EDITORIAL

Two anniversaries:
Much to celebrate - more to be done

WHO is 40 years old this year and the concept of essential drugs was launched 10 years ago.

We believe that there is much to celebrate. WHO as an organization has contributed in both big and small ways to the dramatic improvement in health recorded in the last 40 years. People are healthier today than 40 years ago. The relationship between socio-economic development and health is much better understood, as are many of the causes of illness and premature death. We now have better tools to prevent and cure disease and a better understanding of the role that life-style changes can play to improve health.

A major killer — smallpox — has been removed from the earth and millions of lives saved by simple and inexpensive interventions such as immunization and oral rehydration.

The concept of essential drugs, once so controversial, is now almost universally accepted. Some 110 countries have national lists of essential drugs and 40 countries are actively operating national programmes in support of primary health care, with many more at the planning stage.

But we cannot be complacent. The two billion or so people who lack access to a regular supply of even the most essential drugs, at a price they can afford, bear witness to the toll of unnecessary disease and death that cannot continue to be tolerated. If they are to have "health for all" by the year 2000 then a vast amount of work remains to be done at the country, regional and global levels. We share one world and the degree of our understanding that, metaphorically, no man can be an island will establish the width of our horizons and the boundary of our possibilities. This was never more true than in ensuring equitable access to health care, for which the provision of essential drugs plays so vital a role.

On an anniversary it is right and only human to reflect on the past, to weigh up achievements and failures; but we must now look to the future which beckons bright if our motivation and political will to share our knowledge and resources is truly strong.

The Editor
Essential Drugs Monitor

PUBLISHED LATELY

TWO WHO PUBLISHING FIRSTS


Estimating drug needs is notoriously difficult and too often stocks reach expiry date or run out because orders were too large or too small. The economic and health care consequences of such miscalculations are particularly grave in developing countries. For the first time ever, detailed, step-by-step instructions for estimating drug needs are now available in a newly issued WHO manual.

In 1984 the Action Programme decided to help countries tackle the problem by developing a drug estimation methodology that could be used throughout the world. Careful analysis and testing led to the choice of two key methodologies, one based on morbidity and the other on consumption. In the morbidity method, future drug needs are calculated on the basis of expected frequency of common diseases and complaints. In the consumption method this is done by analysing drug use in a sample of health facilities, with past consumption used to estimate future needs.

The WHO manual details both methods and also explains the importance of accurate drug assessment in the whole supply process. The manual can be used for self-tuition or as the basis of a formal training course, for which a draft programme is included, and all modules contain comprehensive examples and exercises.

WHO hopes that this newly developed training and reference tool, which was made possible through grants from Interpharma and the Swiss Development Agency, will provide valuable practical assistance to national programmes in their goal of rationalizing drug supplies.


This very useful manual provides clear, objective and comprehensive information on 40 drugs commonly used in developing countries, with two full pages devoted to each drug. The information is intended for all prescribers, but will particularly interest doctors working in districts. It can be adapted to the needs of each country in collaboration with national health professionals.

Available from: Institut Universitaire d’Études du Développement, Service des Publications, 24 rue Rothschild, CH-1211 Genève 21, Switzerland. Price: Sw.Fr. 10 (Europe and North America), Sw.Fr. 6 (other countries).


Descriptive sheets on how to produce a score of simple and basic drugs for use in a health centre or dispensary. The drugs can be prepared by a mid-level health worker or by a pharmacy technician at relatively low cost, using easily available active ingredients and simple equipment. In addition to the instructions for manufacture, the sheets include guidance on the maintenance of material, and some basic principles for formulation, labelling, and storage.

Available from: CREDES, 4 rue Franklin, F-93200 Saint-Denis, France.


Using medicines properly at the extremes of age — in the young and the old — is one of the problems which practitioners face. Children may react to medicines quite differently from adults, and there is a lot of variation in the reaction from one age group to another, and from child to child. In particular, the busy general practitioner dealing with all members of the family may find it difficult to adapt his or her prescribing to the needs of each patient. WHO’s new pocketbook is designed to help solve this problem.

Written by — or in consultation with — 35 paediatricians, it tackles general problems but also gives clear advice on a basic list of the most essential (and safest) drugs for use in the young. How do I decide if a drug is needed at all? How do I choose the right drug for the case? What is the best way to set the dose? How can the drug be given, and how can I be sure that it will be taken?

Drugs for Children comes down firmly in favour of individualized therapy for children. However, reasonable some of the traditional formulas for calculating the right dose of a drug in childhood may be, the WHO view is that the doctor will be safer with recommendations fitted to the drug and the child concerned. 140 pages of brief, clear monographs provide such recommendations for the drugs the doctor is most likely to need, suggesting how each can be used most safely and effectively from birth up to adolescence. And where it is wiser not to use drugs at all, the authors suggest alternatives.

The Treatment of Acute Diarrhoea, WHO/CDD/SER/87.11.

The result of collaboration between WHO and the International Pharmaceutical Federation (FIP) and is specifically designed for use by pharmacists. Presents an overview of the nature of acute diarrhoea and its treatment, especially through the use of oral rehydration therapy, and advice on the limited uses of antibiotics and the inappropriateness of antibacterial agents.

At present available in French and English, with a Spanish version in preparation. Distributed primarily by FIP and its national affiliates, but can also be obtained from: Diarrhoea Diseases Control Programme, WHO, CH-1211 Geneva 27, Switzerland.


Gives the reasons behind special measures designed to facilitate and improve medication for the elderly, and discusses means of simplifying medication, instructions and aids, together with ways of reinforcing patient motivation and ability to manage medication without assistance. Training of health personnel in communication techniques and problems associated with patient compliance are also briefly reviewed. A more detailed publication on this subject, Drugs for the Elderly, published by the WHO Regional Office for Europe, was reviewed in Monitor 2/1986.


More publications on page 10

Important. The Action Programme usually cannot supply these publications. Please write to the address given at the end of each item.
ACTION PROGRAMME

Papua New Guinea still going strong

In 1950, when the pharmaceutical supply system in Papua New Guinea began, the now well-known concept of essential drugs and the policies built around it for selection, procurement, management and distribution were still more than 20 years in the future. Papua New Guinea was a quietorer for many of the principles later put into practice in countries adopting national essential drugs programmes. It has succeeded in developing, maintaining and financing a pharmaceutical supply system which provides continuous access to a limited range of essential drugs of acceptable quality and reasonable cost, tailored to each level of health care.

This has been done in a country of diverse and often rugged terrain with many islands and few roads, and where, historically, the different population groups had quite limited access to one another. The widespread routine use of small aeroplanes and traditional waterways has been exploited to bring even remote areas within reach.

WHO team assessment

In the summer of 1986, the Papua New Guinea Department of Health agreed that an Action Programme team should assess its long-running pharmaceutical supply system. This was done not only to draw on PNG's long practical experience for the benefit of "newcomers" embarking on national ED programmes, but also to identify features which would profit from examination by dispassionate outside evaluators.

PNG has been a pioneer in the selection and use of a limited number of essential drugs chosen to meet medical needs and the skills of the different categories of health care workers dispensing them. Most impressive is the use of standard treatment schedules for illnesses commonly seen in children and adults, and their genuine incorporation into the health care system and into training programmes for all health care workers, including at the medical school.

The tightly managed Pharmaceutical Services (with six Area Medical Stores, each staffed by a pharmacist), the Medical Store Catalogue (the only source for drugs ordered by the health care system), and the functioning Pharmaceutical Advisory Committee are all the responsibility of the central-level Department of Health. Responsibilities for health services, on the other hand, is decentralized to the provincial level. In addition to hospitals, there are health centres, headed primarily by health extension officers, and aid posts staffed by aid post orderlies.

Problem areas

The WHO team did see a certain number of problems in drug supply management, for example, an excess of old stocks and lack of feedback of prices, have made the PNG system very demand-oriented.

Each level strives to satisfy the demand (not necessarily equivalent to the need) all along the line, down to the level of the patient. The central level is little involved in rational drug use in the present situation of an inadequate procurement budget. Rational use of drugs is the theoretical duty of the provinces which have not yet tackled the problem of the lack of adherence to standard treatment schedules. The result is that every patient gets a drug, even for very minor conditions and sometimes for no reason at all.

Favorable climate for growth

While the aim of the team was to pinpoint strengths and weaknesses, a discussion of problem areas should not lose sight of the fact that Papua New Guinea has a basically very sound system. Fine tuning of management procedures and improved dialogue in decision-making between the pharmaceutical services and their partners, the provincial health authorities, will do much to create a climate in which this innovative and pioneering system can further evolve and strengthen.

Essential Drugs Programme launched in Yemen Arab Republic

The Essential Drugs Programme of the Yemen Arab Republic, for which the Government of the Netherlands has given generous financial support, got under way in July 1987 with a multitude of different activities. The National Essential Drugs List, drawn up in 1986, is being revised by a national expert committee. Extensive renovation of the Central Medical Stores has started, including the building of additional offices, a cold room, dangerous drugs store, shelving and cupboards, and the provision of fork-lifts and trolleys. A drug quality control laboratory, with equipment and training to be provided by WHO, is being built.

Drug ration kits are being distributed to 22 health centres and 150 primary health care (PHC) units. The kits are delivered to the health centres at three-month intervals, to be collected by PHC workers. For diseases which show regional variation in prevalence, such as malaria and schistosomiasis, only small quantities of essential drugs are included in the kits; additional quantities are distributed by the health centres according to need.

The department of PHC at the Ministry of Health organizes training of the health workers in the rational use of drugs. A steering committee, consisting of the National Programme Coordinator, the Director of PHC, the Director of Medical Supplies and the WHO Representative, meets at least every three months to coordinate the various activities. Technical support is given by the WHO Regional Office in Alexandria and by the Drug Action Programme; this includes regular visits by WHO staff and consultants to advise on specific aspects of the programme, e.g., training, procurement practices, and computerized drug registration systems and inventory control. A separate Plan of Action is drawn up for each year to allow for maximum flexibility.
ACTION PROGRAMME

Bhutan — landlocked, magnificent Himalayan mountain kingdom — is the stuff of which travellers' dreams are made. The climatic contrast of jungle and forest, steaming in the rainy season, and cold, wet, misty highlands creates the violent thunderstorms which gave rise to Bhutan's name, "Land of the Thunder Dragon".

The inaccessibility and independence of Bhutan have helped preserve a traditional way of life in which much of the population functions outside the cash economy. Most people live by subsistence farming or herding and the country is nearly self-sufficient in food production. Despite the relative abundance of food, life expectancy at birth is low, with waterborne parasites, diarrhoea, dysentery, malaria, tuberculosis, pneumonia and goitre taking a heavy toll in terms of disease and death.

An iodizing plant set up in 1984 and a ban on the sale of uniodized salt were major steps towards eradicating hypothyroidism and cretinism — much as another mountainous country, Switzerland, tackled the same problem in earlier times. Basic Health Units, staffed by health assistants, auxiliary nurse-midwives and basic health workers are at the core of Bhutan's public health system, but the shortage of trained personnel is still a major constraint in health development programmes.

In 1985, with help from WHO, Bhutan embarked on a comprehensively essential drugs programme, aimed at strengthening every component of the country's drug supply system. A national drug policy drawn up the following year: [Editors note: text is not legible.]

Drug selection. Selection criteria have been defined and a national list of essential drugs for five levels of health care has been distributed to all health workers. A BHU formulary/therapeutic manual, including standard treatment schedules, has been produced and will soon be tested. Drug information sheets will be compiled into a national formulary.

Quantification. Past consumption data have been used for quantification of hospital drugs, while the morbidity data/standard treatment method has been used for BHU and dispensary estimates.

Quality control. This has been tightened by improved storage management and an agreement with the Central Drugs Laboratory, Calcutta, to undertake QC of random drug samples.

Information. General awareness about the essential drug programme has been promoted in radio and newspaper campaigns. Patient information material has also been tested.

Monitoring and evaluation. A drug supply questionnaire was used to gather baseline data on the availability of essential drugs at health facilities before the improvement. Data on irrational prescribing prior to the introduction of the national formulary and the teaching of rational use were provided by an audit of 1,000 patient prescriptions at Thimphu Hospital. A six-monthly drug report recently introduced will monitor drug availability at health facilities, indicating monthly drug consumption and stock-outs if they occur.

Training. Seminars were held on the essential drug concept, rational prescribing, good storage practices, and the new essential drugs list, and fellowships have been provided for the study of pharmacy. Training is treated as an integral part of the programme.

Although WHO's Action Programme on Essential Drugs funded the first two years' development of the Bhutan Programme (with extrabudgetary resources from FINNIDA and the British Overseas Development Agency), the Government uses national revenue to finance drug purchases and does not depend on external support for its main drug supply. The drug budget has increased by 50% and will now cover a 15-month period, rather than 12 months, to ensure continuity of supplies. This financial commitment demonstrates the vital political support so necessary to achieve the continuous availability of essential drugs.

Tanzanian workshop

Over 70 medical officers, pharmacists, educators, nurse-tutors and managers attended a workshop on the Essential Drugs Concept and the Role of Medical Schools in its Dissemination, organized jointly in Dar-es-Salaam from 11-18 December 1986 by the Ministry of Health of Tanzania, the Faculty of Medicine of the University of Dar-es-Salaam and WHO.

The aims of the workshop were to familiarize participants with the ED concept, to start discussions on a national essential drugs list that would apply to all levels of health care in Tanzania, and to discuss a revision of the medical schools' curricula.

Bhutan has made great progress in two years. At the start of the project, the country had no national pharmacists; today, one has finished a degree course in India and two more are pursuing studies there. It has not been an easy road. However, one setback occurred when UNICEF procured drugs were several months late in delivery and had to be re-shipped. The Thunder Dragon himself might murmur a rumble of approval. ☝
Vietnam moves ahead with essential drugs

A basic health service network combining government input and community participation continued to function even during the very difficult war years in Vietnam. Since transportation and supplies of drugs presented almost intractable problems, an approach of "on-the-spot" logistics, "on-the-spot" drugs and "on-the-spot" physicians (health brigade workers) was adopted. In each communal health centre there were a small pharmacy or drugs kit and a medicinal plants garden. Many families grew their own plants. A list of drugs, classified into three priority groups, was used as a guideline for the supply of the drug kit issued per 1,000 inhabitants each month.

Early in 1980, the old concept of priority drugs was replaced by the WHO concept of essential drugs, defined as those which "satisfy the health care needs of the majority of the population and should therefore be available at all times in the appropriate dosage forms". Vietnam decided to apply the core factors outlined by the WHO Action Programme:

- An essential drugs list of 250 items was adopted, responding centrally to needs in the provinces, districts, and communes. At the commune level, in addition to 33 pharmaceuticals, a further 35 kinds of medicinal plants were included.

- National and regional seminars were held in 1986, 1987 and 1988 for key health staff at the central and provincial levels, to promote the essential drugs concept and inform health workers about efforts to increase the availability of essential drugs and their rational use. Workshops and training courses were also organized for rural and urban health workers to discuss how the essential drugs programme could best be implemented.

- A therapeutic manual for physicians was published in 1986 and 20,000 copies distributed.

- The draft of a guide to essential drugs used in primary health care is now being tested prior to publication.

- Three pilot districts were selected in which to test the application of essential drugs for use in primary health care. Surveys were made of health care needs, morbidity, drug requirements, quality of diagnosis, and treatment facilities. Training courses on statistics, use and storage of drugs were organized for auxiliary doctors, nurses, and midwives.

- Work started on upgrading drug manufacture and storage facilities, while raw materials for basic essential drugs have been supplied through Swedish bilateral aid.

Much has been done in a short period but many problems remain unsolved. Vietnam has not yet been able to ensure adequate quantities of essential drugs for use in primary health care because of the difficult economic situation, the need for modernizing drug manufacturing and storage facilities, and other constraints resulting from lack of resources. Furthermore, prescribing habits of physicians are sometimes irrational and the misuse of antibiotics and vitamins, for example, is all too frequent. Many prescribers do not take into account national economic realities and this causes the drug shortage to worsen.

However, the overall trend and situation is positive and the structure and approach of the Vietnam Essential Drugs Programme is specifically designed to tackle the problems which are being encountered. They should not prove intractable and the contribution of WHO, UNICEF, the Swedish bilateral aid programmes, UNDP and others will undoubtedly facilitate the long-term success of Vietnam's essential drug strategy.
LETTERS TO THE EDITOR

FDA clarification on generics

I am writing in response to your article, “FDA Repels Attack on Generics” in Monitor 4/1987, based on excerpts from an article that appeared in the NABP Newsletter April 1986. That article had responded to various myths regarding US generic drug products. We would suggest that it be pointed out to your readers that the article was written only as a description of FDA’s experience with pharmaceuticals subject to US regulatory requirements, and may not be descriptive of the situation elsewhere.

Teaching medical students about essential drugs

I have just received No 4/1987 of the Essential Drugs Monitor. It is a useful tool of non-formal education on the Essential Drugs List (EDL) in the teaching of our medical students. Unfortunately its presentation stacks up well against the opposition we have — glossy drug advertisements. The medical students’ common room is sprinkled with the brochures: the Monitor would be a useful antidote.

The following is an excerpt from a report on the use of the EDL in our medical curriculum, which I hope you will find informative.

"How do we integrate the concept of the Essential Drugs List into our teaching? Sri Lanka has developed and published our own list for use in the government hospitals and we have copies of the WHO list too.

"1. In the introductory lectures we mention the concept and actually show the students the 22 drugs. Copies are available in the Departmental Common Room and in the faculty library.

"2. In their introduction to learning about drugs in the ward, the EDL is held as the guide to whether a drug is important or not.

"3. In the official guide book of the university, there are brief course outlines on each subject. The statement ‘Emphasis will be laid on the drugs that appear in the Sri Lankan Essential Drug List’ has been included from this year.

"4. In our lectures we always mention the drugs that are in the EDL. For example, in our lecture on beta adrenerceptor blockers we discuss the concepts, the drugs that have beta 1 selectivity and partial agonist activity, giving examples. However at the end of the lecture we mention the drugs that are not in the list.

"5. Unfortunately examinations seem to be the language most students understand best (and sometimes the only one). We have stated that no critical questions will be asked on drugs that are not in the EDL. Even in our multiple-choice questions we try to stick to drugs in the Essential Drugs List, most of the time we are successful.

The Agency would be pleased to provide information to other countries on the procedures and criteria used for approval of generic drug products in the United States. Requests should be addressed to the FDA, Office of Health Affairs (HP-13), 3600 Fisher Lane, Rockville, MD 20857.

Sincerely,

STUART L. NIGHTINGALE, M.D.
Associate Commissioner for Health Affairs
Department of Health and Human Services
Food and Drug Administration
Rockville, Maryland, USA

ACTION PROGRAMME

Pilot project for essential drugs in Guatemala

Solola, in the spectacular highlands of Guatemala, is a province where the ancient Indian culture remains largely intact. Many of the villages are located around the beautiful lake of Atitlan in the vicinity of several inactive volcanoes. But the colourful traditional costumes and distinctive sound of the Mayan languages form a backdrop to a programme which is very much rooted in the twentieth century. For Solola is the site of an exciting WHO/Ministry of Health pilot programme, which began in early 1987, and whose main goal is to create a permanent supply of medicines to support the district primary health care system. The three critical components are technical: building up expertise and infrastructure to provide for the selection, storage and distribution of essential drugs; educational: starting a comprehensive educational programme for professionals and the general population; and financial: setting up a mechanism to fund the provision of drugs.

After one year, the administrative and technical aspects of the programme are well under way. Thirty-two essential drugs have been chosen by local professional health workers, on the basis of epidemiological data, population structure and distribution logistics. No decision has yet been taken on long-term funding although several options have been submitted to the health authorities.

The educational component poses the most formidable obstacles. As in most developing areas, health personnel are in short supply. Also the diversity of languages and the deeply-seated traditions and convictions of the local population have to be very carefully considered in any health message. Traditional community institutions are being used to plant the seeds of change and schools, churches and municipalities will be the channel for health messages and programmes.

The WHO Representative for Guatemala reports that community involvement is crucial, and success or failure of the project may hinge on this single factor.

Experience in the project will be used to guide other essential drugs programmes in Guatemala and elsewhere in Latin America. This exchange of learning has already started. In September 1987, officials from Honduras, El Salvador, the Dominican Republic and Spain came to an international workshop and did a simulation exercise based on an actual situation in the province. Their role-play was recorded on closed-circuit televisi, and they learned about motivation, self-evaluation and practical work with the community. Each of the four countries has now developed a team of multi-disciplinary staff who can start health educational activities, particularly in the field of drug supply, in their own communities.
Generics only for Zimbabwe — a new national drug policy

Some 65 participants from government and private sectors laid the groundwork for a new Zimbabwe drug policy at a National Workshop on Drug Policy and Management held in Victoria Falls in April 1987. The workshop tackled a wide range of drug-related questions covering selection, procurement, manufacture, quality control, distribution, use and management.

Participants recommended:

Generics only. Generic names only will be used for all future imports, manufacture, registration, prescription and dispensing of drugs; the Essential Drugs List of Zimbabwe (EDLIZ) will form the basis of all imports, local manufacture and use of drugs.

Incentives for local manufacture. Government incentives will be given to support the local pharmaceutical industry, particularly for EDLIZ drugs not currently manufactured.

Foreign exchange allocation. The Ministry of Health will be given a regular allocation of foreign exchange for the purchase of finished products and raw materials; a drug supply plan, based on morbidity data and standard treatments, developed by the Zimbabwe Essential Drugs Action Programme with WHO help, will be used to calculate allocations of foreign exchange.

Central procurement. An Advisory Committee composed of all relevant ministries will form a central body for the procurement of drugs.

Quality control. A quality control laboratory, to be fully operational by mid-1988, will act in a national and a regional capacity for SADCC countries.

Special training. Health and pharmaceutical personnel will be retrained under a WHO/DANIDA special programme, using a training manual currently under development. Theory and practice are often divergent but the stakes are high for the Zimbabwe Essential Drugs Action Programme. The implementation of rational drug procurement and delivery will counteract some of the severe foreign exchange problems currently faced by the country. National and individual commitment is strong and backed by support from WHO and DANIDA, so the chances of success look good.

Concern in Pakistan over drug situation

Although around 9,700 drugs are available on the Pakistani market their cost is relatively high and only one third of the population is estimated to have access to even the most essential drugs.

Growing concern about this situation has led to a decision to draw up a national drug policy and a group of experts met in December 1987 to draft the first national list of essential drugs. The national policy is also expected to include computerization of drug registration and progressive review of registered products with, wherever possible, voluntary withdrawal of illogically combined drugs or those with unacceptable adverse reactions. Another crucial component is likely to be the provision of regular, objective drug information to all physicians and pharmacists by means of a drug bulletin sponsored by the Ministry of Health.

Following the visit of a team from the Action Programme, WHO has offered Pakistan assistance in implementing its national policy, specifically in strengthening quality assurance, the production of a drug bulletin and computerization of drug registration.

Nigerian commitment to a better drug supply

The January 1987 budget address of President Babsangida promised that "every effort will be made toward a better implementation of the drug supply system". Action quickly followed words when one month later representatives from the Ministry of Health, WHO, the World Bank and Management Science for Health, Boston, met to develop a specific 1987 work schedule for the preparation of a National Essential Drugs Programme. On the basis of the schedule established, local and international consultants subsequently made assessments of need and proposals to strengthen drug supply logistics.

The Government further demonstrated its commitment to essential drugs by a workshop in October on essential drugs for teaching and special hospitals. Some 50 medical officers, pharmacists, nurses and other health workers met to discuss drugs supply, funding, rational use and management. They expressed support for the national programme and made detailed recommendations for its successful operation.

As well as a comprehensive programme for selection, procurement, distribution and use of drugs, the Nigerian scheme will incorporate a revolving fund under which patients will be charged a token affordable amount for drugs, to ensure community participation. Reputable local manufacturers are being actively encouraged to focus production on essential drugs and there are good prospects that a large proportion of the drugs needed by the National Essential Drugs Programme are within domestic manufacturing capacity. With the active help of WHO and with World Bank financing, plans are progressing well and have received strong support from public health officials at all levels.

The Nigerian adoption of an essential drugs programme is particularly important in view of the size and influence of the country in Africa.
WORLD DRUG SITUATION

Between 1.3 and 2.5 billion people out of a world population of 5 billion have no regular access to essential drugs.

These dramatic figures are taken from a recently published WHO report on the world drug situation, based on a review of more than 100 developing countries. More than 70% of the population in 23% of the countries surveyed - mostly the world's poorest - have no regular access to essential drugs. The drug situation in a second group of countries (33% of the total) was also dismal, with between 40 and 70% of the population without access. National economic development is slightly higher in this group than the first and most countries have a national drug policy or a programme - sometimes at a very early stage - aimed at improving the availability of essential drugs. In the largest group of countries (45%), between 10 and 40% of the population are without regular access to essential drugs. Despite their diversity, most of the countries in this group have many of the components of a national drug policy. The group also includes some developing countries which have achieved a high level of essential drugs coverage.

Increased North-South gap

Global figures for consumption and per capita drug expenditures reflect these gaps in drug availability.

In 1985, the three quarters of the world population who live in developing countries consumed only 21% of the drug production. In monetary terms this means that the 1.2 billion inhabitants of the industrialized world used nearly US$ 75 billion worth of drugs, in sharp contrast to the remaining 4 billion people in developing countries whose share was worth only US$ 20 billion (see figure).

Although monetary factors such as fluctuations in exchange rates and inflation obscure the pleasure, these figures show the immense disequilibrium between North and South. Far from narrowing, this has actually increased over the last decade, during which drug consumption increased by an average of 5.6% per annum in developed countries and only 7.2% in developing areas.

The same trend is apparent in the per capita drug consumption. The gap between the developed and the developing world, already considerable in 1976, continued to grow (see table). While in 1976 in real terms someone in a developed country consumed on average 8.3 times as many drugs as an inhabitant of a developing country, by 1985 this figure had increased to 11.5. The slower drug consumption growth rate in developing areas and accelerated population growth have combined to create this worsening situation.

A review of spending during the decade can be initially misleading. Although the per capita drug consumption, at current prices, was higher in 1985 than in 1976 (US$ 5.4 against US$ 3.4), the situation has in fact deteriorated in many countries, with people spending less in real terms. Furthermore, even these depressing global figures overstate the availability of pharmaceuticals in countries, since they do not reflect the disproportionate consumption between rich and poor in countries where no social security exists.

The amount of money available for drugs is not the only cause of concern; drug consumption patterns and the use of drugs are far from rational. Analysis of leading therapeutic groups and products shows that they respond to the needs of developed countries and that there is a low effective demand in developing countries for drugs which are of the highest priority for the majority of the population. For instance H2 antagonists (against ulcers) were among the four leading products in all the regions of the world in 1985. The report also cites numerous examples of poor prescribing practices, non-compliance and dangerous self-medication.

Research and development bias

In the last decade little change has been seen in the field of drug supply. The top companies, the large research and development-oriented firms, maintained their leading share of the international market, with only minor shifts in their precise market ranking. In 1985, 50 companies accounted for over two-thirds of world sales - the first 25 for about a half - with American companies clearly the market leaders.

The United States is also the major source of new pharmaceutical preparations followed, very recently, by Japan, whose companies seem set on course for further expansion. This sector of the industry, which is still characterized by competition based on product differentiation, patents and brandnames, devotes substantial resources to research and promotion. However, of the 500 new chemical entities marketed in the world during the period 1975-1984, only 30 presented real therapeutic advances. Research into new drugs is still primarily directed towards the health problems of developed countries rather than the more pressing but commercially less advantageous needs of the developing world.

"Social justice demands that all citizens of the world should reach an acceptable level of health that permits them to lead socially and economically productive lives. Before sophisticated measures for individual health care are provided, beyond what can be afforded for the population as a whole."

H. Mahler, Director General, WHO
Generic money savers

The report forecasts that research and development will become more costly, time-consuming and complex, unless innovation can be provided with competitive conditions. However, new developments, such as the success of the generics in the US and other markets will probably bring some changes in the market in developed and developing areas as the availability of low-cost drugs increases. The sale of generics in the US rose from 20% to 25% of the total pharmaceutical market in the period 1978-1985 and it was estimated that in 1984 their sale provided US consumers with approximately US$ 236 million in savings.

Local manufacture developments

In the developing world, some of the larger countries have maturing pharmaceutical industries producing bulk materials and finished products which cover most domestic needs, and which increasingly include exports. Many larger countries are nearly self-sufficient in the production of finished products but these, with some notable exceptions, have been largely unsuccessful in producing drugs at an internationally competitive price. Without supporting industries, without trained staff, and with difficulty in securing a position on the local market, they tend to operate at a low capacity.

Progress in national drug policies

Since the global data are too broad to reveal improvements at the country level, for example, the better use of scarce resources or training of health workers in the rational use of drugs, the report moves from macro (global) to micro (country) level.

People with no access to essential drugs often buy ineffective and sometimes dangerous medications from sources such as this street vendor in Cameroon.

Many countries were found to have taken active steps to bring order out of the prevailing confusion in the pharmaceutical sector and it is obvious that important changes — not always discernible in global data — have occurred at both the international and national levels.

The past decade has witnessed a major debate on the subject of drugs, as governments throughout the world manage to develop mechanisms which will improve the availability and effective use of drugs. Most of the developing countries have adopted a list of essential drugs to be used in their public sector and many have embarked on essential drugs programmes and rational drug policies. Procurement and distribution have been improved in many cases and efforts made to train health personnel in correct drug use. Political commitment also appears stronger and this is a vital element in any drug policy. It can be assumed, in the absence of a baseline survey, that the coverage of the population with essential drugs has increased, mainly in the past five years. But many challenges remain. Progress is slow and endangered by the global economic crisis and the very difficult financial situation of many countries, particularly those in the developing world.

Achieving a more rational use of drugs, and reducing the unacceptable gap between the developed and developing worlds by expanding coverage in essential drugs and consolidating the progress already made by many countries, should be the goals of the next decade, the report concludes. This is clearly not a small challenge and will require not only a deep understanding of the issues involved, but an immense amount of energy, will and commitment to change.


Structure of the world pharmaceutical consumption and population in 1976 and 1985

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<tr>
<th>Country</th>
<th>1976</th>
<th>1985</th>
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<tbody>
<tr>
<td>USA</td>
<td>7.39</td>
<td>18.3</td>
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<tr>
<td>Japan</td>
<td>0.90</td>
<td>9.3</td>
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<td>Total for top 20 drug markets</td>
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<td>Total worldwide</td>
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Source: UNMC Global study of the pharmaceutical industry, 10/WS/G33/16, 1989
IMF, Wirtschaft, 11/80, p. 35
* SDPR: Pharmaceutical Business Opportunities with China, 1987

Developed Countries

Developing Countries

Pharmaceutical Consumption

Population

Pharmaceutical Consumption

Population

1976

1985

74%

73%

24%

27%

79%

75%

21%

25%
New national drug policy for the Philippines

Dr Tomas Maramba, Undersecretary of the Department of Health, Philippines, outlined his country's plans for a new national drug policy at a Bi-Regional Consultative Meeting on Pharmaceuticals in Jakarta, 7-10 December 1987.

He described the problems faced by the Philippines: limited resources were being wasted though irrational drug use and because product information and the prescribing habits of physicians were largely influenced by pharmaceutical firms. Furthermore, 70% of Filipinos were so poor they could not afford the cost of most drugs. Given this situation, the Government had decided to draw up a comprehensive National Drug Policy that would involve all sectors: government, the pharmaceutical industry, professional organizations, educators and consumer groups. Consultations and two multilateral conferences had been held. In addition to doing local research, the Government had also studied the drug policies and experience of 10 countries.

Dr Maramba detailed the four pillars of the National Drug Policy:

First, the rational use of drugs. The National Drug Committee, under the auspices of the Department of Health and Health Minister Dr Alfredo Bengzon, will draw up a National Drug Formulary. Harmful and useless drugs will be deleted and there will be generic labelling and prescribing.

Second, the thorough regulation of pharmaceuticals. The Bureau of Food and Drugs has been reorganized, followed by manpower development and training. Japan has assisted in the construction and equipment of a quality control laboratory, while inspection, product registration and monitoring of drug promotion are being strengthened.

Third, Government procurement of drugs. DOH procurement has been systematized, resulting in 30% savings. Bulk purchasing and contract manufacturing are under study.

Fourth, self-sufficiency. UNIDO and UNDP have agreed to help develop a master plan for the pharmaceutical industry, which will include a multipurpose formulating unit and the potential for backward integration.

The pillars are all interdependent and support each other. Dr Maramba concluded. As the Philippines works through the detailed steps of implementation, it also wishes to exchange its experience with other countries which have gone through the same process.

Health worker home-visiting in the Philippines. WHO recommends a list of 22 essential drugs for community health workers to use.


Records the views of conference participants from all over the world who were drawn from fields as diverse as ministries of health, national and international regulatory authorities, the pharmaceutical industry, consumer protection groups and academic research. The complex issues discussed concerned national drug policies, prescribing practices, the manufacture, marketing, distribution, quality control and regulation of pharmaceuticals and the provision of information to prescribers and consumers.

The first sections of the book include the introductory speeches and a summary of the points debated, indicating the extent of disagreement on each point. They are followed by the 17 working papers prepared for the conference which cover the responsibilities of governments, prescribers and consumers, possible ways of making drug information more objective and more accessible to prescribers and consumers, and suggestions for improving drug marketing and distribution schemes. National case studies from developed and developing countries are used to illustrate some of the ways these suggestions can be put into practice.

Available from: Distribution and Sales, WHO, CH-1211 Geneva 27, Switzerland.


The UNICEF Procurement and Assembly Centre in Copenhagen holds about 10 million dollars' worth of essential drugs in stock for rapid delivery, including most of the 220 essential drugs and vaccines comprising the WHO Model List of Essential Drugs. With UNICEF's system of international tendering, supplies can be bought on the world market at prices that have declined steadily in real terms.

Available from: UNICEF Procurement and Assembly Centre, UNICEF, P.O. Box 240, Copenhagen, Denmark telephone 01.26.24.44.


Includes WHO information on: drugs of contemporary relevance, international Nonproprietary Names, WHO Essential Drugs and model information sheets; and information from research centres and regulatory agencies on: newly detected side-effects, dangerous drug combinations, drug contraindications for certain patients, amendments in product information, changes in treatments of choice, and new indications.

RATIONAL USE

Bangladesh flipchart helps teach correct drug use

In a joint project, WHO, DANIDA, and PATH (US Program for Appropriate Technology in Health) have developed educational material to improve drug use and understanding in Bangladesh.

Beginning in 1985, project staff first talked to prescribers and dispensers, to determine their knowledge of the most frequently used drugs, of patient education and of dispensing practices; and to consumers, to find out about their drug knowledge and behaviour, sources of information, interactions with drug dispensers, consumption patterns and use of non-prescribed medicines.

The concerns of both groups were taken into account in a flipchart and in drug-specific instruction sheets. For example, many clients believe that the same drug is prescribed for all people and all diseases, or that some physicians prescribe "harmless" medication, such as aspirin, simply to satisfy the client's wish for drugs. Some physicians do not mention possible side-effects, and some clients would refuse a medication if told of these.

The project staff developed a series of educational messages and artwork for each of a few selected essential drugs, using pictures rather than words, in view of the low literacy levels in the target population. Initial printing of the sketches, to ensure that they were appropriate and easily understood in both rural and urban areas, provided invaluable insights which were then incorporated into the materials. A final round of printing ensured that the changes were understood and acceptable.

In 1987, the Bangladesh Essential Drugs Programme used the flipchart and drug-specific instruction sheets in a training-of-trainers project. Later, health workers were also trained to use the materials, of which 20,000 copies have been printed and distributed.

It is still too early to determine whether or not drug compliance has been improved as a result of the project, but an impact evaluation of consumer knowledge currently being carried out should provide this information.

EGYPT: workshops focus on rational use and essential drug education

The concept of rational use gained impetus at a recent National Workshop on Rational Use of Essential Drugs, held in Cairo from 29-30 November 1987 and co-sponsored by Ciba-Geigy Ltd.

Participants examined the status of Egypt's Essential Drugs Programme, and reviewed principles and problems related to rational prescribing, particularly of antibiotic, analgesic, anti-inflammatory and psychotropic drugs. They recommended that:

— the Egyptian National Formulary be updated and a standard list of essential drugs prepared in keeping with national drug policy;
— a major information campaign be launched to advise the community on the rational use of drugs;
— objective information on essential drugs be provided to all doctors and pharmacies;
— the curricula of schools of medicine, pharmacy, dentistry and nursing be revised to include the concept of essential drugs, with emphasis on rational prescribing and the use of generic names;
— programmes be organized for continuing education on rational drug use, in collaboration with WHO; and
— studies be initiated to monitor drug use.

Pharmacology teaching reviewed in Cairo

Curriculum content, teacher/student profiles, sources of teaching material and assistance, teaching methods and ultimate educational goals were among the subjects examined at a Cairo Workshop on Teaching in Pharmacology, 1-6 December 1987, held in conjunction with the III Conference of the Union of African Societies of Pharmacology.

One of the principal recommendations to emerge from the Workshop was that the essential drugs concept be introduced and thoroughly covered in schools of medicine, pharmacy, dentistry and nursing. WHO was asked to provide technical assistance and fellowships in support of this goal.
RATIONAL USE

Belize Towards a new drug system

An Essential Drugs Seminar held in June 1987 was a double first for Belize: its first conference on pharmaceutical management programmes, and its first to bring together doctors, pharmacists, nurses and administrators in health care. Three mixed groups examined drug selection, financing the supply system, and the management of the national drug service. The seminar was sponsored by the USAID/PAHO/WHO Essential Drugs Project for Central America in cooperation with the Ministry of Health. In 1986, Belize published an interim edition of a new government national formulary (previously a city hospital formulary only). The Drug Selection Working Group reported that major constraints in the use of the formulary had been the lack of motivation and cooperation of doctors and pharmacists, and difficulty in obtaining feedback from health personnel. Practitioners tended to be concerned with local needs rather than the national perspective. This could be counteracted by assigning more definitive levels of use for each pharmaceutical, with emphasis on the primary health care system. Making the formulary work required the backing of government officials and the cooperation of each member of the health care team.

Problems cited by the Financing Group included inadequate funding for the necessary coverage, lack of teamwork by health professionals leading to inefficient use and waste, and lack of public awareness of the cost of drugs. Funding problems could be eased by the contribution of consumers to drug cost according to their financial means, and by exempting from customs duty only those drugs included in the national formulary.

Lack of data on which to base forecasts, unpredictable procurement leadtimes, unnecessary record-keeping required by out-dated regulations and scattered, crowded warehouse facilities were cited as management problems. Proposed solutions included a modern, comprehensive information system, a longer financial accounting period to provide greater flexibility, a specially designed building for essential drugs with trained staff, and a national tendering system.

Participants concluded by recommending the urgent establishment of a committee to plan and bring into operation a comprehensive national pharmaceutical policy, using the findings and impetus of the seminar.

Barbados to combat irrational prescribing

The Barbados Drug Service is calling on all prescribers to contribute to the more rational use of drugs, so that the free supply of drugs to health service patients can be maintained. A protocol covering the 20 most frequently prescribed drugs now limits the permitted quantities of such items as antibiotics, analgesics, antacids, anti-inflammatory products, antihistamines, ointment and creams, which account for 4% of the national drug bill.

The BDS points to the fact that whereas once only a few residents had access to free drugs, now all have an equal entitlement. This has been achieved at a limited cost through good management, careful financial control and cooperation between health care professionals. A well-managed and functioning drug service has an impact not only on the health service but in a broader realm on national economics.

Every doctor is now being asked to conduct a self-audit of prescribing habits.

Lennox Preedoe, Director of BDS, says that early results have been very promising, with a preliminary review of prescriptions indicating a concerted effort to comply with the protocol. He has also received many letters and calls of support for the initiative from doctors and pharmacists throughout the island.

Fewer drugs, better therapy: learning from the Third World?

BUKO, a coalition of about 200 German development groups, held an international conference in Bielefeld, FRG, in October 1987 to highlight the fundamentally similar irrational use of medicines in many developing and industrialised countries. Participants from NGOs, academia and industry learnt that in both West Germany and India, for example, well over 40,000 different formulations are on the market, whereas the WHO model list of essential drugs contains only about 250. The conference discussed the relationship between such numbers and the quality of drugs.

The Bielefeld agenda also covered the successful Bangladesh drug policy, the urgent need for the adoption of an essential drug policy in developing countries threatened by the current debt crisis and the creation of hospital and general practice formularies.

A report of the conference, can be obtained from BUKO Pharma Kampagne, Dritte Welt Haus, August-Bebel-Straße 62, D-4800 Bielefeld 1, FRG.

— HA! News, No. 38, December 1987
French ED Symposium breaks all records

"Une conférence formidable"

An international symposium in Paris, 19-20 May 1987, brought together over 700 people from French-speaking countries, universities, research groups, the pharmaceutical industry, and non-governmental organizations — the largest group ever to meet to discuss essential drug programmes and policies.

The symposium, organized by the Groupe d’Etudes d’Epidemiologiques et Propylactiques (GEEP), a non-government research group based in Paris, was co-sponsored by the Action Programme, the Ministry of Cooperation of France and the UNICEF/France committee.

Some 60 oral presentations and 100 posters covered essential drugs-related topics, including the sociological, anthropological, and economic aspects of drugs; legislation; monitoring and evaluation; quantification; traditional medicines; transfer of technology; local production; quality control; and improving prescription, training, and the use of pharmaceuticals.

The consensus: "C'était formidable — et on a bien mangé aussi!"

Zimbabwe seminar on ED financing

Nearly 40 people from a dozen African countries and organizations met in Harare, Zimbabwe, from 14-18 March 1988 to discuss ways to improve the financing of essential drugs in developing countries. Sponsored by WHO, the conference also brought together various donors and international organizations, including UNICEF, the World Bank, and USAID.

Participants, who included economists, pharmacists and medical personnel, shared their experience in financing drug supplies. They emphasized the need to make the drug supply system more efficient through improved quantification, selection and procurement; appropriate storage and distribution systems; good security and management; and better prescription practices.

Financing and cost recovery issues were explored, including equity and income levels, how to set prices, alternatives to direct cost recovery for drug financing, and administrative and financial arrangements to ensure the availability of foreign exchange.

The participants drafted a brief statement on drug financing at the end of the seminar. WHO will produce a document distilling the experience presented in the seminar and offering concrete guidance to those wishing to improve drug financing.

Hoechst offers QC training to developing countries

On-the-spot training in quality control is offered to pharmacists from developing countries by Hoechst, Federal Republic of Germany. Two pharmacists from Tanzania who recently spent six weeks at the Hoechst laboratory in Cairo praised the relevance and practical value of the training they had received.

The goal of the programme is to improve third world capacity in quality control, particularly for Africa, where the shortage of trained people is most acute. During the last few years Hoechst has trained some 50 pharmacists at its quality control laboratories in Germany, Egypt, France, India and Indonesia. The company’s commitment to Third World training is also reflected in the special three month course offered each year to 175 pharmacy students in ten other countries: Bangladesh, Ecuador, India, Indonesia, Morocco, Mexico, Pakistan, Thailand, Turkey and Venezuela.

Latin American essential drugs initiative

The first Latin American Conference on Pharmaceutical Policies and Essential Drugs will be held in Mexico from 10-14 October 1988. Pharmaceutical policies, production and the rational use of drugs will be discussed in the light of experiences in the Region. Participants will include policy and decision makers, researchers, regulators, industry and consumer groups.

For further information write to: Dr Nadine Casman Instituto Nacional de Salud Publica 177-5 Francisco P. Miranda, Mexico D.F., 01480, Mexico Tel. (525) 680-4556.

Barrier contraceptives now in Model List

Condoms, IUDs, diaphragms and spermicides are now included in the WHO Model List of Essential Drugs. The WHO Expert Committee on the Use of Essential Drugs, which met in Geneva in December 1987, updated the Model List and stressed the importance of barrier methods of contraception.

"The Committee stressed the importance of barrier methods of contraception."

In all, 21 new compounds were added to the list, eight deleted and a further 10 transferred from the main to the complementary list. Six of the newly admitted compounds (benzimidazole, ivermectin, levamisole, mefloquine, meglumine antimoniate and praziquantel) are intended exclusively for the treatment of tropical diseases.

The Committee decided not to include in its report a model list of drugs for primary health care since experience has shown that both drug requirements and the training of health care workers responsible for the delivery of primary health care differ so markedly from country to country. It emphasized the flexibility of the essential drugs concept and its relevance to primary health care. The full report will be published in the WHO Technical Report Series in mid-1989.

Quality control is an important part of the manufacturing process.

WHO helps donors with Sudan aid coordination

At the request of the Sudanese government, WHO is to help coordinate donor activities in the field of drug supplies. Donor assistance for this largest country in Africa may range from major structural support programmes, such as the $10 million Sudanese-Dutch bilateral programme to renovate the Central Medical Stores, to individual consignments of drugs sent by NGOs.

A WHO mission reported in November 1987 on past and future activities of all possible donors and assisted the Ministry of Health in drafting a donor policy document and information material. Two months later, a large donor conference held in Khartoum with WHO assistance facilitated coordination between donors and government and provided a forum in which to analyse and discuss the need for future aid.

Sudan now plans to site donor support coordination in the Department of Medical Supplies and establish a national working group to forecast and analyse drug and medical supplies needs. WHO will continue to advise the government.
NEWS DESK

Ivermectin: New drug for river blindness

American pharmaceutical company Merck, will provide its new microfilaricide, ivermectin, (now included in WHO's Model List) free-of-charge to qualified onchocerciasis control programmes. WHO estimates that 18 million people are currently infected with onchocerciasis around the world, with another 85 million at risk in areas where the disease is endemic. Onchocerciasis is transmitted from person to person by the bite of the blackfly, which breeds in fast-flowing rivers — hence the name river blindness. Caused by a parasitic worm that invades the human body, the disease is characterized by severe itching, disfiguring skin nodules and — in untreated cases — eye lesions that eventually lead to blindness.

WHO, through the Onchocerciasis Control Programme in West Africa (OCP) and the Special Programme for Research and Training in Tropical Diseases, collaborated with Merck in the development of ivermectin for wide-scale use. Halfdan Mahler, WHO's Director-General, says that this fruitful collaboration will continue in large-scale trials of the drug now being organized. He called the development, testing and use of ivermectin for the treatment of river blindness a critical breakthrough in the struggle against disease, which exemplified the useful results that can be achieved from collaboration between the pharmaceutical industry and WHO for the improvement of health.

Financing discussed at Addis Ababa

Programme, logistics and training managers from nine countries met in Ethiopia in November 1987 at a WHO Workshop on Operating Essential Drugs Programmes. The participants found they had much the same successes and problems with national programmes, the most common being the distribution of drugs to the peripheral health facilities.

It was clear from the talks that many countries are beginning to come to terms with the fact that drugs can no longer be supplied entirely free, and are considering measures to recover some costs. The managers examined a number of options for drug financing and cost recovery systems. Logistics, distribution, training in rational use, and monitoring/evaluation systems also gave rise to lively discussion.

Board endorsement of ethical criteria

The January meeting of WHO's Executive Board recommended that the Forty-First World Health Assembly, to be held in May, endorse ethical criteria for medicinal drug promotion prepared by an international group of experts and reviewed by the Board's Ad Hoc Committee on Drug Policies. The Board also recommended to the forthcoming WHA the adoption of a resolution calling for continued support of WHO's revised drug strategy, including assistance to developing countries in setting up and carrying out programmes aimed at ensuring the rational use of drugs, particularly essential drugs programmes. A full account of the WHA debate and resolutions on the revised drug strategy will appear in the next issue of the Monitor.

American training in hospital pharmacy

The first Regional Training Course in Hospital Pharmacy Administration, co-sponsored by the WHO Regional Office for the Americas, will be held in San José, Costa Rica from 4 April-24 June 1988. Its aim is to provide training in the administrative, operational and technical aspects of running a hospital pharmacy, with emphasis on the practical participation of the students in every aspect of the programme.
ICU World Congress held in Madrid

The adequacy of drug information provided by health workers to patients, and how patients perceive and use such information, was examined at a workshop on "Patients, Health Workers and Drug Information" held during the 12th International Organization of Consumers Unions (ICCU) World Congress, Madrid, September 1987.

An Australian Consumers' Association survey on the elderly disclosed that many patients were taking several drugs at a time and some were using 13 different drugs a day! The bulk of the information given to patients came from doctors and pharmacists but was inadequate. More detailed information about their drugs and treatment was clearly needed.

Core group of consultants meet in Burundi

Too often the experience acquired in the field in implementing essential drugs programmes remains local property. Each country ends up experiencing the same difficulties as its neighbors, without having the opportunity to learn from their mistakes.

In an effort to develop regional capacity to share expertise and experience, WHO sponsored a seminar to brief a Core Group of 11 French-speaking African consultants in Bujumbura, Burundi, from 19-23 October 1987. A similar seminar had been held for English-speaking countries in Nairobi in October 1986.

The objective was to fully prepare the experts to carry out consultations in various aspects of essential drugs programmes for the WHO African Regional Office (AFRO). At the end of the seminar, participants were expected to be able to inform national authorities and others about the essential drugs programmes and policy; to analyse problems in detail and prepare recommendations for solutions; to provide technical assistance in their respective areas of expertise; and to develop strategies, methods, and materials to support the implementation of essential drugs policies.

The seminar used the case-study method to examine what previous consultants had recommended; participants then discussed whether they would have made the same recommendations, and why.

Essential drugs and NGOs

Medicins du Monde France and Frères des Hommes, an affiliate of Health Action International, organized a three-day seminar in Paris, from 11-13 December 1987, on the role of NGOs in promoting essential drug policies in developing countries. About 40 people from French NGOs, including the Centre International de l'Enfance and Médecins sans Frontières, debated their role and the merits of the widespread practice of collecting leftover drugs for distribution in developing countries.

The need for improved information on drugs and prescription practices emerged as an area where NGOs could play an important and positive role. Mr Jacques Pinel of Médecins sans Frontières explained the work that had been done to produce drug information for use in emergency situations and in primary health care, and showed the prescriber's manual prepared by MSF.

Quality control in Latin America

The Third Meeting of the Latin American Network of Official Pharmaceutical Quality Control Laboratories was held in Lima, Peru, in October 1987, with the co-sponsorship of the Pan American Health Organization.

The Network facilitates inter-laboratory communication, works to standardize methodology for better reproducibility of results, fosters collaborative research, technical cooperation and training activities, and promotes the systematic quality control by Latin American countries of pharmaceuticals on the international market.

Planning meeting for technical cooperation

Participants from the WHO South-East Asia and Western Pacific Regions attended a bi-regional meeting on Technical Cooperation in the field of Pharmaceuticals, in Jakarta, December 1987. Their main recommendations included a directory of available training courses; exchange of new drug evaluation reports; establishment of pool procurement; sharing of expertise in procurement, storage and distribution; and the creation of a database on commonly used medicinal plants.

US drug education campaign for public

A second "Talk about Prescriptions" month was launched by the US National Council on Patient Information and Education in October, in a campaign to improve communication between health professionals and prescription drug users.

It highlights techniques for effective communication on drug use and gives five key questions which the patient should always ask:

- What is the name of the drug and what is it supposed to do?
- How and when do I take it — and for how long?
- What foods, drinks, other medicines or activities should I avoid when taking this drug?
- Are there any side-effects and what do I do if they occur?
- Is there any written information available about the drug?
REVISED DRUG STRATEGY

DRUG STRATEGY
STEADY
ON COURSE

Financial support

Development agencies and industrialized countries have donated more than $500 million in the last few years to support national essential drug programmes, according to a report on WHO's revised drug strategy issued for the January 1988 meeting of the WHO Executive Board.

Progress

This huge injection of finance and technical services was matched by impressive progress in developing countries during the first 18 months after the strategy became operational, says the report. At the latest count, 109 countries had national essential drug lists, 37 had operational programmes, 24 were at the planning stage, and 19 were actively considering a national drug policy.

Bamako Initiative

Meanwhile, the Dutch Government and Band Aid have given a combined total of $6 million to the $33 million UNICEF procurement fund, which helps poor countries finance essential drug purchases. UNICEF is also pressing ahead with its Bamako Initiative of September 1987, a procurement scheme for African countries.

Industry

The report commends the pharmaceutical industry for its support to developing countries and for its training schemes, and says that manufacturers are bidding good prices in response to UNICEF/WHO international tenders for essential drugs, although the fall of the dollar has caused a price increase for some products. To help countries still paying too much for drugs and raw materials, market information on prices, availability and sources of products compiled with the help of UNIDO and UNICEF, should be available from WHO by mid-1988.

Training

Pointing to an area where less progress has been made, the report notes that regrettably few training schools for doctors, pharmacists and health workers have yet changed the curriculum to include instruction on essential drugs and their rational use. Bangladesh, Democratic Yemen, India, Nepal, Sudan and Tanzania are among the rare exceptions where efforts are being made to improve prescribing habits by changing the syllabus.

Rational use

Tackling the same problem from another angle, consumer groups continue to be active in promoting essential drugs to the general public. General sources in the Philippines sell western drugs tiki-tiki a few pails at a time. People depend on themselves, often irrationally.

Operational research

Contributing to the drug strategy's operational research programme, Botswana, Lesotho and Zimbabwe are testing methods of estimating drug requirements by using the illness rates in the population combined with standard treatment schedules. Another study in India, Kenya, Malawi, Sri Lanka and Thailand is designed to find out how much people from various income groups and areas actually spend on medicines for themselves and their relatives, and how much they might be able to pay for their own health care. Many countries have been reluctant to charge for drugs in the past, but economic pressures are now forcing them to test various “cost-sharing” alternatives.

Licensing

Turning to drug licensing and regulation, the report says that a team of two or three pharmacists and a supporting staff are enough to set up an effective small national regulatory authority, using the WHO Certification Scheme, information from WHO and other governments, and microscopy. But they should be able to stay long enough in their posts to both acquire and use training and experience, the greatest asset such an authority can have.

The World Situation

On a sobering note, the report estimates that up to a “staggering” two billion people are still deprived of regular access to essential drugs.

Although WHO guidelines on national drug policies are now available, many countries have apparently failed to drum up enough political will to change their policies in favour of the increased availability and use of essential drugs in primary health care.

PHOTOGRAPHS OR DRAWINGS WANTED FROM READERS

The Monitor wants to share any photographs, slides, drawings or cartoons you may have depicting essential drugs activities where you work or where you live. What are we particularly interested in? ANY ASPECT AT ALL of your drug program, whether it be pictures of drug kits arriving at your health centre (especially if the means of transportation is unusual), place of storage, dispensing clinics, training sessions or educational material you are using.

We will pay US$ 5 for any picture published but regret that we cannot return material we don't use. Please mark on the back of your picture what is taking place and where. If we do decide to publish your picture we may write to you to ask for the negative. The address to send your material is: The Editor, Essential Drugs Monitor, World Health Organization, CH-1211 Geneva 27, Switzerland.