Essential Drugs: A Cornerstone to Refugee Health Care

RUDI CONINX

HISTORY

In his report to the twenty-eighth World Health Assembly in 1975, the Director-General of the organization, Dr Hafdan Mahler, reviewed the main drug problems facing the developing countries and outlined possible new drug policies. Following his statement, the Health Assembly requested him, through resolution WHA 28.66, to implement the proposals contained in his report and, in particular, to advise member states on the selection and procurement, at reasonable cost, of essential drugs of established quality corresponding to their national health needs.

Following wide consultation, an initial list of essential drugs was included in the first report of the Expert Committee on the Selection of Essential Drugs in 1977. This was subsequently revised and updated in four further reports (in 1979, 1983, 1985 and 1988 respectively).

Loyal to its commitment to the Essential Drug Programme, WHO created the 'Action Programme on Essential Drugs and Vaccines' in 1977. This programme focuses, amongst other things, on essential drug availability in primary health care and has become the engine of a world-wide effort to enhance the idea of essential drugs and to make them easily available (Lauridsen, 1984).

At the international conference on Primary Health Care in Alma Ata in 1978, the Essential Drug Programme was recognized as an essential part of primary health care and was included in the 'Declaration of Alma Ata', the principles of which are seen as essential to achieving the goal of 'Health for All in the Year 2000'.

Since then, many countries have chosen to use an essential drug list in their national health programme, for example, Ghana (Hogerzeil, 1986), Bangladesh (Ghulam Mostafa, 1984), Tanzania (Yudkin, 1980), and others.

RATIONALE FOR AN ESSENTIAL DRUG LIST

To a lay person, the bare concept of an essential drug list may seem very strange and potentially doing injustice to a patient. Aren’t all drugs essential? Why would a physician prescribe a drug that is not essential? People familiar with prescribing behaviour in third world countries — and not only there — know that the truth is very different (Greenhalgh, 1987; Harndon and Van de Geest, 1987). Many drugs prescribed are only marginally useful to the patient and often to the patients’ detriment. Many drugs on the market are useless, of unproven value, in illogic combinations or even downright harmful or dangerous. There is considerable pressure from pharmaceutical companies to keep things as they are.
are, often in the name of freedom of choice for the physician and the patient. Developing countries spend a considerable amount of their hard-earned foreign currency importing these drugs (Wang'ombe and Mwabu, 1987).

A closer look at the need for different drugs reveals that many drugs are not necessary, and that their absence will not result in any change in health status. Although it is debatable exactly how many drugs are necessary (Bakke, 1987), there is agreement now that good health care can be ensured with a reduced number of drugs. These are called 'Essential Drugs' and are limited to drugs of proven efficacy and safety, well known therapeutic properties and which are available at low price.

WHO has come up with a list, limited to about 200 different drugs and vaccines, which will permit any health service to provide basic but good health care.

ESSENTIAL DRUGS AND REFUGEE HEALTH CARE

Although the general principles of the essential drug programme apply, characteristics of refugee situations are such that an essential drug programme becomes all the more important. We shall look into the reasons why an essential drug list is not only feasible in refugee situations but essential for a comprehensive health programme.

Refugee health programmes differ from national health programmes in the sense that they are usually geographically limited and involve a limited number of people. Speed is often required and health services have to be set up without existing infrastructure. Efficiency in procurement and logistics of drugs becomes all the more important. Many refugee situations attract a vast spread of different aid agencies from all over the world, usually under the coordination of a United Nations agency or the host government. Without active coordination, the end result is likely to be chaos resulting in inefficient use of resources, the drugs in particular. The WHO Essential Drug List provides health planners a useful guideline to decide which drugs to concentrate on.

ARGUMENTS PRO AND CONTRA AN ESSENTIAL DRUG LIST IN A REFUGEE CAMP

Arguments Contra

First, it limits the choice of the prescribing physician.

As it is now well established that good health care can be provided with the drugs on the Essential Drug List, it is clear that an individual’s preferences will not add anything to the patients’ wellbeing. Bearing in mind the fact that many physicians from different countries — all with different prescribing behaviour — will have to work together, it is only logical that a consensus be reached on which drugs to use. As many physicians tend to stay for relatively short periods of time, to give in to an individual’s preferences is likely to result in a kaleidoscope of drugs representing different prescribing practices in the world. Large stocks of drugs may remain unused once the physician has left the scene and new stocks will have to be procured for his or her successor. In view of the role a physician needs to play in training local health personnel, it is also obvious that there cannot be a consistent training programme on such a basis and there will be a lot of confusion for the local health worker, who will be left trying to figure out the rationale behind all these different prescribing practices.

Second, patients may need drugs not on the Essential Drug List.

By definition, it is very unlikely that the drug that is needed will be essential. It is, however, conceivable that a patient may need a drug for a rare condition or for
another specific reason. Although this is likely to go beyond the level of care that is available in a refugee situation, a health provider may decide to make an exception on a case by case basis if the drug is thought to be life-saving, if affordable, and will not lead to chronic care dependent on this drug.

Third, patients may have a perceived need for a drug not on the Essential Drug List.

Proper health education should be part of primary health care. This includes information about the use and misuse of drugs and should be guided by health professionals. Too many drugs are attributed qualities they do not have and people are willing to pay an exorbitant amount of money for them. It is the role of the health worker to ensure that people receive drugs they need at a low price. The Essential Drug List is the tool to do this.

Fourth, the existence of a competing ‘free market’.

In many refugee operations, people are able to procure for themselves, at great expense, drugs available on the free market in order to meet a perceived need. These drugs are likely to be of doubtful therapeutic value, often harmful, often expired or not stored in good condition and likely to consume a large part of the refugee’s already meagre budget. In most situations, it will not be possible to outlaw this free drug market. The refugee health worker will have to rely on the principles of primary health care and health education to achieve the goal of health for all. Dealing with the free market may be one of the most frustrating issues to face. As the often almost mythical value of certain free market drugs has no reasonable basis, it is difficult to undo this by health education, which is exactly based on logic and reason.

Arguments pro

First, a limited list of essential drugs does meet the need.

In fact, a much more reduced list would be sufficient to deal with the problems faced at a primary health care centre. It is therefore undefendable to spend resources over and above this.

Second, easier logistics.

For the agency in charge of drug procurement, there is a strong advantage in dealing with a restricted list of drugs.

Third, it is cheaper.

Treatments for similar diseases will be dealt with in the same way. Drug orders for single items will be bigger, which may result in price reductions. Less shelfspace will be necessary as many items can be stored together in bulk. As only drugs from the Essential Drug List will be used, the procurement agency will be assured that the use will be regular, resulting in a high turnover and reducing the likelihood of drugs expiring on the shelves. In many countries with a reliable domestic supply of pharmaceuticals (Thailand, Pakistan, etc.), there is no need to keep very large stocks, which tie up large amounts of money. Smaller stocks also reduce the likelihood of drugs expiring on the shelves.

Fourth, the Essential Drug List can be used in conjunction with a Standard Treatment Protocol.

A Standard Treatment Protocol, outlining in an unequivocal manner the agreed-upon treatments for the most common conditions the expatriate as well as the local health worker might encounter, should be instated in a very early phase of the operation. This will avoid therapeutic confusion and even conflicts between physicians with different backgrounds and prescribing behaviour. If the epidemiology is known, the combination of a Standard Treatment Protocol and an Essential Drug List can be used for planning purposes, as it can be estimated which drugs are likely to be consumed in large quantities.

Five, its usefulness in the training of local health care workers.

It will be easier to train health care
workers in the safe use of a limited number of drugs, which they will learn to know very well. Supervision of health care workers will become much easier as the choices are now limited by both the Standard Treatment Protocol and the Essential Drug List. Once the diagnosis is made — which eventually can be done through the use of simplified flow charts — all the rest follows logically from it.

Six, linkage with the WHO/UNHCR/UNICEF Emergency Drug Kit.

The Emergency Drug Kit was originally developed by the WHO Emergency Relief Operation in conjunction with the Office of the United Nations High Commissioner for Refugees (UNHCR) and the London School of Hygiene and Tropical Medicine. The Kit contains reliable, standardized, inexpensive and appropriate drugs and health equipment, urgently needed in a disaster situation. The contents are calculated for the needs of 10,000 persons over three months. The Kit is readily available from UNIPAC in Copenhagen. In some refugee situations, especially in the initial stages, one may call on these resources. As the Kit contains only drugs from the Essential Drug List, it fits in well with the pharmacy supply system that will be set up later.

Seven, the Essential Drug List is a useful and powerful tool in banning harmful drugs.

This can only be in the interest of the patient.

CONCLUSION

An Essential Drug List is not only useful but essential to a comprehensive health care programme in a refugee setting. It should be part of an integrated primary health care programme and part of the health care workers’ training programme. It facilitates supervision of health care workers and it reduces cost while guaranteeing a basic level of health. Anybody involved in refugee health care should therefore make sure an Essential Drug List is introduced right from the beginning of the operation.

References


Rudi Coninx
WHO Co-ordinator
GPO Box 776
Peshawar
Pakistan