WORKING TOGETHER
LEARNING TOGETHER

EDITORIAL

ONE theme, which although unplanned appears as a leitmotiv through this issue, is collaboration: between countries, between organizations and between professional disciplines.

Striking examples of such regional collaboration include the Caracas meeting reported on page 10 at which 15 countries discussed how they could work together to increase access to essential drugs, and how harmonization of pharmaceutical regulations could facilitate trade, reduce the cost and increase the safety of medicines; IOCU's Colombo meeting which brought together academicians, ministry of health officials and representatives from consumer organizations to discuss national drug policy and to share regional experience; and the Health Action International workshop on rational drug use in Southern and Eastern Africa, where a multidisciplinary group of people from government, universities, consumer groups and international agencies met to develop practical strategies for more appropriate drug use.

Collaboration in education is intensifying and creating a new style pedagogic triangle in which students learn not only from teachers but from each other, while teachers in their turn also learn from students. The report on the first Aberdeen course in drug management and use, which had participants from four continents, states: "all of us involved in the course realised just how much we need to learn from each other and how much there is yet to be done", and also makes the point that both developed and developing countries have to tackle issues of cost/benefit. The forthcoming course on rational drug use in Zimbabwe, announced on p. 12, also demonstrates this cooperative approach with its joint sponsorship by MSH, the International Network for Rational Drug Use, the Action Programme on Essential Drugs and the Department of Pharmacy of Harare University.

Information is another area where collaboration is increasing. Cameroon's excellent new drug bulletin, described in Newsdesk, has a strong multidisciplinary national editorial committee and focuses on national prescribing needs and problems. Yet the publication also draws strength from its international contacts with editors of drug bulletins in other countries, from its association with the International Society of Drug Bulletins, and from working closely with WHO programmes in the development of articles on specific treatment guidelines.

Another example of this international trend is the global informal network aimed at stimulating interdisciplinary research on pharmaceuticals and its application in national drug policies, an outcome of the International Conference on Social and Cultural Aspects of Pharmaceuticals, reported under Research.

The International Pharmacy Associations, in their response to the interview with Professor Ransome Kuti, Minister of Health, Nigeria in EDM-12, are also offering international collaboration to countries or national pharmacy associations wishing to introduce a system of pharmacologically controlled distribution and supply of medicines.

UN and other international agencies too are joining forces, as in the joint mission to the former Soviet republics to prepare a technical basis for health and development support, reported under Newsdesk. And a recurring theme of the World Health Assembly essential drugs debate was the need for and benefits of international collaboration.

In terms of transfer of skills and information the globe is shrinking and the unprecedented ability to share knowledge and experience augurs well for the development of more rational drug policies and practices. Of course, information transfer is a two sided coin. While its potential as a positive social and educational force is immense, vigilance is also needed so that it promotes drug usage patterns that are based on scientific medicine, rational use and social equity.
Rational Use Network launched in Pakistan

"DRUGS are an important component of health care and play an important role in saving lives, but there are a large number of diseases, particularly those of the chronic type, that require long-term care. Instead of being preventive measures that are required", says Prof. Tariq Iqbal Bhutta, Pakistan's new Network for the Rational Use of Antimicrobial Drugs.

Professor Bhutta, who is Professor of Paediatrics at Lahore's King Edward Medical College, deployed the fact that while some 24 companies produce anti-diarrhoeal drugs, for which there is no scientific evidence of efficacy, he says, only eight or nine companies make ORS, which is the only proven treatment for diarrhoea.

Similarly, drugs are marketed as appetite stimulants, when the real need is either food or diagnosis of the underlying cause of loss of appetite. Drugs for improving brain power and liver tonics etc. are also freely available and prescribed in Pakistan and are being used by the unwary public. People also use them to self-medicate.

Nearly 14,000 drugs are registered in the country, says Professor Bhutta. But although the Ministry of Health is committed to the WHO essential drugs concept and to supply the drugs which are on the national essential drugs list (1500), medicines are freely available over the counter without any prescription, which encourages self-medication by the unwary public. Health workers and quacks dispense drugs freely, sometimes in totally irrational combinations, he says.

This situation has led a group of concerned people in the Pakistan health sector and general public to take action and form a network for rational drug use.

Although this patient is well treated at a healthcare centre in Quetta, concern remains in Pakistan about irrational therapies and there has to be a launch of a rational network for rational use.

The Network's objectives are to enlist the help and support of health professionals and the government to promote the rational use of medication in Pakistan and to engender public awareness about the importance of rational use of medication. The Network will also focus media awareness on issues regarding the abuse of unapproved medicines.

Current and planned activities include the provision of unbiased drug information and lectures on rational use; promotion of the essential drugs list; scientific studies; lobbying for the proper enforcement of drug registration legislation; and coordinating action against proven dangerous drugs.

The Network has already published the first issue of its newsletter, containing features on irrational use, news of activities and details of educational resources.

For further information write to: Dr. Zafar Mirza, Coordinator, The Network, Association for Rational Use of Medicines in Pakistan, House 857, G-12/2, Islamabad, Pakistan.

Dutch Government campaigns to lower drug costs

Dutch readers have been finding a rather unusual advertisement when opening their daily newspapers. Interposed among the more typical promotion for soft drinks, cold remotes and the like was a message from the government about the rising costs of medicine.

"From now on, just ask for the drug for which you don't have to pay extra", said the headlines the full page government advertisement. "From 1 July 2001 there is a new system of reimbursement for everyone in the state insurance system (not two thirds of the Dutch population)." Some medicines have become too expensive. Very often, one complained, are there several medicines which are equally good but which may vary greatly in price. From now on the state health insurance will only cover the lower priced medicines, so if you choose cost effective medicines, you don't have to pay any extra.

"Health care costs rise by 3% in Holland every year but drugs rise by 9-12% in the Netherlands are already much more expensive than in other countries in Europe", readers are told. "Medicines which are too expensive mean that health insurance premiums cost there more. Where insurance exists, it is important that people use the system." There are two solutions, explains the government. Either the patient pays the difference in cost so that others don't have to pay unnecessarily higher premiums or the manufacturers are free to adapt product prices so that they fall within the range of fully reimbursable medicines.

Consumers are reassured that under the new system a complete range of all necessary medicines will continue to be available free of charge, but if patients insist on the most expensive of a range of similar medicines then they will have to pay the extra cost.

"Be cost conscious. Ask your doctor or pharmacist for a drug which does not incur extra payment", citizens are encouraged.

"All doctors and pharmacists have the list of products and comparable prices available. If you don't want to spend too much money then ask your doctor for a medicine that is fully reimbursed or ask your pharmacist for a similar but cheaper product.

The Dutch Government estimates that this new policy will save the Dutch millions of guilders a year - money which, it says, can be used for other urgent needs like health and social care, such as reducing waiting lists, old people's homes, better nursing care. A free tele- phone information number has been set up to respond to questions from the public. The Government has also issued posters and an illustrated leaflet explaining the new policy.

The Network has also published the first issue of its newsletter, containing features on irrational use, news of activities and details of educational resources.

For further information write to: Dr. Zafar Mirza, Coordinator, The Network, Association for Rational Use of Medicines in Pakistan, House 857, G-12/2, Islamabad, Pakistan.

Although this patient is well treated at a healthcare centre in Quetta, concern remains in Pakistan about irrational therapies and there has to be a launch of a rational network for rational use.

The Network's objectives are to enlist the help and support of health professionals and the government to promote the rational use of medication in Pakistan and to engender public awareness about the importance of rational use of medication. The Network will also focus media awareness on issues regarding the abuse of unapproved medicines.

Current and planned activities include the provision of unbiased drug information and lectures on rational use; promotion of the essential drugs list; scientific studies; lobbying for the proper enforcement of drug registration legislation; and coordinating action against proven dangerous drugs.

The Network has already published the first issue of its newsletter, containing features on irrational use, news of activities and details of educational resources.

For further information write to: Dr. Zafar Mirza, Coordinator, The Network, Association for Rational Use of Medicines in Pakistan, House 857, G-12/2, Islamabad, Pakistan.

Although this patient is well treated at a healthcare centre in Quetta, concern remains in Pakistan about irrational therapies and there has to be a launch of a rational network for rational use.

The Network's objectives are to enlist the help and support of health professionals and the government to promote the rational use of medication in Pakistan and to engender public awareness about the importance of rational use of medication. The Network will also focus media awareness on issues regarding the abuse of unapproved medicines.

Current and planned activities include the provision of unbiased drug information and lectures on rational use; promotion of the essential drugs list; scientific studies; lobbying for the proper enforcement of drug registration legislation; and coordinating action against proven dangerous drugs.

The Network has already published the first issue of its newsletter, containing features on irrational use, news of activities and details of educational resources.

For further information write to: Dr. Zafar Mirza, Coordinator, The Network, Association for Rational Use of Medicines in Pakistan, House 857, G-12/2, Islamabad, Pakistan.

Although this patient is well treated at a healthcare centre in Quetta, concern remains in Pakistan about irrational therapies and there has to be a launch of a rational network for rational use.

The Network's objectives are to enlist the help and support of health professionals and the government to promote the rational use of medication in Pakistan and to engender public awareness about the importance of rational use of medication. The Network will also focus media awareness on issues regarding the abuse of unapproved medicines.

Current and planned activities include the provision of unbiased drug information and lectures on rational use; promotion of the essential drugs list; scientific studies; lobbying for the proper enforcement of drug registration legislation; and coordinating action against proven dangerous drugs.

The Network has already published the first issue of its newsletter, containing features on irrational use, news of activities and details of educational resources.

For further information write to: Dr. Zafar Mirza, Coordinator, The Network, Association for Rational Use of Medicines in Pakistan, House 857, G-12/2, Islamabad, Pakistan.

Although this patient is well treated at a healthcare centre in Quetta, concern remains in Pakistan about irrational therapies and there has to be a launch of a rational network for rational use.

The Network's objectives are to enlist the help and support of health professionals and the government to promote the rational use of medication in Pakistan and to engender public awareness about the importance of rational use of medication. The Network will also focus media awareness on issues regarding the abuse of unapproved medicines.

Current and planned activities include the provision of unbiased drug information and lectures on rational use; promotion of the essential drugs list; scientific studies; lobbying for the proper enforcement of drug registration legislation; and coordinating action against proven dangerous drugs.

The Network has already published the first issue of its newsletter, containing features on irrational use, news of activities and details of educational resources.

For further information write to: Dr. Zafar Mirza, Coordinator, The Network, Association for Rational Use of Medicines in Pakistan, House 857, G-12/2, Islamabad, Pakistan.

Although this patient is well treated at a healthcare centre in Quetta, concern remains in Pakistan about irrational therapies and there has to be a launch of a rational network for rational use.

The Network's objectives are to enlist the help and support of health professionals and the government to promote the rational use of medication in Pakistan and to engender public awareness about the importance of rational use of medication. The Network will also focus media awareness on issues regarding the abuse of unapproved medicines.

Current and planned activities include the provision of unbiased drug information and lectures on rational use; promotion of the essential drugs list; scientific studies; lobbying for the proper enforcement of drug registration legislation; and coordinating action against proven dangerous drugs.

The Network has already published the first issue of its newsletter, containing features on irrational use, news of activities and details of educational resources.

For further information write to: Dr. Zafar Mirza, Coordinator, The Network, Association for Rational Use of Medicines in Pakistan, House 857, G-12/2, Islamabad, Pakistan.

Although this patient is well treated at a healthcare centre in Quetta, concern remains in Pakistan about irrational therapies and there has to be a launch of a rational network for rational use.

The Network's objectives are to enlist the help and support of health professionals and the government to promote the rational use of medication in Pakistan and to engender public awareness about the importance of rational use of medication. The Network will also focus media awareness on issues regarding the abuse of unapproved medicines.

Current and planned activities include the provision of unbiased drug information and lectures on rational use; promotion of the essential drugs list; scientific studies; lobbying for the proper enforcement of drug registration legislation; and coordinating action against proven dangerous drugs.

The Network has already published the first issue of its newsletter, containing features on irrational use, news of activities and details of educational resources.

For further information write to: Dr. Zafar Mirza, Coordinator, The Network, Association for Rational Use of Medicines in Pakistan, House 857, G-12/2, Islamabad, Pakistan.
RATIONAL USE

First let us do no harm

INJECTIONS are very often given even when the same drug can be administered orally with greater safety, effectiveness and at lower cost. This problem is of growing concern to many health authorities. Although the risk of abscesses and hepatitis B has always been considerable when needles and syringes are used without effective sterilization, the new species of AIDS gives an added urgency to the need to eliminate unnecessary and unsafe injections. It is therefore crucial to investigate the extent of the problem and its underlying causes is already underway in a number of countries to introduce intervention strategies.1

But the use of injections cannot be eliminated totally. It should be realized that, probably well into the 21st century, injections will still be necessary to give most vaccinations and several essential drugs. This implies a continuous need for good injection practices.

A safe injection requires the choice of suitable medication, administered in the correct dose at the right site. Safety also includes the use of sterile injection equipment, and action to guard against accidental injection of workers or anyone else during and after the injection.

Injections can be given in a number of ways, including jet injectors, prefilled syringes, scalpel, etc. However, the major choice for most health services remains whether to use disposable or sterilizable syringes and needles. A new type of disposable syringe - an autoclave syringe - has recently been developed to meet some of the problems referred to above. Choice of equipment will be determined by factors such as the health budget, health worker training and practice, and access to assured supplies of equipment and fuel.

Sterilizable syringes and needles

Widely used in 0.5 ml size within the Expanded Programme on Immunization, these plastic syringes are predominantly made from a high grade polypropylene and can withstand repeated sterilizations at temperatures up to 130 degrees C. Sterilizable plastic syringes of 2 and 5 ml, which are suitable for a wide range of injectable drugs, are also available. The usefulness of these syringes varied very much when they were introduced six years ago but now they consistently achieve more than 100 sterilizations before they need replacing.

The recommended method of sterilizing such syringes is by the use of steam sterilization. More than 50,000 such sterilizers have been distributed through the EPI programmes and it is hoped that the majority will still have to use boiling to sterilize. Boiling is disinfection not sterilization, since some pathogens and spores tolerate this procedure. Experience shows that disinfection technique and subsequent handling can be poor, for example when health workers use fingers instead of sterile forces to remove syringes from the water in which they have been boiled. Boiling should only be used until steam sterilizers become available.

Steam sterilizers can use a multitude of heat sources, are portable, and come in three sizes. The smallest unit is designed exclusively for needles and syringes and has changeable tacks for use with 42 syringes and needles of other 0.5 ml or a mixture of 2 ml and 5 ml. The medium size sterilizer holds twice as many syringes and needles but can also accept other primary health care equipment such as forceps, dental instruments or gynecological examination equipment. The triple rack sterilizer can sterilize all instruments likely to be used in primary health care.

When the health worker takes responsibility for cleaning the syringes after use and for properly carrying out the sterilization, and is the only person to handle the sterilized equipment right up to the point of giving in the injection, he or she need not have doubts about the sterility of the syringes and needles being used.

Single-use syringes

Single use syringes and needles are manufactured under strictly controlled conditions. The sterility of such needles and syringes is assured until such time as the protective wrap is opened. Health workers using freshly opened single use disposable syringes and needles, and destroying the syringe and needle after use, can be confident that they are using injection equipment with a very high assurance of being sterile.

Unfortunately we do not all live in an ideal world. A used syringe, even though it is contaminated, still has a value. In many developing countries, syringes and needles are unlikely to be destroyed. Therefore, single use syringes and needles should only be used if it can be ensured that they will be safely and finally disposed of immediately after single use.

The following questions can help determine the appropriateness of adopting single use syringes:

Are the health workers negligent about disposing of all their syringes after use, in a manner that makes their rehabilitation impossible?

Are syringes and needles, no longer sealed in their sterile pack, frequently seen in drawers, health workers pockets, bags or other places?

Is the number of syringes and needles distributed less than the number of doses of medication being given?

Do the health workers describe various ways in which they prepare syringes for re-use, none of which should be considered as sterilization?

Are there frequent signs of infection at the injection site following injection?

If the answer is yes to one or more of the above questions there may be a risk of cross-infection carried by the distribution of syringes and needles. If so, the health authority should not wish to use sterilizable syringes and needles, but the introduction of single-use syringes should be considered.

Auto-destruct syringes

An auto-destruct syringe is a disposable syringe that after one use cannot be reused. This new technology has recently been introduced into many EPI programmes. As of the 9 vacs currently used in the EPI are administered by injection it was considered a priority that injections given for vaccination be of the highest safety standards. The injections given after the EPI syringe are simple as the dose is a standard volume. Auto-destruct syringes are a safe alternative to other essential drugs are not currently manufactured but could be made available.

Auto-destruct syringes work in many ways. Two syringes that have been tested by the EPI, auto-destruct by restricting the total movement of the plunger, which can be withdrawn up to the capacity of the syringe only once. The plunger force cause damage to the syringe making reuse even more difficult. Giving a syringe to another person is highly unlikely, tools and skill may find it easy to manipulate the syringes but the chosen designs make this very difficult and visible.

Auto-destruct syringes provide good protection against cross-infection to the patient but new risks will be introduced if there are any stock shortages. If health workers use all the auto-destruct syringes and still need to give injections they will have to do so. Some health workers may stop giving injections. Others may seek out the few conventional disposable syringes and reusing and reform them repeatedly. The EPI recommends that each health centre using auto-destruct syringes should have an emergency contingency supply of sterilizable syringes and sterilizer as a back-up in the event of stock shortages.

The increased number of contaminating auto-destruct syringes and needles could present an extra risk to the community. The equipment is therefore distributed in specially designed boxes that can safely hold the needles and syringes after use and become a self-contained incinerator for their final disposal.

The introduction of auto-destruct syringes into a programme usually involves a substantial financial investment. However, this does not represent a change in policy. It is merely an additional step to reinforce the already high safety of disposable syringes after use.

Weighing up the pros and cons

In summary all three methods have economic and/or safety advantages and disadvantages.

The reuse of syringes and needles after sterilization is usually culturally acceptable, the risk of not using sterile syringes and needles available when needed is greatly reduced, and the cost is not likely to rise through the introduction of the new practice.

The use of single-use equipment and syringes, although expensive, is a safe and inexpensive method of all, costing about US$0.13 per injection, which will be beyond the means of many health services. It should only be considered when disposable syringes are required but there is no assurance that standard disposable syringes will not be reused.

Training v. technology

Although appropriate technology is undoubtedly contributing to the safe delivery of drugs and vaccines, a key issue which technology alone cannot address is that of training and awareness. Health workers simply must be taught to understand the enormous potential risks of using unsterile equipment; to safely sterilize and dispose of syringes and needles; to correctly administer injections; and most important of all, to understand that unnecessary injections are bad clinical practice with serious public health consequences. The public also requires education, so that patients will not press health workers to give unnecessary injections, or inject themselves or their family, which is an increasingly common and dangerous practice.

Many reasons are put forward for the popularity and overuse of injection. In some countries they represent an addition to the burden, and to an additional (and vital) source of income for the poorly paid health worker, and access to this western medicine technology may also be a source of societal status.

For the community, injections may symbolize the power of modern medicine, with the psychological impact of the intervention in marked contrast to the undramatic dispensing of small white pills. Paradoxically, the visible success of the EPI programme may have contributed to the belief that injected medicine is the best medicine. Investigating and tackling these issues and perceptions are the other side of the technology coin and undoubtedly represent a major challenge to health services.

Yet we must take care when warning against overuse of injections not to impair the justified confidence gained in the effectiveness of vaccination for which the needle and syringe are the essential tools of delivery.2

1 WHO’s Action Programme on Immunization and the Action Programme on Essential Drugs

2 Immunization, a chance for every child.

Source: WHO Expanded Programme on Immunization and the Action Programme on Essential Drugs

Photo: WHO/Greg Cooper2

* WHO’s Action Programme on Essential Drugs, in consultation with the Expanded Programme on Immunization and the Global Programme on AIDS, is undertaking an injection practices research project in Indonesia, Senegal and Uganda.
Australian children learn about medicines

Inappropriate use of legally obtained medicinal drugs is a costly affair in Australia. The Australian Pharmaceutical Benefits Scheme (PBS) has spent nearly $1 billion on medicines for children in the last 10 years. This cost is due to the high proportion of children under five who are prescribed medicines, and the high cost of medicines prescribed for children.

The PBS has the responsibility of ensuring that medicines prescribed for children are appropriate and that children are not prescribed medicines that are inappropriate for their age group. This is important because children are still developing and their bodies are still growing. This means that medicines that are appropriate for an adult may not be appropriate for a child.

Inappropriate use of medicines can lead to a number of problems, including:

-**Increased costs:** Inappropriate use of medicines can lead to increased costs for the PBS and for the Australian healthcare system.
-**Increased risk of adverse effects:** Children are more vulnerable to the side effects of medicines than adults. This is because their bodies are still developing and their organs are still maturing.
-**Decreased efficacy:** Children may not receive the full benefit of medicines that are prescribed for them if the medicines are not appropriate for their age group.

To help reduce the inappropriate use of medicines for children, the PBS has developed a number of strategies, including:

-**Medication reviews:** These are reviews of a child's medication to ensure that it is appropriate for their age group.
-**Medication guidelines:** These are guidelines for the appropriate use of medicines for children.
-**Medication education:** This is education for parents and healthcare professionals about the appropriate use of medicines for children.

The PBS is also working with healthcare professionals to improve the appropriate use of medicines for children. This includes training healthcare professionals about the appropriate use of medicines for children and providing them with the tools they need to make appropriate decisions about the use of medicines for children.

In conclusion, inappropriate use of medicines for children is a significant problem in Australia. The PBS is working to reduce this problem by implementing strategies to improve the appropriate use of medicines for children. These strategies include medication reviews, medication guidelines, and medication education.

---

**Reference:**


---

**Standard treatment guidelines: a first for Tanzania**

**Tanzania’s Standard Treatment Guidelines and National Essential Drugs List (NEEDLIT), produced by the Tanzania Essential Drugs Programme is the first national manual of its kind.**

Introducing the publication, Minister of Health, Professor P.M. Sarungi, said that 35-45% of the country’s health resources is currently being spent on drugs alone. There could be no excuse for failure to maximise their use through rational prescribing, which despite the importance of selection, procurement and distribution, was the foundation for success of the whole programme, he emphasised.

"It is Ministry policy that all health workers whether in government, private institutions or NGOs adhere to NEDLIT," said Professor Sarungi. "All prescribing, purchasing, labelling and dispensing should be by generic name as far as possible.

The Minister thanked WHO’s Action Programme on Essential Drugs for its support and contribution to the preparation of the manual."
Essential Drugs Monitor

RATIONAL USE

People who live in glass houses...

An account of the first course in effective drug management and rational use held at the Robert Gordon Institute of Technology (RGIT) in Aberdeen, Scotland.

by Paul D. Spivey

They call room no. PDI “the glass house” because three sides of the room are virtually all windows. Situated at the very top of the city centre campus of RGIT (soon to become the Robert Gordon University), the room gives plenty of light and roof top views of the city of Aberdeen. Participants on the course knew Aberdeen and “the glass house” (our course room) quite well during the twelve weeks from 20 January to 10 April. Aberdeen is known as “the granite city” of Scotland because most of the buildings are made of granite which can look very warm and pleasant in the sunshine, but dark and cold in the rain. Course participants experienced both the warmth and friendliness of Aberdeen and its people, as well as the cold and darkness of winter-time in the north east of Scotland. Both aspects will be remembered and were mentioned when one of the participants spoke at the closing ceremony.

Eight participants from six countries — Bolivia, Ethiopia, Malawi, Nigeria, Saudi Arabia and Sudan — joined the course. This meeting of ideas and experiences frequently turned the “glass house” into a “hot house” as opinions were expressed and debated within the healthy atmosphere of an interactive and constructively critical discussion of the subject matter. The use of role-play, group exercises, case studies, and presentations emphasised and enhanced the participatory nature of the course evolving the comment that “this must be the only course which critically evaluates the basic premises of the essential drug concept.”

Not all of the time was spent in the glass house, field trips contributed to 10% of the total available teaching time. This gave participants an opportunity to see the drug supply systems, of which drug management, supply and distribution within the Scottish health care system. Both hospital and community pharmacists participated. It became clear that limited resources are not exclusively a third world problem and some problems discussed in the classroom were seen to be effectively and advantageously applied in Scotland.

Eighteen different lecturers shared in the classroom teaching with a further ten presentation evenings with visiting doctors, dentists, and nurses. Field visits. Lecturers included World Health Organization staff from Geneva and Bhutan, RGIT School of Pharmacy staff, the Chief Pharmacist for Scotland, other UK pharmacists with work experience in the third world, and Dr Andrew Herxheimer. The glass houses are normally used for growing plants and producing fruit. One tangible piece of fruit from the twelve weeks is the course document which the participants produced as a common document after a lot of hard work. It represents a joint reminder of the course material and a common set of objectives for active implementation on return home. One participant has already written (within three weeks) of his organization of a meeting to discuss changes in tendering and supplier evaluation, etc. Time will reveal what other fruit may come out of the twelve weeks spent within the glass houses. There is a declared interest to meet again in two years’ time in order to realistically evaluate the outcomes of the course.

The complete English proverb used in the article’s title is “people who live in glass houses should not throw stones”, meaning that it is not wise to be critical when one is in no position from which to criticize. It is very easy to criticise what other countries may or may not be doing in terms of drug policy and control without realising how weak one’s own situation is. All of us involved in the course realised just how much we need to learn from one another and how much there is yet to be done in the areas of drug management and rational drug use within the respective countries. In many respects we all “live in glass houses” where successful drug management is concerned.

How did the participants view the course themselves? There were plenty of complimentary remarks regarding the benefits gained and also, of course, on the course, constructive comments on potential improvements for the next course:

— One participant wrote, “the course stimulated me to find solutions to my own personal problems, and to see possible shopping around for solutions to my country’s problems.”
— Another found the course an exciting and very unusual event, where health professionals from different backgrounds gained experience on the rational use of drugs and the opportunity to discuss their points of view with experts and lecturers, raising relevant questions and seeking valid alternatives to improve the drug situation in the world.
— A third was “grateful for the opportunity to broaden my concepts of the role of the pharmacist... I have been a ‘glass pharmacist’ before, now I hope to become a real pharmacist.”
— A different participant wrote “the course is very important for a country like mine which has managerial problems. It enables every participant to express his experiences, most of the tutors are highly experienced and are able to share their knowledge... personally, I have gained a lot from the training”.
— One participant singled out the modules on presentation skills and teaching techniques as being particularly helpful and concluded that “my overall management skills, I believe, were broadened through the lectures on personnel management, finance, and communication skills.

The course incorporated the use of a fully equipped audio-visual project for presentation skills and the use of a new method of teaching using “interactive video” to develop management skills in finance and communication.

Whilst there may be nothing startlingly new in the context of the course, in that the curriculum is based on the established elements of a national drug policy, it does appear to have provided a significant forum for discussion of ideas and experience — at least for eight people! The strongly participatory style of the course indicates that participants should not be more than twelve at one time, and preferably come from a similar background level of professional experience and development.

Continued on Page 19

Street theatre: taking the message to the people

by Jörg Schaaber

The scene is the pedestrian zone of a German city. People are busy shopping. Quite unexpectedly an old but brightly painted bus comes into view. In front of the bus, a group of actors with a few props are using the pavement as a stage. BUKO Pharma- Campaign’s street theatre group is back in action. BUKO, a network of development NGOs in Germany, is committed to raising public awareness about issues related to the marketing and use of medicines.

People stop and forget their shopping for a while as they watch sketches about drugs and health both in their own country and the third world. Although linked by an overall theme, each sketch has a complete storyline so you don’t need to see the whole play. But many spectators stay for the entire performance. Afterwards they are invited to watch a slide show on drugs in the Third World. There is also a small book stand with leaflets, publications and background reading material where members of the audience and passersby can get further information.

Always something new

Each year there is a new programme taking up “hot” issues of the Pharam-Campaign. In 1992, “Columbus Year”, the play starts with the “discovery” of the Americas. Then Columbus and his crew set an unfair exchange with the natives: glass beads against gold. In the next scene we are back in the 1990s. Mr M., a pharmaceutical entrepreneur has a problem. He wants to get rid of his old stock of superfluous drugs. First he tries to get a licence for them in his own country but fails. Then the "ghost" of Columbus appears on the scene (in this case from the top of the bus) and advises Mr M. “I took glass beads, why don’t you take your pills to Latin America to get some nice gold?” And so Mr M. does. But first he has to develop some advertisements... and so the play unfolds. In the last scene, the successful marketing of the drugs in Latin America is reported. Mr. M. and Columbus drink champagne to celebrate their success.

How does it work?

The street theatre group of the BUKO Pharma-Campaign consists of volunteers from different cities in Germany. The group usually meets three times to prepare. They develop the play themselves. The community reads the practical advice from development experts and a theatre animator. The sketches often draw on popular fairy tales or are widely viewed TV-shows but develop their own story.

The group tours twice a year through some 20 German towns and often gives performances in response to invitations from local Third World solidarity groups or medical students. Depending on the size of the town there can be between 10 and 200 spectators at each performance, while there are often five times a day. There is also often an after-event which usually includes an expert speaker from BUKO Pharma-Campaign and a discussion.

Participation is an important element. For example, one of the main themes is a quiz. “The World Health Organization has drawn up an essential drugs list which includes medicines to treat most of the illnesses that can be treated with

Continued on Page 19
NATIONAL DRUG POLICY

ZEDAP: A Retrospective 1987-1992

by Hanif Nazerali*

Mosi Oa Tunya (the smoke that thunders)

A continuous thundering is heard as the Zambezi River falls, a spectacular curtain of water, into the gorge below. The Victoria Falls has a special place in the history of the Zimbabwe Essential Drugs Action Programme (ZEDAP). Its popular name mosi oa tunya (the smoke that thunders) comes from the Makololo people. Before them, the Tonga called the place shungwe, which is translated as "soothing curtain". A place with such inspired and dramatic names seems appropriate to mark the start of Zimbabwe's Action Programme which began, with DANDA support, at a time of great turmoil in the drug supply system in Zimbabwe.

It was here in the Falls in 1987 that a "National Workshop on Drug Policy and Management" drew up the framework of a national drug policy, subsequently endorsed by the Cabinet. The Workshop brought together officials from the Ministries of Finance, Trade and Commerce, Supplies, and Health; as well as manufacturers, importers, and retailers. This broad participation of the various parties concerned with drug utilisation encouraged a consensus on how to implement the new policies. And the well thought out recommendations from the workshop contributed much to the dynamism of the programme's early years.

Five years downstream ZEDAP is now embarking on a second five year plan so it seems an opportune time to review some of the Programme's many achievements as well as the unresolved problems.

Evolution of the essential drugs programme

Despite the importance of the Victoria Falls National Workshop, much had been accomplished before 1987. The Drugs Control Council was constituted in 1966 to administer a new Act in 1969, and drug registration began in 1971.

In 1981, Zimbabwe published its first proposed essential drugs list "PEDLIZ" which, four years later, was translated by the National Drugs and Therapeutics Policy Committee into "EDLIZ", a definitive list of 375 drugs classified by level of use and therapeutic guidelines, though this had not been fully operationalised through the Government Medical Stores.

The distribution system was restructured and decentralised with donor agency support.

Zimbabwe is well known for its swift move, after independence in 1980, towards the goals of the Alma Ata Declaration. A primary health care approach and appropriate referral structure was adopted and substantial investment went into rural health facilities and training of appropriate health personnel. "Free services" for those earning less than 150 Zimbabwe dollars per month (approximately 75 US dollars in 1981) covered a large part of the population.

Impending crisis

Removing the existing inequities in health provision resulted in a three-fold increase in demand on curative services by 1984. The drug supply system failed to cope and the shortage of essential drugs persisted at rural health facilities. Recognising that this component of PHC laggard behind, the Ministry of Health asked WHO for help. The outcome, following two appraisal missions, was the formulation of the Zimbabwe Essential Drugs Action Programme, which was launched in November 1986 with financial and management support from DANDA, and technical support from WHO.

Dynamic team

DANDA provided four advisers as counterparts to four Zimbabwean posts (two existing strategic positions and two newly designated trainers' posts) to form the Management Team of ZEDAP. These were individuals with extensive experience and a clear vision of the mission and goals of the Essential Drugs Programme for Zimbabwe. Within six months of inauguration of the programme, the team had visited all eight provincial medical directors' offices to brief the staff there about the programme; estimated the national drug requirements (with assistance from WHO); completed a baseline survey; and organized the National Workshop.

At the time of the country-to-country agreement, the Government of Zimbabwe remained committed to financing drug supplies and the request for assistance was aimed at ensuring the best possible gains from the resources invested by the Government.

Shooting the rapids

After the Falls comes a zig-zag pattern of gorges through which the Zambezi river churns. The crisis in drug supply with which the country was faced and the challenge to ZEDAP after the 1987 Falls Workshop could be compared with rafting through white-water rapids.

DRUG SUPPLY

Financing drugs - an emotive issue

Back in May 1986, the rapid and unchecked escalation of drug prices and recurrent shortages of essential drugs became sufficient cause for concern that a "Special Cabinet Committee on Drug Pricing and Supply" was appointed.

Robert Mugabe, then Prime Minister, made reference to the economic problems arising from irrational drug use at the official opening of the Regional Medical Store in Bulawayo. "While I commend the fact that more than 65% of drugs consumed in Zimbabwe are locally manufactured, I am informed that only a small percentage of these are truly essential and this position should be reversed..." Expenses precluding habits continue by and large due to the lack of sensitivity to or appreciation of our economic circumstances... There is a clear case here for the use of generic or approved names instead of brand names for all registered drugs.

While the efficient use of foreign exchange was very much in question, the overall shortage was clearly a major factor in the drug shortages. Foreign exchange had been severely limited in Zimbabwe since 1981 and from 1987, a 40% across-the-board cut had to be made, with spending Ministries such as Health worse affected than those producing revenue.

Local manufacturers received only 30% of the foreign exchange for tenders awarded to them by Medical Stores in 1986/7; 70% was outstanding at the time the matter was discussed at the National Workshop. Government institutions were then forced to buy direct from private wholesalers at unaffordable prices, over-specifying in the private sector, while non-essentials remained freely available. A more streamlined system for allocation of foreign exchange was clearly a prerequisite for a sustainable flow of drugs, and the Falls Workshop presented this to the Special Cabinet Committee.

Cabinet accepts drug supply plan

In July 1987 the creation of a special reserve of foreign exchange for CMS tenders was agreed by the Cabinet. This meant that for every six months quota period, when the "foreign exchange cake" was shared out, the Ministry of Health would receive a special reserve for pharmaceuticals directly from the high level "Committee on Foreign Currency Allocation". At last, drugs were a recognised priority item for foreign exchange. When Cabinet requested estimated foreign exchange needs, the Ministry of Health presented the ZEDAP drug supply plan with minor additions.

A quantification exercise had been carried out by members of the ZEDAP team together with three consultants from WHO in January 1987. Based on the demand-mortality method and taking into account EDLIZ standard treatments, costs were projected for 150 drugs. The plan also estimated the foreign exchange component for the importation of raw materials by local industry (able to manufacture 60-65% of the listed EDLIZ drugs) as well as finished products. The Falls Workshop subsequently highlighted the additional requirements to alleviate drug shortages and to clear arrears in the Medical Stores tenders.

In October 1987 the Cabinet accepted the global estimates of foreign currency requirements for both public and private
Sector. The Finance Ministry authorised a forward commitment of ZS 6.4 million to clear up the backlog of public sector teachers in readiness for the new system of allocation in the first quarter period of 1988 (January - June).

Drug shortage prolonged

But in January 1988, however, the implementing ministries continued using the old system of separate ad hoc allocations, amounting to ZS 5.6 million out of the promised 11.5 million. A mid-term project review mission concluded from ZEDAP monitoring data that:

- The result of the delayed and reduced foreign exchange allocation is that MOH is seriously short of drugs. Some hospitals are operating with zero stocks of 25-35% of the 146 essential drugs regularly used, and the average for drugs out of stock in health centres is 52%. The GMS is completely out of stock of 50% of regular supply items. Until the GMS is adequately capitalised with timely and sufficient allocations of ZS and foreign exchange, the situation can hardly improve. What is needed now is a concerted, well documented approach to cabinet to secure the second half 1988 quota of ZS 11.5 million by the end of May.

This task was tackled head on by the ZEDAP team and foreign exchange allocations were in fact secured and maintained for a period of two years.

Improved public sector drug supply

Once GMS was able to control the disbursement of foreign exchange, procurement was far more effective. Also, by now the Medical Stores inventory had been rationalised, removing obsolete items and bringing it up to date with the revised drug lists, EDLIZ 1988 and 1989, as well as developments in the health care industry. Customers orders were scheduled and processed much faster.

By the end of 1990, referral hospitals reported 82% of 342 EDLIZ drugs in stock. For 10 items specified for PNC facilities, 82% were available while for the same list district hospitals reported 89% in stock.

The stock situation at rural health centres appeared to have improved more gradually; moreover the availability figures showed a wide range, a difference of 43% between the best and the worst (56% surveyed in May 1989 and May 1990).

There was a clear indication that drug management (ordering practices, stock control) and logistics of delivery played a large part in determining availability. It underlined the importance of the ZEDAP training programme.

DANGER POINT - 1992

At the end of 1990 a cumulative shortfall in foreign exchange allocation once again heralded a drug supply crisis. Worst still, the old problem of delays and ad hoc returned, the allocation coming in spurs only after considerable lobbying by MOH.

Drug allocations to the six main local manufacturers, single large wholesaler and 50 odd importers serving the private sector were also severely reduced in real terms. The strategy adopted to maintain supply was increasing use of the special allowance for importation of drugs on individual prescriptions, which was supposed to cater for exceptional cases. Although extremely cost inefficient and unsafer, this became the major channel for private sector procurement in 1991.

Abuse of prescription import system

Lobbying by those with a vested interest in this system resulted in its institutionalisation, a large proportion of these prescriptions being brought to a single enterprise in Harare. From here, consolidated orders were placed and importation effected using the special facility for import of individual prescriptions under the "Open General Import License" (OGIL, 1990) system. The government financing the scheme had the task of retrospective monitoring of this central agency. The ZEDAP Project Coordinator reported a finding: irration al use of resources. Monitoring data showed:

- USS 2.5 million spent in one year by a small minority.
- Many unregistered drugs, 50% of drugs non-EDLIZ.
- 50% of drugs on EDLIZ lists.
- 50% of drugs under local manufacture.
- Expensive brand name drugs, few generics.
- Unit cost 6-7 times that of GMS tender price.
- Excessive non-essentials such as vitamins and tonics.
- Improper use of expensive antibi otics (eg cephalosporins), hypnotics and anxiolytics.

Private sector/public sector: an uneasy interdependence

The current scenario is a throw-back to the difficult times of 1986/88, but proposals by the Trade Liberalisation Committee, recently accepted by the Government, should resolve the foreign exchange bottleneck. All EDLIZ drugs are to be placed on OGIL under a revised statutory instrument allowing bulk importation. Local industry will be permitted by only allowing in finished products which are not registered for manufacture in Zimbabwe; in this case, importation of only the raw materials will be permitted.

The effects on drug utilisation remain to be seen. Sustainability of the system depends much on responsible use and self-policing by the various private sector associations, with the Ministry of Health taking a position, once again, of monitoring retrospectively.

TRAINING: THE KEY TO RATIONAL USE

A major objective of the project was to develop an appropriate training programme to ensure that, as the drug supply improved, the management and use of drugs also improved. Beginning at a time of worsening drug shortages presented great difficulties: the ZEDAP team at one of the first provincial workshops to launch newly produced training materials, was literally sent packing by the provincial medical director, who said: "you're welcome back when you have the drugs". Fortunately, the producers of the training materials had involved people throughout the country, and engendered sufficient confidence in the ZEDAP team to overcome these "cross currents".

The baseline survey carried out in February 1987 identified the need for up to date and relevant reference materials. Health workers' responses during that survey guided the choice of subjects for a series of ZEDAP training modules. The aim of each module was to provide the minimum necessary knowledge at the level of a primary care unit for effective clinical and drug management.

ZEDAP - Zimbabwe Essential Drugs Action Programme

Objectives

- To ensure a regular supply of low-cost good quality drugs in the government and non-profit health service.
- To ensure optimal and rational use of drugs.

Special features

- Political commitment to essential drugs concepts.
- Comprehensive national drug policy (US$14.0 million per annum).
- Significant local pharmaceutical production (60%).
- Low cost management support programme (US$ 1.4 million over 6 years) with 4 Danda advisors.
- Participatory methods in planning and implementation.
- Innovative approach to training and production of drug management/health training materials.
- Bottom-up "pull" system for ordering and needs information.

Production of learning materials - an innovative approach

The production of the ZEDAP modules and the methods used for their dissemination have been described in detail elsewhere and have provided a model for programmes in other countries such as Malawi. By involving the healthcare workers in the planning and the implementation of the training relevant learning style, the team provided the best training materials.

Several publications and workshops have followed.

ZEDAP workshops: 1988-89

In April 1988, only nine months after beginning the materials production programme, of week-long provincial workshops began aimed at informing provincial and district staff about programme activities, introducing the first nine modules with prepared teaching aids, and initiating the subsequent district-level workshops.

The district-level workshops principally targeted the nursing staff at the
**Essential Drugs Monitor**

**MONITORING THE IMPACT - ZEDAP SURVEY 1991**

After the initial baseline survey, a second system provided additional data on drug availability in 1988. By 1989, there was need for a more comprehensive survey, which would measure the effects of the training programme as well as rationalisation in the supply system. The methodology was developed in a training session which included provincial staff as well as staff members from WHO’s Action Programme on Essential Drugs. The key indicators included:

- availability of essential drugs
- application of the national stock control system
- lead times and delays within the distribution system
- drug prescription and use

The survey was conducted with the help of pharmacists at provincial level in May 1989 and repeated, with minor modifications, at intervals of one year. A stratified random sample of PHC facilities (60%) and district hospitals (30%) were surveyed. A small part of the findings are illustrated here.

We believe that a target of 80% availability of the selected range of items means adequate care can be provided. Availability has gradually improved and in the last round we found an average of 78% stock coverage. A large proportion of facilities (32 out of 56) fall in the ideal range 80-100%. Unlike a small number (less than 2%) are far worse than others, suggesting management problems. Antibiotics are not on top of the stocked list, which was the case in 1989 and before.

A standard, nationwide system of stock control was the foundation for an effective and sustainable drug supply system. Zimbabwe differed from other countries in choosing a “pull system”, where estimation of needs is done by the health worker in each facility, rather than the logistically simpler “top-down push system”. A greater investment in training was needed, but was proven worthwhile by the results presented here. At this point, the degree of rationalisation in the system is really impressive.

Quantitative indicators on drug prescription are well within the expected range, and suggest a rational use of drugs much better represented by other countries. Of course, the use of antibiotics can always be improved. Initially an inappropriate use of antibiotics, which is still a problem, and more recently correct diagnosis and treatment of genital ulcer disease, which has a lot of room for improvement. Effective management of such conditions is more important than ever now, with the increased potential for transmission of HIV.

**MORE CHALLENGES FOR ZEDAP**

The second phase of ZEDAP, which will continue to receive DANDA support, will be as challenging as the first. It will need to navigate the yet uncharted waters of another, far more pervasive five year programme, Zimbabwe’s Economic Structural Adjustment Programme (ESAP). Recently introduced cost recovery measures rely on drug charges to the extent that drugs - although available - may no longer be affordable. The balance of payments position and greater export orientation may also have repercussions for the procedures and policies which will include the updating of EDLZD, further improvements in the operation of the EDLZD administration and EDLZD operations at Medical Stores; improving quality assurance programmes; and coping with the effect of HIV/AIDS on the drug situation. In this critical period, we hope once again to count on the support of all our readers and users of Essential Drugs, with its expertise and experience derived from similar programmes in other countries.

---

**Colombo meeting: partnership in national drug policy**

**THE** Asia-Pacific Workshop on Pharmaceuticals for Health Ministry Officials held in Colombo, Sri Lanka from 8-12 June 1992, is likely to be as important in years to come as the event where “a new level of partnership between government officials, NGOs and academia was forged”, reports HAI News in its August issue. Forty-five participants from 15 countries in the region representing these three sectors attended the workshop, which was opened by Mrs Remukku Herath, Sri Lanka’s Minister of Health.

The meeting was convened by the International Organization of Consumers’ Unions, Regional Office for Asia and the Pacific, in collaboration with the Sri Lankan Ministry of Health and the Department of Pharmacology, University of Colombo. Explaining its rationale, IOCU states that although some countries in the region have formulated and implemented major components of a drug policy, with varying degrees of success, none has an integrated and comprehensive policy. It concludes that this lack has resulted in the non-availability of safe and effective drugs at affordable prices.

The meeting therefore centered on the key components of national drug policies and aimed to:

- give senior health ministry officials a chance to meet and share their experiences, successes and failures in formulating and implementing national drug policies;
- create close interaction among policy makers, health workers, and educators;
- identify national and regional activities which could promote rational drug use;
- comment on a draft model drug policy.

The model provisions for such a policy are focused on the need to control the imbalance between drug promotion and drug use, to promote alternative measures and policies which would improve accessibility; to develop regional cooperation to share information, technology and skills; and to introduce courses on drug policy, rational use, the national drug policy, and WHO’s Ethical Criteria on Medicinal Drug Promotion into the national pharmacy curriculum.

With the conclusion that best depicts the spirit of the workshop, reports IOCU is, the strong support from participants and observers alike - for the future implementation of a “health need” clause in all new drug policies. This would ensure that the health needs of the people would be the most important criterion for the selection of drugs, it says.

Based on the conclusion, recommendations and working group discussions, IOCU ROAP will finalize its Model drug policy: a discussion document. This will detail the various components of an integrated drug policy, and implementation options related to individual country needs.

The policy document will be widely distributed to health ministries, schools of medicine and pharmacy, and NGOs.

The workshop closed with the announcement that every hospital in Sri Lanka would set up its own drug and therapeutic committees. This would include the preparation of a hospital formulary, the formulating of therapeutic guidelines, and promotion of the concept of essential drugs and their rational use.

A report of the workshop is available from IOCU Regional Office for Asia and the Pacific, Box 10145, 10300, Penang, Malaysia.
NATIONAL DRUG POLICY

MONGOLIA: First conference on national drug policy

Mongolia has been facing an acute shortage of essential drugs since the changes in the political and economic system in 1990 meant that drugs had to be bought with scarce foreign exchange. Until that time, physicians and pharmacists were used to a large range of pharmaceuticals, mostly under brand names, coming from the USSR and other Eastern European countries. Many of the drugs purchased were non-essential, nor was objective drug information available.

In an urgent attempt to tackle the crisis and rationalise the structure of drug procurement, a government recommendation called for WHO technical support. In response, staff and consultants from the Action Programme on Essential Drugs in Mongolia conducted a series of missions in 1991 resulting in the development of a national essential drugs list and the analysis of the drug situation. This identified priority problems and laid the groundwork for a national drug policy and a selective drugs programme. These preparatory activities culminated in Mongolia’s first conference on national drug policy, held in May 1992 and attended by some 300 physicians, pharmacists, administrators, researchers and teachers, together with representatives from international health and development agencies.

Urgent need for a national drug policy

Opening the conference, Mongolia’s Minister of Health, Dr. D.T. Nymadaw, explained its background and objectives. He recalled the recent political, economic and social changes in Mongolia and their impact on drug supply. A new problem had emerged in the last two years, he said, in the area of the most essential drugs, mainly due to financial constraints and shortage of foreign exchange. Earlier there had been little concern for economics, selection and rational use of drugs. Doctors had ordered and received more or less what they wanted. Mongolemimpex (the central procurement agency) purchased drugs mainly from the former USSR without having to use any foreign exchange. Overuse and consumption - in particular of antibiotics - was a widely recognised problem, but not much had been done about it.

The minister referred to WHO resolutions covering, in particular, essential drugs and rational drug use, drug safety, efficacy and quality, but also medical plants, which had been passed by the 32nd, 33rd and 34th World Health Assemblies. None of these had yet been implemented in Mongolia, he said.

Dr. Nymadaw also recalled the March 1991 review meeting of South-East Asian Action Programmes on Essential Drugs (reported in EDM-12). There it had become clear that Mongolia required assistance in developing a national drug policy, with issues such as legislation and regulatory control, multisource procurement, quality assurance in local production, drug management, human resources training, rational drug use and the provision of objective drug information.

It was in this context, and following the WHODAP missions, that the Ministry of Health had proposed that Mongolia should formulate a national drug policy. In broad terms such a policy would aim to strengthen the infrastructure for the selection, procurement, distribution and use, not only of modern drugs, but also of traditional medicines, which were an important part of Mongolian heritage and culture.

International backing

The international community next expressed its support. Action Programme representative, Mrs. Margareta Helling-Bordal explained the rationale and the development of the essential drugs concept and its fundamental role within a national drug policy. She gave some examples of national drug policy development in other countries and related these to the current situation in Mongolia, stressing the Action Programme’s commitment to providing the maximum possible technical support to the Mongolian initiative.

UNICEF representative, Mr. L. Brown, described the conference as a “milestone in Mongolia’s making” and referred to UNICEF’s involvement in supply of essential drugs to Mongolia, particularly related to maternal and child health.

Dr. Frederique Bonnier, speaking for Médecins sans Frontières, highlighted the practical problems of drug management and use at the district level and proposed approaches to solutions for these. Technical information about drugs, particularly those drugs that the health workers are now asked to prescribe, was missing, she stressed. Furthermore, because of lack of awareness by health workers of drug and health care costs, prescribing practices had not been adjusted to the new economic conditions. Dr. Bonnier concluded that better availability of essential drugs could be achieved through simplified logistics infrastructure, training in rational drug use and focussing available financial resources on essential drugs.

Widespread irrational use

Dr. Chulunsuren, Head, Chair of Pharmacology, Medical University, Ulaanbaatar, referred to a recent study to determine drug use patterns in the area, which had shown widespread irrational use of drugs. In particular, the use of antibiotics - frequently purchased without prescription - was widespread. The speaker stressed the need for the development and dissemination of objective drug information. Doctors and pharmacists needed training in rational drug use, he emphasised. Physician education in clinical pharmacology must be reinforced as a consequence of the fact that until now Mongolians have only been familiar with trade or brand names. This led many in the audience to entertain the importance of education in clinical pharmacology, of promoting rational drug use in health worker training, and of focussing available financial resources on essential drugs.

A new policy: goals and strategies

The conference concluded by adopting a series of recommendations covering a new national drug policy structure. The main aim of the policy will be to provide effective, safe, cost-effective drugs of quality to all the population. Pharmacological legislation, priority for essential drugs, improved drug registration and prescribing, and the provision of objective drug information to health workers and the general public are the main guidelines of the policy.

Legislation will be enacted to control and regulate drug production, procurement, marketing and quality control. A comprehensive system of drug registration will be set up and the drug control authority will be extended, including a network of drug inspectors.

In order to rationalise drug use, standard treatments for the most frequent diseases in Mongolia will be introduced and a proper estimate made of drug requirements. A national list of essential drugs, priority in the allocation of financial resources for drugs will be given to the procurement of essential drugs.

The curricula of health personnel will be revised and revised to include the essential drugs concept and to incorporate a greater emphasis on practical clinical pharmacology. Retraining of managers and prescribers will take place to improve drug logistics and use.

Drug information will be improved through the development of a computerised drug information system, a prescriber’s manual containing therapeutic guidelines and a list of non-proprietary names (INNs).

Production and use of traditional medicines will be revised with the goal of harmonising and optimising the use of modern and traditional medicines.

Modern technology for the production of both traditional and modern medicines will be introduced, with the attention paid to good manufacturing practices.

A detailed workplan with objectives, activities, expected outcomes and assignment of responsibilities will be prepared by a specially convened working group. Long term donor funding in support of the project will be actively sought through WHO and other channels.
Sharing regional experience

Recent months Colombia has been conducting a vigorous publicity campaign on its new drugs policy, with the slogan: "Essential drugs are the doctor's best option", and "Generic forms are the patient's best option".

The publication of 50,000 copies of the new therapeutic formulary has provided the prescribers with up-to-date, sound and objective information on essential drugs as the preferred therapeutic option to match national health needs.

Seminars to present the policy are being held in the six major cities. The Minister of Health personally presents the fundamentals of the drugs policy and the participants - mainly health professionals - are informed about the formulary and about the other features of the campaign. Each seminar has been attended by an average of 1,000 people, so they are an important means of communicating with health workers in the government and private sectors.

A programme of visits to the main hospitals is being conducted parallel to the seminars. The approach is three-pronged: first a meeting is held with all the scientific staff to present and discuss the drugs policy. Second, visits are paid to the offices of all the doctors working in the hospital to hand them personally a copy of the national therapeutic formulary, together with a leaflet explaining the essential and generic drugs policy and samples of the printed matter being distributed to users.

Through these and other mechanisms the country's doctors and health personnel have personally been handed over 30,000 copies of the national therapeutic formulary. The third activity targets consumers: at the entrance to the hospital a drugs policy information post is set up which gives guidance to patients on the importance of essential drugs and on the choices open to them when they receive a generic prescription.

Freedom of choice

As a back-up to these activities, public information in post offices have been set up in the pharmacies to provide people with guidance on exercising their freedom of choice. The recent decree on essential drugs allows the doctor to prescribe the generic name of the drug in such a way that, unless the prescription states otherwise, the patient may select the most suitable brand and price from the catalogues available. The catalogues list all commercially available drugs by active principle, dosage form and potency, thus making it easier for the user to find the specific drug prescribed and the commercially available alternatives.

Although the generic drug market in Colombia is not yet strong, this freedom of choice (preferably guided by the patient's own physicians) could lead to savings of up to 40-50% on prescribed treatment.

Educational posters and leaflets have been printed for consumers. They explain why the government is encouraging the use of generic drugs (which are usually cheaper than the others) and how to identify them from the green strip on the label. The leaflets also explain that the use of a generic drug is equivalent to the branded product and how it is important that there should be competition between manufacturers so that prices do not go up unreasonably.

In order to have competition it is essential that patients, advised by their physicians, can exercise the right to choose the product they find most suitable.

Good consumer education is important for winning over the retailer; if users are able to demand their rights, the distributors will be convinced of the importance of making available the price catalogue and the generic products whose price is more acceptable to the consumers. Furthermore, 10,000 packages have been sent to pharmacies and small retailers, each containing a copy of the national therapeutic formulary, a promotional poster on essential and generic drugs, an explanatory flyer, and a letter from the Minister of Health inviting them to participate in the programme.

It is no easy matter to convince doctors and consumers that essential drugs and generic forms, which are cheaper, are just as good as the others. Advertising has convinced them that the best products are the most expensive. For this reason the Ministry of Health, with the advice of WHO's Regional Office for the Americas, has been supplementing its campaign with a programme to strengthen quality control. In this way both doctor and patient can feel sure that all drugs available in the country, including the essential and generic drugs, are products which comply with strict quality standards and can be prescribed and used with safety.

Finally, Colombia is currently engaged in negotiations with the health authorities of the Andean countries and Mexico on the creation of a common market of essential drugs. The intent is that harmonised specifications for essential drugs in each participating country will create the basis for a simplified import procedure under which only a quality certificate issued by the authorities of the country of origin and a certified copy of the original health registration of the product will be required. An Andean drug review committee will be responsible for monitoring the arrival of new substances in the subregion and for the gradual harmonisation of pharmacological standards in the subregion. Subregional integration will thus become a supporting factor for health policies.
aspects of drug use in the country, in both the public and private sectors.

In a little over a year the programme structure has been put in place and the staff who will constitute its operational nucleus have been trained.

At the central level a national department of drugs, pharmacies and laboratories has been set up within the Health Ministry as the standardising authority, and a central supply service has been set up as a decentralised enterprise responsible for the procurement and distribution of drugs.

In each of the 12 health regions, regional supply units have been established to decentralise programme implementation to the local level, with an emphasis on local health systems.

The first important steps to modernise pharmaceutical legislation have already been undertaken, with the preparation of a draft drug law based on the country’s own experience, on WHO recommendations, and on comparative analysis of the legislation in Andean countries.

A special commission, with representatives from scientific associations, the universities, professional bodies and pharmacies throughout the country has compiled a new national therapeutic formulary. This contains some 300 products with therapeutic indications for each level of medical care.

On the basis of procurement by international tender, the central supply service started by distributing some 60 essential drugs under their generic names through a network of health care services run by the Ministry of Health and by non-governmental organisations in Cochabamba, Chuquisaca, El Alto, Santa Cruz and Tarija.

Great efforts have been made to train administrative and health personnel in the administrative and financial management of drugs’ 14 runners-up at regional and district level in eight health units, followed six months later by an evaluation meeting and a final refresher seminar.

From 1992 onwards the rational use of drugs has been given priority with action including:
- a ministerial decision simplifying the registration of generic essential drugs for use by the national essential drugs programme;
- 62 radio spots in three languages (Spanish, Quechua and Aymara), 7 posters and 4 leaflets have been produced to promote the national programme;
- a cross-index of pharmaceutical, generic and brand names has been compiled to facilitate prescribing by generic name;
- the information and documentation centre has begun publicisation of a drug bulletin, the “Boletin Informativo de Medicamentos”, in collaboration with various health agencies in the country which have also been involved in publishing “Medicamentos y Terapéuticas”, the Spanish translation of three independent drug bulletins from the United States of America and the United Kingdom.

While there is not always consensus between the various sectors, a climate has been created that facilitates collaboration and the detailed study of important issues, such as drug financing, ethical promotion, distribution and prescription of generic drugs and quality assurance, which will be considered by the National Advisory Committee on Drugs. This committee was set up in December 1991 by the Ministry of Health to advise on the development of its drugs and health policy.

Guatemala

During the past ten years, with WHO technical cooperation, the Guatemalan authorities have undertaken a number of initiatives to rationalise use of drugs, and improve the availability and accessibility of essential drugs, particularly to the poorer segments of society.

These initiatives include:
- the development of a national essential drugs list, the establishment of a drug quality control laboratory, and the establishment of a national drug information centre.

Although these important steps in pharmaceutical policy were not in themselves sufficient to tackle the many problems related to drug supply and use, the government therefore decided to develop two model essential drug projects to gain experience in a broader approach, which if operationally effective, could be subsequently expanded.

In 1986 and 1991 respectively, essential drugs programmes were started in the departments of Sololá and Totonicapán, which have one of the poorest levels of health status in Guatemala.

The first studies of logistic support and drug supply to the health services in the areas revealed the absence of essential drugs, supplies of drugs which did not match local needs and were of poor quality, inadequate storage facilities, difficulties in distribution, inappropriate prescribing and failure to comply with prescribed treatments.

It was decided to take a comprehensive approach to improve drug supply and use. Under the direction of the departmental health authorities, and with technical and financial support from WHO, a working system of drug supply and management has been established.

Both areas have a permanent therapeutic committee that has selected essential drug lists appropriate for these levels of care, based on prevalent morbidity and mortality. Although drug procurement is currently undertaken through PAHO/WHO, the proportion of drugs obtained with WHO funds has progressively increased and now accounts for only 13% in Totonicapán and 7.2% in Sololá. A strict inventory control system has been established and a quality assurance scheme has effectively identified problems with drug quality and prevented distribution of these drugs to the health posts and centres.

Warehousing facilities have been greatly improved, reducing wastage due to poor storage conditions. A programme of continuing education for health personnel emphasises rational prescribing based on standard treatment protocols. Drug prescribing and dispensing is monitored, and attempts are being made to involve the community in village pharmacy programmes. Anthropological and social science research is being used to provide information on community perceptions and practice related to pharmaceuticals, in order to develop patient education in the appropriate use of drugs.

One key technical factor in the system’s development was the preparation of the basic list of drugs for health posts, which ensured that the drugs sent by the National Drug Supply Service were appropriate for the health needs of the area.

It was also the first step towards the development of a basic national list for health posts which has now received ministerial backing and serves as the legal and administrative basis for the procurement of drugs for these services. Since the implementation of the essential drugs programmes, a reliable drug supply appears to have been ensured. A 1990 evaluation found that, unlike neighbouring districts not involved in an EDP, Sololá had suffered no drug shortages in the past three years.

A recent evaluation of changes in the drug supply system in the Department of Totonicapán was equally positive: stocks of essential drugs in the health services were 1.5 times higher than the stocks reported in the base study in the previous year.

We wish to thank the following contributors to this feature:
- Dr. Juan A. Ardaiz, Project Manager, National Essential Drugs Programme, Colombia.
- Dr. Edgar Bautista, Medical Coordinator of the Primary Health Care and Essential Drugs Programme, Totonicapán health area, Guatemala.
- Mr. Philippe Lamy, Project Manager, National Essential Drugs Project, Belgium.
Seminar towards rational drug use in Southern and Eastern Africa

The first day of the seminar examined the macro perspective of policy issues and operational constraints for achieving rational drug use. Strategies to promote the rational use of drugs were discussed on the second day. Day three was used for field trips - participants had a choice of visiting urban or rural health centres, community groups, or with health education department. The focus was the fourth day was on campaign development, with an emphasis on skills training. The final day was used for the development of national and regional action plans and future coordination and support.

Many problems were shared, participants concluded at the end of the seminar, and much needed to be done. There were many contradictions to rational: weak or non-existent national drug policies; lack of prioritizing in drug selection; poor training; inadequate legislative infrastructure; aggressive marketing practices; and lack of consumer knowledge were among those cited.

The seminar had been helpful in crystallizing some of these concerns, placing them in a broader perspective, and assessing practical operational strategies for more appropriate drug use; it would also be helpful to network and to share information on future activities, the group decided.

A report on the seminar and follow-up activities is available from ISU-Europe, Jacob v. Lennephlaus 334 - T, 1053 NJ Amsterdam.

HAI international meeting

An international meeting of Health Action International was held in Geneva in April 1992 with over 50 participants from Asia, Africa, North and South America Europe and the Middle-East. In addition to workshops on campaign planning, consumer education, working with health professionals and media skills, five main themes were covered: structural treatment and patent policy; drug policies; children and drug promotion; women and drugs; and teaching rational prescribing.

Many at the meeting commented on the growing strength of regional HAI networks. Since the last major HAI international meeting in 1988, there has been the emergence of a strong network in Latin America, as well as increasing strength in Africa and the Middle East.

There were several outstanding themes in the plans for future campaigns. HAI will continue to push for stronger essential drug policies within the framework of primary health care. It will continue its campaigns on women and drugs, drugs for children, and specific problem drugs. European groups will continue to focus on the problem of double standards and to work with support from HAI. In developing countries, and the North American groups are also planning these issues. A resolution on the need for control of pharmaceutical exports was passed by the participants.

Another important theme was the importance of making independent information on drugs available to health care professionals and consumers. Towards this end a new HAI product ‘Med-Sense’ a pill box packed with tips on rational use was launched.

The meeting ended with a one day open forum entitled Promoting Health or Selling Drugs? with the publication of a new public domain publication - see Published Laterly, at which representatives of international organizations, industry, NGOs and the media listened to presentations by Dr Ken Harvey (La Trobe University, Australia), Ms Danielle Bardley (La Revue Prescrire, France), Professor T.I. Bhatia (paediatrician, Pakistan), Mr Charles Medawar (Social Audit, UK), Dr Joel Lexchin (Medical Reform Group, Canada), and Dr Roberto Perez (Peru), on current drug marketing practices. A lively panel discussion concluded the Forum. There was general consensus that although some progress had been made, misleading and unethical promotion of pharmaceuticals continues to be commonplace and to contribute to ill health and wasted resources.
**France: Stricter rules for drug exports**

N June 30 the National Assembly passed a bill that tightens controls on drug exports, report Agence France-Presse in the July 18 issue of the Lancet. Initially the bill was intended to translate the EC directive on export of drugs (89/341) into French legislation, but this directive imposes very few constraints on exporters. As in the World Health Organization’s Certification Scheme, it required a document attesting whether or not a specified product is licensed for use in the exporting country to be issued only at the request of the manufacturer or the importing country. Moreover, the bill omitted the French law’s requirement for previous authorisation of export.

The French medical action group PIMED, together with the Agric (Icu) group, which campaigns for the rights of developing countries, called for amendments to the bill so that all French drugs exported to non-EC countries would require full French marketing approval. Members of the public sent about 7,000 postcards to their local MPs and to the Health Minister Bernard Kouchner, and articles appeared in the press.

After the National Assembly adopted PIMED’s amendment, the Minister proposed an amendment of his own, which the Assembly then accepted. The exporter must obtain from the Health Ministry a certificate stating that the exported drugs have been produced in accordance with Good Manufacturing Practices. When the drug is not licensed in France the manufacturer must explain why it is not registered. The Health Minister transmits this explanation to the Health Minister of the importing country. Drugs that have been withdrawn or suspended in France cannot be exported. The Minister may ban the export of unlicensed drugs or drugs with an unfavourable risk/benefit ratio. The Senate is likely to approve all these measures in October.

**World Health issue on Essential Drugs**

The March/April issue of WHO’s World Health magazine has the September theme of essential drugs. How essential is an essential drugs policy asks WHO Director-General, Dr Hiroshi Nakajima in his introduction. "National drug policies and essential drugs programmes are now, and in the foreseeable future, the best means we have available of pursuing and eventual-ly attaining the dual objectives of national management of drug resources and better health for all," he says.

Features in this special drugs issue include: a account of the Bhutan essential drugs programme; research into why injections are so popular; how many drugs do we really need; consumer action throughout the world; guidelines for drug donations; public education campaigns in Australia and France, the key elements of a national drug policy, and the work of WHO’s Action Programme on Essential Drugs.

Copies of this issue of World Health are available free of charge from the Action Programme on Essential Drugs, WHO, CH-1211 Geneva 27, Switzerland.

**New drug bulletin in Cameroon**

PRIL, 1992 saw the launch of Cameroon’s first drug and therapeutics journal “The Pharmacist’s Bulletin,” a quarterly published in English and French with support from GTZ, UNICEF, Coopération Française and WHO’s Drug Action Programme. The Bulletin is a lively, excellently written publication, clearly focused on the practical needs of the pharmacist. It draws on both international sources of objective drug information, adapted to national prescribing problems and practices, and local professional knowledge and experience. The strength of this dual approach is reflected in its national editorial committee and its international scientific committee.

Major themes of the first issue were the relative advantages of amoxicillin or amoxicillin, the management of gonorrhoea, the withdrawal of glafenine from the Cameroonian market and malaria prevention. Future issues will consider diarrhoeal diseases, acute respiratory infection and malaria.

The essential drug concept is introduced into the pharmacy degree curriculum at Aberdeen

The School of Pharmacy at the Robert Gordon Institute of Technology has introduced a new 15 hour unit into the fourth year of the BSc honours degree in pharmacy. The unit is entitled “The Essential Drug Concept and Rational Drug Use” and is taught within the subject area of “Pharmacy Practice.” The response of the first group of 73 students to study the unit has been very positive.

In April 1992 the Royal Pharmaceutical Society of Great Britain evaluated the module and course at RGIT and commended the school for the initiative taken by introducing this unit into the curriculum. Further information is available with WHO recommendations on the introduction of teaching on rational drug use and the essential drug concept into the training of health professionals worldwide.

---

**Nigerian local production hopes**

CREASED production of essential drugs in the Nigerian pharmaceutical industry, one of the targets of the national drug policy, is expected to meet about 50% of total demand by 1995 and 75% by 2000. Local industry accounted for about 20% of national drug consumption in 1987 and there has been no appreciable change in the situation since, according to a report on the Nigerian pharmaceutical sector published by the UK Department of Trade and Industry.

All pharmaceutical active ingredients and about 98% of excipients are imported, together with a substantial proportion of the packaging used, including tamperproof packs. The drug policy contains provisions to promote local production, including a possible ban on imports of products which can be manufactured locally in sufficient quantities.

There are around 65 registered pharmaceutical manufacturers in Nigeria, mostly producing finished formulations from imported products. The most common products are anti-infectives and antibiotics - there are no local producers of anticancer, contraceptives and fertility agents, the report notes. Most pharmaceutical companies are privately owned and are primarily subsidiaries of the major multinationals; these subsidiaries are said to contribute about 80-90% of medicines on the market. Under present Nigerian law, pharmaceutical companies can be 100% foreign owned.

---

**Danish substitution rules**

SCENCE the beginning of November Danish doctors have been able to substitute unregistered generic multitudes by products with mark-perscriptions with the letter “G”. The pharmacists are free to substitute the cheapest version available, but does not have to substi-ute if the difference in price between the equivalent product is less than Dkr 5.

The guidelines insist that the patient must be informed by both the doctor if the prescription is to be marked with a “G” and by the pharmacist if another product is being substituted. The patient can object to the product selected by the pharmacist as a substitute, but it seems that there have to be good grounds, such as “poor previous experience” with the chosen product or a general reluctance to switch to something new. Under these circumstances, the pharmacist must dis- pense either the prescribed product or a different, though cheaper or equivalently priced, substitute.

With repeat prescriptions the pharma-cist may also be forced to issue the product originally dispensed, unless the patient decides to revert to the prescribed prod-uct. Such a decision must be notified to the patient and any notation in the medical record of the doctor to dispense alternative is also referred to a period of validity of the prescription.

The guidelines were published after discussions between the doctors, the pharmacists, and the health insurance negoti-ating committee.

---

**Two francophone countries embark on a collaborative effort with DAP to improve their drug situation**

The Ministries of Health of Algeria and Benin have requested the assistance of the Action Programme on Essential Drugs to assess the drug situation in their respective countries, to develop a preliminary plan to improve drug availability and use and to identify where WHO technical and financial support is needed. Activities for WHO were selected in both countries after a careful review of the objectives of the national drug policy and a discussion of strategies.

In Algeria activities fall under four objectives:

- to improve the availability of essential drugs in the health facilities, through setting up of a procurement process;
- to improve the affordability of drugs through the development of a pricing policy;
- to ensure the quality of drugs through the strengthening of the drug regulatory authority and inspection;
- to improve prescribing practices and the use of drugs by the public through the development of a national formulary and HEI campaigns.

In Benin the objectives of strengthen- ing the role of the state, improving the availability and accessibility of essential drugs, and improving the use and the quality of the drugs include the elabora-tion of a master plan for the national drug policy. This will function as a planning and a coordinating body for the Mi-nistry of Health, the revision of the EDL, the training of the health personnel, pub-lic information and education, and strengthening of inspection.

In both countries, a plan of action for 1992-93 has been prepared and activities are already underway.
How to investigate drug use at community level

SELF-MEDICATION is the most common form of therapy choice in developing countries and people often rely on informal drug distribution channels as much as on pharmacies. However, very few studies have focused on community drug use. Such studies are important because they can help in identifying the most serious forms of drug misuse in an area. They offer insight into the various channels through which people in communities obtain drugs and people’s ideas of drug safety and efficacy, their self-medication practices and the extent to which they follow the advice of health workers.

This guide, developed by the Action Programme on Essential Drugs, is intended to provide researchers and staff involved in health and/or essential drugs programmes with tools to investigate the drug provision and use in communities.

The guide first discusses relevant research themes and it then presents a rapid assessment methodology. The whole research process lasts around 4 months: 2 months to collect the data and 2 months for processing, analysis and report writing. A series of research questions, various sampling options, a description of the research process and suggestions for data processing and analysis, including indicators, are proposed. The human and financial resources required for this rapid assessment are also covered and finally suggestions are given on how the research results can be used. An additional chapter provides further details on more elaborate sampling and data collection methods.

The guide is still a draft and will be developed further as additional field experience is gained. Interested researchers can obtain copies by writing to the Action Programme on Essential Drugs, which will welcome any comments and experience in using the guide.

LETTERS TO THE EDITOR

Herbal remedies can also be hazardous

I was interested to read the article “An interview with Nigeria’s Minister of Health” concerning national drug policy (Essential Drugs Monitor No. 12, 1991, page 4). However, I was concerned that the “Nigerian policy includes the promotion and support of research into herbal and traditional remedies which are widely considered to be effective”. I would be grateful if you could elaborate on this statement in a subsequent issue of the potential for adverse side effects from herbal remedies.

The medical profession in general, and the general public in particular, needs to be alerted to these hazards since in Australia, and I would assume in many other countries, herbal preparations may be marketed without the mandatory clinical trials to evaluate efficacy and safety which apply to the pharmacological drugs.

I would also urge you to alert readers of “Essential Drugs Monitor” to problems which have escalated in the medical profession due to the practice of certain so-called traditional practices. In particular, I would refer you to the articles by Huxtable (1991) and Talajic et al. (1990).

A drug used properly is a blessing...

Clarity and simplicity, yet with far-reaching implications, are usually the desirable features of messages intended for public education.

I think the message “A drug is not something to be taken lightly” that appeared in the article entitled “Don’t take drugs lightly. French consumers warned” (EDM No. 12, 1992) fits the above criteria of a good message. In Myanmar we have a traditional saying regarding the rational use of drugs that also meets these criteria: “A drug used properly is a blessing but in excess is a curse.”

Dr Thant Syn, Secretary, Drug Advisory Subcommittee, Myanmar Drug Committee

International pharmacy associations call for professionally controlled drug distribution

The interview with the Nigerian Minister for Health (Issue No. 12, 1991) has prompted this letter which we write on behalf of the international profession of pharmacy. We do not wish to comment on the details of the situation in Nigeria, except to say that we hope that differences which appear to exist between the Minister and Nigerian pharmacy can be resolved through constructive dialogue.

We were heartened by the Minister’s stated wish that pharmacy should be the means of distributing medicines to the public. We agree, and would add that the arrangements would not only serve to enhance professionalism in both the public and private sectors. We realise of course that this would be but one strand in the strategy to rid countries in West Africa and elsewhere of the circulation of fake and substandard medicines. Nevertheless it is a vital component. Even if effective controls can be introduced and enforced for the licensing and import of medicines, there needs to be a secure and professionally controlled distribution network, not to isolate and harm, but to enhance the detection of medicines that have been manufactured or imported illicitly.

Of course, there are other major public health benefits associated with pharmacy controlled distribution, including purchase of reputable sources; standardising the medicines in conditions that will maintain efficacy; distribution and supply in accordance with professional standards and legal requirements; the association of professional advice within the community and the ability to withdraw defective products from known outlets.

The situation in extensive rural areas would have to be addressed. In those without pharmacies, medicines should be supplied by persons who have been trained by pharmacists. In the private sector such persons could operate from premises that conform to agreed standards and are regularly inspected, and which supply a restricted range of medicines.

The achievement of such an effective, professionally controlled distribution network requires a commitment on behalf of government to create the legal and administrative environment that will support a regulated pharmacy profession and for the regulated distribution of medicines. It is our hope that this profession will demonstrate to the world in an active and trustworthy manner that its regulatory control can eventually lead to a substantial element of formal self-discipline within the overall regulation of the profession.

This situation exists in a number of our member countries. In some, all medicines are sold or supplied from pharmacies and in others the medicines which are not restricted to pharmacy supply are safe, home remedies, and only for minor ailments.

We will be happy to assist any country that is a part of our international pharmacy association that wishes to introduce a system for the professionally controlled distribution of the medicines, as an effective component within the range of measures needed to ensure the availability of safe and efficacious therapeutic treatments, whether prescribed or purchased for self-medication.

I

NTEREST in drug issues was high at the Forty-fifth World Health Assembly with countries from every part of the world taking the floor during the debate on essential drugs to express their continued support for the essential drugs concept.

The debate opened with a presentation of a progress report by the Director-General on the implementation of WHO’s Revised Drug Strategy: Action Programme on Essential Drugs. The report described a situation in which approximately half of the world’s population still lacks regular access to the most needed essential drugs. It estimated that perhaps over 50% of the developing world does not have regular access to essential drugs, with dramatic deterioration in the developing world over the past decade having made progress difficult. This disturbing estimate for the developing world reflects a situation where poorly coordinated policies and strategies, inefficient procurement, uneven distribution, inadequate assurance of quality, unaffordable prices and improper drug use are often more the norm than the exception, says the report.

The Action Programme on Essential Drugs has made significant progress during the 1990-1994 biennium in addressing these issues. At the Forty-third World Health Assembly in 1990, the Director-General reported that the Programme’s strategies had “had a positive impact on the understanding, acceptance and implementation of the concept of essential drugs introduced by WHO,” but that methods of implementation needed to be improved.

In response to the deepening crises in much of the world, the Action Programme on Essential Drugs intensified its level of country support activities during the biennium, particularly in Africa and the Americas. In the country programmes, human resource development has been a priority: extensive training programmes, in which thousands of health workers have participated, have been carried out in over 30 countries. Operational research has also increased during the biennium, primarily to address obstacles to the successful implementation of national programmes. In addition, the Programme has published numerous technical guidelines and reports, including ones on a new emergency health kit, financing drug supplies, and drug stability, together with various training manuals.

The primary challenge that remains for many country programmes is to overcome the difficult socioeconomic conditions that are currently afflicting the developing world. Most developing countries continue to depend on international markets for their drugs - even though they have less foreign currency because of fluctuating prices for export commodities and high indebtedness. In health sectors that have been weakened from economic conditions and adjustment policies, drugs are often scarce, thereby forcing communities to look more to cost-sharing mechanisms and the private sector to help meet their health care needs. Yet these developments, in turn, have brought a host of other concerns. The most important is equity.

As more experience is gathered on the effects of cost-sharing mechanisms, it becomes clearer that their potential role is limited. Access must be ensured for those unable to pay, and charges should not be placed only on patients when they are ill. Recovery of costs, when tied to drugs, can provide incentives for over-prescribing. Further, rapid inflation and the unavailability of foreign currency to replenish drug supplies weakens the effectiveness of local financing schemes.

In response to worsening financial conditions, many countries are considering privatization of their public drug sectors. Although the viability of privatization, of course, varies with the particular circumstances, many countries are grappling with the difficulty of harnessing the power of private enterprise and directing it toward the goals of public health. However, reaching the most impoverished rural areas and keeping prices affordable are typically public sector goals, and these will be critical in attaining health for all.

Developing country drug sectors have made significant progress, but the needs largely remain the same as those of a few years ago: greater coverage, lower prices, improved quality and better use. The causes of this situation, however, are changing. No longer is the primary cause lack of understanding of the problem. Today widespread socioeconomic deterioration in developing countries is impediment implementing of effective, efficient, sustainable programmes. If socioeconomic difficulties become more intractable, the drug situation is likely to get worse. It is in this context that the Action Programme on Essential Drugs is working, and looking for broader support not only from economic and social partners in development, such as UNICEF, the World Bank and other organizations, but also from the private sector and nongovernmental organizations, in order to provide a comprehensive broad-based effort.

From the floor...

Forty-five countries took the floor to describe the numerous problems they faced in the drug sector such as those relating to procurement, registration, quality assurance and rational use. Developed and developing countries alike spoke of the critical role of the Action Programme on Essential Drugs and called for its continuation and strengthening (see summary resolution in box). Highlights from some of the interventions are given below.

Indonesia said that it was grateful for the assistance provided to it by WHO over the years. In 1979 the Organization had carried out a situation analysis and had helped Indonesia to identify the major problems as being drug proliferation, inefficient drug procurement, storage and distribution, and wastage and loss (due to lack of effective management of drugs within the framework of an integrated and comprehensive national drug information system). A project based on that recommendation was supported by the WHO Action Programme on Essential Drugs for the period 1991-1993. The UK commitments and essential drug policies and programmes were not only integral components of the WHO’s Revised Drug Strategy but were also vital inputs for reforming health services and infrastructures. The Action Programme on Essential Drugs was therefore an important instrument for promoting health services development in the UK and afforded high priority to its activities.

Malawi attached considerable importance to the Action Programme on Essential Drugs, its representative said, since a health service without basic drugs lacked credibility. Furthermore, the essential drugs concept represented a means of achieving more equitable access to safe, effective and affordable drugs and of making considerable savings in a country which already has a very high portion of expenditure for most health services in developing countries. Malawi - with the assistance of the World Bank, the Netherlands and the WHO Action Programme on Essential Drugs - had developed a comprehensive essential drugs programme as an integral part of its National Pharmaceutical Programme. The guiding principles of that programme were contained in Malawi’s National Drug Policy, which emphasized the importance of such a written policy was the centrepiece of a sound essential drugs programme. It was also vital that the key players in a country’s public and private sectors should participate actively in the formulation of such a policy at national level.

The Islamic Republic of Iran said the Organization’s concern about the lack of access to essential drugs in developing countries. In 1990 Iran had initiated a new drug policy aimed at replacing brand-name drugs with their generics, dependent on the availability of generic drugs, achieving national self-sufficiency in producing generic drugs and making essential drugs available to the poor. In spite of some opposition, the Ministry of Health had developed comprehensive guidelines and incorporated in training programmes and a mass education campaign had been launched to increase consumer knowledge and discourage irrational use of drugs.

Malaysia was encouraged by the widespread adoption of the essential drugs concept and the fact that an increasing number of countries had operational essential drugs programmes. Progress would ultimately depend on the level of the country. It had been implementing the essential drugs concept since the inception of the Action Programme on Essential Drugs. The Malaysian Ministry of Health produced a list of essential drugs that were to be used by the public sector. Those drugs were available to the poorer population groups at no cost. Malaysia had implemented the main components of an ideal national drug policy. The quality assurance which included sound manufacturing practices and drug registration, had been undertaken. These included monitoring of the procurement and delivery of essential drugs. This enabled the country to endorse the strategies and activities of the Action Programme on Essential Drugs and participate fully in its programmes, thereby strengthening national capabilities through technical and managerial support to maintain essential health professionals, and public education on the rational use of drugs.

Malaysia said that, as in many developing countries, its essential drug situation...
Essential Drugs Monitor

The development of the new and effective drugs was supported by the Vision 2020 program, which aimed to reduce the burden of disease and improve health outcomes. The program was funded by international donor countries, including WHO and the European Union, who provided technical assistance and financial support.

The success of the program in these areas was evident in the reduction of the disease burden and improvement of health outcomes. The program's success was also attributed to the strong partnerships and collaborations established with local and international stakeholders.

In conclusion, the Vision 2020 program was a significant milestone in the development of the new and effective drugs, and its success highlights the importance of strong partnerships and collaborations in achieving health goals.

The Netherlands expressed its appreciation for the program's success and its commitment to continuing support for similar initiatives in the future. The country believed that such programs are crucial in achieving global health goals and improving the lives of people worldwide.
Essential Drugs Monitor

Summary of World Health Assembly drug related resolutions

WHO Ethical Criteria for Medicinal Drug Prescription

WHO Action Programme on Essential Drugs

The Assembly recognised that well over half the population of developing countries still lacks regular access to the most needed essential drugs and that socioeconomic decline in the years ahead was likely to exacerbate the problem. The Assembly therefore endorsed the essential drugs concept as a means of achieving greater equity of access to safe and effective medicines, the Assembly urged Member States to intensify their efforts to ensure that the required legal, administrative, and financial measures to support the implementation of national drug policies and essential drugs programmes consistent with WHO’s Revised Drug Strategy. The Director-General was asked to intensify WHO’s support in conformation with the mandate of the Action Programme on Essential Drugs, to co-ordinate in formulating, implementing and evaluating national drug policies and essential drugs programmes; to strengthen the role of WHO in providing conceptual leadership and advocacy in the field of drug policy and in coordinating a global effort against the world drug situation and to ensure that adequate human resources are provided to implement the Programme and to find financial resources from regular and extrabudgetary sources.

Harmonising Drug Regulations

Recognising that international harmonisation of technical requirements for drug registration will contribute to reducing the cost of pharmaceuticals, increase their availability and accessibility, and in developing new drugs, while retaining a high standard of quality, safety, and efficacy, the Assembly urged Member States to complete the harmonisation of their national drug strategies, including a full inventory of drugs available in their markets. It also called on Member States to harmonise their pharmaceutical legislation in order to collaborate with drug regulatory authorities and with WHO, in order to achieve the advantages of harmonisation which would benefit all concerned. It asked the Director-General to continue to offer Member States appropriate technical assistance and to further the international harmonisation of drug regulatory regimes.

Proposed Guidelines on the WHO Certification Scheme for Quality Products moving in International Commerce

The Assembly reviewed the report on the implementation of WHO’s Revised Drug Strategy, and in particular the proposed guidelines on the implementation of the Certification Scheme. It expressed the belief that the adoption of the proposed guidelines will contribute to the effectiveness of the efforts of the expert group and countries, including the Council of Europe, and the WHO itself in the field of pharmaceuticals. It also asked the Director-General to continue to implement the guidelines and to issue certificates within five years.
PUBLISHED LATER


The economic aspects of drug supply and use are a key element in national drug policy. This publication offers a framework that enables policy makers and administrators to analyze the economic and financial aspects of pharmaceutical policies based on the essential drugs concept.

The first section provides guidance on the economic analysis of national drug sector and development monitoring through the use of selected indicators. The second section examines alternative methods of financing an essential drug supply with the objective of ensuring regular supplies of drugs and promoting equity and efficiency within the health services. The analysis concludes that resolving the problems of financing drug supply is not just a matter of seeking new financial resources. In many countries these are already available but are not being used to the fullest potential.


The number of people infected with the human immunodeficiency virus (HIV) continues to increase worldwide. Infections and tumours are the paramount clinical problems confronting health care providers caring for patients with HIV-related disease. Treatment of these infections and tumours is of great importance as it decreases suffering and prolongs life in the absence of effective and non-toxic antiretroviral drugs or immunotherapy against HIV itself. However, clear treatment guidelines are lacking in many parts of the world and the health care workers have not been given a clearer guideline in the management of HIV-related disease.

To respond to this situation, the WHO Global Programme on AIDS (GPA) has developed guidelines for the clinical management of HIV infection in adults. There are wide variations in the presentation of HIV-related diseases, availability of resources and health infrastructures. The guidelines are intended to provide a model to assist all countries, but especially those in the developing world, to formulate national guidelines in accordance with their own particular needs and resources.


This book explores the ways in which knowledge about the health impact of development policies can be systematically integrated into the process of policy-making, so that health objectives, along with macroeconomic objectives, are present at the outset of development planning. Noting that three decades of sustained development efforts have failed to improve the lives of the world's disadvantaged groups, the book argues for a change of policy that puts health at the centre of economic choices and development decisions, with the health status of vulnerable groups regarded as a reliable indicator of socio-economic progress. Details range from a discussion of lending schemes that can reduce dependence on welfare to a summary of measures that can mitigate the social costs of structural adjustment. Throughout, numerous case studies are used to illustrate the interactions between health status and economic development in a wide range of settings.


This is a discussion of the safety of medicines from a consumer perspective. It focuses attention not so much on molecules, as on the conduct of the medical profession, government agencies and the drug companies. The book examines drug safety, elaborated mainly through an historical analysis of the marketing and use of hypnotics and tranquillizers. It argues for increased transparency by government, greater responsibility by industry, and better informed prescribers and consumers. Readers are encouraged to provide confidential feedback in the form of their own views and experience of pharmaceutical medicine, using report forms included in the book.


This publication is a handbook for community treatment of onchocerciasis and was written to assist people or organizations funding, designing, implementing or evaluating ivermectin programs. There is a growing body of scientific literature documenting the safety of this new drug and its effectiveness in the prevention of blindness due to onchocerciasis, says author Bob Pond, who worked on the design and implementation of an ivermectin programme in Kware State, Nigeria. However, there is a notable absence of publication which offers practical advice to organizations interested in starting mass distribution programmes. This manual is meant to help fill that gap.

Guidelines for the Diagnosis and Treatment of Malaria in Africa (reports of an informal consultation of experts), AFRO Technical Papers No.22 Rev.1, WHO/AFO, 1992

This is an update of the 1987 guidelines produced by WHO's Regional Office for Africa. One subject, the prevention of malaria complications in pregnancy, had to be completely revised in the light of research findings; the remaining subjects have only undergone final revision. The report provides guidelines for the diagnosis and management of malaria in the rural and peri-urban community without laboratory facilities, staffed by a community health worker; the health institution staffed by a trained medical assistant, and with and without laboratory facilities for making a microscopic diagnosis of malaria; the district and higher level hospitals.


A practical guide to organizing effective pharmaceutical quality control. The publication describes conventional methods and techniques particularly suitable within the context of quality control in developing countries.


Sexually transmitted diseases are among the most common causes of illness and continue to make severe demands on human and economic resources throughout the world. This report of a WHO study group considers the ways in which higher-quality and more comprehensive care might be provided for patients, in particular at the primary health care level, within the broader context of the prevention and control of this disease. The report details the principal components of adequate patient management — diagnosis and treatment, health education, counselling and partner notification, testing for other sexually transmitted diseases and case-reporting — and proposes management protocols for the most commonly encountered syndromes, including those due to chancroid, syphilis, gonococcal and chlamydial disease, trichomoniasis, genital and anorectal herpes, and non-gonococcal urethritis. Annotated to the report are details of laboratory diagnostic methods, treatment recommendations and model forms for case-reporting.


CDHU is a non-profit organization committed to assisting NGOs to obtain low cost, quality generic drugs. This latest publication contains an introduction to the essential drugs concept, WHO's latest model list of essential drugs, guidelines for national essential drugs lists, and the CDHU price list. CDHU also publishes a quarterly National Drug Bulletin.

Guidelines for the Diagnosis, Treatment and Control of Malaria in Africa (report of an informal consultation of experts), AFRO Technical Papers No.22 Rev.1, WHO/AFO, 1992

This is an update of the 1987 guidelines produced by WHO's Regional Office for Africa. One subject, the prevention of malaria complications in pregnancy, had to be completely revised in the light of research findings; the remaining subjects have only undergone final revision. The report provides guidelines for the diagnosis and management of malaria in the rural and peri-urban community without laboratory facilities, staffed by a community health worker; the health institution staffed by a trained medical assistant, and with and without laboratory facilities for making a microscopic diagnosis of malaria; the district and higher level hospitals.


The NED Guide contains prescribing information for all drugs included in the Nigeria Essential Drugs List, classified by generic name and therapeutic category. The guide is distributed free to government hospitals and colleges of medicine and pharmacy.

Available from: Tropics Interpharm Services, 73 Ijora Road, P.O. Box 6043, Surulere, Lagos, Nigeria.
Promoting Health or Pushing Drugs? A critical examination of marketing of pharmaceuticals, HAI, 1992, 46 p.

Do the marketing practices of the pharmaceutical industry help or hinder attempts to achieve rational drug use and introduce sensible public health policies? Self-policing through voluntary industry codes has failed to prevent excessive marketing practices, says this report by the international consumer network, Health Action International.

The report examines all types of promotion, both direct and indirect, and provides many recent examples from industrialized and developing countries. It concludes that the much heralded promotion is misleading and that the main consequence is irrational drug use with its associated health and continually spiralling costs. A number of solutions are put forward: industry codes of conduct should be strengthened, there should be a regular review of WHO's Ethical Criteria for Medicinal Drug Promotion as well as national implementation and monitoring; stronger national legislation to reduce conflicts of interest; and health worker associations can provide codes and guidelines to introduce some distance between the industry and prescribers; decisions about controlling drug promotion have to be made with full public participation since the issue is too important to leave to self-regulation by the pharmaceutical industry, the authors state.

Available from: Health Action International Europe, Jacob van Lennepkade 334T, 1053 NJ Amsterdam, the Netherlands. Price: DE50 for individuals and non-profit organizations, DE60 for profit organizations.


Malaria continues to be a major health problem in many parts of the world, with over 2000 million people in some countries at risk of infection. Delay in treating falciparum malaria - the most serious form of the disease - can result in severe deterioration of the patient's condition, together with the development of life-threatening complications.

This handbook provides practical guidance on the diagnosis and management of severe and complicated malaria. After outlining the general nursing care needed for these patients, it considers in turn the possible complications, including anaemia, renal failure, hypoglycaemia, and pulmonary oedema, and gives specific and concise advice on their management. While intended primarily for physicians and other responsible health staff working in hospitals and health centers in endemic areas, it is also of practical use to physicians in non-endemic areas, who are increasingly having to deal with patients suffering from malaria-related complications.


Outlines the historical development of Gambia’s National Drug Policy, and evaluates impact and areas of weakness.

The study concludes that the essential drug programme is functioning to a limited extent and some progress has been made. However, the main shortcomings of the National Drug Policy relate to human resource development, the provision of information and the training of prescribers in the appropriate use of drugs.

Guidelines for DDD (Defined Daily Dose), The WHO Collaborating Centre for Drug Statistics Methodology and the Nordic Council for Medicines

This includes the main principles for establishing DDDs - the assumed average dose per day for a drug used in its main indication in adults. The Centre notes that, because DDDs do not only have a close connection with the ATC (Anatomical Therapeutic Chemical) classification, it is important to be familiar with the ATC system when looking at the DDD guidelines.

Available from: Department of Pharmacoeconomics, University of Oslo, Norway.

Problem Drugs (Arabic Edition), HAI/Arabian Resource Collective, 1992

What is a problem drug? asks the introductory article to this wide-ranging information kit. All drugs are potentially "problem" drugs, it concludes, since any drug is harmful if misused. What makes a drug a problem is not so much its inherent pharmacological risks, but the way in which it is used, says the kit. In the wrong hands or at the wrong time, even the most carefully quality-controlled medicine can become transformed from a life-saver to a life-destroyer. In some cases the consequences can stretch beyond a single patient or group of patients, to encompass the globe, it says, citing the example of the misuse of antibiotics, which has resulted in many bacteria developing resistance to the cheaper, older drugs.

Drugs do have a role to play in better health - the right drugs, at the right time, at the right price, to the right people. But today’s market place is full of the wrong drugs, claims the authors. So mass distribution of drugs is the inevitable result of a market littered with products which are ineffective, inappropriate, irrational, useless or needlessly expensive, they say.

The kit contains an extensively referenced series of articles which examine some of the problems associated with antimicrobial drugs, antibiotics, analgesics, cough and cold remedies, pregnancy, psychiatric medicines, combination drugs and contraceptives.

Available from: Arab Resource Collective, PO Box 7677, Nicosia, Cyprus.

Dictionnaire européen des médicaments (European medicines dictionary), which includes 55,000 European products in a single volume, is now being published in France. The dictionary comprises four main sections: a list of the principal medicines in 12 European countries (including Austria, excluding Denmark): a list of 3,500 products under their INNs; an index of therapeutic classes; and a list of drugs grouped by therapeutic class, with commentaries and advice on use, definitions of therapeutic forms, and the countries in which they are available. There is also a section on drug interactions and contraindications.


The Action Programme on Essential Drugs cannot supply the publications reviewed on these pages. Please write to the addresses given at the end of each item.


This book provides a visual presentation of selected facts and figures that document the inferior health status of women and illustrate the many gender-specific factors that contribute to health problems and undermine the ability of women to improve their lives.

Facts and figures are used to demonstrate the complex determinants of women’s health status in different countries and at different ages throughout the life span, moving from discrimination against women to the health problems of elderly women.

The book, which is a wide range of sources, draws upon a growing body of evidence that shows how social, political and economic inequities are ultimately reflected in women’s health status. The book also raises a number of questions regarding the implications of women’s health needs for health services, including questions concerning the importance of distance, costs, supplies and quality of health services from a woman’s perspective.


Gina House...Continued from Page 5

There is considerable interest in the course but applicants are entitled to participate in the course in receipt of their own financial support via normal channels for staff development through government and/or agencies funding health care programmes and in particular EDP programmes.

School of Pharmacy is grateful for the cooperation of the WHO Action Programme on Essential Drugs for making this initiative possible.

A second course started on 7 September 1995.

The third course will begin on 1 March 1996. Enquiries to Head of School of Pharmacy, RGIT, Schoolhill, Aberdeen AB9 1PS, Scotland, Fax No. 0224 - 626569.

Mr Paul Spivak is a lecurecurator, Robert Gordon Institute of Technology, Aberdeen, Scotland, UK.

Street Theatre...Continued from Page 5

The quiz master explains and then asks the audience to guess how many drugs are on the list. The answer is a grand prize "the result of thousands of years of pharmacological research and development, vitamin manufacture, and the cosmetic products of which they are available. There is also a section on drug interactions and contraindications.


Important

Further information about the street theatre campaign can be obtained by writing to Jürg Schäfer, Balbo Pharmaka GmbH, August-Bebel-St. 62, D-68060 Biebelich
"Looming crisis" reported by UNICEF-WHO in former Soviet Republics

"The human needs are great, the time for action is now"
UNICEF/WHO mission report

A UNICEF-WHO collaborative mission, which in February carried out assessments of the urgent health and human needs in 14 republics of the former Soviet Union, reports a "looming crisis" in many regions - particularly for vulnerable women and children - which demands an immediate response from the international community. Five mission teams, with the participation of the United Nations Population Fund, the World Food Programme and the United Nations Development Programme, visited 11 republics of the Commonwealth of Independent States and the Baltic States.

Urgent action needed

The mission found varying degrees of crisis in the new republics - which have a total population of over 200 million people - triggered by the dissolution of the Soviet Union, hyper-inflation, poor wages and consequent huge reductions in household purchasing power.

Referring to the situation in the five Central Asian republics, the report stated that the crisis there was "wholly unprecedented, rapidly evolving, and entirely unpredictable in its future trajectory and velocity". It said although large-scale human suffering was not yet visible, "the signs point to the possibility of a sudden and massive collapse of existing systems that could set off a vicious spiral of hunger and disease and political and social disorder".

In the health area, the mission reported widespread disruption of equipment and drug supply, as well as collapse of production due to shortages of raw materials and hard currency. This has led in turn to an imbalanced and inexorably neglected and under-funded health system. There is a need to modernise the disease prevention strategies and immunisation delivery. Technical support in the form of training programmes for health professionals, needs to be undertaken. Hospitals and health centres are in urgent need of technological upgrading, the report said.

Acute respiratory infections, diarrhoeal diseases, vaccine-preventable diseases, tuberculosis and nutritional deficiencies are the dominant child health problems. Medical practices are deficient in breastfeeding promotion, maternal care, the excessive use of antibiotics and drugs of questionable efficacy. Serious environmental hazards causing chronic health problems were also noted by the missions, particularly the use of agricultural pesticides, industrial pollution and inappropriate use of water and the results of nuclear testing.

Drug supply...

One major mission objective was to assess the emergency requirements for drugs that can provide immediate, cost effective treatment for prevalent diseases.

Before the dissolution of the previous USSR, pharmaceutical supply of local and foreign products was centrally planned by the Moscow Central Pharmacy Depot, and distributed to the republics according to availability and needs.

Now, health ministries of the new republics must undertake their own procurement, directly from the manufacturers.

Production facilities are often situated in the framework of the WHO model list of essential drugs. In addition, a rationing system has to be introduced to ensure that the most needed have access to the drugs available.

Medical Working Group on the CIS

A Medical working group on the CIS, co-chaired by France, Japan and the USA, met at WHO in Geneva from 30 April - 1 May 1992 to consider joint evaluation reports. The meeting was attended by some 30 special rapporteurs, representatives from the new independent states, and various international bodies.

Dr Richard Jolly, UNICEF Deputy Executive Director and joint team leader, summarising the mission's findings, said the work had focused on three principal areas: urgent basic medical needs over the short-term, the closely-related medium-term reconstruction of the health care system, and the broader social and economic measures necessary to ensure that urgent human needs are met during the transition process.

"In all of these areas, and in each one of the CIS republics, we found that a crisis is looming," he said. "The number of people affected and the severity of the crisis will depend greatly on the speed and relevance of the actions taken to provide timely well-focused support. This must involve both restructuring priorities at the national level and accelerated international support."

WHO Information Exchange Centre

Following the recommendation of the coordinating conference on assistance to the former Soviet Union, held in Washington, January 1992, WHO has established a "clearing house" or information exchange centre to facilitate the provision of humanitarian assistance to the republics by the international community. The objective of the centre is to act as the hub of a partnership drawing on the strengths of the different partners involved, such as, agencies, countries, such as the United Nations system, organisations such as the EEC, the Organization for Economic Cooperation and Development and the European Bank for Reconstruction and Development, as well as WHO and its partners. The task of the centre is to focus on the task of collating, updating, assessing and distributing information on the status of health needs of the new independent states and drawing these to the attention of the international community.

References
1. UNICEF/WHO press release PR/92/028
3. NIS News, Issue 1, 1992 (the newsletter of the WHO Information Exchange Centre for the new Independent States of the former Soviet Union)

Meeting of the Medical Working Group on the CIS, Geneva, 30 April-1 May 1992

Widespread inappropriate drug use...

A personal report by three mission participants published in the Lancet stated that although the mission's findings have been reported in the press, there is a lack of coordination and little action has been taken. The authors describe widespread and inappropriate prescription for diarrhoea along with an extensive array of antibiotics, anti-diarrhoeal agents, vitamins and steroids. Properly diagnosed patients with pneumonia were given appropriate antibiotics but those were supplemented extensively with drugs of questionable value. Almost all medications were given parenterally, and in many cases, because of the large number of injections this would entail, a central venous cather was inserted for the sake of deferring druging children who were otherwise ambulatory and seemed well. The authors were told by health workers that the average age child receives some 40 injections per year. They witnessed children in hospital with uncomplicated bronchitis or simple diarrhoea, receiving as many as 12 injections and infusions. Even minor illness often leads to hospital admission, and to the hazards of excessive medication and lengthy absences from home, says the Lancet report.

National drug policies needed

Development of a national drug policy has a high priority and the republics need expert assistance in the selection and use of drugs. In all republics it was agreed that the donations should be with