Essential Drugs Monitor

The Essential Drugs Monitor is produced and distributed by the WHO Action Programme on Essential Drugs. It is published in English, French, Spanish and Russian, and has a global readership of some 200,000 to whom it is free of charge. The Monitor carries news of developments in national drug policies, therapeutic guidelines, current pharmaceutical issues, educational strategies and operational research.

WHO's Action Programme on Essential Drugs was established in 1981 to provide operational support to countries in the development of national drug policies and to work towards the rational use of drugs. The Programme seeks to ensure that all people, wherever they may be, are able to obtain the drugs they need at the lowest possible price, that these drugs are safe and effective, and that they are prescribed and used rationally.

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EDITORIAL

Medicines play an important part in international humanitarian relief efforts, and drug donations can take many forms. They may be channeled through aid agencies in emergency situations or be included by governments in development aid. They may be sent from groups of concerned individuals or NGOs with regular links to the developing world. Drug donations may also have a commercial face; used by companies to obtain tax deductions on unused stock or create a later market for certain products.

In most cases the individuals and organizations involved see donations as tangible expressions of concern and solidarity with people in need. But despite good intentions, experience over the years shows that some drug donations can be more harmful than helpful. They may not be relevant for the emergency situation, for the disease pattern or for the level of care that is available; they may even be dangerous. They may be unknown to local health professionals and patients and may not comply with local drug policies or standard treatment guidelines. Many donated drugs arrive unsorted, or without an international nonproprietary (generic) name on the label. When this occurs, scarce resources are wasted and people in need continue to suffer.

There are several underlying reasons for these problems. Probably the most important is the common but mistaken belief that where there is a scarcity of drugs any type of drug is better than none at all. Another is a lack of communication between donor and recipient, so that needs and local resources are not properly determined. Donating drugs is a complicated process in which donor and recipient need to cooperate in order to ensure that the donation is useful.

In order to help both donors and recipients to maximise the potential benefits of drug donations, WHO has been working with the major international relief agencies (UNHCR, UNICEF, ICRC, IFRCRCS, MSF, CMC and OXFAM) to develop interagency guidelines. These were finalised and formally endorsed in April 1996, and are reproduced in full in this issue. The guidelines build on earlier work by the International Committee of the Red Cross and the Christian Medical Commission of the World Council of Churches. They reflect not only an interagency consensus but also consultations with over 100 humanitarian organizations and individual experts.

The guidelines are based on four core principles:
1) a drug donation should benefit the recipient to the maximum extent possible; 2) a donation should respect the wishes and authority of the recipient, and support existing government policies; 3) there should be no double standards in quality – if the quality of an item is unacceptable in the donor country, it is also unacceptable as a donation; and 4) there should be effective communication between the donor and the recipient.

Much has been written about the problems and extent of inappropriate drug donations. But in highlighting and tackling these it is also important not to lose sight of the many donations which have met critical needs in time of crisis and shortage. The new guidelines are intended to encourage and facilitate this work and to help both donors and recipients make sure that they really get the best out of the resources expended. The use of the guidelines will be monitored and they will be reviewed after one year’s experience to determine any areas in which they need to be strengthened or modified.
PUBLIC EDUCATION

Consumers and drugs in Poland

Barbara Mintzes

"O ne can only wonder – if these drugs are ineffective, why are so many prescribed by doctors?", asked Wojciech Maselbas of the Warsaw Academy of Medicine. He was referring to a list of the most frequently used drugs in Poland, during a meeting of consumers, health workers and policy makers, held in Warsaw in September 1995. The Polish Consumer Federation embarked on a one-year consumer education project in late 1994, so beginning work to improve the way medicines are prescribed, used and regulated in Poland. This project was co-sponsored by Health Action International (HAI-Europe) and financed by the European Union’s PHARE Programme.

The creation of the bulletin, Consumers and Drugs, is another important step in the campaign to educate the public about the problems of drug prescription. The Consumer Federation surveyed Polish consumers about their use of medicines and found that many used drugs without first consulting a doctor. The Federation compiled a list of the most frequently sold drugs in Poland - a list that included many antidepressants, laxatives and painkillers. The Federation then surveyed consumers about their use of these drugs and found that many were using them incorrectly. The Federation then began a public education campaign to inform consumers about the dangers of drug use and to encourage them to use medicines only when necessary. The campaign was successful, and it is now easier for consumers to understand the dangers of drug use and to make informed decisions about their health.
Med-Sens: more is not always better

“Med-Sens” (the Polish pill-box) was launched at a packed press conference in Warsaw in September 1995. The journalists all received not only a pack of Med-Sens but a proverbial “apple a day to keep the doctor away”.

Med-Sens has leaflets on:
- every drug has side effects
- the essential drugs concept
- 12 questions to ask your doctor
- contraceptives
- drugs and the elderly
- drugs in pregnancy
- vitamins and minerals
- analgesics
- antibiotics
- cough and cold remedies
- tranquilizers and sleeping pills
- contraceptives

“Med-Sens” has proved a great success in Poland, where consumer interest in drug issues is increasing.

Seven thousand copies were printed, many more than was originally planned, because of the large amount of interest shown in the press and by regional consumer clubs.

The Consumer Federation plans to print many thousands more and has been discussing financing for a second edition with the Ministry of Health.

The Consumer Federation also produced a bulletin called “Consumers and Drugs”, with articles on consumer education for rational drug use, defining a problem drug, the drug market in Poland and recent problems with promotion targeting consumers. Each Member of Parliament received a copy of this bulletin.

Providing independent information for doctors

The balance of information for doctors is heavily weighted towards commercial information, and as one wry seminar participant said, “The biggest problem in Poland is that doctors don’t know what to read”. However, more and more independent information is becoming available. In 1995 the first edition of a national formulary was published. It is modelled on the British National Formulary and will be updated annually. The Pharmacy Institute produces an independent drug bulletin for doctors.

Courses in pharmacotherapy at the Warsaw Academy of Medicine have begun to incorporate a problem-based approach to pharmacotherapy training, developed by WHO’s Action Programme on Essential Drugs and the University of Groningen in the Netherlands, (see EDM-20). As Wojciech Maselbas said, “Teaching doctors how to prescribe rationally is part of this wide campaign which I hope will spread like a forest fire”.

Plans are underway in Poland for a new national drug policy. As Dr Mazurek, Director of the Polish Drug Institute admits, “The 1991 medicines law has not been adequate to deal with problems caused by the rapid introduction of free market principles”.

Dr Kuzmierekiewicz described the consensus among health professionals on the need for expanded consumer education. Education is a high priority, and one that has never been achieved before in Poland. The wide press coverage and distribution of materials have helped to raise public awareness and to promote the idea that, as Dr Chrusciel put it, “We should not bow to the great power of a pill, the assumption that there is a drug for every ailment”.

It is, however, only a first step. The Consumer Federation hopes to bring Med-Sens and other educational materials into the regular school curriculum and to train teachers in principles of rational drug use. It is also looking for funding for workshops for teachers from the Warsaw Academy of Medicines to train consumer advocates and nurses. Wojciech Maselbas captured the mood of a pressing need for change when he said, “In Poland, discussions take a long time. What can we do now to improve the situation?”.

Eritrea: a community ORT education programme underway

Over 15,000 sachets of ORS and 5,000 T-shirts with the logo, “ORS Saves Lives”, were distributed free of charge. Banners and posters were displayed in five towns in three languages: Tigriyina (a common local language in which a large number of people are literate), Arabic and English. While these were intended to increase the visibility of the campaign, the main educational tool used was a pamphlet in Tigriyina. The pamphlet addressed the causes of diarrhoea and its appropriate management with both commercial ORS and home-prepared solutions. It explained what to provide for rehydration as opposed to other means of management, and provided detailed, well-illustrated instructions on the preparation and administration of oral rehydration mixtures. Ten thousand copies of the pamphlet were printed and distributed throughout the country.

The campaign materials were designed by pharmacist/artists experienced in the preparation of community education materials. The cost was partly covered by ERIPA with additional assistance from UNICEF and Save the Children Fund (UK).

An enthusiastic reception

The main educational strategy was interaction between pharmacists and mothers in the communities. Public meetings were organized through the municipal structures and health facilities. Mothers met in community buildings, health centre “community areas” and in open air meeting areas. The strategy proved extremely successful, attracting over 20,000 people. Some women were so keen to attend that they walked for 2 hours to reach a meeting. Men were also welcome and many came along.

ERIPA pharmacists planned the content of the presentations, and organized and allocated areas to different pharmacists. They were equipped with battery powered public address systems for outside meetings, and they carried the necessary mixing utensils and water containers. The pharmacists were responsible for the presentation and demonstration of the messages, and then called for questions from the audience. There was no shortage of questions, from both women and men, covering all aspects of diarrhoea, its treatment and features of dehydration as well as questions relating to prevention and sanitation. It was encouraging that sometimes women wanted to present the demonstration again, this time themselves, to make sure they had understood.

Building on the campaign

Although the campaign focused on mothers, prescribers could not avoid the messages. Oral rehydration was also a focus of the ERIPA Conference associated with the Pharmacy Week, which was attended by many prescribers. The results of the survey were presented at the Conference. Examples of different educational strategies from a number of countries were also presented.

Further activities are planned to build on the campaign messages. This year school children will be important targets. One plan involves the circulation of a drama which depicts a battle over the life of a child between characters representing dehydration and oral rehydration. School children will be asked to produce this in their own way, and prize winning productions will be broadcast nationally on television. Another idea being pursued is a children’s poster competition.

ERIPA’s role in these community education activities shows how a national pharmacist association can play a key role in community education. ERIPA sets an excellent example of a truly professional association in which public interest no longer matches the economic interests of its members.

*Beverly Snell is a pharmacist with the Victorian Medical Postgraduate Foundation of Australia. She has worked extensively in primary health care in Eritrea and Somalia.

References
Zimbabwe: targets prescribing of opinion leaders

B. Trap, C. Lessing

The Reverend can open the Bible many times daily without losing credibility so can we open the Essential Drugs List many times daily", said one of the specialists attending a two-day consultative meeting in Kadoma, Zimbabwe. The high level prescribers were gathered to develop national recommendations for improving rational drug use and use of the Essential Drugs List for Zimbabwe (EDLIZ) and Standard Treatment Guidelines.

Since the start of the Essential Drugs Action Programme in Zimbabwe (ZEDAP) in 1986 almost all rational drug use activities have been aimed at the primary health care level. In order to achieve rational drug use and adequate drug availability, an extensive training programme was conducted. From 1989 to 1992 more than 5,000 health workers, mainly prescribing nurses, were trained in stock management, the essential drugs concept and the use of EDLIZ. Training was also provided on the ZEDAP clinical and management modules. The impact of the training has been measured on a regular basis, with very encouraging initial results. Stock management and adherence to standard treatment guidelines improved and peaked in 1991 but later decreased5 (see Table).

The WHO/INRUD indicators used in the impact assessment do not indicate rational drug use problems. However, more specific studies, looking at the use of antibiotics at primary health care level, found that only 22% (range 2-66%)4 of antibiotics were used correctly (correct dose and duration). In 24% (range 4-47%)2 of cases, treatment with antibiotics was unnecessary. Interviews with prescribing nurses found that non adherence to standard treatment guidelines was related to behaviour, attitude and motivation and not to knowledge3. In addition, surveys of central and provincial hospitals found that in only 5% of cases where selected indicator drugs were prescribed was the drug chosen actually the drug of choice2.

Based on these and other findings, the National Drug and Therapeutics Policy Advisory Committee found that the previous “bottom up” approach, based on primary health care level training, was not enough to ensure rational drug use and adherence to EDLIZ. A “top down” approach was also needed to involve higher level prescribers more directly.

In recognition of the major role consultant doctors play as trainers of future prescribers and as opinion leaders, a meeting was organized in March 1996, with consultants from all over Zimbabwe. The main aim was to confer with high level prescribers on how rational prescribing and adherence to EDLIZ could be improved.

Speakers emphasised that if Zimbabwe’s limited resources were not to be depleted, rational use of drugs must have an important place in all health workers’ daily work, that EDLIZ was for everyone – from health assistant to consultant; and that new approaches have to be adopted in the education of health care providers, with emphasis placed on skills more than knowledge.

On the first day discussion centred on agreeing that rational use problems actually existed amongst higher level prescribers and that the standard treatment guidelines in EDLIZ were also made for specialists to follow. The problems identified were then discussed in groups, in order to agree on recommendations for interventions or activities that could address these problems.

### Main recommendations of the meeting

#### Rational prescribing

- Incentives must be introduced at facility level for cost effective treatment and drug management.
- Hospital therapeutic committees should be strengthened and guidelines developed.
- Undergraduate medical (and allied) training should have a more problem-oriented approach, teaching the students skills rather than just knowledge.
- Therapeutic training must be based on the principles of rational drug use and EDLIZ. The teachers must set a good example and be seen to use EDLIZ.
- A diagnosis should be indicated on every prescription or patient card to facilitate assessment of rational use of drugs. Auditing prescribing habits and drug consumption should be promoted at all levels.
- Studies to obtain information on rational drug use must be encouraged.

#### Promoting EDLIZ

- Availability of EDLIZ must be assured for all health professionals.
- All medical clinical/bedside training should refer to EDLIZ, and be examinable.
- The curricula for all health workers should be revised to include training in the essential drugs concept and use of EDLIZ, and should also include teaching the principles of rational prescribing.
- Introduction course on EDLIZ and rational prescribing in Zimbabwe to be established for health professionals trained outside Zimbabwe.

#### Drug availability

- Privatisation of the Government Medical Stores.
- Improve dissemination of information regarding drug consumption and drug unavailability.
- Promote computerisation of Medical Stores and central/provincial hospitals.
- Promote supervision in drug management.

### Table 1 Impact of training on health workers6

<table>
<thead>
<tr>
<th>Indicator</th>
<th>1989</th>
<th>1991</th>
<th>1993</th>
<th>1995</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence to Standard Treatment Guidelines at all levels of health care in Zimbabwe</td>
<td>83%</td>
<td>68%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>82%</td>
<td>62%</td>
<td>38%</td>
<td></td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>73%</td>
<td>60%</td>
<td>39%</td>
<td></td>
</tr>
<tr>
<td>Acute respiratory infection</td>
<td>69%</td>
<td>55%</td>
<td>41%</td>
<td></td>
</tr>
<tr>
<td>Implementation of stock management</td>
<td>30%</td>
<td>69%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>WHO/INRUD Indicators</td>
<td>1.4</td>
<td>1.3</td>
<td>1.65</td>
<td>1.65</td>
</tr>
<tr>
<td>% of drugs per prescription</td>
<td>85%</td>
<td>94%</td>
<td>92%</td>
<td>90%</td>
</tr>
<tr>
<td>% of generics</td>
<td>22%</td>
<td>29%</td>
<td>30%</td>
<td>27%</td>
</tr>
<tr>
<td>% of antibiotics</td>
<td>14%</td>
<td>13%</td>
<td>14%</td>
<td>13%</td>
</tr>
</tbody>
</table>

References
4. Unpublished data from ZEDAP five-drug study

A clinic in rural Zimbabwe. The country’s campaign to promote the rational use of drugs now targets prescribers at all levels of health care
**Essential Drugs Monitor**

**RATIONAL USE**

**Effective drug management: Thai course spreads the message**

Paul Spivey*

DM-19 announced that the Aberdeen course in “Effective Drug Management and Rational Drug Use” (EDMRDU) would spread its wings. The “flight” took 11 hours in an easterly direction to Khon Kaen in Thailand. The purpose was to see if the course could be given effectively in a regional location, which would make it available to a greater number of participants from that region.

Khon Kaen, one of Thailand’s major cities, is about one hour’s flight North-East from the capital, Bangkok. The University is spread over a large and green campus with many trees and open areas. The Faculty of Pharmaceutical Sciences extends into a building which houses the Faculty of Medicine and the Teaching Hospital (Srinagarind Hospital). It was here that the EDMRDU course was conducted for five weeks in November and December 1995, at the invitation of the Thai Consortium of Pharmacy Faculties, in collaboration with WHO’s Action Programme on Essential Drugs (EDMRDU), Robert Gordon University, Aberdeen, Scotland.

At an opening ceremony, the President of Khon Kaen University extended a contribution of lecturers from Thailand. The style of the course also followed that used in Aberdeen. This encourages participants to highlight, analyse and discuss problem areas and possible solutions relating to their personal and national working situations. There was plenty of active involvement (and laughter!). One participant wrote, “the contributions of my colleagues also helped me a lot... the different systems available under generic names but may also be sold under different brand names. Prices for similar drugs with different brand names can vary considerably. However, they are generally comparable in terms of safety and efficacy. The example of rifampicin shows how great price differentials can be (see Box).

**Back in Scotland...**

The next annual course in Aberdeen will be held from 12 May to 11 July 1997. It will look at vital aspects of drug management and rational drug use at national and institutional or programme levels. The majority of lecturers have experience of working in Africa or Asia. The course is suitable for health professionals, especially pharmacists, who are involved in the management of drug supply, whether in the public sector or in nongovernmental organizations. Tuition fees are £2,800.

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**India: guidelines on rational use in medical curricula**

Further progress has been made in India’s drive to ensure that instruction in rational prescribing takes its rightful place in medical training. A three-day national level consultation has resulted in the formation of a task force of experts to develop guidelines for undergraduate and intern training in rational drug use. The point was forcefully made that the credibility of such training would grow with the increase in the number of medical schools involved in training in rational use of drugs. Organized by the Foundation for Health Action, the Calcutta School of Tropical Medicine and the West Bengal Voluntary Health Association, the meeting took place in Calcutta from 2–4 November 1995. It brought together 25 senior professors and heads of department from medical colleges, representatives of professional bodies, and consumers. Participants discussed how to make young medical graduates aware of the consequences of irrational drug use and the importance of making special provision for training in rational drug use in undergraduate curricula.

**Philippines: monitoring drug prices**

As part of the Philippines National Drug Policy, there is a commitment to monitoring drug prices and keeping consumers well informed on this subject. All drugs on the market are available under generic names but may also be sold under different brand names. Prices for similar drugs with different brand names can vary considerably. However, the figures give average drug prices at several drug outlets being monitored. They illustrate the savings possible if consumers exercise their right of informed choice when buying drugs.

**RIFAMPICIN**

<table>
<thead>
<tr>
<th>450 mg capsule or tablet</th>
<th>Price in pesos</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medifam</td>
<td>20.38</td>
</tr>
<tr>
<td>Ramicin</td>
<td>20.37</td>
</tr>
<tr>
<td>Rimactane</td>
<td>22.94</td>
</tr>
<tr>
<td>Rifadine</td>
<td>24.17</td>
</tr>
<tr>
<td>Rifampicin (UL)</td>
<td>14.79</td>
</tr>
<tr>
<td>Rifampicin (USA)</td>
<td>15.70</td>
</tr>
<tr>
<td>Rifampicin (DLI)</td>
<td>9.00</td>
</tr>
<tr>
<td>Rifampicin (Lumar)</td>
<td>17.45</td>
</tr>
<tr>
<td>Rifampicin (Pharex)</td>
<td>15.26</td>
</tr>
<tr>
<td>Rifampicin (Biosis)</td>
<td>9.50</td>
</tr>
</tbody>
</table>

**Highest price:**

Rifadine 24.17

**Lowest price:**

Rifampicin (DLI) 9.00

**Difference:** 15.27

**Savings/course**

2,748.60 (1 cap./day for 6 months treatment)

Prepared by the Essential Drugs Price Monitoring Unit, the Philippines, 26 July 1995.

* Source: RDU Update 1995: vol 4; no.2. Published by the Philippine National Drug Policy Office, c/o The National Drug Information Centre, Department of Pharmacology, College of Medicine, University of the Philippines, 547 Pedro Gil Street, Manila, the Philippines. Further information on the Philippines’ drug pricing strategy may be obtained by writing to this address.

**Correction**

Dr Budiono Santoso has brought to our attention that the article in EDM-20, “From research to action: the Gunungkidul experience”, was attributed to him instead of Drs Sunartono and Drs Darminto. Dr Sunartono is Former Head of Gunungkidul District Health Office, and now Head of Sleman District Health Office, Jalan Candi Jonggrang, Sleman DIY, Indonesia. We apologise for the error.

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I n spite of a delayed start due to bad weather, nothing could dampen the enthusiasm of participants at a workshop for health professionals held in Seenu, Hithadhoo, the Maldives, from 15–17 August 1995. Organized by the Maldives Essential Drugs Programme, the workshop aimed to improve rational drug use, drug supply management, and diagnostic and communication skills. Thirty doctors, dentists, pharmacists, pharmacy assistants and community health workers from the southern atolls of Gaaf Alif, Gaaf Dhaal, Fuvahmulah and Seenu, benefited from sharing experiences and exchanging views.

Discussions centred on the essential drugs concept and its implementation through the Essential Drugs Programme. A session on clinical diagnosis and treatment focused on how to diagnose more accurately and how to treat the underlying cause of illness economically. Case studies were used to help participants identify and solve their common prescribing problems. Participants’ justifications for first-line drug choices were analysed on the grounds of pharmacology, epidemiology and sociocultural beliefs. In addition to prescribing behaviour, self-medication, and patient information and adherence to treatment were discussed.

The strengths and weaknesses of the current drug supply system were reviewed. Discussions ranged from methods of record keeping and inventory control, and regulations on drug import and sale, to how to protect drugs from high temperatures, humidity, sunlight and pests. Participants also reviewed the various forms of financing drug supplies. The Government wants to encourage those capable of paying for treatment to do so. However, the workshop stressed the importance of developing criteria to help health professionals identify the needy, who should receive drugs free of charge.

One reason for the workshop’s success was the open-minded, cross-disciplinary approach to issues encouraged by the facilitators. They helped participants apply critical, logical thought rather than simply using standard techniques and guidelines. Various teaching methods were used, including small group discussions, “buzz” sessions and demonstrations.

The Republic of Maldives is made up of hundreds of islands grouped into atolls, which stretch for hundreds of miles in the Indian Ocean – a problem for those supplying drugs, and one of the issues addressed at the workshop.

Essential Drugs Monitor...
standard treatment guidelines; they may even be dangerous. Many donated drugs arrive unsorted and labelled in a language which is not easily understood. Some donated drugs come under trade names which are not registered for use in the recipient country, and without an International Nonproprietary Name (INN, or generic name) on the label.

Many donated drugs arrive unsorted and labelled in a language which is not easily understood. Some donated drugs come under trade names which are not registered for use in the recipient country, and without an International Nonproprietary Name (INN, or generic name) on the label.

Drugs may be donated in the wrong quantities, and some stocks may have to be destroyed. This is wasteful and creates problems of disposal at the receiving end.

There are several underlying reasons for these problems. Probably the most important factor is the common but mistaken belief that in an acute emergency any type of drug is better than none at all. Another important factor is a general lack of communication between the donor and the recipient, leading to many unnecessary donations. This is unfortunate because in disaster situations and war zones inappropriate drug donations create an extra workload in sorting, storage and distribution, and can easily overstretch the capacity of precious human resources and scarce transport volume. Often, the total handling costs (duties, storage, transport) are higher than the value of the drugs. Stockpiling of unused drugs can encourage pilfering and black market sales.

Donating returned drugs (unused drugs returned to a pharmacy for safe disposal or for free samples given to health professionals) is an example of double standards, because in most countries their use would not be permitted due to quality control regulations. Apart from quality aspects, such donations also frustrate management efforts to administer drug stocks in a rational way. Prescribers are confronted with many different drugs and brands in ever changing dosages; patients on long-term treatment suffer because the same drug may not be available the next time. For these reasons this type of donation is forbidden in an increasing number of countries and is generally discouraged.

In the early 1980s the first guidelines for drug donations were developed by international humanitarian organizations, such as the International Committee of the Red Cross (ICRC) and the Christian Medical Commission (CMC) of the World Council of Churches, later called Churches’ Action for Health. In 1990 the WHO Action Programme on Essential Drugs, in close collaboration with the major international emergency aid agencies, issued a first set of WHO guidelines for donors’, later refined by the WHO Expert Committee on the Use of Essential Drugs. In 1994 the WHO office in Zagreb issued specific guidelines for humanitarian assistance to former Yugoslavia.

In view of the existence of these different drug donation guidelines, the need was felt for one comprehensive set of guidelines that would be endorsed and used by all major international agencies active in emergency relief. For this reason a first draft was prepared by the WHO Action Programme on Essential Drugs and further refined in close collaboration with the division of Drug Management and Policies and the division of Emergency Preparedness, major international relief organizations and a large number of international experts. The final text reflects the consensus between the World Health Organization, UNICEF, the Office of the United Nations High Commissioner for Refugees, the International Committee of the Red Cross, the International Federation of Red Cross and Red Crescent Societies, Churches’ Action for Health of the World Council of Churches, Médecins sans Frontières and OXFAM. In the process, comments by over 100 humanitarian organizations and individual experts were taken into consideration.

The examples of inappropriate donations quoted above constitute ample reasons to develop international guidelines for drug donations. In summary, guidelines are needed because:

- Donors intend well, but often do not realise the possible inconveniences and unwanted consequences at the receiving end.
- Donor and recipient do not communicate on equal terms. Recipients may need support in specifying how they want to be helped.
- Drugs do not arrive in a vacuum. Drug needs may vary between countries and from situation to situation. Drug donations must be based on a sound analysis of the needs, and their selection and distribution must fit within existing drug policies and administrative systems. Unsolicited and unnecessary drug donations are wasteful and should not occur.
- The quality requirements of drugs are different from other donated items, such as food and clothing. Drugs can be harmful if misused, they need to be identified easily through labels and written information, they may expire, and they may have to be destroyed in a professional way.

In emergency situations, such as the 1985 Mexican earthquake, drugs and other medical supplies are the first and most crucial needs of the victims.

II Core principles

The 12 articles of the Guidelines for Drug Donations are based on four core principles. The first and paramount principle is that a drug donation should benefit the recipient to the maximum extent possible. This implies that all donations should be based on an expressed need and that unsolicited drug donations are to be discouraged. The second principle is that a donation should be given with full respect for the wishes and authority of the recipient, and be supportive of existing government health policies and administrative arrangements. The third principle is that there should be no double standards in quality: if the quality of an item is unacceptable in the donor country, it is also unacceptable as a donation. The fourth principle is that there should be effective communication between the donor and the recipient; donations should be based on an expressed need and should not be sent unannounced.

Core principles of a donation

1. Maximum benefit to the recipient
2. Respect for wishes and authority of the recipient
3. No double standards in quality
4. Effective communication between donor and recipient

cont’d on pg. 8
III Guidelines for drug donations

Selection of drugs

1 All drug donations should be based on an expressed need and be relevant to the disease pattern in the recipient country. Drugs should not be sent without prior consent by the recipient.

Justification and explanation

This provision stresses the point that it is the prime responsibility of the recipients to specify their needs. It is intended to prevent unsolicited donations, and donations which arrive unannounced and unwanted. It also empowers the recipients to refuse unwanted gifts.

Possible exceptions

In acute emergencies the need for prior consent by the recipient may be waived, provided the drugs are amongst those on the WHO Model List of Essential Drugs that are included in the UN list of emergency relief items recommended for use in acute emergencies.

2 All donated drugs or their generic equivalents should be approved for use in the recipient country and appear on the national list of essential drugs, or, if a national list is not available, on the WHO Model List of Essential Drugs, unless specifically requested otherwise by the recipient.

Justification and explanation

This provision is intended to ensure that drug donations comply with national drug policies and essential drugs programmes. It aims at maximising the positive impact of the donation, and prevents the donation of drugs which are unnecessary and/or unknown in the recipient country.

Possible exceptions

An exception can be made for drugs needed in sudden outbreaks of uncommon or newly emerging diseases, since such drugs may not be approved for use in the recipient country.

3 The presentation, strength and formulation of donated drugs should, as much as possible, be similar to those commonly used in the recipient country.

Justification and explanation

Most staff working at different health care levels in the recipient country have been trained to use a certain formulation and dosage schedule and cannot constantly change their treatment practices. Moreover, they often have insufficient training in performing the necessary dosage calculations required for such changes.

Presentation, packing and labelling

7 All drugs should be labelled in a language that is easily understood by health professionals in the recipient country; the label on each individual container should at least contain the International Nonproprietary Name (INN, or generic name), batch number, dosage form, strength, name of manufacturer, quantity in the container, storage conditions and expiry date.

Justification and explanation

All donated drugs, including those under brand name, should be labelled also with their INN or the official generic name. Most training programmes are based on the use of generic names. Receiving drugs under different and often unknown brand names and without the INN is confusing for health workers and can even be dangerous for patients. In case of injections, the route of administration should be indicated.

8 As much as possible, donated drugs should be presented in larger quantity units and hospital packs.

Justification and explanation

Large quantity packs are cheaper, less bulky to transport and conform better with public sector supply systems in most developing countries. This provision also prevents the donation of drugs in sample packages, which are impractical to manage. In precarious situations, the donations of paediatric syrups and mixtures may be inappropriate because of logistical problems and their potential misuse.

9 All drug donations should be packed in accordance with international shipping regulations, and be accompanied by a detailed packing list which specifies the contents of each numbered carton by INN, dosage form, quantity, batch number, expiry date, volume, weight and any special storage conditions.

Justification and explanation

This provision is intended to facilitate the administration, storage and distribution of donations in emergency situations, as the identification and management of unmarked boxes with mixed drugs is very time and labour intensive. This provision specifically deals with donations of small quantities of mixed drugs. The maximum weight of 50 kg ensures that each carton can be handled without special equipment.

Quality assurance and shelf-life

4 All donated drugs should be obtained from a reliable source and comply with quality standards in both the donor and recipient country. The WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce should be used.

Justification and explanation

This provision prevents double standards: drugs of unacceptable quality in the donor country should not be donated to other countries. Donated drugs should be authorised for sale in the country of origin, and manufactured in accordance with international standards of Good Manufacturing Practice (GMP).

Possible exceptions

In acute emergencies the use of the WHO Certification Scheme may not be practical. However, if it is not used, a justification should be given by the donor. When donors provide funds to purchase drugs from local producers, those which comply with national standards should not be excluded on the sole grounds that they do not meet quality standards of the donor country.

5 No drugs should be donated that have been issued to patients and then returned to a pharmacy or elsewhere, or were given to health professionals as free samples.

Justification and explanation

Patients return unused drugs to a pharmacy to ensure their safe disposal; the same applies to drug samples that have been received by health workers. In most countries it is not allowed to issue such drugs to other patients, because their quality cannot be guaranteed. For this reason returned drugs should not be donated either. In addition to quality issues, returned drugs are very difficult to manage at the receiving end because of broken packages and small quantities involved.

6 After arrival in the recipient country all donated drugs should have a remaining shelf-life of at least one year.

Justification and explanation

In many recipient countries, and especially under emergency situations, there are logistical problems. Very often the regular drug distribution system has limited possibilities for immediate distribution. Regular distribution through different storage levels (e.g. central store, provincial store, district hospital) may take six to nine months. This provision especially prevents the donation of drugs just before their expiry as in most cases such drugs would only reach the patient after expiry.

Possible exceptions

An exception should be made for drugs with a total shelf-life of less than two years, in which case at least one-third of the shelf-life should remain. An exception can also be made for direct donations to specific health centres in the recipient country, provided the responsible professional at the receiving end is aware of the shelf-life and the remaining shelf-life allows for proper administration prior to expiration. In all cases it is important that the date of arrival be communicated to the recipient well in advance.

Information and management

10 Recipients should be informed of all drug donations that are being considered, prepared or actually underway.

Justification and explanation

Many drug donations arrive unannounced. Detailed advance information on all drug donations is essential to enable the recipient to plan for the receipt of the donation and to coordinate the donation with other sources of supply. The information should at least include: the type and quantities of donated drugs including their International Nonproprietary Name (INN, or generic name), strength, dosage form, manufacturer, and expiry date; reference to earlier correspondence (for example, the letter of consent by the recipient); the expected date of arrival and port of entry; and the identity and contact address of the donor.

11 In the recipient country the declared value of a drug donation should be based upon the wholesale price of its generic equivalent in the recipient country, or, if such information is not available, on the wholesale world-market price for its generic equivalent.

Justification and explanation

This provision is needed in the recipient country to prevent drug donations being priced according to the retail price of the product in the donor country, which may lead to elevated overhead cost for import tax, port clearance, and handling in the recipient country. It may also result in a corresponding decrease in the public sector drug budget in the recipient country.

Possible exceptions

In case of patented drugs (for which there is no generic equivalent) the wholesale price of its generic equivalent should be taken as a reference.

12 Costs of international and local transport, warehousing, port clearance and appropriate storage and handling should be paid by the donor agency, unless specifically agreed otherwise with the recipient in advance.

Justification and explanation

This provision prevents the recipient from being forced to spend effort and money on the clearance and transport of unannounced consignments of unwanted items, and also enables the recipient to review the list of donated items at an early stage.
IV Other ways donors can help

The New Emergency Health Kit

In the acute phase of an emergency, or in the transitional situation where large refugee populations without any medical care, it is better to send a standardised kit of drugs and medical supplies that is specifically detailed for this purpose. Example the New Emergency Health Kit, which has been widely used since 1990, contains drugs, disposable supplies and basic equipment needed for general medical care for a population of 10,000 for three months. Its contents are based on a consensus among the same group of major international aid agencies that also issued the drug donation guidelines. It is permanently stocked by several major international suppliers (for example, UNICEF and IDA) and can be available within 48 hours. It is especially relevant in the absence of specific requests.

Donations in cash

After the acute phase of the emergency is over, a donation in cash for local or regional purchase of essential drugs is usually much more welcome than further drug donations in kind. Such a cash contribution is very supportive to the activities of the local government or coordinating committee, it is supportive to the local and regional pharmaceutical industry and it may also be more cost effective. In addition, prescribers and patients are usually more familiar with locally produced drugs.

Russian Federation, 1992

Russian pharmaceutical production has fallen far below its 1990 level, and donations of drugs have been welcomed. However, initial enthusiasm soured when the nature of some donations was discovered. Examples of donations include: 189,000 bottles of dextromethorphan cough syrup; pentoxifylline and clonidine as the only antihypertensive items; tricyclic antidepressants as diuretics; pancreatic enzyme and bismuth preparations as the only gastrointestinal drugs.

Additional guidelines for drug donations as part of development aid

When drug donations are given between governments as humanitarian support to longstanding complex emergencies and as regular development (commodity) aid, there is usually more time to consider specific demands from the side of the recipient. On the other hand, there is also time to link more restrictions to the donation, e.g. to products from manufacturers in the donor country, and to drugs registered for use in the recipient country. It should be recognised that drugs do not arrive in an administrative vacuum. Drug donations should not create an administrative burden which may obstruct or delay national capacity building in selection, procurement, storage, distribution and rational use of drugs. Special care should therefore be taken that the donated drugs respond to an expressed need, comply with the national drug policy, and are in accordance with national treatment guidelines in the recipient country. Administratively, the drugs should be treated as if they were procured. This means that if they should be registered or authorised for use in the country through the same procedure that is used for government tenders. They should be entered into the inventory, distributed through the existing distribution channels and be subject to the national quality assurance procedures. Cost-sharing procedures are operational in the recipient country, the donated drugs should not automatically be distributed free of charge.

Guinea Bissau, 1993

In September 1993 eight tons of donated drugs were sent: all were collected from pharmacies in quantities between one and 100 tablets. The donation contained 22,123 packages of 1,714 different drugs which were very difficult to manage and greatly interfered with government efforts to rationalise drug supply and drug use.

Lithuania, 1993

Eleven women in Lithuania temporarily lost their eyesight after using a donated drug. The drug, closanol, was a veterinary anesthetic but was mistakenly given to treat endometriosis. The drug had been received without product information or package insert, and doctors had tried to identify the product by matching its name with those on leaflets of other products.

Manage donated drugs carefully

The value of donated drugs can be considerable, and the gift should be treated with due care. On arrival the drugs should be inspected and their receipt confirmed to the donor agency. They should then be stored and distributed in accordance with normal principles of good pharmacy practice and under the responsibility of adequately trained professionals. There must be due vigilance to ensure that donated products are not diverted for export, commercial sale, or into illicit channels.

Action required from donor agencies

Donors should always respect the four core principles for drug donations presented above. Donors should also respect national guidelines for drug donations and respond to the priority needs indicated by the recipient. Unsolicited donations should be prevented as much as possible.

Former Yugoslavia, 1994, 1995

Of all drug donations received by the WHO field office in Zagreb in 1994/1995, 15% were completely unusable and 30% were not used at all. By the end of 1995, 340 tons of expired drugs were destroyed. Most of these were donated by different European nations.

The public at large in the donor country is not always aware of the common problems with drug donations. It is therefore important that governments in donor countries spend some effort to create more public awareness on “good donor practice”. The best moment for this is probably at the time of the public appeal through the media. Within the donor country it is recommended that the different donors choose a “lead-donor” amongst themselves, who coordinates donor activities and who may also act as the central contact point in discussions with the recipient government. The recipient country should supply as much information as possible on requested and approved donations. On the other hand, the donors themselves should also inform the recipient well in advance and in great detail about which donations are coming, and when. This will greatly assist the coordinating body in the recipient country to plan for the proper reception of the donations and to identify the need for additional supplies.

V How to implement a policy on drug donations

Define national guidelines for drug donations

It is difficult for a recipient to refuse a donation that has already arrived. Prevention is therefore better than cure. Recipients should indicate to their prospective donors what kind of assistance they need and how they would like to receive it. If this information is provided in a rational and professional way, most donors will appreciate it and will comply.

Therefore, recipients should first formulate their own national guidelines for drug donations, on the basis of these international guidelines. These guidelines must be included in the national drug policy. Therefore, recipients should first be officially presented and explained to the donor community. Only after they have been presented and officially published can they be enforced.

Define administrative procedures for receiving drug donations

It is not enough for the recipient to adopt and publish the general guidelines on the selection, quality, presentation and management of drug donations. Administrative procedures need to be developed by the recipient to maximise the potential benefit of drug donations. As much as possible such arrangements should be linked with existing drug supply systems, but there are several questions which apply to donations only. Examples of such important questions, which have to be addressed in each country are:

- Who is responsible for defining the needs, and who will prioritise them?
- Who coordinates all drug donations?
- Which documents are needed when a donation is planned; who should receive them?
- Which procedure is used when donations do not follow the guidelines?
- What are the criteria for accepting/rejecting a donation; who makes the final decision?
- Who coordinates reception, storage and distribution of the donated drugs?
- How are the donations valued and entered into the budget/expenditure records?
- How will inappropriate donations be disposed of?

Specify the needs for donated drugs

The third important action by the recipient is to specify the needs for donated drugs as much as possible. This puts the onus on the recipient to carefully prepare such requests, indicating the required quantities and prioritising the items. The more information given, the better. Information on donations that are already in the pipeline, or anticipated, is very helpful to other potential donors. Full information from the side of the recipient is greatly appreciated by donors and pays off in the long run.

A handy hint: the core guidelines on page 8 can be photocopied easily if turned sideways to make two A4 pages.

Essential Drugs Monitor


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Issue No. 21, 1996
Tamil Nadu is one of India’s largest, most urbanised States, with a relatively well developed infrastructure. The last census, in 1991, showed a population of 55.9 million, with approximately 34% living in urban areas. The State has a good industrial base and there are a number of drug manufacturing companies. There has always been a plentiful supply of drugs available in the private sector. However, the poorer sections of the population cannot afford these drugs and use the Government sector, which dispenses drugs free of charge. But drug availability in the public health system was a problem. The State Government of Tamil Nadu decided to act, and this article describes the measures it has taken to ensure that all its people have access to essential drugs.

**Considering the options**

The State Government’s main objective was to purchase quality drugs at competitive prices and make essential drugs available to all Government health facilities. Inefficient indenting procedures and poor inventory management were seen as major problems. Faced with a number of options, the Government decided the best for Tamil Nadu was an open tender system. It would no longer permit any purchase or price preference to particular suppliers. The Government’s concern with open tendering was how to ensure drug quality. It decided to purchase drugs only from manufacturers and not, as previously, through agents. It was further stipulated that these manufacturers should have a Good Manufacturing Practice Certificate and a market standing of at least three years. A minimum turnover was also fixed, to eliminate very small firms which it was thought might be unable to keep up delivery schedules. The Government clearly spelt out its stipulations, to try to ensure that only reputable firms would tender. To avoid dependence on one firm, it was decided to use a number of suppliers willing to match the lowest price. For its part, a Government decision to pay for drugs within 15 days encouraged manufacturers to quote competitive rates.

Change has also been introduced in the area of drug packaging. To prevent wastage and pilfering, manufacturers use strip or blister packing for all tablets, instead of the previous system of hand packing in bulk at the time of distribution. The strips and tablets are marked to show that the drugs are manufactured only for State Government supply and not for sale. Concern was expressed that strip packing could increase drug costs. However, the counter argument, that any marginal increases would be more than offset by reduced wastage and increased public acceptance of the drugs, won the day.

**Creating Tamil Nadu Medical Services Corporation**

A major Government initiative was to set up Tamil Nadu Medical Services Corporation (TNMSC), a Government company, to provide necessary services to Government hospitals. One of the main objectives of the Corporation is to organize an efficient, centralised drug procurement and distribution system. The Corporation has a Board of Directors, with the State’s Secretary for Health as an ex-officio Chairman, and a full-time Managing Director.

**Promoting the essential drugs concept**

Under the previous system, hospitals put in requisitions for drugs and then tenders were invited. It was soon evident that the total of 960 drugs procured in this way could be substantially reduced. Many of the drugs were wanted in very small quantities, and central purchasing for such small quantities was uneconomical. Other drugs on the list were deemed non-essential. The Corporation decided to introduce the essential drugs concept and an essential drugs list based on WHO’s Model List. TNMSC’s first task was to finalise the list of essential drugs it would procure. A Committee of leading professors of medicine and therapeutics (including a WHO representative) was constituted to do this. The Committee held several meetings with drug managers and specialists, and after detailed discussions a final list of 240 generic drugs was agreed. An analysis of these drugs indicated that only about 100 drugs made up 90% of the total value of all 240 drugs. While recognising the scope for further reduction in the list, it was decided not to introduce more cuts in its first year. As services in primary health centres and sub-centres are limited, the Committee decided to standardise the drugs that can be supplied to them. The centres can only requisition drugs outside this list in special circumstances.

The reduction in the existing drugs list meant that the Corporation could procure the drugs it needed with approximately 90% of its drug budget. This left other drugs to be purchased locally by the hospitals out of the remaining 10%, which TNMSC divided among them. These funds cannot be used to purchase drugs which are on the Corporation’s list. After further discussions, the list of drugs which can be procured locally was finalised and circulated to all hospitals. To minimise costs, the possibility of calling for tenders for such drugs was considered. But this would have reduced flexibility, been time consuming and in emergencies hospitals might not have received drugs quickly enough.

In a centralised purchase and distribution system, such as that created in Tamil Nadu, some degree of flexibility for local purchase by medical institutions is essential to meet the needs of all. The system of distributing 10% of the annual budget to hospitals has helped the Corporation counter any criticism that the drugs list is inadequate.

**Improving distribution**

The main objective of Tamil Nadu’s drug management policy is to ensure regular supply and prevent stockouts. Previously when drug companies received an order they sent supplies to the medical institution concerned. One or two companies tended to receive huge orders which they could not meet. Another problem was the considerable delay in paying companies, so that they stopped supplying. It was decided to create a chain of “godowns”, warehouses which stock all drugs. A warehouse for storage and distribution of drugs has been established in each of the State’s 23 districts. Drug manufacturers are required to supply the drugs to the warehouse. A distribution schedule has been given to the hospitals, which can take drugs from the store according to that schedule. The drug godowns carry three months’ stock, with hospitals permitted to draw a month’s supply at a time. The safety stock limit is about one month’s requirement, although this depends on the turnover of the particular drug and the lead time for obtaining supplies.
Supply quality: a priority of aid programmes

Some prospects led to calls for PAHO/WHO to set up major humanitarian aid programmes, one of the priorities of which would be to bolster Haiti’s health sector by ensuring the supply of reasonably priced, quality drugs corresponding to national needs. It was a daunting task. Although drugs were specifically excluded from any embargo, Haitian supply networks were disrupted, and both available stocks and local production capacity were inadequate. As a result, prices rose, while at the same time purchasing power fell, due to a decline in the local economy.

Raising cost consciousness

Under the previous system hospitals kept on buying drugs without any accurate assessment of future requirements. Very quickly their funds were exhausted, leading to shortages even of essential drugs. There was no preference for low cost options, largely because there were no incentives for cost consciousness. Instead it was decided to distribute drugs to the hospitals within an overall budgetary allocation. Each institution is given a pass book, indicating its annual financial entitlement, and within this it can draw any drug from the district godown. There is no need for an advance requisition. Any drug on the approved list can be obtained, provided funds are available. It is the Corporations’s responsibility to order drugs well in advance, based on turnover. To prevent institutions exhausting their funds too quickly, drug supply is controlled via the qualified allocation. The system is simple and user friendly, in that hospitals do not have to forecast their requirements in advance. They can requisition based on actual consumption and so avoid wastage. If funds are scarce, the hospital knows the price of drugs on the approved list and can choose low cost alternatives. As part of TNMSC’s proposed computerisation process, it is hoped to link each hospital’s drug consumption to morbidity patterns and thus improve rational drug use.

Quality control: a high priority

TNMSC was anxious to change the quality control system, as sampling was infrequent, the sampling system unscientific and complaints about drug quality common. The Corporation decided on an in-house quality control organization, with testing contracted out to reputable laboratories. A highly qualified quality control manager was appointed and devised a system for drawing samples and testing drugs. Samples are picked at the godowns by the staff there and sent for scrutiny. The samples are coded and sent to reputable private laboratories hired by the Corporation.

Increased availability

The Government of Tamil Nadu’s innovations in drug procurement and management have improved drug availability in nearly 2000 Government medical institutions throughout the State. There is better budgetary control on drug consumption and medical institutions have become more cost conscious. There has been a significant improvement in the quality and appearance of supplies in the Government sector. The planned computerisation of the entire operation should enable even better inventory management, cost control and improved availability of drugs in hospitals.

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PROMESS: a model supply centre for essential drugs in Haiti

Guy Rino Meyers*

The Haitian crisis

1991–1994

In February 1991, as Haiti’s democratically elected Government came to power, it was hoped that development would finally be possible for the poorest country in the Americas. Expectations were high, particularly for the woefully inadequate health system. Barely seven months later, hopes for change were dashed by a military coup that plunged the country into an unprecedented political crisis. The international community was quick to react: most development projects were suspended, as was, de facto, all cooperation between technical agencies and the Haitian authorities. The Organization of American States imposed a first trade embargo, and the United Nations soon followed suit.

The health sector was in a state of emergency, and PAHO/WHO distributed an initial batch of drugs to selected institutions in order to meet the most urgent requirements. This necessary measure quickly proved to be inadequate since, contrary to expectations, the crisis continued, increasing the likelihood of violent clashes, a cholera epidemic, a rapid deterioration in health conditions and a substantial rise in tuberculosis, AIDS and other diseases.

PROMESS: providing structure in a problem sector

At the outset, those familiar with the state of the pharmaceutical sector found PAHO/WHO’s project to be highly ambitious. Even before the military coup, the sector had been experiencing a long series of problems similar to those besetting many developing countries. Not only were most people unable to pay for drugs, but the sector also had to deal with problems such as an inadequate legal framework, frequent stockouts, lack of quality control, parallel distribution of unauthorised drugs and poor training standards among professionals. The supply facility for community pharmacies, set up in 1981 as a result of a bilateral agreement between the United States Agency for International Development and the Ministry of Public Health and Population, had been unable to fulfil its mandate properly and had suspended activities in May 1991.

When the democratically elected Government came to power, the situation was so critical that on taking office the new Minister promised to establish an essential drugs policy for Haiti, with the technical assistance of PAHO/WHO. As part of the new drug policy a national supply centre would be set up, financed by the World Bank. PAHO/WHO based PROMESS on that project, which had been suspended after the military coup.

In that way the Organization sought to combine humanitarian action with sustainable development of the Haitian health sector.

Sharing risks and responsibility

Setting up PROMESS in the summer of 1992 was generally perceived to be a risky venture. The social and political...
the country’s entire non profit health sector.

The directors of PROMESS counted on the active involvement of all partners in health-related humanitarian aid programmes to ensure the success of this far-reaching venture, launched under such exceptional political circumstances. In fact, seeking the active involvement of those partners was one of PAHO/WHO’s most decisive strategic choices. The Organization wanted to share risks and responsibilities in relation to project orientation, finance and implementation, with its technical and financial partners.

The Management Committee

Although PAHO/WHO assumed legal, technical and administrative responsibility for PROMESS, a Management Committee was set up at the outset with the role of planning, following-up, promoting and assessing the Centre’s activities. This Committee was unusual in a number of respects, bringing together the main figures in the Haitian health sector. Its personal and institutional links ensured that PROMESS was present at the grassroots level, while at the same time enjoying privileged relations with donors and with other UN agencies.

PAHO/WHO, the United Nations Children’s Fund (UNICEF), major donors (Canada, France, the United States and the European Union) and certain NGOs were also brought in on the Management Committee. The NGOs included AOPS (Association des Oeuvres Privées de Santé), an organization coordinating health-related NGOs), ASPHA (Association de Santé Publique d’Haiti, which brings together Haitian public health workers), CDS (Centres pour le Développement et la Santé, representing a number of beneficiary institutions) and ICC (International Child Care, representing the interests of institutions in the country’s entire non profit health sector.

The Management Committee also drew on the expertise of the National Association of Importers and Exporters of Pharmaceutical Goods. The Association’s involvement is worth mentioning, since it obviated needless conflict between PROMESS and the Haitian commercial drug distribution network. Depending on requirements, PROMESS purchased up to 5% of its supplies from Haitian producers and contracted out transport for 10% of its imported supplies to local firms. In spite of certain political risks, the private sector responded to PROMESS’ invitations to tender and, in this way, contributed to its success. A relationship of trust and mutual respect was established which has lasted to the present day.

As soon as a new constitutional Government was appointed, the Ministry of Public Health and Population was also invited to join the Management Committee.

Selection Committee

The Selection Committee was drawn from members of the Management Committee. Its function was to rule on the eligibility of institutions seeking to be recognised by PROMESS and on the potential allocation of aid to those institutions; decisions were to be reached by consensus or, in some rare cases, by a simple majority vote of those members present. An appeals procedure was established.

PROMESS: partners and beneficiaries

From the very beginning, PROMESS has sought to respond to the specific needs of its various non-profit partners in the Haitian health network – health institutions, specialised agencies and local or international NGOs.

Non profit health institutions: first-line partners

All non profit institutions legally recognised by the Ministry of Public Health and Population (public, private or mixed), and providing a genuine health service to the general public are entitled to apply to PROMESS. Whether or not they are selected and what type of aid they might be granted depends on their managerial skills, their reputation in the area concerned and the quality of their service. Consideration is also given to the ultimate beneficiaries, with priority being accorded to the most remote areas and to the most underprivileged inhabitants. Similarly, note is taken of the institution’s involvement in community and preventive health programmes. Over the months, the number of non profit facilities supplied by PROMESS has grown steadily, to include small, remote clinics, centres run by the Ecumenical Aid Service (whose strong presence in remote, underprivileged communities is widely recognised) and health development centres (catering for thousands of people living in the capital’s slums).

PAHO/WHO has always supported a policy of self-finance for pharmacies, in line with the general principles of the Haiti Action Programme on Essential Drugs. That policy was already well accepted in Haiti, a situation the Organization sought to preserve, especially by subsidising health-related humanitarian aid programmes. Thus, during the crisis, those centres which had been accredited by the Selection Committee generally received an initial free batch of drugs corresponding to approximately three months’ requirements. This subsidy was to enable them to restore revolving funds (which had often been used up during the crisis) and facilitate the development of an adequate cost-recovery system. Following the initial subsidy, such institutions had free access to PROMESS but had to pay on delivery. In so far as available resources permitted, PROMESS took social and political developments into account, and particular circumstances into account. For example, institutions unlikely to recover costs, such as psychiatric centres and homes, and orphanages, were provided with long-term subsidies. Similarly, special arrangements were made for institutions experiencing specific problems or operating in remote or particularly underprivileged areas.

Local NGOs: partners with a wide variety of needs

Several NGOs play an essential role in the Haitian health network, which entitles them to procure supplies from PROMESS. Such NGOs include ICC, which is very active in tuberculosis control throughout the country, and the Haitian Red Cross, which is responsible for the national blood transfusion service.

International NGOs: cooperating to increase efficiency

During the Haitian crisis, a number of large international NGOs, such as Médecins sans Frontières and Médecins du Monde, sought to participate in humanitarian efforts to help the country’s underprivileged. These organizations had not been active in Haiti until then. They therefore called on the Directors of the Action Programme and PROMESS to help them shape their involvement and target intervention areas, particularly in relation to the needs and absorption capacity of local partners. Such cooperation eliminated any loss of time and energy, and made it possible to combine international emergency aid with national priorities.

UN specialised agencies: serving the same population

From the outset, PROMESS has been responsible for immunization materials and for certain goods relating to maternal and child health, supplied by UNICEF. The Centre also distributes contraceptives and iron supplements for pregnant women, on behalf of the United Nations Population Fund.

Donors: better informed partners

PROMESS has already obtained backing from a number of governments (Canada, Denmark, the Netherlands, Norway, Switzerland and the United States) and from the European Union and the Organization of American States. Due to their direct involvement in the PROMESS Management Committee, several donors are in a position to appreciate the usefulness of Haiti’s Action Programme on Essential Drugs.
and, as a result, have increased their contributions.

How PROMESS operates

The day-to-day running of PROMESS relies on the work of qualified staff members motivated by a few important general management principles.

Staff

The PAHO/WHO consultant pharma-cist is responsible for the technical and financial administration of PROMESS; all other PROMESS staff members are local people. They include two pharmacists (Head of the Pharmacy Department and Head of Supplies), an administrative and financial director, an accountant, a cold-chain technician, an administrative secretary, an administra-tive assistant cum receptionist, two drivers, a packing and cleaning and security staff. The staff quota is minimal given the amount of work to be done.

In a sector where resources are scarce, PROMESS pays particular atten-tion to selecting its staff members and providing them with ongoing training. It might be said – and hoped – that PROMESS is helping to reaffirm the importance of the pharmaceutical profession and attract new talent.

Product selection

PROMESS currently offers more than 300 products, including drugs, medical supplies, syringes, x-ray equipment and small surgical instruments. To make things as easy as possible, the Centre is seeking to become Haiti’s sole medical supplier, offering institutions a range of goods corresponding to all their requirements. In this way, PROMESS hopes to facilitate the management of institutions and reduce costs.

The sales prices set by PROMESS correspond to the cost price plus 10% to cover operational expenses. During the crisis, the Centre offered its customers a fixed exchange rate (for a set period) to strengthen institutions in the face of major fluctuations in the national currency and help them plan expenditure. PAHO/WHO decided to base the standard list of goods to be supplied by PROMESS on the WHO Model List of Essential Drugs and, in doing so, ignored certain products traditionally used in Haiti, such as cough lozenges and multi-vitamins. This decision created problems for some institution administrators who had difficulties getting supplies or who knew little about generic drugs. To ease the changeover, PAHO/WHO drew up and distributed flow charts and data-sheets explaining the use of the main drugs distributed by PROMESS. These initiatives quite naturally became part of the training activities of the Action Programme on Essential Drugs.

Procurement procedures

PAHO/WHO’s normal procurement procedures had not been designed to meet the needs of a centre the size of PROMESS, nor to cope with a crisis on the scale of that which struck Haiti. The necessary adjustments were complex and at times placed heavy demands on all involved. Nevertheless, most problems were adequately solved despite hitches, and the solutions found will now form the basis of the next revision of PAHO/WHO crisis procedures.

Today, PROMESS issues a number of limited invitations to tender to international and local institutions. Suppliers and manufacturers alike have to respect good manufacturing practices in order to ensure consistent quality. The particular circumstances surrounding the crisis and the subsequent transition period have meant that a large quantity of supplies are still being procured directly. However, a more regular form of management, based on standardised planning, should soon be possible.

The management system

PROMESS has based its management system on the locally developed Medicam software. Medicam allows operators to manage client and supplier files, monitor stock levels and process offers, invoices and reports by computer. The next version, Medicam II, also includes accounting software (Exacute), which provides a direct link between the pharmaceutical and finance divisions. PROMESS uses the PAHO/WHO bank account in accordance with the Organization’s requirements.

Buildings and equipment

PROMESS is located in Port-au-Prince, the capital of Haiti. At its main site the Centre has roughly 2,085 m² of warehouse space and 240 m² of office space, with a further 400 m² of storage space for strategic reserves elsewhere in the capital.

PROMESS is equipped with modern technology, both for administration (computers) and for storage and transport (conveyor-belts, forklifts, etc.). In view of the unreliability of the public electricity supply, the Centre is serviced by two generators powerful enough to ensure that drugs and vaccines are properly preserved.

Distribution and decentralisation

Due to the unstable political climate in Haiti at the time PROMESS was set up, the Centre initially concentrated on supplying and maintaining stocks, while institutions themselves were responsible for collecting orders. In this way, PROMESS avoided the huge logistical, security and waste problems linked with setting up a delivery system.

While such a policy was undoubtedly inevitable in a crisis, it did penalise institutions operating far from the capital. As soon as it was feasible, PROMESS currently offers more than 300 products

PROMESS set about establishing a network of peripheral warehouses. Several are already operational and all will eventually form part of the decentralised health facilities promoted by the public authorities. This will involve a considerable degree of autonomy for community health units and corresponding pharmaceutical warehouses.

Some PROMESS achievements

During the crisis, PROMESS supplied a total of approximately 470 health institutions (public, private and mixed), covering an estimated number of 4,510,000 people. Institutions supplied included the country’s main hospitals, clinics, health centres (with or without beds), orphanages, and psychiatric homes. Coverage (beneficiary health centres/registered health centres) varied from 45.4% in the North-East Department to 91.6% in the Department of Grand’Anse.

Within the framework of humanitar-ian aid programmes, donor countries invested roughly US$450,000 in setting up PROMESS (building leases, installa-tion of cold rooms and generators, purchase of storage and distribution systems), while PAHO/WHO provided substantial technical, logistical and administrative assistance. During the crisis, PROMESS distributed essential drugs subsidies worth approximately US$2.3 million and made over 5,000 deliveries, with a total value of approxi-mately US$4 million. At the end of the crisis in October 1994, the Centre had stock estimated at roughly US$3 million.

The future for PROMESS

PROMESS is now an accepted part of daily life in the Haitian health sector. The name PROMESS figures prominently in numerous pharmacies throughout the country’s various departments. It is found on drug sachets to be distributed to the sick, on drug data sheets given to health auxiliaries, on reserves in peripheral warehouses and on treatment guides for doctors. PROMESS has been at the heart of a minor revolu-tion aiming at developing a genuine essential drugs programme in Haiti.

While it is difficult to assess the overall impact of PROMESS, a few initial observations should be made. It is generally considered that PROMESS has fulfilled its primary task, by supplying a health network responsible for imple-menting humanitarian aid programmes. Indeed it is generally considered to have done a lot more besides. The Centre’s professional and dynamic approach has firmly established it within the highly strategic supply branch. Through its widespread presence, PROMESS has helped develop other aspects of the Action Programme, such as training schemes, and decentralisation and integration of services. Furthermore, given the fact that most of the Haitian population lacks the money to purchase drugs directly on the private commercial market, PROMESS has given the coun-try’s poorest almost unprecedented access to necessary drugs. Without competing unfairly with the private pharmaceutical sector, the Centre has had a regulatory effect on the local market and has helped to raise quality standards.

A supply centre the size of PROMESS is a major asset, particularly in a country where resources are scarce. It promotes financial self-sufficiency in institutions and can have an important impact on the whole Haitian health network. As the driving force behind an essential drugs programme capable of revolutionising patient care and thus transforming the different levels of the health system, the Centre could make a vital contribution to restructuring the Haitian health network. In this respect, discussions undertaken with the authorities and with representatives of various partner organizations will be important for the future of the Haitian health network.

Important decisions concerning the future development of PROMESS have yet to be taken. The aim in all cases should be to turn PROMESS into a distribution facility capable of supplying the entire country. Such a facility could be managed by an executive council consisting of representatives of the authorities, beneficary institutions and relevant professional associations. That would be an interesting model of joint management, combining the forces of national public bodies, international organizations and beneficary organizations.

* Guy Rino Meyers is Pharmacist Advisor, PAHO, P.O. Box 1330, Port-au-Prince, Haiti.

The contribution of Francine Tardif to this article is gratefully acknowledged.
Philippines: training on rational use

The international training course on Promoting Rational Drug Use organized by the INRUD/Indonesia Core Group, the Action Programme on Essential Drugs, Gadjah Mada University and MSH, held in Indonesia in September 1994, has produced a national offshoot. The INRUD/Philippines Core Group and Philippine National Drug Policy staff recognized the potential of a course promoting rational use to strengthen the implementation of the National Drug Policy and the Generics Law.

In June 1995, 41 participants representing health professionals, local government units and health NGOs, met in Manila to discuss a wide range of topics. These included: frameworks for changing drug use; decision making for rational use interventions; sampling to study drug use; and effective public education. Participants were encouraged to form a network to coordinate rational drug use activities and undertake community studies to improve drug use in their respective regions.

Source: RDU Update 1995: vol 4; no.1. Published by the Philippine National Drug Policy Office, c/o The National Drug Information Centre, Department of Pharmacology, College of Medicine, University of the Philippines, 547 Pedro Gil Street, Manila, the Philippines.

Guide to Good Prescribing – positive feedback

DM-20 announced the publication of the WHO manual, Guide to Good Prescribing, which describes a new method of problem-based pharmacotherapy teaching. The same issue reported on a training workshop in the Philippines, which introduced the concepts included in the manual to 22 pharmacotherapy teachers. A follow-up to the June 1995 workshop was held in November of that year, and showed that in just a few months impressive progress had been made in implementing the Guide’s recommendations.

In nearly all the Philippine medical schools represented, problem-based pharmacotherapy teaching had been introduced in one or more years of the medical curriculum, either in integrated teaching, as extra hours, by replacing laboratory hours or as a separate course. The perceived strengths of the method were: its relevance to the medical students; that it was less threatening to them by encouraging more discussion than the usual one-way lecturing; and that it promoted a much better interaction between students. Difficulties were: “finding a place in the curriculum”, allocating enough curriculum and staff time; and a few resistant senior clinicians.

Participants commented that the development of a personal approach is probably particularly relevant in places such as Asia, where so many drugs are available on the market, and formularies such as Asia, where so many drugs are probably particularly relevant in places.

An impact study in Uganda...

“Highly effective in improving students’ therapeutic skills”. This was the encouraging conclusion reached after a three-week field trial of the pharmacology training methods advocated in Guide to Good Prescribing. Organized by the Department of Pharmacology and Therapeutics in the Medical School of Makerere University, Kampala, the study involved 44 fourth and fifth year medical students. Over 90% of those in the study group reported that the training methodology was more practical and relevant to patient care and that it helped them in their clinical examinations. Students have since appealed to other departments in the Medical School to include problem-based training in their curricula.


Director says farewell to DAP

Mr Margaretha Helling-Borda, Director of the Action Programme on Essential Drugs, will be published at the end of 1996. Published in collaboration with the Action Programme on Essential Drugs, will be published at the end of 1996.

Ms Helling-Borda, who joined WHO in 1987, is known to many as the editor of Managing Drug Supply and for his work on rational drug use and drug financing. Dr Quick is known to many as the editor of Dialogue on Diarrhoea, for his work on rational drug use and drug financing.

Getting together: African RUD groups strengthen ties

A DAP-supported meeting in Malawi in November 1995 saw the beginning of closer regional collaboration between three African networks concerned with the rational use of drugs. Many members of the Society for Clinical and Experimental Pharmacology for Preferential Trade Agreement

Countries (SOCEPTA), the Drug Utilization Research Group in Africa (DURG-AFRO) and INRUD are already affiliated with the other two networks. They therefore welcomed the chance to discuss developing common goals and methodologies, ways to exchange experiences and opportunities for collaborative links. It was agreed that INRUD-Africa regional meetings will be scheduled jointly with SOCEPTA and DURG-AFRO every two years and that INRUD News would be used as a forum for SOCEPTA News.

Teaching pupils about medicines: has the new French initiative got it right?

B. Minzes*

What do schoolchildren of nine to 11 need to learn about medicines? A kit produced collaboratively by the French consumers’ organizations, physicians’ and pharmacists’ associations and the national pharmaceutical industry association (SNIP), is a beautifully illustrated and well-presented set of curriculum materials. Does it provide children with the basic information they need in order to use medicines well?

The information in the kit is straightforward and clear. There are worksheets to fill out and an amusing cartoon to read, with stories about children giving each other medicines when they shouldn’t, taking extra spoonfuls of good-tasting medicines and otherwise illustrating how not to treat medicines. It is a good presentation of the basic principles of compliance: how to use medicines as directed, avoiding sharing prescribed medicines with friends or family, and keeping a well-ordered family medicine cabinet to avoid accidental misuse. The kit also covers the “first two medicines” and whether they are curative, preventative, diagnostic or relieve symptoms of disease.

The fundamental problem, especially in the materials directly for children, is what is missing: the idea you might be sick and not need a medicine; the idea you might visit a doctor and leave without a prescription; the idea that medicines can cause harm as well as bringing benefits; the idea that children and parents might ask questions about a prescription; and the broader underlying concept of partnership in health care – that patients can move beyond being passive recipients of doctors’ instruction to taking part in discussion and joint decision making on treatment options; and the critically important information that two medicines with different names (brand names) may contain identical substances.

Since the children receive no negative information about medicines, the recommendations to comply with a doctor’s instructions are a little thin on why. Nowhere does a child read that medicines should not be shared or treated like sweets because they can be dangerous.

A “chain of cure” is presented, discussing symptoms of disease, the parents’ role in deciding whether to take a child to doctor or not, the role of the doctor in diagnosing a disease and prescribing a medicine and the role of the pharmacist as dispenser. The most surprising part of this text is that it gives the impression that every single doctor’s appointment ends in a prescription. Elsewhere as well, in a worksheet asking children to describe a sickness and a visit to the doctor, the question is not, “Did the doctor prescribe a medicine?” but “What medicine did the doctor prescribe?”

The background materials for teachers do include a section on the label which mentions side effects, contraindications and interactions, and an explanation that medicines cannot replace good diet, hygiene and adequate sleep and exercise. However, even this section skirts the idea that some common diseases are self-limiting and there is no need for a “pill for every ill.”

What do children of nine to 11 need to learn about medicines? They need to learn to use the right medicine as directed and “Le Bon Usage du Médicament” will teach them this. They also need to know they have a right to ask questions about medicines and to get answers they can understand. And they need to know that medicines are not magic potions: that they can treat some illnesses very well and others not at all; that they can be potent cures but can also be ineffective; that they can be very helpful but also very harmful.

*C. Minzer, Publications and Information, HAI-Europe, Jacob van Lennepkade 334 T, 1051 NL Amsterdam, the Netherlands.

Improving your drug supply management skills

The International Dispensary Association (IDA), of the Netherlands, and Management Sciences for Health, of the USA, are joining forces in Amsterdam to run a course on Managing Drug Supply for Primary Health Care. The aim is to improve participants’ ability to modern management principles of drug supply systems, and to teach them how to apply these in their own situations.

The approach will be highly participatory to facilitate an exchange of views and experiences between senior level staff. Major topics will include: national drug policy; selection and quantification of drugs; procurement methods and strategies; quality assurance; kit distribution; financing drug supply systems, and indicator based assessments.

The course will take place from 30 September to 11 October, 1996. It is intended for physicians, pharmacists, senior health system managers, and technical assistance professionals from ministries of health, nongovernmental organizations and donor agencies.

The total fee of US$4,500 includes tuition, field trips, accommodation and most meals.

For further information contact: Ellen van den Bosch, IDA Foundation, P.O. Box 37908, 1009 AB Amsterdam, the Netherlands. Tel: +31 20 4405795, fax: +31 20 4015554, e-mail: ilda_info@zomer.nl

South Africa: pharmacotherapy teaching course

The first African Problem-based Pharmacotherapy Teaching course is to be held in Cape Town, South Africa from 25 November to 6 December 1996. The course will be run by the Pharmacology Department of the University of Cape Town in collaboration with the Action Programme on Essential Drugs and the University of Groningen, the Netherlands. Further information is available from: Department of Clinical Pharmacology, University of Groningen, Bloemsingel 1, 9711 BT Groningen, the Netherlands. Tel: +31 50 3562312, e-mail: courses@pharmac.ubsg.nl

Promoting rational drug use

The next INRUD/DAP courses on Promoting Rational Drug Use will be held in: Dhaka, Bangladesh, from 2–13 December 1996; and Tanzania in Spring 1997.

For further information contact: Management Sciences for Health, 1303 N. Fort Myer Drive, Suite 930, Arlington, VA 22209, USA. Tel: +703 524 6575, fax: +703 524 8831; e-mail: nssd@bu.edu

Second course on drug policy issues

Boston University’s Center for International Health, in collaboration with the Action Programme on Essential Drugs, is to hold its second course entitled, “Drug Policy Issues for Developing Countries”. The course, which takes place in Boston from 17–28 February 1997, is intended for policy makers, senior managers responsible for pharmaceutical systems in developing countries and senior officials of donor agencies.

For further information contact: Dr Richard Laing, Center for International Health, Boston University, 53 Bay State Road, Boston MA 02215-2106, USA. Tel: +617 353 4524, fax: +617 353 6158, Telex: 200191 BUUR, e-mail: cih@bu.edu

Effective drug management

The next course on “Effective Drug Management and Rational Drug Use”, is to be held from 12 May to 11 July 1997, at Robert Gordon University’s School of Pharmacy, Aberdeen, Scotland, UK. (See p. 5 for more details and contact address.)

For further information contact: Robert Gordon University’s School of Pharmacy, Aberdeen, Scotland, UK. Tel: 0224 342351, Fax: 0224 342385, e-mail: rgh@rgu.ac.uk
Introducing DAP’s homepage

The Action Programme on Essentials Drugs’ (DAP) homepage on the World-Wide-Web service on the Internet offers the user a range of information on the functions and activities of the Programme. This information, which is frequently updated, includes links to the essential drugs concept, national drug policies, and the work of WHO and the Action Programme in developing countries.

The titles of selected WHO, DAP and other pharmaceutical publications are available on the homepage, to increase awareness of available resources.

The actual content of carefully selected publications can be viewed. For example, feature articles from the English version of the Monitor are available from issue 19 onwards and users can also obtain and print out the Guidelines for Drug Donations (see p. 6).

You can find DAP’s homepage on the WWW at http://www.who.ch/programmes/dap/dap_homepage.html

AHRTAG Update – Primary Health Care Current Awareness Service, 1996

A current awareness service focusing on primary health care and disability issues in developing countries and on health and welfare issues on line from the Appropriate Health Resources and Technology Action Group (AHRTAG).

AHRTAG has published 10 volumes a year, describes 150–200 new materials added every month to AHRTAG’s bibliographic database. The database includes articles, books, manuals, reports, and unpublished materials on a wide range of issues. Among these are: adolescent health, evaluation, health education, HIV and AIDS, planning and management, programme implementation, structural adjustment and training.

AHRTAG Update lists materials focusing on the practical aspects of primary health care and community-based rehabilitation.

Price: US$32/US$10. For further information and subscription details contact: Resource Centre, AHRTAG, 29-31 Fairspring Road, London EC1M 3JR, UK Tel: +44 (0) 71 275 8242, Fax: +44 (0) 71 244 0943, e-mail: ahrtag@apc.org

PAHO Web Server

The Pan American Health Organization (PAHO) has launched its Web Server, containing information on public health and related issues in the Americas. You can visit the Web and go to Web servers at: http://www.paho.org or go to gofer@paho.org or webmaster@paho.org

Drugline on CD-ROM

The work of the Drug Information Centre at Huddinge Hospital, Sweden, and the production of its database, Drugline, was described in EDM-14. Drugline is a full text question and answer database containing evaluated and problem-oriented drug information. The documents in Drugline deal with a variety of therapeutic drug problems, such as adverse effects, choice of drug, drug interactions and drug use during pregnancy or breast feeding.

Online since 1984, a CD-ROM version of Drugline is now available. The retrieval service is called SilverPlatter’s SPRIS, the same program as for Medline on SilverPlatter, and available for DOS, Windows, Macintosh and UNIX.

You can find Drugline CD contains 7,500 documents and is updated six monthly. So far the language is mainly Swedish, but more than 1,000 of the English documents will increase. This type of problem-oriented drug information is of particular value in training.

The emphasis will be on the dissemination of information through drug bulletins, scientific publications and formularies, the non specialist press and the Internet. The role of drug information in politics as well as pharmaceutical care will also be discussed.

For further information contact: International Secretariat, European Society of Clinical Pharmacy, Parallelweg 214 2D 2001 BT Nieuwegein, the Netherlands.

International Congress of Public Health Associations

“The Health in Transition: Opportunities and Challenges”, is the topical theme for discussion at the International Congress of the World Federation of Public Health Associations. Supported by WHO and UNICEF, the Congress will be held in Arusha, Tanzania, from 12-16 October 1997. The World Federation of Public Health Associations is a nongovernmental organization, composed of national public health associations from 48 countries around the world. Participation at the Congress is open to all, and health practitioners, policy makers, municipal planners, health workers, researchers, and many others from governments, academia, international and nongovernmental organizations are expected to attend.

For further information contact: World Federation of Public Health Associations, c/o AFAH, 1015, 21th Street NW, Suite 700, Washington DC 20036, USA. Tel: +1 202 780 3932.

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The need for public health pharmacy: ongoing E-Drug debate

A number of individuals interested in public health aspects of pharmacovigilance have been using the E-Drug list server at Healthnet. The focus is on the concepts involved in public health pharmacy and the need for specific training programmes in the field.

The list server is available for anyone with Internet access wishing to contribute further thoughts to the discussion. The list server is available for anyone with Internet access wishing to contribute further thoughts to the discussion. The list server is available for anyone with Internet access wishing to contribute further thoughts to the discussion.

To subscribe to the E-Drug listserver and automatically receive all future correspondence, send a message to: majordomo@us.nihs.org

The following command should be the only line in your message: subscribe e-drug
Essential Drugs Monitor

NATIONAL DRUG POLICY

South Africa’s new National Drug Policy

Minister of Health, Dr Nkosazana Dlamini Zuma talks to Essential Drugs Monitor Editor, Daphne Fresle, in Geneva

Daphne Fresle: Why did South Africa decide that it needed a national drug policy?

Dr Zuma: Firstly, South Africa was facing a situation where its drug prices were amongst the five highest in the world. Secondly, the majority of our people did not have access to health care, which was limited to just a few. Thirdly, we were faced with the same budget that was used to provide health care for the few but we had to stretch this to provide for everybody. This meant that we had to reprioritise and we had to make sure that whatever we did was cost effective. One of the major expenditures in our health services, obviously, was drugs. But because there was no drug policy, and hence no coordinated rational strategies of the type that we are now targeting, the cost of health care was constantly being pushed up. We therefore decided that amongst other things we needed a drug policy to be able to regulate some of the activities of health workers, of pharmacists and of the industry, and to also make sure that we were able to provide a core of essential drugs to the health services at an affordable price. Those are really the major reasons why we decided we needed a drug policy.

DF: They are very fundamental reasons, aren’t they? Having decided that you needed a drug policy how did you go about its development?

Dr Zuma: Before the elections the different factions had developed their own vision of what they would do if they came into office. And the organization to which I belonged, the African National Congress, had worked on its own policy development. So when we were elected, we looked at that policy to see how it could be applied in government. If we had just wanted a process involving government then the easiest way would have been to take a number of people from across the country and form them into a committee to review the issues and produce a policy. But we considered that such a committee, alone, would not have all the ideas or the necessary experience. We therefore wanted, in addition, a wider approach that would involve consultation with all the stakeholders of the country. We also thought it essential to get information about international experience, because we considered that although we were the last to be free we had to use some of the advantages of being last. This meant learning from people who had gone before us, in two ways: first, learning how and what has worked, and second, learning what has not worked and what we should avoid. This doesn’t mean that you never make mistakes but at least you are enriched by the experiences of other people.

So this Committee undertook a very wide consultation process, which included international expertise, such as that of WHO. It then developed a framework that we could use. This was presented to the Minister and to all the members of provincial health executives. Their contributions led to some modifications and strengthening of the policy, which was formally adopted by the Government in January 1996.

DF: You talked about learning from the lessons and experiences of others. Did you encounter any problems yourself in this policy development process? I ask this because stakeholders sometimes have very divergent views of where they want to go or a country to go.

Dr Zuma: Yes we do. But, of course, where there is a real need for the doctor to dispense they must continue to do so. To me that is when patients do not have a pharmacy within walking distance and would have to pay for transportation to get their prescription. In these circumstances, I think it is justified for the doctor to dispense. But where there are a lot of pharmacies around, I don’t see why doctors should dispense. And in terms of pharmacies, I also think that they should be able to substitute generic drugs for each and every drug a patient is prescribed, and that they should inform the patient of the benefits.

DF: And that is included in your policy isn’t it?

Dr Zuma: Yes, it is. I also think that we should be able to open up ownership of pharmacies to people other than pharmacists. There should not be a monopoly and competition helps. I start from the premise that pharmacists are first and foremost professionals before they are business people because if they really wanted to do business they would not have studied pharmacy. But obviously if someone who is not a pharmacist owns a pharmacy you must make sure that there is a pharmacist employed.

So those are some of the difficulties we encountered. We also knew that it was important to gain the support of the general public to keep them informed about what we were doing, why, and the potential benefits.

DF: And how are you undertaking that sort of advocacy?

Dr Zuma: We are developing information, education and advocacy project that will develop materials, identify channels of communication and partnerships, to explain such concepts as essential drugs lists and other drug policies, and why it is important to support this work. The heart of the message, the bottom line, is that we are trying to make drugs affordable so that health care is accessible to the majority and not just a minority.

DF: Because the availability and quality of health services, and whether you can afford them, is of great concern to people, isn’t it? When I am in South Africa, people in the community – even those who are economically privileged – often express their concern about the price of drugs and the rising cost of health care. It certainly seems to be an important issue for very many people.

Since we are talking about important issues, what would you say are the core issues underpinning the new policy and what will you be giving priority to?

Dr Zuma: Well, we are going to give priority to the use of essential drugs, particularly in primary health care, because that is where we started, although...
Minister... cont’d from pg. 17

We intend to develop an essential drugs list across the board. But our priority for now is primary health care. That is one major issue. The second issue is replacing the mark up on drugs by a professional fee for the pharmacist because part of the problem is the current huge mark up.

We should also like to know the exit price of the drug from the manufacturer. At the moment there are different prices according to whether the drug is ordered by a pharmacy or by a private doctor. We consider that there should be one price. We also consider that this price should be transparent so that we know what the mark up is between the exit price from the manufacturer and the price that is paid by the patient. The other priority obviously is to encourage generic prescribing and generic substitution. At present most people don’t even know that for the same illness you may be prescribed the same pharmacological substance but different prices. Those are the major different prices. Those are the major issues.

The second issue is the need for trained primary health care workers. We need to train people, for instance, to use essential drugs appropriately and to follow the treatment protocols. Second, there is a problem with the distribution of retail pharmacies since most of them are in the centre of cities, and are rarely found further afield.

Another major issue is the need to set up good distribution chains, particularly in rural areas. Management skills are also needed: making sure that people don’t only re-order essential drugs when they are taking the last tablet out of the container but have a stock in reserve. Health workers also need to be able to predict when stock will be used up more quickly and an urgent order is needed, for instance in the case of a particular disease outbreak. These things are still going to take a long time. Also, most staff are not used to generic prescribing and it will take time to change that, and to update their skills and familiarise them with the international nonproprietary names of the products they use, and so on. So these are some of constraints we are facing.

About doing away with the mark up on drugs. But we can’t expect that all the aspects of the policy will please everybody equally.

DF: And is the public very happy with the new policy?

Dr Zuma: The public is happy but I think that the public will only be very happy when prices start to go down.

DF: Yes, people want visible action and results to follow statements of good intent, don’t they? But how quickly you can produce results will depend not only on good policy formulation but on the sort of constraints you are facing in implementing the policy. I don’t mean now the attitude of different stakeholders, but rather constraints such as the availability of human resources or finances, or perhaps conflicting priorities.

Dr Zuma: Well, human resources are always an issue, at two levels. First, just the critical mass of physical human resources, second, the need for trained people able to implement the policy properly, particularly at the primary health care level. We need to train people, for instance, to use essential drugs appropriately and to follow the treatment protocols. Second, there is a problem with the distribution of retail pharmacies...
Dr Zuma: I think that is actually almost bringing in the world’s experience on those issues. I think that is of WHO – in this sort of consensus development and implementation of national programmes.

Dr Zuma: Well perhaps just to say that making a drug policy is really a minute step towards what we want to achieve. The real test is in implementation. I hope that WHO and other people in health care in the developed world who have helped us so far are not going to tire... that they will help us through the difficult route of implementation and solving problems that we may find along the way.

Dr Zuma: Well I would say both ‘yes’ and ‘no’. Neutral in terms of the dynamics in the country and the relationship between the different stakeholders, but I would hope that you are not neutral about the principles of providing health care in an equitable and accessible way.

DF: Quite! WHO is not neutral about those fundamental principles, of course. Before we close, is there anything else that you would like to add in conclusion?

DF: Drug policy development often involves so many sensitive issues and many strong opinions, that it can also be helpful to have a neutral voice – such as that of WHO – in this sort of consensus reaching.

Dr Zuma: It has been very helpful. First of all, even when there is national expertise, it is always reassuring to have access to other expertise. This is particularly true of an organization such as WHO which not only has the technical knowledge but also a global view of what is happening, what has been tried and what has worked elsewhere. And so, when you bring in WHO, you are actually almost bringing in the world’s experience on those issues. I think that is a very valuable input to policy making.

DF: The aim is to promote research that will facilitate the implementation and evaluation of the National Drug Policy. Strategies include:

- support to operational research on NDP impact, prescribing and dispensing, economics of drug supply and use, and sociocultural aspects of drug use.

- technical cooperation

The aim is to maximise the effective use of limited resources through technical cooperation with international agencies. Strategies include:

- maintaining and strengthening cooperation with international agencies, such as WHO, in a comprehensive range of technical areas related to pharmaceuticals.

Traditional medicines

The aim is to investigate the use of effective and safe traditional medicines at primary level. Strategies include:

- encouragement of traditional healers to work more closely with the formal health sector.

- establishment of a national reference centre for traditional medicines.

Monitoring and evaluation

The aim is to support the successful implementation of the National Drug Policy through establishing mechanisms for monitoring and evaluation of performance and impact that will identify possible problems and effective strategies. Strategies include:

- use of indicators for monitoring NDP, systems for monitoring of the private sector and, to a limited extent, international pharmaceutical markets.

Meeting health needs through national drug policies

Organized by the Australian Government and the Action Programme on Essential Drugs (DAP), the conference also included, in addition to country delegations, participants from the World Bank, UNICEF, UNIDO; industry associations and individual companies; consumer organizations, such as Health Action International/Consumers International, international voluntary organizations; professional associations; the Dag Hammarskjöld Foundation; Karolinska Institute; Harvard University and other universities; and non-profit organizations, such as the Medical Lobby for Appropriate Marketing and Management Sciences for Health.

The conference theme, “Can a comprehensive approach to national medicinal drug policy meet both health and economic needs?”, was explored through country presentations and four concurrent workshops. Participants endorsed an overall set of recommendations on NDPs and the policy process (see summaries in Boxes 1 and 2). In addition, specific recommendations were developed for each of the four workshop topics: access to medicines; rational use of drugs; quality, safety, and efficacy; and the role of industry (see summaries in Box 3).

Access to medicines

In some countries of the Region, government health services are able to ensure access to drugs for a large portion of the population. But in most countries, the private sector predominates. High prices and inadequate consumer information limit access to affordable essential drugs. At the same time, government health services face financial pressures and other constraints. Emphasis was placed on the need for exploring economic mechanisms and incentives to increase access, through both public or private sectors, and to improve public sector efficiency in achieving health objectives. Examples of promising possibilities included the integration of the essential drugs concept in social and community health insurance, incentives to improve access in under-served areas, application of cost effectiveness analysis to pharmaceutical expenditure decisions, price competition through generic dispensing, contracting certain public drug supply functions, and group pharmaceutical procurement for smaller islands of the Western Pacific. At the same time, it was observed that the pharmaceutical market is not fully competitive and that public health interests require a degree of state regulation.

The meeting emphasised that political will is essential for implementation of successful policies to improve equitable access to drugs, particularly for the poor, and that market forces alone cannot guarantee access to needed drugs for the entire population, and should be regulated.

Rational use of drugs

Using medicines appropriately was a major focus of discussion. Since the 1985 WHO Conference on the Rational Use of Drugs held in Nairobi, understanding has increased of the social, cultural, and behavioural determinants of medication use. Building on this wider perspective, progress has also been made in identifying effective strategies and interventions, particularly targeting prescribers. However, interventions to improve drug use – especially those directed to the public – are still often mounted without adequate exploration of underlying causes, a thorough analysis of possible alternative strategies or in-built systems to monitor outcome. Successful interventions often remain unpublished and so can rarely be replicated; and strategies for their dissemination are poorly developed. In many countries the political will to implement programmes to encourage rational use appears to be lacking and specific funds are seldom made available. Other contributory problems cited included that drug promotion is rarely monitored and is not always ethical, and that many consumers lack information about the rational use of drugs.

Participants from Indonesia, Nepal, Bangladesh, Thailand, New Zealand and other countries described the impact of creative approaches to promoting rational drug use, including focused clinical guidelines, district-level self-monitoring, drug audits, doctors’ self-audit, interactive patient-provider groups to reduce injection use, and mothers’ drug information groups to improve self-medication. The conference endorsed the right of health providers and consumers to objective, understandable drug information.

Quality, safety and efficacy of medicines

Countries noted that there is considerable variation in capacity to ensure the quality, safety and efficacy of drugs on the local market. Inadequacies were cited in drug legislation and regulation; inspection and enforcement; standards for quality, safety and efficacy; use of the
**Box 3**

**Specific conference recommendations**

**Access to medicines**
- Affordability should be promoted through generic drug policies, social and community insurance schemes and creation of incentives for improving access in underserved areas.
- Information should be exchanged on prices, pricing mechanisms and policies, performance of manufacturers and suppliers of essential drugs and raw materials, patterns of drug use and economic analysis.
- Governments should analyse the cost effectiveness of health care interventions, including economic analysis of individual pharmaceutical products where appropriate.
- Governments should ensure effective procurement systems in the public sector.
- Governments should support efforts of non-government organizations to make affordable essential drugs available to low income and other target populations.

**Rational use of drugs**
- Governments should publicly endorse rational use of drugs.
- National rational use of drugs coordination units should be established with multisectoral advisory committees, qualified staff and an operating budget.
- Rational use of drugs programmes should involve relevant departments in the ministry of health and other ministries, health professionals, academia, industry and consumers.
- Governments should ensure competency-based training for all drug providers including doctors, pharmacists, other health professionals and drug retailers.
- Governments should foster cost effective targeted interventions with measurable outcomes aimed to promote the rational use of drugs at all levels of health care.
- Health providers and consumers have a right to objective and usable drug information provided through health education programmes, the news media and ethical drug promotion.
- National ethical criteria for drug promotion, based on the WHO Ethical Criteria for Medicinal Drug Promotion, should be developed and enforced.

**Quality, safety and efficacy of medicines**
- Registration of pharmaceutical products should be strengthened by development and implementation of guidelines and processes for good regulatory practice.
- Adequate human and financial resources must be allocated to ensure quality, safety and efficacy of drugs.
- Training activities should include academia, government and industry facilities.
- Harmonisation activities within the Region should consider standards for quality, safety, and efficacy; good manufacturing practice; drug evaluation; standards of drug information; and effective communication and collaboration between countries.
- Countries with specific expertise within government and industry should be utilised for the training and upgrading of personnel from other countries.
- The WHO Certification Scheme should be complemented with indicators of its effectiveness, guidelines for implementation, a system for peer review among countries and a system for handling complaints from importing countries.
- There should be adequate drug regulatory controls over exported products by exporting or donating countries.
- The International Conference on Harmonisation should be expanded to allow active involvement by all countries and access by consumer organizations, for example, to evaluate its implications for the Region and also to emphasise consumer interests and health policy perspectives.

**Industry contribution**
- A new paradigm is required which recognises that a socially responsible industry and profitability are compatible. Both industry and national drug policies should recognise a drug as a medication process incorporating honest and full information related to health outcomes.
- Involvement of industry with all partners is essential in the development and implementation of NDPs.
- Industry should work with governments, funders, recipients and providers to improve affordability, availability, and access to essential drugs and drug information.
- Industry should be encouraged to participate in human resource and technical development both within the industry and with the other partners.
- Research and development in the Region as well as development of local industry are desirable.
Developing national drug policies: WHO update

Countries continue to have serious problems in ensuring the availability and the rational use of drugs. The reasons are complex and linked not only to financial and budgetary constraints but also to the characteristics of the market, the attitudes and behaviour of governments, prescribers, dispensers, consumers and the drug industry.

The experience of many countries has shown that pharmaceutical problems and issues can best be resolved within a common framework. To help in this work, WHO’s Guidelines for Developing National Drug Policies were published in 1988. They provided an overview of core policy issues and incorporated the essential drug concept.

The guidelines have been used by many countries in formulating their own national drug policies. However, with experience gained from their use, and rapid global change impacting on the pharmaceutical sector, it became apparent that important new technical issues and developments needed to be addressed in an updated publication. A WHO Expert Committee met in Geneva in June 1995 to provide a contribution to updating the 1988 Guidelines. The Committee recommended that every country should formulate and implement a comprehensive national drug policy. While goals and objectives would depend upon national circumstances and priorities, their broad thrust should be to make essential drugs available and affordable to all those who need them; to ensure the safety, efficacy and quality of drugs; and to promote their rational use by consumers and prescribers.

A drug policy should form part of a broader national health policy, and whenever possible should emphasise preventive health care. Policy development and implementation calls for a partnership of all stakeholders: government, health care providers, consumers, manufacturers and universities, the Committee stressed.

Key national drug policy issues covered in the report include:
- legislation
- drug selection and supply
- quality assurance
- rational use
- economic strategies
- monitoring and evaluation
- research
- human resource development
- technical cooperation among countries.

The document concludes with guidance on the policy development process, such as priority setting, policy formulation and implementation, monitoring and evaluation.

Policy makers, development organizations and other stakeholders should find the report a useful contribution to pharmaceutical policy development. Additional inputs will be sought to prepare the second edition of the WHO guidelines on developing national drug policy, planned for 1997, which should provide a further practical tool in this area.


Asia-Pacific seminar promotes national drug policies

The implementation of national drug policies in the Asia-Pacific Region was the subject of lively debate at a seminar held in Sydney in October 1995. Organized by Consumers International Regional Office for Asia and the Pacific in collaboration with the Dag Hammarskjold Foundation, Sweden, the meeting brought together 55 participants. They included members of Consumers International, network partners, health ministry officials, academia, and the media, many of whom went on to attend the International Conference on National Medicinal Drug Policies (see p. 20).

Four broad themes were chosen to reflect some of the main problems countries in the Region face in implementing the major components of national drug policies. The themes were: national drug policies and drug legislation; drug pricing policies; regional cooperation and sharing of information; and economic, commercial and technological developments of the Asia-Pacific Region’s pharmaceutical sector. Small working groups discussed these issues, followed by a plenary session to share experiences, problems and successes. The seminar concluded with participants resolved to work together to promote rational drug use and the adoption of national drug policies. They agreed on the need to:
- enact legislation, formulate rules and regulations to make national drug policies and essential drugs applicable to both the public and the private sectors;
- enter into a regional cooperative agreement to enable drug regulators to share relevant and vital information on different aspects of pharmaceuticals;
- regulate, control and monitor prices;
- strengthen the economic, commercial and technological development of the pharmaceutical sector.

Understanding injection preference

Editor,

I was pleased to read in EDM 20 the research article on unnecessary injections in Thailand and additional remarks on polypharmacy. It is necessary to look back about 60 years to find the basic reasons for injection preference.

In Zimbabwe, and I am sure many other Third World countries, western medicine was not perceived as very effective until the arsenicals appeared in the 1920s. These were normally given by intravenous injection for syphilis and with even more spectacular results for yaws. It was so much better than anything which had gone before that many people soon sought the magic. This was succeeded by the sulphonamides, also given by injection, which were also pretty miraculous with lobar pneumonia, the answer to this is hard going at first, but now in our community hardly anyone wants an injection and returns to our community clinic without going elsewhere to receive treatment, in the last 20 or 30 years it has been a horror, because nearly every new patient indicates they will not be happy unless they have an injection. The answer seems to be to take the time to explain, on an individual basis, the reasons for not giving an injection and why the patient has come to believe in the value of injections.

Polypharmacy...

Some years ago I conducted a small research project amongst the elderly living in their own homes in Harare. We found one old lady who had been prescribed 14 different items, not one of which had to be taken at the same time as another. Seven were thought completely unnecessary, three were to counteract the effects of another of her drugs, and so forth. It was not until she was taken off all medication that she regained her health. The answer to this is continuing in-service training in rational prescribing.

At a time when the Zimbabwe Health Service is under increasing stress because of shortage of funds, more thought needs to be given to spending the little we have in a more rational way. Health professionals should pay more attention to EDLIZ. Zimbabwe’s excellent manual on drug treatment guidelines and essential drugs. Prescribers should take patients into their confidence more often. If they were to do so patients would be more likely to leave the health unit confident in their treatment, even with no drugs at all.

---Dr Raymond T. Mossop, (Retired), Former Head, Community Medicine, University of Zimbabwe and Former President of College of Primary Health Care Physicians, 7 Fleetwood Road, Alexandra Park, Harare, Zimbabwe.
PHARMACEUTICAL ISSUES were high on the agenda at the World Health Assembly in May 1996. Globally, the drug situation remained characterised by a polarisation of those with reliable access to essential drugs, who are mainly in developed countries, and those with little or no such access, who are mostly in developing countries, WHO reported to delegates.

Population growth and the rising incidence of tuberculosis, AIDS and other diseases are putting further pressure on already inadequate drug supply systems. Demand is growing while local and community resources are decreasing or static. The private sector is increasingly taking over parts of the drug supply system. The challenge therefore is to help countries make the best use not only of limited public funds but also of private sector resources. More data are needed to determine which methods of drug financing enhance or diminish people’s access to essential drugs in developing countries. As free market economies expand and privatisation grows, many countries urgently require new and enforced drug legislation to meet the changing situation.

Education and training programmes to ensure technical efficiency and management capacity at national level are crucial to the successful implementation of national drug policies but are frequently neglected. Countries also need to tackle the problems of salaries and career development in the public sector, the inadequacy of which is a major contributory factor to staff shortages and low performance levels.

There continues to be an imbalance between commercially produced drug information and independent comparative, scientifically validated and up-to-date information on drugs for prescribers, dispensers and consumers. Essential for the monitoring of ethical criteria have to be introduced in most countries. Those exporting drugs to developing countries have an ethical responsibility to ensure that drug information, safety and quality meet the standards of the country of origin. Inappropriate drug donations, whether as emergency or other bilateral aid, continue to be a cause of concern.

Direct country support is the highest priority of the Action Programme on Essential Drugs, the Assembly was informed. The number of countries requesting assistance is rapidly increasing. Technical and financial cooperation has been provided to some 60 countries. Underlying this country support is the development of practical tools and training materials based on operational experience. The Action Programme provides strong support in promoting the essential drug concept as a technically sound and realistic approach to rationalising drug supply systems and to making drugs accessible to the whole population. It will be important to maintain its coordinating and advocacy role, globally, at regional and country levels, at a time when many new actors are entering the pharmaceutical sector.

In a lively and frank debate delegates focused strongly on issues related to drug pricing, access to market intelligence, quality control, drug donations and the impact of the GATT agreement on the pharmaceutical sector. Many of the concerns expressed were reflected in a resolution on the revised drug strategy (see highlights below), adopted by the Assembly.

Revised Drug Strategy

The resolution urges Member States to:

- reaffirm their commitment to develop and implement national drug policies to ensure equitable access to essential drugs;
- increase efforts to promote the rational use of drugs through the intensification of training and education of health workers and the public;
- enhance drug regulatory mechanisms for the monitoring and control of efficacy, quality and safety;
- establish and strengthen, as appropriate, programmes for the monitoring of safety and efficacy of marketed drugs;
- control unethical marketing of drugs;
- eliminate inappropriate donations of drugs, as recommended by the interagency Guidelines for Drug Donations, issued by WHO in May 1996; and
either the World Health Organization and WHO, as appropriate;
- develop a clear strategy for review and assessment of the effectiveness of the WHO Ethical Criteria for Medicinal Drug Promotion;
- promote vigorously the use of the WHO Certification Scheme on the Quality of Pharmaceutical Products moving in International Commerce;
- disseminate the interagency Guidelines for Drug Donations issued by WHO in May 1996 and encourage, in collaboration with all interested parties, its use and review after one year;
- continue the development, harmonisation and promotion of standards to enhance drug regulatory and quality control mechanisms;
- continue the development and dissemination of information on pharmaceutical products thereby assuring the safe, effective and rational use of drugs;
- encourage the promotion of research and the development of drugs for rare and tropical diseases.
- report on the impact of the work of the World Trade Organization with respect to national drug policies and essential drugs and make recommendations for collaboration between the World Trade Organization and WHO, as appropriate;
- report to the 51st World Health Assembly on progress achieved and problems encountered in the implementation of WHO’s revised drug strategy, with recommendations for action.

Delegates at the Assembly took part in lively discussions on pharmaceutical issues

Making good use of the Monitor

Editor,

I always enjoy EDM as it gives me so much information. I use a lot of the material from it to help me in writing articles and giving talks.

In Nepal, we have just established a group of journalists and health workers which aims to put the message over to the public that too many drugs are used unnecessarily. For example, large amounts of money are spent on such items as liquid vitamins and tonics. It is almost universal practice in Nepal to take vitamins and tonics while using antibiotics, which are thought to make you very weak. Patients believe in the way they only want to regain their strength.

We are using a variety of media — radio, television and journals — to try to make more people aware of the importance of using drugs rationally. Thank you for helping in our work by sending us EDM.

—Dr Aruna Uperty, Resource Centre for Primary Health Care (RECPHEC), P.O. Box 117 Bagbazar, Kathmandu, Nepal.

Editor:

I read EDM-17 with much interest and pleasure. It contains a great deal of the practical and theoretical information necessary in the day to day work of professionals in the pharmaceutical sector.

I am a teacher in the Pharmaceutical Faculty of the Medical and Pharmaceutical University of the Republic of Moldova. During lectures and practical sessions we teach our students the basics of pharmaceutical information and legislation; marketing and management; and problems related to drug supply and distribution.

Due to the difficult financial situation, the libraries, particularly the Moldova Republican Medical Library, cannot subscribe to foreign pharmaceutical publications, and this is creating an information gap concerning relevant professional issues.

EDM provides us with current, reliable information on drug policy issues at international level. Could you please ensure that I am on your mailing list.

—Mikhail Lapu, A. Rusu str.4, app.23, Kishinev 30, Republic of Moldova.

Also in the WHO Model Prescribing Information Series.


This second edition of Drugs used in Parasitic Diseases reflects the changes in treatment since the publication first appeared in 1990. In particular, the sections on malaria, African trypanosomiasis, cysteide infections, schistosomiasis and onchocerciasis have been extensively revised.


Also in the WHO Model Prescribing Information Series.


A joint study, involving the Action Programme on Essential Drugs and UNICEF, is underway to analyse and evaluate drug management and distribution systems in some developing countries. The study aims to define the constraints on the drug distribution systems’ effectiveness, in order to improve accessibility and the quality of health services generally. This report describes the Chilean drug system, particularly the public and private sector roles.

The publication begins with an overview of the country’s economic, demographic, educational and health situation. A more detailed description of health policy and strategy follows, including public and private sector provision and financing systems. The section on pharmaceutical policy gives a breakdown of the pharmaceutical market as a whole, the generic drugs market, registration and quality control. The public and private sector distribution systems and the role of the Central Supply Agency are then discussed. The authors also assess the extent of rational use of drugs in Chile.

The conclusion suggests future developments in Chile’s pharmaceutical sector.


The publication reports on a study which analyzed the role of Thai community health workers in drug distribution at the village level, particularly their impact on rational drug use. (See p. 28 for a more detailed description of the research).


Spraovitch Vidal 1995 (The Russian Pharmaceutical Reference Book), Editions du Vidal

The first Russian version of the French pharmaceutical reference dictionary includes drug monographs on 3,500 prescription drugs. Available, free of charge, from: AstrelPharm-Servis, Pervoi Hvatoj, Perselolok, DOM 11, Office 423, Moscow, Russian Federation.

In addition, a supplement to the French edition has been published in Vietnamese. Available from: The Hanoi Business Centre, 51 Ly Thai Quan Hoon Kiem, Ha Noi, Viet Nam.
Essential Drugs Monitor


One of the main problems faced by health centres in developing countries is how to maintain a steady and reliable supply of essential drugs, particularly when resources are scarce. Since How to Look After a Health Centre Store was first published in 1983, there have been many improvements in systems for managing stores and supplies. Along with a change of title, this new edition updates previous guidelines and includes examples of lists of essential drugs. Topics covered include: planning and organization; equipment; procuring and issuing supplies, and dispensing.

Available from: TALC, PO Box 49, St Albans, Herts AL1 4AX, UK. Price: £5 plus postage and packing charges (UK/surface mail add 30% of cost of book, airmail add 60% of cost of book).

Where There is No Doctor, Chinese ed., 1995

Health workers in China can now benefit from a Chinese edition of the publication. Where There is No Doctor. This detailed manual gives practical advice and instructions on primary health care. It provides health workers and villagers with information on the identification, diagnosis and treatment of specific illnesses, first aid, nutrition and prevention. Guidelines are given for the use of traditional and modern medicines, with risks and precautions clearly described.

The Chinese edition was translated by the Asian Health Information Department of Nanjing University. More than 90,000 copies have been printed and distributed, free of charge, in the remote rural areas of Western China.


This paper discusses the political aspects of policy reform, particularly in relation to health sector reform. While many studies exist of health policies from epidemiologic and economic perspectives, few address the political aspects of health policy in developing countries. Reich provides practical advice on how to identify opportunities for change. The first section of the publication addresses the general issue of why policy reform is political. The reasons are briefly explored, providing an approach to thinking about policy change in general, which can then be applied to the health sector. He goes on to describe three political economic models of the policy reform process: the political will, political factions and political survival models.

Reich suggests that major policy reform in the health sector is feasible at certain definable, and perhaps predictable, political moments, especially in the early period of new regimes. The most important and easily manipulated political factors seem to be: political timing, which provides opportunities for political entrepreneurs to push their ideas; and the political management of group competition, which allows leaders to control the political effects of distributional consequences and protect the regime’s stability. The paper argues that for reform to succeed, policy makers must develop methods to help them understand, analyse and shape the political conditions in favour of policy reform. The method of “political mapping” is introduced as a technique that can help policy makers in analysing and managing key political dimensions of health sector reform, and in improving the political feasibility of reform by suggesting clusters of political conditions when reform is possible.

Available from: Harvard University, Department of Population and International Health, 665 Huntington Avenue, Boston MA 02115, USA. Also in Health Policy, 1995; 32: 47–77.


Published with the support of the Action Programme on Essential Drugs, the brochure publicises the four Regional Drug Quality Control Laboratories in Africa, and provides potential users with the necessary information for their optimal use. For each laboratory, the brochure gives a brief background, indicating the equipment available, tests performed, sampling procedure and the time required to carry out particular tests. Indications are given on how to pack and dispatch samples.

Available, in English and French, from: World Health Organization, Regional Office for Africa, P.O. Box 6, Brazzaville, Congo or Action Programme on Essential Drugs, World Health Organization, 1211 Geneva 27, Switzerland.


The publication provides a list of current information, availability and sources of reference substances and infrared reference spectra for pharmacopoeial analysis. These materials are for use exclusively in analysis according to the respective pharmacopoeia. A list of addresses for the purchase of reference spectra is given. The publication will be updated on a regular basis and additional data and comments are welcomed.

Available, free of charge, from: World Health Organization, Division of Drug Management and Policies, 1211 Geneva 27, Switzerland.


Drugs are the most commonly used therapy. Prescribing, dispensing and waiting for medication have become, for professionals and public alike, among the most frequent and “natural” of practices. However, irrational drug use is costly and dangerous and it is also a phenomenon which is rapidly spreading throughout the world. More than half the drugs currently consumed only act on the symptoms of an illness – the consequences of the disease but not its causes, the author argues. He believes that the health paradigm based on medical care and drugs is in crisis. Pharmaceutical companies are facing a more complex environment than in previous years. Drug prices are being questioned by consumers, politicians and health administrators. Concern about the adverse effects of drug use are now definitely on the agenda of the health care community.

The publication analyses these issues, with sections covering: the pharmaceutical industry; quality and consumption; and pricing, monopolies and equity. The author provides a description of the drug programme in Buenos Aires Province, Argentina. Finally, the publication looks to the future. While asserting that we may have to take some “bitter pills” before the problems connected with pharmaceuticals are resolved, the author is optimistic about the opportunities for change.


This is the book version of HAI’s Problem Drugs Information Pack (reviewed in EDM-16), which has been a valuable resource for health workers, pharmacists, policy makers, activists, researchers, students, journalists and many more around the world. Chetley states in clear terms which independent evaluators have said about a wide range of drugs, including antibiotics, antidiarrhoeals, analgesics, cough and cold remedies, contraceptives, and psychotropic drugs. He compares the evaluations to how the drugs are actually being used in different settings and finds serious cause for concern. Inappropriate and unnecessary use is widespread, and the point is made that in the wrong hands and at the wrong time even the most carefully quality controlled medicine becomes transformed from a life saver to a life threatener. In some cases (misuse of antibiotics), the consequences stretch beyond a single patient or group of patients to encompass the globe.

Chetley argues that stronger controls on drug promotion are needed, and that prescribers and consumers should have greater access to independent drug information. The publication’s contribution is particularly important as many products are coming off prescription, and increasingly consumers themselves are deciding which drugs to use. Chetley concludes that the evidence in Problem Drugs reinforces the need for governments, consumers and prescribers to be increasingly vigilant in their efforts to achieve more rational use of drugs.


1. As a result of funding from a German charity, Misereor, HAI-Europe is able to distribute free copies of the Problem Drugs Information Pack to health NGOs, health centres, medical community groups, educational establishments, and for use at seminars and workshops in developing countries. Funding covers surface mail rates, so plenty of time should be allowed if the pack is to be used as a resource for a workshop or other event. Pricing and ordering information can be provided to those in industrialised countries or the business sector of a developing country.

A limited number of information packs are available in English, Spanish, and Bengali via an organization in Bangladesh.

(For further information contact: WHO Europe: Jacob van Lenneplaat 3347, 1033 ND Amsterdam, the Netherlands.)
In view of the great financial pressures experienced by conuntries, a double perspective which links economic and logilics; rational use and quality assurance. The first volume concerns methodology. It describes the concept, development and strategies. The first volume constitutes an effective and efficient way of improving the rationality of pharmacotherapy. However, it is stressed that this can only be successful when it is accompanied by a fundamental change in the teaching methods of the trainers, away from the habit of transferring the problem-solving routine. The students not only have to learn how to solve all patient problems (retention effects), but they also should have access to knowledge about pathophysiological principles, and rational drug management.

The recommendations are not prescriptive, but clear guidelines are proposed. The main causes identified are: close analysis of the impact of trade and harmonisation initiatives on the pharmacotherapeutic market, and of regulation, support for WHO's Drug Action Programme, and a wide-ranging educational campaign, targeting health professionals and consumers in particular.

The publication will be useful for health ministries, supply organizations, health care institutions and development agencies. Available from: ECHO International Health Services, Ullswater Crescent, Coulsdon, Surrey CR5 2HR, UK. Price: £3.


Ensuring that all its citizens have access to essential medicinal drugs—and are protected from useless or harmful ones—should be a high priority for any country. But national drug policies, a vital part of overall health policy, have faced strenuous opposition from powerful vested interests, and no country is immune to negative international pressure, argues this special edition of Development Dialogue.

The publication covers six country stories—from Brazil, Sri Lanka, Bangladesh, Nigeria, Mexico and the USA. The drug policy and pharmaceutical industry must be tackled as an integral part of the general development of a country, including health, education, access to information and regulation. A crucial lesson from all the six country studies is that pharmaceuticals must be tackled as an integral part of the general development of a country, including health, education, access to information and regulation. A crucial lesson from all the six country studies is that pharmaceuticals must be tackled as an integral part of the general development of a country, including health, education, access to information and regulation.

Concerted action is urgently needed to safeguard well-functioning NDDPs and improve health care and drug provision. As a result, the strategy paper argues persuasively for a holistic approach. This will involve international and regional collaborations, national governments, health professionals, non-governmental organizations, the pharmaceutical industry itself and consumers.

The recommendations are not prescriptive, but clear guidelines are proposed. The main causes identified are: close analysis of the impact of trade and harmonisation initiatives on the pharmacotherapeutic market, and of regulation, support for WHO’s Drug Action Programme, and a wide-ranging educational campaign, targeting health professionals and consumers in particular.

Available from: The Drug Mammomarktfeld Centre, Oye Slottsgatan 2, S-733 10 Uppsala, Sweden. Fax: +46 18 122072.
The book focuses on drug promotion in developing countries, where it states, companies are more restrained and factual in their advertising than in industrialised ones. The author argues that promotional material often extends indications for drugs into areas for which there is no scientific evidence, with side effects and contraindications minimised or even ignored.

Lexchin believes that among the main problems are too many advertising with too little training and knowledge, giving too many “free” samples and “gifts” to doctors. He raises the issue of bogus clinical trials and biased conferences which drug companies finance but which are then claimed to be “independent”.

Another major concern is what Lexchin calls the “war” on generics. He wants consumers to be aware that for nearly all the most important medications there are low cost generic equivalents, identical in composition and equal in quality to the brand name products so heavily promoted by drug companies.

The book argues that while problems associated with drug promotion in developing countries may be serious, it is possible to take concrete steps to deal with them. Already a variety of consumer and professional groups, nongovernmental organisations and governments have started the process. Lexchin makes a number of recommendations to expedite change. Among these he calls for an end to self-regulation by the pharmaceutical industry and the introduction of rigorously enforced laws “banning irrational, useless and dangerous” products. In addition to removing these products from the market in developing countries, developed countries must accept responsibility for drug products.

A special discount price is available to pro-group in developing countries, HAI Health Promotion, Distribution and Sales, 1211 Geneva 27, Switzerland. Price: SFp 175/SUS$ 50, and in developing countries SUS$ 11.90.


Colombia’s Ministry of Health is committed to promoting rational drug use and to encourage this it produces a National Pharmaceutical Catalogue. The publication contains an alphabetical list of drugs available on the Colombian market and their prices. Products are under generic name and comparative prices of brand name drugs are given. Essential drugs are highlighted in green. The catalogue not only helps doctors and dentists to select drugs on the grounds of quality and cost, it also makes patients more aware of pharmaceutical pricing. Updated every three months, the publication has been the subject of a major national promotional campaign. It is obligatory for all public and private sector pharmacies to put up posters informing their customers that the catalogue exists, and urging them to request a copy.


The book provides a global index of drug formularies, therapeutic guides and essential drugs lists, which is available free of charge. (Please note that we are unable to supply copies of the publications themselves. Requests should be addressed directly to the countries concerned.) Some recent additions are:

- Côte d’Ivoire’s Liste des Médicaments essentiels, 1995. Ministère de la Santé publique et des Affaires sociales. Full list contains 281 drugs in 18 therapeutic groups, also includes sub lists for 5 levels of health care.

Available from: Director, Health Financing Programme, Management Sciences for Health, 165 Allandale Road, Boston, MA 02130, USA.

Drug bulletins and newsletters

- Etruria’s Drug Bulletins. The first issue of Etruria’s Drug Bulletin was launched in August 1995. Published bimonthly by the Department of Pharmaceutical Services in the Ministry of Health, it aims to promote rational drug use among health workers by providing reliable information on drugs and therapeutics.
- Zanzibar’s Pharmaceutical Newsletter. Published by Zanzibar Drug Information Centre. A quarterly newsletter which covers drug policies, use, warnings and adverse drug reactions, distributors and patient information, and traditional medicines.


This is a report of a working group meeting on drug quality control in Africa. Representatives of nine countries discussed how, through training, information, technical and financial support, quality control in the Africa Region can be improved. The report focuses on four main topics: the publication of a brochure on the four Regional Drug Quality Control Laboratories, the conditions for WHO financial support to analyse 400 drug samples, training for the laboratories’ technicians; and the conclusions of the assessment of the use of the WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce, with a view to reinforcing drug registration and controlling drug importation in Africa.

The document concludes with implementation plans drawn up by participants, followed by addresses to the countries concerned. Some recent additions are:

Available, free of charge, in English and French, from: World Health Organization, Regional Office for Africa, P.O. Box 6, Brazzaville, Congo or Action Programme on Essential Drugs, World Health Organization, 1211 Geneva 27, Switzerland.

Update on new formularies, treatment guidelines, essential drugs lists, drug bulletins and newsletters

The Action Programme on Essential Drugs produces a global index of drug formularies, therapeutic guides and essential drugs lists, which is available free of charge. (Please note that we are unable to supply copies of the publications themselves. Requests should be addressed directly to the countries concerned.) Some recent additions are:

- Côte d’Ivoire’s Liste des Médicaments essentiels, 1995. Ministère de la Santé publique et des Affaires sociales. Full list contains 281 drugs in 18 therapeutic groups, also includes sub lists for 5 levels of health care.

Available from: Director, Health Financing Programme, Management Sciences for Health, 165 Allandale Road, Boston, MA 02130, USA.


The thoroughly revised and updated edition further refines WHO’s simple yet highly effective method for the relief of cancer pain. WHO advocates the use of a small number of relatively inexpensive drugs, including morphine, to alleviate suffering.

The book begins with a practical guide to the relief of cancer pain, which is followed by the section on the principles of treatment including a tabular list of 11 basic drugs and 18 alternatives. The most extensive section sets out detailed guidelines for drug selection and prescribing. Readers are reminded that psychological dependence does not occur in cancer patients.

A new section has been added, describing the international system by which morphine and other opioids are made available to patients who need them. This part of the publication will be of interest not only to health care workers, but also to drug regulators responsible for implementing the Single Convention on Narcotic Drugs at national level.

Available in English, (French and Spanish in preparation), from: World Health Organization, Distribution and Sales, 1211 Geneva 27, Switzerland. Price: SFp 175/SUS$ 50, and in developing countries SUS$ 11.90.


Experience with cost sharing in Africa is still growing. The importance of health financing issues, and the difficulties of designing and implementing cost sharing programmes, make the interchange of experience among countries a vital part of the successful development of health financing strategies.

Initial efforts to introduce cost sharing in Kenya in 1989 failed because of flaws in design and implementation. The programme almost collapsed in the face of widespread public and political reaction. Between 1991 and 1994, the programme was redesigned and reimplemented. Health Financing Reform in Kenya: The Fall and Rise of Cost Sharing, 1989–94 describes the implementation of the cost sharing programme and the lessons learned from it.

This monograph will help policy makers, planners and implementers to understand some of the requirements for the successful introduction of cost sharing.

Available, free of charge, from: Director, Health Financing Programme, Management Sciences for Health, 165 Allandale Road, Boston, MA 02130, USA.
The aim was to analyse the role of community health workers in providing drugs. The study on implications of community health workers' drug provision role. The national primary health care programme has been set up throughout the country. One, the village health volunteer (VHV) undertook curative and preventive tasks, and the second, the village health communicator (VHC), had a narrower range of duties, such as disseminating information on health problems affecting the village. One of the community health workers' important functions was to provide essential drugs through the village drug fund (VDF), a community-based organization devised and promoted by the Ministry of Public Health. The main objectives of such funds were to: be a distribution outlet for essential, cheap and good quality drugs; enhance health workers' performance; encourage community participation; raise funds for other community development activities; and contribute to the protection of consumer rights. By 1991, 35,819 such funds had been set up throughout the country. However, there had been many obstacles to the success of community health workers' drug provision role. The national primary health care programme has been faced with the problem of a high drop out rate among VHVs and difficulties in retaining the active VHVs. In addition, community health workers have tried to establish their drug distribution role in an environment where drugs are plentiful and available from a number of sources.

Luechai Srirngernyuang, Thavitong Hongvivatana and Penchan Pradabmuk.* A study was undertaken in Thailand as part of a research project, “Intercommunity Study on Implications of Community Health Workers Distributing Drugs”. The aim was to analyse the role of community

**Essential Drugs Monitor**

**Where Thai villagers get their drugs**

Luechai Srirngernyuang, Thavitong Hongvivatana and Penchan Pradabmuk.*

**The next steps**

Generally, it can be concluded that community health workers and single VDFs play an extremely limited role in the provision of medicines to Thai villagers, and their contribution towards appropriate use of drugs by consumers is very small.

On the basis of these findings, the research team made three main recommendations to the Thai Ministry of Public Health. First, Thailand should immediately implement drug policies that encourage and promote rational use of drugs by consumers at all levels. National drug policy must emphasize the appropriate use of drugs in self-medication. Enforcement of regulations and strict control of the distribution of prescription drugs in particular, are needed. According to the Alma Ata Declaration, should include the promotion of essential drugs, especially in the private sector, a reduction in the range of available alternative essential drugs, and regulation and control of all forms of drug advertising. Second, a public education campaign on appropriate use of drugs must be instigated, using a participatory approach. It should address the reasons why people use drugs inappropriately, and inform consumers about the effects and contraindications of drugs. Third, because the prevailing socioeconomic conditions allow, their community health worker scheme difficult to sustain, the Government should study ways to develop primary health care which is better adjusted to the needs and health requirements of village populations.

An additional recommendation, to health NGOs, is that they should address a decentralised consumer organization to monitor drug provision and consumption at the village level.

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This project was technically and financially supported by the Action Programme on Essential Drugs, and technically and financially supported by the Action Programme on Essential Drugs, World Health Organization, 1211 Geneva 27, Switzerland. Copies of the full report, Essential Drugs, and technically supported and coordinated by the Royal Tropical Institute (KIT) in Amsterdam, the Netherlands. Copies of the full report, Community Health Workers and Drugs, WHO/DAP/94.19, are available, free of charge, from: Action Programme on Essential Drugs, World Health Organization, 3211 Geneva 27, Switzerland.

Ed. note: The fifteen-year experience with Thailand’s village drug funds, the early history of which is described in WHO/MSD/88.5, demonstrates that community drug schemes can be established on a large scale. Inadequate start-up funding, active community participation, a reliable source of essential drugs and trained village health workers. At the same time, Thailand has undergone tremendous economic growth and social change during this period. When such dramatic change occurs, community health worker programmes to promote access to essential drugs and rational use of drugs may also evolve if they are to meet the changing needs of communities. Ed.

**References**