

# Health Link for Pharmacist-led Public Health Programmes in Zimbabwe: Developing education pathways through partnership.

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## Abstract

**Background:** Forming collaborations and partnerships across borders is a principal component of transnational education practice. One approach to establishing transnational partnerships is to form alliances based on best-practice. Pharmaceutical public health education and training and the delivery of pharmaceutical services with a public health message is an area where transnational approaches can be fostered.

**Objectives:** The objective of the project was to establish a partnership (Health Link) between the pharmacist professional bodies of Zimbabwe and Great Britain in order to develop the capacity and capabilities of pharmacists in Zimbabwe to deliver public health programmes.

**Methods:** The process involved partner selection and engagement, as well as engagement with a range of stakeholders. The methods of engagement involved partners' meetings, a field visit to Zimbabwe for discussions with relevant stakeholders, a feedback workshop and dissemination activities. The set indicators of success were: agreed aims and objectives, agreed work streams, and establishment of a Memorandum of Understanding (MoU).

**Outcomes:** The project was successfully implemented with two of the three indicators of success (agreed aims and objectives and agreed work streams) achieved. A formalized Memorandum of Understanding is now being developed across the partner organizations, which forms the basis of a formal transnational approach to developing pharmaceutical public health education in Zimbabwe.

**Keywords:** *Education Pathways, Health Link, Public Health Programs, Zimbabwe*

## Introduction

There is increased recognition, both in developed and developing countries, of public health as a key area of pharmacy professional development (Anderson, 2007). In many countries pharmacists are one of the most accessible health professionals (Hasan *et al.*, 2011; Dent *et al.*, 2009), and are often the first point of contact with the health care system (Hasan *et al.*, 2011). Thus, there has been increased interest by governments to make the most of pharmacists in pursuing national public health agendas (Anderson, 2007).

Zimbabwe's national vision on public health recognises the multi-sectoral and multi-disciplinary nature of public health, and thus the need to engage with individuals, the various disciplines and state or non-state organisations within the

health sector, as well as those outside the health sector (Ministry of Health and Child Welfare, Public Health Advisory Board 2011). Chief amongst the public health imperatives are disease prevention and health promotion activities focusing on communicable diseases, excessive alcohol consumption, smoking and illicit drug use. Pharmaceutical aspects include the equitable provision of good quality, affordable essential medicines, equity in access to pharmacy services, promotion of rational drug use and applied health research. As one of the most accessible health care professionals in Zimbabwe, pharmacists are in a key position to engage individuals and communities in public health initiatives. Currently, the main role of pharmacists is as custodians of medicines and other pharmaceutical products (Govo *et al.*, 2008). There is a potential however for

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pharmacists to make an even greater contribution to public health than is presently the case, including active participation in illness prevention and health promotion (Govo *et al.*, 2008; WHO, 1998). At present their role is yet to be fully defined and documented. This project will assist with the progression towards consensus and agreement.

In a study conducted in Harare, Zimbabwe, patients indicated a desire for the expansion of pharmacists' roles to include activities such as monitoring of blood glucose, blood pressure and cholesterol levels, as well as measurement of weight, height and temperature (Govo *et al.*, 2008). Research and experience elsewhere has demonstrated that pharmacists who delivered public health interventions such as tobacco cessation and chronic disease management can be highly effective (Dent *et al.*, 2009; Posey, 2003) and can provide a highly cost effective use of public funds (Posey, 2003; Owen *et al.*, 2011).

In comparison, pharmacists in Great Britain have made great progress in pharmaceutical public health in areas such as smoking cessation, promotion of self-care, early identification of ill-health and disease risk factors through screening. Anderson (2007) describes this progress as a result of "convergence between a professional imperative to develop its role, on the one hand, and state recognition of the need to draw a broader range of health professionals and lay people into public health activities, on the other".

Zimbabwe and Great Britain have an opportunity for mutual learning regarding knowledge exchange and transfer. The limited resources for education and health care worldwide have created a climate that is open to the development of partnerships (WHO, 1997), and applying what is already known to achieve a significant impact on health (Pang *et al.*, 2006). Partnerships offer a vehicle for sharing knowledge, experience and expertise, allowing a more efficient use of scarce resources and application of knowledge to improve health care, particularly for underprivileged populations.

The aim of this project is to establish a Health Link between the Pharmaceutical Society of Zimbabwe/ Pharmacist Council of Zimbabwe (PSZ/PCZ) and the Royal Pharmaceutical Society (RPS) as the lead partners; with the International Pharmaceutical Federation and the University of York as partners. The aim of the Health Link is to develop capacity and capabilities of pharmacists in Zimbabwe to deliver public health programmes. We also describe the achievements, lessons learnt, and plans for the future.

## Methods and Processes

### *Project inception and partner selection*

Partners were selected on the basis of their ideology and shared interest in advancing knowledge and practice among health professionals, pharmacists in particular; and the improvement of population health and quality of life. The structure of the Health Link was limited by the funding body's eligibility criteria which specified that Link partners could only include: NHS Trusts, professional associations, public hospitals/clinics, not-for-profit hospitals/clinics (direct health service providers only), teaching hospitals and medical technical training institutions. The institutions involved in the link had to be recognised by the appropriate Ministry or relevant regulatory authority and be included in local or national health plans.

Partners met to discuss the aims and objectives of the Health Link and their expectations. Indicators of successful establishment of the Health Link were also defined as: agreed aims and objectives, agreed work streams, and a Memorandum of Understanding (MoU).

### *Field Visit to Zimbabwe*

A field visit to Zimbabwe was conducted early 2012 to assess local public health needs and capacity, inform different stakeholders about the Health Link, discuss priority areas and potential projects (Table 1). Meetings were held with representatives from multiple stakeholders including PSZ, PCZ, the Retail Pharmacist Association, public sector pharmacists, Research Pharmacists Association of Zimbabwe, Directorate of Pharmacy Services (Ministry of Health and Child Welfare), and the Public Health Advisory Board. We also engaged with a patient group, the Chronic Therapy Association of Zimbabwe (CTAZ).

### *Feedback workshop and dissemination of results*

A feedback workshop was held and attended by 10 pharmacists including those representing the stakeholders described above, and two final year pharmacy students. Feedback was also provided to partner institutions via e-mail and telephone calls, and the end-of-project report was distributed to all stakeholders consulted during the process.

## Results and Discussion

The project was successfully implemented with two of the three indicators of success achieved; they are the establishment of 1) agreed aims and objectives, and 2) agreed work streams. The Memorandum of Understanding is now being established through the formal governance processes of the partner organizations. We engaged with 21 individuals representing 11 organisations, as well as final-year pharmacy students in the process. The ability to establish shared interest among partners was one of the major facilitators of success, particularly on reaching consensus over the aims, objectives and work streams (Schattschneider, 1960; Mitchell and Shorthell, 2000). We also set measurable indicators of success, which acted as measures of accountability and instilled a sense of purpose.

### *Barriers to overcome*

Equitable access to pharmacy services and pharmaceutical products remains a challenge in Zimbabwe for a number of reasons (Castiglia *et al.*, 1997; Chikanda, 2006). Firstly, there is a general shortage of financial resources for health in Zimbabwe. Secondly, pharmacists are generally in short supply mainly due to migration to developed countries (Chikanda, 2006). Thirdly, although most of the country's health care needs are provided through the public sector, most of the available pharmacists favour working in the private sector primarily due to better remuneration (Castiglia *et al.*, 1997, Chikanda, 2006). A study published in 1991 reported that approximately 80 percent of the 350 pharmacists registered in Zimbabwe practiced in the private sector which served about 10 percent of the population (Jameson *et al.*, 1991). Chikanda reported that in 1997 only 18.7 per cent of

**Table 1: Activities undertaken**

Activity	People involved	Objective	Outcome
Teleconference 1 (21/12/2011)	<i>PSZ/PCZ</i> : 1 representative  <i>RPS</i> : 1 representative  <i>FIP</i> : 1 representative  <i>University of York</i> : 5 representatives	<u>To discuss:</u> Aims and objectives of the Health Link  Partners' expectations  The schedule of activities  Potential future projects Identify contact persons from each institution	<u>Draft aims and objective</u> Partners contributions and expectations discussed  Contact persons identified  Potential future projects identified
Meetings in Zimbabwe (29/02/2012- 09/03/2012)	<i>PSZ</i> : 2 representatives  <i>PCZ</i> : 1 representative  <i>School of Pharmacy</i> : 1 representative  <i>Retail Pharmacist Association</i> : 3 representatives  <i>Research Pharmacists Association of Zimbabwe</i> : 2 representatives  <i>Directorate of Pharmacy Services (Ministry of Health and Child Welfare)</i> : 2 representatives  <i>Public Health Advisory Board</i> : 1 representative  <i>Parirenyatwa Hospital</i> : 1 representative  <i>Chronic Therapy Association of Zimbabwe</i> : 1 representative	<u>To:</u> Assess local needs and capacity  Inform different stakeholders about the Health Link and potential projects  Receive input from stakeholders on the feasibility and acceptability of potential projects	Local needs and capacity identified  Awareness of the Health Link raised  Potential projects finalised
Workshop in Zimbabwe (05/03/12)	10 pharmacists and 2 pharmacy students	<u>To:</u> Provide feedback on the findings from the meetings  Have input from the stakeholders on the identified potential projects	Potential Projects finalised
Report writing	<i>PSZ/PCZ</i> : 1 representative <i>RPS</i> : 1 representative <i>FIP</i> : 1 representative <i>University of York</i> : 4 representatives	To summarise project achievements	End of project reported finalized and submitted to sponsors.
Feedback to Health Link Partners	<i>PSZ/PCZ</i> : 1 representative  <i>University of York</i> : 1 representatives	To provide the partner institutions with a summary of what was achieved.	Achieved through e-mails and telephone calls. End of project report also sent to partners.

the available public sector pharmacist posts were filled (Chikanda, 2006). Fourthly, huge discrepancies exist between rural and urban areas. Although the majority of the population in Zimbabwe reside in rural areas, pharmacists prefer urban areas mainly due to better salaries and working environments (Castiglia *et al.*, 1997). Pharmacy education in Zimbabwe has addressed this in a number of ways including incorporating a two-week rural attachment within the curricular where students interact with a rural health care team at a clinic or hospital based on the conjecture that early introduction to rural health care may encourage future pharmacists to practice in these underserved areas (Castiglia *et al.*, 1997). However this approach has not been successful. This inequitable distribution of pharmacists has a negative impact on equitable

access to pharmacy services and good quality, affordable essential medicines.

Although there is recognition by Zimbabwe's pharmacy professional body that embracing public health is a desirable activity, there is still a need to demonstrate potential benefits to encourage pharmacists to carry out such activities. Some of the planned educational work streams may involve expanding the role of pharmacists from the "traditional" role of being custodians of medicines. This re-orientation of pharmacy practice is in line with contemporary pharmaceutical care concepts (Govo *et al.*, 2008), and converges with the desire by the pharmacy community in Zimbabwe to maintain international standards whilst at the same time responding to local needs. It might however imply

the need to also re-orient pharmacy education, training and continuing professional development. As a marker for initial educational development in this field, the Health Link programme will address the key areas of non-communicable diseases, smoking cessation, promotion of alcohol abstinence and illicit drug use cessation.

It is also important to note that national statutory requirements or policies which stipulate the tasks that can be performed by different health professionals could also challenge pharmaceutical role development. The general shortage of human resources for health worldwide has led to significant changes in perceptions on what different health care professionals can and cannot do (WHO, 2008). It could be relevant therefore, not only for Zimbabwe but also in other countries, to re-evaluate statutory restrictions to the practice of different health care professionals including pharmacists where appropriate.

One potential risk to the success of the Health Link will be obtaining the required resources (financial and otherwise) for the following: programme/project implementation; providing the appropriate structure and coordination mechanisms; continued engagement and maintenance of institutional members' interest in the shared vision; and information systems to monitor progress over time.

#### *Health care priorities*

Zimbabwe's disease profile and health priorities remain dominated by communicable diseases (Ministry of Health and Child Welfare, 2009). However there is recognition that non-communicable diseases are on the rise, and there is increasing attention to underlying causes of non-communicable diseases such as excessive alcohol consumption and tobacco smoking (Ministry of Health and Child Welfare, 2009). The knowledge and experience of pharmacists practicing in the United Kingdom on health promotion and disease prevention activities in this area will be of great use.

#### *Mutual benefit*

The Health Link will not only benefit Zimbabwe, but also the partner institutions through developing greater transnational cooperative practices and increasing understanding of global health issues; the issues of globalisation impact on all nations and the concept of the 'global pharmacist' is one that embraces all leadership fora. We also hope to reach the wider pharmacy community through dissemination of information on effective and best practices, and advocating for change in pharmacy practice where necessary, leading to better patient care.

#### *Sustainability*

The implementation phase will involve:

- 1) development of a pharmacist public health agenda and professional standards for public health led by the PSZ/PCZ
- 2) development of measures of accountability that are easily recognisable and accepted by a wide variety of stakeholders
- 3) implementation of public health programmes within defined work streams
- 4) monitoring and evaluation of progress
- 5) establishment of a Health Link website

To ensure effective implementation of public health programmes, phased implementation will be preferred, starting with one or two well-defined and focused projects. We hope that these projects will provide lessons for improvement in the implementation of future projects.

For the first project the Health Link will explore three key areas of pharmacists' education and practice development that address some of the underlying causes of non-communicable diseases which include: smoking cessation, promotion of sensible alcohol consumption, and illicit drug use cessation. This initial phase will ensure that competence is built through education as a foundation for service delivery development. The second project will explore ways to encourage pharmacists to choose to work in underserved areas, particularly rural areas and the public sector.

#### **Conclusion**

The project was successfully implemented with two of the three indicators of success achieved, and one forthcoming. This project also demonstrates that besides differences in patterns and burden of disease between developing and developed countries, common areas of interest still exist and these offer opportunities for collaboration. However in order to build a successful partnership there is a need to establish a shared vision and facilitate acceptability, relevance and sustainability through stakeholder engagement.

#### **Declarations**

##### *Conflict of interest*

The Authors declare that they have no conflict of interest to disclose.

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