Introduction

Given the increasing need for access to healthcare with short fall in the number of healthcare givers compared to increased population growth in the 21st century with the increasing need for preventive healthcare and public health, it becomes necessary to empower patients and the public to take varying degrees of responsibilities for their health irrespective of their present health status. Between the potential benefits in medication use, administration, and the actual outcome values lay myriad of limitations that must be addressed to ensure to achieve defined treatment endpoints. Gaps do exist between a potentially healthy individual and the same person in the diseased state, which must be filled to prevent disease development and subsequent progression to a diseased state. In-between the healthy and diseased states lay the dynamics of health promotion, which tries to bridge the gap and reverse the trend disease development and progression while improving the quality of life. Health promotion is the process of enabling people to increase control over and improve their health [1-4]. An important aspect of health promotion promotes community action and participation through health education and promoting socioeconomic, cultural, and environmental determinants of health. Diseases associated with lifestyle modifications like diabetes, and hypertension, has been on the increase with lopsided ratio of population to healthcare givers and essential health services [5,6]. It underscores the need for improved and disseminated health promotion activities in our communities. The primary health care (PHC) was introduced in 1978 by Alma Ata declaration to address key health issues at the grass root through promotion of preventive, curative, and rehabilitative healthcare services [7]. These services combined with service integration (the process of including either the elements of one service or an entire service into the regular functioning of another service), community mobilization and advocacy have been implemented to varying levels through the activities of international agencies and collaborators [8-11].
However these services have been limited poor rate of manpower development, poor funding, lack of political will, Poor inter-sectoral collaboration and conflicts between the Local and State Governments, among others have been identified as the key constraints that have limited the implementation of PHC activities at the grass root [9-12]. These limitations associated with PHC presently created a gap, which underscores the need for proactive preventive and curative healthcare services at the grass root. Health promotion can fill this gap along the healthcare value chain. This study described and discussed the expended roles of pharmacists in health promotion and public health services.

Methods

The study was a retrospective cross sectional narrative overview. Literatures search was conducted and relevant materials were retrieved from authorized texts, hand search, and computerized databases. Search of literature was conducted in Cumulative index to Nurses and Allied Literature (CINAHL), Embase, and Medline using search terms to conduct adjacency searching, truncation, combination of search terms using the linkages "AND" and "OR". Studies and materials related to pharmacist involvement in health promotion activities from 1985 to 2016 were explored. Only articles published in English Language within the period under review with clearly defined methods and relevance to the topic were considered for the study. Of the 96 articles found, 42 were eligible for the study, while 54 were excluded for lack of merits. The key search words were health promotion, pharmacists, community, healthcare, grass root, health education, and Nigeria. Hand search of references of the materials retrieved was carried out. The study lasted from February to June 2017.

Result and Discussion

Healthcare services have shifted from the era traditional care to value-based care where patients pay for actual values added to their health. Quality improvement in health care services is now topical with new studies and operational research on evaluation and quantification of healthcare services exploring better ways of promoting quality improvement services in health care [13-16]. This move is associated with improved patients’ outcomes while grappling with shortage of healthcare providers [17]. This move coupled with high patients accessibility to community pharmacists has brought to the fore the expanded roles of pharmacist in preventive and curative healthcare services which is a positive trend in community and population health [18,19]. Health promotion activities of pharmacists at the grass root include education of the populace on ways behavioral and life style modifications can influence health. Getting people informed encourages the adoption of positive behavioral change. This is not without information on policy areas that borders on health like good nutrition, physical exercise, weight control, avoidance of overcrowding, medication use, good housing, self-care, monitoring of illnesses, and working conditions. These activities empower individuals and communities to take responsibility for the control of modifiable determinants of health. Support, promotion, and diversification of these activities and maintaining them in a continuum as a process will sustain the positive outcomes and impacts in community health. These activities encourage people to move to a state of optimal health, which is a balance between physical, emotional, social, spiritual, and intellectual health [20-22].

Community based activities at the grass root, which could be injury, or illness specific constitute the concept of health protection while the measureable improvements in individual or community health that are attributable to interventions carried out earlier account for health gain. A survey of pharmacists’ participation in health promotion activities in two cities in Nigeria showed 90% participation irrespective of reimbursement [23,24]. Pharmacists’ health promotion activities over the years has continued to evolve from drugs supply, medication education, health education, treatment of self-limiting conditions, to chronic disease management, health advice, promotion of healthy lifestyles, and targeted interventions at varying levels of collaboration with other healthcare givers. These activities have continued to improve and diversify over the years. These have contributed to improved access to community pharmacies in recent times [25-28]. A study in Uganda showed that patients and clients accessing injectable contraceptives in a community pharmacy were satisfied with the quality of care [29]. However, the cost of care was not considered. In Canada, patients treated by community pharmacists were satisfied with the general services and symptomatic improvement [30]. The study did not discuss the domains of satisfaction. A randomized controlled trial on diabetes patients in Denmark showed improvement in drug therapy implementation in community pharmacies. Study showed improvement in patients’ quality of life [31]. An evaluation of the effectiveness of pharmacists’ primary care consultations in a pre-post intervention study in Australia showed that patients were satisfied with pharmacists’ consultations and effectiveness in resolution of drug therapy problems [32]. A quasi-experimental study in United States of America (USA) indicated decrease in hospital readmission, reduction in drug therapy problems, and improvement in quality of care and patients quality of life [33].

A collaborative practice agreement in USA enhanced community access to Lyme disease prophylaxis and high level of satisfaction with community pharmacy healthcare services rendered. Neither relapse nor major side effects were recorded [34]. Another study in USA showed that pharmacy-based cognitive memory screening and referral programs yielded positive impact and suggested its incorporation into community pharmacists’ clinical services [35,36]. An observational study in England on expanded practice status of pharmacists stated that community pharmacies activities and involvement improved vaccination rate with high level of patients’ acceptability [37]. Pharmacists interventions in community pharmacies have been found to among others improve patients’ knowledge and self management of asthma [38], improved adherence and glycemic control in diabetes patients [39], and improved satisfaction with opioid substitution treatment [40].

A cross sectional study in Quebec Canada showed positive attitude of community pharmacists in health promotion especially...
in the area of health screening for hypertension, diabetes, dyslipidemia, smoking cessation, sexual health, infectious diseases, and immunization. However, the limitations, which hinder their full involvement, included limited interaction with other healthcare givers, non-reimbursement for their services, policy issues, and organizational barriers [41]. These have contributed to the gap between their actual and ideal involvement in health promotion activities. Other studies suggested that pharmacists and the general population would welcome greater participation of community pharmacies in preventive healthcare services.

It underscored the need for greater utilization of community pharmacies in maximizing the services of other healthcare givers, and continuity of care in the planning, development, and execution of public health programs in the 21st century [41-43]. Many published studies have shown that the level of pharmacist’s involvement in public health programs and activities, which range from preventive, curative, to continuity of care, necessitates their full integration into public health programs. This will be invaluable in optimizing community health programs and population health [44-49].

Some studies identified remuneration for service delivery, inter-professional communication, and collaboration with other healthcare givers, government policy, and patient’s expectations as the key facilitators of practice change in community pharmacies that could be explored in maximizing their input in present and future public health programs [50,51]. Other factors, which influence the implementation of health promotion activities by pharmacists, include community factors like religious beliefs, cultural practices, and gender. Non-availability of data or demographic information of the targeted population, poor communication between the media, schools and communities, and institutional factors were all considered as limitations [52,53].

The first public healthcare facility in Nigeria was a dispensary established by the Church Missionary Society at Obosi in Anambra State in 1880 followed by others in Onitsha and Ibadan. This was before the take-off of Sacred Heart Hospital, the first hospital established by the Roman Catholic Mission in Nigeria in 1885 at Abeokuta Nigeria and St. Margaret Hospital built in 1889 at Calabar, Nigeria [54,55]. Community pharmacy outlets in Nigeria today offer free consultation services, which make them readily accessible by the populace. They serve as referral centers and carry out health improvement services, promotion of self-care, management of prescribed medicines, caregivers’ education, and targeted health promotion services among others [56].

Community pharmacies stock health promotion products for newborn, infants, children, adolescents, women, geriatrics, and the general population. They offer harm reduction services to injection drug users. In Canada, India, China, Australia, and Europe, community pharmacies are centers of opioid substitution therapy, human immune deficiency virus (HIV) and hepatitis prevention services [57-62]. A quasi experimental study conducted in Abuja, Kwarra, Abia and Edo States of Nigeria indicated that community pharmacists serve as a bridge between patients and physicians and offer varying levels of maternal and child healthcare services. However, intervention on focused antenatal care produced significant improvement on their knowledge of the subject and services. Such intervention services could be improved upon to complement on already existing ones.

More than 15% of the community pharmacists attend to 5-10 pregnant women daily [63]. This shows that high population of pregnant women accesses the services of community pharmacists. In the US, the Centers for Disease Control and Prevention (CDC) in finding new ways of protecting the health of her citizenry and stemming the increasing trend of many chronic diseases in the elderly population reorganized that pharmacists roles have evolved into active participation in disease management and an essential player in team-based care. In view of the expanded roles, they CDC have initiated the process of building team-based relationships with pharmacists and other strategic stakeholders to improve population health [64-70]. Policy makers in other countries need to adopt this trend to promote the population health of their citizenry.

Conclusion

Delivery of public health services is everybody’s business in the 21st century. The public health roles of pharmacists are evolving and have greatly expanding. Community pharmacists and pharmacies are readily and easily accessible healthcare providers and outfits in the community. The increasing need for healthcare and limited number of healthcare workers created a huge gap in public healthcare services. This underscored the need to leverage on their expanded roles, expertise, and accessibility in bridging the gap between healthcare manpower need and provision of public healthcare services. This will help in powering and optimizing universal health coverage while promoting access to preventive and curative public health services.

Conflict of Interest

None.

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