Public education in drug use: a growing need

To meet this need the Action Programme is conducting a global survey of public drug education programmes – both national and local – which will include a critical assessment of their effectiveness. The aim is to establish a reference collection of related materials and strategies, which can be drawn on by programme implementers and which will be regularly updated. The knowledge and experience gained will be published and widely disseminated. The goal is not to replicate one country’s materials in another – to be effective communication materials have to be culturally specific – but rather to develop practical tools and approaches for programme development and implementation. Readers are invited to participate in this survey and will find further details on page 16.

A critical element in the proper use of prescription drugs is the communication between doctor and patient. An Australian study, in 1986, which examined doctors’ attitudes to and practice in giving information to patients, and patients’ experiences and expectations in receiving information, concluded that doctors were giving less information than patients wanted. This led a working group of consumers, health and legal professionals to formulate guidelines on the provision of information to patients about proposed treatment and procedures. “An open exchange between doctors and patients is crucial” the guidelines emphasise, “Each brings to the consultation different information, options and understanding which are important for making decisions and achieving the patient’s well being. Allowing opportunity for discussion may be as important for patients as giving and receiving information.” Although written for a developed country, with an advanced health system, the core principles underlying the Australian guidelines, are globally valid.

For this reason they are reproduced in this issue.

People who are prescribed drugs and those who purchase them over the counter have a right to be fully informed about the potential benefits and risks of the pharmaceutical products they are prescribed or which are available over the counter, and to gain a balanced understanding of appropriate treatment options. Governments, manufacturers, educators and health professionals have clear obligations to meet their respective responsibilities to ensure that the community can acquire the skills and has access to the knowledge to understand the potential role and hazards of medicine use and individual therapies.
Essential Drugs Monitor

NEWSDESK

First National Essential Drugs List for Pakistan

Pakistan has joined the growing list of countries to introduce a National Essential Drugs List. Dr Naik Mohammad, Director General of Health introduced the list at a meeting of government, health and WHO representatives in Islamabad in May 1994. He said that it would replace previous provincial lists “which contain products of doubtful efficacy and irrational combination which are a burden on Pakistan’s already limited financial resources”. There is no place for costly medicines which have equally effective cheaper substitutes, he continued. The Government’s objective is to provide safe and effective drugs, to rationalise prescribing and to have one drugs list which is strictly adhered to throughout the whole country.

The list was prepared by specialists, health experts, pharmacologists and many of the country’s leading medical associations. It contains 471 essential medicines and in based on WHO’s Model List of Essential Drugs. The list has been divided into three categories: drugs for primary health care in basic health units and rural health centres; drugs for all hospitals; and drugs for use in tertiary care facilities (specialist and sub-specialist levels).

Dr Mohammad announced plans for a national formulary, based on the British National Formulary, which will contain indications, contraindications, side effects and dosage forms of drugs. Arrangements have also been made to introduce “People’s Packs” for some of the most common diseases. These will contain a full course of treatment, with clearly written instructions for use. The packs will be distributed through the basic health units or by community health workers, who are receiving training in their use.

Groningen: first summer course on pharmacotherapy teaching

Eindhoven university teachers in pharmacology and clinical pharmacology assumed the unaccustomed role of students for a week in August, during a course on problem-based pharmacotherapy teaching. The first such event organised by the University of Groningen and jointly sponsored by the Action Programme on Essential Drugs, it was attended by teachers from 16 developed and developing countries.

For the first week of the 12 day course participants were exposed to teaching on the principles of rational pharmacotherapeutics, using the draft WHO manual Guide to Good Prescribing. In the second week each participant actually taught the same course to small groups of Dutch medical students. Comments by staff and students, as well as video recordings, were used to assess the participants’ performance and to review and discuss the teaching methodology.

The next course will be held in Groningen in August 1995. Tuition fees, which include board and lodging, will be approximately US$3000. Information can be obtained from the Department of Clinical Pharmacology, University of Groningen, Bloemstraat 1, 9713 BL Groningen, the Netherlands. Fax: +31-50-6628212; e-mail: summercourse@farmaco@MED.RUG.NL.

Regional INRUD training course on rational prescribing

The first rational prescribing course organized by a regional group of the International Network for the Rational Use of Drugs was declared a great success by all involved. Thirty seven people from 12 Asian countries attended the two week course which was run in conjunction with WHO. Participants were mainly pharmacists and doctors working in national essential drugs programmes or teaching at medical or pharmacy schools. The course followed the same format as the previous ones held in Yogyakarta, Kathmandu, Harare and Accra. The first week was devoted to methods of detecting drug use problems, including two field days to actually undertake a survey on drug use patterns, based on WHO’s rational drug use indicators. The second week was devoted to discussion of various intervention strategies to promote rational drug prescribing.

The next global WHO/INRUD training course on promoting rational drug use will be held in Pretoria, South Africa, from 26 March to 7 April 1995. Tuition fees, which include board and lodging, will be US$5000. Information can be obtained from Management Sciences for Health, 165 Aldadalne Road, Boston 02110, USA. Fax: +1-617-547-4225; e-mail: inrud@waven.men.harvard.edu. The next Asian regional training course will be held in the Philippines in the autumn of 1995.

Eritrea’s “Pharmacy Week” focuses on antibiotic abuse

Following the success of last year’s events the Eritrean Pharmacists’ Association held its second Pharmacy Week in association with the Annual Scientific Conference in August 1994. The theme of both events was antibiotic abuse and pharmacists from both the public and private sectors participated enthusiastically.

Posters and leaflets were distributed and radio programmes and newspaper articles, in all the local languages, addressed the major problems which had been identified.

Among the papers presented at the conference were the results of an extensive study based on the analysis of diagnosis and treatment statistics from Mekane Hwot Hospital. These showed that inappropriate prescribing of antibiotics occurs regularly and that there is an alarming increase in resistance of organisms to antibacterials commonly prescribed in Eritrea. These conclusions were endorsed by the results of a study on diagnosis and treatment of sexually transmitted diseases. The issues concerned with irrational use of antibiotics, raised by both these presentations were explored by participants. Agreement was reached on the need for an integrated approach to the development of standard treatment guidelines for all levels of the health service. Such guidelines could optimise the management of diseases and control the inappropriate use of drugs in all therapeutic categories.

On a wider issue, a panel including representatives of community and hospital pharmacy, doctors and Ministry of Health officials explored the role of pharmacists in Eritrea and formulated recommendations for the future. A recurring theme in these discussions was the need for increased communication between health professionals, and greater coordination and integration of services. Participants called for a pharmacy committee to be established in the Central Referral Hospital. The committee would consist of doctors, nurses and hospital pharmacists and would determine policy on the use of safe, efficient and cost effective pharmacological therapies.

For further information please contact: The Eritrean Pharmacists’ Association, P.O. Box 5145, Asmara, Eritrea.
NEWSDESK

Ethnopharmacology: Congress reviews developments and looks to the future

Approximately 70% of people in developing countries rely mainly on indigenous traditional practitioners and local medicinal plants to satisfy their primary healthcare needs. For this reason WHO works, through its programme on Traditional Medicine*, to support countries in providing safe and effective traditional remedies and practices. One of the programme's objectives is to promote the exchange of scientific information. To facilitate the dialogue, WHO and the International Society of Ethnopharmacology sponsored the Third International Congress on Ethnopharmacology and its Contemporary Utilization, held in Beijing in September 1994.

More than 450 participants from 33 countries, including professors, doctors, pharmacists, researchers and traditional medical practitioners from universities, medical institutions, hospitals and the pharmaceutical industry reviewed the latest developments and strategies in ethnopharmacology. The Congress focused on bioscientific and ethnopharmacology research, clinical trials on the application of herbal medicines and quality control of herbal products.

Internationally the importance of herbal medicines and natural products has been rising significantly over the last decade and their trade has become big business. For example, in China in 1993, the total sales of herbal medicines amounted to more than 14 billion yuan, (100 yuan is approximately 12 US$), excluding US$400 million worth of exports. In the USA, over-the-counter sales of herbal medicines grew by 15% in 1993. The picture is the same for the Western European market, with national growth rates of up to 22% reported. In Japan, from 1987 to 1989, there was a 15-fold increase in herbal sales in comparison with only a 2.6 increase in the sale of pharmaceutical products.

Preparing prescriptions of herbal medicines in China, where there is a thriving export trade in such remedies

WHO promotes the safe and effective use of traditional medicines

WHO's role is to assist those countries where traditional medicine is widely practised to incorporate it into their national health systems, and to bring the potential of services by traditional practitioners into full play in primary healthcare. It aims to enhance national programme development, operational research, clinical and scientific investigations, education and training. WHO also promotes the exchange of information on country experiences in policy formulation in the field of traditional medicine.

In order to facilitate the safe and effective use of herbal medicines, a series of technical guidelines have been prepared by WHO, Quality Control Methods for Medicinal Plant Materials have been endorsed by a WHO Expert Committee on Specifications for Pharmaceutical Preparations, and will be published next year; Research Guidelines for Evaluating the Safety and Efficacy of Herbal Medicines have recently been issued by the WHO Regional Office for the Western Pacific, P.O. Box 2932, 1099 Manila, Philippines.

Price: SUS7.50, US$5.25 and in developing countries SUS5.

Too many tranquillisers for women

General practitioners are less stringent when prescribing benzodiazepine sedatives for women than for men, according to a Dutch study reported in the British Medical Journal, 7 Aug. 1994. The study found that women aged 45 to 64 received their first prescription of benzodiazepines almost twice as often as men, when neither symptoms nor diagnosis warranted the drug. In fact, in this age group, significantly more men than women had legitimate reasons for starting benzodiazepine treatment. However, doctors frequently diagnosed women with symptoms such as headache and general fatigue as suffering from anxiety, stress or insomnia and therefore as candidates for these drugs. Their excessive use was encouraged as a result of repeat prescriptions (89% of total prescriptions) given by an assistant at the patient's request without re-evaluation by a doctor. Although studies show that only short-term use of benzodiazepines is recommended, one third of users are on long-term regimens, the researchers note.

If I don't take a pill, what else can I do?

Australia: use of medicines booklet launched at consumer workshop

A booklet to encourage safer and wiser use of medicines entitled "A Policy on the Quality Use of Medicines" was launched at a workshop in Sydney in July. Federal Minister for Human Services and Health, Dr Carmen Lawrence, said: "This booklet will be a great help to health professionals and consumers alike, who are interested in improving the way in which medicines are used in Australia, and I strongly recommend it."

The booklet is a 'plain English' version of the national policy on the quality use of medicines developed in 1992 by the Commonwealth Department of Human Services and Health (DHSS) in conjunction with the Pharmaceutical and Rational Use of Medicines (PHARM) Committee. It highlights the potential risks as well as the benefits of medicinal drugs and suggests ways of improving their use.

PHARM is a multi-disciplinary group of people with experience in promoting the quality use of medicines. It was established in 1991 to advise the Federal Government on strategies to counter the inappropriate use of medicines (see EDM-15). It includes members with expertise in general practice, pharmacy, nursing, consumer advocacy, clinical pharmacology, the pharmaceutical industry and government.

The workshop at which the policy booklet was launched, entitled "Consumers taking Charge", was sponsored by the Commonwealth's Pharmaceutical Education Programme. It brought together a broad spectrum of consumer groups to discuss their priorities for education in the area of pharmaceutical health. The results of the workshop, which will be published, will assist in targeting future education initiatives.

"PHARM and the Government have recognised for some time that it is important to adopt a team approach in educating the community about the wise use of medicines," Dr Lawrence said. "Links between health professionals, consumers, government and the media must be fostered and developed to ensure that medicines are used to their full advantage in Australia."

PHARM and DHSS produce a quarterly publication promoting the quality use of medicines entitled the "QUM Newsletter". This is distributed free of charge to interested organizations and individuals.

For further information contact: Mary Murray Hodge, Chair, PHARM, Health Care Access Division, GPO Box 9848, Canberra ACT 2601, Australia or Sue Greenshields, Quality Use of Medicines Unit, Department of the Federal Government and Community Services, GPO Box 9848, Canberra ACT 2601, Australia. Tel: +616 289 7602, fax: +616 289 8846.
Uganda: national launch for Treatment Guidelines

This is the title of the July 1993 edition of Critical Health, the independent quarterly South African journal, which aims to reflect current debates among the country's health and welfare workers. The editorial describes the pharmaceutical sector in South Africa which is beset with problems, with rising prices and cutbacks in the public sector. This wide ranging issue is in three sections: the drug manufacturing industry, pharmacy in the state sector, and national drug policy options for South Africa. Twelve articles are included covering such topics as possible strategies for the country's pharmaceutical industry, lax implementation of safety standards for workers within the industry, the role of traditional medicine and staff shortages and discrimination against women in state dispensing services. There is also an outline of the African National Congress' views on drugs policy relating to price controls, an essential drugs list and a generics policy, all within the context of a strong national health service.

The Republic of Uganda
Ministry of Health

NATIONAL STANDARD TREATMENT GUIDELINES
1993

Drugs: what's behind their prescription?

India: debate on the validation of traditional medicine

Practitioners of modern and traditional systems of medicine met at a three day workshop on ethnomedicine held in Thiruvanthapuram, India in May 1993. Sponsored by the Danish International Development Agency (DANIDA), the workshop provided an opportunity for a lively exchange of views between the 250 doctors, pharmacists, scientists and traditional healers attending. In particular, the debate centred on the role of ethnomedicine in validating traditional medicines in modern scientific terms. Participants from a background of traditional medicine felt that such validation is impractical as the two systems are rooted in different cultures, and that centuries of successful use prove the value of traditional methods. Whereas the modern medical practitioners stressed the need for scientific evaluation and integration of traditional techniques into modern medicine. There was agreement, however, on the need for interaction between the two systems and the importance of preserving endangered species of medicinal plants.

A report of the meeting is available from: S.C.S. College of Pharmacy, Kannur, India.

French drug advertisements: what controls?

A review of Prescrire, a leading French drug journal, examined drug advertisements which target doctors and concluded that French controls on them are ineffective. In 1996 France introduced legislation requiring prior approval of drug advertisements published in medical journals. However, this system was later replaced by a system of controls applied after their publication. Manufacturers are now required to send a copy of each advertisement to the French Medical Agency.

It appears to contravene regulations, it is reviewed by a Commission before approval. The Commission decides whether an advertisement should be published, but this occurs in fewer than 1% of cases. Prescrire believes that this reflects inadequate implementation of the advertising directive and a uniformly high standard of drug advertising in France. For example, the Medicines Agency has recently ruled that the ads for an antibiotic are acceptable, despite earlier rulings to the contrary. Manufacturers of the medicine are now required to provide scientific evidence that the drug is effective. This is the current practice in most countries where the drug is marketed, but it is likely to be viewed as unacceptable in France. The French system also allows advertisements to be published in official journals, these are not reported in medical journals.

Prescrire believes that misleading prior approval of drug advertisements would improve the process. It also calls for qualitative evaluations of promotional material and effective sanctions to be imposed when they can still influence promotional campaigns. Journals which have published an advertisement or advertisement which break the current regulations should also have responsibility for publishing a notice of withdrawal or correction.

Meanwhile, in what it views as the absence of effective controls, Prescrire is encouraging doctors to take a more active role in questioning unacceptable advertisements. It is urging them to send letters of complaint to the Medicines Agency and advertising companies.

New Indian drug bulletin

The main aim of BODHI (Bulletin on Drug and Health Information), a new quarterly newsletter, is to promote the principle of national therapy among health care providers in India. The first issue was published in March by the non-profit voluntary organization, Foundation for Health Action. As a result of a specific drug treatment, it contains an analysis of "facts and fantasies" in recent promotional statements, a discussion on selection of alternatives, asthma management and an adverse drug reaction reporting card. To maintain its independence BODHI will not accept advertising from drug or medical equipment and will depend on readers' subscriptions for funds.

For more information contact: The Editor, BODHI, 254 Lake Town, Calcutta 700 059, India. Annual subscriptions for individuals in India is Rs. 25, in Africa and most of Asia US $5 and in Europe, the USA, Australia and Japan, US $10.

Delegations at the ethnomedicinal workshop

Issue No. 18, 1994
Thai seminar on drug promotion

WHO's Ethical Criteria for Medicinal Drug Promotion urges countries to develop their own national ethical criteria, taking into account what has been developed by the Organization. The goal of such ethical criteria is to ensure that drug promotion supports the aim of improving health care through the rational use of drugs. A national seminar to develop Thai Ethical Criteria was organized by the Food and Drug Administration of the Ministry of Public Health on 5th April in Bangkok. Attended by over 60 national and international participants representing Government, prescribers, pharmacists, consumer organizations, the pharmaceutical industry and WHO, the seminar received wide coverage in the national press.

At the opening ceremony, the Minister of Public Health stressed the importance of the subject. During a later press conference, the Minister also highlighted and explained the rationale of Government plans to make mandatory the inclusion of generic names on drug labels. This would help consumers to understand that the same ingredients could be marketed under different trade names, which the vast majority did not realize at present, he said. Thai legislation on the use of generic names in drug labelling is currently being finalised, despite opposition from industry.

Seminars participated heard presentations on the WHO Ethical Criteria, its implementation and evaluation, and pharmaceutical industry marketing codes. Draft Thai Ethical Criteria for Pharmaceutical Promotion (strongly based on the WHO Ethical Criteria) were discussed and modified during the seminar, to suit national circumstances. The draft document will now be submitted for approval and further action. It is hoped to incorporate the Ethical Criteria into the National Drug Policy after final approval.

Vaccines against lethal pneumococcus soon to enter field tests

According to recent estimates, every year more than one million young children in developing countries die of pneumonia and acute infections caused by the bacterium Streptococcus pneumoniae (pneumococcus). Within the next 24 months, scientists expect to start field trials of new vaccines designed to prevent many of these deaths.

Last November, WHO brought to Geneva a group of experts — researchers, representatives of vaccine manufacturers and potential funding agencies — to lay the groundwork for trials of this vaccine, as well as of several other similar vaccines that are at earlier stages of development. A pneumococcal vaccine already exists, but it is not effective in young children. The new vaccines use immune-stimulating molecules (antigens) linked (conjugated) to a carrier protein, which should trigger protective immunity even in infants. A similar conjugate vaccine against Haemophilus influenzae type b (Hib) which causes meningitis, as well as respiratory disease, is proving effective in children of all ages.

The meeting, which was organized by WHO's Division of Viral and Rickettsial Disease Control (CDR), made several recommendations for conducting field trials of potential pneumococcal conjugate vaccines. The trials will assess safety and immunogenicity in small groups of infants and young children (Phase I), and safety and protective efficacy in larger groups (Phase II) and after (Phase IV) regulatory approval.

Among the recommendations of the meeting were the following:

- a vaccine combining antigens of the nine commonest types (serotypes) of pneumococcus would be adequate for use in developing and developed countries;
- the ability of the pneumococcal vaccines to produce a strong immune response should be evaluated in different groups of children, e.g. children of diverse racial origin, HIV-positive children and children with pathological evidence of malaria infection;
- other ways of preventing pneumococcal disease should be considered, such as use of the currently available vaccine to immunize mothers and thereby protect their newborn infants.


China to work with the European Pharmacopoeia

China was granted observer status with the European Pharmacopoeia Commission in August this year. This will allow China to participate in the Commission's scientific work and to share the benefits of European experience. It will have access to work being carried out on analytical methods and on quality control of medicines. Observer status was also granted to Lithuania during July, bringing the number of observer states to ten. These include central and eastern European countries (Albania, Bulgaria, the Czech Republic, Hungary, Lithuania, Poland, Slovenia and non-European states interested in cooperation in the pharmaceutical field (Australia and Canada as well as China).

The Convention on the Elaboration of a European Pharmacopoeia was drawn up under the auspices of the Council of Europe in 1964. The aim was to gradually build up a common pharmacopoeia in Europe and define specifications for official standards in member countries for active ingredients and excipients used in making up medicines, as well as quality control methods. To date, 22 states are contracting parties to the Convention: Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Luxembourg, Netherlands, Norway, Portugal, Slovenia, Spain, Sweden, Switzerland, Turkey, United Kingdom and the Former Yugoslav Republic of Macedonia. On September 22 1994 the European Union acceded to the Convention.

For further information contact: Christian Detunayeu, Council of Europe, Directorate of Information, F-67075, Strasbourg Cedex, France. Tel: +33 88 41 25 63, fax: +33 88 41 27 99.

Essential Drugs Monitor

The meeting on ethical drug promotion attracted a great deal of media attention.

Chinese scientists will now have access to European work on analytical methods and quality control of medicines.
Essential Drugs Monitor

SUPPLY

Private donations: an ounce of prevention is worth a pound of cure

G. Forte

O nce the help to those in need is a natural human instinct, especially when faced with war and suffering on a vast scale. The survival of thousands of people who are victims of the conflict in the former Yugoslavia has depended on assistance from governments and private individuals alike. Without donations of food, medicines, clothing, building materials and other items from all over the world, the casualties of the conflict would have been even greater. UN Agencies, such as WHO, and nongovernmental organizations (NGOs) coordinate and distribute this aid as part of their work in the region. Most agencies are funded privately, or by governments and depend on donations of some kind to operate. WHO is no exception. There are actually three types of donations: cash-in and-kind, and WHO’s experiences in the former Yugoslavia have given a valuable insight into the advantages and disadvantages of both types of aid and these are discussed here. In particular the lessons to be learned from the management of private sector assistance given in emergency operations are highlighted.

Pros and cons of cash donations...

Cash donations are ideal in times of emergency as they are more flexible (even if earmarked for particular purposes), easy to coordinate and organize. Procedures for cash donations are very well established. On request, proposals are made to major government donors, who then allocate funds or procure items suggested to them. If funds are earmarked, supplies are purchased through the regular WHO supply system, ensuring quality and well-organized shipments. There are two main problems with cash donations—the funding schedule often covers a short period of time, which can make long-term planning difficult and also, people can be wary of giving money in case it is misused.

Donations in-kind... better than nothing?

Another type of donation which is frequently given by private organizations and individuals, but which is much less standardized and more variable, is the donation in-kind. It is this type of donation which is a challenge to channel effectively. Although many people automatically assume that any donation is better than nothing, this is not true. Those giving their donations in-kind are often unaware of the problems that they can create and may be puzzled and angry to hear that their “gift” is not needed or “wanted.”

WHO’s involvement with private donations in former Yugoslavia began through its coordination with the Office of the United Nations High Commissioner for Refugees (UNHCR) which was receiving in-kind donations, including medical items. As UNHCR is not a medical agency these items were distributed regardless of need without follow-up. They would often reach WHO, NGOs in the field and other institutions without warning. Many of these donations were poorly packed, without adequate labels, damaged and out of date, and contained mixed and/or unusable drugs. They would take up valuable resources, create many logistical problems and in some cases pose environmental and other threats.

In order to fully appreciate the impact of such donations it is important to understand that pre-war Yugoslavia was a country with a relatively high standard of health care in which all citizens had health insurance. Medicines included in the country’s list of priority drugs were free, hospitals were relatively well supplied and there was large scale pharmaceutical production. Although all organizations in the field are aware of this, private donors are rarely informed about the previous health care structure or the current situation. This lack of background knowledge has an obvious impact on donations that are sent.

Poor logistics risk waste and lives...

Along every step of the journey a consignment makes from its point of departure in the donor country to its final destination, regulations, costs and logistical aspects must be considered. A frequent mistake committed by donors is the failure to consult or check procedures for sending donations, including local and transit laws. For example, aid intended for Bosnia and Herzegovina does not have the status of humanitarian aid in Croatia or Slovenia and is treated as a consignment “in transit,” which involves a different set of procedures. Delays caused by incorrect paperwork can result in large warehouse bills. Further complications exist for donations sent to the Federal Republic of Yugoslavia. Each humanitarian aid consignment must be specially approved by the Sanctions Committee of the UN Security Council in New York and sometimes it takes months for a consignment to receive approval.

Depending on the type of transport, its cost can be higher than the actual value of the donation. For example, the average cost of one truck going from Rotterdam to Zagreb is approximately US$5,000. Air transport is even more expensive. Perishables such as sera, vaccines, and some drugs and reagents need special cold storage in warehouses and their transportation is difficult. Before a consignment can be distributed it must be properly packed in its original packaging and placed on pallets, covered by plastic wrap. At times, consignments spend a long time outside warehouses (on airport runways, in open trucks, etc.) and are vulnerable to bad weather. Consignments worth thousands of dollars have been ruined by rain damage.

Inadequately documented and marked consignments can create nightmares situations. For example, an emergency came to the city almost turned back and a driver threatened because someone "forgot" to document two candles in a consignment. In Sarajevo, WHO field staff had risked their lives under sniper fire trying to identify unmarked medical supplies lying on the airport runway.

Quality, priority and needs...

Even if transport and handling are done properly, the actual goods may be of poor quality. Donated medicines past or close to expiry date are a chronic problem. Even if professional organizations distributing medical aid know that many drugs past expiry date can be used safely, they cannot accept and distribute them and expect to maintain credibility. Since long delays occur from their acceptance to distribution, drugs close to their expiry date have a good chance of passing it before reaching their destination. These items can create environmental hazards. In Sarajevo, there are huge quantities of expired medicines which are waiting to be destroyed, but lack of fuel prevents this. They take up valuable space from potential incoming supplies and may be distributed to patients regardless (see EDM-16).

Another problem associated with private donations concerns the choice of drugs and medical material. Donors often have no clear picture of priorities and needs and so can easily spend large sums of money buying items which are not a priority or which have already been supplied. At times donors may send things they want to “get rid of,” such as boxes of miscellaneous drugs, most of which are in quantities too small to cover a course of treatment, or large quantities of doctors’ samples and partially used medicines. Drugs are sent that are useless for the area, such as bulk laxatives for regions where waterborne diseases are prevalent. Naturally great frustration is experienced by field workers when non-priority or non-useful supplies come after a wait of weeks or months.
Solving the problems...

In an attempt to rectify the situation WHO, as the medical advisor to UNHCR, has agreed with the Commission, that all requires for transport of medical supplies and equipment to Bosnia and Herzegovina, directed to UNHCR will first be referred to WHO for approval. In addition, WHO's Medical Supplies Department has produced "WHO Donor Guidelines for Former Yugoslavia." All potential donors must agree to follow these before approval for transport is given. The aim is to educate donors and draw their attention to the many factors they may not have considered. It encourages them to establish contact with WHO and promotes the donation of appropriate, good quality and well packed medicines. Lists of priority medical needs are decided by WHO field offices, in agreement with local health authorities. The information is collected by the WHO coordinating office on a monthly basis and given to donors as suggestions for procurement.

For donors wishing to send medicines instead of money, the new emergency health kits developed by WHO in close collaboration with other aid agencies are highly recommended and avoid many of the problems of donations in-kind described here. These kits cover the basic needs of large numbers of people in specific health areas and have proved to be most effective in emergencies. As the media have such a great influence on the flow of in-kind donations, it was decided to use them to help put the message across. Press release and press conferences were arranged asking donors to "think before they send", to contact and build up contact agencies such as WHO before compiling in-kind donations. In addition, an information network used by international agencies, NGOs and other organizations in former Yugoslavia is provided with updated lists of requirements.

Lessons learned...

The results of WHO’s efforts to assess the value of donations have been significant. Reports from UNHCR Frankfurt, a major transit station for supplies, have indicated a 30% increase in the regulation and donations in addition, UNHCR Ancona and WHO field offices have reported improvements in the quality of consignments. The ministries of health, especially of Croatia and in Sarajevo, have been very enthusiastic in working with WHO to establish systems to deal with private donations.

Suggestions for future operations...

WHO has learned many lessons about in-kind donations from its experience in former Yugoslavia. On the positive side they can meet real health needs that may not be helped through established humanitarian aid programmes. They also enable those far away from an emergency situation to become involved in improving conditions. WHO’s aim has been to try and harness the positive efforts of individuals and maximise the value of their donations. Suggestions for similar operations in the future include:

- Allocation of resources at the beginning of an emergency situation or operation specifically to coordinate the efforts of donors and recipient countries. The idea that “an ounce of prevention is worth a pound of care” is true in this case.
- The creation of collection centres in recipient countries to sort, pack and redistribute donations according to need.
- Support for health authorities to establish policy and regulations on donations.
- An education campaign for the public. The media should be involved as much as possible to inform the public about the best ways to help. It is possible to formulate basic guidelines for donor which would be applicable to almost every situation.

Although cash donations are more flexible and easier to work with, the reality is that people will usually send supplies in-kind. Resources to cope with such items are often limited. It is therefore necessary to reach donors at the planning stage. Donors need to understand that agencies working in the field have the greatest insight into needs and must be approached for advice. Preventing the waste of resources and making consignments as useful as possible are crucial in efforts to save lives, ease suffering and maintain the health of those caught in emergency situations, wherever they may be.

* Dr Gilles Foret is Medical Supplies Officer WHO Area Office, Zagreb. 12th Floor, Savska 41, 41000 Zagreb, Croatia.

This paper was requested by DAP for presentation during the session "Availability, Regulation and Quality Assurance of Drug Procurement" for the Seventh International Conference of Drug Regulatory Authorities, the Netherlands, April 1994.

References

Think before you send*

The humanitarian relief effort benefits enormously from the regular donations received from private individuals, from groups and from organizations... Not all donations are welcome, however, estimates suggest that 15% of donations which come are completely unusable and of the rest 30% are not needed. Sorting the useful items from the useless in these donations wastes valuable time. Transporting materials or medicines that are not used takes up very scarce space on aircraft and convy and storing them for disposal uses up limited warehouse space that should be available for much needed food and medicine.

Basic medical needs are coordinated with agencies present in the field and WHO has available lists of specific needs which would be gratefully received from donors.

UN Agencies in former Yugoslavia have issued guidelines for people or organizations wishing to contribute to the humanitarian relief effort. The guidelines are designed to encourage donors while avoiding unnecessary waste from inappropriate donations. The guidelines produced by WHO detail the procedures for sending donations, how donations should be packed and documented and how transportation can be arranged. Donations that do not conform to the guidelines can no longer be accepted by WHO.


In September 1994 WHO’s Division of Emergency and Humanitarian Action asked the Action Programme on Essential Drugs for guidelines for donors, because Rwanda was receiving donations of unwanted and expired drugs. The Action Programme’s response is reproduced here as another example of WHO’s determination to ensure that those suffering in emergency situations receive medicines which are useful and safe.

"As a result of the international community’s response to the crisis in Rwanda, tons of drugs arrived there and in the Great Lakes Region. But are all these drugs necessary and can they be used?

On the subject of drugs which have, or are about to expire, WHO reminds donors of the Fifth Report of the WHO Expert Committee, Technical Report Series No.625, The List of Essential Drugs, 1992 (p.13):

"All drugs must have a remaining shelf life of at least a year."

In addition, in the same Expert Report, donors are requested to adhere to the following principles:

No drug should be provided that is not on the national list of essential drugs or, if such list exists, the WHO Model List of Essential Drugs.

All drugs provided should be obtained from a reputable source. The WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce should be used.

Labouring should be in a language that is understood locally and should include the generic name of the drug. Labelling of the outside of boxes is advised.

Drugs should be packaged in large quantities, as possible.

No drugs should be donated that have already been issued to patients and returned to a pharmacy in the donor country.

A financial contribution should be considered instead of a drug donation since it may be cheaper to buy the drugs locally.

An abridged version of all of these recommendations is available in The New Emergency Health Kit (p.5) published by WHO in 1992 and revised in 1994.

Adherence to these guidelines allows for rapid intervention in the field, saving more lives and avoiding wastage of resources for sorting, storing and distributing drugs and medical supplies in emergency situations."
Essential Drugs Monitor

SUPPLY

Benin Central Purchasing Office for Essential Drugs: a new experiment

C.P. Hessou, M.P. Fargier*

Benin is a small West African country of almost five million inhabitants. Making drugs accessible to the whole population was one of the main objectives of its health strategy for 1989–1993. To achieve this, plans were made, in collaboration with development partners, to set up a national supply system using a central purchasing system for the public and non-profit private sectors. Certain features of the structure break new ground for drug supply in Africa. Previously accountable to the Ministry of Health, the Central Purchasing Office is now an independent structure with financial autonomy, mandated by statute and governed by civil law. Its private style management allows for a high degree of flexibility, and its function as an integral part of the Health Services Development Project, financed by the World Bank, exempts it from customs duties and direct taxes. The new structure, operating and responding to the needs of health facilities since October 1991, has genuinely improved Benin’s drug situation. This experience suggests a potentially suitable model for tackling some of the drug supply problems of small developing countries.

Numerous factors have contributed to the creation of Benin’s Central Purchasing Office. These included the adoption of an essential drugs policy, the gap created in the public sector by the liquidation of the Central National Stores and the Para-public Supply Organization (ONSP), and the support of various development partners, who played a crucial role. Benin has received financial and technical support from a number of development partners to improve its health facilities and to introduce community financing and cost recovery schemes in the health system. Initially, the partners acted independently, deciding on their own projects and developing their own supply systems. But the Government recognized the importance of creating a structure capable of surviving the withdrawal of these partners from the country. In 1988, therefore, the Ministry of Health and its backers began discussions, which lasted almost three years. It was decided to create a single national supply and sales structure for essential drugs and medical supplies intended for public sector health facilities and the private non-profit sector (units run by religious bodies, nongovernmental organizations, etc.). The idea of the Benin Central Purchasing Office for Essential Drugs and Medical Supplies was born. All the financial backers collaborated with the Government in the design, implementation and financing of the project. The largest financial contribution was made by Switzerland, with a donation of almost US$3 million, managed by the World Bank. The European Union and UNICEF contributed US$500,000 to build up initial stocks. However, the success of the Central Office as the main supplier of health facilities has depended to a large extent on the purchasing capacity of these facilities. It is also due to the country’s community financing policy that the various working capital funds at the disposal of health units have been replenished, making the units financially viable without state assistance.

The Central Purchasing Office must ensure that generic, high quality essential drugs are constantly available to people at a price they can afford. It is governed by a decree adopted by the Council of Ministers and is subject to civil law. Previously accountable to the Ministry of Health, the Central Purchasing Office is now an independent structure with financial autonomy. Its private style management allows for a high degree of flexibility. It currently functions as an integral part of the Health Services Development Project, financed by the World Bank, and is, therefore, exempt from customs duties and direct taxes. The Office is controlled by a Management Committee, which checks that it is being well run, adopts the budget and monitors financial operations. The Committee is made up of nine members and is chaired by the Director of Pharmaceuticals and Laboratories. Other members include: two representatives of bilateral cooperation agencies, one representative of multilateral cooperation agencies and the President’s representative, and one representative of national nongovernmental organizations involved in the health sector. A second Committee, the New or Steering Committee, has the task of checking whether objectives have been adhered to and attained. Half the members are representatives of the Government of Benin (Ministries of Health, Finance, Justice and Commerce) and half are development partners involved in health financing.

The management of the Central Purchasing Office has adopted four basic principles:
- only cash sales are allowed; no credit to clients;
- customers collect products themselves, so there is no expensive and problematic distribution network to manage;
- no regional depots are maintained, since these are difficult to control;
- the operational budget and personnel are kept to a minimum.

Efficient team work...

Fifteen staff work at the Central Purchasing Office: three pharmacists, who also provide technical assistance, a secretary, an accountant, two assistant accountants, two storekeepers, an assistant storekeeper, three caretakers, a driver/forwarding agent and a service and maintenance person. The staff were recruited by competitive examination or by invitation to apply. A precise job description exists for each post and the staff work closely together as a team. They do not have the status of permanent civil servants but work under contract, so it is in their interest to ensure that the Office operates efficiently.

How the Office functions...

Before the Office opened for business it was preceded by a session of the Management Committee, which adopted the annual budget estimates, approved the various management procedures and tools, and the market price of products. The various activities carried out by the Central Office are set out on data sheets, which are contained in the Office’s manual of management procedures. For example, the data sheet for receiving products covers the various simple operations which the storekeeper should carry out. In particular, he or she should check the number of boxes delivered, the number of units in each box, whether this figure corresponds to the quantity ordered, the expiry date, the labelling, etc. Once delivered, the products are immediately stored in three different warehouses: one for drugs, radiology products, vaccines and sera; the second for medical consumables and intravenous fluids; and the third for inflammable goods. Warehouse One is divided into three sections: ambient temperature section, air-conditioned section and cold store. The drugs are arranged by dosage form, then in alphabetical order according to their international nonproprietary name. A storekeeper is responsible for each warehouse.

Getting value for money...

Purchases are made according to the financial procedures clearly defined by the Management Committee. There are three types:
- Direct purchase: this is authorised for total amounts of less than US$70,000 and is executed directly by decision of the Central Purchasing Office management. Purchases of this kind are carried

* Private style management...

** The Central Purchasing Office has rigorous stock control systems.
Essential Drugs Monitor

The inauguration was well publicised, with a journalist enlisted to write articles for national and regional newspapers. Regular information on its activities and essential drugs is published under the heading “Echo de la Centrale” in Rétro-sortie, a newspaper on health information published by the Ministry of Health. The Office also has a small pharmaceutical documentation centre open to medical staff. A project to make a video cassette about its work is being developed in collaboration with the World Bank and the World Trade Centre. In addition, the Central Office participates in various Ministry of Health activities aimed at the introduction of a drugs policy. Central Office management considers that the Office’s integration into the national pharmaceutical system will guarantee its survival.

Assuring drug quality...

A quality assurance system has been introduced. The forms used to follow up the suppliers include a section on quality assurance. All purchases are subject to the production of a certificate. This must either be a marketing authorisation in the producing country or meet the requirements of the WHO Certification Scheme on the Quality of Pharmaceutical Products moving in International Commerce. A procedure for checking samples has been established in collaboration with the Paris Central Pharmacy’s control laboratory. Samples are taken according to the following criteria: products with a high rate of turnover, e.g. chloroquine, quinine and paracetamol; highly active products, e.g. digoxin; and products with problems of bio-availability, e.g. atorvastatin, ampicillin, cotrimoxazole, furosemide, griseofulvin, hydrochlorothiazide and indomethacin. Particular attention is paid to local manufacturers. At the request of the Central Purchasing Office, national manufacturers have undergone a technical inspection of their laboratory by a WHO consultant pharmacist, to determine the quality of products manufactured locally.

Technical and motivational training...

A continuing education programme has been developed to strengthen the technical competence of personnel and to increase their motivation. Subjects taught include: management, accounting, product knowledge and computing. Twice a month the Central Office also runs courses for nurses and midwives from health centres. Training sessions on various aspects of good stock management are organized for health centre managers and last two to four weeks. The Central Office also trains pharmacists from other countries, with courses tailored to their specific needs. Pharmacists from Burkina Faso, Cameroon, Ghana, Guinea and Togo have already benefited from such training.

Spreading the message...

When the Central Office opened, it developed its own communications strategy. The Office has not only publicised its activities in the media, but it has also used its own facilities to reach the population. A number of leaflets have been produced, including one on the dangers of counterfeit drugs. The Office has also held seminars for health workers, and has distributed information to medical students. The Office has also sought to involve the local private sector, and has arranged for it to take part in the training of health centre staff.

Not without problems...

There were a number of difficulties in the first years of the new supply system. The first was the lack of confidence with which the suppliers regarded the Central Office. Many demanded payment at the time of ordering. The second problem was dealing with the private pharmaceutical sector and local opposition, since the Central Purchasing Office was seen as a major and dangerous competitor. These problems are not yet totally overcome and no doubt others will arise. However, making essential drugs available to the population at competitive prices will create demand and favour the future development of the national pharmaceutical market. On the other hand, illegal sales of drugs acquired by health workers, drug selling in markets, offices and on the streets, and also certain donations, handicap the viability of the Central Office. The potential market loss is estimated at 40%.

A promising future...

The Central Purchasing Office is still young but there is every indication from its financial results that it can be self-financing. However, a number of tasks still lie ahead. These include: a decision on its definitive legal status; a strategy for the efficient techniques and procedures for purchasing; improvement in stock management and achieving the correct balance between acquisition costs and holding costs; collaboration with forwarding agents in order to improve delivery times, transport conditions and freight prices; promoting its acceptance and use; and computerization of all procedures.

Success factors...

The achievements of this project are essentially due to its initial concept as a small, flexible structure, which combines social objectives with private-sector management. Key factors for success will continue to be:

- financial autonomy;
- funds from cash sales;
- a small staff selected for their competence;
- a reduced operating budget;
- carefully planned management which is constantly overseen by the Committee and an audit office.

At the national level the Central Office has provided a real tool of health policy for the Ministry of Health. Its survival depends on a number of factors. These include political will, commitment and the implementation of measures to guarantee its sustainability, autonomy and, above all, its integration into the national pharmaceutical system. However, the project already raises hopes that Africa will at last see the development of a national pharmaceutical supply system which is non-profit making.
From research to practice – bridging the gap

A researcher questions a mother in Korea. Carefully selected, participatory research can be a powerful tool in helping to solve world drug problems.

Some studies do not deal with the problems considered most important by policy makers, many of whom consider that the critical problem remains the unavailability of essential drugs for the majority of a population and who regard research more as an expendable luxury than a powerful tool for improving the situation.

Research on the same subject conducted by different experts may offer varied recommendations. This is confusing for administrators and policy makers, who may not know how to select among these options. It also diminishes the credibility of research among those who do not understand that very often more than one explanation and one solution are cogen.

Research is relevant but there is a gap between researchers in their sophisticated learned environments and administrators at the front line of drug delivery services. This is exemplified by Tunison’s observation that “idealism increases in direct proportion to one’s distance from the problem”. Researchers project an apparently easy solution (displaying a penchant for “you should”), whereas the real circumstances offer impediments. As a result, there is a strong likelihood that proposed solutions are weak because they cannot be feasibly implemented “in the field”.

Involving the users

The value of research is markedly diminished when conducted without the participation of those who can use the results, such as policy developers, administrators and local communities. If decision makers are not involved and interested in the early stages of research they are not likely to demonstrate sudden interest in using the findings at the end of the study.

Initiatives for many projects are based on the interest of individual researchers (both nationals and outsiders) rather than on the needs of pharmaceutical programmes and health care systems. This reflects the primacy of professional/academic objectives compared to applied concerns.

There is a tension between the need for timely delivery of information and projected in-field research strategies, for example in anthropologic inquiry. In a rapidly changing world, research which cannot provide quick results can become dated and/or will not be used by policy makers who, while waiting, will have identified other problems. This is reinforced by the different problem orientations of managers (“active”) and researchers (“inquisitive”).

Finally, many studies have made little effort to link research results to action, either before or after, and to translate these results into realistic policy recommendations.

Based on these findings, the Action Programme on Essential Drugs has redefined its research policy in order to bridge the gap between research and practice. Research now focuses on the identification of constraints to the implementation of country plans, is better integrated into the management processes at the country level, and is a fundamental part of essential drugs programmes and national drug policies. It is the type of research which is needed to make improvements in health service systems.

The selection of projects is directed at these four principles:

- need-driven focus: research projects are driven by specific needs established in the field
- capacity building: this is developed through research projects, mainly by training researchers and developing simple methodologies
- decentralization: this is accomplished through support extended to networks such as the Drug Utilization Research
Injections in Uganda – cause for concern

Harriet Birungi, Susan Reynolds White

The popularity of injections in Uganda is not new. But in the "old days" of the 1960s, when Uganda was considered to have one of the best health care systems in Africa, injections were mainly administered by health workers in the officially recognised system: the government run dispensaries, health centres and hospitals; the missionary medical services; and, in urban areas, the private clinics run by licensed medical practitioners. The Pharmacy and Drug Act of 1970 made it illegal for any lay person to own a syringe for injection. Although anecdotal evidence suggests that even then untrained neighbours, "hedge men" provided injections in their communities, the scale of this "informal" activity was limited.

Now all this has changed. Beginning in 1971, fifteen years of civil war and economic decline weakened the government health care system. Facilities fell into disrepair and the government could not afford to supply free medicines, to maintain adequate supervision or to pay health workers a living wage. Private profit oriented health care proliferated, including licensed and unlicensed private clinics and drug shops. Survival strategies of government health workers included treating patients in their homes, selling medicines, and demanding "informal" payments for services at government units. By the middle of the 1980s donors began to mount programmes to rehabilitate Uganda's health care system and deal with the growing problem of AIDS. Donors flowed in, but it was always possible to control their use because the debilitated formal sector had developed an intimate symbiotic relationship with a loosely defined informal one. Drug supplies, equipment and human resources flowed through a system in which the boundaries between the formal and the informal are clear on paper and vague in practice.

In this situation, injection equipment, injectable medicines, and the provision of injections are no longer the monopoly of trained staff working in officially recognised units.

At the same time, morbidity and mortality rates are high. Malara remains the number one cause of morbidity and mortality overall. For adults, AIDS is now the most common cause of death. Acute respiratory infections, diarrhoea, anaemia, meningitis and tuberculosis contribute to ill health, together with common conditions like hemnias and insect-borne diseases. People experience a strong and often acute need for treatment, and they are well disposed toward biomedical care as the first recourse for most sicknesses.

Investigating injection practices

Such widespread misuse of injections in Uganda and many other developing countries has long been of great concern to WHO. Indeed, in 1990 it was decided to initiate a collaborative study on injection practices. This study formed part of that research. Its purposes were: to examine the extent to which injections are used, the ways in which they are perceived, the indications for which they are given, the sources from which they are obtained and the hygienic level of their administration.

The methods were designed to collect data from the point of view of users and providers. A household survey was carried out in two regions: Busoga (Jinja, Iganga, and Kamuli Districts) in Eastern Uganda, and Ankole (Mbarara and Bushenyi Districts) in Western Uganda. In each region, two communities were selected in urban, semi-rural, and rural settings. Fifty households with children under five were randomly chosen for interviews, yielding a total of 360 households in each region. At the initial interview, questions were asked about the last injection received by anyone in the household. A fortnight later the household was visited again in order to enquire about symptoms and use of injections in the confined two week period. Providers-oriented methods included the use of open-ended questionnaires, a review of prescriptions and actual treatment received and the observation of hygienic measures in 35 provider facilities. These included government and non-governmental organisations' units, private clinics and various "non-formal" sources of injections, such as drug shops.

Ethnographic fieldwork was undertaken in Eastern Uganda, for one year in 1992-1993, which allowed opportunities for participant observation, in-depth interviews and informal discussions with users and providers of injections. The primary focus of the ethnographic research was the social relations of therapy in family, neighbourhood and institutional settings. This part of the research provided qualitative and contextual data that supplement the material collected as part of the WHO collaborative study.

A more detailed description of the methods and results of the WHO Uganda study will be available in a forthcoming WHO report. The ethnographic work is being analysed by a Ph.D. thesis by the first author for the Institute of Anthropology, University of Copenhagen.
Injections... couldn't from pg. 11

Several points are important for understanding the frequent use of injections for fever. One is that in the Bantu languages of Southern Uganda, the term used for fever (omusundu or omsuzu) has a broad semantic range. It covers rise in body temperature, cough and cold, joint pains and other symptoms. Although the local term is used to convey a translation of malaria, it is much wider. In our questions, we asked specifically about perceived elevation in body temperature, but the term is often used without specifying symptoms precisely. People have learned that biomedical thinkers consider chloroquine and penicillin injections appropriate for some kinds of fever, and they seek them as treatment for the whole range of symptoms included in the category omusundu. They know from experience that some of these symptoms can develop into fatal conditions. It is also important to remember that diagnostic procedures, even in explicitly medical terms, are highly unreliable. Laboratory tests are seldom given, so treatment is almost always prescriptive.

Sources of injections

An analytical distinction was made between those facilities that are formally recognised and those that are not. Government units, from rural dispensaries to hospitals, NGO facilities and licensed private clinics are considered legitimate sources of injections by the Ministry of Health. Non-recognised sources include drug shops, unregistered clinics, informal providers, neighbours and relatives who give injections in homes. For the total sample, the last injection received was in the 'normal sector' for 71% of households. However only 29% were given in government facilities; 42% of households reported that they had received their last injection from a private unit, either church-run, or privately registered to a medical professional. The 'informal sector' was the source of the last injection for 29% of households. 16% of the total sample had received the last injection at home, while 13% had gone to a drug shop or unregistered clinic.

The analytical distinction between the formal and the informal sectors does not necessarily correspond to that between professional training and non-professional providers. In recognised health units, diagnosis, prescription and administration of treatment are sometimes done by untrained staff like dressers and nursing aids. Trained nurses, midwives and medical assistants may treat neighbours in their homes or in unregistered storefront clinics. In Eastern Uganda, where it was possible to determine the qualifications of the person who administered the last injection, half of the 350 injection providers were trained paramedical staff, while the other half had no formal medical training. Discussions revealed that most people do not believe that formal training is necessary for the administration of injections.

The Uganda Essential Drugs Management Programme suggests that no more than 5% of prescriptions should include an injection. The proportion was well over this figure in the 26 facilities from which we collected prescriptions were examined. In Eastern Uganda, 68% of patients received an injection, while the figure for Western Uganda was 60%. The rates were only slightly higher in private non-profit facilities. The lowest rates, 38%, were from two government hospital outpatient departments in Western Uganda.

Perceptions of risk

Health planners are concerned about the overuse of injections because they may cause paralysis, abscesses and infection with hepatitis or HIV. Restricting the use of injection, proper administration and concern for patients' reactions are the recommendations of reducing risk. Lay people in Uganda are aware that injections may cause complications. Lay people, when asked by household survey respondents, were asked whether any household member had ever experienced problems from an injection. Of the 720 households, 51% reported that someone had complications from an injection (some had had more or several kinds): 47% had experienced abscesses; 5% had allergic reactions; and 2% reported lameness. Respondents generally did not blame these on poor hygiene or inappropriate injection techniques. Rather they referred to personal qualities of the provider, a provider with a 'bad hand' may give a bad injection.

In Uganda today the greatest risk in the minds of users and providers is not the transmission of HIV. Messages from the AIDS Control Programme emphasise the dangers of using and sharing unsterile needles and syringes. There are essentially no intravenous drug users in Uganda; the warnings about needle sharing served to strengthen the mistrust people already had of the government health services. Many are apprehensive of the 'communal' sterilisation of health units; they are worried that health workers are demoralised and unmotivated in their work. They do not like the idea of using the same needle as someone else: 'you don't know who else other people have.' The fear of AIDS has had unplanned consequences for injection practices in the villages.

In order to avoid 'public' needles, many householders try to obtain, by purchase or otherwise, their own needles and syringes. The household survey revealed that 63% of households in Busoga (Eastern Uganda) and 83% in Ankole (Western Uganda) possessed injection equipment. Some families kept extra needles and syringes for their children. Patients can thus bring their own equipment when visiting a health facility. The ownership of equipment facilitates 'formal' treatment too: if a child is sick at night, a neighbour or family member can administer an injection at home. Injectable chloroquine and penicillin are readily available in most areas: 21% of households in Busoga and 34% in Ankole had injectables at home at the time of the survey. Provision of equipment reduces the ownership of needles and syringes has been encouraged by health workers at many facilities. They give or sell equipment to the patients and encourage them to bring it again at the next visit. In some cases they encourage them to purchase it from local drug shops, which usually stock disposable needles and syringes. In remote areas, where most patients are poor, health centres may sell needles to the patients while syringes are provided free of charge. The assumption that needles are more likely to transfer infection than syringes is the responsibility for cleaning the equipment at home. This practice is in part an AIDS prevention measure that has developed to counter the mistrust of communal equipment. It also fits in with a general pattern in which patients at government facilities are required to provide their own supplies of medicine and even paper upon which to write the diagnosis and treatment. Just as a maternity patient must bring soap, a plastic sheet, and disposable gloves, so must other patients supply needles and syringes.

The policy of the Uganda Essential Drugs Management Programme and the Expanded Programme on Immunization is to supply reusable needles and syringes. In a country where disposable needles and syringes are not discarded, but reused until the needles are bent or blocked and the graduation markings are worn off the syringes, it is better to use equipment that is designed for continued use. But disposable equipment has been supplied through AIDS control programmes and by well-meaning donors. It is also brought into the country through private channels, which are not among the most significant source of disposable injection equipment.

Thus the law forbidding lay people to own needles and syringes is completely ignored in a practice that has spontaneously developed. The fear of AIDS, together with the de facto 'cost sharing' that evolved during the years of shortages in government facilities, has not only put greater responsibility for one's own health in the hands of the layperson; it has also put injection equipment and injectable medicines there. Here, as is often the case in developing countries, there is a great gap between paper policy and practice. There is a need for policy relevant for the actual situation.

Conclusions

This study has shown that injections are a very common form of therapy in Uganda. The medicines injected are penicillin and chloroquine, both relevant to common diseases in the country, but probably not appropriate for all the cases in which they are administered. Injections are given by a wide range of providers, about half of those administering them have no formal training in how to do so. The weakening of government health services and the continuing high levels of morbidity have encouraged private, informal and home care. This trend, together with the fear of AIDS, has made injections more easily available to people. Ownership of needles and syringes is widespread.

Attempts to deal with the health hazards posed by frequent, inappropriate and unsterile injections should address the whole range of providers as well as users. Training sessions should be offered in particular to nurses' aides, dressers, and informal providers. Simple messages should be developed about indications and procedures for injections. For what symptoms and in what doses should penicillin or chloroquine be injected? What steps are involved in giving a proper, safe and sterile injection under local conditions? Although the messages for lay people and health workers may differ in complexity, they should be similar in content. Lay people must be given standard by which to evaluate the care they pay for. Knowledge in the "normal" sector diffuses to lay people in any case, but it is often distorted in the process. It is better to inform people properly in the first place. The mistrust of 'communal' sterilisation should be addressed specifically. It is instructive that parents accept common use of immunisation equipment. Particularly this is because the risk of HIV infection from small children is not considered grave; but it is also the case that the immunisation programme now provides for periodic mass inoculation effort to train health workers in proper methods. Sterilisation is often done publicly so that parents witness the procedure. Perhaps this same approach could be used to develop more trust in the administration of "public" therapeutic injections. The private ownership of needles and syringes must be acknowledged as a common pattern and steps taken to ensure proper sterilisation of injectable equipment when patients bring it to health facilities. In the longer term, private possession of needles and syringes is not desirable. In order to discourage it, the causes of this trend must be recognised. This issue should be discussed at district and local levels by the health management committees who should formulate a realistic and workable policy concerning injection equipment.

* Harriet Birungi is a PhD student at the Institute of Social Research, Makerere University, and is a research assistant to Professor Robert Reynolds. Rheinhold is Associate Professor, Institute of Antropology, University of Copenhagen, Copenhagen, Denmark.

Reference

Essential Drugs Monitor

NATIONAL DRUG POLICY

Delhi leads the way with new drug policy

A comprehensive “basic drug policy” aimed at making available carefully selected essential drugs to the people, was announced by the Delhi Government on 4 March 1994. The policy also strives to improve the procurement, storage and distribution systems, to strengthen public education and to rationalise prescribing. Delhi Minister for Health, Dr Harsh Vardhan, says that the policy – the first of its kind in the country – will ensure that all the basic drugs needed for health care are available in Government hospitals and health centres. Such a policy is necessary, he emphasises, because although 30% of the State’s health budget is currently spent on drugs, there are constant complaints about the non-availability of essential drugs. The main objective, he says, is to provide a life-saving and cost-effectively selected drugs to ensure rational use and availability at all times in the health centres. The new list contains 225 essential drugs, estimated to cover 90% of the health needs of the population. Forty experts from various disciplines participated in drafting the list which will be updated every year. In future, 90% of the State drug budget will be spent on these essential medicines, says Dr Vardhan.

POLICY DETAILS

- Pooled procurement of drugs for all hospitals in Delhi State and the establishment of a central drug procurement, storage and distribution centre

The present practice of every hospital ordering its own drugs will be phased out. Only drugs on the essential drugs list will be procured by a central procurement unit, which will invite tenders and order medicines for all hospitals and medical facilities in the State. In the first phase of the new policy a contract will be prepared for the different drugs needed. This will be done by floating tenders and selecting suppliers based on strict criteria, such as their past performance, price, quality and whether they manufacture the medicines. The contract will be supplied to all hospitals, which have to order from this list of approved suppliers. In the next phase, the drugs for all hospitals will be ordered centrally, but the medicines will be delivered directly to the hospitals. Finally, when a computerised procurement, storage and distribution centre has been established, all drugs will be ordered by the centre, stored there and distributed to the State’s hospitals. Modern drug storage and inventory control techniques will be introduced.

- Preparation of a formulary

A Delhi State Formulary will be prepared to provide information about drugs on the essential drugs list. This will be regularly updated by a Formulary Committee. It will include information on therapeutic indications, contraindications, interactions and side effects associated with each drug and will be made available free of charge to all doctors, pharmacists and para-professionals in the public sector.

- Quality assurance

The State Drug Control Authority will be considerably strengthened, so that drugs reaching the patient are safe and effective. Effective and approved specifications and standards. The quality control system will cover managerial and legal aspects as well as technical. Charges will include strengthening the Drug Inspectorate Unit and the Quality Control Laboratory. An efficient system for withdrawing substandard products from the market will be established.

- Training in rational use

A series of workshops on rational drug use will be held throughout the State for all staff involved in drug prescribing. These will be carried out in collaboration with medical, nursing and pharmacy institutions in Delhi. The Government will help to implement and improve ongoing programmes which introduce the essential drugs concept into the medical and nursing curricula.

- Drug information

The aim of the policy is to ensure that practical, unbiased information on rational use of drugs and on drug handling is provided to all health workers. Appropriate information will be provided to traditional medical practitioners, retailers, patients and the general public, using all available communication techniques, including the traditional folk media. Training programmes, workshops, lectures and discussions will be held for different groups.

It is intended to establish a computerised Drug Information Centre, in collaboration with the National Informatics Centre and the Delhi Medical Association. In due course a Delhi State Drug Information Letter, a newsletter containing objective, up-to-date, information about drugs, will be published and widely circulated.

- Preparation of standard treatment schedules

In an effort to rationalise prescribing and reduce costs, standard treatment schedules will be prepared for drugs used at primary health centres and at hospital out-patient departments.

Drug advertising and promotion

Ethical criteria for drug promotion and advertising, following WHO guidelines, will be implemented. Promotional activities which are not in accordance with the law or with such criteria will not be permitted.

Research

Research on all aspects of drug use is an integral part of the new policy. Initially, this will involve situation analysis surveys. Later, studies on the economic and behavioural aspects of drug use by the public will also be carried out. The results will be used continuously to modify the different components of the programme.

Monitoring and evaluation

A monitoring and evaluation section will be set up at the Ministry of Health to study performance in relation to projected activities. Three standing committees will also be established: one for drug selection, one for drug procurement and store management and the third for preparing the formulary.

Delhi has now provided a strong framework within which all components of its drug policy can be implemented in the coming years. The State’s Government is strongly committed to this policy, which it sees as its hope for achieving equity in health care for its population, one third of whom live in urban slums. If successful, Delhi’s drug policy may become a model other states in the subcontinent choose to follow.

Both patients and health workers have much to gain from the introduction of the new drug policy.

The Gambia: stage set for National Drug Policy

The Gambia is a small West African country surrounded by Senegal, except at the mouth of the river Gambia. The size of the country and its small population of approximately one million has not deterred The Gambia from forging ahead as a nation-state, and developing national policies.

The Gambia’s National Drug Policy was developed with the assistance of WHO’s Action Programme on Essential Drugs. In December 1993, two consultants assisted the Chief Pharmacist in preparing a draft document that was widely circulated to all interested parties. This was then discussed at a national consensus workshop held in April in Banjul, the capital.

Participatory approach...

The 49 people who attended the workshop represented a broad mix of interested groups in both the public and private sector and development agencies. To set the stage, brief presentations on the concept of essential drugs and the components of a comprehensive national drug policy created an atmosphere conducive to a fruitful exchange of views. A participatory approach was used to actively involve everyone in the first day’s group work and in the plenary session on the second day.

The changes in the various areas of the policy, which were agreed during the plenary session, were subsequently incorporated into the policy by a drafting group. This second draft is now circulating for comment before it is finalised and submitted for Cabinet approval.

The next steps...

After Government approval, the policy will be published and widely disseminated by the Ministry of Health. Implementation will start as soon as possible but within the context of the Five Year Plan for the Pharmaceutical Sector. This will include a review of existing legislation and regulations by the Ministry of Health, which will propose the changes necessary to bring them into line with the drug policy.

The challenge...

The shortage of trained human resources, (only four pharmacists in the public sector) and funding, will certainly slow the pace of implementation, but for The Gambia an initial and important first step has been taken.

Issue No. 18, 1994
PUBLIC EDUCATION

Public education in drug use: a growing need

Activities related to public education in rational drug use are a growing area of work of WHO's Action Programme on Essential Drugs. They are also the focus of increasing national and international interest. In November 1993 the Action Programme held an informal consultation to review its work in this area and to develop a strategy for the future that would build on experience gained by the Programme and by other organizations and individuals working in this field.

This article, based on the meeting's report, reviews the need for public education in drug use; sets forth guiding principles; describes constraints and facilitating factors; and outlines DAP's role at the national and international levels.

In 1981 the Action Programme on Essential Drugs (DAP) was established to provide operational support to countries in the development of national drug policies and essential drugs programmes, and to work towards the rational use of drugs worldwide. In addition to its country support, the Programme conducts operational research and development work to clarify problem areas and identify practical tools for their solution.

During the last decade DAP's country support, research and development activities have included a number of projects aimed at improving drug use by patients and the general public through elucidating drug use practices, knowledge and perceptions, and developing public education materials. Research in this area has been conducted in such countries as Indonesia, Malawi, Nepal, Senegal, Sudan, Uganda and Zimbabwe; while public education campaigns have been supported or are underway in such countries as Bangladesh, Bolivia, Colombia, Kenya, Malawi and Sudan.

From patient to public: a wider focus...

The Action Programme's initial approach to public education focused on information to the patient at times of illness. A 1985 Working Group on Educational Material for Patients, held in New Delhi, exemplified this approach. The group looked into common problems associated with the use of medicines by patients and defined important messages that needed to be communicated. The Action Programme's support to the Bangladesh Essential Drugs Programme in the development of a flipchart for use as an educational tool by community health workers and graphic handouts with medicines were also part of early Programme work in this area.

Although this was a useful first step it became clear from DAP's field experience and studies, reinforced by the findings of many other researchers and programme implementers, that a broader perspective of community information, education and empowerment was needed which would take into account the sociocultural framework within which medicines were used and which influenced people's perceptions and behaviours. It was recognised that educational campaigns were unlikely to be effective if conducted primarily from a top-down and biomedically perspective without an understanding of the sociocultural framework within which decisions are taken.

It was in this light that a number of research studies into drug use in the community were conducted and are being used in the development and implementation of community-based and national interventions to improve the appropriate use of drugs. A simple research tool How to Investigate Drug Use in Communities has also been developed in order to assist researchers and programme implementers.

However, it has to be said that DAP's operational country support in public education has been difficult to implement, even where this has been specifically included in plans of operation of essential drugs programmes. Reasons include the low priority accorded by governments and institutions to health education in general; scarcity of research and materials development resources (both human and institutional) in many developing countries; the high cost of printed and mass media materials production; weak infrastructures creating problems in materials testing and dissemination; paternalistic attitudes of health professionals to consumers and patients; the top-down approach to education frequently regarded as appropriate; and the imbalance between non-commercial and commercial sources of information about medicines, the latter often uncontrollable and unsupportive of rational drug use. In some countries, the few trained Information, Education and Communication (IEC) personnel are already committed to work in other programmes with a substantial communication component, such as AIDS and immunization programmes. Few staff in national essential drugs programmes have any training in IEC. Probably because of this lack of training ED programme staff tend to concentrate their efforts on technical areas more closely matching their professional experience and expertise, rather than on IEC activities.

DAP's operational experience and research have also shown that, in many parts of the world and at all levels of the health care system, prescribers are not fulfilling their "natural" health (including drugs) educational function. Thus by the early nineties emphasis was being placed by DAP in prescriber training programmes, on improved communication between health workers and patients. Where studies have been made of such communication, the findings are being fed back into training programmes. DAP is trying to strengthen the link between prescriber training in patient education skills to reinforce public education strategies.

Why public education in drug use is needed...

The overall aim of public education in drug use is to provide individuals and communities with information, and to foster skills and confidence, which will enable them to use medicines in an appropriate, safe, and judicious way. Public education in this area should include a wide range of different activities.

Public education in the appropriate use of drugs is needed because without it people lack the skills and knowledge which they require to make informed decisions about how to use drugs (including when they should not be used) and to understand the role of drugs in health care. Inappropriate drug use has serious health and economic consequences, not just for individuals but also for the community and for the success of national drug policies themselves.

The Alma Ata declaration clearly states that "People have the right and duty to participate individually and collectively in the planning and implementation of
Improving public understanding about medicines will not resolve all of these issues but, together with other activities designed to implement national drug policies, it will contribute to the development of solutions.

At an individual level the benefits of improved public understanding include:
- a better appreciation of the limits of the role of medicines within health care and less concern in the idea that all diseases require pharmaceutical treatment;
- an improved balance of power between consumers/patients and health professionals;
- a more critical attitude to advertising and other commercial information, which often fails to give balanced information about drugs;
- a better understanding of how to take medicines when needed.

At a more general level the benefits include:
- more understanding and support for drug policy and for measures to rationalise drug use. In particular, people need to understand that policies which encourage judicious prescribing are in everyone’s interest;
- a more economic use of drugs and less waste of resources;
- improved confidence in health services and in health professionals;
- increased success of measures to deal with public health problems.

Education is needed at a general level so that people have a better understanding of what medicines are and what their role in health care is. Inclusion of basic education on drugs in schools could lay a foundation for appropriate drug use and management of health problems. At a more specific level, education is needed to tackle problems of misuse which are identified as being particularly serious. Campaigns for the wiser use of specific drugs (e.g. in diarrhoeal disease control programmes) have proven that campaigns can have some effect in reducing morbidity and mortality, and in reducing needless expenditures.

Guiding principles...

Drug use should be seen within the overall context of a society, community, family and individual. Public education on drugs should recognise and take into account cultural diversity and the influence of social factors such as poverty, disadvantage and power relations that can influence drug use.

Specifically:

- It is important to integrate public education in the appropriate use of drugs within comprehensive national pharmaceutical and health policies.
- Public education should encourage informed decision-making by individuals, families and communities on the use of drugs and non-drug solutions;
- Public education on drugs should be based on the best available scientific information on drugs, their efficacy and side effects;
- Public education should be accompanied by supportive legislation and controlled drug use to make informed choices on drug use easier;
- NGOs, community groups and consumer organisations have an important role to play in public education programmes and should be involved in the planning and implementation of education activities;
- communications training and a reorientation of health care providers’ attitudes is necessary if prescribers are to give effective and consistent public education on drug use in their interaction with the community;
- public education should be based on sound educational principles, which take into account community perception and needs, decision-making processes in families, and the constraints that communities face in their daily lives.

Commercial interests

Commercial interests may not always match public interests. Industry marketing has a commercial goal of increasing sales and profits of a given product. Since it does not generally provide independent, comprehensive and comparative information, it can contribute to inappropriate drug use and the purchase of needlessly expensive products. Moreover, where government regulation of drug promotion is weak — the situation in many developing countries — uncontrolled and inaccurate promotion can be a major contributor to inappropriate drug use, with serious consequences.

Lack of communications skills training in professional curricula

Communication skills training frequently receives low priority in the curricula of schools of medicine, pharmacy and nursing, compared with biomedical subjects. In some institutions it is not covered at all.

Professional interests

Resistance to change within professional groups can serve as a constraint to public education. In some cases, professional groups do not perceive the need for or the importance of public education. In addition they often do not fulfil their professional role in providing advice on the appropriate use of drugs on either a personal or organizational basis.

Prescribers tend to hold influential and powerful positions. Public education can appear to conflict with existing values and power relationships, for example, leading the public to challenge the traditional pre

Weak infrastructures

Lack of infrastructure within the health system for implementation of drug policies, including public education, is a major constraint for some countries. Any effort to educate the public on appropriate drug use can be undermined if there is a lack of necessary drugs and easy access to them.

A bell game helps to convey the message of immunization to children in a Beijing park.
access to prescription drugs from infor-
mal sources. Consumers are then faced
with the dilemma of reconciling pub-
lic educational messages which motivate
appropriate behaviour with the reality of
the drug market.

Poor health infrastructures often lead
to inadequate distribution of health, ed-
uca tion and other services, including pub-
lic education initiatives. It is recognised
that the most vulnerable groups are often
at the fringe of health systems and are thus
the groups most likely to miss opportuni-
ties not benefiting from such initiatives. Ac-
cess to these people is difficult.

Health education support services are
weak in many countries with a shortage of
qualified health educators available. Lack
of independent, objective sources of
information for both prescribers and pub-
lic on drugs can be a constraining factor.
This often leads to reliance on commer-
cial sources of information.

Resource availability

Resources include both funds and hu-
man resources, both of which are often
inadequate. Effective public education
requires sufficient funding to enable tar-
g eting of population groups through appro-
 priate strategies.

Public education on drugs will require
an extensive programme of training of
health workers and other field staff in
communication skills and new develop-
ments in drug use. Mechanisms for con-
tinuing education in many countries need
strengthening. Since public education is a
low priority, training courses providing these
skills in this area are often not
funded or supported.

Social, economic and cultural factors

Public education programmes fre-
quently fail to take into account the so-
cial, cultural and economic factors that
influence community behaviour. The as-
sumption is often made in public educa-
tional activities, that people will passively
accept and respond to “obvious” health
messages. In reality, people’s behaviours
are moulded by a range of beliefs and at-
itudes which need to be understood sen-
tively in the development of public edu-
cation programmes. Lack of involvement
and participation of the target groups of-
ten lead to failure of the programme. The
failure to recognise that bringing about
behavioural change is a slow and long
term process can lead to support for pro-
grammes being prematurely withdrawn.

Facilitating factors

Facilitating factors are defined as any
factors which stimulate, provide, or promote,
a fertile environment for public education.

Increased awareness of the need for
public education on drugs
Over the past decade there has been
increasing public interest and subsequent
demand for comprehensive drug informa-
tion. Allied with this is the understanding of
the right to know and expectations that indi-
viduals should and want to take an active
role in health care decisions. This has, in
part, been stimulated by the democratic
process, and also by a movement for
individuals to take more responsibility for
their own health care, and the growing
organized consumer and public interest
groups.

Both at international and at national
levels, there is growing recognition that

public education can be an effective tool
for promoting appropriate use of drugs. Some
countries are encouraging the de-
velopment of innovative public education
programmes.

Public education networking is facili-
tating the sharing of experiences of public edu-
cation between government health serv-
ces, NGOs and community-based
activities. In this way, groups are learning
from the experience of others and begin-
ing to work together.

Some national and international pro-
essional associations, particularly those
in the area of pharmacy, are now strongly
promoting a community educational role
for their members, and backing this
through the development of related strat-
egies and materials.

Some pharmaceutical companies are
moving towards the provision of Im-
proved and user-friendly written patient
information. This is partly in response to
regulatory requirements and also to con-
sumer pressures.

Improvements in health
infrastructures

Following the Alma Ata Declaration
many countries have begun to implement
programmes of primary health care. With
improvements in the health infrastructure
and the formulation of national drug poli-
cies, there is increased opportunity for the
development of public education.

Expanding coverage of mass media and
information technology
Recent major advances in communi-
tication technology have created powerful
mechanisms to convey educational mes-
sages. In the last decade the proportion
of the world’s population that can be
reached through radio and television has
increased dramatically. This increasing
coverage can have negative consequences
through greater exposure to misconforma-
tion on drugs. However, it also opens
up new opportunities to reach large
audiences, including non-literate popula-
tions.

With enhanced information technol-
yogy, there is greater accessibility to in-
formation through on-line data bases, sat-
ellite links, etc. This has many positive
benefits, including the access to objective
information, and the sharing, pooling, and
critical evaluation of different metho-
dologies.

Conclusions...

The meeting concluded that the global
need for public education in the field of
appropriate drug use is evident. Countries,
programmes and organizations working in
the pharmaceutical sector should be en-
couraged and assisted to embark on pub-
lic education activities. Public education
should form an integral part of national
drug policy and the training of prescribers
and dispensers. The Action Programme
has a critical teaching, advocacy, infor-
mation and development role to play in
this area. The Programme’s earlier
support, research and development
work should be built upon and strengthened.
DAP should make a particular effort to
widen its network of partners in this field
to include support to smaller scale
programmes, community and nongovern-
mental organizations, which could serve as
development models for subsequent larger
programmes. Consumer and professional
organizations are especially logical partners
in this support.

A comprehensive international infor-
mation base on drug education pro-
grammes for the general public is needed.
DAP should commence as soon as possi-
ble the global survey of such public edu-
cation programmes, that is already
planned as part of the Programme. The
survey will form a logical basis for the planned
guidelines on the development of
public education programmes.

Essential Drugs Monitor

DAP Global Survey of
public education in drug use

Can you help us?

Public education activities on the use of drugs have been undertaken
in many countries, often on a small scale by NGOs. While
some experiences in drug education have been published, most are
not documented. A comprehensive review of existing activities is
needed. This would provide guidelines for future educational
programmes, and help to build on successes, to learn from problems and to
identify the need for future research.

The following is a draft version of the Action Programme. Action
Programme is conducting a global survey of public education activities.
It will include a critical assessment of their effectiveness, to
cover both broad based efforts on the

rational use of drugs and drug education initiatives as part of single
issue programmes. The aim is to establish a reference collection of
related materials in order to identify suitable education strategies that
can be promoted by DAP and other organizations.

We are particularly interested in programmes which target school
children.

If you have been involved in or know of a public education activity
related to the rational use of drugs which is currently ongoing or
which has taken place in the last five years, and would like to help our
research, you are kindly invited to contact the Action Programme at
the address given on page one.

Initially we should like to have the following brief information:

- the aim of the project;
- the problem targeted;
- the duration;
- materials/activities developed, e.g. workshops, radio, theatre;
- the principal thematic;
- the target group;
- the scope, i.e. how many people are covered by the activity.

If it is decided to include your project in the global survey we will
send you a structured questionnaire to fill in. At that time, you
will also be requested to provide examples of materials produced.
The cost of data gathering and postage will be reimbursed to partici-
pants in the survey.

We hope to hear from you.

References

2. Injection Practices Research, Action Programme on Es-
sential Drugs, WHO/93/9, 1992, WHO, Geneva
3. People’s Perceptions and Use of Drugs in Zambia, Action
4. Self-realization and its Impact on Essential Drugs
5. Public Knowledge, Attitudes and Practices regarding
Drug Use in Malaysia, Action Programme on Essential
6. Public Knowledge, Attitudes and Practices regarding
Drug Use in the Philippines, Action Programme on
Essential Drugs, WHO, Geneva (in press)
7. Access to Essential Drugs: A View from a Manual on How to Im-
prove Drug Use in Communities, Action Programme on
Essential Drugs, WHO/DAP/92/4, 1992, WHO, Geneva (also available in French)

A full report of the meeting, Public Edu-
cation in National Drug Use, is available
free of charge, in English and French,
from the Action Programme on Essential
Drugs, World Health Organization, 1211
Geneva 27, Switzerland.
Australia: fostering better communication between doctor and patient

In many countries there is growing recognition that patients should be given more information to enable them to make decisions about their treatment. In Australia, as long ago as 1986, the Victorian Law Reform Commission became concerned at the lack of clarity in the law in this area. It therefore conducted empirical studies examining attitudes to and practices in giving information to patients, and patients’ experiences and expectations in receiving information. It was concluded that doctors were giving less information than patients wanted, and on occasion less than was required to fulfill the common law standard of reasonable care. The prevalent attitude among doctors seemed to be that the patient’s best interests were served if doctors decided what information to give and what treatment was best.

In 1989 the Law Reform Commission therefore recommended that the National Health and Medical Research Council (a Government advisory body on standards of individual and public health) formulate guidelines for the medical profession on the provision of information to patients about proposed treatment and procedures. In January 1991 the Council established a working group of consumers, health and legal professionals to undertake this task. After extensive public consultation, guidelines were adopted in June 1993. These have been widely circulated among health professionals and the public in Australia.

As the issue of patients’ right to information will affect almost everyone at some time in their lives, the guidelines adopted in Australia are reproduced below. Although the guidelines were written for a developed country with an advanced health system, the core principles underlying them are valid globally.

**Introduction**

These guidelines are intended to enhance doctor-patient communication. They reflect good medical practice and should encourage cooperation and improve health outcomes. They cover:

- the type of information which should be given to patients;
- the particular need to give information about potential risks, as well as benefits, of a proposed medical intervention;
- the manner in which information should be given;
- circumstances where withholding information may be justified.

The community recognises that patients are entitled to make their own decisions, in order to do so, they must have enough information about their condition, investigation options, treatment options, benefits, possible adverse effects of investigations or treatment, and the likely result if treatment is not undertaken. It is not possible, however, to provide complete information or to predict outcomes or assess risks with certainty, and patients need to be aware of this uncertainty.

An open exchange between doctors and patients is crucial. Each brings to the consultation different information, opinions and understanding which are important for making decisions and achieving the patient’s well being. Allowing opportunity for discussion may be as important for patients as giving and receiving information.

Consultations between doctors and patients take place in a wide variety of circumstances which are not always ideal.

Often patients are sick or injured and they and their relatives may be anxious. For these and other reasons, patients may be found difficult comprehending the information given by doctors. It is important that doctors use language which is simple and free of medical jargon, and that they try to ensure that the information is understood and retained.

Many doctor/patient contacts are of a relatively straightforward and minor nature. In practice this will usually mean that the exchange of needed information can be accomplished simply and briefly, while the spirit and intent of the guidelines are observed.

Careful and conscientious adherence to the guidelines may on occasion demand extra time (for example to ensure that key information has been grasped and retained) with attendant cost implications. The guidelines reflect the common law right of legally competent patients to make their own decisions about medical treatment, and their right to grant, withhold or withdraw consent before or during examination and treatment. The guidelines do not change the law, nor do they set a mandatory standard. Rather, they reflect the doctor’s existing common law responsibility always to take reasonable care. In appropriate circumstances, diversion from the guidelines would not inevitably be regarded as negligent or unprofessional behaviour. The guidelines may be consulted in disciplinary or civil proceedings in deciding whether the doctor has behaved reasonably in giving information, although ultimately it will be the role of the court to decide the reasonableness of a doctor’s behaviour in a given case.

**Informing patients of risks**

Doctors should give information about the risks of any intervention, especially those that are likely to influence the patient’s decisions. Known risks should be disclosed when an adverse outcome is common even though the detriment is slight, or when an adverse outcome is severe even though its occurrence is rare. A doctor’s judgement about how to convey this risk will be influenced by:

- the seriousness of the patient’s condition; for example, the manner of giving information might need to be modified if the patient was too ill or badly injured to digest a detailed explanation;
- the nature of the intervention; for example, whether it is complex or straightforward, or whether it is necessary or purely discretionary. Complex interventions require more information, as do interventions where the patient has no illness;
- the likelihood of harm and the degree of possible harm; more information is required the greater the risk of harm and the more serious it is likely to be;
- the questions the patient asks; when giving information, doctors should encourage the patient to ask questions and should answer them as fully as possible. Such questions will help the doctor to find out what is important to the patient;
- the patient’s temperament, attitude and level of understanding; every patient is entitled to information, but these characteristics may provide guidance to the form it takes; and
- current accepted medical practice.

**Presenting information**

The way the doctor gives information should help a patient understand the illness, management options, and the reasons...
Essential Drugs Monitor

ESSENTIAL DRUGS PROGRAMMES

Drugs programme managers meet in Malawi

Health care financing, training, autonomous central medical stores and donor coordination were among the many subjects discussed at the East and Central African Essential Drugs Management Meeting held in Lilongwe, Malawi from 20–24 June 1994. Organized by the Action Programme on Essential Drugs (DAP), the meeting provided an excellent opportunity to share experiences and exchange views on topics of current interest affecting essential drugs programmes in the sub-region.

The meeting was attended by 50 people, mainly managers of Essential Drugs Programmes in Kenya, Malawi, Mozambique, Somalia, Sudan, Tanzania, Uganda, Zanzibar, Zambia and Zimbabwe. The Gambia, Nigeria and South Africa participated as observers and WHO staff acted as resource persons.

UNICEF (Maputo) and the Danish Red Cross (Copenhagen) represented nongovernmental organizations.

The meeting started by reviewing the current status of the essential drugs programmes. Presentations and discussion then centred on health care financing, the impact of structural adjustment programmes, donor coordination, cooperation on health in the sub-region, and the new WHO drug policy indicators.

Most countries represented have national drug policies although these are at varying levels of development. Most programmes are donor-funded, and are using the kit system, focusing supply on primary care facilities, which are mainly rural. There was general agreement that the training of health workers has progressed well. In many countries the concept of essential drugs and rational drug use have been incorporated into the basic curricula of health workers. However, public information campaigns to promote rational drug use have lagged behind the training of health workers.

Alternative methods of health care financing were discussed after a presentation of Kenya’s experience with the USAID sponsored Kenya Health Care Financing Project. Participants stressed that any financing system must be fair to all, especially the poor. Community participation is vital in deciding on how the funds collected are used and who should be exempt from payment. The success of any health care financing scheme is dependent on the availability of drugs. It was recommended that the cost of implementing cost-sharing mechanisms and price mark-ups on drugs should be studied.

The changing role and status of national medical stores were discussed after presentations on different models of autonomous medical stores from Zambia, Sudan and Uganda. The general trend is towards establishing in-country medical stores that can operate efficiently. Nevertheless, the ministry of health’s policies on essential drugs must be taken into account. It was recommended that there must be concurrent capitalisation of the stores and the ministry of health facilities for the system to operate smoothly. Countries should also explore the role of private pharmacies in government hospitals.

World Bank Adjustment Programmes are in operation in all the countries represented at the meeting. All experienced negative aspects of these programmes. In most countries, drug costs have increased, partly because of trade liberalisation and the devaluation of local currencies. As a result, cost recovery schemes have been introduced. It was recommended that as far as possible countries should avoid borrowing for recurrent expenditure such as drugs. Programme managers recognised the need to develop skills in economics to enable them to argue with their needs with government economists and planners.

Donor coordination is improving as most actors see the need to use limited resources effectively. A new trend is for some donors to give support to a whole sector instead of a programme or project. It was recommended that the ministry of health and essential drugs programmes should always have national policies and priorities, plus data on drug needs, availability, and funding gaps, instantly available for interested donors. Each country should also have a donor coordinating policy and office to prevent potential overlap of activities at country level.

The treaty which established the Common Market for Eastern and Southern Africa (COMESA) contains a section on cooperation in health matters, including pharmaceutical affairs. Most participants were unaware of this. It was recommended, that in future, national pharmaceutical programmes should be involved in COMESA discussions and a meeting of chief pharmacists in the region be organized to examine the feasibility of the pharmaceutical components of the treaty.

There was a great deal of interest in the use of the WHO-developed indicators for monitoring progress in implementing national drug policies. A manual to systematically monitor progress and evaluate performance of drug policies has been developed by DAP and is ready for publication. Each country will need to adapt these indicators to its specific situation.

The future sustainability of many of these essential drugs programmes was a major concern during the meeting. Many programmes receive insufficient government funding and the acute shortage of pharmaceutical staff in the public sector also makes implementation of programmes difficult in a number of countries.

This exchange of experience highlighted for participants the fact that, despite coming from different countries and programmes, they share many common problems with colleagues in the region.

Participants take a well deserved break by the shores of Lake Malawi
RATIONAL USE

When healers become dealers

Sanjeewa Ranwella*

"Doctors pour drugs of which they know little, to cure diseases of which they know less, into patients of whom they know nothing." - Voltaire

Times changing for the better? Medical students in Colombo now hold weekly meetings to discuss rational prescribing and drug use

When I first came across this saying, ten to fifteen years ago, I thought the great reformer must have been a very incorrigible man. But then, with the passage of time, I began to see through the humour that lies on the surface to see the ironical truth that lies beneath. Of course, doctors are not the only people who are responsible for the present situation regarding the unscientific and hazardous use of drugs.

In today's society, you need not get in touch with WHO, or for that matter with anyone else, to realise the enormity that are being committed at every level in the field, sometimes unknowingly, sometimes not. In fact it was one of the doctors in my hometown (whom I still honour a lot for every good thing he has done for me since my childhood) who taught me the first lesson. One day he prescribed a drug. To my horror, I found it extremely expensive and hence bought two days dosage only. When I returned to the pharmacy to buy the rest after two days, I inquired about it and found it was a fancy preparation of erythromycin. That was the beginning.

A few months after that incident I saw a pharmacist writing "B COMPLEX" on a cover which contained a very large amount of something totally different. I thought that he was mistaken and inquired. He said the particular medicine was something that should not be issued without a prescription so he was writing the wrong name purposely. It was prednisolone he was giving to a teenager who didn't have a prescription. I headed back home wondering what would happen if someone took that drug thinking it to be B complex. Now that I know the drug, I know that something beyond the wildest of my imaginations may have happened. That pharmacist is a highly qualified one and he is much honoured for his gentle manners. As Mark Anthony said about Brutus "He is an honourable man".

Then there is my aunt who swallows a plethora of drugs every day for apparently no reason at all. How can I teach the dear old lady about the rational use of drugs when the person who prescribes those drugs has got two post-graduate qualifications that I could never dream of having? This doctor has the highest qualifications, invaluable experience and a very good reputation, whereas I have nothing of the sort. And for that prestige, one consultation with him costs her Rs.500 – and she comes home holding a handbag full of drugs, gleaming with joy. For her there are four basic human needs – food, shelter, clothing and DRUGS.

Some of the most important of my observations were made in the wards. I can still recall how a relative of mine who was taken into hospital suffering from severe diarrhoea was inexplicably given chlordiazepoxide. Clearly he had no need for it and the house officer who prescribed it fell prey to our inquisitive questions. "It's the boss's favourite" he explained. So an inexplicable treatment had an even more inexplicable cause. In spite of the polypharmacy (or perhaps because of it) my relative's condition got worse and he got himself discharged and entered a nursing home. There again he was inundated in a sea of drugs. But luckily this time he recovered (the disease may perhaps have been self-limiting).

These observations have played a crucial role in opening the doors of a new dimension of health care for me. Yet the question arises, when a lay person can get sensitised about this "disease" so easily, why not the doctors? Why is it that only a handful of doctors, mostly academics (and a very few number of clinicians), are talking about the rational use of drugs.

Perhaps these are the questions that have never been answered and will never be answered satisfactorily. After all, asking questions is the doctor's job – not the patient's, isn't it?  

Source: New Initiatives for Rationalization of Drugs & Health Actions (NIRODA), Sri Lanka.

*M. Sanjeewa Ranwella is Chairman of Students Involved in Rational Health Activities (SIHRA), Faculty of Medicine, University of Colombo, P.O. Box 271, Colombo, Sri Lanka.

The problem of irrational prescribing is certainly not confined to developing countries, as the following article by a British general practitioner illustrates.

Medication review

T. Greenhalgh*

He wants what? Stemetil, co-proxamol, quintine, enalapril, Fluimil, Slow-K, two strengths of digoxin, ranitidine, lactulose, emulsifying bath oil, aqueous cream, hydrocortisone ointment, cefadroxil, allopurinol, and multivitamins, all for 60 days each, plus eye drops, ear drops and two pairs of elastic stockings. Sorry, I’m not signing this. I don’t mind doing locums for friends, but this chap needs to see his own doctor. "But that’s what he always gets, doctor, and he’s very good; he always sends a stamped addressed envelope..." When I visited the patient he was surprised to see me. The practice receptionist had recently advised him not to stop taking anything at his age. I asked him to talk me through his medication. He correctly identified the blood pressure and heart pills, and explained that the diuretics pills (prescribed by a casualty officer) were to prevent him fainting when he stood up. He took a white digoxin every day, and a blue one on alternate days ("That’s why I always have blue ones left over"). The various skin preparations had been suggested by the district nurse for his varicose eczema, which was now better. His indigestion had disappeared years ago (in fact he had no pain anywhere), but he took the occasional stomach pill to keep it at bay. He handed back several unopened packages, saying that when he requested only selected items from his repeat medication card they always sent him the wrong ones. The elastic stockings were for his wife.

You can guess the rest. The cost of the patient’s repeat prescription was £112 (£1 is approximately $1.60 plus dispensing fees. The three items he really needed (after adjusting the dose but without generic substitution) cost £6.50, and I put £76 worth of unused medicines in the boot of my car. The savings don’t stop there. If his paracetamol gets better he may no longer need ambulance support every time he goes to see the cardiologist, and if his general wellbeing improves his doctor may get away with seeing him less than nine times a year.

When I left the patient, I did three more visits – all unexciting but unavoidable call outs to households and elderly patients. Back at the surgery, drained of enthusiasm, I signed 30 or so repeat prescriptions without reference to the notes. By that time I was acceding to anything that was not blatantly dangerous. I know my friends work hard, draw a modest salary, and easily outshines the national average for overall prescribing costs. I also know that anyone even one step removed from the coal face of a busy general practice will argue that regular review of patients’ medications is a contractual duty not an optional extra. But I live in the real world. To the government who brought us anything goes health promotion clinics and indiscriminate mass urine analysis, I have this to say: If you are seriously interested in getting a return on your investment, put the money on the table for regular medication review clinics.


*T. Greenhalgh is a general practitioner in London.
RATIONAL USE

South America: how to stop misuse of psychotropic drugs?

In South America inappropriate use and abuse of psychotropic drugs for therapeutic purposes are widespread, particularly among older women. A 1992 survey of the consumption of minor tranquilizers in the city of Montevideo illustrates the scale of the problem. It found that 49% of the population covered by the survey had taken tranquilizers at least once in their lives and 21% had done so in the last 30 days. A WHO/PHLO Working Group on the Rational Use of Psychotropic Drugs in the Southern Cone met in Montevideo in October 1993 to discuss this problem. Legislation, medical and public education, research and pharmaceutical industry promotion were among the issues debated by doctors, legislators, drug inspectors, health administrators and representatives of the media.

The importance of legislation

Participants discussed the vital role of legislation in controlling psychotropic drug use by providing the legal framework that underlies health structures. It was agreed that specific provisions should include laws on the production, import, export, distribution and use of psychotropic drugs. Another recommendation was that drug regulatory bodies should be strengthened and given the necessary authority to be effective. Legislators currently lack up-to-date and reliable information to guide them in the formulation of policies, said participants.

Improving prescribing practices

Prescribing is often inappropriate, reflecting not only the limitations of current policies and drug control systems but also inadequate training received by general practitioners, primary health physicians and specialists. Inadequate access to specialist literature and its cost exacerbate the problem. As does the fact that most technical information reaching professionals is supplied by the pharmaceutical industry, and may therefore be biased.

To address these problems members of the Working Group recommended a revision of the undergraduate curriculum, updating of specialist education programmes and the introduction of continuing education courses on the use of psychotropic drugs. They called for the inclusion of essential psychotropic drugs on national drug lists. A national technical information service should be established in each country to provide details of pharmacological advances and observations in the field of psychoactive drugs. Epidemiological studies on psychoactive drugs, research on their use, prescribing patterns, costs and risk factors would also help prescribers. Another approach would be to establish surveillance committees at all centres dispensing services, to analyse the prescription of psychotropic drugs in practice and introduce corrective measures when necessary. Participants also advocated scrutinising the information supplied by the pharmaceutical industry to ensure its accuracy and reliability.

Another discussion centred on many doctors’ ignorance of the important ethical considerations involved in prescribing psychoactive drugs, particularly with regard to informed patient consent. Those at the meeting urged that this should be guaranteed as a right and that hospital ethics committees should monitor that patients are fully informed.

The role of communication

It is not only those who are currently prescribing psychoactive drugs who need information. Communication plays an essential part in preventing disease and promoting health, and in relation to psychotropic drugs it can be an effective instrument for making members of the community into informed users. Participants heard that in South America, however, information given to the public is often limited and distorted, with health educators frequently lacking access to sources. This makes it difficult for them to transmit credible and effective messages to the public. Members of the Working Group urged that consumers receive adequate information on the drugs they are given. They also advocated greater collaboration with the media to give them the necessary support in educating the public on psychotropic drugs.

Psychoactive drugs are a legitimate form of therapy but their inappropriate use constitutes a risk for health both in developed and developing countries. The implementation of recommendations from the Montevideo meeting would be one step in tackling this serious public health problem in South America.

A report of the meeting, The Working Group on the Rational Use of Psychotropic Drugs in the Countries of the Southern Cone, Montevideo, 12-15 October 1993 (mimeographed document), is available in Spanish from the Pan American Health Organization, Pan American Sanitary Bureau, 525 Twenty-third Street, N.W., Washington D.C. 20037, USA.

Reference


PUBLISHED LATESTLY


Financial constraints mean that there is a constant shortage of drugs at Nepal’s health posts. The annual consignment they receive often lasts less than six months, so for most of the year people are forced to turn to the private sector. This consists of drug shops, traditional healers, spiritual practitioners and astrologers. Given the limited availability of public health care services, self-medication is common in Nepal. The aim of the research study reported here was not to obtain information about various methods of self-care and medication from both consumers and providers, but more importantly to identify and evaluate intervention strategies which could improve the health of the communities studied. Having collected information on the use of beneficial and harmless medications in self-care, training was designed to discourage the use of unnecessary and harmful drugs and to reduce the part of the intervention strategy was to try to incorporate key primary health care elements into the self-care system, such as oral rehydration therapy, immunization, sanitation and hygiene, improved nutrition, family planning, and first aid. Finally, the project explored the options for community participation and community supervision in the self-care system.

The project was divided into two ten-month phases. The first was devoted to gathering information on self-care patterns and providers in the selected area (chosen for its ethnic and sociocultural mix and urban/rural split). The second consisted of educational interventions, one for consumers and one for health providers in the private sector. Subsequent evaluations of the effectiveness of the interventions took place after two and six months. Results were mixed. The training of providers proved to be effective in improving preventive and curative practices in the community, while the work with consumers was less successful. In part this is attributed to an overemphasis on written material rather than oral and visual messages, (many Nepalese have limited literacy). The researchers suggest that the baseline information collected in this study could be a valuable starting point for future integrated primary health care training schemes in Nepal.

Self-medication and its impact on essential drugs schemes in Nepal

Available in English only, free of charge, from: Action Programme on Essential Drugs, World Health Organization, 1211 Geneva 27, Switzerland.

This guidebook is designed to be used by countries that are considering the introduction of social health insurance financing for health care, as a replacement for or to supplement existing funding. A close look at the range of different systems of health service financing reveals that there are advantages and disadvantages with all financing methods. Nevertheless, depending on a country's specific circumstances, some methods may be more appropriate than others.

The guidebook focuses on one particular health financing approach - social health insurance. It aims to lead policy makers and programme planners through the process of evaluating the usefulness and feasibility of social health insurance, in the context of existing political, sociocultural and economic circumstances. It also provides detailed planning advice for the design of a social health insurance system, and it offers insight into the process of improving the chances for a successful implementation. As a planning tool, this guidebook will be useful in all countries where alternative health financing mechanisms are contemplated.

Social health insurance can only be successfully introduced if the conditions are suitable. It must make a contribution to the achievement of health policy objectives, notably the improvement of health status, and it must serve to improve both funding for health services and access to care for the population. Social health insurance must clearly be viewed as a policy tool, rather than an end in itself. This means that the goals of health policy must be clear, so that the new funding arrangements can be seen to help to meet them. Accordingly, the guidebook reviews the importance of health policy objectives and considers the constraints on achieving these objectives.

If social health insurance is introduced into a country without careful consideration of the objectives and without proper preparation, it will fail. Efforts and resources will be wasted, and it may be more difficult or even impossible to introduce the system successfully at a later stage. The guidebook thus focuses on determining if social health insurance is desirable, in the context of health policy objectives, and feasible, in the context of existing constraints. It also provides guidance for countries that need to lay the groundwork for the eventual introduction of social health insurance.

If a decision is taken to proceed with the introduction of social health insurance, the next step is the detailed design of the system. This decision must be made in the context of the population to be covered, how access to health services is to be organized, how services are to be paid for, how providers are to be paid, how costs are to be controlled and how the system should be managed. These are important and time-consuming tasks, and require attention at an early stage.

Finally, the guidebook looks at experiences with social health insurance in several countries. The country examples provide insight into how varying circumstances can lead to the development of alternative forms of social health insurance financing. The book also reviews the important issue of ensuring that social health insurance will be acceptable to those who will use it. Advice is provided on how to build consensus and support for the new system.


This report reviews the results of the Hypertension Management Audit Project, a large research project designed to assess the extent to which hypertension is adequately controlled and managed in different communities. Carried out in seven European countries, the study aimed to identify weaknesses in the detection and management of hypertension and to examine the development of more effective public health policies. Factors assessed included awareness of hypertension in the general population, management of hypertensive patients, and their satisfaction with the prescribed therapy. The project also assessed the extent to which patients had achieved normal blood pressure levels, the drugs most frequently prescribed by physicians and the sources of information that influence physician prescribing. The study gave particular attention to the importance of doctors' attitudes and practices, especially concerning non drug treatment and the management of risk factors.

The first part of the book describes the design, protocol and objectives of the study and discusses its major findings. The second and most extensive part consists of 14 reports of country projects, ranging from a survey of employees at a chemical plant in Hungary, to a study of the discrepancies between attitudes and self-reported behaviour among physicians in Germany. The final chapter of the research project is reproduced in an annex.


A comprehensive guide to the rational and safe prescribing of antimicrobials in the treatment and prevention of bacterial infections. Particular emphasis is given to the management of infections commonly found in Eastern Mediterranean countries. The guide responds to the urgent need to prevent the misuse of antibiotics, protect against the emergence of resistant bacterial strains and reduce the waste of resources spent on useless treatments. Both bacterial species and the specifics of good prescribing practice are covered in detail.

The first section explains the general principles of safe and effective antimicrobial therapy, emphasising the many factors that need to be considered when selecting drugs, doses and modes of administration. Information ranges from an outline of factors responsible for the failure of antimicrobial therapy, advice on the treatment of infections in the compromised host and the simple reminder that frequent use of antimicrobial combinations points to imprecise diagnosis. There is also a tabular presentation of 19 antimicrobials which have adverse effects, the precautions to be followed and contraindications. The major part of the manual, provides precise prescribing guidelines for the management of bacterial infections. For each infection, information includes relevant diagnostic advice, the most likely causative organisms listed in order of priority, the first choice drug or combination plus alternatives, advice on dosage, method of administration and duration of therapy. Cases where antibiotics are useless or contraindicated are clearly stated and details are given of the general properties and most appropriate uses of eight general categories of first choice drugs.

The publication outlines essential information about the properties, advantages and limitations of topical preparations for use as disinfectants, antiseptics, cleaning agents and antibiotics. Also included are indications for chemotherapy to prevent wound infection and sepsis in surgery, to prevent selected infections and to prevent bacterial endocarditis. The concluding chapter sets out dosage ranges - for adults, children, neonates and patients with renal impairment - for 25 commonly used antimicrobials.


A practical step-by-step guide to the clinical management of infections and other symptoms commonly seen in children with HIV infection. Responding to the need for a clear and practical bedside reference, it sets out the information needed to facilitate a provisional or definitive diagnosis, appropriate treatment and suitable resource planning. Focussed on common symptoms and diseases, the manual makes use of "decision maps" or flow chart algorithms that guide readers from the recognition of a clinical state, through a decision, to the appropriate therapeutic or diagnostic action at three different levels of care; facilities with no laboratory or X-ray service; small hospitals; and fully equipped major hospitals. Throughout, emphasis is placed on measures that can decrease suffering and prolong life. The information ranges from precise guidelines on appropriate drugs and therapeutic regimens, and advice on what to do when no improvement is observed, to the simple reminder that the possibility of tuberculosis should always be considered in an HIV infected child. The first part of the manual provides basic information on the recognition of symptoms. "HIV infection in facilities with no laboratory or X-ray service" describes the various tests available or under investigation for obtaining laboratory evidence of infection. Subsequent chapters set out guidelines for the diagnosis and management of seven common clinical conditions: persistent diarrhea, oral thrush, respiratory conditions, including pneumonia, and tuberculosis, neurological abnormalities, persistent or recurrent fever, failure to thrive and HIV associated skin diseases. Advice is given on the counselling of infected children and their families and the follow up of infected or symptomatic children, including nutritional, physical and laboratory examinations, drug therapies and immunizations.


A well-illustrated guide to the many simple things that can be done in the home to care for people with AIDS. Intended for health care workers, the handbook sets out the essential information and advice needed to help individuals, families and communities manage AIDS-related problems and build confidence in their ability to provide safe and compassionate AIDS care at home. Information in the handbook draws on accepted international guidelines as well as the extensive experience of many individuals and agencies.

Innovative in both its format and its lively approach to teaching, the book uses simple text supported by numerous drawings, stories, lists of rules and points to remember, in order to facilitate understanding of its simple yet vital messages. Information ranges from Ready Reference for Preventing HIV Transmission in the Home and an Explanation of Typical Emotional Reactions to AIDS, to examples of pictures that can be used to help people to remember when to take their medicine.

Chapters in the first part of the book cover the essential information and skills needed to teach people about AIDS. The first chapter explains the importance of teaching and illustrates some of the difficulties commonly encountered and the mistakes frequently made when trying to communicate information about AIDS. Much of the additional information content around a story, illustrated with drawings and accompanied by teaching notes, about how HIV and AIDS affected the lives of a woman and the people around her. Told in three episodes, the story communicates essential facts about HIV and AIDS, encourages people to live positively with AIDS, and helps families know how to care for the dying and cope with death. To facilitate the use of this story for teaching purposes, the accompanying pictures are reproduced at the back of the book in an enlarged format.

The second part of the book, which serves as a reference guide on the essentials of home care, opens with a detailed guide to the home management of the 12 most common symptoms of AIDS, moving from fever, skin problems, nausea and vomit to pain, tiredness, mental confusion and dementia. Each symptom is covered in a similar format, giving clear information on problems and possible causes, what can be done at home, and when to seek help. Emphasis is placed on the use of simple medicines and medicines that can ease suffering and help people with AIDS remain comfortable in their homes. Home care in the special cases of tuberculosis and pregnancy is covered in a separate chapter. The book concludes with a general guide to the appropriate and safe use of 27 common medicines using relevant therapeutic guidelines. Health care workers are also alerted to dangerous medicines and to the signs and symptoms of serious side effects.

Available from: World Health Organization, Distribution and Sales, 1211 Geneva 27, Switzerland. Price: Frs.10.00 or US$10.00 and in developing countries SFr.6.30.


This report of research into problems associated with the export of drugs from the Netherlands to developing countries attempts to answer three central questions: which “problem drugs” are supplied by Dutch companies or under licence to them, on what scale are they supplied, and to what extent are the product information and registration requirements for these drugs satisfied in the Netherlands?

A pharmacological evaluation of 161 Dutch drugs obtained in pharmacies in seven developing countries formed the main part of the study. The evaluation was based on the principle that drugs for export should be safe and effective and that product information should not differ in pharmacological content from the Dutch product information. Forty two percent of the drugs tested were classed as problem drugs according to the criteria used and product information was lacking in one third of the drugs sampled. The available data show that a relatively high number of drugs that are produced under licence have lost their market in the Netherlands, where they do not qualify for registration in the Netherlands. The authors conclude that the current system of voluntary codes and guidelines, with limited legislation in exporting countries and limited capability to regulate importation in the recipient countries, is functioning inadequately.

The book includes numerous recommendations. It calls on the Netherlands to support developing countries in their attempts to introduce measures for drug quality assurance as part of an integrated national drug policy. The authors also urge the Netherlands to act in the international arena, where drug legislation and guidelines are formulated. At the United Nations this should include trying to strengthen the WHO Certification Scheme, while in the European Union (EU), the Netherlands should address the issue of compliance with relevant EU guidelines and increased harmonisation of national’s export legislation. Within the Netherlands, the authors propose that the Dutch authorities and the pharmaceutical industry set up a joint monitoring system to ensure full implementation of the existing voluntary codes and guidelines. This includes improved observation of the International Federation of Pharmaceutical Manufacturers Association code, the authors state.

Available from: Professor Flora Haaijer-Ruskamp, Northwestern University, Department of Pharmacology, University of Groningen, Ant. Deesingarns, 7, 9713 AV Groningen, the Netherlands. Price: Dfl.10 for postage and packing.


The author’s experience as an economist interested in health issues and also as former Director General of Pharmacy at the Spanish Ministry of Health and Consumption brings a dual perspective to this publication. The first two chapters are concerned with health policy and administrative issues relating to medicines. These include the implementation of financial controls and the development of the concept of national drug policies by WHO. The book also describes how actions by the European Union in the pharmaceuticals field have affected Spain. It goes on to look at public expenditure on drugs in that country and concludes with an analysis of industrial economics. This wide ranging book should prove a useful reference for economists, educators, health policy makers and administrators and those in the pharmaceutical industry.

Available in Spanish only from: Masson SA, Balanza 151, 08089 Barcelona, Spain.

SELECTED ANNOTATED BIBLIOGRAPHY ON ESSENTIAL DRUGS

FELIX LOBO

MEDICAMENTOS POLÍTICA Y ECONOMÍA

Available from World Health Organization, Distribution and Sales, 1211 Geneva 27, Switzerland. Price: SFr.31.00 or US$22.90, in developing countries SFr.21.70.

An authoritative guide to the many changes needed at national and local levels, in order to implement the new global strategy for malaria control, a plan of action adopted at a Ministerial Conference in 1992 (see EGM 65). The strategy calls for a fundamental change in the way the disease is tackled. The report helps planners redefine priorities, think through the various options for control, recognise when resources are either wisely invested or wasted, and adjust programmes accordingly.

The publication describes the many complex factors that have contributed to the deteriorating malaria situation and explains why and how the new control strategy was developed. It offers advice on the development of a national policy for disease management and describes practical measures that can help programmes meet the urgent need for rapid diagnosis and effective treatment.

Available from: World Health Organization, Distribution and Sales, 1211 Geneva 27, Switzerland. Price: CHF 100.00/$89 and in developing countries SwFr 7.


There is increasing recognition of the importance of health economics in the formulation and implementation of health policies worldwide and in 1993 WHO’s Task Force on Health Economics was established. This aims not only to strengthen the technical content of WHO programmes so that they can better adapt the tools of health economics to country needs, but also to foster cooperation among development agencies in applying health economics at country level. As an initial step the Task Force is preparing a series of documents, the first of which is a bibliography of relevant literature. This includes a large selection of publications, documents, and articles related to health economics produced by WHO headquarters and regional offices since 1985 (1987 in the case of articles), with occasional reference to earlier material of special interest. Sections include: macro-economic and health; health care financing; economic evaluation; WHO programme areas; training; and country case studies. The final section informs readers how to obtain the material included in the bibliography.


An abstracted bibliography has also been prepared by the WHO Task Force on Health Economics, Health Economics: a Guide to Selected Literature, WHO/TFHE/94/1 will be available early next year.


This publication reports on two WHO meetings, one held in New Delhi in 1988 and the other in Tokyo in 1993, which examined the role of pharmacists and made recommendations on how to optimise their role in health care systems. The Delhi consultative group meeting considered the scope and functions of pharmacy, whereas in Japan the focus was on the responsibilities of the pharmacist to the health care needs of the patient and the community. Pharmacists were urged to be proactive in promoting the provision of pharmaceutical care. At both meetings the view was strongly expressed that the profession can only be an efficiently organized element of health systems when it is represented at senior level in national administrations. Pharmacists need to be involved in the formulation of drug policy, including drug regulation, the development of guidelines and criteria for formularies and the design and monitoring of procurement and distribution systems. They should participate in public education and health promotion campaigns. Participants at the meetings also drew up proposals to improve the undergraduate, postgraduate and continuing education of pharmacists and support staff training.

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

Update on new formularies and essential drugs lists

The Action Programme on Essential Drugs produces a global index of drug formularies, therapeutic guidelines and essential drugs lists, which is available free of charge. (We are unable to supply copies of the publications themselves). Future editions of the Monitor will update readers on the index. Some recent additions are:

- Cameroon’s Essential Drug Information Sheets and Diagnostic and Treatment Guide, which contains diagnostic flowcharts for all common morbidity, cross referenced with treatment guidelines.
- Madagascar’s Therapeutic Manual (In French), a treatment guide to common illnesses in Madagascar incorporating the National Essential Drugs List.
- Zanzibar’s Essential Drugs List, classified by therapeutic category, with a key for 3 health care levels.
- Pakistan’s National Essential Drugs List which contains 471 drugs listed by generic name.
- South Africa’s Primary Health Care Formulary which includes drugs listed with indications, dosage, side effects, drug interactions and information for patients. Emergency protocols and advice on storage and stock rotation are also given.
Devaluation of the CFA franc – repercussions for the pharmaceutical sector

On 12 January 1994 the Communauté financière d’Afrique (CFA) franc was devalued by 50% against the French franc, the currency to which it has been linked since 1948. This devaluation affected more than 80 million people in 14 countries – nine of them among the world’s least developed*. The impact of the devaluation has been serious. In the health sector drug supply, which is dependent upon imports, has been particularly hard hit. Unless measures are introduced urgently the situation in the pharmaceutical sector is potentially disastrous.

The environment...

The pharmaceutical sector in the CFA countries is characterised by:

- A small market: the total pharmaceutical consumption of the CFA zone represents approximately 0.2% of the global consumption; this means US$400 million for a population estimated at 80 million in 1990.
- The predominance of drug imports: 90% of pharmaceutical products are imported. When taking into account raw materials for production, this rises to 95%.
- A weak public sector: drug consumption in the public sector represents 5 to 20% of the market depending on the country (around US$20 million). This sector has been strongly affected by the economic crisis, structural adjustment policies and the subsequent decrease in the public budget. However, at the end of the 1980s, with the support of the main international development agencies, a number of countries put in place some elements of an essential drugs policy; lists of essential drugs were formulated everywhere and new mechanisms for purchasing drugs at low cost were established in countries such as Benin and Côte d’Ivoire. This was generally linked to the introduction of user fees in the health services. Nevertheless, the public sector is far from meeting all drug needs and is hampered by lack of financial resources, inadequately trained personnel, poor management and limited planning capacities.
- A large private sector: the private sector has expanded during the 1980s. The growth of this sector is often uncontrolled and has led to high retail prices, concentration of the distribution network in the main towns, a shift to less essential drugs with a higher profit margin and a predominance of expensive drugs under brand names.
- An increasing illegal market in some of the countries of the zone coupled with weak drug regulatory authorities.
- Badly informed prescribers and consumers: objective therapeutic information is very short supply and education campaigns for the public are rare. All this means that, even before the devaluation, the availability and accessibility of essential drugs were limited, and the use of the wide range of drugs marketed in the zone largely irrational.

The consequences of devaluation...

The immediate risk was that a large part of the population would be left without drugs, with access to health care or drugs. Without government intervention, the devaluation would lead to a doubling of drug prices in the public and private sectors. In the private sector, this would result in a decrease in demand for drugs, as prices would be too high for patients’ reach. In the public sector the demand for drugs and health care would probably increase. In countries where patients pay for drugs, the poor would not be able to afford them anymore, even if prices are much cheaper than in the private sector. In countries where drugs are free, there would be shortages as no additional budget is available.

The measures proposed...

Immediately after the devaluation, the main actors in the pharmaceutical sector at national and global level tried to formulate measures to prevent people being without access to drugs. The first meeting of donors and international agencies took place in Paris in February 1994, organised by the World Bank. It defined a number of principles for interventions and financial support to the governments concerned. It reaffirmed the need to rationalise drug supply in the public sector on the basis of the essential drugs concept; to favour the introduction of generic drugs in the private sector through innovative pricing policies; and to strengthen drug regulatory authorities. In March 1994, the Ministers of Health of the 14 countries met in Abidjan and agreed on a number of mid-term measures to decrease the negative impact of the devaluation on the pharmaceutical sector. These included mandatory use of essential drugs lists, procurement of generic drugs in the public sector; generic substitution; changes in the pricing mechanisms; use of international procurement; easier registration procedures for generic products in the private sector; and information campaigns on essential drugs and the generics issue for prescribers and the public.

The reality...

Most of the governments took measures to block drug prices in the public and private sectors immediately after the devaluation. These measures were made possible in the public sector by subsidies from major donors. Unfortunately not all countries were able to get support from the international community. In some cases drug prices increased by 30% to 50% (Niger, Cameroon). In others, when drugs were free to the patient, shortages increased. In the private sector, wholesalers and pharmacists agreed to reduce their margins, although the decrease was not identical in all the countries. Even with such measures, a study carried out in March 1994 by the WHO Action Programme on Essential Drugs on a basket of 10 essential drugs shows an increase in drug prices from 46% in Côte d’Ivoire to 50% in Cameroon, 62% in Central African Republic and 66% in Togo. Other measures taken by governments include: a decrease in customs duties (in Mali, they went down from 22% to 6% for drugs under brand names; drugs under their International Nonproprietary Name [INN] are exempted); the right to substitute brand name drugs by generic products (Burkina Faso); the right for private pharmacists to sell drugs from bulk procurement (Senegal); regulations to facilitate the registration of generic drugs (Côte d’Ivoire); and new methods of fixing prices for generic products which allow a fair profit to wholesalers and pharmacists (Central African Republic).

The future...

Devaluation has caused consternation and many problems. However, these have been partially offset by some benefits. It has pushed governments to take measures to ensure a limited availability of essential drugs. It has shown that the only feasible strategy is to increase rationalisation of the drug sector through the essential drugs concept and to introduce products under INN. Yet although such strategies will contrib- ute to more rational long-term pharmaceutical policies, in most countries the situation today is worse than before the devaluation. For example, from anecdotal reports it seems that in Côte d’Ivoire, the price of drugs in the private sector has increased by 60% and sales have decreased. This shows clearly that the volume of drugs sold has diminished and that people have less access to drugs than before January 1994. Much more needs to be done to enable people to treat even the most common and life threatening diseases. The coming months will show if governments and the international community are courageous and innovative enough to address the problems caused by devaluation. The challenge facing them goes beyond the issue of drug supply, as drug availability cannot be separated from the broader, fundamental issue of health financing in the least developed countries.

* Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d’Ivoire, Equatorial Guinea, Gabon, Mali, Niger, Senegal and Togo

Reference