Beyond the dispensary: Listening to the voices of pharmacists working in resource-constrained settings

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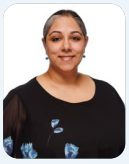
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In our previous "Beyond the dispensary" article in Cancer Control 2025, we reflected on what we had learned from working alongside pharmacists in resource-constrained settings. One lesson stayed with us. Meaningful global partnerships begin with humility, curiosity, and a willingness to learn rather than teach. If we truly believe that, then we also need to know when to step back and let others tell their own stories. This commentary is our attempt to do that.

We invited three pharmacy leaders from different parts of the world to share their experiences. Fazle-noor Biswas is the Coordinator and Chief Pharmacist at the Cancer Services and Research Center in Dhaka, Bangladesh. Azza Ahmed Abdel-Aty is the Senior Pharmaceutics Specialist at the Pediatric Palliative Care Hospice BACH/Sabah Main Pharmacy in Kuwait City, Kuwait. Saroja Gangaiah is the Senior Pharmacist at the Department of Palliative Medicine at Kidwai Memorial Institute of Oncology in Bengaluru, India.

Although they work in different healthcare systems, many of the same ideas came up throughout our conversations. Their stories remind us that the best global partnerships begin by listening before offering solutions.

Theme one: Expanding the pharmacist's professional identity

One message came through right away. None of our colleagues described themselves as pharmacists whose work begins and ends with dispensing medicines. Instead, they spoke about being medication experts, educators, clinical partners, and advocates for their patients. Their work includes optimizing complex medication regimens, counselling patients and families, managing symptoms, improving medication safety, and contributing to multidisciplinary care. They also described growing responsibilities in antimicrobial stewardship, deprescribing, and reducing inappropriate polypharmacy.

Despite everything they contribute, many still feel that people do not fully understand what pharmacists do.

Fazle-noor described this frustration well: "When people assume pharmacists 'just dispense medications,' it feels almost surreal because it erases about 90% of what pharmacists do, especially in a complex health system like Bangladesh. That assumption does not match my experience at all, and honestly, it does not match the reality of modern pharmacy anywhere in the world."

Saroja described a similar reality: "Indian pharmacists often work at the intersection of patient care, medicine access and system management. We do clinically meaningful work inside a system that still demands intense dispensing and logistics performance."

Azza described her role in practical terms: "My role is to help patients as much as I can by finding medications or suitable alternatives and explaining those options to physicians,

especially when newer treatments may not yet be familiar."

Although they work in different settings, they all described a profession that is steadily becoming more involved in direct patient care. Public and professional perceptions have been slower to change.

One thing we kept noticing was that none of them talked about expanding pharmacy practice simply for the benefit of the profession. The conversation always came back to patients. Better symptom control. Safer medication use. Helping families understand treatment. Reducing suffering. Recognition was important, but only because it helped them care for patients better.

At the same time, they were realistic about the challenges that remain.

As Fazle-noor explained: "Pharmacists are in a good position to assist Bangladesh in addressing its growing problems, which include poly-pharmacy, non-communicable diseases, and antibiotic resistance. However, their impact is restricted by systemic obstacles such as poor policy recognition, a lack of clinical positions, and insufficient training pathways."

Theme two: Pharmacy practice has tremendous opportunities for growth

Although each pharmacist described different challenges, they all pointed to the same underlying issue. Healthcare systems have not always kept pace with what pharmacists are trained to do.

Fazle-noor described how these challenges affect pharmacy practice in Bangladesh: "In Bangladesh, community pharmacies are managed by non-pharmacists. This set-up commonly results in inconsistent medication counselling to patients and their families, and there might be irrational dispensing. The cultural norm further devalues pharmacists' expertise, with medication decisions dominated by doctors and families frequently dependent upon informal advice from drug shops. Ultimately, it has created a feedback loop of mistrust by the public and the perception of our profession as a business rather than a clinical service."

Saroja described a similar challenge from a different healthcare system: "The infrastructure and healthcare culture do not always utilize pharmacists as full members of the clinical team. In many cases, the problem is not what pharmacists cannot do, but what the system does not yet allow or support us to do."

That sentence stayed with us. It shifts the focus from individual pharmacists to the systems they work in. Even with these barriers, the conversations never felt discouraging. Instead, each pharmacist spoke about the moments that continue to give them hope.

For Fazle-noor: "Hope comes from patients' resilience and colleagues' determination for safe medication usage despite systemic challenges."

For Saroja: "I find hope in the moments when medicines are used well, suffering is reduced, families feel supported, and local teams create meaningful solutions despite limited resources. I am encouraged by the fact that pharmacy practice in India is evolving towards a more clinical, visible, and patient-focused role."

Those comments are impactful. They remind us that meaningful change often happens one patient, one family, and one healthcare team at a time.

Theme three: Finding solutions in resource-constrained settings

Working with limited resources is simply part of everyday practice. It requires flexibility, creativity, and constant problem solving. They described finding practical ways to adapt evidence-based practice to the realities of their healthcare systems.

Community-based care, volunteer-supported programmes, and other locally developed models were described as strengths. Rather than seeing limited resources as barriers, our colleagues described them as opportunities to think differently and adapt care to local needs.

Saroja shared one example from India. Some of the most meaningful innovations in palliative care have come from community-based services, multidisciplinary home visits, and volunteer-supported care. These models are built around patients, families, and communities rather than expecting patients to navigate the healthcare system on their own.

Reading these stories made us rethink one of our own assumptions. We often think of innovation as new technology or bigger budgets. Our colleagues reminded us that it can also come from necessity. These conversations reminded us that meaningful innovation is already happening every day in resource-constrained settings.

Theme four: Access to medicines and relief from suffering

No matter where the conversation starts, it eventually came back to one issue: access to medicines. Medications, such as morphine, that should be routinely and universally available and are recognized as such by the WHO (World Health Organization. The selection and use of essential medicines, 2025: WHO Model List of Essential Medicines, 24th list. Geneva: World Health Organization; 2025. Report No.: B09474. Available from: https://iris.who.int/handle/10665/381503) remain difficult or impossible to access because of regulatory barriers, supply challenges, affordability, and stigma.

Fazle-noor described how these barriers affect patient

care every day: "My ability to deliver high-quality care is directly impacted by our system's ability to access necessary medications."

He continued, "Strict regulations, limited prescribers, and administrative barriers delay or block access to essential medicines like morphine, leaving patients in avoidable pain. Even when opioids are available, financial pressures lead families to stretch doses, choose less effective options, or travel long distances, adding emotional and economic stress. Stigma from patients, families, and even healthcare providers further restricts appropriate use, as fears of addiction, judgment, or regulatory consequences discourage timely prescribing and dose adjustments."

Listening to these stories reminded us that access to medicines is never simply about supply. It is about whether patients can live with comfort, dignity, and relief from suffering.

This is where pharmacists become advocates, educators, and navigators who help patients receive the care they need. They help patients and families overcome barriers and work with healthcare teams to provide the safest and most compassionate care possible.

Theme five: Education and advocacy around opioid use

Our conversations naturally led to another important topic – education.

All three pharmacists described stigma as one of the greatest barriers to effective pain management. Often, patients and families are afraid of opioids. Sometimes healthcare professionals are too. Misunderstandings about addiction, dependence, and appropriate opioid use continue to influence treatment decisions.

So, how have they addressed this challenge? They all began by listening.

Education is not simply about giving patients more information. It is about understanding their concerns, building trust, and helping them make informed decisions that reflect their goals and values.

Fazle-noor described these conversations as an opportunity to translate clinical evidence into language that patients and families can understand.

"I emphasize that in palliative care, the goal is comfort and function, not sedation, and that addiction is extremely rare when opioids are used correctly for serious illness."

Azza shared a similar approach in her own practice.

"Many patients and families are worried about addiction when opioids are prescribed. My role is to explain the benefits and risks, discuss possible side effects, and help them understand how these medicines can improve quality of life.

Saroja captured the importance of those conversations in a single sentence: "Trust matters as much as pharmacology in whether pain relief is accepted."

Clinical knowledge is essential. So are empathy, communication, and trust. Without trust, even the best treatments may never be accepted. These conversations also reminded us that opioid stewardship looks different depending on where you practice. In many high-income countries, stewardship has largely focused on reducing inappropriate opioid use in response to the opioid overdose crisis. In many low- and middle-income countries, however, the greater challenge remains access. Patients continue to experience unnecessary suffering because essential opioid medicines are unavailable or inaccessible.

When asked what global support should look like, Fazle-noor said: "It would start with international policies that prioritize balanced opioid regulation, helping countries modernize outdated laws so that fear of misuse no longer outweighs the obligation to relieve suffering. It would also include global investment in local production and supply chains to make opioids affordable and consistently available, rather than relying on expensive imports or fragmented procurement. Equally important is addressing stigma through worldwide education campaigns for clinicians, policymakers, and communities, so opioids are understood as essential medicines, not symbols of addiction or moral failure. Finally, true support would strengthen the workforce by training pharmacists, nurses, and physicians in safe opioid use, symptom management, and compassionate communication. In essence, global support would mean aligning policy, supply, education, and funding so that no patient suffers simply because of where they live."

Theme six: Learning from one another

Our conversations eventually turned to partnership. We asked each pharmacist what makes an international collaboration feel respectful and helpful. We also asked what approaches have not worked well, whether they had experienced partnerships that unintentionally created dependency, and what real co-learning looks like.

They are built through curiosity, shared leadership, and recognizing that local expertise is just as valuable as international experience. They do not begin with assumptions or ready-made solutions.

Fazle-noor described this particularly well: "I feel valued when partners come in with curiosity and ask how things work in Bangladesh, what our constraints look like on the ground, and what innovations we've already created. It matters when they listen first instead of assuming their model will automatically fit here. I do not want someone to hand me ready-made solutions. I want to shape something together that works for Bangladeshi

patients, the country's health system, and our culture."

Saroja echoed this: "It feels helpful when it leads to practical change and better access to training rather than recommendations that do not fit my setting."

Each pharmacist emphasized that meaningful partnerships include shared authorship, visibility, and leadership.

As one contributor reflected: "Sharing credit fairly in authorship, visibility, and leadership feels like a true partnership rather than extraction."

Another reflected that meaningful collaboration happens when international colleagues are willing to learn from local realities, adapt their ideas, and acknowledge what they do not know. When this happens, both sides benefit, but local capacity grows stronger.

Not every partnership had been positive. Across the conversations, several examples were shared where well-intentioned international initiatives depended heavily on external funding, expertise, or leadership without fully developing local ownership. When outside support ended, programmes often struggled to continue.

Fazle-noor reflected on one of these experiences: "Partnerships could be more effective had they prioritized early investment in community capacity-building, including local volunteers' training, strengthening family- and neighbourhood-level networks, and establishing governance structures that were genuinely rooted in the community. A gradual transition of responsibility and mechanisms for local resource generation would have shifted the model from externally supported to locally owned."

So, it starts when local leadership is built into the work from the beginning. When we asked what real co-learning looks like, all three pharmacists returned to the same principle concept: it is built on equality.

Fazle-noor summarized it this way: "Each side brings forms of knowledge the other simply cannot access. Local teams understand culture, patient behaviour, resource constraints, and system realities, while international colleagues bring global evidence, frameworks, and comparative experience from other health systems."

Co-learning combines global evidence with local knowledge to develop solutions that fit the communities being served. Sometimes the most valuable thing we can bring to a partnership is a willingness to listen.

Theme seven: Where pharmacists are clinical leaders and partners in care

As our conversations came to a close, we asked each pharmacist about their hopes for the future.

They want pharmacists to play a greater role in direct patient care. They hope to see pharmacists more involved in research, education, policy development, and leadership. They want stronger integration within interdisciplinary healthcare teams and greater involvement in medication-related decision making.

Their vision was never about professional recognition alone. It was about improving care for patients. Instead, they reflected a shared belief that patients benefit when pharmacists can contribute fully as medication experts.

They reminded us that progress cannot simply be imported from elsewhere. It must be built within each healthcare system by the people who understand it best.

Despite the challenges they described, every conversation ended with hope. Hope for patients. Hope for the profession. Hope that pharmacy will continue to grow as healthcare systems recognize the value pharmacists bring to patient care.

Looking ahead

When we finished these conversations, we found ourselves thinking less about what we could teach and more about what we still must learn.

Our pharmacist colleagues are not waiting for someone else to improve pharmacy practice in their countries. They are already leading change within their own healthcare systems through patient care, education, advocacy, and innovation.

Last year, we wrote that meaningful global partnerships begin with listening.

We set out to create space for our colleagues to share their experiences in their own words. We hope this commentary has done that. If there is one message, we hope readers take away, it is recognizing that the future of global pharmacy will not be shaped by one healthcare system teaching another. It will be shaped by pharmacists around the world learning from one another, listening to one another, and working together as equal partners. ■

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