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Health for all now

HAI News presents the happenings in the international campaign for more rational and fairer health policies. The organ of Health Action International, an informal network of non-governmental organisations and individuals committed to strive for 'health for all now', this newsletter also carries material supportive of the participants' work.

Essential Drugs in Developing Countries

by Andrew Herxheimer*

Olle Hansson

I feel very honoured to be giving this lecture in memory of my friend Olle Hansson. His close and deep involvement in the subacute myeloptic neuropathy (SMON) epidemic in Japan, which turned out to be caused by the drug clioquinol, made him a pioneer in helping people injured by drugs to get compensation and a leader in efforts to prevent such tragedies. It was a surprising second career which grew out of his work as a paediatric neurologist, and in his book CIBA-GEIGY BAKOM FASADEN – Inside Ciba-Geigy – he describes how that happened. I first met Olle Hansson in 1976, when he visited me in London. There were no polite preliminaries: he angrily asked why I had done nothing about clioquinol. When I said that I had written an unsigned editorial about it for the Lancet we became friends.

I want to begin by saying something about SMON, because some of you will not know how it is connected with the issues of essential drugs that are the subject for the evening.

SMON

SMON is a serious neurological disease which leads to paralysis and blindness. It affected over 10,000 people in Japan and several hundred in other countries around the world, and it took many years to prove conclusively that it was due to the antidiarrhoeal drug clioquinol, and many more years for the victims in Japan and elsewhere to obtain compensation. In parallel with this huge effort to help the victims went an international campaign to get clioquinol and closely related drugs banned and withdrawn. Eventually, in 1985, a few months before Olle Hansson died, Ciba-Geigy (CG), the main manufacturer of clioquinol, withdrew its drug worldwide. But until this day the drug continues to be sold in many developing countries; some local manufacturers in Indonesia have even faked CG's brand. Now you will understand how Olle Hansson during the work with SMON became very aware of the problems of drugs in developing countries.

Availability of essential drugs

For a start I should explain what essential drugs (ED) are. The idea is simple: they are those that satisfy the health care needs of the majority of the population.

Of the 5 billion people in the world, between 1.3 and 2.5 billion have little or no regular access to essential drugs. That is the enormous problem which the World Health Organization, Drug Action Programme (WHO DAP) has been addressing. You can see that it is a very positive programme to bring help to at least a quarter of the world's people.

But the lack of essential drugs is only half of the drug problem. The other half is the oversupply or flood of inappropriate drugs – inappropriate because they are ineffective, dangerous or just too expensive. These drugs are sold with great commercial energy and drive throughout the world wherever they can be sold. Clioquinol was and still is one of them, but there are thousands.

WHO, voluntary agencies and essential drugs

WHO has not been able to tackle this half of the

* an edited version of a lecture given in memory of Olle Hansson to medical students in Gothenburg, Sweden, given by Dr Andrew Herxheimer, editor, Drugs & Therapeutics Bulletin, UK.

problem, because it would involve major political difficulties. Let me explain them very simply. The policy of WHO is determined by the World Health Assembly (WHA), which consists of the delegates of all the member states. There are at present, over 150 member states. The funds of WHO come predominantly from the richer member states: the US, West European countries, Japan. These are also the most important drug exporting countries, and their delegations are much influenced by the pharmaceutical industry. If WHO showed any intention of developing a programme to eliminate inappropriate drugs, its funding would be very seriously threatened. This seems to have happened a few years ago, and one result was the appointment of the present Director-General, Dr Nakajima, who has a more sympathetic and understanding attitude to the industry than his predecessor, Dr Mahler.

So because WHO could not attack the problem, it was left to voluntary groups to make a start. Health Action International (HAI) was a coalition of several such groups, a network founded in 1981. The founding organisations included IOCU, BUKO, Oxfam, and Social Audit, and soon many others joined. Now there are HAI groups in all continents, and in many individual countries. I am happy to say that HAI-Sweden is prominent among them. For the last 9 years HAI has campaigned against the sale of useless or dangerous products, against unfair pricing policies, the provision of irrelevant and inappropriate drugs, especially in the third world, and companies' provision of inadequate and often misleading information to doctors and regulatory authorities. However in the last 5 years, HAI has also been working for the safe, economic and rational use of drugs, especially in developing countries, and does much to work together with WHO in its Essential Drug Policy and Primary Health Care (PHC) programme. This closer collaboration came about in an interesting way. I mentioned the difficult position of WHO in relation to the pharmaceutical industry on the one hand and its critics on the other. By the end of 1984 these quarrels were seriously affecting the work of WHO. WHO cleverly managed to lower the temperature by organising a conference on the Rational Use of Drugs in Nairobi at the end of 1985, at which both the industry, the critics – including HAI – and governments were represented. That was the foundation for WHO's revised drug strategy which was adopted the following year. I should add that HAI groups are not the only NGOs that have been cooperating with and supplementing the drug action programme. There are many others; some of these are listed on the back page.

At first almost everyone thought that all that was necessary was to identify the essential drugs, and then the problem would be halfway solved. That was a wild over-simplication, but it is true that the EDs must be selected first.

Selection of essential drugs

Their choice depends on:

- the pattern of prevalent diseases;
- the treatment facilities;
- the training and experience of the available personnel;
- the financial resources;
- the genetic, demographic and environmental factors.

Only those drugs are included for which there is sound and adequate data on efficacy and safety from clinical studies.

WHO produced a model list to demonstrate how the

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HAI news is produced 6 times a year by the Regional Office for Asia and the Pacific of the International Organization of Consumers Unions (IOCU) to support the work of Health Action International (HAI). HAI is an informal cooperating network of consumer, development action and other public interest groups worldwide. It works to further the safe, rational and economic use of pharmaceuticals throughout the world, to promote the full implementation of the World Health Organization's Action Programme on Essential Drugs and to look for non-drug solutions to the problems created by impure water and poor sanitation and nutrition. HAI News is a means of communication within the network.

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choices could be made, but it took a long time for countries to work out their own lists in the same way. There are two things that are difficult: to make the best choices, and to convince the professionals, especially the most senior and influential doctors, who have over many years gotten used to having their own way, that the choices are acceptable. That may need a lot of diplomacy.

When it became clear that an essential drug list was not a magic solution, people discovered more and more ingredients that were necessary for an essential drug policy to work. I am going to go through these quite briefly, to give you an overview of the complexity of the task.

National drug policy

i) Drug legislation
First, because inappropriate drugs get in the way of essential drugs, there needs to be a national drug policy, backed by a law. For example, drugs must be registered, and be approved for use in the country. The government must have the power to control the import, manufacture, distribution and promotion of drugs. We take that for granted in Europe. When there is such a framework of policy and law, the essential drugs can fit into it; without it they are swamped and easily get lost.

ii) Estimation of requirements and procurement
Then, when the essential drug list has been decided, the needs for the individual drugs have to be quantified. That usually requires data which no one has, so estimates have to be made. The next step is to obtain the right drugs in the quantities needed and to find good quality at a reasonable price. Sound procurement is not easy. It needs knowledge, good information and experience. As in daily life, the poor usually have to pay more for their necessities than the well off – who are better educated and have more choices of where to buy. It's the same with countries. For example, some are forced to buy dearer products from their only provider of credit.

iii) Storage, distribution and quality assurance
When the drugs have been bought they must be stored and distributed. That is often very difficult in a large, poor, thinly populated hot country, where motor vehicles and petrol are hard to get. The quality of the drugs must be monitored and assured at all stages until they reach the final user. First when they are bought, then when they arrive in the country, then during storage and finally when they arrive in the periphery. That requires laboratories and trained skilled people.

iv) Drug information
Information must be provided about the proper use of the drugs: to doctors, nurses, pharmacists, drug sellers, village health workers, patients. It is often needed in several languages, and must also be provided to illiterate people.

Training of health workers is often required on a large scale. Education of the public has hardly begun to be thought about. Efforts must be made to understand patients' beliefs and attitudes and traditions.

v) Pharmaco-epidemiology
Monitoring of the extent and appropriateness of drug use and of adverse reactions must be organised to ensure that the system is functioning as intended and to detect and identify problems. But pharmacoepidemiology is a new science, so far developed in only a few Western countries. Recently there have been initiatives especially from the Nordic countries and Italy to train people in pharmacoepidemiology, initially in Africa. All this takes a long time to develop and to integrate.

A point I want to emphasise is that rational use of drugs is a necessity in all countries, and we must work towards it together. It's not a case of us in advanced countries teaching the poor deprived people in the South how to manage their drugs.

We can learn a lot from each other. Many of the problems exist in the North and the South, but whereas the North has resources to improve matters, the South has not.

In conclusion I suggest you look around and see where you can apply the basic essential drug concept in your own working environment. An obvious example is the development of district formularies and standard treatment policies for common conditions.

Olle Hansson Day is celebrated on May 23.

The Olle Hansson Award named in his memory is given annually to recognise the work of a Third World individual who best demonstrates the qualities of Olle Hansson in promoting the rational use of drugs. Further particulars of this award can be obtained from the Editors, HAI News.

'Inside Ciba-Geigy', a book by Olle Hansson is available from IOCU, PO Box 1045, 10830 Penang, Malaysia.

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