ONE PHARMACIST’S JOURNEY

The story of Dr. Anil Shah, a senior colleague with PSK

Official Publication of the Pharmaceutical Society of Kenya
What is Parkinson’s Disease?

Parkinson’s is a progressive neurological condition. People with Parkinson’s do not have enough of a chemical called dopamine because some nerve cells in their brain have died. Without dopamine, people can find that their movements become slower so it takes longer to do things. The loss of nerve cells in the brain causes the symptoms of Parkinson’s to appear.

Incidence of Parkinson’s increases with age, but an estimated four percent of people with PD are diagnosed before the age of 50. There is currently no cure for Parkinson’s and we don’t yet know why people get the condition. Parkinson’s does not directly cause people to die, but symptoms do get worse over time.

The following are features that are associated Parkinsons.

- Tremor of the limbs
- Speech changes
- Depression and anxiety
- Stiff muscles
- Sleep problems
- Bladder problems
- Slowed movement
- Thinking difficulties
- Stooped posture and poor balance
- Swallowing problems
- Loss of facial expression
- Smell problems

- Writing changes
- Weight loss
- Sexual dysfunction
- Constipation
- Unexplained fatigue
- Blood pressure issues

Among the famous people who have the disease?

Retired boxer Mohammed Ali, the late Pope John Paul II, American actor Michael J Fox, former Chinese communist leader Mao and Evangelist Billy Graham.

See more at: www.pdf/about_pd
www.parkinsons.org.uk/content/what-parkinsons#6hash.AE4KPlJv.dpuV

What is Parkinson’s Plus or Parkinsonism?

Other neurological conditions that are similar to Parkinson’s and may have some of the same symptoms. These may be harder to diagnose than Parkinson’s Disease.

Conditions such as:

- MSA - Multiple Systems Atrophy - www.msanauk.org.uk/
- PSP - Progressive Supranuclear Palsy - www.pspassociation.org.uk/
- CBD - Cortico-basal degeneration - www.bdaa.org/node/7

Do you, a relative or a friend have problems related to speech or motor resulting from Parkinson’s or Parkinson’s Plus?

Parkinson’s Support Group, Kenya.

A group of people have come together with the intent of helping those suffering from Parkinson’s Disease and Parkinson’s Plus. A multicultural group with no religious affiliations which include:

- Those suffering from the condition and their families and friends.
- Professionals working in Kenya who work with people with these conditions.

The mission of the support group is:

- To support and advise patients on PD and PD Plus and where to get help.
- Raise funds for people with PD who cannot afford the medications and therapies they need.
- Provide long-term support with others in a similar situation.

For more information please email:
Fr. Thomas Kevin Kraft: tkkraftop@gmail.com
Hansa Patel: altongpatel@gmail.com
Harsh Maroo: harsh.maroo@philipskenya.com
Zahir Mandani: zminknde@gmail.com

The Nairobi-based “Parkinson’s Support Group” is a non-lucrative, voluntary association of people with Parkinson’s Disease (and closely related conditions collectively referred to as “PD Plus”), together with their family members, care-givers, and health-care professionals involved with PD patients. The group is non-denominational, and people of any faith (or no faith) are welcome; people of any race, culture, language and economic condition are welcome to participate. It has at present no dues nor official register of members. Our meetings are usually once monthly on the 2nd Thursday of the month, from 10:30 AM – 12:30 PM. We have been generously given an appropriate venue of 2 classrooms (with bathroom facilities nearby) at the Consolata Shrine, Westlands (off Chiromo Rd / Waiyaki Way just before the Westlands roundabout).
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USEFUL WEBSITES
1. www pv pharmacyboardkenya org
2. www mayoclinic org
3. www who int
4. www essentialdrugs org
5. www who int immunization policy / immunization schedules en/
6. www medscape com

Dear Members,
We welcome your comments/views on our articles. Kindly give us your feedback on the magazine to enable us to improve. Also, feel free to share your happy moments with our PSK family. We will publish them in the next issue. Please contact us via e-mail at pskjourn al@gmail.com.
Dear Members,

The year 2015 has been a great year for the Pharmaceutical Society of Kenya in which we have made great strides in many fronts. PSK now has established branches all over Kenya serving our over 1800 member base in the quest of decentralizing activities. This has been a huge success with increased membership and recognition ceremonies for active pharmacists, CSR activities and creation of investment arms with the objective of creating value for members. Specific mention of the Nairobi Branch meetings where the concept changed from delivery of CMEs as a stand-alone activity to a more interactive panel based discussions as well as Mombasa Branch having an Awards and Recognition ceremony at their annual GM.

PSK is also proud to have an in house advocate after having realized that there were a lot of litigation matters to be handled. There are success stories that have rallied behind this department pertaining to judicial review of CAP 244 Section 3, the nursing Council case 79 of 2015, the registrar’s case 402 of 2015 and PPB appointment case no 244 of 2015. We are also dealing with the complaints from Branches, over harassment by agencies other than PPB and primarily the Public Health Officers.

There have also been several engagements with different stakeholders on projects that PSK has been working with and PSK would like to take this opportunity to thank all of our sponsors who have made our initiatives a success.

The PSK dinner and dance 2015 was filled with pomp and color with our members from all sectors gracing the event and especially worth noting were the younger pharmacists embracing the society by appearing in large numbers. We take this opportunity to thank all of you who were in attendance as well as the companies that sponsored the Dance, that was a grand end of year activity.

I would especially like extend a hand of appreciation to all PSK committee members who have volunteered their time and expertise during the year to serve and attend meetings, your contribution and sacrifice has been highly appreciated.

Finally I would like to wish all our members and all our colleagues at large a Merry Christmas and Happy New Year 2016.

Dr. Paul Mwaniki
PSK President
A time to reflect on the future of pharmacy, not a referendum on the Pharm.D.

J.S Mwawaka, Pharmaceutical Society of Kenya (Coast Branch)

INTRODUCTION

Growing the professional status and space of the pharmacist should be every pharmacist’s concern.

The Nairobi branch of Pharmaceutical Society of Kenya-PSK, the youngest branch of PSK, announced, early in the year, plans to host a panel discussion to determine whether Kenya needs to adopt the US type of Doctor of Pharmacy (Pharm.D) programme. It is noteworthy that the venue of the forum will be the United States International University –Africa (USIU) which in early 2015 spawned the youngest school of pharmacy. One may argue that the debate is belated as Kenyatta University (KU) another nascent school of pharmacy, in 2013, produced a draft Pharm. D programme which was reviewed by a battery of stakeholders including PSK and pharmacy students. A confident Dr T. Kahiga Muhu, MPSK, the promoter of the proposed programme, then declared that the meeting was “not a referendum on the Pharm. D” and that KU was ready to have the programme implemented. The proposal to adopt the Pharm.D is the most radical change ever suggested by PSK. We, however, need to pose and ask ourselves whether this is the solution to our perceived problems, whatever these are.

A BROADER DEBATE

The debate being proposed is about change. Understandably, the movers of the motion presumed that members of PSK know that change is needed in this area. Why do we need change? Is it because the current pharmacist is probably not serving society as he/she should? We need to ask more questions: Does Kenya still need pharmacists? If so, what kind of pharmacists and how many? Who will employ pharmacists? What is needed to retrain the current “obsolete” practitioner?

The debate we need to have is, therefore, broadly on the future of pharmacy in Kenya.

WHY PHARM.D?

The Pharm. D has lately been in vogue in Nigeria (University of Benin), Egypt, Philippines, Korea, India, Pakistan, South Africa, Pakistan, Canada, Malta, United Arab Emirates, Qatar and several other nations.

In Pakistan, the 5 year Pharm.D is now the only entry level qualification. It is, however, a product-oriented programme with limited clinical content. The Indian Pharm.D is remarkable in that its quality is assured by the pharmacy regulator by means of a common curriculum, limits on class size, minimum entry requirements and mandatory pre-graduation internship. In India the Pharm.D may be pursued as an undergraduate programme (6 years) or a post graduate qualification (3 years). In both cases, the last one year of the curriculum is dedicated to supervised clinical internship.

This group of (Anglophone) Pharm. Ds, modelled after the US one, is distinctly different from the more rigorous French (Francophone) tertiary Pharm.D degree which prepares pharmacists to be scientists, consultants and researchers.

US PHARM.D

The inspirational value of the United States of America in pharmacy circles cannot be gainsaid. It should be stated that the US Pharm. D has been in existence since 1950 (University of Southern California). Initially, the Pharm. D was a post graduate clinical pharmacy specialisation which became an undergraduate degree before finally gaining the status of sole entry-level qualification for practice. During the same period, patient-oriented practice, in the USA, evolved from drug information to clinical pharmacy, to Pharma-co-therapy, to pharmaceutical care; and finally to Medication Therapy Management (MTM). This is to be contrasted to events (in late 90s) in the UK, where pharmacy training moved from an undergraduate BSc to an undergraduate M. Pharm that was supposed to be more patient oriented. Here, however, no effort was made to eliminate post graduate clinical pharmacy programmes which had been in existence for about two decades.

The US Pharm.D is unique and no other country has been able to replicate it. It seeks to produce an all-rounded, autonomous and self-driven professional who can practice, teach, research and lead
practitioner in the US is the Clinical Pharmacist Practitioner who has limited prescriptive authority under protocol. The virtues of the US Pharm.D are many and one could go on and on about them. However, the big question is: has this innovative programme delivered the pharmacy dream? Do pharmacists in the USA enjoy a greater status than they do in other countries? Are they better integrated in patient care? Have all pharmacists in the US embraced the clinical mission or pharmaceutical care philosophy of pharmacy? Are pharmacists in the US more likely to employ their skills than their counterparts elsewhere? Are they more satisfied? Do they have a greater say in pharmaceutical policy or regulation? The answer to all these questions is, sadly, no. This year (more than 30 years after the birth of clinical pharmacy) US pharmacists are looking forward to gaining recognition as providers after many years of lobbying. The encouraging part is that, the public is participating in the debate on the expanded role of pharmacists as providers of health care.

**SWOT ANALYSIS OF THE KENYAN PHARMACIST VERSUS THE US BASED PHARMACIST**

**Strengths and Opportunities:** The Kenyan situation has certain positive attributes which could constitute unique opportunities for change: One, many Kenyan consumers have embraced pharmacy workers (not necessarily pharmacists) as providers of medical services. The proposed Pharmacy Practitioners Bill 2014 seeks to consolidate this role.

Two, pharmacists in the public sector enjoy stipendial parity with medical practitioners and dentists. This would facilitate inter-professional collaboration and upward mobility of pharmacists into policy-making positions.

Three, many pharmacists in Kenya work or have worked in more than one sector. This implies that, in essence, many pharmacists are generalists. Clearly, it would be uneconomical to train pharmacy specialists in a country where chances to utilise specialist skills are limited. What is probably needed is a broader and more comprehensive undergraduate programme.

Four, with less than four thousand pharmacists, the pharmacy profession in Kenya is like a small club and this should facilitate internal professional dialogue.

Five, Kenya has no less than six universities (source: Pharmacy and Poisons Board of Kenya) training pharmacists, three of which are non-state entities. This number is set to rise following the recent directive from the Education Cabinet Secretary urging all universities to discontinue diploma programmes; three public universities (Kenya, Mombasa and Kisii) which have been offering the Diploma in Pharmaceutical Technology may upgrade to the Bachelor of Pharmacy Programme. As they compete for students, locally amongst themselves (and regionally/internationally with others), these nine or so institutions will have to come up with really innovative programmes whose graduates can practice locally/regionally and internationally.

**Weaknesses and Threats:** Is the Kenyan scenario any different from the US scenario? Yes. First, the Americans spend more, per capita (USD 8895 or 17.9 % Gross Domestic Product), on health care than any other country in the world. In Kenya, total health per capita was USD 84 or 4.7% of GDP (WHO 2012). Second, there is a substantial presence of third party players in the health market. In Kenya most consumers pay for their own health care. Third, there is more concern in the US for patient safety and thus for greater investment in quality assurance in health. Yes, quality assurance is the value that pharmacy has been contributing to the efforts of the health care team.

In Kenya, in contrast, the main concerns are product availability, affordability, quality and rational use in order of decreasing importance. Fourth, so far, there have been fewer than five clinical pharmacy posts created in the Kenyan private sector, in the last 2 years. This tells us that few employers are willing to pay pharmacists to offer cognitive patient care services. Five, many public sector clinical pharmacists in Kenya are unable or unwilling to function in this capacity for various reasons including the need for career progression, lack of support and frequent drug shortages.

The biggest threat to change in pharmacy is the establishment(s) charged with the responsibility for the review, approval and implementation of proposals for change - the Pharmacy and Poisons Board. To facilitate implementation of the badly needed change, the Pharmacy and Poisons Board’s Committee on training should be strengthened to the level of the Accreditation Council for Pharmacy Education, so that it can objectively undertake accreditation, assessment and inspection of curricula, training institutions and students.

Lastly, our academic culture is not tolerable to the notion of a terminal degree; Kenyan pharmacists may still want to pursue additional degrees in their field as is the practice, locally, in many other professions.

**CALL TO ACTION**

From the foregoing analysis it is clear that Kenya cannot engage in a “copy and paste” adoption of the American terminal Pharm.D degree. In fact global pharmacy leadership bodies have held that “pharmacy education must ...(be) directed towards societal health care needs, the services required to meet those needs, the competences necessary to provide these services...”(WHO UNESCO FIP Pharmacy Education Taskforce, 2009)

This means that the local pharmacy fraternity, led by PSK, should first undertake a county-wide pharmacy educa-
tion-needs assessment. Such an exercise should involve not just pharmacists but also pharmaceutical technologists, pharmacy dispensers, employers, pharmaceutical industry, trainers, consumers, health economists and health system managers, pharmacy regulators, pharmacy professional guilds, pharmacy leaders, health policy makers. The needs would in turn determine the training objectives and hence the training curriculum. It is the curriculum that determines the kind of degree programme to be rolled out and the training philosophy.

The organisers of the proposed debate should aim to come up with a position paper that would then be proposed to the entire spectrum of pharmacy stakeholders but most importantly the implementers. It is important that the Position Paper be the product of wide consultations involving all stakeholders.

CONCLUSION

The call to debate was a move in the right direction. It is a call to re-engineer the profession through innovative training. The debate should, therefore, not be a referendum on the American terminal Pharm.D. Rather, the discussion should be broader and address the change needed to create the future of pharmacy. Proposed change should be driven by evidence rather than the mere fascination (of trainers and pharmacists) with change. In the meantime, the Pharmacy and Poisons’ Board needs to be strengthened to give it the capacity required to objectively assess all proposals for pharmacy training. The forum at USIU will hopefully come up with a position paper on the future of pharmacy which could be presented at the annual symposium for adoption by the entire profession and industry.

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One Pharmacist’s journey

Narrated by Dr. Nadia Butt

Dr. Anil Shah, a senior colleague with the Pharmaceutical Society of Kenya (Registration number 377), allowed us to join him down memory lane as he recalled his journey as a Pharmacist and his adventures along the way.

It is indeed after hearing Dr. Anil’s story that one understands that everyone’s journey in life is unique and more importantly, when you discover your niche and strength however new or different it is, and then the rest just follows through.

Dr. Anil was born and raised in Mombasa, Kenya. His father, the late Mohanlal Dharamshi Kachra Shah was a businessman in the line of textiles, and his mother, the late Shantaben Popatlal Karman Malde was a housewife. He is brother to Arun and Sudha.

Dr. Anil had a humble upbringing. After high school at Allidina Visram High School, Mombasa, he left for the United Kingdom in 1961 for further studies. No University in Kenya offered a Pharmacy Program. He went on to complete his A-levels at Leicester College of Technology, followed by a Pharmacy degree from the Leicester School of Pharmacy in 1967. This is also where he met the Late Dr. Pravin K. Shah, a fellow pharmacist and at the time a lecturer, who became a lifetime close friend.

Dr. Anil as he started his journey from 145 Abbots Drive, Wembley, Middlesex, UK 1969.

Dr. Anil also thrived on adventure, so upon graduation he decided to work locum in London for a year in order to raise
some cash to begin his backpacking trip to India with a group of 10 friends. An advert in the Sunday Times on Overland to India had captured his eye and became his inspiration. In the Colonial Era, individuals were provided with a Colonial Office Protected Persons Passport in order to travel, he applied for it and with that he was ready to backpack. He wrote to his mother and asked her and her sister to meet him in Mumbai. A four month journey of adventure began from London, England to Istanbul, Turkey via the famous Orient Express that would eventually end in India.

After approximately two weeks of roaming the streets of Istanbul and absorbing the sights and culture, the group of friends continued hiking rides on top of trucks and buses to Iran, Afghanistan, and finally India where Anil met his mom and Aunt. At the end of the overland Journey and glorious adventure, the friends went their separate ways. Dr. Anil took some time to take his Mom and Aunt on a Yatra - a procession or pilgrimage, especially one with a religious purpose. Hiking rides with them wasn’t possible so he travelled via “Gandhi class” - third Class from Mumbai to Kanyakumari, the tip of the Indian Subcontinent, and finally back to Mumbai, a most memorable trip for all of them, he recalls.

After the 4 month long adventure came to an end, Dr. Anil travelled back home to Kenya. He wanted to settle down and begin working as a pharmacist. Apparently, when he was originally leaving to travel out of the United Kingdom, he wasn’t informed that by applying for the Colonial Office Protected Persons Passport (Newly formed Kenya Embassy had no facility to issue Passports) he would be forfeiting his Kenyan rights. By that time, work permits were not required so he began practicing at Kilindini Chemists Ltd, Mombasa. He was actually among the first Pharmacists registered by Fellow Dr. Albert Mathenge, the Chief Pharmacist and Registrar at the time under the Ministry of Health in Kenya when the regulations were modified.

Dr. Anil still enjoyed travelling. He would visit Nairobi often and steal a small vacation not too far away from his family. In 1970 during one of his visits to Prabulal Malde and meeting family friends, he encountered a young lady, Sunanda who he recalled seeing in the Sunday Nation modeling jewelry. It took a meeting or two at the most that led to an engagement in 6 days. Following the engagement, Dr. Anil was to return to Mombasa.

While awaiting his flight back, he was having lunch at the Intercontinental Hotel and started chatting with the neighboring gentleman, Mr. Keith Mclough who happened to be the marketing manager of Boots (under Kenya Overseas Company Ltd.) in Kenya who insistently invited him to visit their factory. With an hour left to reporting time for the flight, Dr. Anil decided to join Mr. Keith for the visit, where he was introduced to Mr. Kevin Fitzpatrick, the Managing Director. Whilst leaving the factory and brief discussions with both gentlemen, he was offered an appointment to fill the position of Company Pharmacist. Eight weeks later Dr. Anil and Sunanda, the charm of his life, wed and he took up the job.

Dr. Anil and Sunanda became parents to two boys, Sujay and Ajay. Today, Sujay is the Managing Director of Livie Biopesticides Ltd. (UK), and Ajay is a Professional Golfer (Kenya), taking cue from his parents who have been golf enthusiasts. Ajay and his wife are parents to Amar who is a fond golfer as well, and his grandparents’ joy. Sunanda remained a housewife to raise her children, and enjoys many activities. Besides modeling jewelry in her earlier days, she creates beautiful Ikebana flower arrangements (a Japanese art of flower arrangement - Ikebana artists display Shin, Soe and Hikae which translates to the philosophy of Heaven, Earth and Humans). The couple has travelled to Japan and India to enjoy the Ikebana exhibits.

In the past couple of years, Dr. Anil has volunteered his time, pro bono, and expertise to overseeing the licensing, supervision and set up of the Lion’s Eye Hospital pharmacies.
Sunanda has been the Golf Captain of Veterinary Labs Sports Club Kabete, and also plays Bridge. Dr. Anil was the Captain and Chairman of the Kenya Medical Golfing Society in 1992. Dr. Anil belonged to many sports clubs and was fond of squash and equestrian dressage. “Equestrian dressage” has nothing to do with making clothes for horses, as you may have imagined; it is a form of gymnastics that horses take part in with a rider.

In the past couple of years, Dr. Anil has volunteered his time, pro bono, and expertise to overseeing the licensing, supervision and set up of the Lion’s Eye Hospital pharmacies. He is enjoying retirement with his wife.

Retirement has afforded Dr. Anil plenty of time which he utilizes to learn about different philosophies and ways of life. The late Dr. Bro. Fellow James Njogu introduced him to Freemasonry, while his son, Sujay, introduced him to Buddhism, both of which he has embraced. Although born a Hindu, Dr. Anil explained that both practices allow people to be happy and upright therefore does not see any conflict with his Hindu beliefs. Whilst practicing Buddhism and following his Mentor Daisaku Ikeda, President of Soka Gakkai International (www.sgi.org), in promoting world peace, education and culture, Dr. Anil shared that this has helped him discover the true meaning of life. Daisaku Ikeda holds more than 300 Honorary Doctorate’s from Universities all over the World including one from the University of Nairobi.

Those who know Dr. Anil say he is a very kind, contented and happy person. When asked what advice he would like to give our fellow colleagues and budding new Pharmacists, he said with a smile on his face:

“There is so much to learn. Keep your eyes open for opportunities and take up any challenges that come your way. Always follow your passion. Most of all, be content in life.”

“Happiness doesn’t exist on the far side of distant mountains. It is within you, yourself. Not you, however, sitting in idle passivity. It is to be found in the vibrant dynamism of your own life as you struggle to challenge and overcome one obstacle after another, as you clamber up a perilous ridge in pursuit of that which lies beyond.”

-Daisaku Ikeda
Presenting the Editor-in-Chief, Pharmaceutical Journal of Kenya (PJK) and ‘The Pharmacist’ Newsletter

Jennifer Akinyi Orwa is Chief Research Officer at the Kenya Medical Research Institute (KEMRI) Centre for Traditional Medicine and Drug Research (CTMDR). She holds a PhD degree in Pharmaceutical Sciences from Katholieke Universiteit Leuven, Belgium; MSc in Pharmacology from Chelsea College (now Kings College) University of London, UK; and Bachelor of Pharmacy degree from University of Nairobi. Prof. Orwa upholds her passion in ensuring continuity of the Pharmaceutical Journal of Kenya amidst her numerous responsibilities and the very many challenges that arise in the laxity of the professionals to provide adequate scientific articles in time for publication in order to sustain the quarterly Journal. Following the challenge from the PSK President, Dr. Paul Mwaniki to provide a forum for discussing non-scientific work as well, Prof. Orwa and her team started to roll out this PSK magazine ‘The Pharmacist’ that as we can see now allows pharmacists to express their views concerning issues in the profession, including challenges and opportunities the profession can offer as well as health updates and updates from the PSK Branches.

Prof. Orwa in her endeavour to remain relevant in the rapidly evolving scientific world sustains her knowledge through continuous professional education, the current trend. She has had short courses on Project cycle management, Quality Management systems, Pedagogy Training, Management Skills Development, Mentoring the Mentors in Global Health Research, Strategic Leadership Development Program, Intellectual Property Rights, Corporate Governance Training Course for Directors, Strategies for Innovation-led Sustainable Growth, Training Workshop for Medical Journal Authors and Reviewers, among others.

Prof. Orwa has been honoured by various awards including Head of State Commendation: Order of the Grand Warrior of Kenya (O.G.W) for Excellence in Health Research and, Fellowship of the Pharmaceutical Society of Kenya (FPSK), by the Pharmaceutical Society of Kenya for distinguished service to the Society in the field of Pharmacy and outstanding original contribution to the advancement of Pharmaceutical Knowledge. She has been included in Biographical record in Marquis Who’s Who in Medicine and Healthcare.

A seasoned researcher, Prof. Orwa is currently on a one year sabbatical leave from KEMRI to collate and analyse data from her various research activities in order to continue with scientific publications. In addition, she is efficiently using this time to enrich her personal stature and intellectual

Prof. Orwa has developed competitive protocols that have attracted research funds to facilitate the implementation of biomedical research. Her current area of research focuses on medicinal plants innovation and product development

Prof. Jennifer Akinyi Orwa receives the award of Order of Grand Warrior (OGW) of Kenya from former President, Mwai Kibaki at State House Nairobi, of Dec. 12th 2009
growth. Thanks to the recent inauguration of the School of Pharmacy at the United States International University – Africa (USIU-A), the University appointed her as Associate Professor of Pharmacy to assist in the academic development of the newly commenced School of Pharmacy and Health Sciences, an academic position she embraces with immense satisfaction.

Prof. Orwa has developed competitive protocols that have attracted research funds to facilitate the implementation of biomedical research. Her current area of research focuses on medicinal plants innovation and product development. She has mentored undergraduates, postgraduates and young upcoming scientists to achieve their desired education and experience in research methodology. Prof. Orwa, the Chief Editor of Pharmaceutical Journal of Kenya, has authored and co-authored 37 peer reviewed publications. She has also published 17 editorials, a book review and conference proceedings as editor. She has presented 83 abstracts in international, regional and national conferences, 30 of which were invited keynote presentations. Prof. Orwa continues with her passion in research for health, mentorship, authorship and editorials.

Vaccines: Why the Controversies?

By Dr. Patrick W. Okanya

The last four months brought Kenya into the international limelight over vaccine controversies. The first was a heated debate between religious groups and the Ministry of Health on polio vaccination for children under five. The allegation making rounds was that the vaccine contained birth control agents aimed at reducing population growth in sub-Saharan Africa. The other controversy followed a month later when measles vaccination resulted in the death of two children in Kerio Valley of Elgeyo Marakwet County, leading to residents refusing vaccinations for their children.

To address these controversies, it is important to understand the basics of vaccines: what they are and what they do. By definition, a vaccine is any biological preparation obtained from a killed or weakened (live attenuated) pathogen formulated to boost the body's immune system against a particular disease. In principal, the weakened or killed agent serves as a threat to the normal functioning of the body to elicit an immune response. The body reacts by producing antidotes to destroy the threat and file a record of the antidote in the memory of the immune system to be used later against a similar threat. The history of vaccine and vaccination dates back to 1798 when Sir Edward Jenner discovered that cowpox virus affecting cows and humans, albeit with minor effects on the later when compared to the fatal effects of smallpox virus, could boost the body's immune system against the smallpox virus. He performed an experiment by immunizing an eight year old boy with cowpox virus by inoculating the child with smallpox virus. After about two weeks incubation, there were no observable symptoms of smallpox; these results formed the basis for the creation of vaccines. World Health Organisation (WHO) declared a complete eradication of smallpox two centuries later, and to date more than twenty different vaccines have been developed against most infectious ailments. This has resulted in the restriction and complete eradication in some regions of infectious diseases such as measles, polio and tetanus that enjoy almost 100% immunity rate to individuals who have been vaccinated against them. With this background, the advantages of vaccination have been found to be enormous and far outweighing the disadvantages, such that it is mandatory in some countries like the US for children to be vaccinated against infectious diseases such as measles, BCG, hepatitis A and B, polio, mumps, rubella, diphtheria, tetanus, haemophilus influenza type B (HiB), chicken pox, rotavirus, influenza, pneumonia and meningococcal disease. Vaccines have therefore been touted to be the most effective method of protecting the public against infectious diseases. Despite this success, vaccine development has its own challenges; today there still isn’t a vaccination available for serious diseases like HIV, malaria and cancer.

Case studies of rejection to vaccination programmes

There are many countries that have in the past rejected international efforts to eradicate some infectious diseases through national vaccination programmes, and Kenya is...
therefore not the first one. In 2003, three states in Nigeria rejected a polio immunization programme due to political and religious propaganda claiming that the vaccines were contaminated with anti-fertility agents (estradiol hormone), HIV and cancerous agents. This boycott led to a series of polio outbreaks in Nigeria including new strains that showed some forms of resistance to the vaccines. While three or four doses of polio vaccine administered to a young infant are enough to provide protection in most parts of the world, in Nigeria, with the increased incidence present, children under five years must be immunized up to eight or more times.

Another example of rejection to vaccination occurred in Ukraine in 2008. This happened due to an unfortunate occurrence where a Ukranian high school student died of sepsis shortly after receiving vaccination for measles, mumps and rubella. The President at the time ordered the stoppage of all measles immunization until all thorough investigations took place. The Health Ministry and the United Nations Children's Fund, which supplied the vaccine, insisted that the death was a coincidence and that the vaccine was safe; investigations found the vaccine to be legitimate. The incidence however caused fear among Ukranian parents leading to a decrease in vaccination rates. The down side of this rejection led to a sharp rise in measles incidence from 100 in 2010 to 12,700 cases two years later!

The two vaccination rejection cases outlined above for Nigeria and Ukraine, despite happening a few years ago, bear resemblance to the polio and measles debate experienced in the recent past in Kenya.

What critics do not know

The “nay sayers” of the vaccination programme who mostly belong to civil society, religious groups or simply from the emotional erratic uproar from a community that has suffered a fatal incidence, point out issues to do with safety, morality, effectiveness and ethics of vaccination. They claim that vaccine safety studies are inadequate, or vaccines are ineffective against the disease. Occasionally, religious groups maintain a reserved opinion, and due to the lack of knowledge, they spread scary false rumours.

Civil society groups can oppose mandatory vaccination on the premise that it infringes on an individual’s freedom to choose.

These unfounded rumors and opinions about the medical risks of vaccination actually increase the rate of life threatening infection incidences.

Unfortunately, the infection threat is not limited to those who refuse vaccination, but to those group of individuals who cannot be vaccinated due to age or immunodeficiency.

What critics do not know is that all vaccines undergo rigorous testing before they are approved for administration. For instance all vaccines procured by UN agencies such as WHO and UNICEF must meet the specifications set by the Expert Committee on Biological Standardizations (ECBS). These specifications govern the exact contents used in the production of the vaccine and the purity that meets all technical criteria. ECBS specifications makes it impossible to have undeclared biologically active agents appearing in vaccines. ECBS outlines the procedures for assessing acceptability of vaccines procured by WHO. All vaccines procured and disseminated by WHO are deemed as safe for vaccination; isolated fatal incidences are extremely low. Nonetheless, side effects may occur as a result of vaccination, as they do with other medicines. Fortunately, vaccine risks are much lower than the diseases they prevent. These side effects may include temporary pain, swelling in the area where the shot was given and flu like symptoms (mild fever, vomiting, fatigue, loss of appetite and headache).

Vaccination programmes are the most effective method of protecting the public against infectious diseases.

Dr. Patrick W. Okanya is a lecturer in the department of Biochemistry and Biotechnology of the Technical University of Kenya. He is also Secretary of the Biorisk Management Association of Kenya (BMAK) and an active member of the Biotechnology Research Programme (BRP) - KEMRI.
MANUSCRIPT WRITING
Butt N., Oluka M., Orwa J., Nyamu D., Munene D., Mungoma M., Muthumbi C., Kimani N.

Publishing Your Work
Research should be reported in a way that allows readers to determine what was planned, what was done, what was found, and what conclusions were drawn (von Elm BMJ 2007;335:806)

Tips for preparing your manuscript

Before you begin writing:
- Be clear about your message. Spend time defining what your paper means. Boil it down to one sentence.
- Make sure your co-authors agree about the message and where you will publish it. Review and follow the guidelines for the particular journal you will publish in. Review published manuscripts for style and form.
- Check with the methodologists. No amount of cleverness will be able to rescue a piece of research in which your conclusions are simply not supported by the evidence.

The Order of a Written Manuscript:
- Title
- Abstract
- Introduction
- Methods
- Results
- Figures and tables
- Discussion and Conclusions
- References

Getting Started
Consider your audience:
- Who is going to read this?
- Who would be interested in this study?

Preparing to Write:
- Start with a thorough review of the relevant literature. Do a comprehensive database search, as well as searching references of retrieved articles.
- Read carefully and keep comprehensive notes.
- Always keep a detailed record of your references along the way.
- If your study was part of a prior grant proposal, this is a good time to review the original proposal.
- Talk with colleagues. Feedback is important and helpful eg. making a formal presentation in front of a group of colleagues or at a scientific conference.
- Inadequate Preparation prior to writing is a fatal flaw.

Starting to Write
Consider making an outline:
- Prepare an outline of your paper.
- Think about content of major sections (introduction, methods, results, discussion and conclusions)
- Look at the organization of ideas within and between the different sections
- Include major points to be included in each section. Write them down. Do not leave them to memory, as you may forget an important message.

TITLE
- A well written title is the key to ensuring your article will be found.
- The importance of writing a good title and abstract
- The title and abstract are the most visible parts of your article
- During peer review, the title and abstract are used to invite reviewers.
- On publication, more people will read the title and abstract than the whole article.
- Electronic search engines utilize databases that contain only the title, author names and abstract of articles.
- It is important to include in the title and/or abstract, words that potential readers of the article are likely to use during a search i.e., key words.
- Make the title and abstract as concise, accurate and readable as possible.

The title is an essential way to bring the article to potential readers' attention. This is particularly important in cases where the database being searched, does not include the abstract of the article.

The title must therefore be as accurate, informative and complete as possible.

Some tips on titles:
- Be as descriptive as possible and use specific rather than general terms e.g., include the specific drug name rather than just the class of drug.
- Use simple word order and common word combinations, e.g. it is better to use “juvenile delinquency” than “delinquency amongst juveniles.”
- Avoid using abbreviations, acronyms and initials; they may have different meanings in different fields e.g. DOA may mean date of admission or dead on arrival, or “Ca” often referred to for calcium could be mistaken for “CA” which means cancer.
- Write scientific names in full, e.g. Escherichia coli rather than E. coli.
- Refer to chemicals by their common or generic name instead of their formulas.
- Avoid the use of Roman numerals in the title as they can be interpreted differently, for instance, part III could be mistaken for factor III.
ABSTRACT

The abstract must select the most important information and summarize it.

Consider waiting to write the abstract until after the study is complete or until one or more drafts of the other sections in the body of the manuscript are complete.

i) The abstract must outline the most important aspects of the study, while providing only a limited amount of detail on its background, methodology and results.

ii) Authors need to critically assess the different aspects of the manuscript, and choose those that are sufficiently important to deserve inclusion in the abstract.

iii) Once the abstract is ready it can be helpful to ask a colleague who is not involved in the research to go through it to ensure that the descriptions are clear.

iv) After the manuscript is written, the authors should go back to the abstract to check that it agrees with the contents of the final manuscript.

Abstract structure:

1. Abstracts should have a structured format. This serves several purposes:
   i) It helps authors summarize the different aspects of their work in an orderly manner.
   ii) It clearly defines the study.
   iii) It helps peer reviewers and readers assess the contents of the manuscript.

2. The abstract structure varies between journals and between types of articles. Authors should check that the abstract is consistent with the requirements of the article type and journal to which the manuscript will be submitted.

3. The abstracts of manuscripts submitted to most Medical Journals most often are structured as follows:

**Introduction**

- Explain scientific background and rationale for your study
- State the objective of the study
- Include any pre-specified hypotheses

**Note:** Introduction to a research manuscript is distinct from a literature review

**Method**

- Provide sufficient detail to allow others to reproduce the experiments, but not more. Consider it from the perspective of your reader.
- Frequently, organization of the methods has fewer components, for example:
  - Population and Procedures
  - Laboratory Methods
  - Statistical Methods

**Results**

- Research doesn’t always proceed in a linear fashion from observation to hypothesis to experimental proof. Results should be re-organized to tell a logical story rather than a chronological one.
- Essential details include:
  - Participants: numbers at stages of study
  - Consider a flow diagram
  - Descriptive characteristics: Participant demographics, clinical, social characteristics, study follow-up time (average and total)
  - Number of events
  - Results of primary analyses/comparisons
  - Other analyses: subgroups, interactions, sensitivity analyses

**Discussion**

- Provide summary of key results presented in relation to the study objectives
  - State the main findings in plain language. Cautious interpretation of results
  - Compare and contrast with similar studies and other relevant evidence
  - Provide possible mechanisms to explain findings (biological, social, etc.)
  - Address unexpected findings
  - Explain the importance of the findings as they relate to public health and/or clinical practice and/or advancement of the field

**Background, Methods, Results, Discussion and Conclusions.**

4. The Methods section should summarize how the study was performed mentioning the different techniques employed. It should also include details of any statistical tests employed.

**Some tips on writing abstracts:**

- Check the abstract length: Abstracts should not exceed 350 words. Abstracts that are too long lose their function as summaries of the full article, and excess words may be omitted by some indexing services.
- Include synonyms for words and concepts used in the title: e.g. if referring to ‘stillbirths’ in the title mention ‘perinatal deaths’ in the abstract.
- Use simple word order and common word combinations.
- Include the salient points of the manuscript; the abstract should only reflect points covered in the manuscript.
- Minimize use of abbreviations.
- No citing of references.

**Main manuscript**

- Introduction: normally 2-3 paragraphs on why you undertook the study, with the last sentence summarizing what you did.
- Methods: aim for six paragraphs elaborating on what you did.
- Results: six paragraphs describing what you found.
- Discussion and conclusions: seven paragraphs on what it all means. Start with a sentence summarizing what you found, and end with a clear message in the last sentence.

Below is a chart that summarizes the sections of a manuscript and what should be included in each:

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Method</th>
<th>Results</th>
<th>Discussion</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explain scientific background and rationale for your study</td>
<td>Provide sufficient detail to allow others to reproduce the experiments, but not more. Consider it from the perspective of your reader.</td>
<td>Research doesn’t always proceed in a linear fashion from observation to hypothesis to experimental proof. Results should be re-organized to tell a logical story rather than a chronological story.</td>
<td>Provide summary of key results presented in relation to the study objectives</td>
<td>Consider using a reference manager or use the reference method you may have to use for the manuscript; read through the referencing method before you begin your research.</td>
</tr>
<tr>
<td>State the objective of the study</td>
<td>Frequently, organization of the methods has fewer components, for example: Population and Procedures Laboratory Methods Statistical Methods</td>
<td>Essential details include: Participants: numbers at stages of study Consider a flow diagram Descriptive characteristics: Participant demographics, clinical, social characteristics, study follow-up time (average and total) Number of events Results of primary analyses/comparisons Other analyses: subgroups, interactions, sensitivity analyses</td>
<td>State the main findings in plain language. Cautious interpretation of results Compare and contrast with similar studies and other relevant evidence Provide possible mechanisms to explain findings (biological, social, etc.) Address unexpected findings Explain the importance of the findings as they relate to public health and/or clinical practice and/or advancement of the field</td>
<td>Cite articles that provide scientific background, methods, comparison, or explanation – Also cite articles providing unique ideas or content - Ensure that when you cite a reference in your document, it is not used word for word, otherwise it will be referred to as plagiarism. Plagiarism is a serious offense. – Edit references carefully prior to submission Full articles often suggest a range of</td>
</tr>
</tbody>
</table>
Introduction | Method | Results | Discussion | References
--- | --- | --- | --- | ---
 | effect modifiers | Tables and figures should be complementary to text. Do not repeat everything from tables and figures in the text. Provide a summary in the text, while referring to the table or figure for a full presentation of the relevant details | • Discuss generalizability of the results (external validity) | • 30 references
 | • Address how these variables were measured: | | • Address strengths and limitations of study: | |
 | • Statistical methods - address confounding variables | | | |
 | – Methods to examine subgroups/interactions – Missing data/loss to follow-up – Sensitivity analyses | | | |

After you have completed the first draft:
1. Check that your message is still clear. It should be contained in the last sentence, of the last paragraph, of the Discussion.
2. Check the structure of your article.
3. Ensure you used the outline as the basic building blocks in all of your paragraphs.
4. The most important sentence of each paragraph should appear at the beginning of that paragraph, and these key sentences should lead on from one to another in a logical way.
5. Check your facts.
6. Make sure that everything is still reported accurately and that errors have not crept in.
7. Double check your calculations. Make sure that, were you to be challenged, you could back up everything with concrete evidence.
8. Check your references - try to use them only to support the statements you are making.
9. Write references in the required style. Re-read them to ensure that you are still quoting them correctly.
10. Get the basics of language right. Obey the basic rules of English grammar and spelling.
11. Get help if English is not your first language.
12. Keep your style as simple as possible. Don't be afraid to use short words and short sentences - it will make your work accessible to a larger number of people internationally.
13. Use the active voice - 'In this study we...' rather than the old fashioned and pompous 'It was discovered in this study that...'
14. Request a friend or colleague to proofread your manuscript

The final stages:
1. Follow the style of your publisher. Read through the Instructions for Authors and make sure you comply. Also, look at previously published work and make sure your submission is similar in shape and tone.
2. Get the agreement of your co-authors. They should all sign.
3. Deal promptly with any requests from the editor. Don't be offended if editors ask you to make changes; that's what they are there for. Do them, and do them fast.
4. Celebrate success. This is something we do too rarely and too late. Reward yourself as soon as you send off the manuscript.

THE IMPORTANCE OF PUBLISHING
• Your work gains authenticity and verification after being peer reviewed and edited by peers
• Your work gains credibility
• Authorship is the primary means of acknowledging contributions made by individuals involved in a project
• Publishing in a journal with an ISSN allows for international recognition
• To share your findings with colleagues & allows for exchange of scientific information
• The process of publication gives scientific feedback on the work which was conducted
• Publishing may be free as with PJK
• Sometimes publications are a requirement for funding of research
• Other scientists learn from your manuscript and can build research around the new findings
• Career Development & promotion
• It is a requirement of some employers and degree programs to have a certain number of publications
• Develop a reputation amongst colleagues
• It's a way of earning Continuous Professional Development points
• Allows an opportunity to learn new skills
• It is a way to contribute new knowledge to the field
• Allows for one to network with researchers in your area of interest
• It is a culmination of the efforts made by all researchers involved ie., fruit of your labour
• It is a rewarding experience to see your name on a published manuscript; it's a great achievement
• It is an ethical obligation to the study participants to report back results

What types of studies can be published:
• Retrospective Study
• Clinical Trials
• Dissertation
• Thesis
• Literature Review
• Prospective Study
• Case Reports

Bibliography
1. Liumbruno, G. M., Velati, C., Pasqualetti, P., & Franchini,
Pharmacist intervention in preventable drug related problems

By Dr. Mogere, SPF Kisii South

The frequency at which the drug adverse effects occur at our hospital setting is alarming, ranging from minor drug events such as rash to life threatening Stephen Johnson syndrome. The clinical pharmacist is the expert to identify, advice in care provision, research and document them.

Honestly speaking, the number of pharmacists available in the country could be approximated at 4000 such that the demand for services outweigh the human resource. Consequently, this has led to improper management of both pharmaceutical commodities and services in our health facilities. There is increase in the irrational medication use, medication errors and lack of dose individualization in special populations such as neonates, children and patients with renal problems.

The vast knowledge in pharmacokinetic, pharmacodynamics and toxicological information vested in the pharmacist is key in the prevention of common drug errors that now engulf the entire myriad of activities involving drug use in our hospitals.

The competency of our nurses in the management of drug administration and use is not in question nonetheless we need more expertise in the dispensing of family planning commodities which has been entirely in the hands of the nurses. Notwithstanding the fact that family planning commodities interact with majority of drugs ranging from some antibiotics, anticonvulsants, and disease conditions such as pulmonary hypertension, undiagnosed vaginal bleeding and thromboembolism of any form.

Pharmacists are tasked with the responsibility to oversee the uses and provide necessary interventions in order to alleviate emerging issues such as antibiotic resistance, irrational use of anti-malarials, emergence of MDR TB and superinfection. If we develop a habit of patient individualized care by actively getting involved in ward rounds, we will get to uncover and prevent common medication errors that may occur due to mere omission or commission. Let us always remember we are the experts when it comes to drug use and we are an integral part of the health management team.

Are You Taking HIV Medicines?

Talk To Your Pharmacist
About Their Important Side Effects You Need to Watch For
A Review of Jiggers Prevention, Control and Treatment

By Dr. Peter Ongwae

About Funza or Jiggers infestation.

- The condition is known as Tungiasis
- It is caused by Jigger fleas, known as sand fleas (Tunga penetrans)
- It is not transmitted from person to person
- It is caused by an insanitary environment and poor hygiene
- It is not a cultural curse
- Tunga penetrans is a parasitic arthropod found in most tropical and sub-tropical climates

Males leave the host after a blood meal like other fleas, but female fleas burrow head-first into the host’s skin, leaving the caudal tip of its abdomen visible through an orifice in a skin lesion. This orifice allows the flea to breathe, mate, defecate and reproduce while feeding on blood vessels in the cutaneous and subcutaneous dermal layer. In the following two weeks, its abdomen swells, in a process called neosomy, with up to several dozen eggs being formed. It then releases them through the caudal orifice to fall to the ground when ready to hatch. The flea then dies and is sloughed off with the host’s skin.

Life cycle of Funza Penetrans

Within the next three to four days, the eggs hatch, and mature into adult fleas within three to four weeks. On burrowing and feeding on blood inside the skin of its host, the female’s abdomen becomes enormously enlarged between the second and the third segments so that the flea forms a round sac with the shape and size of a pea. Tunga penetrans predilection sites in the skin are under the toe nails and finger nails of man where the resultant sores may fill with pus and become infected.

Signs & Symptoms of infestation

Often the first sign of infestation is a tiny black dot on the skin at the penetration point; this later turns to a papule that become evident. Infestation causes irritation of the skin when the female flea is almost fully developed. It may cause inflammation and ulceration, and secondary infection if left untreated. Spread of the condition may become fatal.

Prevention and Control Measures

(i) Personal Hygiene

- Keep nails short by clipping.
- Daily feet washing and regular bathing with soap and
Jigger treatment and care

- Surgical extraction of embedded Jiggers. However this is time consuming, painful and can result in secondary infection such as tetanus and HIV/AIDS.
- Sterilization of sore areas and suffocation of Jigger by soaking infested areas such as hands, feet in antiseptic solution e.g. Savlon, Potassium permanganate or hydrogen peroxide for at least 15 minutes followed by topical application of petroleum jelly.
- Flea repellents such as deet, zanzarin (coconut oil preparations), Jojoba oils or aloe vera extracts applied twice daily for a week.
- Oral antibiotics, for secondary bacterial infection; these do not treat Jiggers.
- Vaccination against tetanus as tetanus infection can be life threatening.

Conclusion

Pharmacists as health care professionals encounter tungiasis in several fronts, which include their professional practice, in outreach and medical camps or their villages. Knowledge of tungiasis is handy, as it empowers the pharmacist to deal with such situations.

Bibliography

Summary of PSK Branch Activities for 2014-2015

PSK Western Branch Update

By Dr. P. Ongwae

The branch encompasses the Counties of Bungoma, Busia, Kakamga and Vihiga. It has a dedicated team of branch officials namely:

Dr. Ongwae – Chairman (NGC)
Dr. J. Salim – Vice Chair
Dr. E. Ndombi – Secretary General
Dr. C. Naliaka – Treasurer.

Dr. T. Sindani is a member of the branch serving at the NGC. The branch interim Secretary is Miss Emily Barasa.

The branch has had numerous activities comprising of 8 branch meetings, 8 council meetings and AGM. Anti-jigger campaign conducted in parallel with a medical camp held at Nangeni Primary School was a huge success with a huge health impact on the community. 5 day medical camp were held at Musungu Primary School and Sikusa Prison in Malava and Kakamega respectively.

Investments

The branch membership is considering various options of investment to grow its financial base. The idea of the moment is to purchase an acre of land and plant 800 – 1200 trees after 3 years return on investment promises to be phenomenal with a direct benefit to the members.

Education

The membership of the branch has shown great enthusiasm to post graduate studies. Currently over 10 members are pursuing master’s programs and one is on a PhD program.

Challenges of the branch

Attendance of branch meetings has been below par, we will continuously improve on meeting alerts, and in fact the branch has invested in a Smartphone for that purpose.

The resources for the branch are scarce, however the branch is considering securing office space.

Conclusion

We look forward to a bright 2016; we will ensure that branch activities are all inclusive with broadened agenda. Much appreciation to the western Kenya branch members and PSK at large.

PSK Coast Branch Update

E.Mail: pskcoast@yahoo.com

Chairman: Dr Murtaza Mohammedali.
Secretary: Dr Farida Chakera

EVENTS – OCT 2014 – SEPT 2015

Summary Of 2015 Events undertaken by PSK Coast Branch

- 4 GENERAL MEETINGS/CME and AGM - all sponsered.
  - 19th November – AGM/CME – Malaria Management
  - 29th April 2015 – GM/CME – Family Planning
  - 10th June 2015 – GM/CME – Osteoporosis
  - 29th July 2015 – GM/CME – Cough and Cold Management
  - 30th Sept 2015 – GM / CME - Diarrhoea GERD
- CPD Commitee - Dr Yaaqub Ahmed, Dr Kassam Bagha actively emailed 3 CPD articles.
- Pharmacist Awareness Activites - Participation in Medical Camps Lamu County
- Active database of all members maintained , email, whatsapp.
- Members list submitted to kenya medical directory
- Members embraced pharmacist oath again, and display in practice.
- Hopak 2 day symposium coast branch 12th sept 2015

- Organised by – Dr Jao Majimbo, Dr Yaaqub Ahmed and Dr. Annie Tracie.
- 10 pharmacies Accredited for Green Cross – Dr Farida Chakera / Dr Yaakub Ahmed
- Radio talk show – Baraka Fm – Dr Yaakub Ahmed
- > 50 % attendance achieved in meetings

CHALLENGES

- Office not setup yet in coast
- Membership fee re-imbursed to branch to low, cannot cater for expansion
- Psk national office should direct pharmacists in coast to contact us for membership
- CPD points must be regulated – ensure no member gets psk receipt without cpd clearance from our branch.
- No support for cme/meetings sponsorship from national office. Request national office to sponser one meeting per year.
- Online psk CPD diarry portal not good, many members not able to exsccit it smoothly and points and activity type structure not setup effectively. Hence points given for general meeting/cme – 2 points too little ?? Members will stop attending our psk meetings if this is the case !!
- Coast branch shall manage its own cpd diary manually
and our cpd committee shall keep records in coast branch.

**CALENDAR OF EVENTS: OCT 2015 - SEPT 2016**

All members must complete 40 points to register in 2017

<table>
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<tr>
<th>DATE</th>
<th>ACTIVITY</th>
<th>VENUE</th>
<th>POINTS</th>
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<td>31ST MAY – 2ND JUNE</td>
<td>PSK ANNUAL SYMPOSIUM -3 DAY</td>
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**PSK Nyanza Branch Update**

**Introduction**

This is a brief report on the state of PSK Nyanza branch as compiled by the branch chairman. We wish to convey our regret at not being able to send a representative to attend the NGC meeting today at KIVI due to tight schedules at the various places of work. Our wish is, however, that such meetings should be held over the weekends in future to enable all branch representatives to attend. We hope that this report will give an overview of the branch as it is today.

**Membership**

It is currently not possible to determine the number of members of the PSK Nyanza branch as it is not yet clear who among the original members left to join the southern Nyanza branch. However, the number of active members have increased significantly since the current officials were elected into the office towards mid this year following the abrupt resignation of all the former officials.

**Finances**

The branch has basically been depending on sponsors and well wishers to hold branch meetings and CMEs. The current office bearers inherited only Ksh. 18,000 from the out going officials. The branch has spent only Ksh. 8,000 out of this amount. There has been no remittances from the national office so far, but we are optimistic. No bank account was handed over, so the current officials have managed to open a bank account with the support of the national office. The bank balance stands at Ksh.10,000 as of today.

**Achievements**

1. Increasing the number of active members from less than ten to over 40 despite the fact that the members from Kisii split away during this period. Due to sustained campaign by the current officials, attendances of branch meetings has improved tremendously.

2. Opening a functioning account.

3. Holding successful meetings and CMEs despite the financial difficulties.

4. Holding the branch together after the sudden splitting away of South Nyanza members from the branch. These formed the majority of active members at that time and their sudden departure made the branch to nearly collapse.

**Challenges**

1. Lack of adequate funds has made it difficult to hold branch meetings regularly. The branch now only holds meetings when there's a sponsor for a CME. This is one of the reasons why we are yet to hold our AGM.

All membership fees must be cleared by 31st dec 2015 inclusive with broadened agenda. Much appreciation to the western Kenya branch members and PSK at large.

All membership fees must be cleared by 31st dec 2015 inclusive with broadened agenda. Much appreciation to the western Kenya branch members and PSK at large.
Thank you to our Editorial Team who give their time to ensure members receive The Pharmacist newsletter throughout the year. Your support does not go unnoticed.