Professor Sultan Suleman’s office is small and cramped. It’s one of four offices shared by 21 staff members of the School of Pharmacy at Jimma University in Ethiopia. But Prof Suleman, who is Head of the School, has grown accustomed to making use of limited space – and resources. Lectures at the School are rotated through three classrooms. One laboratory space has to be adapted for a range of pharmaceutical science lessons, like medicines production and industrial pharmacy through to pharmaceutical microbiology, using whatever equipment is available.
In spite of these challenges, and perhaps largely because of them, Suleman has ambitious plans for the future of pharmacy education at Jimma University. In addition to increasing the number of faculty members and expanding infrastructure, he wants to shift the School’s curriculum from one that he calls “product-focused” to one that is patient-focused; integrating training with pharmacy practice within the country; and launching a new Pharmacy program.

It is these ambitions that have brought Suleman in contact with the Global Pharmacy Education Taskforce, a tripartite initiative of FIP, WHO and UNESCO to foster pharmacy education development. Launched in March 2008, the Taskforce was formed on the belief that appropriately-resourced academic institutions and a competent academic workforce are key drivers to producing pharmacists that can meet pharmacy service needs within countries.

In an effort to focus on regions where workforce needs are greatest, the Taskforce invited seven academic leaders from different African countries to the FIP Congress in Basel to share their experiences and brainstorm ways to collaborate on projects. Six, including Prof Suleman, were able to attend.

During the Taskforce’s 3rd Global Pharmacy Education Consultation, as part of a panel discussion, each of the academics expressed a number of challenges, both at the local and national level: a severe shortage of practicing pharmacists, few experienced faculty members to educate students, limited access to quality medicines, low public awareness of health care services that can be provided by pharmacists and a lack of political support for basic policies governing pharmaceutical services.

The need for pharmacists that are trained locally was also underscored. Dr Lungwani Muungo, Head of the Pharmacy Department at the University of Zambia, said that before 2005, pharmacists working within Zambia had “all been trained from abroad or overseas, except for pharmacy technicians... [and that] over some time, the country realized that foreign-trained pharmacists did not address the needs of the country effectively.”

But finding the resources to adequately facilitate local education and training is difficult. Dr Olipa Ngassapa, Dean of the School of Pharmacy at Muhimbili University of Health and Allied Sciences (MUHAS) in Tanzania said inadequate funding hinders academic growth and structural expansion.

Panelists from Kenya and Malawi, which have recently funnelled more resources into building new pharmacy schools, also face issues like quality. “Raising the quality of pharmaceutical services is as important, if not more so,
than merely increasing the number of pharmacists,” said Dr Michael Berry, Head of the Department of Pharmacy at the University of Malawi. The pharmacy programme in Malawi, which opened in 2006, is the country’s first and expects its first graduates in 2009.

The representatives also cited issues within pharmacy practice they would like to address. “Because of the critical shortage of pharmaceutical personnel,” said Dr Mumugo, “dispensing of medicines to the patients is not generally regarded as a professional procedure.” It’s thought that anyone with any level of drug knowledge can handle and dispense drugs to patients, he commented. And simply graduating more skilled pharmacists won’t immediately combat long-standing misconceptions about the role of pharmacists in the community health setting.

The panelists emphasized the importance of product-related issues, given that access to medicines and supply chain management are important areas where input of pharmacy is required. With much of pharmacy curricula based on the Old British system, the development for an “African model” of pharmacy education, which is based on regional needs such as supply chain management, was introduced.

Although the needs within their countries are great, the panelists said they were seeing some improvement. For example, they reported an expanded intake of students at their institutions and an increase in employment of pharmacists in the clinical field, especially in private hospitals. Within the last several years, Kenya has focused on increasing the number of well-trained technicians to augment the pharmacy workforce, and optimising the current skill-mix. Zambian pharmacy schools have placed a stronger emphasis on clinical training and medicines-related public health issues.

Despite small advances, the development needed in pharmacy within these countries – spanning education, practice, policy and regulation – seems overwhelming. So where does the Pharmacy Education Taskforce come in?

A plan for action

The Taskforce arose from two global consultations held on pharmacy education in September 2006 in Salvador Bahia, Brazil and September 2007 in Beijing, China. During the Second Global Education Consultation, more than 40 national, regional and international leaders in education, practice and science reached consensus and shared commitment on an Action Plan encompassing four domains. These domains, outlined in the Pharmacy Education Taskforce Action Plan 2008 – 2010, relate to developing a vision and competency framework for education development, quality assurance and building academic workforce capacity.
The role of the Pharmacy Education Taskforce, comprised of an advisory group, project teams and partners, is to oversee the implementation of the Action Plan, identify resources, serve as a connection and conduit for stakeholders and provide strategic and technical guidance to facilitate achievement of the Action Plan outcomes. The Taskforce reports to the FIP Executive Committee, FIP Bureau, UNESCO and WHO.

According to the Action Plan, the Taskforce’s aims are: “To develop evidence-based guidance and frameworks through which to facilitate development of pharmacy education and higher education capacity to enable the sustainability of a pharmacy workforce relevant to needs and appropriately prepared to provide pharmaceutical services.” Among its seven objectives is the commitment to provide advocacy and technical guidance to country-level stakeholders and educational institutions.

Through professional and personal connections, the Taskforce identified leaders in seven countries to collaborate on this first wave of case studies. These education leaders (of Ethiopia, Ghana, Kenya, Malawi, Tanzania, Uganda and Zambia) will partner with the Taskforce to identify country needs, define relevant pharmacy services that meet these needs, understand the competencies required of the pharmacy workforce to provide such services and, ultimately, map the education necessary to support the development of these competencies.

Prior to the FIP Congress, two of these leaders – Dr Muungo and Professor Mahama Duwiejua, Dean of the Kwame Nkrumah University of Science and Technology in Ghana – and Taskforce project lead Mike Rouse piloted and tested a quality assurance tools based on the Global Framework for Quality Assurance of Pharmacy Education in Ghana. During the 3rd Global Education Consultation, Muungo and Rouse reported that the pilot was successful and, after some revision, the tools would be made available. The Global Framework for QA was also announced as an official FIP document approved by the FIP Bureau during the FIP Congress.

In addition to expressing their country’s needs during a panel session at the consultation, the country case leads met with the Taskforce at a private workshop to brainstorm the objectives, principles and methodology for undertaking the case studies. The country case leads selected priority areas within their countries where they saw potential collaboration with the Taskforce and prioritized curricular development, supply chain management and regulation. The panellists emphasized the importance of engaging stakeholders, including the media, to promote policy changes. The country case leads also suggested creating terms of reference to better clarify roles and responsibilities between the Taskforce and leads.

The Taskforce and country case leads reached consensus on five action points, which will unfold over the next several months:

1. Rouse, Duwiejua and Muungo will finalise the project report for the Quality Assurance Self-Assessment Pilot, revise the situation analysis and stakeholder

Based on figures from WHO’s Working together for health: The World Health Report 2006. In comparison, the United Kingdom has a density of 0.51 pharmacists per 1,000 population.
analysis tools and share the results with the country case study leads via the Taskforce’s “Community of Practice.”

2. The Taskforce Advisory Group and country case study leads will draft and agree upon a statement of principles or terms of reference for the country case study work.

3. The Taskforce Advisory Group will provide communications and advocacy support to the country case study leads as they begin to build a local team to implement the country case studies. The leads will identify “champions” for their local team and will identify key stakeholders to whom the advocacy support will be disseminated.

4. The Taskforce Advisory Group and leads will investigate sources of funding and availability for cross-country exchange visits, similar to the QA pilot study for Ghana/Zambia.

5. The results of the workshop and consultation will be shared and the outcomes will appear in publications like the IPJ and other health and education journals.

Next year will mark the halfway point for the Taskforce, which was formed as a three-year initiative. It is also an important year for Professor Suleman, whose School is set to launch new graduate programmes in clinical pharmacy and pharmacy administration, a move designed to help fill the gap in patient-oriented practice.

The theme for FIP Congress 2009 poses the question: “Responsibility for Patient Outcomes: Are We Ready?” It’s a question at the heart of pharmacy education, and one that drives development.

For now, that answer is: we are on the way.

For more information: please contact the FIP Pharmacy Education Taskforce at education@fip.org

References


4 WHO UNESCO FIP Pharmacy Education Taskforce News Release, 3 September 2008