One international attempt to rationalise the provision of emergency medical supplies has been the development of the New Emergency Health Kit (NEHK), which started life in 1984 as a WHO/UNHCR kit aimed to facilitate the response to emergency relief needs. The kit, whose contents, rationale and development are described in this issue, has now been adopted by most relief organisations. Although not originally intended for the acute phase of disaster relief, the kit is increasingly being used for this purpose. In the course of the last six years it has been thoroughly field tested in different parts of the world and, based on this experience, has been modified to better meet needs. The combination of technical, medical and evaluative skills contributed by the international agencies, the NGOs and the non-profit suppliers, which led to the kit’s successful development, demonstrates the potential and the strength of global health collaboration.

Unsuitable pharmaceutical donations are not limited to emergency situations but can also occur as part of more regular donor support. The same problems as those outlined above are being increasingly reported by health workers and administrators in relief and health agencies in developing countries. The reasons vary – many donors wish to help but lack the necessary expertise; others use a philanthropic cloak to offload outdated or banned products and claim tax relief; some recipients regard any gifts as potentially useful, or may not wish to seem ungrateful by refusing what is offered freely. Whatever the cause, the result is often the same: wasted resources and wasted opportunities.

Concerned by this situation the humanitarian organisation Frères des Hommes, in collaboration with other non-governmental organisations, has just published guidelines on pharmaceutical donations to third world countries, which build on and expand its earlier 1984 protocol. The Christian Medical Commission of the World Council of Churches has also been a vigorous proponent of a more effective approach through its guidelines on pharmaceutical donations (EDM-7).

aimed at both donors and recipients. The guidelines emphasise that donations should be restricted to drugs which are included in existing national lists or in the WHO model list of essential drugs, which match national priorities, which are generally labelled, and accompanied by appropriate prescribing information. Drugs shipped internationally incur heavy transportation costs which in some cases could be better used to purchase essential medicines locally.

Although drug donations cannot and should not replace long term national autonomy it is likely that they will continue to populations in distress, whether acute as in the case of the displaced and homeless in situations of natural disaster or war, or whether chronic through endemic economic attrition. Such donations play a double role: they help to meet vital health needs; they also enable the more economically disadvantaged members of the global community to take action that recognises their global responsibilities. It is important for both groups that donated medicines should be useful, safe, and packed in such a way that local recipients can use them rapidly and effectively. Ill considered drug donations, not only fail to help but actually hinder relief to countries in crisis. The New Emergency Health Kit, the drug donation guidelines now available, and the published accounts of how and why donated medicines may fail to meet needs, should provide us with the information and the motivation to ensure that drug donations are valuable and not “poisoned” gifts.

References

43rd WHA reaffirms Revised Drug Strategy

Dr Hu Ching-Li, Assistant Director-General, introducing the progress report on the Action Programme on Essential Drugs, said the evidence was that the Programme's strategies had a positive impact on the understanding, acceptance and implementation of the essential drugs concept.

The need for the Action Programme had been recognised by the World Health Assembly in the mid-1970s because essential drugs vital to the prevention and treatment of diseases, affecting millions of people in many regions of the world, were not available in sufficient quantities, were too expensive or were not effectively distributed and utilised. The International Conference on Primary Health Care at Alma-Ata (USSR) in 1978 had recognised that regular access to essential drugs was a key component of primary health care and, indeed, that it was an indicator of primary health care implementation. The World Health Assembly had specifically requested the Director-General "to establish a special programme on essential drugs" and the operational structure for the Programme had been established in 1981.

From a global perspective access to essential drugs remained critical for reasons which included lack of resources, poor infrastructure and shortages of trained technical and national management staff. Although progress in the formulation of national drug policies and their implementation had been impressive, a vast number of people still lacked regular access to the most needed essential drugs, either because they were not available or because their cost was beyond the reach of most of the rural and urban poor. Many countries had also failed to mobilise the necessary political will to make changes in their drug policies to favour increased availability and use in primary health care. Mechanisms to rationalise approaches for essential drug procurement and use existed in far too few countries.

Dr Hu concluded by highlighting that the economic crisis of the 1970s and 1980s had had a dramatic effect on the health sector in developing countries. The reduction in health benefits, together with limited availability of convertible currency, had led to drug shortages in most countries. In many instances, owing to the disproportionate allocation of resources in favour of urban hospitals, shortages for primary health care were most acute in rural areas. The supply of drugs for primary health care had therefore become a major priority for the countries concerned.

FROM THE FLOOR

Delegates took the floor to express their support for the draft resolution (see box) which reaffirmed WHO's Revised Drug Strategy and called for strengthening of the Action Programme. Many delegations recounted and praised the technical assistance which their countries had received from the Programme, and also described the development of their national drug policies. They called on donor agencies and countries to continue their support for the Programme so that it could continue and expand its valuable work.

DEBATE HIGHLIGHTS

Pharmaceutical exports...

The Netherlands emphasised that, besides WHO, national authorities in industrial drug-exporting countries had a special responsibility to help combat irrational drug use in developing countries. It was encouraging that the draft resolution on the Action Programme recognised that responsibility, among other things, by its reference to ethical criteria for drug promotion. The Netherlands and its European partners would actively seek to prevent the export of unlicensed medical drugs to developing countries. In that connection, regulatory agencies in developed countries might usefully assist developing countries in setting up certification and quality control schemes.

African Preferential Trade Area...

Zambia stated that it had recently become the focus for a joint WHO/African Preferential Trade Area (PTA) initiative to improve good manufacturing practices, quality control and the implementation of the WHO Certification Scheme on the Quality of Pharmaceutical Products moving in International Commerce in 16 states in eastern and southern Africa. The PTA would also cooperate on the rationalization of production, harmonization of regulatory procedures and freer trade within the area.

International Nonproprietary Names (INNs)...

Cuba welcomed the emphasis on the use of International Nonproprietary Names for drugs in preference to commercial names. The use of the former had caused no problems in Cuba.

Role of the Action Programme...

Denmark, speaking on behalf of the five Nordic countries, said that the Action Programme was one of the most important of WHO's programmes. It had been highly successful in promoting the essential drug concept and backing the formulation of national policies and supply of essential drugs of good quality at the lowest possible cost.

The external evaluation of the Programme in 1989 had confirmed its achievements. It had recommended that WHO should intensify its work in the promotion and advocacy of the Revised Drug Strategy, with its global aspects focusing on the rational use of drugs, and that WHO should increase its research activities and technical support.

Proposals to strengthen the Action Programme

(introduced by the Director-General's Report on the Action Programme on Essential Drugs to the 43rd WHA)

Integrated approach

Promotion of an integrated approach at all levels of the health care system and the establishment of formal links with other WHO units and programmes

Cooperation

Development of more effective mechanisms for coordination between WHO, UNICEF and donors in order to ensure effective support of national primary health care programmes.

Rational use

Further promotion of the Revised Drug Strategy, focusing on the rational use of drugs, in collaboration with other WHO units and programmes.

Advocacy

Further promotion and advocacy of the essential drugs concept as a technically sound and realistic approach to rationalizing drug supply systems and to extending access to essential drugs for whole populations.

Operational research

The extension of operational research to new areas, if sufficient funds are available.

Management

Work plans and targets will be set, and indicators developed for monitoring progress. Relations with WHO regional and country offices will be reviewed to create greater sustainability of support for country programmes. Other WHO units and programmes will be consulted and their experience used.

The Programme will stimulate countries to monitor the effectiveness of the implementation of essential drugs programmes.

The world drug situation will be reviewed, using improved methods to monitor progress.
In the interests of sustainable and comprehensive national drug policies. The Nordic countries fully endorsed the recommendations of the evaluation report and were pleased to note that the Director-General had done likewise. It was imperative that the Essential Drugs Programme not be designed as a vertical programme to solve financial and logistical problems but as one providing all people with the most appropriate drugs at the lowest possible cost. To that end it was not the drug itself that was important, but the cure of state of good health. For that reason the rational use of drugs was a matter of priority, and that implied changing or improving the habits and attitudes of health personnel and consumers. There was consensus for improving drug supply in many essential drugs programmes into the health care systems, particularly at the primary health care level, as well as into the medical education system.

It was clear that the majority of people in the developing countries were still denied adequate access to essential drugs. Experience showed that governments faced enormous political and economic pressures from various national and international interests, and that the role of WHO in providing moral, political, and to some extent financial support to countries could be crucial.

Some members on the formulation of the Action Programme, which it had helped to fund, had produced useful findings and recommendations. The essential Action Programme lay in the utility of its objectives. Those were the following: to help countries to prepare and implement a pharmacological policy, to secure an adequate supply of all essential drugs and appropriate drugs of good quality at the lowest possible cost and, thirdly, to help countries to improve the training given to medical and nursing staff and to improve the quality of information on drugs. The Action Programme was supposed to be an essential part of WHO's Revised Drug Strategy, which remained useful and pertinent. It was time for it to be made explicit in the implementation strategy, together with the concept of essential drugs and the need for full support of health care in all countries. The essential drugs concept should therefore not be restricted to the area of primary health care and need not be incompatible with free market practices.

National sovereignty

The Federal Republic of Germany put the view that although the Action Programme was an important instrument for improving drug supply in many countries, especially developing ones, there were some in which the health care systems were affected, the country, the economic situation and the research capacity would make it advisable to carry out a national risk-benefit analysis of a given drug.

The United States of America strongly endorsed the programme, and the countries’ principlers in establishing their own essential drugs lists and implementing their own essential drugs programmes, even though WHO could be of great assistance.

Traditional medicine

Lesotho said that considerable research was needed in the area of traditional medicinal plants, and hoped that such research would be welcomed. African countries continued to buy large quantities of raw materials outside of Africa and it would be helpful if such purchases could be reduced. Zambia also requested that WHO assist countries in the African Region to exploit indigeneous traditional medicinal herbs which could replace or supplement conventional drugs.

Role of the pharmacists

Japan said that pharmacists, or dispensers where there was no pharmacist, should play a more active role in promoting the rational use of drugs and drew attention to the findings of a meeting on the role of pharmacists in the health care system that had been held in New Delhi in 1988 (see details of report under Published Lately).”

WHO Action Programme on Essential Drugs

The Fourty-third World Health Assembly, Reaffirming resolutions WHA37.32, WHA37.33, WHA39.27, WHA41.16, WHA41.17 and WHA41.18, Having reviewed the Director-General's progress report on the WHO Action Programme on Essential Drugs; Noting the growing recognition, in particular by the national authorities concerned, of the concept of essential drugs as a means of encouraging the rational use of drugs, facilitating access to essential drugs for all, and improving health care while containing health costs; Recognizing with satisfaction the increasing awareness of all parties concerned of their responsibilities, as mentioned in resolution WHA39.27, in the implementation of the revised drug strategy; Stressing the importance of having drug policies as an integral part of primary health care and the other components of health care systems, as appropriate to the needs identified by Member States, as well as the importance of the interaction between the Action Programme and other WHO programmes, and between WHO and other agencies concerned; Acknowledging the activities of the Programme Board’s Committee on Drug Policies and those of the Action Programme’s Management Advisory Committee; 1. ENCOURAGES all parties concerned to promote the implementation of the revised drug strategy; 2. REAFFIRMS the need for the Action Programme on Essential Drugs to strengthen its activities, in conformity with the revised drug strategy; 3. URGES Member States:

1. (i) to support, or to continue to support, the Action Programme on Essential Drugs;
   (ii) to cooperate in the exchange of information and experience concerning the formulation and implementation by Member States of their drug policies and the development of essential drugs programmes as part of their health care strategies, particularly as regards primary health care;

2. INVITES bilateral agencies, multilateral agencies inside and outside the United Nations system, and voluntary organizations, to support developing countries in setting up and carrying out programmes aimed at ensuring the rational use of drugs, particularly essential drugs programmes, and thanks those already doing so;

3. REQUESTS the Director-General:
   (i) to strengthen his support for the promotion of the essential drugs concept as part of the revised drug strategy;
   (ii) to ensure, in collaboration with the Executive Board, that the revised drug strategy is adequately documented in the Forty-fifth World Health Assembly on the use of the ethical criteria for drug promotion endorsed by resolution WHA41.17, and that progress made and plans for implementation of the revised drug strategy, the report to cover drug supply, prescribing practices, development of human resources, training of relevant health personnel on the rational use of drugs, quality

DG's report to WHA

In his report on the work of WHO, the Director-General pointed to the fact that 50% of the 50 million deaths each year are not counted and that nearly 80% occur in developing countries. He cited diarrhoeal diseases, acute respiratory infections and tuberculosis as causes of much preventable mortality, while water, the ancient pest killer was cardiovascular disease. Immunization coverage, although still low, was improving. He said that other serious threats to human life were the new acute global problem of AIDS, and the spread of drug abuse, especially among young people. "Unless current trends are arrested, some 200 million people may die prematurely in the 1990s from preventable diseases and avoidable causes of death," he warned. "In spite of all technological and economic progress, especially in the developed world, for the majority of the population in many developing countries, the basic conditions for health care, health education and daily living remain unacceptable. They still carry the double burden of non-communicable diseases, with infectious diseases, while facing many of the degenerative diseases prevalent in the developed world and associated with development."

"Everywhere the world is facing pollution and loss of natural resources, while water, the vegetation, and even genetic diversity — with many unknown consequences for human health. The health issues of the 1990s cannot be dealt with in isolation!" he stressed. "They are intrinsically related to issues of development and social equity. We must strive to close the gap both within and between nations. Unless we, and the entire international community, are able to co-operate, we will not succeed in taking advantage of our efforts on behalf of these populations, we shall only see a widening of the gap between rich and poor, the ‘haves’ and the ‘have-nots’.

Dr Nakajima informed the Assembly that five programme areas had been identified as needing “added emphasis because of their critical influence on the rest of what we do.” These were:

* nutrition;
* educational information;
* the relationship between health development and national/global cooperation;
* the relationship between the environment and health;
* the relationship between control of diseases of public health importance and overall development.

He drew attention to the progress report on the Essential Drugs Programme and emphasized that “the success of disease control programmes is dependent on the availability of affordable drugs.”
NGOs state their views

Medicus Mundi International

Dr Eidehenn said that Medicus Mundi International comprised seven national branches and various international organizations. It had 600 physicians working in the Third World and contributed to health care throughout Africa and Latin America.

Medicus Mundi International had always considered that distribution of drugs was crucial and had supported WHO's Action Programme on Essential Drugs since its inception. Medicus Mundi Suisse had negotiated with the Swiss pharmaceutical industry in an effort to ensure that essential drugs could be made available at reasonable prices.

Detailed analysis had shown that export of drugs required legislation, since normal information channels had proved ineffective to ensure adequate controls. Only drugs registered in the country of production should be exported and all information provided on those products should be identical in both the country of production and recipient countries. In addition to such controls, the Organization recommended that importing countries should insist on seeing the registration documents from the producing country before approving any import. Importing countries should also obtain documentation from WHO regarding certification of quality and test results, and making sure the movement of drugs was not moving in international commerce.

Through such international controls, the export of unnecessary, useless and sometimes dangerous drugs could be avoided, as could unnecessary prescribing.

International Pharmaceutical Federation

Mr Blaek said that his organization represented 67 national pharmacists' organizations in 47 countries and 400-500 pharmaceutical manufacturers worldwide. For many years IPF had been involved with pharmacies working in developing countries. Special discussion forums dedicated to such countries was held during the Federation's annual congress.

The report and draft resolution emphasized the need for effective quality assurance of marketed products. The training and skills of experienced pharmacists were indispensable on matters relating to drug procurement in the public sector and to ensure that products of good quality were obtained at competitive prices to serve the public interest.

The pharmacist had a specialist role to play and should be recognized as an important member of the health care team.

He stressed that it was desirable for national and international authorities to cooperate in establishing traditional attitudes towards some medicines as an essential and indispensable part in all problems concerning pharmacy and pharmaceutical preparations.

International Federation of Pharmaceutical Manufacturers' Associations

Dr Arnold reaffirmed the commitment of the pharmaceutical industry to work in close cooperation with the Action Programme to improve the availability and proper use of effective medicines of high quality in countries where current supplies were seriously inadequate. Over the past year IPFPA had been working to improve collaboration between the pharmaceutical industry and WHO in fulfillment of WHO's agreed policies. One result had been the elaboration of an IPFPA Memorandum of Intent, mentioned in the Director-General's report.

IPFPA believed that in its work with the Division of Drug Management and Policy, particularly the Action Programme on Essential Drugs, the emphasis should be on bringing pragmatic and lasting help to developing countries in solving those health problems in which drugs played a major role, including the important issue of drug quality.

At a symposium organized by IPFPA in December 1989, with the participation of a number of WHO staff and some 100 industry personnel, more than 130 recent and current collaborative projects involving the industry and developing countries had been reviewed with the aim of identifying opportunities, encouraging future collaboration and drawing useful lessons from past collaboration. The proceedings would be published shortly and would be made available to national health administration and to other national and international interested parties on request.

World Federation of Proprietary Medicine Manufacturers

Mr Reifstein said that WPPMM had 33 national member associations which comprised manufacturers of non-prescription medicines in developed and developing countries. WPPMM recognized that, for lay consumers to understand and use medicines sensibly, they required easy access to appropriate information. Consequently, the Organization was heavily involved in supplying consumer information on the appropriate use of non-prescription medicines, including promotion of home safety by encouraging people to use medicines properly and keep them safely.

Many of the member associations had conducted attitudinal and behavioural consumer studies to determine what people do when faced with minor ill health. The studies revealed that they were cautious in their approach to the use of medicines and generally responsible in their practice of self-medication. However, there was a need to learn more about behaviour and attitudes to self-medication and self-care, taking particular account of and respecting its root in local established traditions and local theology. Traditional medicines were of major importance in many countries of the world, both developing and developed. WPPMM was cooperating with the WHO Programme on Traditional Medicine, with the aim of developing guidelines for their evaluation. The Federation encouraged and supported an understanding of the use of traditional medicines, in particular, within primary health care.

Essential Drugs Monitor

WORLD HEALTH ASSEMBLY

NATIONAL DRUG POLICY

Burundi: Update on National Drugs Policy

SINCE 1987 WHO's Action Programme on Essential Drugs, Interpharma and UNICEF have been collaborating with the Government of Burundi in the development of its national drug policy and essential drugs programme. At a joint progress review in mid-1989 it was decided to convene a national meeting to thoroughly examine current drug policy, and identify problems, constraints and practical solutions.

A multidisciplinary meeting...

As a result, over 70 high level decision makers from the Prime Minister's office, the Ministries of Public Health, Social Affairs, Information, Finance, Commerce and Industry, the armed forces, the health insurance scheme, the University, the National Bank, together with representatives from professional organisations, private physicians and pharmacists, met from 25-5 May 1990 in Bujumbura. Representatives from WHO, Interpharma and UNICEF also participated in the meeting, which was financially and technically supported by the Action Programme.

After introductions and an overview of the National Essential Drugs Programme and the WHO Action Programme on Essential Drugs, discussions centered on five major areas: drug selection and quantification, procurement and quality assurance, distribution and legislation, accessibility, and rational drug use. Following a short expose on each topic, participants were divided into small groups and asked to examine a specific sub-theme, and later present to the plenary session their findings and recommendations. This method of work made it possible to look in depth at problem areas and for people from different institutions and ministries, who normally have little or no contact with each other, to exchange views and experience.

A working group session at Burundi's National Drug Policy Meeting.
Myanmar develops national drug policy

Health Minister opens landmark Yangon meeting

OPENING Myanmar’s first National Drug Policy Meeting, Minister of Health, Dr U Pe Thein, spoke of constraints such as drug shortages, a weak distribution system and irrational use. It is the rural areas, he stressed, that face the greatest shortages. With the help of WHO, developing countries are now being assisted in the development and promotion of drug policies, appropriate selection and procurement, and the rational use of drugs. The positive results of this work had led to the Government’s decision to follow the WHO guidelines and develop a drug policy relevant to the country’s needs, within the context of the Myanmar National Drugs Programme.

The Minister emphasized that the availability and use of medicinal drugs necessitated the active involvement of many authorities in addition to the Ministry of Health. Departments such as Trade, Planning and Finance, Industry, Labour, Cooperatives, Home and Religious Affairs, all had an important role to play and would need to cooperate closely in fulfilling their responsibilities for such activities as importation, production, finance, purchase, distribution and regulation.

Frank and comprehensive discussions

Over 60 participants from a wide professional spectrum encompassing doctors, pharmacists, economists, nurses, pharmaceutical manufacturers, health educators, planners, administrators, and legal experts engaged in a frank and comprehensive dialogue from 10-15 July 1989. Changes that would result from the country’s newly announced “open door” policy of free market development stimulated particularly lively discussion. While other major focuses of debate ranged from problems of pharmaceutical supply, management and use within the national and international context, areas of collaboration, to priority action for improving drug availability. The meeting alternated plenary with working group sessions, so that both an exchange of views on broad areas of concern and detailed technical discussions could take place. Representatives from WHO’s Action Programme and the WHO Regional Office for South-East Asia also participated as resource persons and working group facilitators.

Outcomes

The meeting had two principal outcomes:

one, a draft national drug policy document covering, inter alia, drug legislation, quality assurance, the supply system, production, rational use, information and marketing, traditional medicine, training, research, allocation of financial resources, monitoring and evaluation, and technical cooperation between countries. This draft policy document has been formally submitted to the Government and is presently under review;

two, recommendations, addressed to the Government, on priority action which called for:

Improving supply...
The constitution of an interministerial committee to suggest immediate measures to improve the supply of medicines;

Retail outlet registration...
The registration of all retail shops selling medicinal products, with the sale of drugs preferably by pharmacists;

Drug registration...
The importation, or local manufacture, of drugs which are registered;

Regulatory control...
A committee to study the regulatory control of medicinal products of local and foreign manufacture, the establishment of a Drug Regulatory Authority, and the improvement of quality control;

Pharmacy training...
A review and appropriate modification of pharmacy training in view of the expanded role of pharmacists in the management of the pharmaceutical supply system, quality assurance, production and drug information;

Rational use...
A review and modification of training of medical and paramedical personnel to incorporate the essential drugs concept and promote the rational use of drugs;

Local production...
Fiscal incentives to promote local production, the modernization of technology for the local manufacture of essential drugs, and the introduction of WHO’s good manufacturing practices (GMP);

Legal enforcement...
The strict enforcement of existing legislation and regulations relating to the manufacture, sale and promotion of pharmaceutical products.

A rare opportunity...

The meeting had been a great success, concluded participants at the end of the week. The adoption of a national drug policy would represent a major step towards a better and safer drug supply; while they themselves had benefited from a rare opportunity to examine a broad range of pharmaceutical issues within an interdisciplinary context.

* In 1989 the Union of Burma changed its name to Myanmar
Monitor readership now over 160,000 world wide

We should like to thank the hundreds of readers, who as part of a randomized sample, received and returned the readership survey questionnaire. We are particularly grateful to those of you who wrote additional comments and shared your ideas about how the Monitor could be an even more effective source of information.

What did we learn from the survey?

We gained a much better picture of the work and needs of you our readers.

We learned that you like the Monitor; that you find it contains a good balance of technical and general information; that you consider it to be reliable and unbiased; that it is useful in your professional life and that it contains information not available elsewhere.

We discovered that the Monitor's 14,000 subscribers reflect only a small percentage of the actual number of readers, since there are on average eight readers for each subscriber. In addition another 7000 copies of each issue are printed for distribution at workshops, seminars and international conferences, which also adds to our readership. It appears from the survey that the global Monitor readership is already in excess of 160,000, a figure which is fast growing with the ever increasing number of subscription requests that we receive in the Action Programme.

Readership profile

One of the reasons for the survey was to find out more about you, our readers: who you are, what you do, where you work, so that we could have a better idea of how to meet your needs. The readership profile charts summarise these data.

Although for reasons of priority and needs Action Programme support to national programmes is directed towards developing countries, we are glad to have a sizeable proportion (43%) of Monitor readers in the developed world. Not only is the rational use of drugs a question of global concern but the whole chain of research and development, quality control, drug supply and marketing necessarily crosses national and North/South boundaries.

25% of readers are either doctors or pharmacists, which is unsurprising, but the remaining 25% represent a wide professional spectrum ranging from nurses, public health administrators and educators, to health development workers, scientific journalists and government officials. Readers' work covers policy making, management, education and training, pharmaceutical production, communications, and grassroots primary health care.

Our respondents generally had a very high level of education, which created an initial reaction of some concern that perhaps we were addressing an audience of the educational elite. However, since more than eight people on average read each copy, it seems likely that although the official subscriber is a relatively senior person, the journal is shared with more junior colleagues representative of a wider educational range. Why not write and let us know more about who else reads your copy of the Monitor?

Teaching with the Monitor

Questionnaire comments also reinforced what has been increasingly apparent from readers' letters, namely that the Monitor is often used in teaching situations, whether as part of formal academic programmes, as source material for workshops, or during routine training of PHC staff (see picture from Nigeria on page 7). If you use the Monitor in this way please write and tell us about it. We also appreciate being informed when articles are reprinted or translated. Sometimes we learn quite by chance that a Monitor feature has been reproduced elsewhere. We are always glad when our information reaches a wider audience but we do appreciate having its source credited and receiving a copy of the publication in which it appears, since this helps in evaluating the impact of our communications work.

Readers' ratings

An overwhelming majority of readers (89%) find the Monitor useful in their professional life, with another 10% neutral on this subject. 57% consider that it contains information not available elsewhere (36% neutral) while 46% stated that it influences their professional decision making (42% neutral). Most readers (71% with 23% neutral) believe the Monitor to be unbiased, while 90% (9% neutral) find it a reliable source of information.

In addition to finding the journal of professional value, readers are also strongly positive about the balance and content of technical/general material, writing style, layout and graphics. Book reviews tended to get a lower rating than other aspects of the journal and regular readers will have seen that these have been much more comprehensive in the last two issues. Although the book page always carries the request that readers should write to the address given at the end of each item and not to the Action Programme we still receive many requests each month for publications reviewed. We cannot meet these requests and they create a large amount of extra work for our hardpressed staff. Please therefore write to the addresses given and not to us.
Number of issues
Many respondents asked for the Monitor to appear more frequently. Others state that they are not regularly receiving every issue. In fact, the journal has been appearing on average twice a year, and you can always check whether you have missed an issue from the number appearing on the first page. The issue you are now reading is the tenth to have been published since the Monitor's inception. We share your wish for more frequent publication but are constrained by the resources we have available.

Format
Some readers would prefer an A4 type format since this would facilitate photocopying and filing. We understand this viewpoint but one of the reasons that a larger format was originally chosen, together with the Monitor's distinctive green border, was precisely so that it would catch the eye and not be filed away. Additionally the larger format means that it can be used for a display, as was done at the Myanmar National Drug Policy Meeting (see photo above).

Some of you question why the Monitor is printed on such thick paper. We do this so that it will have a better chance of surviving the difficult and humid climatic conditions of many developing countries, and also being passed from hand to hand.

Content
We received suggestions for literally hundreds of subjects you would like to see covered by the journal. Many of you are interested in the development of national and essential drugs policies in different parts of the world. We already give considerable coverage to national programmes and will continue to do so. Some readers requested more technical information concerning drug selection, interactions, side effects and appropriate pharmaceutical therapy for specific illnesses. The Monitor cannot replace the technical reports and bulletins, therapeutici guides and pharmacopoeia which are the appropriate source of such information. What we can, and will increasingly try to do, in this and other technical areas is to provide a general review of the issues involved, and offer pointers to good sources of more comprehensive and detailed data, or regional and national initiatives. You also ask for more information about education and training initiatives, and many of you are interested in research taking place in the field of essential drugs and rational use. We hope to publish more on these areas in future issues. Finally, a number of readers drew attention to the importance of traditional medicine. We plan in future to examine regularly issues related to traditional practice, the use of medicinal plants, and essential drugs programmes which incorporate traditional with western systems of medicine.

Write to us...
Don't forget that the Monitor was conceived as an interactive and not a one-way medium. Write and let us know what is happening in your country or professional area to promote the rational use of medicines and tackle problems. If space permits we will share this information with other readers.

Finally, thank you all, once again, for your interest in the Monitor, your encouragement and your ideas.

Essential injections and no others
Drugs are not only expensive and have side effects, but the method of use can also add both cost and risk. Essential drugs, yes, but let us campaign for safer use. Only essential and sterile injection should be given; pills and syrups are safer. Unsterile injection cause abscesses, transmit malarial parasites, Hepatitis B Virus (HBV), Human Immunodeficiency Virus (HIV), Eboea Virus and can precipitate paralytic poliomyelitis, yet few sterile needles and syringes are used.

We know a little about who gives injections! but scarcely anything about who receives injections, what is injected and why. We do know, however, that many children with a fever, and some with diarrhoea are given an injection of antibiotic or anti-histamine, and injections are often repeated.

Doctors say that patients demand injections. However, although doctors in Togo said that mothers wanted injections for their children, when questioned, two thirds of the mothers preferred syrups and only 10% preferred injected injections.

Adults may continue to prefer injections but mothers, on behalf of their children, may be more responsive to health messages concerning the dangers of injections.

Health worker vaccinating in Ethiopia.

Medical students, nurses and doctors must be constantly reminded that injections can cripple, injections can kill. When traditional healers and primary health workers are trained for medical work, we must emphasise the dangers of injections. Child to Child programmes and all teaching of mothers must emphasise the benefits of syrups for children.

Essential drugs, essential injections and no others: the message is crucial.

Dr H.V. Wyatt, 1 Holholyoke Terrace, Leeds LS17 7BG, United Kingdom.


LETTERS TO THE EDITOR
PHC Workshop at the Federal Tertiary Institute, Iny, Nigeria.

Teaching PHC in Nigeria
You may be interested to know that we use the Essential Drugs Monitor for teaching purposes, as you can see from the photograph of a recent workshop. We often use the Monitor to let the community know that similar activities are taking place in different parts of the world and that intervention strategies depend on the nature and dimension of the problems and the available human and economic resources.

The work of the Federal Tertiary Institute here in Iny is solely centred on the rural areas and thus, unlike some other regions, the rural dwellers happen to be the more privileged beneficiaries of health care. In our institute we have nursing and midwifery departments which work closely with the public health unit. We try as far as possible to enlighten the community on the factors which influence their health and preventive strategies. We also try to use simple visual material such as posters, flower cards and models to add impact to the message.

In our teaching programme we aim to involve a wide disciplinary and geographical range of health care personnel and students. In this way we gain a greater insight into existing problems and can arrive at long lasting solutions. After a teaching session each group returns to its community to disseminate the information and knowledge acquired.

For example, the group in the photograph is discussing issues related to primary health care and focusing on the topical issue of procurement, prescribing and dispensing of essential drugs. We also discussed at length in the same session the preparation of oral rehabilitation solution (ORS) using different types of native soups. This discussion led us to examine local beliefs regarding the therapeutic efficacy of some indigenous herbs, roots and leaves, although it has not been possible to conduct any laboratory analysis or scientific research in this field due to lack of financial resources.

We look forward to continuing to receive the Monitor and to sharing the experience of colleagues in many different disciplines and countries.

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The first issue the Monitor, published in 1985, was less than one third the size of today's publication.
TRADITIONAL MEDICINE

Medicinal plants and primary health care: an agenda for action

Olayiwola Akerele *

Traditional medicine has been practised for the last several thousand years but found a place in the WHO programme only 14 years ago.

Traditional medicine, in one form or another, is widespread throughout the world. Its practices are based on beliefs that were in existence, often for hundreds of years, before the development and spread of modern scientific medicine and that are still prevalent today. As its name implies, it is part of the tradition of each country, where it is handed down from generation to generation. Its acceptance by a population is largely conditioned by cultural factors and much of traditional medicine, therefore, may not be readily transferable from one culture to another. What WHO encourages countries to do is to identify and exploit those aspects of traditional medicine that provide safe and effective remedies or practices for use in primary health care.

In some countries, traditional medicine is an integral part of the formal health system, on an equal footing with modern medicine. In others, this is not the case and traditional medicine, although important for individuals and communities, remains a form of private practice outside the formal health system, one that cannot easily be organized by government. What governments can do is to ensure that the practice of traditional medicine is not harmful, and to foster those aspects that are useful in keeping with the beliefs of people. Governments can also help to develop the economic potential inherent in plants of medicinal value.

Medicinal plants are a small but important part of the biological heritage of the earth. Traditional societies place a high value on this inheritance, which they express through their intimate relationship with nature. What is significant is the growing recognition from the industrialized world that these so-called traditional values are valid for all people. Responding to the environmental and ecological deterioration that threatens health and development everywhere, a worldwide movement has arisen to awaken people to the dangers facing our planet and to help preserve its integrity.

Primary health care and medicinal plants

Primary health care requires the utilization of all appropriate and available local resources which, in developing countries, almost always include traditional medicine and its practitioners. Where traditional medicine is well patronized by communities, it makes good sense to adopt safe and useful traditional practices and incorporate them in the design and implementation of national health systems. However, this means putting traditional medicine on a scientific basis. Countries must make a critical examination of the local materia medica and practitioners, accurately identify the plants and other natural substances employed, decide which remedies and practices are useful and suppress those which are patently ineffective or unsafe. This means a lot of work but it is worth it. It is an undeniable fact that in today's world herbal medicines play a vital role in the health care for large sections of the population, especially in developing countries; in many cases, they bridge the gap between the availability of and the demand for modern medicines.

The use of medicinal plants in traditional medicine finds its natural expression and further development in primary health care. It is at this level that the transition from traditional practice to medical care can most easily be made. In China, for example, medicinal plants are an integral part of the formal health system and are used in about 40 per cent of cases at the primary care level. Formally, medicinal plants were mostly collected in the wild, but as more land is brought under cultivation, the natural sources are becoming depleted. Special encouragement has, therefore, been given for the cultivation of medicinal plants, and agricultural departments at all levels take part in formulating policy and establishing plantations, which now cover some 200,000 hectares.

Medicinal plants in national development

The attention paid by health authorities and administrations to the use of medicinal plants has increased considerably, although for different reasons in different settings. In the developing countries, this has largely resulted from a decision to take traditional forms of medicine more seriously and to explore the possibility of utilizing them in primary health care. In other countries, the health authorities have been compelled to react to the great surge of public interest in the use of herbs and plants.
TRADITIONAL MEDICINE

The contrast between the situation in developing countries and that of the developed world presents a challenge to the national health authorities. Whereas it is acknowledged that the tropics are a rich source of plants with medicinal properties, the study and knowledge of these properties remain largely in the hands of the industrialized countries. For example, the United States National Institutes of Health (NIH) will collect for study 4500 higher plant specimens per year during the next five years from African, South American, and southern Asian tropical countries. The specimens are not being collected randomly; this will be a deliberate attempt to use local knowledge of traditional medicines to focus on those plants that are or have been used for their medicinal properties.

Countries wishing to make full use of their heritage of traditional medicine, including the wealth of medicinal plants which most of them possess, thus have a special interest in sponsoring ethnomedical studies, bringing together botanists, clinicians, pharmacologists and others for the purpose of assessing and realizing the potential of developments in this area.

These studies would include making a review and an inventory, on a national basis, of the utilization of medicinal plants and of medicines derived from them. Such inventories, still to be made in many countries, would need to describe the geographical and climatic distribution of these plants, their source (collection from the wild, cultivation in situ or ex situ in botanical gardens, commercial plantations, etc.) and an indication of their relative abundance or scarcity.

For each plant there would be an account of its utilization (e.g. folk medicine, traditional healers, pharmaceutical or food industries) and its place in commerce (e.g. local use, internal trade, export). There would also be a description of the preparation of traditional remedies, their constituents, pharmacological properties, and therapeutic indications.

Conservation

Logically, the investigation, utilization and exploitation of medicinal plants by a country should include measures for conservation. Conservation and inventories of medicinal plants should go hand in hand, the latter being essential for the identification of endangered species, for setting priorities, and for monitoring the situation.

On a plant-by-plant basis, pharmacological and clinical studies could be carried out to assess their safety, therapeutic efficacy and potential for commercial utilization, leading to the development of policies for their conservation. This wide-ranging programme of activities has important developmental and technological ramifications. Few developing countries can afford the luxury of esoteric studies; national resources are too scarce and competing priorities too great in most instances. Pragmatism should be encouraged and opportunities for linkages with other interests must be seized. Where agriculture and forestry departments are developing national resource maps, medicinal plants can be added to them. Where universities and research and development institutions are involved in the study of the environment and ecology, a place can be found for medicinal plants, especially those whose survival is threatened. Where em-phasis is placed on the development of small local industries, the industrial potential of medicinal plants can be given priority. Where ministries of education are seeking innovative approaches for teaching the natural sciences or for promoting knowledge of traditional values, the use of local medicinal plants can be incorporated into school curricula.

What is needed is, therefore, to take a comprehensive approach to bring together the main disciplines and interests concerned—health, agriculture, industry, trade, universities—and find some form of coordinating mechanism. Such a body would assess needs and priorities, formulate policies to mobilize resources, and ensure the orderly development of work and research in this field.

The priority to be given to this subject can be argued rationally in modern terms of utility and economics but one must not forget the cultural importance of traditional medicine. Many traditional cultures are being threatened by new values, some modern and some foreign. Governments concerned with safeguarding national identity and well-being will wish to explore traditional medicine with this intent. In the same way that the genetic richness and diversity of tropical plants ensures their greater biological potential, mankind should look to its own cultural diversity as a source of strength for future development.

Part 2 of this review, which will look at WHO’s role in Traditional Medicine and transfer of technology, will be published in the next issue.

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Medicinal plants featured in new issue of UN stamps

In May 1990 the UN Postal Administration issued a new set of six commemorat-ive stamps on the theme "Medicinal Plants". This stamp issue is intended to honour the work of the United Nations Industrial Development Organization (UNIDO) in its quest to make essential drugs widely available in developing countries by concentrating on herbal medicines on an industrial scale, in order to provide a low-cost alternative to the more expensive conventional synthetics used in industrialized nations.

UNIDO programmes on the industrial use of medicinal plants started in 1976 with a "mobile unit" of experts visiting several countries in Asia and Africa. This was followed by the launching of several individual technical assistance projects. One such project involving medicinal plants was started in Turkey in 1983 when the Turkish Government asked for assistance in setting up a pilot extraction and processing plant. By 1986 the pilot plant and a quality control laboratory were operational in Es-kerith along with an information service to help local pharmaceutical firms. These activities are spearheaded by the Medicinal Plants Research Centre at the University of Anatolia in Eskerith.

Other major technical programmes to assist developing nations to generate pharmaceuticals from raw plant material have been launched in several countries, including Nepal, Tanzania, Burkina Faso, Thailand, North Korea and Viet Nam. These programmes stress the importance of research and development required to facilitate the technological processes involved in the preparation of pharmaceutical products.

An illustrated booklet on the subject of medicinal plants has been published by UNPA Geneva, compiled with the help of the Geneva Botanical Gardens and the University of Illinois, Chicago.
A sizable disaster does not always lead to an objective assessment of the emergency medical needs, based on hard facts and past experience; very often an emotional appeal for massive medical assistance is issued, sometimes combined with a pragmatic attempt to take advantage of the "golden opportunity" to get routine supplies at no cost. The terms "medical supplies" in times of emergency have magic connotations which have often prevented a critical approach.

### Inappropriate drug donations

The problems can be summarized as follows:
- The drugs that arrive are expired, or will expire before they reach the patient, or they are damaged or they are still in the half-finished packages that have been returned to the pharmacy.
- Drugs are uncertain, not easy to identify and labelled with brand names only or in a language which is not easily understood.
- Drugs are dangerous or useless.

### A new revised kit

In 1987 a thorough evaluation was made of experience with the kit, which formed the basis for a subsequent review of its content. This work was undertaken jointly by WHO, UNHCR, UNICEF, Medicins sans Frontieres (MSF), the League of Red Cross and Red Crescent Societies, the CMC and the International Committee of the Red Cross.

The results of field tests of the revised kit by UNICEF and MSF, and further comments by a large group of international organizations and suppliers, were incorporated into the final revision. It was renamed the "New Emergency Health Kit" because now not only WHO but a large number of United Nations agencies and other bodies had participated in the kit's revision and had adopted this list of drugs and medical supplies for their emergency operations.

One important finding of the evaluation was that while the kit has proved its worth during the emergency phases of drought, famine or war, it is the list of drugs that has probably been the most valuable tool for individuals, organizations and countries. Used as a policy, an emergency drug list can guide...
and control donor response. For this reason it was considered useful to publish the new list together with information on the conditions for which it is intended and on the related training material that has been developed.

Use of the kit

The New Emergency Health Kit is not intended for the acute phase of epidemics, war, earthquake, floods, etc., but is designed to meet the needs of a population with disrupted medical facilities in the second phase of a natural or other disaster, or a displaced population without medical facilities at all. It must be emphasized that, although supplying drugs and medical supplies in the standard kit is convenient in the second phase of an emergency, specific local requirements need to be assessed as soon as possible and further supplies must be ordered accordingly.

Quantifying drug needs

Morbidity patterns (the relative frequency of different illnesses) may vary considerably between emergencies. For example, when malnutrition is common morbidity rates may be very high. For this reason an estimation of drug requirements from a distance can only be approximate, although certain predictions can be made based on past experience. Estimates for the new kit have been based on the average morbidity patterns and the use of standard treatment guidelines for a population of approximately 10,000 people for about three months. The quantities of drugs supplied will, of course, only be adequate if the prescribers follow these guidelines.

Contents of the kits

To facilitate distribution to smaller health facilities on site the New Emergency Health Kit has been divided into two different sets of drugs and medical supplies. The kit now consists of ten identical basic units (for 1,000 people) and a separate unit for one supplementary unit for 10,000 persons.

The BASIC UNIT contains drugs, medical supplies and some essential equipment for health workers with limited training. The contents allow for the establishment and running of a small peripheral health unit with facilities for simple outpatient care including disinfection, dressings and record keeping. The unit contains twelve drugs, none of which are injectable. Simple treatment guidelines, based on symptoms, have been developed to facilitate the training of personnel in the proper use of drugs and are included in each unit.

The SUPPLEMENTARY UNIT contains drugs and medical supplies for a population of 10,000 for approximately three months and is to be used only by professional health workers or physicians. It does not contain any drugs or supplies from the basic unit and should be used with it. A manual describing the standard treatment regimens for target diseases is included in each unit. Renewable supplies and equipment are intended for a support and referral station for the peripheral units, with facilities for sterilization and chlorination of water, and for the sterilization of instruments, syringes and dressing material. The unit also includes infusion sets, nasogastric tubes and catheters.

Referral

Health services can be decentralized by the use of basic health care clinics (the most peripheral level of care) staffed by health workers with limited training and using the basic units. The first referral level should be staffed with professional health workers, usually medical assistants or doctors, who use drugs, supplies and equipment from both the basic and the supplementary units. It should be stressed here that a second level of referral is also needed, usually a district or general hospital. Such facilities are normally part of the existing system.

Procurement

The New Emergency Health Kit can be procured from a number of major non-profit pharmaceutical suppliers, some of which have a permanent stock of kits ready for shipment within 48 hours. Each basic unit can be packed in one carton of approximately 180 litres, weighing about 40 kg. The supplementary unit has a total volume of about 1,900 litres and a total weight of about 400 kg and is packed in several cartons. The total volume of the kit is therefore approximately 3.3 m³, weighing about 800 kg.

It is important to note that many drugs in the kit can be considered as examples of a therapeutic group, and that other drugs can often serve as alternatives. This should be taken into consideration when drugs are selected at the national level, since the choice of drugs may then be influenced by whether equivalent products are immediately available from local sources, and their comparative cost and quality. National authorities may wish to stockpile the same or equivalent drugs and supplies as part of their emergency preparedness programme. The kit can also serve as a useful baseline supply list of essential drugs for primary health care. Although not designed for this purpose, the kit may, under certain circumstances, be useful for a second supply of essential items. For this reason the drugs, renewable supplies and equipment of the supplementary unit, are packed in separate boxes so that, if requested, units without equipment can be supplied.

Conclusion

The New Emergency Health Kit has been drawn up by WHO in close collaboration with virtually all international agencies working in emergency situations. The new kit is intended for a population with disrupted medical facilities in the second phase of a natural or other disaster, or a displaced population without medical facilities at all. It is designed for the start up and operation of basic health facilities staffed by health workers with limited training, and a first referral clinic with professional health workers or doctors. Treatment guidelines are included for both levels. The kit is kept in stock by several pharmaceutical suppliers.

References

DRUG FINANCING

Financing essential drugs

It is often stated "there is not enough money to pay for the drugs needed" but this could be viewed from a different perspective, namely that "the cost of drug supply is too high to permit needs, even fundamental needs, to be met."

In the 1980s, the developing countries faced the most serious difficulties they had ever known. Except for certain countries in Asia, their economies were at a standstill and were even negative in some years. Plunging prices for raw materials and commodities sharply reduced their export earnings. The extent of external indebtedness in most countries in Africa and Latin America has placed a heavy burden on their economies. Programmes of structural adjustment have sought to reestablish a balance, reduce budgetary deficits and inflation, and revive savings, investment and growth; but this recovery remains highly precarious. The economic recession and adjustment policies have especially affected vulnerable populations, particularly women and children in disadvantaged areas. In numerous countries of sub-Saharan Africa and Latin America, nutritional levels, educational opportunities and access to health care have deteriorated.

Drug financing: a crisis...

These countries can no longer pay their pharmaceutical bills. This creates a crisis in the financing of drug supplies, and seriously jeopardizes the goal of universal access to essential drugs. The question is how to reconcile the recovery of economies with the satisfaction of basic human needs.

This situation, far from raising doubts about essential drug policies, does the opposite. The problem of the use of insufficient resources has always been fundamental to these policies. The essential drugs concept provides criteria to be used in making choices in pursuing the dual objectives of rational management of resources and promotion of public health. The current crisis makes this problem more urgent and calls for rethinking of methods for financing drug consumption. Can populations take the place of governments that can no longer contribute the same financial resources as before? The whole set of economic and financial constraints thus becomes a key element in pharmaceutical policies.

There is a promising side too: the world drug market is witnessing the development of generic drugs and the growth of competition in that area. Many patents are expiring and increasing numbers of companies are breaking into this growing market. This could facilitate the access of the poorest countries and populations to essential drugs marketed at lower prices in the form of generic drugs.

Socio-economic dimensions...

Owing to the rising pharmaceutical bill of a number of countries, the socio-economic dimensions of drug use have today taken on special importance. National pharmaceutical policies have moved from the purely technical and clinical sphere to encompass economic and social issues. Essential drug policies must include economic and financial components, based on a careful analysis of the socio-economic context, in order to use resources to the best advantage and to adapt to the prevalent situation.

In the face of reduced access to drugs because of the crisis in the financing of health systems, what alternatives can be found, other than that of making consumers pay a growing portion of drug bills? Is government disengagement, and the social crisis that will follow, the only possible "economic" option? What economic and financial tools can we give decision-makers to enable them to come up with options that do not work against the target of health and drugs for all in, and especially, for the most disadvantaged?

The question of financing falls within the scope of economics but economics cannot be reduced to financial terms only. We speak of financing when monetary values (money) are involved, either as means (financial resources) or as objectives (search for financial profit). But the scope of economics is much broader: it covers "real" means (including human as well as physical resources, such as drugs).

When questions of financing are discussed it is often stated "there is not enough money to pay for the drugs needed by the population", but this could be viewed from a different perspective, namely that "the cost of drug supply is too high to permit needs, even fundamental needs, to be met." This would imply that two courses of action are required: to acquire more money and to reduce the cost of supply. Such a strategy could involve getting people who had not so far paid for drugs to do so, which might yield interesting results but which could also lead to a new set of difficulties arising from the complexity of the problem. Incomes are low in developing countries and requiring people to pay for drugs could mean that health services are priced beyond their means. Moreover, the responsibility for resolving the problem represented by financing difficulties should not fall first upon consumers, particularly the most disadvantaged, whose numbers are growing in this crisis situation.

Rather than viewing financing issues in isolation, we should focus on the keys to the problem, namely access and supply. How to make drugs available to the population is ultimately the problem we are seeking to resolve. Financing, money and prices are merely the economic tools to be used. We need to establish priorities on the basis of a precise description of how drug needs are satisfied or why they remain unmet.

This description can be provided from the standpoint of the population and that of the commodity, which offers two separate but complementary approaches to the same problem, that of need and that of products. Fundamental to the first approach is consideration of how to satisfy needs, as a function of health problems, within a socio-economic context. In the second case, the emphasis is on the chain of drug supply, analysis of flow, costs and malfunctioning of the system.

In seeking to determine how changes in drug management and financing can better enable real drug needs to be met there are three important aspects to consider:

Access...

Access to essential drugs can vary widely, even within a country, as can the immediate or long term potential of a specific population group to participate actively in the organization of drug supply. The population should therefore be...
DRUG FINANCING

classified into relatively homogeneous categories on the basis of constraints in access to drugs. Such categories must be readily identifiable, for example, the population of a given region or the wage-earning population.

Supply...

Next it is necessary to examine the chain of drug supply, pinpoint where this malfunction and determine the cause. Analytical and problem-solving exercises should be carried out for each of the population categories defined and for the country as a whole for some problems touch all categories. We need to know whether the priorities defined will be effective in improving access to essential drugs and how critical licensing can be rectified to make the whole chain more consistent.

Financing...

The third stage is to answer the questions: how much money is needed, who will supply it, how will it be used and who will be the beneficiaries? But the question of financing is only a part, and arguably, not the most important part of the entire question of access of the population to essential drugs: the selection of drugs, for example, might be the strategic issue.

Open questions...

It is worth recalling that in the last few years a whole series of drug financing initiatives have been tried in various countries. These have included payment by consumers, pre-payment schemes, payment for service, and the pooled purchasing of drugs. Although data is available on some of these initiatives, in general it is incomplete, has been prepared too soon after implementation, and often appears designed more as a promotional than an evaluation exercise. It is difficult, using such information, to make an objective assessment of whether or how such experiments should be expanded. A precise analysis of their effects on the use of health services, on the functioning of the rest of the health sector and on the health of the population has still to be carried out. Their financial validity also remains open to question. Is this because of an implicit selection process, by which experiments undertaken with external financial assistance are better publicized, and accompanied by difficulties in disengaging from that assistance, a problem which those funded solely by local resources might not encounter? Or has the period of implementation been too short to permit an objective evaluation? Or is it simply not possible to finance essential drugs for certain populations from local resources alone? These and many other questions remain to be answered. To do this we need both qualitative and quantitative information and a sound methodology for its collation.

CONFERENCE ON PRIMARY HEALTH CARE 1987

* Concluded from a working paper prepared by the Action Programme on Essential Drugs for the Seminar on Economic and Policy Choices of Pharmacists in Developing Countries, Copenhagen, Denmark, 24-27 July 1989, sponsored by the Economic Development Institute of the World Bank, the Australian International Development Assistance Bureau and the Danish International Development Agency.


*** WHO, Health economics, a programme for action, Geneva, Division of Strengthening of Health Services, 1988

NEWSDESK

African research group meets in Harare

IN 1988 health administrators and academics from 11 African countries, who all shared a special interest in research into the rational use of drugs, founded the African Drug Utilization Research Group, commonly known as DURG-AFR. The work of the group is being supported by national and international bodies such as the Drug Action Programme, UNICEF, the Italian Society of Hospital Pharmacy, Milan's Mario Negri Institute for Pharmacological Research, and Oslo University's Department of Pharmacotherapeutics, with the Government of Italy providing additional funding.

The group met in July of this year to determine priority areas of research and to coordinate activities. During five days' discussions in Harare members decided on four major areas for immediate action:

- the dissemination of prescribing information through the establishment of independent drug information centres linked to both ministries of health and schools of medicine and pharmacy;
- the development, jointly with universities and ministries of health, of management tools to monitor drug consumption and prescribing practices in order to improve educational programmes and drug supply;
- population or disease-specific research to develop or to assess the efficacy of therapeutic strategies in specific areas of public health, such as treatment protocols for sexually transmitted disease in rural and urban Zimbabwe, and the prevention of anemia-related maternal deaths in selected areas;
- the development and testing of teaching and training materials on the rational use of drugs for health professionals of all levels. Such material would focus on relating drug policies to available resources and recognised health needs.

The group also decided to seek funding for a drugs library network that would facilitate information exchange between members, and contribute to making its work more widely known and membership expansion. In addition, work is already underway on a handbook on drug utilization research methodologies.

DURG-AFR is an important initiative and step forward in promoting the rational use of drugs in the African context. The group is therefore calling for the support necessary to carry out its ambitious programme of work, to enhance its visibility and credibility, and to contribute to the creation of a "critical mass" of informed health professionals and administrators in a major area of health care.

A report of the meeting and further information about DURG-AFR can be obtained by writing to Dr Charles Nhachi, Department of Clinical Pharmacology, University of Zimbabwe Medical School, P.O. Box A180 Avondale, Harare, Zimbabwe.

Three Latin American doctors win rational use award

THE 1990 Olle Hansson Award has been won by three individuals from Latin America - Dr Jose Augusto de Barros from Brazil, Dr Arturo Lomeli from Mexico and Dr Roberto Lopez from Peru. This award recognizes the work of outstanding Third World individuals in promoting the rational use of drugs.

The chairman of the international selection panel, Anwar Fazal, said: "These three special persons have displayed outstanding qualities of commitment and excellence in their work; they combine the best of science with the highest conscience in dealing with issues of social justice."

Dr Lomeli is described by the selection panel as "the foremost and earliest campaigner on consumer health issues in Latin America". He is editor of "La Voz del Consumidor".

Dr Lopez has been associated for several years at the grassroots and policy levels in the campaign for rational drug use in Peru. The award citation states that his "commitment, drive and leadership have contributed substantially to consumer awareness - particularly in the rural areas."

The award, which carries a prize of US$1000 each, is managed by an international panel coordinated by the International Organization of Consumers Unions. The IOCU is a federation of consumer organizations dedicated to the protection and promotion of consumer interests worldwide through research, information and educational activities. An independent non-profit foundation, it links the activities of consumer organizations in some 60 countries and represents the consumer interest at international forums.

A young patient receives a drug from the village health worker.

Every year millions of people around the world come down with the "common cold". The symptoms are well known: a sore throat, a stuffy or runny nose, a minor cough, sore aches and pains, and sometimes even an irritating cough. The cause is also well known: one of more than 200 different strains from six families of viruses. Author Andrew Chetley, a well known, experienced designer for rational drug use, argues that despite the fact that there are no methods of prevention or cure, the "common cold that costs" the expenditure for various cold treatments is in excess of US$3 billion.

"Peddling Placebos" analyses the major types of cough and cold remedies currently marketed. It provides a detailed listing of 2986 preparations arranged according to the number of ingredients, and categorised as those which are considered by independent authorities to be of little or no value in the treatment of cough and colds, those which are considered to be potentially harmful, and those for which little or no independent information is available and which are therefore considered to be of doubtful value.

The publication is the latest in a Horizon Internationals series which has been examining different pharmaceutical issues. Earlier publications included the "Problem Drugs" pack: "Drugs and World Health"; "Cleared for Export"; "Antibiotics: The Wrong Drugs for Diarrhoea"; "Adverse Drug Events: Women and the Pharmaceutical Industry"; and "Women and Pharmaceuticals". Available from: Health Action International, HAI Europe Foundation, J. van Lennepkade 334-T, 1033 NJ Amsterdam, The Netherlands.


A very useful therapeutic guide which places particular emphasis on cost effective prescribing. The author justifies this approach by pointing out that the limited financial resources available to developing countries a rigorous economic approach is needed in order to provide even minimal medical facilities. It is indeed "irrational" to say to find shortages of essential drugs such as penicillin, chloroquine and iron tablets in many places in the country contrasting with some hospitals and clinics where drug expenditure is really irrational and extravagant. While a variety of factors operate in favour of doctors prescribing extravagantly, he continues, one of the most important is the absence of any pressure on them to do otherwise. Medical institutions do not teach students that they should always consider cost as a factor when choosing a drug. Once a student has graduated he is usually granted freedom to prescribe any drug and for the rest of a doctor's professional life he is subjected to advertising pressures to prescribe the latest type of expensive proprietary preparation. He advises medical professionals to reali se that it has a wider context of responsibility to the health needs of a whole community and the senior members should play an exemplary role.

Major-General Akhtar divides drugs into their main groups: Costly drugs which comprises those which were invented more than 10-15 years ago, have been widely used and withstood the test of time, are cheap, are available as generic preparations and are not advertised commercially. Drugs invented within the last 10-15 years, are still under patent and only available under brand name, are heavily advertised, are extremely expensive compared to type 1 alternatives, and for which some quantity is claimed in efficacy, safety or convenience. He cites many examples when the supposed advantage does not in reality exist and argues that the whole therapeutic emphasis in a developing country should be placed on type 1 drugs since every time a type 2 drug is used unnecessarily it wastes resources and a country's precious foreign exchange that could be used on type 2 drugs for more people. The worst offenders, according to the author, are usually specialist teaching hospitals which too often act as a vehicle for introducing new type 2 drugs into the country by making them fashionable.

A plan of action is proposed to improve the situation:

- the economic aspects of therapeutics should be included in all medical training programmes and in all discussions in the literature on recent therapeutics;
- journals should require drug advertisers to supply data on the drugs advertised and publications containing details of proprietary products, such as MIMS, should include price guides of drugs in the information they supply;
- information on drug costs and the virtues of basic cheap drugs vis-a-vis their new competitors should be widely disseminated to practicing doctors by the Ministry of Health;
- departments of clinical pharmacology and therapeutics in the teaching institutions should be developed and which should provide training on the rational and effective use of drugs. The old fashioned concept of delivering only theoretical classes should be replaced by progressive practical training demonstrating the use of drugs on patients and the virtues of using cheaper drugs.

"Rational Therapeutics" also contains an excellent chapter on the techniques and the importance of good physician/patient communication, emphasizing that what the patient remembers will be influenced not only by the type of information provided, but by the manner in which it is presented. The information must be practical, concise and in a language which the patient can understand; he/she must be motivated to participate in the drug treatment and modify daily behaviour to accommodate the dosage schedule. The most effective method of meeting the informational and motivational needs of a patient, the author states, is by using a combination of oral and written instructions, and each visit these should be reinforced to improve the patient's knowledge.


Provides a brief overview of sociocultural and other factors affecting compliance with iron supplementation programmes in pregnancy and draws attention to the urgent need for additional research in this field. The major part of the publication is a comprehensive literature review covering anaemia, iron supplementation programmes, maternal health and obstetrics, foetal health, childhood development, taboos and traditional beliefs and practices.

Available in English only from: Safe Motherhood programme, World Health Organization, 1211 Geneva 27, Switzerland.

The Role of the Pharmacist in the Health Care System, WHO/PHARM/DAP/90.1, 37p.

Based on the conclusions reached by a WHO consultative group at a meeting in New Delhi in 1988, this report reviews the current contributions of pharmacists to the acquisition, control, distribution and rational use of drugs. It emphasises their importance as vital members of the health care team, and offers detailed recommendations for the development of the profession.

Available in English (French and Spanish in preparation) from: Pharmaceutica, World Health Organization, 1211 Geneva 27, Switzerland.


This report contains the recommendations of the WHO Expert Committee responsible for the updating and revision of the Model List of Essential Drugs. The first part provides general guidance for countries wishing to establish national programmes for essential drugs. Quality assurance, education and dissemination of drug information are discussed, and a new section on bacterial resistance and reserve antimicrobials has been added. The second part contains the sixth revised model list and details of the changes that have been made to the 1984 list.

Available in English (French and Spanish in preparation) from: World Health Organization, 1211 Geneva and Sales, 1211 Geneva 27, Switzerland. Price Sw Fr 8.5, and in developing countries Sw Fr 5.60.
An Evaluation of WHO’s Action Programme on Essential Drugs, London School of Hygiene and Tropical Medicine, UK, and Koninklijk Instituut voor de Tropen, the Netherlands, December 1989, 17p.

 WHO’s Action Programme on Essential Drugs has been successful both in promoting the concept of essential drugs and in providing support to those countries concerned with formulating and implementing essential drugs policies, concludes an evaluation of the Programme’s development.

 The evaluation was co-ordinated by DANIDA (Danish International Development Agency) and was carried out by the Royal Tropical Institute of the Netherlands and the London School of Hygiene and Tropical Medicine, with financial support from the governments of Denmark, the Netherlands, the UK, Sweden, and the USA, with the approval of an historical overview of the Programme; a policy study; case studies of 13 countries providing essential drugs, and the sustainability of programmes.

 The evaluation set out to determine whether the Programme had achieved its targets and objectives, to identify constraints on its activities that hinder the attainment of its objectives, and to make recommendations for the future.

 APED’s original objectives, as formulated in 1981, were to strengthen national capabilities of developing countries in the selection, procurement and distribution, and the proper use of essential drugs to meet the health needs of the majority of the population; to strengthen whener feasible, local production and quality control; and to make essential drugs, including vaccines, available under favourable conditions to governments of the least developed countries in order to extend primary healthcare and disease control.

 However, says the report, by 1983 it was clear that the overall objective was to ensure the availability of a regular supply to all people, of a selected number of safe and effective drugs of acceptable quality at the lowest cost.

 Many aspects of this objective have been achieved, but not for all people in all countries, the report says, and in-depth studies would be needed to assess whether the increased availability of essential drugs, primarily tetracyclines, has had any effect on the accessibility of these drugs to those most in need. The same is true for assessing whether essential drugs programmes and policies have affected the rational use of drugs, and there are also a number of unanswered questions about the prices of essential drugs, the role of the private sector in health research; Essential Link to Equity in Development, The Commission on Health Research for Development, USA, 136p.

 Knowledge is essential to effective action for health. It is the basis on which new tools, strategies and approaches are devised that are applicable to the health problems facing many countries. For the I2 health and development experts brought together in the independent International Commission on Health Research and Development, this new health research is mainly generated by health research.


 Diarrhoeal diseases are a leading cause of child mortality in the developing countries and a major cause of undernutrition. This manual was initially published in 1980 and revised in 1984. This second revision reflects recent clinical experience and research findings, particularly in the area of management. It describes the principles and practices of treating diarrhoea in all age groups, placing particular emphasis on the use of oral rehydration therapy (ORT) in infants and young children, the most vulnerable group. It also covers issues such as hygiene management during and after diarrhoea. It also outlines the child care practices that can be used in the prevention of diarrhoea, including breastfeeding, appropriate weaning practices and domestic hygiene.

 Available in English (French in preparation) from: Diarrhoeal Diseases Control, World Health Organization, 1211 Geneva 27, Switzerland.


 This new publication is designed to help scientists in the planning and conduct of research on the introduction of new contraceptive methods into family planning programmes. The first section deals with the scope of social science research and how it can contribute to a better understanding of problems associated with the first-time introduction of contraceptives into family planning programmes. Further sections describe research design options, methods of data collection and analysis, and practical aspects of research planning and implementation. The annexes include a selected bibliography on research methods, examples of questionnaires used in family planning research, and finally, suggestions for minimizing losses to follow-up of subjects. The annex is addressed to social scientists, programme staff, clinicians and health researchers interested in fieldwork methodology. It also deals with the many issues that arise in the process of contraceptive introduction. A limited number of copies are available free of charge, primarily for scientists in developing countries, from: Special Programmes, Development and Research Training in Human Reproduction, World Health Organization, 1211 Geneva 27, Switzerland.


 The elderly consume more medicines than any other age group. They are also more likely to be unable to follow all instructions given. The Australian Consumer Association therefore decided to examine the issue of older consumers and their medicines. The results of a critical analysis of empirical data obtained from a survey of older consumers, together with resource material developed during a series of workshops, are contained in this loose-leaf binder. This forms an excellent review of the issues involved, and proposed strategies to improve the situation and to tackle what it describes as a serious and neglected problem.

 Available from: Australian Consumers’ Association, 37 Carrington Road, Marrickville, NSW 2204, Australia.


 The first volume in a series of handbooks sponsored by the National Postgraduate Medical College of Nigeria, aimed at producing nationally relevant educational material for Nigerian health professionals. The publication is a reference handbook of essential and commonly used drugs in paediatric practice in the tropics. Brief accounts are included of the management of cardio-respiratory arrest, status epilepticus, tetanus, anemia and some common childhood infections. There is also a section on immunisation.


 The results of a survey carried out by two physicians who examined and classified I273 German and 1084 Swiss drugs marketed in 26 third world countries. The authors state that around half of the drugs marketed are ineffective or irrational products, some of which carry unacceptable risks. The publication highlights the large number of irrational combination products marketed in Third World countries and the number of drugs which have been withdrawn in the country of origin.

Non-compliance: A major problem in anaemia control

Carla Abou-Zahr*

Nutritional anaemia in pregnancy is well documented but compliance with iron supplementation remains low.

"The disregard of women's health beliefs and perceptions in the planning and execution of not only iron supplementation programmes but also prenatal services, may well be important factors in women's non-compliance with treatment regimens and the under-utilisation of prenatal services."

The prevalence of nutritional anaemia and its potential deleterious effects on pregnant women, particularly in developing countries, has been well documented. Numerous studies, from both developed and developing countries have looked at dosages and/or combinations of drugs necessary to most effectively prevent and control anaemia in pregnant women. Researchers have developed models to identify women at risk and have looked at various elements influencing health care delivery services. These efforts have produced a wealth of information on anaemia during pregnancy, indicating that non-compliance remains a major problem in most anaemia control programmes. Perhaps the problem remains because the focus of many studies has been on observing changes in haemoglobin or haematocrit levels, while neglecting other essential areas, such as the pregnant woman's feelings, beliefs and understanding of her own body and her perception of her own state of health as critical factors influencing whether or not she will take the medicine. A new bibliography from supplementation during pregnancy. Why aren't women complying? (see published literature brought together information from studies in many parts of the world in a review of available

knowledge about the factors affecting women's compliance with anaemia prophylaxis during pregnancy.

In all societies, one of the most important roles of women is to produce children. Giving birth to a child is viewed as a rite of passage, a chance for a woman to prove her fertility and improve her status within the community. Pregnant women are expected to carry on with their daily activities as usual and the community may look unfavorably on women who complain about symp-toms associated with pregnancy. Thus, health problems associated with nutritional anaemia may not be recognized or may be ignored. Cultural idiosyncrasies may play important roles in a preg-nant woman's decision to seek health care and to comply with a prescribed treatment regimen (whether with traditional or Western health care).

In India, for example, women from 'dirty' it. To replace or purify the blood, traditionally red foods and medicines are used. Western medicines, red in colour (iron tablets, diuretics, pile tablets and tollic acid) are widely accept ed because they strengthen or purify blood. If anaemia is known to be a dis-order and red iron tablets then may be considered as an ac-ceptable treatment measure.

In many societies, notions of health and illness are based on a system of defining health as a balance between opposing elements in the body, where ill health is an imbalance, a deficiency or excess of these elements. Within the context of complementary medicines, both food and medicines are identified as possessing humoral characteristics and having physical effects on the body. Humoral theo ries may also pervade indigenous perceptions of conception and pregnancy. Pregnant women, desiring to carry their babies to term, avoid eating foods and taking medicines that are thought to adversely affect the pregnancy state. For example, among the Malay in Indonesia, pregnant women avoid medicines believed to be "hot". Hot substances are thought to cause the womb to be come uncomfortably hot and to induce abortions. Among the Kanara of South India, for example, the health staff distributing iron tablets have been told that the tablets are "good for health" and as a tonic to "produce a big baby". This marketing strategy negatively affected women's decisions to take iron tablets because big babies are associated with difficult deliveries.

The disregard of women's health beliefs and perceptions in the planning and execution of not only iron supplementation programmes but also prenatal services, may well be important factors in women's non-compliance with treatment regimens and the under-utilisation of prenatal services. Several of the studies reviewed in this report have brought together information from studies in many parts of the world in a review of available

But not for weakness or bloodiness. In addition, they perceive tablets as inappropriate forms of medicine because hard pills are considered difficult to ingest and are thought to share the same body space as the fetus. In both examples, pregnant women refrain from taking iron tablets. In Sierra Leone, certain illnesses, including worm infesta-tions, are said to drain the blood or
RATIONAL USE

Australia: an audit of GPs antibiotic prescribing

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he best performance indicator of prescribing quality comes from comparing actual drug use with peer consensus recommendations concerning cost effective drug use, says Dr Ken Harvey of Melbourne's Victorian Medical Postgraduate Foundation. He recently led a study which compared the antibiotic prescribing of a random sample of general practitioners with the recommendations in the 5th edition of Antibiotic Guidelines. Considerable variation was found between actual prescribing practices and the recommendations of the guidelines.

For example, 50% of the general practitioners prescribed norfloxacin for acute uncomplicated urinary tract infection although it is not recommended by the guidelines for this indication. For tonsillitis, broad spectrum antibiotics such as amoxicillin and co trimoxazole accounted for 43% of 2343 prescriptions and were prescribed by 66% of the general practitioners despite lack of evidence justifying their use, the study reports.

In general, prescribing patterns appeared to reflect promotional activities of the pharmaceutical industry, concludes the study, with practitioners prescribing the latest, most expensive, heavily promoted antibiotics rather than older, less expensive, but equally effective drugs, recommended by peer consensus guidelines.

Dr Harvey is now working on a follow-up campaign, combining educational material with academic detailing, directed at half the original sample of doctors with the other half serving as controls. The techniques are similar to those used in a recent controlled trial of educational intervention to improve antibiotic use in 12 Victorian public hospitals, he reports. In addition, lessons learned from the general practice antibiotic audit have been incorporated in the continuing education programme of the Royal Australian College of General Practitioners and the sixth edition of the Antibiotic Guidelines (which now has the support of all Australian states).

Further details can be obtained from Dr K.J. Harvey, Victorian Medical Postgraduate Foundation, Melbourne, Australia.

In three months it helped cure one disease wonder drugs dealt.

In Thailand, improvements in haemoglobin levels were achieved in two groups of pregnant women: for one group tablet-taking was supervised by trained village health volunteers; the second group was motivated by midwives who helped the women to understand the purpose and importance of the supplementation regime. The midwives visited the women once or twice a month to monitor progress of the pregnancy and encourage them to continue taking the tablets. In addition, monthly calendars with illustrations showing how iron makes pregnant women and their babies stronger were provided so the women could record their daily intake of iron. In India, following the introduction of the screening and treatment of anaemia in pregnant women by community health workers, the prevalence of anaemia dropped dramatically.

In a malaria control programme, the distribution of antimalarials by traditional birth attendants was found to be an effective means for treating gravid women and for encouraging them to take the chemoprophylaxis. Good compliance rates with weekly prophylactic chloroquine were achieved with supervised distribution of tablets at monthly prenatal clinics in Papua New Guinea.

Cultural and religious beliefs, attitudes towards taking medications, logistical factors and marketing techniques are instrumental factors which affect women's decisions to seek health care and to follow through with prescribed preventive or treatment regime. Yet data on these factors are sparse. These high priority areas need to be explored to begin to develop a database on factors which influence women's compliance and health care utilization so as to be better equipped to develop and implement successful health care services. In particular, anaemia control programmes. Levels of compliance need to be evaluated in relation to operational efficiency of maternal and child health clinics including accessibility and acceptability of services and availability of drugs at any given time. Cross-cultural surveys to examine women's attitudes to taking medications and their perceptions of the importance of health care services for both wanted and unwanted pregnancies are needed. In order to examine women's perceptions of women's perceptions of their pregnancy state and factors influencing their health decisions, cross-cultural studies using both closed and open ended survey techniques and focus group discussions need to be conducted. Studies are required to determine the efficacy of using different categories of health personnel for medication distribution.

Drug Policies in Groningen, The Netherlands, presented their experience with an innovative course in clinical pharmacology for medical undergraduates, which has been given since the early 1970s. Experience with this course is now being used, in collaboration with WHO, in training medical staff and teachers. The course has established a core group of individuals from institutions already engaged in such activities to provide coordination and support for the various teaching institutions in their efforts to promote rational prescribing. The secretariat of the core group is at the Department of Clinical Pharmacology, University of Groningen, 9700.0 AR, in The Netherlands. Details are available from WHO.

In Indonesia, universities discuss teaching rational use

n October 1989 more than seventy representatives of medical and pharmacy schools and the Ministry of Health met in Yogyakarta, Indonesia to discuss ways and means of introducing the concept of essential drugs and rational prescribing into undergraduate curricula. The meeting was organized by the Department of Clinical Pharmacology of the Gatja Mada University, with the technical and financial support of the WHO Action Programme.

Discussions centred round several international initiatives currently taking place in Indonesia. Participants heard an impressive account of activities at the Medical School in Surabaya, where teaching staff have developed an ever increasing range of reference and teaching materials, which now include a set of diagnostic and treatment guidelines for the various departments of the teaching hospital as well as a hospital formulary.

The Secretariat of the WHO Collaborating Centre for Clinical Pharmacology and Drug Policies in Groningen, The Netherlands, presented their experience with an innovative course in clinical pharmacology for medical undergraduates, which has been given since the early 1970s. Experience with this course is now being used, in collaboration with WHO, in training medical staff and teachers. The course has established a core group of individuals from institutions already engaged in such activities to provide coordination and support for the various teaching institutions in their efforts to promote rational prescribing. The secretariat of the core group is at the Department of Clinical Pharmacology, Faculty of Medicine, Gatja Mada University, Surabaya, Indonesia. Telephone (212) 74-8568 Ext. 579; Fax (212) 74-5039 (attention Dr Budiono Santoso).

A new international programme in pharmacoepidemiology

The International Clinical Epidemiology Network (INCLEN), which is supported by the Rockefeller Foundation, is developing a new programme in pharmacoepidemiology, whose long-term goals were outlined at a meeting in Belgrade in April this year. The programme is an outgrowth of global efforts to improve the availability and rational use of essential drugs and vaccines throughout developing countries, and was intended to facilitate linkages between organizations active in this area. Considerable interest was placed on the achievements of the WHO Essential Drugs Programme in promoting the rational use of drugs throughout the world. Participants, who came from a variety of disciplines, countries and organizations, included the international pharmaceutical industry, heard reports on essential drugs programmes in Brazil, Indonesia, Nigeria, Panama, the Philippines and Tanzania.

The curriculum of the new training programme will foster the WHO essential drugs concept and take advantage of the extensive reference material prepared by the Drug Action Programme, such as "The World Drug Situation". It will also stress the social and behavioural aspects of therapeutic drug use, incorporating behaviour modification techniques and methods to improve each link of the drug chain. Start-up funding has been made available for INCLEN fellows (who at present number over 200 in developing countries), through a competitive seed grant programme.

INCLEN plans to coordinate its efforts with other international organizations and will request assistance from specialists in the field working in their countries. The pharmacoepidemiology programme should enable INCLEN fellows in clinical epidemiology, biostatistics, social sciences and health economics to expand the scope of their efforts to improve the final common pathway of drug use, through the rational use of drugs, says Professor Calvin Kunin, programme coordinator. Further details concerning INCLEN and the Belgrade Conference can be obtained from Scott Halsted, M.D., The Rockefeller Foundation, 131 Avenue of the Americas, New York, N.Y. 10036, USA.

A report of the conference proceedings will be published in a supplement to the Journal of Clinical Epidemiology in 1991.
RATIONAL USE

Latin America: a regional network of drug information centres

Health care professionals regularly call attention to the need for up-to-date and objective information on drugs given the large number of new products on the market and the increasing discovery of new compounds and applications for existing products. To meet this need, specialized scientific and technical documentation centres are required to process, store and make easily accessible a large volume of pharmacological data.

In addition to such sources of technical bibliographic data, there is an additional need for centres which not only compile but evaluate information, providing reliable data that can facilitate decisions on which drugs to use in specific clinical situations. These are known as drug information centres.

The primary function of such centres is to provide prompt, objective and up-to-date scientific and technical information. To do this, they must be well provided with literature and reference works, specialized information systems, properly trained staff and the necessary equipment. The centres also typically carry out education, training and research activities.

Creating national centres...

In response to this need for drug information by health care prescribers, dispensers and consumers, and with the goal of furthering rational drug use, the Essential Drugs Programme of WHO’s Regional Office for the Americas/ Pan American Health Organization is promoting the creation of drug information centres throughout Latin America.

Its strategy has been to:
- locate a drug information centre with sufficient experience and trained staff to act as a regional training centre;
- evaluate existing national resources, determine requirements and identify those institutions that could take charge of the development and maintenance of drug information centres;
- identify, and where necessary, train staff to coordinate and operate the drug information centres;
- provide the necessary bibliographic material and specialized equipment to start operations.

On the job training...

Activities started in 1986 when the Information Centre of the University of Central America’s School of Pharmacy (CEDIMED) – already a WHO Collaborating Centre – was designated to provide technical assistance and professional training. Since that date, four workshops have been held in CEDIMED for pharmacists and physicians, working in the information field, from health institutions and universities of Central America, the Caribbean and Andean countries. Training is geared to practical applications and participants learn on the job to use drug information systems to respond to the most diverse queries. At the close of the workshop, each participant drafts a project proposal for the establishment of a drug information centre tailored to the features, needs and resources of his or her country, and receives a list of essential bibliographic material and an operating manual.

This support from the Regional Essential Drug Programme has enabled 35 pharmacists and physicians to be trained. As a result, 12 drug information centres are now operating in the participating countries compared with only one before the project began. These centres’ function under the aegis of a variety of institutions such as ministries of public health, universities, social security institutions and hospitals, which contribute to their maintenance.

In addition to responding to queries and providing educational and research activities, the centres provide back-up for national drug registry and control services and for pharmaceutical and therapeutic councils, providing easy access to objective information on evaluation of pharmacological substances.

The establishment of a national drug information centre can be regarded as only a first step, albeit crucial, in providing accessible data. Many countries can go further and are fully capable of operating a network of such centres located in selected hospitals and universities throughout the country. This has particular advantages for territories where communication links are weak in some areas.

A regional network...

WHO/PAHO’s Regional Programme on Essential Drugs is now exploring the possibility of creating a regional network of drug information centres in Latin America in order to facilitate national initiatives and foster technical cooperation. To this end, a systematic identification of individual country problems and specific needs is being undertaken so as to accurately target technical cooperation and enhance resource management. The Inter-American Pharmaceutical Organization (OPIN) is also providing support to this initiative and has invited the coordinators of the drug information centres to attend its forthcoming congress in San Juan, Puerto Rico, in order to discuss the network’s organization, objectives and operations.

Additional information on the Latin American Network of Drug Information Centres is available from: Dr. Vassenes Balea de Paris, CEDIMED, WHO Collaborating Centre on Drug Information, Facultad de Farmacia Universidad Central de Venezuela, Caracas, Venezuela. Telephone 662.9220.

Research findings support use of rice-based ORS

Oral rehydration therapy (ORT) using the WHO/UNICEF glucose-based Oral Rehydration Salts (ORS) solution is the preferred method for treating most children with dehydration due to diarrhoea (except those with severe dehydration); it has been used successfully in millions of cases worldwide. In many countries glucose-ORS solution is also recommended for home treatment of children with diarrhoea after they have been seen at a health facility, even when there are no signs of dehydration. Glucose-ORS solution works because glucose is rapidly absorbed from most parts of the ileum, and this causes salt and water to also be absorbed, thus replacing the fluid losses.

Although glucose-ORS solution efficiently replaces faecal losses of water and salts, it has one important shortcoming: it does not reduce stool volume during diarrhoea or shorten the duration of the illness, which are the results that mothers and many health workers seek. If an ORS formulation could be developed that had the positive features of the standard glucose-ORS, including low cost, safety, and stability during prolonged storage, but also an effect to reduce the rate of stool loss during illness and/or the duration of diarrhoea, it could have considerable advantages over glucose-ORS. Most importantly, it could be promoted as having a true diarrhoea effect, which should lead to increased acceptance and use of ORS by both health workers and mothers, and perhaps also to a reduction in the use of ineffective "antidiarrhoeal" drugs and inappropriate antibiotics. This would represent a major advance in efforts to control diarrhoeal morbidity and mortality through appropriate case management.

Recent studies suggest that an ORS with these advantages may be possible, according to WHO’s Programme for Control of Diarrhoea Diseases. The first evidence came from clinical trials in Bangladesh and India, which showed that dehydrated diarrhoea patients given an ORS solution containing 50 g of cooked rice powder in place of the usual 20 g of glucose were satisfactorily rehydrated and had an appreciably reduced rate of stool output during treatment as compared with patients given glucose-ORS solution.

These promising results led to further clinical trials using ORS-Rice solution and of solutions based on other cooked cereal powders. To date, at least 13 randomized trials involving nearly 1300 patients with acute diarrhoea have been conducted to compare glucose-ORS with ORS containing 50-80 g of cooked rice powder.

The results of the clinical trials performed to date indicate that:

- the rate of stool loss is significantly reduced in patients with acute diarrhoea given rice-ORS solution as compared with patients given glucose-ORS solution; this effect appears to be twice as great in rapidly purging patients with cholera as in children with less severe, non-cholera diarrhoea.
- Treatment with rice-ORS solution also reduces the duration of diarrhoea.
- The percent reductions in the rate of stool loss and in the duration of diarrhoea combined to cause an even greater percent reduction in total stool output during the entire illness; the average reduction in total stool output in children with acute, non-cholera diarrhoea treated with rice-ORS solution has not been precisely defined, but may be in the range of 30-55%.
- Feeding rice to patients given glucose-ORS solution (especially cholera patients) does not appear to cause the same decrease in stool output as treatment with rice-ORS solution plus a rice diet.
RATIONAL USE

Peru: A major drive to rationalize treatment of diarrhoea

Patricia Paredez* and Hilbrand Haak**

Despite national and international efforts, the inappropriate use of antibiotics for diarrhoea, often without adequate dehydration therapy, remains a major impediment to the control of diarrhoeal diseases in developing countries. Peru is no exception. Although the Peruvian CDD Programme has consistently advocated the correct treatment with ORS and the use of a few selected anti-microbials for dysentery, national surveys indicate that adoption of oral rehydration treatment (ORT) is very low and that the use of pharmaceuticals is high for diarrhea in under fives.1 The scientific community in Peru and the PAHO/WHO office in Lima decided to focus more attention on the problem through a workshop held in November 1989 in collaboration with the Ministry of Health. Health professionals and administrators, international agencies, Peruvian researchers, and health activist groups were represented at this multidisciplinary gathering. Discussions revealed that there already were surprisingly ample data on this issue but that these had not been widely disseminated.

Results from two national surveys indicated that 50% in 1984 and 62% in 1986 of all the diarrhoeal episodes in children under five were treated with some kind of drug. The most frequently used drugs were antibiotics, such as Chloramphenicol, Tetracycline, Neomycin, Cotrimoxazole, and antimotility agents such as Loperamide.1 An anthropological study conducted in the outskirts of Lima in 1985 indicated that traditional remedies were widely used for diarrhoea, but that modern pharmaceuticals, which can be easily bought in local shops, were also used often in combination with traditional treatments.

The problem, however, is not only of so-called "self-medication". Doctors also prescribe this type of drugs. A survey of patterns of drug prescribing found that no less than 57% of patients attending a health facility or a private surgery for diarrhoea treatment received a prescription for antibiotics and 55% for an anti-diarrhoeal drug.1

Residents, pharmacists and students. These messages were reinforced throughout the additional teaching sessions and radio interviews. The Ministry of Health plans to devote special attention to the problem in the next update of the national treatment guidelines. In addition, a local health activist group, in collaboration with the Ministry of Health, has organized several forums on the subject for medical and pharmaceutical students. This group has also prepared a popular information folder on antibiotic use.

Key words: diarrhoea, education, training, Peru

References:

1. RNASINE: Informe General Peru 1986. 145-146
2. ENDES: Informe General Peru 1988, pp. 118-121

FRONT COVER: 1

India: State committee to draft Maharashtra drug policy

MAHARASHTRA State's Directorate of Medical Education and Research has announced the formation of an Expert Committee for State Drug Policy. The Committee, whose establishment formed one of the main recommendations of the Workshop on Concept of Essential Drugs and Rational Drug Use held at Solapur in April, will draft a state drug policy, focusing on rational drug use, to be applicable in all government medical colleges and hospitals.

The workshop also drafted an essential drugs list, based on WHO's model list, and intended to encompass the drugs needed for treatment of all prevalent diseases based on therapeutic effectiveness and at a reasonable cost. Other recommendations dealt with the need for improved quality control, computerized drug information systems, therapeutic audit and other health training colleges. The workshop also called for special efforts to educate the general public in appropriate drug use and the need for compliance with prescribed medication regimes.
RATIONAL USE

Training of Pharmacists: shaping new roles

Dzulkifli Abdul Razak*

Traditionally, pharmacy education has centered around the development of technical excellence and skills such as drug formulation, analysis, manufacturing and quality control, and functions such as compounding and distribution of pharmaceutical products. As a result, the pharmacist has come to be seen more as a technician, identified primarily with commercial and industrial activities, having a minimal and frequently indirect contact with patients. But this situation is fast changing and the current expansion of the pharmacist’s professional role calls for a new look at curricula and training.

A changing role

Just as the dramatic progress in medical science has created a changing role for physicians, which has been reflected in changes of medical training, so is the role of the pharmacist taking on new dimensions. Pharmacists are increasingly being consulted about rational drug therapy, and many are already involved in ward rounds, therapeutic consultations and drug monitoring. Services such as total parental nutrition, unit dose system, satellite pharmacy and patient counselling are now a part of the routine daily work of many pharmacists, who with these new services, are becoming directly involved in patient care. Patient-oriented pharmaceutical education is now being introduced in many schools of pharmacy, particularly in the West and a discipline known as ‘clinical pharmacy’, whereby the pharmacist interacts more closely with the patient, especially in aspects of drug therapy, is coming into being. This is a whole new area of study which can help create a bridge between pharmacy and medical education.

Drawing on many of the basic pharmaceutical disciplines, the clinical approach seeks to relate the knowledge acquired directly to patient care. Thus new integrative areas, namely clinical pharmacokinetics and biopharmacy, pathology and disease states, therapeutics, drug use and control, communication skills and management, are being incorporated into the ‘new pharmacy curriculum. Such an approach seeks to enable the pharmacist to assume an expanded consultative role in matters related to drugs, whereby he or she is no longer only a skilled technician but a counsellor-educator to both the consumer-patient and other health professionals.

A new holistic approach

Another aspect receiving serious consideration in pharmaceutical training is the view of the patient as a ‘whole person’ and his/her role in the health-care process, a holistic perspective which has so far been ignored in the conventional product-oriented pharmacy curriculum. There is an increasingly held view that this omission can and must be rectified by including social and behavioural components into the curriculum. This would enable the pharmacist to develop confidence and empathy in dealing with patients, particularly in relation to their feelings, attitude and other behavioural parameters that may affect the outcome of the health-care process. Understanding the various determinants of behaviour will undoubtedly make the pharmacist-counsellor role more effective. This wider professional role could also have a positive impact on inter- as well as intra-professional relationships and facilitate more integrated and hence better health care.

Building bridges

There still remains the process of actually translating theoretical knowledge into practice. The learning environment must be one where health care experience is first-hand, for example, through ward round and bedside discussions, much like that of the medical counterpart. This requires carefully selected teaching-learning sites which could range from health care teaching complexes to community pharmacies, rural health units or nursing homes. The sharing of such training sites with medical students would further contribute to advancing the concept of clinical pharmacy and its implementation in other health settings.

Conclusion

These changes in the pharmacy curriculum would lead to improved patient care. While the main academic thrust would still centre on the use of drugs and drug products, the new generation of pharmacists would be able to function as true members of the health care team, sharing responsibility for ensuring the highest quality of care, especially in relation to drug therapy. The understanding between pharmacists and their medical counterparts would be enhanced by injecting a new body of knowledge in the pharmacy curriculum and educational training.

* This is an abridged text. The full paper can be obtained from Dr A. R. Dzulkifli, Associate Professor and Deputy Dean of the School of Pharmaceutical Sciences, Universiti Sains Malaysia, 11800 Penang, Malaysia.

Sudan: Training in rational use gathers momentum

A hospital pharmacy in Nairobi. Pharmacists are an important part of the health care team.

The Training Manual on Rational Use of Essential Drugs, produced by the Nile Province Essential Drugs Project (reviewed in EDM-9), has already proved its value in two training courses for medical officers, pharmacists and graduate nurses held in Atbara in February and March this year. 10 subsequent courses were held for paramedical staff in May and June, using a shorter Arabic version of the manual intended for health workers. In all 61 professional and 407 para-medicall staff were trained in courses of four to five day’s duration.

There was also vigorous advocacy of the essential drugs concept among this period by members of the Sudan Medical Council, which organised a workshop on the National Formulary that included a session entitled: “Revision of formal training curricula in the light of new concepts and principles of essential drugs and their rational use”. Participants included representatives of University faculties of medicine and pharmacy, schools for medical assistants and pharmacy assistants, and the Department of Nurse Training in the Ministry of Health. All speakers reaffirmed the commitment of their institutions to the promotion of rational drug use in their teaching and training. Some have already included the concept of essential drugs and rational drug use in their curricula. Others are at various stages of implementation and they welcomed WHO support and the efforts of the Nile Essential Drugs Project to help with curricula revision.

Nor is the general public being neglected in this sustained educational initiative. A 15 page booklet has been produced which provides an introduction to the essential drugs concept, explains the National Drug Policy and describes the operational plan of the Nile Province Project. The booklet will be given wide distribution during forthcoming seminars for community leaders. Radio and television are also being used for essential drugs advocacy through project team members presenting programmes goals and activities during local broadcasts.