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.

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 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: What is the situation with the pharmaceutical industry?

EC: The pharmaceutical industry has been growing and expanding at an impressive rate. Now we have factories that produce 65% of the drugs we need. This is not only an expansion in capacity but also in the range of products. We have diversified our production to include not just essential drugs but also a wide range of other medicines. We have expanded our production facilities and are now able to meet the needs of our population.
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. 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 scientific, 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 it 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 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 each 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 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 centres with little or no knowledge about their condition or how to take their medications.

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.

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 tools. I have seen over and over again in the university, how one young woman can bring about radical change if she has 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 conference 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.