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Experiences of a volunteer pharmacist in Cameroon

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I had wanted to live and work abroad for as long as I can remember, and the "VSO seed" was planted when, as a teenager, my older sister talked of her university friend who had volunteered with Voluntary Service Overseas (VSO) as an English teacher in Africa. I could not imagine anything more exciting yet rewarding, and certainly had such work in mind when I entered pharmacy on my UCAS form.

Voluntary Service Overseas

VSO is an international development organisation. It does not send money, food, clothes or drugs to its target countries. Instead, VSO sends trained professionals. Volunteers stay in a particular community, generally for two years, where they share their skills and knowledge with those with whom they live and work. Such sharing is a two-way process.

NWPSFH-Bamenda (North West provincial special fund for health) is the essential Drugs Programme for North West Cameroon. This non-governmental organisation (NGO) is my local employer in partnership with VSO. The fund basically procures good quality, generic drugs and distributes these to over 140 health centres and district hospitals throughout the north west province. It also gives basic training to individuals selected from each community. This individual then becomes the pharmacy attendant (PA) for the pharmacy in their local health unit.

Staff from NWPSFH periodically tour the pharmacies for supervision purposes — the basic PA training only allows the sale of simple, essential drugs under strict protocols and against a prescription. NWPSFH supplies the drugs without payment. These drugs must be sold on to patients at a very low, standardised price (often subsidised). Money from drug sales to patients is then collected and used to procure more drugs, ie, a revolving drug fund.

Since its humble beginnings in the early 1990s, NWPSFH has certainly emerged as a success story in its mission to make essential drugs accessible to the

province's communities, especially rural ones. It supplies nearly all the government health institutions in a province with a population of two million. As with most organisations, all is not perfect, but I dread to think of the consequences of the vacuum that would be left if its services were withdrawn.

As pharmacists we are fully aware that supplying drugs is not enough. Patients must receive their medicines in a safe and effective manner in order to improve health — our ultimate goal. It was with this concept in mind that NWPSFH applied to VSO for a pharmacist to extend its procurement and supply functions to include rational drug use, which is where I came in.

Introducing an MI service

The aims of my placement were to introduce a medicines information service, organise the drug and therapeutics committee and assist with HIV services provided by NWPSFH. I had not formally worked in these specialised service areas before, but pharmacists are generally difficult to recruit, especially volunteer medicines information or HIV pharmacists. But everyone agreed that the general skills and knowledge of a pharmacist could only benefit these services that NWPSFH was already informally providing out of necessity.

One of my greatest challenges has been the introduction of medicines information services. A medicines information centre does not exist even at a national level, so I have to admit that my attempts to introduce a UK definition of a medicines information service have been tentative. Why? Well, VSO justifiably insists that development work should be sustainable. When I depart, I do not want to leave behind a reasonably equipped MI service, but with no pharmacist to answer queries or anyone else to carry out activities. Resources would be abused or wasted and the users of the service would be disillusioned. Whether or not a pharmacist can be recruited and trained to replace me remains to be seen.

With this in mind, I have taken a step back to get a wider perspective on what we are trying to achieve by providing medicines information. I believe that our goal is the rational use of the essential drugs we provide, and encouraging prescribing and use of these drugs as opposed to those available through the private and informal sectors. Interventions to improve drug use include educational, managerial and regulatory strategies — medicines information services are only one small part of the picture. I have tried to examine a selection of rational drug use activities and devise ways in which they can be integrated into the organisation, whether under the banner of drug information or not.

Resources

In developed countries, a medicines information service or centre will be staffed by at least one pharmacist and equipped with a range of journals, texts, computers, internet, telephones etc, all of which are considered essential for reliably answering a range of queries. Here in Cameroon, we have only limited access to some of these resources. For example, the telephone line is shared with the rest of the organisation.

In developed countries, the telephone is probably the most widely used method of making enquiries. However, in Cameroon, telephone calls are relatively expensive. Therefore, for most health care workers here, calling an MI service at their own expense is almost out of the question. A fundamental question is therefore posed: how can target users contact or be contacted by the service? The short-term answer is that the individualised query-answer format is not

presently practicable for the majority of requests. Until telephone and internet communications improve, I believe that we should focus on the more proactive functions of an MI service.

Essential drugs list

To date, I have been focusing on a few areas that may have a more widespread impact on rational drug use, and which do not require full-time manning by a pharmacist. One of these areas is our essential drugs list (EDL). The gold-standard EDL is the World Health Organization model list which outlines the minimum range of drugs that should be available to the majority of the world's population at all times. Individual countries streamline this list to fit local needs in producing their own EDL, with fine tuning occurring at the provincial level as with our own EDL for NW Cameroon.

I have been arranging our listed drugs by therapeutic category and checking whether they are in line with those on the WHO and national EDLs. One of the main functions of the provincial drug and therapeutics committee is to decide which drugs should be included in our EDL, so a drug which is not on our guiding lists is presented to the committee with evidence for and against its continued inclusion.

One interesting deletion has been that of chloroquine. Chloroquine remains on the WHO model list, but due to increasing evidence of resistance in Cameroon, it has been removed from the national and now our provincial EDLs. Despite some reluctance, prescribing is slowly changing with the support of changes in the national malaria treatment guidelines.

Essential D and T bulletin

One educational measure is the production of our own 'essential drug and therapeutics bulletin'. Our first issue focused on interactions between antiretrovirals (ARVs) available in the north west and common essential drugs such as rifampicin used in tuberculosis. This subject was chosen in response to many informal enquiries from prescribers.

Our second issue primarily discusses the availability and efficacy of various antimalarials used in north west Cameroon, and outlines new national guidelines for treatment of falciparum malaria. Amodiaquine is now the first-line treatment for "uncomplicated" cases while quinine remains first choice for severe malaria. In 1999, malaria accounted for 23 per cent of hospital admissions and 35 per cent of hospital deaths in Cameroon. Failure of treatment with chloroquine may be approximately 38 per cent, yet, as a cheap drug with low incidence of side effects, prescribers and patients alike are reluctant to relinquish it. The fact that such guidelines are not made widely available does not help the situation. Our bulletin aims to inform prescribers in the north west of such critical therapeutic information.

Bulletins and formularies mainly target prescribers, but we realise the importance of the dispenser in influencing drug use. Although the PA training is basic, we still try to provide sufficient skills and knowledge to be able to give the patient simple advice, even if that is merely to warn them to take ibuprofen with food. A session on the role of the PA in the rational use of drugs has now been incorporated into the annual PA workshop.

I also recently organised a participatory review of PA training attended by a variety of staff including PAs themselves. During this review, we clarified what exactly are the duties of the PA, what are the SKARE (skills, knowledge, attitudes, resources, environment) needed for a PA

to perform his or her job to the required standard, what are the SKARE of present PAs, and which kinds of training can fill in some of the gaps. On the basis of this session, proposals for changes to the PA training have been submitted to our management committee, including revision of the PA manual which I have begun work on.

Most prescribers in Cameroon are nurses, so in the coming year we are planning to work with students of the local nursing school by adapting the WHO Guide to Good Prescribing and incorporating it into their pharmacology modules. An open day, during which patients can come to ask for advice on their medicines, is also planned.

HIV and AIDS

Incidence of HIV in Cameroon is approximately 12 per cent, but the true figure is likely to be much higher in the reproductive age group. Helping in the development of systems for HIV and AIDS was an aim appended to my placement description and I could not have imagined the challenges this area would present to me on every level: professional, social, cultural, ethical and personal. The first four months was a fiery initiation into the world of living with HIV in a developing country. With funding from the World Bank, the government had dramatically decreased the "to patient" price of ARVs by pumping in subsidies at the central level. Scores of patients (but still a tiny minority) were now able to afford the drugs and bring their prescriptions to me for dispensing.

It was so busy and I was still getting to grips with the technical knowledge required for handling these drugs that I did not have time to tackle the source problems. However, I gained invaluable insight not only into the lives of the patients and the problems they face, but also into the technical problems on the ground of providing safe and effective antiretroviral therapy (ART), even when the drugs are available.

Supply of ARVs

Our main problem is the constant struggle to maintain supply of ARVs. At times we have had to use different brand combinations in order to provide the equivalent drug regimens. However, there have been a couple of occasions where, due to circumstances beyond our control, the drugs have simply run out. This unacceptable and extremely frustrating situation arises out of a spectrum of seemingly immutable factors. A dire shortage of skilled health care workers at all levels is one factor, but a few dedicated individuals are doing their best and I believe they are on track providing more help can be guaranteed.

When I first arrived and witnessed the circumstances under which the ARVs were being dispensed, I was shocked and inclined to feel that perhaps the drugs should not be available until all the logistics are in place. I now feel differently, particularly after a conversation with a wise and experienced woman who was a founder and previous manager of NWPSFH and who now works on essential drugs and medicines policy with WHO in Geneva. It was she who originally fought to get ARVs into North West Cameroon. She explained that if we waited for all the infrastructure to be in place, that could take 20 years, or more. By that time millions of people would have died. The answer is that, of course, basic facilities should be there initially, with logistics and infrastructure being improved while ARVs are being provided. Scaling up access to ART can thus take place in a phased manner.

I also feel differently now because we can see the dramatic improvement in many of the patients now on ART. The power of ARV availability as an incentive for seeking HIV-testing is also profound.

In any of the situations I face regarding HIV or ART, I am now guided by the following tenets/questions :

- The HIV/AIDS situation here is an emergency
- What would I do and how would I feel if I were HIV-positive?
- Can I defend this course of action in the case of external inspection?

There is a long way to go, of course. Meanwhile, through my work I have been actively participating in the HIV therapeutics committee and providing as much technical information and support as I can (including dosage guidance for children). I am currently seeking funding for a computer plus database with dispensing training, to improve record-keeping and medication counselling and thus improve ARV procurement and follow-up of patients.

Life in Cameroon

Cameroonian people are friendly and welcoming. I have never worked with nicer colleagues. Cameroon is a bilingual (French and English) country — I live in one of the two anglophone provinces. There are over 200 dialects in Cameroon, most of them found in the north west province. However, Pidgin English is the true common language. This has taken a bit of getting used to, but I fully appreciate the subtleties of language now.

Similar words are used here , but in a slightly different way, which can cause communication problems. For example, I was disturbed when one colleague told another that her sister had died in an accident the previous night. "Wonderful!" was the reply. However, I have since learnt that "wonderful" may be used here to describe both positive and negative phenomena in the sense of "full of wonder", "incredible" or "shocking".

I live in a highland area which is relatively cool for Africa. This also means that there is a colourful array of both tropical and temperate fruit and vegetables available from papaya, tomato and pineapple to carrot, potato and even the occasional turnip!

What next?

A number of people have asked me what I will do when my second year is up. I am certainly interested in improving my clinical knowledge, perhaps through postgraduate study, with the possibility of working in international health or HIV/AIDS in the future. Nothing is yet written in stone. What is certain is that my time in Cameroon has taught me a lot about what is important to me and my capabilities. When you live through a situation like this, it helps you to see more clearly both personally and professionally. What more could a young pharmacist ask for?