

25TH ANNUAL GENERAL MEETING & SCIENTIFIC SYMPOSIUM AND 55TH COUNCIL MEETING OF THE WEST AFRICAN POSTGRADUATE COLLEGE OF PHARMACISTS (WAPCP) HELD AT THE MIATTA CONFERENCE CENTRE, BROOKFIELDS, FREETOWN, SIERRA LEONE, 11TH – 15TH MARCH, 2013

COMMUNIQUÉ

The West African Postgraduate College of Pharmacists (WAPCP) held her 25th Annual General Meeting and Scientific Symposium, and 55th Council Meeting at the Miatta Conference Centre, Brookfields, Freetown, Sierra Leone from 11th – 15th March, 2013. The theme of Conference was “Opportunities and Challenges of Pharmacists in Maternal and Child Health”

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The Special Guest of Honor to the Meeting was His Excellency, Dr. Ernest Bai Koroma, the President of the Republic of Sierra Leone. The Honorable Vice-President of Sierra Leone, Chief Alhaji Sam Sumana, was also present. Ms. Miatta Kargbo, The Honorable Minister of Health and Sanitation, Sierra Leone was the Guest of Honor. Other dignitaries present included: Major (Rtd) Paolo Conteh, Minister of Defense; Dr. Minkailu Bah, Minister of Education; Alhaji Alpha Kanu, Minister of Information and Communication; Mr. Moijeh Kaikai, Minister of Social Welfare and Children Affairs; Dr. Abubakarr Fofanah, Deputy Minister of Health 1; Mr. Foday Sawi, Deputy Minister of Health 2; Mr. Ahmed Kanu, Deputy Minister of Lands; Mr. Mamud Tarawalli, Deputy Minister of Education; Dr. Alemu Wondimagnetiu, WHO Representative; Dr. Brima Kargbo, Acting Chief Medical Officer and Director of HIV/AIDS Secretariat, Dr. Sarian Kamara, Manager of Reproductive and Child Health Programme. Delegates came from member countries: Ghana, Liberia, Nigeria, Sierra Leone, and The Gambia.

His Excellency, Dr. Ernest Bai Koroma, President of the Republic of Sierra Leone formally declared the meeting open. Pharm. Murtada Sesay, Jr. delivered the keynote address on the theme: Opportunities and Challenges of Pharmacists in Maternal and Child Health. Sub-theme lectures on Improving Access and Rational Use of Pediatric Medicines, and Maternal and Child Health Care Financing were delivered by Dr. Evbade Arigbe-Osula and Pharm. Isaac Adams respectively.

Conference deliberated on the theme and sub-themes of the symposium and other contemporary health related issues and resolved as follows:

1. The meeting noted with concern the continuing lack of access to health services by majority of mothers and children in West Africa and called on governments to prioritize the needs of these vulnerable groups by taking steps to remove all obstacles to care for women and children.
2. Noting the importance of external aide in meeting the health needs of mothers and children and realizing the strategic role of government resources in improving health systems as whole in a sustainable manner, the meeting encouraged Governments in the Region to work towards meeting the Abuja declaration and to ensure that donors work within the Paris declaration with regards to funding and prudent funds management to meet the desired goal.
3. Medicines should be physically, economically and socio-culturally accessible for the pediatric population in order to achieve the millennium development goals of reducing mortality rate by two thirds by 2015.
4. Pharmaceutical companies should be interested and encouraged to produce acceptable dosage forms (e.g. liquid dosage form) for the pediatric population. Furthermore, community pharmacists should be encouraged in the compounding of extemporaneous preparations for pediatrics.
5. In support of the above, conference further called for the development of a separate Essential Drug List for the pediatric population and this should be made available to all health facilities in the region
6. The meeting agreed on the need for community pharmacists to provide enhanced services in response to new and increasing demands of clients and to provide such services as would bridge the gap between health facility-based services and community based pharmacy practice particularly in the rural setting

7. The meeting further called on pharmacy and health regulatory agencies to collaborate in the review of existing laws and regulations to accommodate new service demands and improved technology in the health sector and possible specialist licensing of consultants of the College.

8. Conference noted with deep appreciation the approval and official recognition by the Governments of Ghana and Sierra Leone, Fellows of the College as Specialist Pharmacists/Consultants in their areas of specialisation. Conference also noted that the consultancy cadre for pharmacists is being entrenched in the Nigerian Government scheme of service and encourages other member countries to follow suit.

9. Conference ratified the induction of 102 new Fellows who passed the Fellowship examinations of the College conducted in November, 2012 and 2 additional elected Fellows.

10. Conference conferred honorary Fellow of the College on His Excellency, Dr. Ernest Bai Koroma, the President of the Republic of Sierra Leone in appreciation of his immense contribution to the growth and development of the College.

11. Conference thanks the Government and good people of Sierra Leone for the hospitality accorded the delegates.

12. Conference resolved to hold the 26th Annual General Meeting and Scientific Symposium in Ghana, 2014.

13. At the end of Annual General Meeting, the following officers were elected to pilot the affairs of the College in 2013/2015 biennium:

President	Pharm. Wiltshire C.N. Johnson	(Sierra Leone)
1 st Vice-President	Dr. Philip Anum	(Ghana)
2 nd Vice-President	Rev. T.T. Tyee	(Liberia)
Secretary General	Prof. Wilson Erhun	(Nigeria)
Deputy Secretary General	Pharm (Mrs) Markieu Janneh Kaira	(The Gambia)
Treasurer	Pharm. Harrison Abutiata	(Ghana)
Editor-in-Chief	Dr. Ibrahim Oreagba	(Nigeria)
Immediate Past President	Prof. 'Fola Tayo	(Nigeria)

Signed

Signed

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President, WAPCP.

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Secretary General, WAPCP.

WEST AFRICAN POST GRADUATE COLLEGE OF PHARMACISTS

25th Annual General Meeting and Scientific Symposium

Theme: Opportunities and Challenges facing Pharmacists in Maternal and Child Health.

OPENING CEREMONY, 12 MARCH 2013 , FREETOWN, SIERRA LEONE.

KEY NOTE ADDRESS by Murtada Mohammed Sesay BPharm. MSc. MMI, MCIPS

Pharmacist and Procurement Specialist

E-mail kindiatown@hotmail.com

Tel: 00 232 79827200

Residence: 38 Milton Margai College Road

Goderich, Freetown, Sierra Leone.

Mr Chairman,

Your Excellency Dr Ernest Bai Koroma, President of the Republic of Sierra Leone

Members of the Diplomatic Corps

Honourable Minister of Health and Sanitation, Ms Miatta Kargbo

Health development Partners

Fellows of the West African Post Graduate College of Pharmacists

Officials from the Ministry of Health and Sanitation

Distinguished colleagues,

Ladies and gentlemen

All protocols observed

It is a pleasure and privilege to be with you today to present this keynote address, especially so because I also see this as my return to a sub regional professional fraternity that helped hone my own career many years ago; one that has taken me through quite remarkable, satisfying, and rewarding national and international professional opportunities and challenges.

As you would have seen from the initial conference flyer, Mr Edward Bundu-Kamara, a highly respected colleague and Past President of the West African Pharmaceutical Federation, predecessor to the present West African Post Graduate College, was billed to present this address today. Unfortunately, due to ill health which has taken him out of the country, he is unable to be here. I bring you apologies from Mr Bundu-Kamara for his inability to honour your original invitation, and his best wishes for a successful Annual General Meeting and Scientific Symposium.

When I recently returned home to Sierra Leone after almost fifteen years service with the UN abroad, I paid a couple of visits to Past President Edward at his home here in Freetown, and I could see he was in pain and looked rather worried. So, one evening when he called to say he was requesting a special favour from me, I thought something sinister was amiss about his health. As I have always taken him very seriously, I requested him to give me a day or two to revert to him because I wanted to reflect on possible scenarios and thus prepare myself mentally to give any support he would require. Although the task before me today is quite a challenging one, I was quite relieved when he informed me that the favour he was requesting was that he had committed to presenting this keynote address, but that his health was rather preventing him from doing so, and as such, he would like me to stand in for him. In my relief that this had nothing to do with his health situation, I immediately accepted without any further reflection, especially as he also handed to me a reasonable draft of his planned address. It has therefore only taken me to

finalise the draft with some thoughts of mine which I will also share with you today. As I do so, I will try to mimic as much of Mr Bundu-Kamara's passion for his dear profession as I can, in the hope of conveying an important message that, in addition to subject matter and programmatic knowledge of Maternal and Child Health issues, and especially in today's intensely competitive professional world, it takes an equally intense passion for any one to avail of the opportunities and meet the challenges in the practice of their chosen profession.

A profession searching for Opportunities and Challenges?

I will move on quickly in this address to say that, indeed for most of my 30 odd year career as a pharmacist, I have witnessed and participated in the constant search for opportunities and roles for pharmacy and pharmacists, and the consequent challenges as we practise our profession in a variety of settings. In that regard, our effort today is not new. In fact, the literature is awash with efforts to look at this subject. For example, a WHO Consultative group on the Role of Pharmacists in Health Care met in Delhi, India in December 1988, and a similar follow up meeting was held in Tokyo, Japan in 1993, and the reports are published and available for useful reference.

Indeed, in March 1995, at the 11th General Assembly of the West African Federation held in Banjul, The Gambia, I also presented another Keynote address titled "Child Survival and Development – "Pharmacists must fit better". Playing with words from the famous plea of the Late O.J. Simpson trial Lawyer, Johnnie Cochran to the jury i.e. that "If the glove doesn't fit, you must acquit" I likened the health service expectation of society regarding a role for Pharmacists to a glove and humored at the time that "Pharmacy must fit better or quit later". My motivation at the time was anchored in personal experience working as a "home grown" pharmacist, so to say, in an international multi-professional environment for a number of years with UNICEF here at home in Sierra Leone, as well as actively participating in and tracking child health survival and development efforts across the World. During this period, I also observed the professional identities of those who were, in the main, leading this process. I subsequently wrote an article in which I described one of the dilemmas I seemed to run into in those days, which was that, even where a pharmacist has availed of the opportunity as an individual in a multi professional stakeholder setting, to demonstrate significant impact of his or her contribution to a group health programme objective, they are almost always, in the end, not seen as a pharmacist but a generic Health Programme Manager! So, be on he alert dear colleagues, to remember to retain the passion for and identity of your profession, when you are eventually and justifiably moved into such generic roles! In other words, one should never hesitate to remind oneself and other professional colleagues, at every opportunity, that you perform and deliver the way you do, thanks largely to the huge investment and intellectually challenging background in your training as a pharmacist.

More recently, in 2006 to be precise, a handbook to enhance the role of pharmacists in health care titled "Developing Pharmacy Practice - a focus on patient care" was published jointly by the World Health Organization (WHO) and the International Pharmaceutical Federation (FIP). The Foreword to this publication starts with quiet a forthright and blunt, albeit not unfamiliar, opening paragraph which I would like to quote:

"Pharmacists should move from behind the counter and start serving the public by providing care instead of pills only. There is no future in the mere act of dispensing. That activity can and will be taken over by the internet, machines, and/or hardly trained technicians. The fact that pharmacists have an academic training and act as health care professionals puts a burden upon them to better serve the community than they currently do."

Although, as I have indicated, this observation may now sound almost like a broken record, the issue of "role definition" is important for any profession, at any time, because this is what creates the basis for identifying contemporary opportunities and challenges that the profession must then strategically organize to manage, both at individual and collective level, if they are to meet the expectations of the society they seek to serve.

The above referenced handbook is the latest to define a new paradigm for pharmacy practice. It aims at guiding pharmacy educators in pharmacy practice, to educate pharmacy students, and to guide pharmacists in practice to update their skills. It brings together practical tools and knowledge, and was written in response to a need to define, develop and generate global understanding of pharmaceutical care at all levels. Unfortunately time does not permit us today to dwell a bit more on the strategic content of the handbook, except to quickly say that it is divided into two main parts:

PART I: Pharmacists in the health care team: a policy perspective

PART II: Pharmacists in patient care: a practice perspective

Of particular relevance to our subject of "Opportunities and Challenges" is the concept of the "Seven-Star"

pharmacist, introduced by WHO and taken up by FIP in 2000 in its policy statement on Good Pharmacy Education Practice. This sees the pharmacist as a Caregiver, Communicator, Decision-maker, Teacher, Life-long learner, Leader and Manager. The handbook, adds the role of Researcher to this. I suspect some of my pharmacist colleagues may want to check what their star-rating is! But I certainly encourage all of us to take some time off to browse through this useful handbook, as it does prepare us for almost any opportunity or challenge we face in our day-to-day work as pharmacists, regardless of which area. For now, I don't think we need to look further a field in the quest of opportunities and challenges we may face as pharmacists in the practice of our profession. This document, with no stakeholder conflict of interest, is freely and readily available for downloading from the Internet as a public good. I encourage all pharmacists at individual as well as collective level to use this handbook as a platform for debating and planning programmes aimed at improving service to our various communities.

However, my perspective today is not one of a profession still looking for a role within the health care team, since I believe this is quite well articulated internationally and available to all as an example of recommended best practice; the issue as I see it is that we as professionals remain responsible to identify new opportunities for pharmacy practice in a changing health sector context in our local settings, to assess and to test them, and to demonstrate our ability to implement them successfully. As I will stress at the closure of my address, I leave this responsibility squarely at the doorstep of pharmacy and pharmacists.

Maternal and Child Health

So let me now move on to the subject of Maternal and Child Health. Although sometimes this may sound repetitive, it is always good to start with a couple of statistics and facts in the hope that they provide a basis for our motivation to do something about the situation.

- Poor maternal, newborn and child health remains a significant problem in developing countries. According to data released by the World Health Organization (WHO):
- Every day, approximately 800 women die from preventable causes related to pregnancy and childbirth.
- 99% of all maternal deaths occur in developing countries.
- Maternal mortality is higher in women living in rural areas and among poorer communities.
- Young adolescents face a higher risk of complications and death as a result of pregnancy than older women.
- Skilled care before, during, and after childbirth, can save the lives of women and newborn babies.
- Between 1990 and 2010, although maternal mortality worldwide dropped by almost 50%, it is still unacceptably high. In 2010, 287,000 women died during and following pregnancy and childbirth.

Almost all of these deaths occurred in low-resource settings, and most could have been prevented. Most of these complications develop during pregnancy. Other complications may exist before pregnancy but are worsened during pregnancy.

- The major complications that account for 80% of all maternal deaths are.

1. Severe bleeding (mostly bleeding after childbirth)
2. Infections (usually after childbirth)
3. High blood pressure during pregnancy (pre-eclampsia and eclampsia)
4. Unsafe abortion.
5. The remainder are caused by or associated with diseases such as malaria, and AIDS during pregnancy.

Dear colleagues, I would like each of us, for a brief moment, to reflect on how we as pharmacists have been involved in stopping or managing any of these. Either as a matter of routine or “thinking outside the box”.

Improving maternal health is one of the eight Millennium Development Goals (MDGs) adopted by the international community in 2000. Under MDG5, countries committed to reducing maternal mortality by three quarters between 1990 and 2015. In sub-Saharan Africa, a number of countries have halved their levels of maternal mortality since 1990. In other regions, including Asia and North Africa, even greater headway has been made. However, between 1990 and 2010, the global maternal mortality ratio (i.e. the number of maternal deaths per 100 000 live births) declined by only 3.1% per year. This is far from the projected annual decline of 5.5% required to achieve MDG5.

On the child health front some of the statistics are that:

- 6.9 million Children under the age of five died in 2011.
- More than half of these early child deaths are due to conditions that could be prevented or treated with access to simple, affordable interventions.
- Leading causes of death in under-five children are pneumonia, preterm birth complications, diarrhoea, birth asphyxia and malaria. About one third of all child deaths are linked to malnutrition, making children more vulnerable to severe diseases.
- Children in sub-Saharan Africa are about 16.5 times more likely to die before the age of five than children in developed regions.
- A child's risk of dying is highest in the neonatal period, the first 28 days of life. Safe childbirth and effective neonatal care are essential to prevent these deaths. 43% of child deaths under the age of five take place during the neonatal period.

Overall, substantial progress has been made towards achieving Millennium Development Goal (MDG) 4. Since 1990 the global under-five mortality rate has dropped from 87 deaths per 1000 live births in 1990 to 51 in 2011. But, again, the rate of this reduction in under-five mortality is still insufficient to reach the MDG target of a two-thirds reduction of 1990 mortality levels by the year 2015.

Finally it is important to recall that maternal health and new born health are closely linked.

Global response

Naturally and understandably, Improving maternal health is one of WHO's key priorities and the organisation is working to reduce maternal mortality by providing evidence-based clinical as well public health programmatic guidance, setting global standards, and providing technical support to member states. In addition, WHO advocates for more affordable and effective treatments, designs training materials and guidelines for health workers, and supports countries to implement policies and programmes and monitor progress.

During the United Nations MDG summit in September 2010, UN Secretary-General Ban Ki-moon launched a Global strategy for women's and children's health, aimed at saving the lives of more than 16 million women and children over the next four years.

Since more than one third of all child deaths occur within the first month of life, providing skilled care to mothers during pregnancy, as well as during and after birth, greatly contributes to child survival. Member States of WHO have set targets and developed specific strategies to reduce child mortality and monitor progress.

Opportunities for Pharmacists

Against this internationally established evidence, and with specific relevance to the situation in our sub region, the question then becomes, how have we as pharmacists availed of the opportunity to serve and establish ourselves as credible members of the health delivery arm generally, but especially in the Maternal and Child Health endeavours of our governments? What have been the obstacles and challenges to our engagement?

The Norwegian Agency for Development Cooperation (NORAD), The Partnership for Maternal, Newborn & Child Health (PMNCH) in collaboration with the Innovation Working Group (IWG) published a document titled "A Short Guide for Companies." in support of Every Woman Every Child Initiative in which they state that "women and children have multiple, interrelated health needs and whilst drugs and vaccines are important to women's and children's health, they don't represent the entire solution. The problem is complex, because the health needs of women and children are interrelated and overlap within a system, many of these needs have to be addressed simultaneously, if we are to make meaningful progress toward the health-related Millennium Development Goals.

Before we look at the opportunities and challenges, it might be useful to quickly reflect on the empirical building blocs for health care delivery:

- Health Products & Services
- Delivery Systems & Infrastructure

- Workforce Development
- Awareness & Behaviour
- Financing
- Policy & Governance

All these elements form an indispensable part of a complex jigsaw which must come together, often simultaneously. Consider, for example, the health needs of a woman with complications during her pregnancy. Clearly, she needs access to appropriate medical equipment and drugs (Health Products & Services). In all likelihood, she'll need attention from specialist staff in a local clinic – and she may need an ambulance service to get her there (Delivery Systems & Infrastructure). Those staff need to be adequately trained and managed (Workforce Development). But the availability of these things would be of no use if the pregnant woman had not been made aware of the symptoms and physical signs to look out for during pregnancy, and informed of the treatment and entitlements available to her (Awareness & Behaviour). She also needs to be able to afford this medical treatment (Financing). Finally, to guarantee the overall existence and quality of the intervention, the government needs to enforce proper standards of care (Policy & Governance).

So the question drills further to become, yet again, how are Pharmacists placed in the above scheme of maternal and child care delivery? The key opportunities for pharmacists in this integrated service delivery seems to be in the involvement with health products and services along the “Continuum of Care” for reproductive, maternal, newborn and child health (RMNCH), which includes an integrated service delivery for mothers and children from pre-pregnancy to delivery, the immediate postnatal period, and childhood. The Continuum of Care recognizes that safe childbirth is critical to the health of both the woman and the newborn child and that a healthy start in life is an essential step towards a sound childhood and a productive life. Across this continuum of care, essential interventions and the commodities required to provide these have been identified, most recently in the publication “The Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health - A global review of the key interventions related to reproductive, maternal, newborn and child Health”. The WHO publication, “Priority medicines for mothers' and children's health, 2011” also identifies medicines that are in need of enhanced attention and utilization in order to avoid preventable deaths of women and children. The point is that there is ample material available today to challenge our imaginations and creativity but probably the greater challenge is to take time off as busy professionals to look into these materials in our quest for opportunities to serve our communities better.

The role of Magnesium and Zinc Sulphate

Mr. Chairman, your Excellency, honorable minister of Health, distinguished ladies and gentlemen, dear colleagues, I would like stimulate our thoughts today from a traditional health product perspective, with the potential opportunities and challenges for improving mother and child care, through the use of two age-old and basic inorganic elements i.e. Magnesium and Zinc, in the form of their equally well known “Sulfates”. Many of us could probably readily recall from memory the position of Magnesium and Zinc in the Periodic Table and thus predict possible chemical reactivity, or for that matter the fact that the sulfate ion is bivalent with at least 6 resonance structures! We may even also predict, or at least appreciate, a mode of action in which zinc inhibits cAMP-induced, chloride-dependent fluid secretion, by inhibiting basolateral potassium (K) channels. Yes, I do know that the pharmacy training can often get this rigid! But how do these chemical and physical categorizations or projection of possible mode of action create opportunities and challenges for doing "Good" in the area of improved lives for our women and children?

As a pharmacist in the sunset of my career, I would like to flag these two interventions, by asking how much we presently know about the role of and promote these as relatively cheap product interventions, known to positively impact the reduction of Maternal and Child mortality? When last did you stock and supply Zinc Sulphate tablets to influence the course of diarrhoea episodes in a child, or Magnesium Sulphate in an appropriate dosage form to control preeclampsia in a woman at high risk?

Magnesium Sulphate in Eclampsia

The introduction of Magnesium sulphate in the management of Preeclampsia and Eclampsia is a remarkable example of how knowledge of one health intervention context was used as an opportunity to make progress in

another. In 1924, an intern at Los Angeles General Hospital “suggested” the use of intravenous magnesium sulphate to treat eclamptic seizures, knowing that it controlled tetanic convulsions and had mild sedative effects. As a result, intravenous magnesium sulphate was added to the protocol for eclampsia. In the initial trial, which included 17 eclamptic women, all seizures were controlled by magnesium, and maternal mortality was only 6%, compared with the historical average of 30%.

On Friday 31 May 2002, 78 years later, the Lancet carried a headline: “Inexpensive drug prevents fatal convulsions in pregnant women...” The publication went on to say that Magnesium sulphate can halve the risk of life-threatening convulsions and the risk of death in pregnant women with problems of high blood pressure, referring to a three-year study, dubbed the “Magpie” trial., funded by the United Kingdom's Medical Research Council (MRC), with support from the Geneva-based research programme on reproductive health (HRP) at the World Health Organization (WHO), the United Kingdom's Department for International Development, and the European Commission's Directorate General for Research (INCO Programme). The trial was carried out in 33 countries and involved nearly 10,000 pregnant women with pre-eclampsia, a condition marked by high blood pressure and protein in the urine. Pre-eclampsia predisposes pregnant women to the convulsions of full-blown eclampsia. Worldwide, pre-eclampsia and eclampsia occur in about 3% of pregnant women and account for about 12% of deaths (up to 60,000 deaths) related to pregnancy. Data from the trial also showed that nearly 2% of women with pre-eclampsia go on to develop eclampsia. “The needless death of any mother during pregnancy or childbirth is a terrible tragedy—a tragedy multiplied when she has other young children or a family dependent on her,” said Dr Tomris Turmen, former Executive Director of Family and Community Health at WHO. Eclampsia is not the only danger a woman with pre-eclampsia faces. The Magpie trial found that 11.5% of the pregnancies in the untreated women with pre-eclampsia ended in the death of the baby at or shortly after birth. And in more than 53% of the pregnancies, the baby was born underweight (less than 2.5 Kg).

Zinc supplementation for treating diarrheal episodes in children Acute diarrhoea remains a leading cause of childhood deaths despite the undeniable success of oral rehydration therapy (ORT). As a result of the continuing lack of safe water and adequate sanitation in many parts of the world, diarrheal diseases are the leading cause of paediatric morbidity and mortality, with 1.5 billion episodes and 1.5 - 2.5 million deaths estimated annually among children below five years of age. It is estimated that 13% of all years lost due to ill-health, disability, or early death (so-called “disability-adjusted life years”) are caused by diarrhoea.

Zinc supplementation is a critical intervention for treating diarrheal episodes in children. Recent studies suggest that administration of zinc along with the new low osmolarity oral rehydration solutions/salts (ORS) can reduce the duration and severity of diarrheal episodes for up to three months. The World Health Organization (WHO) and UNICEF recommends daily 20 mg zinc supplements for 10 – 14 days for children with acute diarrhoea, and 10 mg per day for infants under six months old, to curtail the severity of the episode and prevent further occurrences in the ensuing two to three months, thereby decreasing the morbidity considerably. Supplementary zinc benefits children with diarrhoea because it is a vital micronutrient essential for protein synthesis, cell growth and differentiation, immune function, and intestinal transport of water and electrolytes. Despite the opportunity created by evidence of benefit, the challenge is that there has been little progress on the widespread introduction of low Osmolarity ORS and zinc for the treatment of diarrhoea.

I am aware that many countries have changed diarrhoea management policies to include low osmolarity ORS and zinc, but I have also experienced that gaps persist between policy change and effective program implementation, with very few children currently being appropriately treated. One of the main reasons for this is the lack of knowledge and awareness among the care providers on how to implement the existing cost-effective interventions. Supply Chain bottle necks remain a major challenge all over the world and especially in resource poor environments. The opportunity for us as pharmacists is that there is sufficient evidence that this cost-effective intervention, whose chemistry and pharmacology we may know so well, works and saves lives, but the challenge remains to achieve greater access coverage of these interventions, especially in our resource -poor settings. Guidelines on the use of zinc supplementation in the management of diarrhoea presents us with opportunities as well as challenges but we should take consolation in the fact that it can accelerate progress towards the United Nations Millennium Development Goal 4 for reducing child mortality by two-thirds by 2015.

Whilst working with UNICEF Supply Division in Copenhagen some years ago, I was a member of a global effort to

improve access to dispersible Zinc Sulphate tablets in countries and I came face to face with the wide gap between the creation of hard health programmatic evidence for the use of a relatively simple product intervention to its actual reflection on the ground in the form of positive health outcomes that saves lives. Much of this could sometimes be related to sheer regulatory bureaucracy but also what I would like to call a simple lack of professional passion to clear bottle necks. For example, those of you who have worked in programmes involving Zinc will know that “Taste Masking” is a big issue and yet we as pharmacists are probably the best placed to resolve this end-user problem which affects conformance to therapy.

I have cited inorganic chemistry with no intention to minimise the complexity of health interventions and technologies but rather as food for thought that if we cannot manage simple cost-effective interventions with known high impact, the more complex interventions can only further fade away beyond our reach! My message is also that no matter where in the health sector one works as a pharmacist, one should be sufficiently passionate to routinely look deeper into national, regional and global health programme paradigms for opportunities to do professional good and thereby make a difference in the lives of our people, including mothers and children. This in my view is relevant both to public as well as private sector players. The road is never smooth or linear, because of externalities often outside our control. However, my experiences teach me that it is frequently the passion to do good, backed by our solid scientific education and knowledge which fuels the perseverance required for success. I know there may be those among us who, perhaps understandably, will claim that it is first conditions of service or recognition by society or our Governments which should inspire us. Well, I have not found this to be necessarily true. Rather, I see this as a vicious trap which keeps us missing opportunity after opportunity. The fact is that opportunities will present from time to time in guises which we may not readily perceive, but with the right passion, our chances of spotting these become significantly enhanced.

Some programmatic opportunities

I would like to briefly share with you work context encounters I have had with pharmacists during my career in many countries:

- Family planning
- Prevention and management of Sexually transmitted Infections (STIs), including HIV for Prevention of Mother-to Child Transmission (PMTCT) of HIV and syphilis
- Tetanus immunization in pregnancy for preventing neonatal tetanus
- Prevention and management of malaria in pregnancy
- Prevention and management of HIV and Prevention of Mother-to child transmission in Pregnancy
- Prevention and management of hypertension in pregnancy
- Prevention and Management of postpartum haemorrhage

More recently, the challenges facing pharmacists in maternal and child health were clearly identified in a two days symposium in Chennai, India in 2010. The symposium was held following an invitation from the Commonwealth Pharmacists Association to the Indian Pharmaceutical Association. As Past president of The Commonwealth Pharmacists Association, I know how passionate the group has been about such matters. Specific areas were identified as being challenges which needed to be tackled to provide better care for HIV/AIDS, Maternal and Child health and TB and these were that:

Pharmacists not well equipped with suitable knowledge

Specific training was required in providing the best treatments and counselling

Training needs to be provided at undergraduate and post-graduate level

CPD and further training requirements need to be identified

Poor awareness levels amongst Pharmacists

Lack of motivation and no incentives

Need to work with other key health professionals

Inadequate facilities available at Pharmacy premises for storage and Consultation areas for Effective communication with clients

Problems with counterfeit medicines

Patient illiteracy
Rural and outreach facilities
Government not aware of Pharmacists potential
No defined role for Pharmacists in National programmes
Little Pharmacy involvement in local/national policy decisions
Incentives for pharmacy involvement
Role of Pharmacists in rural/outreach areas

The above are all issues which can be structurally addressed using the handbook I have referred to earlier. Overcoming these challenges should be the main priority for pharmacists, if they seek an active role in maternal and child health. They should lobby the central and local government to ensure that sufficient training is provided to them and that they are part of any multidisciplinary teams looking after maternal and child health.

Pharmaceutical associations or organisations should actively promote the skills and contributions pharmacists have which make them a valuable member of the multidisciplinary teams.

Returning to “Passion, Opportunities, and Challenges”

Having referred to the very mundane and down-to-earth issues such as professional passion and basic tools and technologies, I again suggest that the opportunities we often have to make a difference and positive impact on mother and child health statistics in our countries need not be necessarily complex. The challenge is for us to be sensitive and reactive to the health programme realities in our often resource-constrained environments, and pick out any opportunities. From time to time, such opportunities may however present in the form of having to “bite the bullet”!

I would like to draw from one example here in our country, where the President and Government, having seen that the unacceptable statistics of Maternal and Child health would no longer be accepted, and that access to services, especially medicines, was key in this process, resolved to institute a “Free Health Care” policy for Pregnant women, lactating mothers and children under five. It is a fact that the programme has faced teething problems, significantly related to pharmaceuticals and related supply chain issues, and indeed continues to do so. And so the question to us Sierra Leonean Pharmacists is, have we joined our President and Government in biting this bullet; if so how ?, and if not why not?

The presence of our head of state today here today speaks volumes about his determination to leave no stone unturned in this matter of healthcare for his people and we as pharmacists take this as a challenge to look for all possible opportunities, in collaboration with all other health care professionals in our country, in meeting the health goals of his Government.

By the way, when I first looked at the title of this address “Opportunities and Challenges....” I felt there was a real danger of looking at Challenges as an obstacle to availing of the Opportunities that may exist. My view, again out of sheer experience, is that the two are opposite sides of the same coin and, in fact they always come closely together, if we care to look on the other side.

In coming to the end of this brief address, I would like to share with you one professional challenge I providentially turned into an opportunity that changed my career so dramatically that I have never had another opportunity to look back! – Yes, what a paradox!

Sometime at the beginning of 1986 or thereabouts, I was then Pharmacist Manager of “Kingsway Chemists”, a leading Pharmaceutical Wholesaler and Retailer in Sierra Leone at the time. I think the company also had branches in some of our sister countries in the Region. I joined the company as trainee pharmacist upon my return home from the University of Science and Technology, (Tech in Kumasi in 1977, yes; I mean my return from Kejetia, in Kumasi!!!!) The company was then owned by the United Africa Company, itself a subsidiary of UNILEVER. Kingsway Chemists represented many leading global pharmaceutical manufacturers, such as Roche, Sandoz, May and Baker, G D Searle, ICI etc. We directly imported goods from those companies we represented but procured locally from representatives of other Manufacturers such as Pfizer, Upjohn, and Abbott etc. Our business was then located in a two-storey building on 12 Rawdon Street here in Freetown. On the ground floor we had a really well-kept retail outlet that could

compare with any in the parent country of the UK, with glass windows and high attractive profession display of surgical, photographic and other sundries. Prior to my elevation as Manager I was worked as pharmacist in a “dispensary” on the same floor, adjacent to the main shop area. The dispensary was a small room with an even smaller window, probably half a meter by half a meter. The only interface with the public was through this window through which only one's head was visible,

Upon my promotion to the position of Manager following the retirement and return to UK of the Expatriate Pharmacist, I thought the small room and window no longer represented the reality of pharmacy. I convinced management and we brought down the physical barrier so that we could now openly relate to our patients and other customers, and medicines were on display for all to see!

One fateful day, a prominent Ghanaian Pharmacist, a senior for me at the University in Kumasi visited me in my office. He was then responsible for the marketing and sales of Upjohn Products in West Africa, including Sierra Leone, where they were represented by another leading Pharmaceutical outlet, City Pharmacy. My office was located on the second floor where we also had a wholesale business. As my former colleague passed through the shop, he noticed what he thought were vials of Lincocin injection, the Upjohn brand of Lincomycin. Unfortunately, as he examined samples, he came to the horrifying conclusion that they were not products manufactured by his company. After exchanging, pleasantries, the time for biting the bullet came, and as any hard-nosed businessman, he said to me “ Sesay, I see you have some Lincocin on display in your Pharmacy ...” and, innocently believing this to be a complementary observation, I wasted no time responding in the affirmative. Then there was a pause and a deep hard breath and my senior followed up with another comment, “Unfortunately, I must tell you that these are not genuine Upjohn products, they are counterfeit!” As I struggled to keep my cheeks from shaking too much, I immediately requested that we return together to the shop floor so I face the reality head-on. With only a few pharmaceutical packaging lapses my colleague pointed out, I did not need to be convinced any further. Anyway; first things first, I instructed that the Lincocin be immediately removed from the shelf and I assured my senior colleague that I will do everything within my power to retrace the procurement steps to the local source and pass on the message. Although my head continued to spin, it did so in a characteristically constructive way. The next question that came to my mind was, “How many more counterfeits were sitting there on our shelves; both in retail and wholesale?” and which must be brought down ? In any case, it became clear to me later that actually the local agent had compromised on his obligations to Upjohn and used other less credible supply channels, and he was already aware of the problem.

What followed was a vigorous mobilisation of some local colleagues who helped me organise a rough and tumble collection of samples of some generic medicines which I sent off to both Germany and Ghana for analysis. The laboratory results and the resulting publication in the Magazine Africa Health truly changed my career. The issue of counterfeits was in all the press, I was hot cake for radio and TV interviews, both national and international, local consumers started asking questions and looking more carefully at the medicines they were being supplied and I can say that it has never really been the same again. 12 years after my first degree, I suddenly became sufficiently motivated to move on to do a Masters Programme in Pharmaceutical Quality Assurance at the University of Strathclyde in Scotland, with a Commonwealth Scholarship which I earned largely because of that article. I could have, like an ostrich, buried my head in the sand of shame, but as I had nothing to conceal, I was not shy of biting the bullet and bringing out the reality in the fore.

I would like to close by saying that the opportunities and challenges we face as pharmacists in the health care field, including in Maternal and Child Health Care can be spotted and responded to only by pharmacists. We do have the intellectual capacity to manage this. However, in the process, we may often have to lose our identity as pharmacists. But it does not matter, as long we remind ourselves and others that our profession presents significant opportunities to add value to health care delivery. Often we have to go and “fight” for it with passion to make things happen.

We cannot, and must not, wait for some other health professional or authority to guide us to opportunities and challenges that present to our profession. “The knot of wisdom can be untied only by the wise” so I am reminded by my Alma Mater in Kumasi! And

In this regard, Mr Chairman Your Excellency, Honourable Minister, ladies and gentlemen, dear colleagues permit me to acknowledge the presence of my two learned University Professors Kwame Sarpong and John Ayim who are here with us today and to thank them sincerely for giving me the right background and training which has enabled me serve my country and indeed the United Nations as a Pharmacist.

I thank you all for listening to me today and God bless you all.