommodation.

A second reason is that the present office is not readily accessible. We need a place that is more centrally located.

If we could have a larger office, I believe we could begin to develop a library and a lounge where we could go to pick up some information and just interact. I believe this would help us individually and collectively.

There are a lot of beautiful office blocks springing up in Accra lately. I am sure that collectively, we have the means to make this possible.

MR. EMMANUEL AGYARKO
(B PHARM (Hons) MPSG)
Vitapharma Ltd. Accra.

Tit Bits

Gray Hair

"To prevent the hair from turning gray, anoint it with the blood of a black calf which has been boiled in oil, or with the fat of rattlesnake.

Ebers Papyrus (A medical book written in Egypt - 1552 BC)

Helping Out

You can't help a man uphill without getting closer to the top yourself.

James S. Hewett, Illustrations Unlimited

Smell of Success

Like perfume, success is to be sniffed not taken internally.

Russ Reid, Eternity

Circumventing Cancer With Circumspect Circumcision

Cancer of the penis is almost entirely preventable by following an instruction that God gave to Abraham over four thousand years ago.

Out of the records of 1,103 cases of cancer of the penis reviewed by Dr. Al. L. Wolbarst of New York in 1932, there was not a single Jew.

Medical researchers have found out that this spectacular freedom of Jewish men from this lethal cancer results from the practice of circumcision.

Endurance

"I am only an average man, but I work harder at it than the average man".

Teddy Roosevelt

Never Say Die

"Man who says it cannot be done should not interrupt man doing it".

Chinese proverb.

BETTER SERVICE IN OUR COMMUNITY

A ChallengeTo Pharmacists

by Noah Acolatse

The Challenge

The dynamic growth in the health industry raises up a lot of challenges for us as members of a health profession, since we have a professional responsibility to keep up to date with this growth. The increasing awareness by the general public of health related issues and the changing environment we are operating in, further place a higher demand for a more effective use of our expertise. There is the need for us to continue learning and adapting to the changing environment, to be sure of our position in the health care team.

I believe it is very important that we take stock of our achievements as a profession, determine which direction we intend to take in the short, medium and long term, what foundation we are laying and how we intend to build on this foundation. Our future depends on it. It is said that 'A person going nowhere, normally gets there "We need to determine a direction for growth and to set ourselves goals.

In laying a good foundation for growth we must realize that the foundation for a profession is the service we render to the public. When we cease to render service then that is our end. It is time we started changing our attitudes towards such currently important health issues as maternal and child care, child abuse, drug abuse, guinea worm eradication and others. It is time we identified ourselves as the most knowledgeable and influential group on contraceptives and drugs in pregnancy. With our vast knowledge in pharmacognosy, what advice are we giving the government concerning issues on herbal medicine? Is the direction herbal medicine practice is taking in the best interest of the general public? As experts on drugs what are we doing about this?

An important aspect of our responsibility as a health profession is responding to the health needs of the people and helping to shape government policies on health issues. What programmes, if any have we initiated in connection with the Alma Ata declaration of health for all by the year 2000. What impact has the PHC made on us as health workers and what impact have we made on the PHC programme as a health profession.

How come that many responsibilities turning up in the health industry because of developments are handled by other health workers apart from pharmacists. Are we abreast with developments in oncology, biotechnology, antidiarrhoea therapy to advice Government health authorities? Are we making them see the need to rely on us? We as a group need to be self motivated. We need not wait for others to start a health education campaign on child abuse, family planning, environmental pollution, immunization and others to be invited to participate. We must initiate such programmes and invite the social workers and educators. We must be the initiators.

> Putting our efforts together we will achieve results which we would not achieve otherwise.

The Demand

We must frankly and honestly assess the service each of us renders, and ask ourselves in what way such service can be improved, and in what way we can reach more people with such services.

The situation demands that we be motivated from a genuine interest to render service, and to see beyond ourselves, our pharmacy business, to the health needs of our society. I believe the saying that 'if you talk the talk without walking the walk, no one will believe the walk that you are talking about'. The editorial of the Ghana Pharmaceutical Journal vol 12 Nos 3 - 4 (July - December 1989) lamented the fact that several years after we had seen the need to extend our services to the rural areas, this laudable idea has not been realised. The solution is that those of us who see the need must demonstrate it by being the first to render service in the rural areas.

We must challenge ourselves more to overcome complacency. We must put our expertise to more effective use. There is the need for continuing education and we need to identify which direction this should take. There must be an emphasis on education that will make us more functional. There has to be a total restructuring of our educational and training programmes to help us become more effective in meeting the national health needs. We need to be acquainted with activities and developments in other health disciplines. As a profession develops there is an increased awareness by its members to specialize. We need to see more of our members specialising in various aspects of pharmacy, and also taking up courses in the behavioural sciences as we see ourselves becoming more pharmacist-patient oriented then pharmacist-drug oriented.

All these will cost us. Some sacrifices need to be made, because such responsi-

bilities demand effort, time, a lot of thinking, planning and money. We must all bear some responsibilities.

Some Opportunities

Looking at these responsibilities individually the challenge may seem very big. But we are quite a big society and quite a united one and I am assuming that we see our duty to keep up to date notwithstanding all the pressures that life presents these days. This makes it important for us to come together for programmes, like workshops and seminars on current trends in health care. Putting our efforts together we will achieve results which we would not achieve otherwise.

Already we have a number of smaller association within the PSG. These could be used to launch education and service awareness campaign. The GPPA could emphasise more pharmacist patient interactions in its programme for the year and discuss the design of pharmacies to facilitate this.

Some Suggestions

It is always a welcome development when various groups are formed in a profession. It is a sign of life and growth. Various interest groups can be formed. Starting with just one person who has the interest, the person could advertise his interest in the pharmaceutical journal seeking to hear from the experience of other colleagues.

Groups can be formed to encourage pharmacists to present short talks on pharmacy practice, currently important topics like Cholera treatment, our role in immunization, demand reduction programmes in drug abuse.

Some of our larger institutions could establish drug information resource centres which could act as focal points for those interested in designing drug information activities in their hospitals, pharmacies etc.

Noah Acolatse is editor of the Pharmaceutical Society of Ghana (PSGH) and Assistant editor of the Health Courier. A member of the 1st Executive of the Ghana branch of the International Council on alcohol and Addiction (I.C.A.A.), his career interests are in the area of fighting drug abuse and also in Family Planning.

His career goal is to be a health communications expert.

ViewPoint!

Views On Continuing Education

A number of pharmacists from various areas of practice were recently interviewed by the editor of the Society to investigate current attitudes towards continuing education for pharmacists. We publish below some of the views expressed by these colleagues:

We Must Update Our Knowledge

All professionals on the field tend to lose touch with current trends. This is because during practice we tend to walk to very narrow path. Moreover, rapid technological, medical and pharmaceutical advancements lay on us a responsibility to update our knowledge if we desire to remain health experts. There is the need for us to come together often to share views and ideas on health related topics.

The Education Committee of the Society should organise weekly seminars for the various sectors of pharmacy practice, and a fixed minimum attendance at such seminars should be made a mandatory condition for reregistration to the Society. This should be treated as urgent because the ignorance displayed by some colleagues at times is very embarrassing to the profession.

Joseph Turkson - Hospital Pharmacist,
Korle-Bu Teaching Hospital Accra:

Maximise Use Of Knowledge

If we are going to talk about continuing education then we must rethink our attitude towards the practice of p;pharmacy. Impressive though such an idea might be, you would get few colleagues opting for such a programme, the reason being that we find ourselves in a straightjacket controlled by higher authorities who would not help us to practice as we should. A lack of intensive application of what we have already learnt at school would render any programme on continuing education a mere fashion.

Could you believe that there is a Manesty machine capable of producing 24,000 litres of distilled water per day lying idle at the hospital for the past fifteen years? Could you believe that we have chloroquine sulphate powder, ampoules and an ampoule filling machine lying around our hospital? All we need to start hospital production of chloroquine injection is the premises and some interest and motivation from the pharmaceutical heads at the hospitals and at the MOH offices. When authorities at the MOH decide that some equipment should be bought, they should take the trouble to ensure that they have been installed and are in use.

In conclusion, I would want to state clearly that maximization of the use of our knowledge should be the prerequisite to any further education programmes.

Coker Kodwo Asaam - Hospital Pharmacist,
Medical Stores/Central Hospital, Cape Coast.

Make it Compulsory

Improvement in technology for more efficient production processes requires that pharmacists be abreast with these trends in order to improve quality and reduce production costs. If we had been more committed to updating our knowledge, practice would have been more professional than it is today.

I believe we need continuing training in formal as well as plant visits. My suggestion is that the society should institute compulsory continuing education as a prerequisite for re-registration every year as is done in certain countries. Short courses of 2 weeks duration could be arranged.

Mark Owiredu (B Pharm (Hons) P.G. Dip Ind MGT - MPSGH) -
Industrial Pharmacist, GIHOC Pharmaceutical Col Ltd., Accra.

Degree is Only First Step

Pharmacy as a profession is both theory and practical application in the preparation of drugs and its use in human for diagnosis, prevention and treatment of diseases. It is, therefore, a scientific instrument for the maintenance of life.

With the evolution of new diseases,s chronic and epidemic, and the emergence of resistant strains of causative organisms, the addictive nature and tolerance of certain drugs to diseased states; the availability of numerous drugs for the same ailment and their possible side effects; there is the need for the man of drugs - the pharmacist in the noble profession of pharmacy to develop his skills to cover all facets of drugs formulation and therapy. The areas of importance would include Research and Development, Good manufacturing Practices, Quality Control, Clinical Pharmacy and Drug Management in Procurement, distribution and sale.

One would therefore, agree with me that pharmacy would not and after the first degree but rather, this should serve only as a first step to pharmacy practice. The pharmacist would then be equipped to offer his maximum service to the community in which he lives as he goes through this continous education programme.

Areas that I will suggest are:

1. Post graduate degree in pharmacy
2. Periodic training programmes for pharmacists in all areas of practice vis Academic, Industrial, Hospital or Community Pharmacy.
3. Periodic training programmes for all pharmacists by the Pharmaceutical Society of Ghana to equip its members with the current developments in the practice, laws of pharmacy, introduction of new drugs, fake and banned drugs, safety of existing drugs and new findings on their effectiveness or adverse effects.
4. Organisation of National and International Pharmaceutical conferences and members encouraged to attend.

To conclude, I wish to say that it is dangerous when one is to practice more than he knows and to make our work effective and beneficial to the society in which we live, we must tune ourselves in consonance with modern events by means of continous education.

Joseph Adu (B Pharm (Hons; MPSGH)
Industrial Pharmacist, GIHOC Pharmaceutical Co. Ltd., Accra.

There is the Need

I see the need for continuing education amongst members of the Society.

We usually don't get the opportunity to utilize much of the knowledge we acquired during our training in school because the demands on us in practice are quite different from what we have been equipped with from school.

My suggestion is that the various arms of the society - ie. GHOPSA, GPPA, Industrial Pharmacists' Association - should organise continuing education programmes for their members, with emphasis on management and clinical aspects of the practice.

Newly qualified pharmacist now have to spend an extra three years at the hospitals before making any choices as to area of practice. Especially for these pharmacists, continuing education programmes should be more patient-oriented.

Mr. Kwesi Eghan (B Pharm (Hons) MPSGH)
Medical Representative, Sandoz Pharm Ghana Office, Kumasi.

Profeesional Responsibility

The importance of continuing education in any profession cannot be over-emphasised and very importantly in pharmacy, because it is a dynamic profession and we have to be alive to our responsibilities.

There are many facets to this topic. A pharmacist ought to educate himself informally by being observant concerning day to day occurrences in his practice, checking on possible drug interactions and establishing the validity of prescriptions that he dispenses.

We as pharmacists have a professional responsibility to attend all meetings, seminars organized by the society, read any medical or pharmaceutical journals that come our way, share ideas and hold discussions on these amongst ourselves.

On the formal side, WAPF seminars are very good continuity education material, and pharmacists must try to attend these irrespective of whether these are in their direct fields of practice or not.

My assessment is that what we have by way of continuing education programmes is inadequate. What we need is a comprehensive programme, initiated from the national level and floated down to all regional groups and wings of the society. An evaluation of such programmes could be done by the journal to assess the impact of such programmes on members.

The West African Postgraduate College of pharmacist is an opportunity for us to involve ourselves in continuing education, and programmes of the College should be placed at vantage points for members to familiarize themselves with.

In concluding, I would want to say the Education Committee of the society has a job to do, and that membership of this committee should be spread over various fields of practice and not from the pharmacy faculty of the University alone.

Mr. T.C. Corquaye - Administrative Pharmacist
(B Pharm (Hons) FWACP FPSG)
Registrar - Pharmacy Board, Accra

Wake Up, Education Committee

It is my opinion that when we leave school and do not get this sort of exposure, we tend to grow stale and rusty.

Let's face it, in the private or public sector, if we do not go out of our way searching for educative material we lose touch. As a regulatory agent, when I talk to colleagues about laws on pharmacy practice in the country, they seem not to be aware that such laws exist. Some have no access to journals and are not aware of what goes on in the shop, but are only interested in what

money they can make.

I will say that some effort at continuing education is being made here and there. For example, the launching programmes of various new drugs. I do not know if it is the novelty of visiting these new hotels where these programmes are performed, but the patronage is very impressive. However, there is the need for better co-ordination of continuing education programmes on the national and regional level.

The education committee must be represented at the regional and district levels by subcommittees for better and effective co-ordination. I am not sure about the membership of this committee but usually, when we talk of education, the tendency is to tap on university lectures alone, but sometimes the experience of those in the field makes a lot of difference. How often does the education committee meet? Has it come out with any programme for the year?

Awuku-Kwatiah - Administrative Pharmacist
(B Pharm (Hons) Msc Pharm Analysis MPSG)
(Deputy Registrar (Technical) Pharmacy Board

We've Not Done Much

Certainly, continuing education is important and I do not think that we have been doing much in this area. Moreover, very few colleagues have patronized the very few programmes that have been organised. This is very disappointing when you consider that pharmacy is growing and developing so fast that a big responsibility is placed on us to keep abreast.

Basically, one could say that the new dimension to pharmacy practice which is clinical pharmacy opens up many opportunities to us which we must seize. Secondly, because of the nationwide advertisement of herbal medicine, we should expect increased usage and, therefore, ought to be aware and advise on possible drug interactions, dosage etc.

The society should also organize continuing education programmes and the pharmacist himself must make his own personal efforts to update his knowledge. Finally, it may be necessary to make participation in continuing education programmes a mandatory prerequisite for reregistration to the society.

Dr. R.A. Acquah - Lecturer
(B Pharm (Hons) PHD MPSG; Member,
Biochemical Society of Ghana)

The Situation Is Bad

Personally, I think it is good and also that the situation as it exists now is bad. When one leaves the confines of the University, one tends to abandon his textbooks. Now if you have the reference books, you may or may not read them because there is no compulsion to keep abreast with developments. If we had a system whereby you could be graded or whereby commitment to continuing education could enhance your standing, it would result in long term benefits for the profession.

In other countries like the U.S. or Britain, the mouthpiece of the Society, ie. the journal plays a useful role here. First, a background lecture is published and then questions are set and all members are required to mail their answers to the editor.

Occasionally, authorities in and outside these countries are invited to give lectures on current developments in the profession. Workshops and seminars are organised which are highly patronised. We need a lot of logistics. The library of the society has to be well equipped and stocked with current journals and textbooks. For starters, we could solicit for some help from The British Council and the Royal Pharmaceutical Society of Great Britain.

Also, I have noticed that our journal is not educative enough. Most editions over mainly news and conferences which is not good enough. To my mind, if it is the mouthpiece of the Society, a lot should go into it and all members must be encouraged to submit articles that are well researched, and at times we must commission people to write articles. Articles to the journal should not be a prerogative of the lectures but the whole society. Finally, I would advise that we should think of establishing libraries in Accra, Kumasi and Takoradi.

Dr. Menlin Mensah (B Pharm (Hons) PHD)
Lecturer, Faculty of Pharmacy, U.S.T. Kumasi

Make Knowledge Available

I see a need for a complete review of practice from the GPPA point of view. There must be a model type of practice which should serve as a standard in the community below which no pharmacy should fall.

These days we see a lot of patients walking into our pharmacies requesting to see the pharmacist for consultation and counselling on health related, as well as sociological problems. This places on us a responsibility to update our knowledge on first aid treatment, communication skills and current trends in healthcare delivery.

My problem, however, is this: What is the point in acquiring more knowledge if the pharmacist is hardly ever at post to make this knowledge available to the public?

Mr. Samuel A. Bentum - Community Pharmacist
(B Pharm (Hons) MPSG) Sambens Pharmacy - Takoradi

Make Use of Academic Groups

A continuing education programme is necessary for every professional group for through such programmes, members are kept abreast with developments in the profession.

Developments in our profession are so fast and so varied that an individual cannot cope on his own. When such programmes are organized, someone researches, summarises the facts and presents them in a nutsheell to the group. Such programmes are made even easier by the use of video clips.

The situation as it is now is very bad, but there are a lot of opportunities for improvements.

We are not making use of the academic group amongst us; for example, now that the vogue is on herbal medicine and we have a whole department specializing in herbal medicine, we

should be giving them more opportunities to talk to us.

I am strongly of the opinion that the Education Committee of the society would have to sit up to its responsibilities and come with good programmes for the good of the society . The Committee could tap resources from the British Council, USAID and even from the various science departments in the universities. Fortunately, two of our colleagues are lecturers in the Biochemistry department of the University of Ghana, Legon and I believe that they would gladly offer their services to the society if the Education Committee should call on them.

Mr. Louis Nortey - Medical Representative
(B Pharm (Hons) Dop Pr/Ad MPSG)
UpJohn Ltd. Ghana Office

Read To Be Informed

I believe that a continuing education programme for Pharmacists is very necessary and would enable us to keep abreast with the changing trends in treatment, not only in our country or W. Africa, but in the entire pharmaceutical world.

If we call ourselves professionals, then it is our duty to read and keep ourselves updated. If the journal does not come out with continuing education articles, we each should still make some personal efforts to look for, and read whatever educative materials we can lay our hands on and keep ourselves always informed.

The situation as it exists now is very appalling especially in community practice. I do not know about hospital and of industrial pharmacy but looking at the quality of products from our industries, I am inclined to suspect that they also are not faring well in this regard.

I find it very embarrassing when medical officers or patients walk into my pharmacy and complain to me that they entered a pharmacy and the superintendent pharmacist had no idea about the ailment they were refering to and did not even have a book to refer to. It could be that it was the technician that they met in the pharmacy but even then, reference books ought to be available for quick references to be made.

In place like the U.K. where it is more or less compulsory for the pharmacist to update his knowledge continually because if his ignorance in any area leads him to make a mistake, it could cost him his certificate of registration, the journal comes in very useful with up to date educative articles to stimulate pharmacists on what is going on around them. These articles usually cover a wide field, not only in community practice, but also in industry, hospital situations etc.

I would like to suggest that if the journal cannot come out regularly, groups of community pharmacists should come together to discuss a topic every week. Alternatively, these discussions could be organised at the bimonthly meetings of the various branches of the society instead of always inviting a medical representative to make a film presentation which invariably is more promotional that educative.

I am near the veterinary services and have been forced to go for a veterinary formulary.

Sometimes veterinary doctors come to my pharmacy requesting for advice on certain treatments. The other day a foreigner came to my pharmacy with a female siamese cat, and his problem was how to keep it from being crossed by the local breeds. Realising that he could not manage this, he came to find out what suitable contraceptives, preferably in injection form I would recommend for the cat. We looked around and found something. I was, however, not personally happy because I was not sure whether the cat would react favourably to it. The veterinary formulary I now have, makes me more confident to advise and make recommendations on such issues. This is an indication that we have to continuously up grade our professional knowledge in order to best meet the needs of the community we are supposed to serve.

The official reference books are expensive. I am wondering if the Pharmacy Board or the society could arrange for cheaper alternatives or extracts from the Martindale (if it si possible to get a permit to do so) at cheaper prices that more colleagues can afford.

Finally, I want to seize this opportunity to mention that we should consider seriously the area of patient record keeping. If the patient is regular and you keep his record of drug purchases, you could advice that he brings to your notice any O.T.C. drugs that he buys to enable you to check on incompatibilities among other things. This would encourage you the pharmacist to read regularly.

MRS. CZARINA RIBEIRO - COMMUNITY PHARMACIST
B PHARM (Hons) MPSGH, M R PHARM.S.
MOKAT CHEMISTS ACCRA

"I find it very embarrassing when medical officers or patients walk into my pharmacy and complain to me that they entered a pharmacy and the superintendent pharmacist had no idea about the ailment they were refering to and did not even have a book to refer to."

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Good Manufacturing Practice (GMP)

As An Aid To A Good Quality Assurance Programme In Pharmaceutical Industries

by Mark Owiredu

The Pharmaceutical Industry in Ghana and everywhere else is under obligation to produce drugs that are of good quality. Quality here means fitness for the consumer's or the prescriber's intended use. The drug se manufactured must be safe, effective and acceptable by the patient, for it to be described as being of good quality.

There are two main quality problems that a pharmaceutical manufacturer must contend with. Firstly, he must be able to test and find out if there are a y defects in his product design before producing commercial batches. some of these design defects could be related to toxicity, side effects, caranggenicity, teratogenicity (the thalidomide episode) and possible drug interaction, and must provide sufficient warnings to all those who may handle or consume the product. The design defect could also be in the sphere of biopharmaceutics, in which case it involves the physicochemical properties of the drug in the dosage form and the therapeutic response. For example, would chloramphenicol palmitate in hard gelatin capsule for oral administration elicit the same therapeutic response as chloramphenicol base? Or even the final presentation of a drug product packaging may be of crucial importance.

The answer lies in the application of certain principles of GMP that would enable the manufacturer establish control over quality of conformance so that he could easily and always steer the manufacturing process towards the quality goal.

Just like any other control mechanism in organised activity, for the control over the quality of conformance to be effective, there must be a standard and performance of the process must be measured or monitored and documented and finally there must be an evaluation of actuals against standards and corrective action taken.

Three basic principles of GMP would satisfy this condition, namely:

1. that there should be a Master Formular and also a general instruction for production and control. This requirement constitutes the standard;
2. That there should be a system of production process documentation as well as reporting controls that were performed - performance measurement and monitoring;
3. That there should be an evaluation of the production process and results of in-process controls and laboratory test against the standards and corrective measures taken. This could result in the rejection of the batch, reprocessing or release for distribution.

The pharmacist must be able to test and find out if there are a y defects in his product design before producing commercial batches.

1. The Master formula and the general production and control instructions for each drug product should include; the name and strength of the product and a description of the dosage form; name and weight or measure of each active ingredient and excipient and any special quality characteristics required thereof; a statement concerning any calculated excess: the theoretical yield at each phase of production and a range for the actual yield outside which an investigation must be carried out; A description of drug product containers, closures and packaging materials including a specimen or copy of each label; and complete instructions for the manufacture, in-process control, sampling and testing procedures, material specifications, special notations and any precautions to be followed.

2. This provides for an accurate reporting signifying that each relevant step in the manufacture, processing, packaging or holding of the batch was accomplished including: dates; identity or major equipment and lines used; an identification of each specific component or in-process material used in the manufacturing operation; weights and measures of components used in the course of processing; In process controls results, samplings performed and laboratory test results; Inspection of production facilities, packaging and labelling area before and after use; A recording of actual yield at each appropriate phase of production and reasons for unusual yield; A record of labelling controls, including specimens of all labelling or copies of all labelling used; Accurate description of drug product containers and closures used; Identi-

fication of the persons performing and those directly supervising or checking each significant step in the operation, and a recording of any unusual event or outcome of the manufacturing process and reasons if any.

3. The last step in the control of conformance to review the production and control records. To compare these records including those of packing and labelling with standards specified in the Master Formula and the general Instructions for production and control.

Only when the responsible pharmacist for production and that of Quality Assurance are convinced beyond all reasonable doubts that the drug product has been manufactured and controlled in compliance with the approved and written procedures or standards should the batch be released for distribution.

Any unexplained discrepancy in the manufacturing or control results or failure of a batch or any of its components to meet any of its specifications shall be thoroughly investigated. A written record the investigation should be made and should include the conclusion and follow up.

The old adage that quality cannot be inspected into a product but must be built into it is even more relevant today than ever before, as pharmaceutical industries have grown in size and drug production involves a complex of activities with its attendant automation. The industrial pharmacist has no other alternative other than to adopt the principles of GMP as a mechanism by which could assume control over quality of conformance and thereby be assured that batch after batch product quality would remain the same.

For the purchaser, be the Ministry of Health, Private retailer or wholesaler or the prescriber, he must always bear in mind that statistical samplings and Laboratory analysis are not an absolute proof of the quality of a drug product. Laboratory tests do not always reveal all cases of contamination, adulteration, products instability, bioavailability and even fake drugs. They must assure themselves that quality has ben built into the product. This means that they should only buy from these manufacturers who have this system in place, and price should not be the only determinant in making buying decisions.

Mr. Mark Owiredu (B Pharm (HONS) P.G. DIP IND. MGT. M PSG) is currently production Manager in charge of Solid Products at GIHOC Pharmaceuticals Ltd., Accra. His main career interests are Industrial Pharmacy and Management and his career aim is to upgrade the presentation of some local herbal remedies into modern dosage forms using modern scientific technique.

Product News

New Antimalarial Launched

S.K. Beecham's Halfan (halofantrine hydrochloride) is now available locally.

It is a phenanthrenemethanol antimalarial which is Schizonticidal with a high degree of activity against the sexual arythrocytic stage of malaria parasites.

Halfan has been shown to be embryotoxic but not teratogenic in animal tests. Treatment with Halfan is, therefore, contra-indicated during pregnancy unless benefits are thought to outweigh risk.

Studies suggest that it may be erected in maternal milk, pruritus and skin rash.

It comes in 250mg halofantrine hydrochloride (233mg halofantrine base) tablets and in a white suspension containing 100 mg halofantrine hydrocholoride (93mg halofantrine base)

Adults and children over 40kg. dose is 3 x 500mg every 6 hours. General dose for children is 24mg/kg/12 hours in 3 divided doses. It is available from Reiss & Co. Ltd.

Controlled Release Salbutamal

Volmax, a controlled release salbutamol oral preparation from Glaxomed Ltd. is now available from Gokals Ltd. the local agents.

It is claimed to employ a high technology osmotic principle, ensuring a reliable 24 hour control of asthma.

It comes in 4 mg and 8mg tablets.

The dosage is 8mg twice daily for adults and 4 mg twice daily for children.

Isradipine - Calcium Antagonist Antihypertensive

Sandozpharma's LOMIR (Isradipine) was recently launched for the treatment of hypertension.

It is claimed to effectively lower blood pressure by normalising vascular tone while maintaining Cardiac function and exerting a modest, sustained natriuretic effect.

The recommended dosage is mild to moderate hypertension is 2.5mg (1 tablet) twice a day.

Lomir is claimed not to have any side effect. It is available locally at GOKALS Ltd. and DEBAG GHANA LTD, local agents for SANDOZPHARMA LTD.

Focus

The Editorial Committee of the Society has decided to devote a column of the journal to interviews granted by members who are striving to establish pharmaceutical roles outside the traditional roles that the pharmacist has always played. In this edition of the journal, we publish for your benefit an interview granted your editor by Mrs. Joyce Addo-Atuah of The Ghana Police Hospital, who recently returned from the U.K. after her postgraduate studies in Clinical Pharmacy.

Editor: Why did you decide to read pharmacy in the first place?

Joyce Addo-Atuah: Because of my desire to be a healthcare scientist and pharmacy is the broadest-based healthcare profession, offering a lot of employment opportunities outside the hospital.

Editor: What was your main reason for deciding to go back to school, and what challenges did you have to cope with after such a long break from school?

Joyce Addo-Atuah: As a professional, I believe continuing education is very important and was simply not satisfied with a basic qualification in pharmacy. As pertains in other professions, I felt there was the need for me to broaden my scope and field of study. I had been out of school for twelves years (1977-89) but I had decided as far back as 1984 to go back to school. What actually held me up was financial support but I finally got a Common wealth award in 1989. Certainly, I had challenges to cope with once back in school. For a professional woman working for so long coupled with family responsibilities, suddenly becoming a full-time student drastically changed my life pattern. It was not easy for the first few months, but I was determined to do it.

Editor: Anything you want to share with us from your experience in school?

Joyce Addo-Attuah: Well, it was an experience worth going through, not only with regards to my own professional advancement but the benefit of all my colleagues in the profession. For one thing, I learnt that determination coupled with hardwork and a well-defined goal, are the basic ingredients for any successful undertaking. Of course, travelling in itself offers a great opportunity for learning. Being able to cope in unfamiliar, harsh and often not-too-often friendly surroundings will certainly aid to one's character build-up. In this regard, I will encourage all interested colleagues to take any available opportunity to travel to enrich their professional, as well as common knowledge.

Editor: Do you even intend to go back to school after this?

Joyce Addo-Atuah: As of now, I don't know, but if the opportunity arises, a short course in Drug Information Technology, for example, would be a welcome one. This is a specialization in Clinical Pharmacy.

Editor: We have heard that you have been appointed to be in charge of the Drug information unit, as well as ward of pharmacist at the Ghana Police Hospital. What does your work involve and what impact do you expect to make on the practice of pharmacy in the hospital?

Joyce Addo-Attuah: A Drug Information pharmacist must of necessity have a sound knowledge of clinical pathology, therapeutics, pharmacokinetics and communication skills added to the basic grounding in the traditional disciplines in pharmacy. This background prepares the practitioner to have a more effective and beneficial interaction with other health professionals because previous barriers in communication have been removed by this training. Speaking the same language with the medical practitioner, for example, allows the exchange of ideas as to the best available means of management, taking into consideration all the given characteristics. This same background offers a better and more meaningful interaction with the patient on his condition and management in activities such as patient counselling, which helps improve their drug compliance.

At the ward level, being a member of the team going on rounds, offers an opportunity to experience at first hand the clinical situation allowing thus, the best possible treatment to be selected through consultation. We have also institute an infra-departmental continuing educational programme consisting of formal lectures on specific disease states and their management on Fridays, followed by the presentation of the relevant case studies identified on our wards on Mondays. This has been very rewarding, well-received and educative for us all as they bring us abreast with current practices elsewhere in terms of drug usage.

Editor: Some people are of the impression that Clinical pharmacy is simply trying to practice medicine? What are your comments on this.

J.A.A.: I am sure this erroneous impression will not be formed if the concept is well-understood. To begin with, the training is not given in a medical school, although one may be lectured by medical practitioners.

The course is structured in such away as to emphasise the role that the pharmacist can and must play as an important member of the healthcare delivery team. Thus the Clinical pharmacist develops a new and wider perspective, ie. a clinical /patient-oriented pharmacy. One does not, therefore, lose his identity or aspire to take on new roles for which he has not received the requisite and prescribed training.

Editor: What challenges do you anticipate in your new role as a drug information/ward pharmacist?

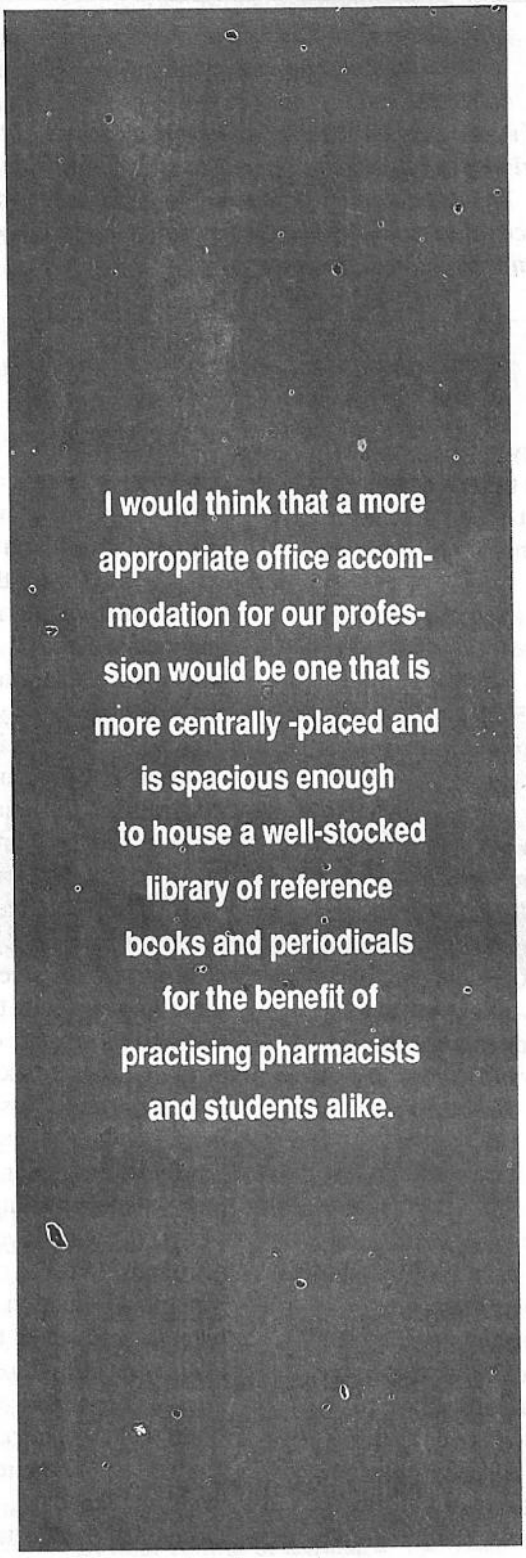
J.A.A. Certainly, not all health professionals will readily accept this new role for a pharmacist especially the ward involvement. However, I don't envisage any difficulty with the medical officers in this hospital because the concept of clinical pharmacy has already been accepted here. However, in other hospitals where is is a novel idea, one would expect some initial opposition or difficulty but this should not deter us from actively participating in patient care.

Editor: Are you of the opinion that clinical pharmacy will be the future of pharmacy in the areas of community and hospital pharmacy?

J.A.A.: Yes, certainly. From my experience in the hospital where I worked in the U.K, wards with no clinical pharmacists were asking for representation. The input of clinical pharmacists on the wards have led to a more cost-effective and safer patient management with increased savings to their respective hospitals. It is even more imperative in community pharmacy practice because a more effective patient education and counselling will be assured.

Editor: In your view how do you see pharmacists benefitting from clinical pharmacy? should it be a course at the faculty?

J.A.A.: The full clinical pharmacy programme is of course a postgraduate one. It involves lectures in the university setting but more importantly clinical involvement in the hospital setting under clinical pharmacists and others. Available resources might not favour the introduction of this course now. I see the need, however, for including an introductory course in clinical pharmacy in the undergraduate pharmacy curriculum at the faculty. Incidentally, I have a joint-plan with Mrs. Esther Osei, another Clinical pharmacist at the police hospital to run an introductory course in clinical pharmacy for practising pharmacists as an ongoing process in collaboration with the Education Committee of the Society. Core groups from the various regions would be trained as trainers in their respective regions.



Editor: What changes would you want to see in pharmacy practice in the country and what role would you want to play to effect these changes?

J.A.A: Currently, the pharmacist seems isolateed from the rest of the healthcare delivery team. This is obviously because of our drug-oriented approach.

With the advent of Clinical pharmacy in this country, I expect a much more active participation. Like other healthcare professionals, it will be a patient-centred practice that will portray us as active members in the healthcare delivery system.

Editor: How do you see the future for pharmacy in this country?

J.A.A: I see a very bright future for our profession. coming back to meet a lot of younger pharmacists interested in continuing education is very encouraging. I believe it is a step in the right direction. I don't see my profession progressing with out continuing education.

Editor: Any suggestions to the society or any of its wings?

J.A.A. The society should take continuing education more seriously. This can start at the level of the Society office. I would think that a more appropriate office accommodation for our profession would be one that is more centrally - placed and is spacious enough to house a well-stocked library of reference books and periodicals for the benefit of practising pharmacists and students alike. The education committee should develop programmes on an on-going basis. This can take the form of a day or more's seminar or short courses. The wings of the society can do the same to meet the special needs of their members.

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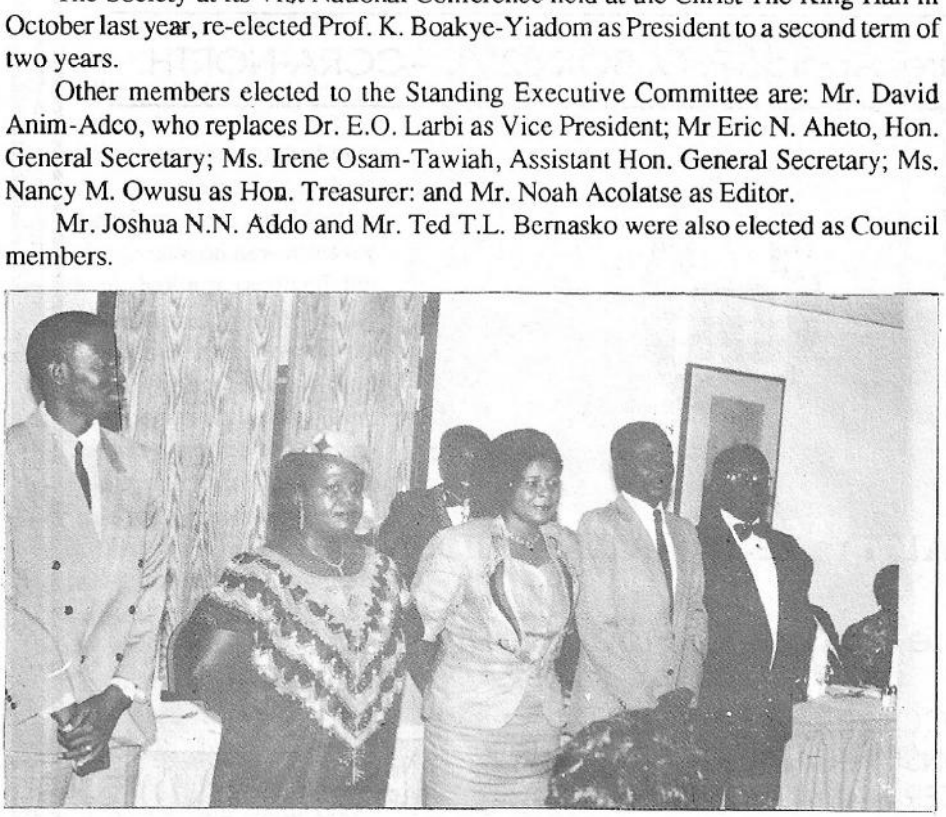
Society News

41st National Conference

The Society at its 41st National Conference held at the Christ The King Hall in October last year, re-elected Prof. K. Boakye-Yiadom as President to a second term of two years.

Other members elected to the Standing Executive Committee are: Mr. David Anim-Adco, who replaces Dr. E.O. Larbi as Vice President; Mr Eric N. Aheto, Hon. General Secretary; Ms. Irene Osam-Tawiah, Assistant Hon. General Secretary; Ms. Nancy M. Owusu as Hon. Treasurer: and Mr. Noah Acolatse as Editor.

Mr. Joshua N.N. Addo and Mr. Ted T.L. Bernasko were also elected as Council members.



Fellowship Awards

Four distinguished members of the Society have been awarded fellowships.

This was at the closing dinner of the 41st National Conference of the Society held at the Golden Tulip Hotel in Accra.

The proud recipients are Prof. K. Boakye-Yiadom, President of the Society; Prof. Reginald Ansa-Asamoah, the Pro Vice Chancellor of the University of Science and Technology, Kumasi; Mr. K. Ohene Manu, a past president of the Society and Mrs Eniton R. Gavu, Chief Pharmacist at the Cocoa Clinic, Accra.

Prof. R. Ansa-Asamoah (left) and Prof. K. Boakye Yiadom (right) congratulating each other after receiving their awards.

Next Issue of Journal

The editorial committee of the Pharmaceutical society intends to release another issue of the Journal before the end of the year. Members of the society are, therefore, encouraged to submit to the editor, articles and letters on various health related issues and on any other topic that would be of interest to the society.

Distribution of Journal

Members of the Society are kindly requested to furnish the secretariat with their current addresses to help in effective distribution of the journal.

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Notice Board

FUTURE EVENTS

Annual General Meeting of PSGH. (3rd - 5th September, 1992) The venue for this year's Annual General Meeting (AGM) is Atlantic Hotel, Sekondi-Takoradi, in the Western Region.

Members of the Society are encouraged to attend and actively participate in all deliberations and thereby contribute to the progress of the profession and the Society.

Bimonthly Meeting Of The Greater Accra Branch Of PSGH

Date: 20th August, 1992
Topic: Talk - Herbal Medicine, The Pharmacist's Point Of View.

Date: 20th October, 1992
Topic: Lecture/Film Presentation
New Trends in Antimycotic Therapy by the Local representative for Cilag Ag. International.

Date: 3rd December, 1992
Topic: General Meeting
Venue/Time: All programmes are held at the Social Advance Hall at 5.30 pm.

Pharmacy World Congress '92 - Lyon, France 13-19 Sept. 1992

This year's copngress is a joint event of the 52nd International Congress of FIP, the 45th National Congress of French Pharmacists and the 25th IPHARMEX (International Pharmaceutical Exhibitions)

Further Infromation from:

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2514 JL The Vague
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Tel: (31) 70 3631925
Fax: (31) 70 3633914

36th International Congress On Alcohol And Drug Dependence '92 - Glasgow U.K. (16th - 21st August, 1992)

Further Information From:

Congress Secretariat
The Scottish Council on Alcohol
5th Floor 137/145 Sanchielhall Street
Glasgow 92 3EW Scotland
Tel (within U.K.) 041 333 9677
Tel (International) +4441 33396 77
Fax (within U.K.) 041 333 1606
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3rd International Exhibition And Conference On Pharmaceutical Ingredients & Intermediates CPHI '92

Venue: The Rhein-Main Hallen Wiesbaden Germany
Date: November 17th - 20th, 1992

For Further Information Contact:

Caroline Kalh
P. O. Box 200
3600 AE Maarsen
The Netherlands
Tel ++ 31 3465 73777
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129th British Pharmaceutical Conference '92 (BPC 1992)

Venue: University of Birmingham
Date: September 7th - 10th, 1992
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Science Theme: "New Medicines Are Better Medicines"

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Announcement

Commonwealth Pharmaceutical Association (CPA) Primary Health Care (PHC) Data Base

As a result of a study of the role of pharmacists in PHC, the CPA is compiling a database of pharmacists who have been involved in non-pharmaceutical PHC activity (ies) in their location.

If you have been involved in PHC activities such as health education, provisional of general health care in rural careas, prompting good hygience and other similar roles which are not part of the traditional pharmaceutical responsibilities, please furnish the CPA Secretariat with the following information and a copy to the Editor of the Pharmaceutical Society of Ghana:

a. Name and Address for Correspondence
b. Qualification and major appointments held
c. PHC activities: Brief description of activity(ies) country (ies) and date(s).

Please use the following addresses:

The Secretary
Commonwealth Pharmaceutical Association
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London SE 1 7JN UK

The Editor
Pharmaceutical Soceity of Ghana
P. O. Box 2133 Accra

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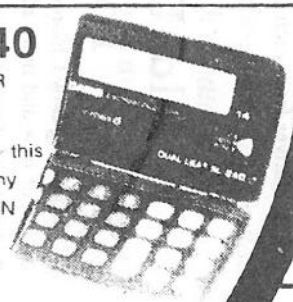

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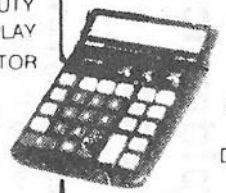

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Current Affairs

Aids On The Syllabus

The School Health Education Project of Uganda's Ministry of Education and Sports has made AIDS education an important part of the new primary basic science and health education syllabus.

"The aim is to ensure that children know how to avoid catching the virus, especially since we have heard of cases where older men and women are seducing young boys and girls who up till now have been AIDS free," says Mary Owor, programme manager of the project.

The new syllabus, on which children are tested in all primary schools, also addresses such issues as immunization, control of diarrheal diseases, nutrition, water and santiation. Children are encouraged to pass their new life-saving knowledge on to their parents

The Epidemic Spread

According to estimates by the World Health Organization, by the end of the century some 30 to 40 million people will be infected with the humane immune deficiency virus (HIV) that causes AIDS, more than 90 per cent of them in developing countries. Some 8 million to 10 million children will have been with HIV, most of them in sub-Saharan Africa. Since the pandemic began, about 1.5 million adults and 500,000 children have developed AIDS. In 19993 the disease is expected to surpass measles and malaria to become the second greatest cause of mortality in children, after diarrhoea.

Culled from First Call For Children, A Unicef Quarterly 1992/No. 2.

Malaria Strategy Means Global Struggle

Malaria kills over 1 million people every year. About 270 million people currently are infected with the malaria parasite and each year, hundreds of millions with the infection required treatment. Over 2 billion people or 40% of the world's population are at risk from malaria and, over the last ten years, the situation in most malarious areas has worsened. Malaria control is becoming is more and more difficult.

Recognising the increasing burden of the disease of global health, its effect on human development and the need for political commitment to reduce this burden, the WHO has convened a global Ministerial Conference on Malaria for October 26 - 27, 1992 in Amsterdam (The Netherlands). The Conference will bring together Ministers of Health and technical representatives from each of 95 countries, where Malaria is a Health problem.

Old Drug Yields Knowledge For New Researchers

Knowing how Chloroquine helps to destroy the malaria parasite, paves the way for the design of new and more effective classes of drugs to fight Malaria. Chloroquine and other quinoline-containing drugs such as quinine disrupt a defense mechanism of the Plasmodium falciparum. The parasite degrades haemoglobin in the host's blood for food. A breakdown product of haemoglobin, a red pigment called haem, is highly toxic to the parasite, which converts it into a crystalline not-toxic brown pigment, called haemozoin.

Culled from Health Horizons May 1992/No. 16

New Secretary For Health

The P.N.D.C. Government has appointed Commodore (Rtd) Steve Obimpeh as the new Secretary for Health, replacing Col (rtd) Osei-Owusu.

Before his appointment Dr. Steve Obimpeh was the Secretary for Agriculture.

The Government in a later reshuffle of portfolios transferred Dr. R.A. Ababio, who was formerly Deputy Secretary of Health to the Education Ministry on Secretary.

As at now, no appointment has been made to replace him at the health ministry.

Premier Monthly Health Care Newspaper Out

The maiden edition of the newspaper, Health Care Tit Bits is out. It is a monthly newspaper that is designed to serve as a suitable medium for the dissemination of information and news on health matters for the general public.

The Editor of this newspaper, Mr. Abraham Gyesie, a pharmacist, in November last year launched the Med-Index, an index of pharmaceutical specialities currently available in the country. Another member of the Pharmaceutical Society of Ghana, Mr. Oscar Bruce, in March last year, also launched the Health Courier, the premier journal for the healthcare professional. The purpose of the journal is to serve as an effective communication link between the various professions of the healthcare delivery team.

For Sale... Children's Bodies And Souls

by Sara Ann Friedman

Editor's Note: *The problem of child prostitution is an evil that is spreading from country to country at an alarming rate. This is especially so in countries where tourism is being developed very activiely. Countries where a few years back this exploitation of innocent children wqas virtually absent are now reeling under the magnitude of this evil.*

My hope is that this article would encourage us to add dour voices to those already working in the field to prevent such a catastrophe occuring in our nation, and to stimulate some members of the Society to take an active interest in specializing in areas that place emphasis on the health and in fact, the total well being of children in our community.

In 1987, a 13 year old Phillipine girl was killed by a European tourist when an electric vibrator broke inside her body and she bled to death. The toruist was acquitted on a technicality.

In the raid of a Bangkok brothel, Thai police rescured 18 girls ages 14 - 19. Seventeen testee HIV-positive. Accordidng to a health worker who interviewed the girls, fewer than half the customers wore condoms, each girl was servicing 17 men a night and receiving the equivalent of US10.80 per customer.

The parents of an 11 year old girl from the Tawian mountain provinces were paid by a policeman's wife to allow their daughter to go to the city. Lured to the house of a *cousin*, she was forcibly injected with hormones to trigger menstruation and the next day began receiving customers. Her family wanted to buy her back but could not find her until the young girl had been sold many times to different brothels.

These are but three of the thousands of documented cases of children as young as age five in many developing countries who are lured, abducted, *adopted* or sold by their families into brothels for prositutution and pronography, to serve the increasing demands of torurists and organized six tours from industrialized countries.

Since the growth of tourism during the 1970's child advocates have noted with alarm the explosion of child prostitution into a multi-million dollar international industry. As field workers have observed, whole villages are bereft of young girls, with children taken from their homes by force of false promises and illegally transported across many borders to prison-like brothels in dozens of Asian cities and adopted homes in the industrialized countries of Europe and North America.

> The worsening situation has prompted campaigns and action against those who trade in the bodies and souls of children.

The worsening situation affecting younger and younger victims has prompted a new international campaign, and several governments, including Germany and Thailand, plan to take stronger action against those who trade in the bodies and souls of children.

A New Campaign

JOint NGO activity, spearheaded by an international campaign and coalition, End Child Prtostitution in Asian Tourism (ECPAT(, is calling for the end of tourism-related prositition in four Asian countries - Tjhailand, the 1993. The time has come, says Ron O'Grady, New Zealand clergyman and coordinastor of ECPAT, "for concerted action among NGOs, churches and the rest of the world to create the necessary moral outrage that will change attitudes, pass new lawa and enforce existing legislation. NO society can go on destroying children in such large numbers.

Common causes

NGOs working in the field have pointed to deepening economic and social problems that make solutions to the problem both more elusive and more urgent. Increasing urbanization, accompanied by the breakdown of family support systems and risisng family violence, wider economic divisions between

North and South and links among poverty, debt service and tourism, are sosme of the complex forces conspring to thrujst these children into a world they cannot cope with, a world eager to exdploit and abuse them. But the problem is not confined to tourism, or to Asia. It is a problem of immense proportions, involving local men on many levels, touching every sector of the world - urban and rural, North and South.

A human rights issue

In Nobember 1991, an African regional conference, 'Culture, Sex and Money: *Its Effects on Woman and Children*, was held in Abidjan, cote D'Ivoire, sponsored by the International Abolitionist Federation (IAF); the International Catholic Child Bureau (ICCB) and Environmental Development Action in the Third World (ENDA). The Conference stressed the human rights aspect of child prostitution, with participants urging governments that have ratified the Convention on the Rights of the Child to implement their committments, and those that have not ratified it to be pressured to do so.

A report published in 1989 by Redd Barna (Norwegian Save the Children), The Sexual Exploitation of Young Children in Developing Countries, 'describes child prostitution as the "worst form of exploitation...an outright attack on the most fundamantal rights of a human being: the right to decide obver his/her own body, own health, own mind".

The AIDS factor

The problem has been most recently exacerbated by AIDs, as men seek younger and younger girls, especially virgins. Paradoxically, it may also be the AIDS crisis - already devastating Africa - now on the doorstep of Asia that has prompted some governments to acknowledge the huge scrope of the problem. The Thia Government has just passed legilation to stiffen penalties for perpetrators and will actively participate in ECPAT's first international conference, being held in April 1992 in Bangkok.

Making the laws work

Many observers are sceptical about law enforcement - present or future. Illegal under almost every national law, and outlawed by the Convention on the Rights of the Child, sexual exploitation of children is denied by officials and winked at by local enforcement officers. Researchers are threatened by organized crime elements, releuctatnt to anxious to develop tourism, are unwilling to touch foreigners, including military personal, who commit crimes in their country. In 1988, the United States Investigative Serviceds mounted an undercover investigation of reported child prostitution rings in Olangapo City, Phillippines. The official report was never released, but a copy found its way to the PREDA Foundation, where Father Shay Allen reported that agents were offered children as young as four and five.

ECPAT has offices in 13 cxountries, including several sender countries where the primary demand for children originates: Austrialea, Canada, Germany, the Netherlands, New Zealand, Switzerland, the USA.

Germany, a major source of European tourism to Southeast Asia, has taken the lead in cracking down on the worst excesses of sexs tourism. The Government has recently passed legislation that will make punishable in Germany the abuse by any German citzen in any country of a child of any nationality.

In India, the largest incidence of child prostitution in the world has been recorded.

Child Prostitution - The Global Toll

"One million children are forced into the sex market every year" (Report from the Norwegian Government to the UN working Group on Slavery, 1989)

An accurate estimate of the number of children involved in prostitution is not easy to obtain because the issue is most times, under reported or unacknowledged. Traffic in children is illegal in most countries, including Ghana. Apart from a few isolated cases that appear in our papers, very little publicity is given to this problem in our country.

Estimates of the extent of this problem in a number of countries is given below:

In Thailand, estimates from the National Youth bureau in 1989 puts the figure of child prostitutes at 2,500. Voluntary agencies and NGOs concerned with protection of Children's rights suggest the number is between 200,000 to 400,000 prostitutes under age 16 who work in 60,000 brothels.

In Sri Lanka, child prostitution was virtually unknown before the 1970s. Today, boys aged 6 - 14 have become victims of international paedophiles, whilst girls are still carefully guarded until marriage. Official estimates of beach bosys engaged in prostitution are 2,000; child advocate researchers estimate more than 10,000.

In the Phillipines, NGO estimates place the number of child prostitutes in Manila today around 40,000, twice UNICEF figures from 1987. In tourist areas and towns near the American military base in Olongapo, they estimate 25,000 or more. During the 1980s, 15 cases of sexual abuse of children aged 11 - 16 and 82 cases of abuse of young women over age 15 were filed against US servicemen. All were dismissed.

In Taiwan, 80 per cent of the prostitues are drawn from 2 per cent of the population, as an etimated 30,000 indigenous women and girls are lured from their home villages in the mountain provinces by promises of a good life.

In India, the largest incidence of a child prostitution in the world has been recorded. According to the Indian Journal of Social Work, 20 per cent of the estimate 1 million prostitutes in Bombay alone are minors. In addition to brothel prostitutes, many thousands of pre-puberty lower caste girls throughout India are dedicated annually as temple prostitutes, and the more than 400,000 young girls employed as domestic workers are at special risk of sexual abuse and exploitation.

In Brazil, there are ChildHope reports of 500,000 street children, many of whom are engaged in prostitution.

Child pornography, another facet of sexual exploitation, exists in all countries where there is child prostitution and, according to the 1989 Redd Barna report, it is the same children who are involved. The report says: "The USA and Europe are the prime markets for child pornography. It is claimed there are about 500,000 paedophiles in the USA and that they represent 85 per cent of the consumers of all pornography produced".

Culled from: First Call for Children, a UNICEF quartely

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Drug Regulation, Information And Quality Control

DSE Course Ends In Lilongwe, Malawi

by Ben Botwe,
B. Pharm (Hons), MPS GH
Pharmacy Board, Accra

DSE, Lilongwe, Malawi, 1991. The writer is first from left

Introduction:
The German Foundation for International Development (DSE) in conjunction with the WHO , organised a three-week intensive course for officers of Drug Regulatory Agencies from 1st to 19th December, 1991, in Lilongwe, Malawi

The course was aimed at equipping young drug regulators with modern trends in Drug regulation, information sources and utilization, Quality Control and Good Manufacturing practices, as well as evaluation of dossiers for purposes of Drug reregistration.

Twenty five participants drawn mainly from English speaking African countries vis, Ghana, Nigeria, The Cameroon, Namibia, Zimbabwe, Sudan, Kenya, Tanzania Uganda, Zambia, Botswana, Mozambique and host nation, Malawi; attended the course.

Course Content:
The course was broadly organized in three parts. The first part was on the need for a Drug Regulatory Authority (DRA) as part of a National Drug Policy (NDP). Guide-

lines for the establishment of small DRA's were highlighted. The need for a legal framework within which the DRA's should operate weals also emphasized. Some of the main reasons for drug control were identified to include consumer protection, protection of the producer's patents, production methods and research investments, protection of wholesalers and retailers, as well as political protection of the government.

The second part dealt with the safety, efficacy and quality in Drug registration and control. The necessary documentation and critical issues involved in this area were examined in detail in order that the drug market , and for that matter, the consumer who is the patient, is not exposed to dangerous,s ineffective and substandard drugs.

Part three dealt with the main issues involved in Quality Control (QC) and Good Manufacturing Practices (GMP) inspections. This included inspection visits to various Pharmaceutical concerns in Malawi, including the Kamuzu Central Hospital, and Central Medical Stores, both in Lilongwe, Pharmanova Limited, Malawi Pharmacies, and the Central Medical Stores in Blantyre.

Apart from these three broad areas, the need for post-registration surveillance and stability studies of drugs on the market were stressed.

Resource persons from various WHO offices wave information on the broad activities of the organisation and emphasised on the specific areas of concern to DRA's These are:

1. Sources of WHO information bulletins, how they are disseminated and their utilization.

2. WHO fellowship, bursaries and other grants fro the training of manpower in Drug Regulation and Control. This, it was emphasized, is available for both local and foreign training programmes.

Orther resource persons from Zimbabwe, Malawi and The Gambia gave their experiences in Computerization of Drug Registration, National Drug Policy and Quality Control Systems respectively. There were sessions for country presentations where various participants presented profiles of their DRA's and various specific activities that they perform.

Recommendations:

The following recommendations were made for the attention of all DRA's of the participating countries:

1. There is the need to have a National Drug Policy - a framework within all policies on drugs are formulated.

2. DRA's should make provisions for effective reporting systems and ensure the right of appeal by its cclients.

3. Information concerning all actions and decisions must be freely and effectively disseminated. To this end, it was suggested that all DRA's bring out a monthly or quarterly newsletter or bulletin.

Drug registration procedures must be critically examined and must include veterinary drugs. It was further suggested that a Veterinary Expert could be c0-opted onto the DRA's Committee on Drug Registration to advise where necessary. It was also suggested that the process should be computerized to provide easy access to Drug registration information.

5. G.M.P. inspection visits to local drug manufacturing Companies must be intensified.

6. DRA's must have monitoring Quality Control Laboratories which must be operated such that they would be self sustaining.

7. DRA's are also to make use of existing WHO fellowships and other areas for the training of personnel which was found to be a major problem of most participating countries.

What Is A Pharmacy?
Who Is A Pharmacist?

Pharmacies - whether they are community pharmacies or hospital or clinical pharmacies - all dispense drugs. Community, or retail, pharmacies are public places of business that sell drugs. Community pharmacies are also known as drugstores and chemist shops. In many countries all these names means the same thing, but in other countries drugstores and chemist shops carry only over-the-counter medicine and are not allowed to dispense prescription drugs. In Columbia, for example, for example, a pharmacy and a drug store are the same. In Zambia, however, drugstores are not allowed to distribute drugs that require a prescription (91). In still other places - Jordan and most Latin American countries, for example - the term drugstore refers to wholesale drug outlets, which do not sell to the public (217,314). In general, this issue of Population Reports uses the same terms adopted by each researcher as appropriate in the country studied.

Pharmacies range from large chain stores to small, independent neighborhood shops. Chain stores are not as dominant in developing countries as they are in some developed countries. In Latin America the botica, the small, independent, family-owned, neighborhood pharmacy, is still common.

In some countries the government runs some of most of the pharmaceutical industry. In Algeria, for example, the state has a monopoly on the importation, manufacture, and wholesale distribution of pharmaceuticals (77). In Cameroon the government runs pharmacies attached to health clinics or hospitals. These pharmacies distribute medicines free or for a small charge. They may be run by a health worker with no special qualifications (308)

The staff at a community pharmacy may consist of the owner and/or pharmacist, pharmacist assistants, and clerks. A pharmacist is a graduate of a professional pharmacy school - usually a 4 or 5 year program - who is licensed to dispense drugs.

Pharmacies range from large chain stores to small, independent neighborhood shops.

There are approximately 157,000 formally trained, licensed, and registered pharmacists in the 27 developing countries for which information is available. This figure includes 86,000 Indian pharmacists. The total number of people working as pharmacists is larger, of course, because many have no formal training. They may be self-taught or have worked in another pharmacy before opening their own pharmacy.

Most countries require pharmacies to employ a licensed pharmacist. In some countries - for example, Egypt and Morocco - the law requires that pharmacies be both owned and managed by a licensed pharmacist. Such laws are not universally observed, however. In some Asian and Latin American countries, pharmacists may rent or lend their licenses to several pharmacies but not work in any of them (241,319). In fact, in most developing countries drugs are available from untrained pharmacists as well. Trained pharmacists tend to open pharmacies in urban areas. They may then serve as wholesalers to shops in villages that are too small to support a full-fledged pharmacy. In Thailand, for example, village drug sellers may have worked in a pharmacy or for drug companies before opening their own village pharmacies. a trained pharmacist may come periodically - perhaps once a week - to satisfy legal requirements that each pharmacy employ a licensed pharmacist (317).

Pharmacist assistants and clerks may have more contact with customers than pharmacists have. When pharmacists own or operate several pharmacies, clerks at one location may be in charge while the pharmacist visits the others. In contract to pharmacists, pharmacist assistants and clerks generally have no professional education and may have little formal schooling. Pharmacist assistants may be simply experienced clerks who have been promoted.

Still, in some countries, particularly in Latin America, the percentage of family planning users supplied by pharmacies is similar in urban and rural areas. It may be that urban pharmacies are convenient to some rural residents, too, because many people travel between urban jobs and markets and the villages where their families live.

Pharmacies also are convenient because they stock many products besides drugs. They can save customers a trip to another store to buy household items such as soap or cosmetics.

Culled from Population Reports Series 1, Number 37.

APPROPRIATE DRUGE USE

The Psychiatrist's View

by Dr. Med. Yaw Osei

Department Of Behavioural Sciences,
UST/School of Medical Sciences, Kumasi.

Lecture delivered at the Annual General Meeting of the Pharmaceutical Society of Ghana at the University of Science and Technology, Kumasi on 1st October, 1990.

Introduction

Ghanaians are currently locked in a great debate on the issue of drugs. Public consideration especially on *drug abuse* has become increasingly important and I consider it a privilege to be asked to contribute to the debate on drug use before a group of health professionals whose stock in trade is *drugs*.

Of course, to really describe the history of drug use would be to write much about the history of mankind. All cultures at all times seem to have had available some type of drug for use. Nevertheless, it is impossible to define *drug* with any precision, that is in a way that would satisfy everybody.

"Appropriate Drug Use" may be seen within two frameworks, namely "use of the appropriate drug" and secondly "appropriate use of a drug". Within the first framework, one should understand use of the most suitable drug for the treatment of a particular disease category as eg. the use of insulin in Diabetes mellitus or Asprin for headache. The second framework connotes the proper way of using a drug: that is to say, whether the drug is supposed to be curative, suppressive or prophylactic. The use of both frameworks is not merely polemic nor splitting of hair but should help throw light on some basic issues involving drugs.

The Appropriate Drug

Half the battle is won if one gets the right doctor of health professional for a particular medical of health problem.

Consequently, the history of Medicine - and probably too of Pharmacy and other health professions - shows clearly that the most appropriate drug is the health professional by whatever name we call him : "Medicine man" traditional healer, physician etc, etc whose interest and duty is to alleviate suffering in others (1) Indeed, in more recent times, Balnit

(2) has clearly demonstrated in a series of seminars at his clinic that "by far the most frequently used drug in general practice was the doctor himself, ie. that it was not only the bottle of medicine or the box of pills that mattered, but the ways the doctor gave them to his patient - in fact, the whole atmosphere in which the drug was given and taken".

A cursory glance at our hospital practice and reflections on remarks concerning the performance of our nurses indicate that the public put similar responsibility on nurses. I should like to suppose that in the Ghanaian setting, the greatest awareness of such responsibility is expected of the pharmacist or the dispenser whose duty indeed is to give the bottles and sachets of drugs to the patient. However, this appears to be a far cry from current reality, and serious attempts need to be made to enable the practising pharmacist become appropriate drug for his patients. Clinical pharmacists of the right calibre, teamed up with doctors, nurses and other health professionals will not only be such drug but should be able to counsel on the proper use of drugs. In other words, we should strive to make the health professional the most appropriate or primary drug and the chemical drug only his auxillary.

Appropriate Use Of Drugs

According to the World Health Organisation, a drug is a substance or product that is used or intended to be used to modify or explore physiological systems of pathological states for the benefit of the recipient"

3. Among health professionals of whichever country in the world, the word *drug* means a single chemical substance that forms the active ingredient of medicine and may be used for curative, suppressive and prophylactic purposes.

4. The current popular debate in Ghana, however, tends to want to label drugs as harmful, dangerous or addictive substances, which is rather unfortunate.

Certainly, drugs bear all these disadvantages particularly when they are abused; for this reason the health professional must learn to chose which drugs to use and to apply them correctly in relation, not only to properties of the drug but also to those of the patient and his disease.

Thus, for the health professional appropriate use of drugs should mean being well informed about scientific principles concerning a drug. These include

a. Rejection of all propaganda slogans in respect of drugs, eg. "stabilizer of the nerves." "blood purifier" "energy for the whole family," whatever these might mean.

b. Skepticism vis a vis drugs alleged to have no side-effects.

c. Prescribing only drugs, the contents of which are qualitatively and quantitatively declared on a label.

d. Inspection of the structural formula of the drug to find out if some analogous drug were not already known and available perhaps at a cheaper price.

Ideally patients should also act similarly, at least with respect to rejecting propaganda slogans and knowing about the side-effects of drugs. In other words, patients should also learn to use drugs correctly.

Classification Of Drugs

From the foregoing, it is evident that drugs intended to relieve suffering, can be *human* or *chemical*. The *human* drug is primary and in the narrow sense of the term involves the relationship between the health professional and the patient whether this patient is the individual or the community. However, we must see the human drug in the wider sense too. We should never lose sight of the fact that it is human beings who bring about the social and economic development leading to improved living conditions that have played the major role in the enormous decline in morbidity and mortality in some parts of the world. Pharmacists should therefore not be content with establishing report with their individual patients but should use their talents and training to help improve the social and economic conditions of our people. When we have both roles in view and play them well, we would be true to the people's conception of us as drugs. This is the basis of Psychotherapy.

With respect to the chemical drug, this is auxiliary to the human but not less important. We might hear the familiar saying ever so often "prevention is better than cure," but those who are unfortunate enough to contract a disease will be grateful for the chemical drug. We *cure* many diseases and symptoms with drugs, *suppress* other diseases and symptoms with drugs and *prevent* yet others with drugs. Whether they cure, suppress or prevent disease, drugs are intended to enable the patient to lead a normal life again, possibly without any hindering influences of illness. This is the essence of *chemotherapy*. Without the *chemical* drug most often the *human* drug can do little as in the case for example, when the psychiatrist meets the severely mentally ill for the first time. It is the auxiliary drug that then facilitates establishment of relationship between the primary or human drug and the patient.

> "For the health professional appropriate use of drugs should mean being well informed about scientific principles concerning a drug."

Looking at the way chemical drugs are used in this country, I am inclined to classify them according to the following criteria:

Group 1: *Anti-morbid* drugs used in connection with some illness or disease. They may be prescribed by the doctor in hospital or clinic, *dispensed* at the pharmacy with or without prescription, or given out by the traditional healer or prepared and taken by the sick himself with or without advice of a trusted second person.

Group II: *Ritual* drugs ie. socially acceptable drugs, almost taken in company and intended to modify mood or performance. Examples are alcohol, tea, coffee, tobacco, cola nuts etc.

Group III: Socially repulsive drugs like marijuana, cocaine, heroine etc, taken by some individuals to obviate states of unpleasure or to obtain hedonic gain.

In the current public debate, undue emphasis and attention have been given to the Group III drugs, and I crave your indulgence to limit myself to the Group I drugs, namely the drugs I prescribe to alleviate or cure a patient's problem.

Appropriate Drug Use

It goes without saying that our people should be provided with the appropriate human drug in quality and quantity, leaving aside the human drug for the time being, I wish to observe that drugs,s in the sense of chemotherapy, are on e of four main pillars, albeit a very important one, for the treatment of psychiatric disorders. Especially the introduction in 1952 of chlorpromazine (Largactil) by Delay and Denniker has brought about much progress in this direction: It has helped us get rid of restraining devices on patients; psychiatric clinics have taken on many characteristics of *ordinary* hospitals and today many General Hospitals (as our own Komfo Anokye Teaching Hospital in Kumasi since 1987) dare accommodate patients with psychiatric disorders under the same roof as patients with

physical problems. Rehabilitation of patients has become largely possible in the community.

Many different drugs are now available for the treatment of psychiatric disorders:

a. The neuroleptics or antipsychotic drugs

b. The anti-depressants, used in cases of depression

c. The anxiolytics or anxiety-relieving drugs

d. The sedatives/hypnotics used to induce or enhance sleep.

Inappropriate use of drugs from any of the four groups leads to untold suffering in the patient and his family as the following examples illustrate:

i. A 34 year old woman has taken Largactil for over four years, ostensibly to increase her appetite and gain such weight as would make her more attractive in her traditional *ntama* dressing. On the advice of her fiance she called at our clinic with complaints of difficulty in falling off to sleep, having first tried all the known sleeping tablets in town, in vain. She was admitted on the medical ward of Komfo Anokye Teaching Hospital and treated successfully of the insomnia but she carried with her a permanent problem in the form of fine tremors of the fingers and an inability to sit still for any length of time.

ii. A 45 year old female foreigner resident in Kumasi committed suicide one afternoon with the help of tablets and alcohol. She had been continuing with antidepressant drugs prescribed for her in her native country. Without adjuvant psychotherapy and close monitoring of her drug treatment, the inevitable happened when she became lucid.

It is worthwhile to remark in this connection that antidepressants show their specific effect only on depressive patients and not on healthy individuals or even on experimental animals.

Since they are of no use to the health, antidepressants hardly stand in danger of inappropriate use by the healthy.

iii. We need not belabour the problem of dependence associated with anxiolytics and sedatives/hypnotics nor with analgesics and alcohol. One who is dependent tries by means of the same drug in increased amounts to obtain a specific effect, be this in behaviour, experience or well-being. He becomes physically and psychologically hooked to the drug and might develop withdrawal symptoms or go to any extent, including use of violence, to obtain the drug when he is denied it.

Finally I am obliged to comment on the many drugs that cause psychiatric comments. Many commonly non-psychiatric drugs can cause serious mental symptoms including depressions and disorders that may resemble schizophrenia. Among the *convicted* drugs, the effect of some we ourselves have witnessed in our clinical practice, are:

a. Chloroquine - which may lead to confusion, delirium and hallucinations.

b. Oral contraceptives - depression

c. corticosteroids - mainia, depression, confusion, paranoia, hallucinations, catatonia.

d. Indomethacin - depression, confusion, hallucinations, anxiety, hostility, paranoia.

e. Methyldopa - seven depression, hallucinations, paranoia, amnesia, nightmares

f. Procaine Penicilline - Terror, Delusions, Hallucinations, disordentation, agitation, confusion, bisarre behaviour, seizures, incoherence.

The list (5) indeed is formidable.

Conclusion

What shall we do? Of course, drugs have more beneficial that adverse effects especially when taken taken appropriately, ie. according to the advice of the qualified, conscientious health professional. As far as psychiatry is concerned, the gains of civilization would be levelled to the ground were we to forego the use of drugs. However, our drugs need to be dispensed with caution: they need to be used critically and we need to improve them further for the benefit of our patients. Above all, the health professional must be aware of his role as the primary drug and play that role well. This is valid in our Ghanaian setting for the doctor, the nurse and probably much more so for the pharmacist.

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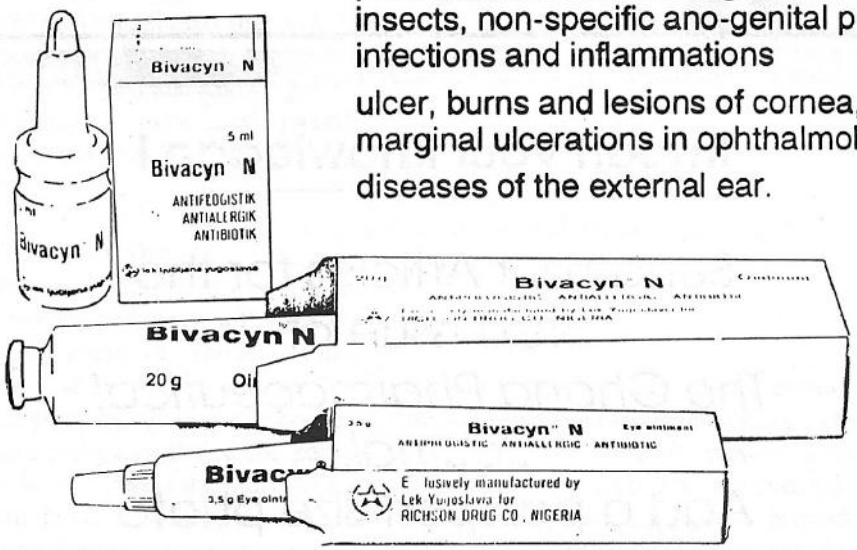

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Inappropriate Drug Use
Problems In General Medicine

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This paper, which was part of a Symposium, was presented at the Annual Genral Meeting of the Pharmaceutical Society of Ghana 27th - 30th September 1990

Inappropriate use of drugs is a matter of concern to health workers in Ghana. Three groups of people namely, the pharmacist, the physician and the suffering patient are those who are involved and mainly confronted with this problem. The major underlying factor for drug misuse result from errors of prescription and administration, which may be due to (a) illegible and inadequate instruction (b) the use of proprietary drug combination (c) poor patient compliance (common in the elderly and the socially isolated, worsened by complexity of drug therapy and poor doctor-patient relationship)

Drugs are prescribed by the physician for no other purpose but to achieve treatment. The aims of treatment may be cure, control of disease, relief of symptoms, placebo or prophyulaxis. Drugs such as antibiotics are prescribed to eradicate the infecting organism and to achieve complete cure as in the case of acute pneumonia. Diseases such as epilepsy, congestive cardiac failure, hypertension and diabetes mellitus relief pain in malignancy or in pleural pain in lobar pneumonia does not alter the course of disease but the patient benefits considerably. In the same way some drugs such as blood tonics, vitamins and liver preparations are given to please the patient or his family (placebo). They are of no therapeutic value and some are merely expensive. A placebo can reasonably be sued during investigation to maintain the cooperation of the patient and sometimes during the long term observation in some patients for whom no treatment is appropriate or available.

Method, Material and Assessment.

Between July 1990 and August 1990 an attempt was made to study the problems of treatment with special reference to

1. Prescription of drugs
2. Routes of administration
3. Drug interaction
4. Reaction to treatment

The study was partly hospital based and partly community based. 200 prescriptions collected from in-patients and out-patients of the Komfo Anokye Teaching Hospital as well as patients from Polyclinics within the city of Kumasi were scrutinized. 50 prescriptions from general practitioners in Kumasi were also examined. 8 pharmacists comprising hospital based pharmacists, pharmacists representing pharmaceutical firms and pharmacists in the private sector, were consulted. 186 patients who have hypertension and some of them suffering form diseases such as congestive cardiac failure, uraemia and stroke were also included in the study. 50 out patients were randomly selected and interviewed.

Results

It was observed that:

a: patients are not given adequate instruction about the use of drugs: 20/50 (40%)

b. names of drugs are not written on the containers: - 32/50 (64%)

c. drugs which are inappropriate and are also expensive are prescribed to patients: - 42/100 (42%).

d. Doctors fail to write the diagnosis of the patient on the prescription form although is is so stipulated by the Ministry of Health: - in patients only: - 4/50 (8%), out patients only: - 118/150 (78.6%).

e. patients abandon orthodox medicine to consult traditional and spiritual healers who promise cure for every ailment: - 35/186 (18.8%).

f. patients admit to irregular medical treatment: - 130/186 (69.89%)

g. patients admit buying drugs without prescription form renowned pharmacy shops: - 26/50 (52%)

h. patients indulge in self-medica-

tion prior to first consultation with a physician: 40/50 (80%).

Assessment Areas Of The Magnitude Of The Problem

Due to ignorance, poverty and or poor doctor-patient relationship inappropriate use of drug is recognised as a major problem in Ghana.

The statement, "your disease has no complete cure yet and can only be controlled is unacceptable among many Ghanaians. Patients (18.8%) seem to abandon the orthodox medicine in such a case. They consult the traditional and spiritual healers who promise cure for all ailment. A diabetic or hypertensive patient goes to them only to come back to the hospital in a worse condition. There are three principle if this treatment (control of disease) is to succeed.

1. The cooperation and understanding of the patient and his immediate family members must be won.
2. An adequate continous supply of drugs must be assured.
3. The interest of the doctor must be maintained.

Problems During Treatment

Problems during treatment: (a) routes of Administration (b) Drug interactions and (c) reactions to treatment

The routes of administration may be oral, talk, parental or intravenous. Many a time we forget that some intestinal diseases may alter drugs absorption and as such oral or rectal application of the drug is inappropriate. In the same way we find that ampicillin is unstable if infused above 2 hours. Frusemide, Benzylpenicillin and Diazepam are stable for 6-8 hours when infused.

Greenblatt also advised that drugs such as digoxin or phenytoin, for which precise dosage is essential should not be given intramuscularly because rates of absorption form intramuscular sites have been found to differ from site to site. Thus absorption is more rapid in the deltoid than in the vastus lateralis muscles; it is lowest of all in the gluteal muscle.

Drug Interaction

It was found that many medical practitioners attempted to use polypharmacy during their practice. This is often the case since in Africa most patients have more than one disease and so need more than one drug. Mistakes in dosage and adverse drug reactions increase exponentially with the number of drugs given. Many physicians (42%) try to please patients by prescribing as many as 10 different drugs. This was the case of a patient who had congestive cardiac failure as a result of hypertension and who had also mild anaemia. He received prescription of valium, fersolate, paracetamol, digoxin, lasix aldactone, methyldopa, ampicillin, folic acid, vitamin B-Complex and Multivite. In addition the relatives provided him minamino, lucozade and multivite-strong.

As a matter of fact only three or four of the drugs might be needed to treat the patient. Namely, Diurectic, antihypertensive agent and correction of anaemia wkith iron therapy. When the patient has recovered, he might need only the antihypertensive agent and the Diuretic with or without potassium supplement. Potassium could be given in the form of fruits such as Banana or Coconut Water. The patient and the relatives who do not understand the drug interaction will protest against the fewer drugs administered and it is the duty of the physician to explain to the patient the basis of the management of the disease.

Simplicity of treatment

When a working diagnosis has been made a treatment is chosen and an appropriate drug(s) is identified. It is necessary to keep treatment as simple as possible. Drugs which are not of proven value should not be given. The choice of a drug depends on several properties and variables including: The therapeutic efficacy, the cost, the likely side effect or toxic effects, route of administration, a continued supply once treatment has started, the availability of refrigeration for storage and the general condition of the patient. It was often noticed that a patient with uncomplicated (mild) viral hepatitis gets Glucose drinks, (iv) infusion of dextrode, paracetamol, vitamin B-Complex at times antibiotics and other expensive drugs such as reducdyn. The relatives also secretly give the patient concotions from the boiled pineapple and or liquid left over from boiled kenkey.

The accepted management of mild hepatitis in orthodox medicine is bed rest. Any of the drugs stated above will not alter the course of the disease. They may even be harmful since they put the sick liver to more work. A low fat diet often prescribed is of no therapeutic value, but many patients are nauseated by fat, in which case restriction is common sense. Antiobiotics are of no value.

Reaction to Treatment

It is the duty of the physician to explain the itching reaction of Diethylcarbamazine in the treatment of oncocerciasis and at the same time prescribed an antidote against the reaction (Type I allergic reaction). It is also the responsibility of the physician not to prescribe sulphonamides, Nitrofurans and Primaquine to a G-6-PD deficient haemolysis in such a patient. Many physicians and pharmacists (40%) did not give adequate instructions to the patients.

Discussion

In the developed countries, we find that 10-20% of the patients in hospitals suffer an adverse reaction to a drug and about 5% of hospital admission are precipitated by drug reactions. The drugs commonly responsible are antimicrobials, Asprin, Digitalis, Diuretic, corticosteroids, anticoagulants, insulin, Phenylbutazone, indometacin, halothane and amitriptyline.

In the developing countries we are confronted with malnutrition, disease of environmental sanitation, communicable and parasitic diseases, once a while we meet adverse reaction to insulin and other oral hypoglycaemic agents in form of coma. We are also particularly concerned about the uncontrolled use of a drug like prednisolone. It is termed P in our community. Some women we examined took this drug on their own to increase their appetite and in effect to be obese. Obesity is regarded in Ghana as a sigh of good living (affluence). We met serious side effects of the unprescribed usage of prednisolone. Application skin lightening soap rendered many permanent skin lesions.

Ofori Adjei (19878) tried to study the treatment of malaria, in Accra by collecting prescriptions from General Practitioners, Polyclinics in and around Accra and also from Korle Bu Teaching Hospital. To his dismay, he observed that only a few physicians prescribed to patients the accepted malaria treatment regime of total doses of chloroquine-base

25mg/kg body weight. The public including some medical personnel equates the decreased sensitivity of P falciparum to chloroquine in vivo to chloroquine - resistance. Thus people tend to take fansidar and quinine contrary to indications.

Ofori Adjei noted in Accra decreased sensitivity of P. falciparum to chloroquine with mean clearance of 3.09 + 1.06 days Matilda in Zaria reported mean clearance of 3.45 + 1.25 days and Acheampong et al reported in Kumasi mean clearance of 3.72 + 1.52 days. In this study it was also observed that: (a) 40/50 (80%) of the patients had some sort of self-medication prior to their first consultation with the physician. Patients who had febrile illness took paracetamol, Asprin or Daga (acetylsalicylic acid, P-acetamidophenol, 1, 3, 7 - Trimethylaxanthine). The children receive enema of ginger and hot pepper and adults took Anthelmintics. There is a strong belief in this subregion that febrile illness is also caused by worm infestation

(b) Patients with stomach or abdominal pains took antibiotics and the children received enema whether were constipated or they had diarrheal stools. Such self-medications masked they clinical picture of the diseases and made diagnosis and treatment difficult.

There is evidence of inappropriate drug use in the general practice. The most important contributing factors are the poor doctor-patient relationship and inadequate instruction from the pharmacist. I am much convinced that, as people in Africa become more prosperous and better educated, we will enjoy the benefits of modern scientific medicine. Infections will cause less disability and death but some non-infectious disease will increase.

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Intrauterine Devices

One Hurdle Less

After years of controversy in some parts of the world, a class of reversible contraceptives known as intrauterine devices, or IUDS, is enjoying a revival. And for good reasons. Today, the second and third generation of IUDs that are available to family planning programmes have a proven track record. Their performance in terms of efficacy and safety differs dramatically from that of twenty years ago. for example, the pregnancy failure rates have improved six-fold over the earliest devices down to 0.5% per year. Health care providers in many countries of the world increasingly consider IUDs as one of the most effective reversible methods of family planning.

For nearly twenty years, the World Health Organization (WHO) has conducted in-depth examinations of different aspects of IUD safety and efficacy. In particular, this has led to the effective life span of specific copper devices to be extended to at least eight years of use. A recent review of twelve studies involving nearly 23,000 IUD users has permitted and investigation of the are, but potentially serious, complication of pelvic inflammatory disease (PID). The disease can lead to chronic pain and infertility. Results of the project conducted by WHO's Special Programme of research, Development, and Research Training in Human Reproduction are to be published shortly in the Lancet, one of the leading medical journals. The studies, which started in 1975, involved women from 47 centres in 23 countries: eleven countries, nine centres in six North, Central and Southern American countries, fifteen centres in China, and one centre in Africa.

The findings indicate that PID risk is minimal in women who are at low risk for sexually trans-mitted diseases, in other words, among couples in monogamous sexual relationships.

The possible association between IUD use and PID has been a central issue of the device's safety and has influenced decisions on its use throughout the world. Since research conducted mostly in the late 1970's and early 1980's suggested such an association IUD use decreased, and, two large American manufacturers withdrew their IUDs from the United States market. In the United States, the number of women using IUDs fell from 2.2 million in 1982, to approximately 700,000 users in 1988. However, worldwide, approximately 84 million women used an IUD in 1987; close to 60 million of these were in China.

Recently, a better understanding of PID etiology has prompted questions about sexual behaviour and other lifestyle factors, such as smoking, in studies of IUD users. The findings indicate that PID risk is minimal in women who are at low risk for sexually transmitted diseases, in other words, among couples in monogamous sexual relationships. The WHO data show that PID risk does not increase with long-term IUD use even up to at least eight years. It was found that the risk of PID was even up to at least eight years. It was found that the risk of PID was higher in the first three weeks following insertion. Because of the increased risk of PID and other potential complications associated with device insertion, the authors of the report suggest that IUDs should be left in place up to their maximum life span and not be routinely replaced earlier, provided there are no contraindications to continued use and the woman wishes to continue with the device.

Medical Mycology

Introduction

Fungal infections are among the most common dermatological disorders. fungi are saprophytes and belong to the negetive kingdom. They live largely on dead organic material and for this reason most of them invade only the epidermis and its appendages and do not penetrate deeper tissue. These cause superficial mycosis.

Some fungi are more aggressive and invade the dermis and disseminate to other parts of the body. Others are inhaled or ingested so that lesions can occur in the respiratory and alimentary tract.

Fungal infections are increased usage of antibiotics and oral contraceptives and the wearing of synthetic under clothing have all contributed to the growing incidence of mycosis.

Q.1. Name 3 important groups of fungi pathogenic in man.

Q.2. Name 3 general symptoms associated with superficial fungal infections.

Q.3. Swelling of skin may be of varying size and is almost always caused by an accumulation of fluid. The fluid may be accumulated in the dermis or the epidermis and may be clear fluid or pus.

Distinguish between the following skin lesions.

1. Macule
2. Papule
3. Pustule
4. Blister

Q.4. Name 2 primary dermatological conditions which are non infectious.

Q.5. How would you distinguish between these two lesions - Tinea Corporis and psoriasis?

Q.6. Classify these antifungal products - Grizeofuluin, Nystatin, Econazole according to their spectrum and use.

Q.7. Indicate dermatological conditions for which you would recommend the ff:

a. Systemic antifungal therapy

b. Both systemic and topical therapy

c. Only topical therapy

Q.8. Pharmacists must carefully choose or recommend an appropriate application form to suit every skin condition when dealing with dermatological conditions.

State skin conditions for which the following formulations are suitable:

a. ointments

b. creams

c. powders

d. Lotions

Q.9. For which dermatological disorders would you recommend the following products and combinations

a. Antifungal/steroid preparations

b. Antifungal/Antibiotic/steroid preparations

c. Steroid preparations alone

Q.10. Explain why the incidence of vulvocandiosis is higher in prepubertal and post menopausal women

Answers should be sent to:
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Patient Counselling

MRS JOYCE ADDO-ATUA.

(B PHARM (Hons); MSC CLIN. PHARM; MEMBER CPA. INST PHARM GMT INT MPSG

INTRODUCTION:

Drugs use review studies are becoming an integral part of patient care review programmes (also called patient care audits) elsewhere in the world. These developments in patient care are bound to take off also in this country in the exercise of our rights and responsibilities as members of the world health community.

We cannot, however, be wholly justified in any attempt at drug use review studies if we have not first laid a firm foundation for the proper use of medication by patients. Patient Counselling has, therefore, become an essential part of the activities of the modern- day pharmacist whose practice has now moved from drug-oriented pharmacy.

This article defines patient counselling and spells out its aims, content and procedure, as well as the benefits to be derived from the practice.

DEFINITION;

Patient Counselling can be defined as a verbal communication between the pharmacist and the patient which provides the latter with all necessary information on his medication, taking into account his medical and surgical history as well as his social circumstances.

This verbal communication on drug use, while not obviating the need for compressive drug labelling, should receive high acclaim in our local circumstances, given our relatively low literate population. Even in the U.K. wherever patient counselling has been given as an extra service by the pharmacists, additional benefits have been documented.

AIMS OF PATIENT COUNSELLING

The patient is counselled on his medication with the following aims:

1. Improving compliance through motivation:

This is the primary aim of counselling. The patient is now regarded as an important member of the health care delivery team and is, therefore, expected to play a significant role in the management of his own condition.

This is especially true for chronic conditions such as rheumatiod arthritis, hypertension, diabetes mellitus and epilepsy, where medication simply controls and not cure the conditions. The medication in these conditions are expected to br taken for life and the active participation of the patient and or his family is central to the successful management of the disease process.

A parallel can be drawn here from the general management principle of decision -making and implementation. It has been establishing that a decision or policy stands a better chance of being successfully implemented if all the parties who will be affected by that implementation have been involved in the decision-making process in the first place.

The patient is thus motivated to comply with his regiman through an increase understanding of his medical/ surgical condition, the reason for his medication and be expectant of certain prescribed changes in his condition as well as looking out for specific side effects.

Improving the quality of life of the patient:

2. All things being equal, the compliant patient is bound to exhibit a relatively greater improvement in the quality of his life through a better control of his condition when compared with the non-compliant one. The awareness of the patient to the medication's side effects and the knowledge gained through counselling on how to minimise or control them will also contribute to the above improvement.

3. Reducing the total cost of treatment per patient:

Counselling on the proper use and storage of drugs to ensure optimum efficacy coupled with the improved patient compliance will serve to reduce the total cost of treatment per patient, especially for acute conditions. With the current world-wide emphasis on cost-effective medical care of patients, the substantial savings made in this way, will help in the expansion of services to cater for a greater percentage of the population.

INFORMATION TO BE DISSEMINATED WHEN COUNSELLING PATIENTS:

The counselling of patients on their medication should at best be tailored to their

particular needs ans circumstances. The content and level of information given will be determined by factors such as the medical/surgical condition of the patient, his educational and social background and the nature of medication(s) being used. Emphasis may be placed on specific portions of the list below which is by no means exhaustive, depending on the class of and/ or the individual medication in question and hence the need for special conditions eg. of storage, usage and handling. The patient receives the information directly if he is adult and is functionally independent. The information is given to the parent/guardian of dependent- adults and children.

Information given during counselling may include:

1. The name of the drug stating the strength , if these vary,eg. phenytion sodium 25mg or 100 mg capsules.

2. The purpose of drug use, ie whether to treat, relieve symptoms or to prevent the development of clinical symptoms of the disease (prophylaxis), eg. phenytion for the prevention of seizures in the epileptic patients. A brief and simple explanation here stressing on the hazards the patient may be exposed to during a seizure will impress on him the need to comply with his regimen.

3. When to take the drug, eg.with breakfast as with glibenclamide. The timing of doses of certain drugs are particularly critical if optimum efficacy is to be expected; oral contraceptive pills and anticoagulants such as warfarin for example, should be taken at approximately the same time each day. The situation becomes more complex for some conditions such as asthma where multiple drug use may be indicated for the prophylais of acute symptoms as with saalbutamol inhalers. The patient must be very clear in his mind the purpose of each and hence when to use which one.

4. Any special conditions or technique for the administration of the medication should e clearly explained. This is particularly important for dosage forms such as aerosol inhalers, pessaries and other topical preparations. Demonstration of inhaler technique has assumed primary importance even in the U.K. where ignorance of their use by asthmatics has led in some instances to their being sprayed on the chest area. Poor inhaler technique leading obviously to lack of therapeutic benefit to the patient, has been indentified as a fundamental reason for non-conpliance among many cheonic asthmatics. Again, serious heamorrhagic and infectious complications have resulted in the insertion of pessaries in their foil wrappings.

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5. The daily regimen and the period of drug use. Stressing the importance of finishing the full course of antibiotics is a good example here.

6. When to expect any benefit from the drug after the initiation of therapy. This is particularly important for conditions such as rheumatoid arthritis,(a chronic inflammatory condition affecting mainly the small joints) where most of the drugs used - penicilliamine, gold, sulphasalazine - take about 3 - 6 months to exert the maximum controlling effect on the disease process.

7. What action to take if the medication appears to be worsening instead of improving the patient's condition eg. to report to the Doctor immediately.

8. The action to take when the patient misses a dose is important for certain drug regimens. For instances with oral contractive pills, a dose taken as soon as the subject remembers will suffice if the time lapse is more than 12 hours. Beyond this time interval, a supplementary protection eg. with virginal pessaries or foam, will be needed.

9. Important side effects which the patient is bound to experience and where possible what to do in order to avoid or minimise them.

10. Any effect of the drug on skill and job performance.

11. Interactions with alcohol is important for drugs such as metronidaxole and chlorpropamide. Food-drug and drug-drug interactions may necessitate the need to separate their intake to ensure maximum therapeutic response.

12. Storage of drugs. The temperature conditions (whether in the refrigerator or at the room temperature) and the maximum period of storage for antibiotic suspensions, are important to ensure maximum drug potency.

PROCEDURES FOR COUNSELLING

For effective counselling of patients on their medication, certain procedures ought to be followed by the pharmacists.

1. Indentification of patients

Ideally, all patients stand to gain from proper counselling on their medication. However, practical consideration of inadequacy of staffing, pressures of time on the available staff etc., make this obviously impossible.

Certain unidentifiable groups of patients however must of necessity be counselled whether they may be ambulatory patients attending the outpatients clinic or filling their prescriptions at the community pharmacy or they are in-patients

on a hospital ward.

Such patients include the following:

(a) Those on chronic medication intended for life-long management of disease such as epilepsy, diabetes, mellitus, hypertension and chronic asthma.

Counselling of such patients is best done with the initiation of therapy when the diagnosis of their conditions has just been made.

(b) Patients on complex therapeutic refimes eg. those on preventers and relievers of acute asthmatic attacks, as well as those on multiple medications due to concomittant disease states, such as the presence of arrhythmais, hypertension and disease mellitus in one patient.

(c) Patients whose established drug-regimens have been altered as whose medications have been changed together.

(d) Those with medications such as phenytoin whose side effects (eg. gum hyperplasia, hirsutism and coarseness of the skin) are bound to have social and/or psychological implications for the patient.

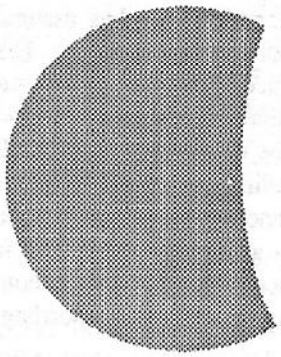
(e) Patients whose medication need special techniques of administration as with aerosol inhalers.

II Gathering all revelant information from the case notes of hospitalises patients. At the OPD and in community pharmacies, a brief interview of the patient will bring out the pertinent information on which to base the counselling.

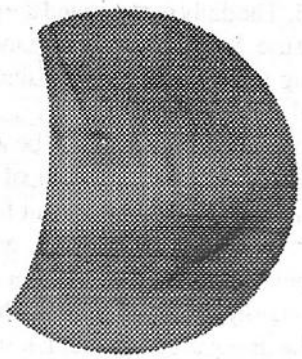
III. Choosing the appropriate time and place for counselling.

For ambulatory patients (OPD), community pharmacies), the most appropriate time is at the collection of their medication. A quite place removed from the main dispensing floor will ensure total privacy and encourage active patient participation and concentration.

For patients in the hospital wards, they be asked to indicate the most conveient time of day to be counselled and this is usually done on the ward whiles the patient is in hospital or just before being discharged.



All things being equal, the compliant patient is bound to exhibit a relatively greater improvement in the quality of his life through a better control of his condition when compared with the non-compliant one.



IV Eliciting the patient's knowledge of his condition, the name(s) of his medication(s) where appropriate, the purpose of taking them in any side effects or difficulty he has experienced with any of his medication if therapy has already started.

The information so gathered, together with that documented, will form the basis on which the pharmacist will conduct his counselling session.

This latter session will then either compliment or add to the patient's knowledge, or to correct any misconception or serve as a teaching session altogether.

V. Counselling-the language used should be as simple, clear, unambiguous and explanatory as possible. Non-technical terminology must be used, if possible, using the patient's own jargon to ensure maximum understanding of what is expected of him. Most importantly, demonstrate the use of special appliances eg. aerosol inhalers. Bland inhalers are available elsewhere for demonstration purpose only.

VI. Eliciting feedback from the patient eg. ask him to use his asthma inhaler.

CONCLUSION

The importance of counseling of patients on their medications cannot be over-emphasised. Drug labelling, even with the provision of patient information leaflets, have not been found to be totally adequate means of disseminating information to patients on their medication. The personal interaction which takes place between the pharmacist and the patient during counselling serves to re-assure, motivate and solicit the latters participants in the management of his condition

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MRS, JOYCE ADDO- ATUAH,who has recently returned from the U.K. after a course in Clinical Pharmacy is directly responsible for handling the Drug Information unit of the Ghana Police Hospital which will be established soon. She's a member of the Instituteof Pharmacy Management International, C.P.A., U.K.C.P.A. - U.K. Clinical Pharmacy Association.

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