NATIONAL DRUG POLICY

Syria's Minister of Health explains national drug policy

Professor Eyad Chatty, Syria's Minister of Health, talked in Damascus with EDM Editor Ms Daphne Fresle

EDM: Syria held a national drug policy meeting earlier this year, which produced a draft document that has now been formally issued as the Syrian national drug policy. Is there a link between this policy development and the rapid expansion in the national pharmaceutical industry, which now produces 65% of the drugs in the local market?

EC: Self-reliance is seen as important to small countries which would like to develop their national resources to the limits. His excellency President Hafez Al Assad has always brought our attention to this fact, and from that point of view we realised that we should produce more essential drugs. We wanted to benefit from technology transfer and to develop a basic infrastructure reaching far into the next century. What we are doing now, although it is a major thrust, is only a preliminary step. We plan to develop our own raw material. This is not just out of national pride but because we believe it to be economically viable. Also - although I don't want to philosophise - if you are committed to upgrading the health system, then drugs are a very essential component.

Photo: WHO/D. Fresle

Syria's rapidly expanding pharmaceutical industry is in the tradition of its rich trading past. Above, the agora or market place of the ancient desert city of Palmyra which flourished two thousand years ago.

EDM: So was this development in production capacity a precipitating factor in developing the policy?

EC: When we started we were not able to formulate a policy but we had a target: to have basic drugs available that would match our needs and at a fair price. By fair I mean there has to be a sufficient incentive for the manufacturers or they won't produce, but the price should be within the reach of the average working man or woman. So we had a target, but I must admit that we worked more with enthusiasm than knowledge. Then as we learned more, we recruited committed and experienced people.

We reached the stage where we had many factories and we also had many components of a policy, but they had not been linked at a "global" level. So we thought, right, now is the time to bring together all of this practical experience within a guiding structure. Now is the right time to formulate a national drug policy. And I have to say that the guidance of WHO was essential for this. I believe that WHO was also willing to provide such support because they considered that our approach was sound.

EDM: How did you actually go about developing that policy?

EC: After we had recruited the right people we looked closely into each of the main components, in particular to see how they were interconnected. For instance, we had to base what we needed on a national drug list. I use that term now. In fact, it is an essential drugs list but it is our national list, which meets our needs. The first list was developed in 1988 after we had identified this as a target. But later, in the light of experience, more data and with a critical eye to maximising economic resources, we re-examined every single item. We deleted many items, we added others, but this time round, the focus on our health system, morbidity pattern and the economic factor, played a role in making the second edition more suitable to our needs.

Then we had to look at legislation. We knew that we could not work alone in this respect, if we wanted implementing power, so we collaborated with the Ministry of Justice and with the Internal Review Department in formulating and updating appropriate legislation.

EDM: Which is critical.

EC: Yes indeed. And then we started work to develop better ties with the professional associations: the syndicates of pharmacists, of dentists and of physicians. As a result of which they help us more and we can apply what we think is right through "longer hands with more fingers".

EDM: Did these better ties come about directly as a result of this policy development process? We find that in some countries the process of policy development or a national drug policy meeting may bring together professional groups who never encounter each other under normal circumstances. It can be very enlightening to listen to what colleagues from different professions have to say about the constraints and targets of their work. Would you say that happened in Syria.

EC We used to have what was called a technical drug committee, but it was more or less obsolete. We decided to revive and restructure the membership so that it could play a dynamic role in drug issues. We brought in the university: the dean of the school of pharmacy and the head of the section of pharmacology of the school of medicine are now members of the committee. We brought in the heads of the syndicates of pharmacists and of physicians. We brought in representatives of the two public sector manufacturing plants, and the body responsible for importing drugs. We also have representatives of the private manufacturing sector and, of course, the committee contains key people from the Ministry of Health. We work together very diligently every Sunday and Tuesday. If you come here at 8 p.m. the committee members are here and they rarely leave before 10 p.m.

EDM: And I know that you personally chair each of these meetings.

EC: I like to chair each one. Although I know there is still much more to learn, I have learned a lot in the process, which has later been translated into policy. From discussions in the committee it is possible to get a really good picture of what is happening. We have now gone a significant stage further. I have established a medical scientific council for the manufacturers, which will "shadow" the technical committee. I purposely delegate some work to them to create an active response.

We are now moving to a new phase. The manufacturers' council now has a drug research fund: for every drug research project there has to be a parallel public health project financed from the fund. Another new activity that started in November is that the scientific council will start meeting with members of professional associations of every medical specialty, such as the Society of Pediatricians, or of Gastroenterologists, to discuss needs and problem areas. Let them interact and something good has to come out of it. I know what I want from it. I want the physicians to express any concerns they may have not through the media or in consulting rooms, but to talk directly to the manufacturers: to ask why, for example, two drugs are the same but one is more expensive than another.

Photo: WHO/D. Fresle

Professor Eyad Chatty,

EDM: So the discussions and recommendations of the drug policy meeting in April were really only the immediately visible tip of the iceberg: the rest was all this work that had gone on beforehand, and is now continuing, and which had enabled you at the policy meeting to articulate a comprehensive policy.

EC: Yes, that's so.

EDM: It is not always possible to implement all components of a drug policy at one time. Is that the case in Syria and do you have priorities?

EC: Many of the components were in place before we could look at them globally. There is now greater integration, but of course not everything can be done at once. One aspect of the new policy was to investigate the possible production and uses of herbal medicine. Over a period of four months we have been calling on herbal experts within the country, and this culminated in a planning and strategy meeting. We had people from throughout the country - 89 in all - to pool knowledge and experience. We are now working in groups to see what medicinal plants exist in Syria, what studies have been done, whether mass production is feasible, how we should go about quality control,and whether there is a need for special legislation. So that is an example of one of our priorities, but of course there are many other policy components and we can't tackle everything at the same time. At the moment we are surveying our pricing policy, because if we produce good drugs but they are priced out of reach for the average citizen, then we have established nothing!

EDM: The current global recession is having a very negative impact on the public sector health services and in some countries the public sector drug supply is drying up. While the public sector is shrinking the private sector is growing, yet people cannot necessarily afford health care and medicines from the private sector, nor do such supplies necessarily match real health needs. How do you, as Minister of Health, view the role of government support to the public sector, and the role of the public sector in health care.

EC: We are deeply committed to supporting the public sector but on a rational basis. We need the public sector because it is a good balancing tool in the hands of the government, and because in our case it has served as a pool for experts. However, the public sector has to support itself before the government supports it. One critical type of support is the rational use of drugs. For instance, a significant problem area that springs immediately to mind concerns the use of oral rehydration salts for diarrhoea. We have

been successful in making ORS available throughout Syria and it is used everywhere. I insist that the physicians must teach the mothers how to use ORS, but they don't do this. They just hand over the packet. And the problem is that they are also using antibiotics at the same time. So, I am eager to tackle this and other urgent problems of rational use. We have to reach the people and the physicians through a well oriented campaign to bring more science, more rational thinking and better habits regarding the use of drugs. As you know, we are planning a public campaign focusing on rational drug use.

EDM: WHO's Action Programme has a strong commitment to such work and we are collaborating with a number of countries in the development of information and educational campaigns to improve drug use. We advocate that countries do not just launch a major information and education campaign without any preliminary research - however basic - on drug use in the community. We often know, for instance, that certain drugs are being misused from a scientific viewpoint, but we don't always understand why. We need to investigate drug use in the community and the beliefs and perceptions on which that behaviour is based, together with the channels of communication through which people learn about drugs - which are not always professional channels. It is notoriously difficult to change people's behaviour, but without an understanding of the underlying motivations I think it is probably impossible. Just providing information is not enough. Look at the number of health professionals who still smoke despite their knowledge of the enormous health risks that result from the consumption of tobacco.

EDM: The national drug policy document does not specify the control of drug promotion. In some countries inappropriate promotion is a major factor contributing towards the irrational use of drugs.

EC: I think that control of promotion is very important. We have delegated this to the scientific committee and all promotional material and practices are closely vetted.

EDM: The drug policy speaks of "promoting" the use of generic names. How is this being implemented.

EC: Firstly, we are decreasing the amount of combination products and this policy will help us promote generics. Then it is mandatory that the generic name has to appear on the pack. Although there are no regulations on type size yet we intend to push for the generic name to appear in larger letters than at present.

EDM: The generic name does not have to appear on the prescription though, does it?

EC: Not at this stage.

EDM: Are you considering making this obligatory, since the mandatory addition of the generic name to a prescription (even where a brand name is given) is in itself a form of public education? It helps patients to understand that drugs with different brand names can be the same substances. There is undoubtedly quite a lot of confusion about that in the public mind at present. It also has a potential contribution to make to more rational drug use by professionals.

EC: I think that this is important because the essential drugs list uses only the generic name. I intend to make the essential drugs list the backbone of teaching pharmacology in medicine.

EDM: May I ask one final question about health education and public education. It seems to me that in much of our medical and pharmacy education we are not teaching students to communicate well and we are not teaching them about their health education role in the community. What are your views on the need for this in health professional education?

EC: I think it is extremely important and we are trying to fill this gap. It is a true gap, and at the moment I don't know what is the best formula, but personally I am aware of it. The concept of health education is carried now in the "souls" of all our graduates from the institute of public health. They are starting to get into key positions in the Ministry of Health and we have to reflect that to the teaching institutes. Fortunately we are now the major contributors to teaching residents. In the Ministry we have two and a half times as many residents as the combined universities at the moment, and we have two disciplines which are not available in the university, one is that of family physician, and the second is public health.

EDM: So would you agree that possibly we need to restructure our curricula somewhat, perhaps diminish a little the biomedical focus and increase the focus on education and counselling and public health in our medical education.

EC: In 1986, when I was dean of the medical school and looking at the restructuring of the curriculum, I decided that my main task really was to define the kind of physician we needed. In that definition we also included "and to deal with patients", in other words to educate them. One problem is that the focus of universities is "minute areas, miles deep and only metres wide", and we need to broaden our approach. So the concept is there but finding the best formula to apply it is not easy.

EDM: I think that basic communication principles are not so difficult to teach and we could do that if we were prepared to allocate the necessary time in the curriculum. The problem is more one of convincing health professionals of the role they should play in empowering the patient and community. Doctors are not always so eager to share their hard acquired professional knowledge with lay people. They often prefer to maintain a professional mystique and to have a patient who just does what they say and doesn't ask "awkward" questions. But in reality this does not lead to a very effective therapeutic encounter because studies show that many patients leave the doctors' consulting rooms or health centre with little or no knowledge about their condition or how to take their medicine.

We hope that the findings from research into drug use in the community that we are supporting in a number of countries can eventually be used as a training tool for health professionals, because they will tell us more of what is going on in the community: how people use drugs and how they perceive them. Such research if acted upon can lead to a better understanding between the health care provider and the patient.

Photo: WHO/D. Fresle

Syria is investigating the possible production and uses of herbal medicine. Here herbs and spices are sold in a Damascus souk.

EC: I think if truly in our minds we had considered this a priority and we had given it proper attention, we would have found solutions. We are convinced of the need but have not given it priority. There has to be a solution but that may be gradual. The key is to find the proper teachers. I have seen over and over again in the university, how one man or woman can bring about radical change if they have the right skills and commitment. And although some expertise can be imported you cannot import all the skills because they have to be supplied locally and this has to do with culture and many other factors. Perhaps the project we are now discussing with our institute of public health will help us find a point of focus.

EDM: Before we close, is there anything you would like to add about policy development that we have not discussed?

EC: As far as drug policy is concerned, I believe that at each stage we shall need to reconsider and, where necessary, revise our policy. Even the priorities may change in time. So it is an ongoing process and I think we have to be open to change. In this way we will match the social advances that are taking place in the world. Without this flexibility we may lag behind. We need to work with people who are not only technically knowledgeable but who also embody a commitment to social ideals and advancement. ■