West African Journal of Pharmacy (2012) 23 (2) 14 – 17

Effectiveness of National Drug Policies in the West African Region

24th Annual General Meeting and Scientific Symposium of The West African Post Graduate College of Pharmacists (WAPCP), Banjul, The Gambia 12th – 16th March, 2012

Ogori Taylor

Pharmaceutical Advisor, World Health Organisation, Abuja, Nigeria

The role of national drug policies

Lives are saved when there are medicines which are accessible, affordable and of good quality. WHO has long recognized the important role of national drug policies in ensuring availability, rational use and quality of medicines. This is because the pharmaceutical sector is one of the most complicated in most countries. Policy objectives are sometimes contradictory and there are many stakeholders with conflicting interests. WHO believes that the problems of the pharmaceutical sector can be addressed within a common framework since piecemeal approaches may leave some important problems unsolved and thus ineffective.

In 1975 the World Health Assembly in their resolution WHA 28.66 requested WHO to support countries in formulating national drug policies and evolve strategies to ensure access and rational use of good quality medicines. WHO has since supported member countries to develop and implement national drug policies and to date at least 150 countries globally and about 40 in the African Region have developed national drug policies.

The big question is: have these national drug policies been effective in improving access to essential medicines in the West African sub-region?

Although a lot of successes have been achieved over the years but some of the problems still persist. Millions of children and adults continue to die each year from diseases such as diarrhoea, malaria, pneumonia etc that could have been prevented or treated with cost-effective and inexpensive essential drugs. For example, insulin was not found in some states in Nigeria during a survey of availability of medicines in the public and private sectors. The consumption of morphine, which is an indicator for access to narcotic drugs for pain treatment, tells the story about the critical shortage of controlled medicines in countries. United States of America that constitutes 5.5% of the world population consumed 55.9% of morphine in 2009, while 78,6% of the world population who are mostly in developing countries consumed just 6.2% in the same period. Consequently patients with end stage HIV/AIDS, terminal cancer, those suffering from injuries caused by accidents and violence, some chronic illnesses and those recovering from surgery undergo untold suffering due to lack of opioid analgesics which can easily control pain. Ergometrine and ephedrine could save the lives of women who suffer from postpartum bleeding if they were made more accessible. Also 80% of the population in our countries affected by epilepsy have no access to essential antiepileptic medicines.

Counterfeit and substandard medicines continue to circulate freely in most countries in the West African sub-region. A survey was carried out to ascertain the Quality of Antimalarials Circulating in Selected African countries i.e. Cameroon, Ghana, Ethiopia, Kenya, Nigeria and Tanzania in 2008. The results showed that while Cameroon, Ghana and Nigeria had unacceptable levels of poor quality antimalarials, Kenya and Tanzania had relatively low failure rates and Ethiopia had no failing anti-malarial sample.

These are just a few examples to show that the policies in countries are not meeting their intended objectives.

Why are National Drug Policies ineffective?

While there are many reasons for this state of affairs, we will only consider very few which are mostly within our power to make changes.

The national drug policy

A policy is a nice document printed and brandished as a fait accompli by health authorities. Many times, it does not make any difference to the health sector. Sometimes, the government develops several documents which are contradictory and pit different ministries, departments, agencies against one another.

One of the mistakes made when developing national drug policies is to think it is a pharmaceutical document and so other key stakeholders do not have any inputs into it. Throughout the policy development and implementation process there should be consultation, dialogue and negotiations with all interested groups and stakeholders. These include other ministries (education, trade, industry), pharmacists, doctors and nurses, local and international pharmaceutical industries, drug sellers, academia, nongovernmental organizations (NGOs), professional associations and consumer groups. It is also important to consult with provincial and district medical and administrative personnel, and to make an effort to include traditional and herbal medicine practitioners. Other government agencies (such as the drug regulatory agency), insurance companies and groups paying for health care must be involved.

We have to understand that formulating and implementing a national drug policy are highly political processes. This is because a drug policy usually seeks to achieve equity of access to basic health care, primarily by making the pharmaceutical sector more efficient, cost-effective and responsive to health needs. This will certainly redistribute the power base in the pharmaceutical sector and some groups will certainly be affected. Given the diverse interests and the economic importance of the issues involved, opposition to the new policy and attempts to change it during implementation can be expected.For this reason it is important to identify political allies, and to maintain their support throughout the process. Strategies to deal with opponents should be developed and ways of working with them must be identified. Decisions and priorities touching on the interests of these stakeholders must be balanced on the basis of estimated gains and losses. Strong political leadership and sustained commitment are vital for the formulation and implementation of a national drug policy.

The policy dialogue process also serves the purpose of creating awareness about the policy and it will then be more easily accepted and implemented when it is developed.

It is important to note that a drug policy without an implementation plan remains a dead document. Careful planning of the implementation steps and activities necessary to arrive at the expected outcome is important throughout the process. Likewise, an unfunded plan is just a beautifully printed document which will not be implemented. Adequate budgetary allocation is thus required to actualize the policy. Efforts therefore should be made to seek resources from governmental and nongovernmental sources to ensure actualisation of the aspirations of the national drug policy. Partnerships should not be overlooked with development partners, other ministries, agencies and departments which have better sources of funding.

Similarly, pharmacists are to take great interests in other policies in the health sector. It is not only important to ensure representation throughout the policy dialogue, but also to keep advocacy and discussion around the bill/policy/legislation until it has been adopted and/or passed. In order words, you do not consider it done until it has been signed into law as it was conceived. Change in burden of disease

Previously, developing countries were mainly plagued with communicable diseases. Now countries are facing a double burden of both communicable and non communicable diseases (NCDs) with their consequences. It is not uncommon to hear of cardiovascular accidents which are now taking their toll on our populations. While prevention is important for these diseases, the burden cannot be reduced without equitable and reliable access to essential medicines and technologies. Pharmaceuticals are an essential component of the treatment of cardiovascular diseases, diabetes, chronic respiratory diseases including asthma, many cancers (including pain relief and symptom control). Patients with NCDs generally need long-term care, often for life and therefore must have reliable medicine supply systems to avoid a break in therapy. Pharmaceutical care becomes very important in the management of non communicable diseases more than is required for communicable diseases. This is because NCDs require individualized patient medication management, patient record keeping, appointment and follow-up systems, patient empowerment and self management

education. This calls on a greater role of the pharmacist which should be negotiated, implemented and showcased.

Essential medicines as a human right

Most of our countries are party to international conventions but these conventions once signed are not implemented at country level. One of such conventions is "The International Covenant on Economic, Social and Cultural Rights adopted in 1966 which calls on state parties to take steps to ensure access to medical services for all. General comment 14 added in 2000 applies the principles of accessibility, availability, appropriateness, and assured quality to goods and services including essential medicines as defined by the World Health Organisation's Action Programme on Essential Drugs. Citizens of countries should start enforcing such rights at country level but these must be available as legal frameworks before enforcement can be successful. There are generally 3 ways available to ensure legal recognition:

1. Enshrining the right to essential goods and services in the constitution. A study reports that already 135 out of 186 national constitutions include provisions on health or the right to health. Of these, 95 constitutions mention access to health facilities, goods and services
2. Another approach is constitutional recognition that international treaties ratified by the state override or acquire the status of national law. This option is available in 31 countries and was already used in Argentina in a landmark legal decision
3. The third option is to include health rights in national legislation but such is easier to create and also easier to change or cancel.

It is however important to note that constitutional recognition of the right to access to essential medicines is an important step but does not guarantee access to essential medicines. However, rights can only be enforced in the law courts only if they have some sort of legal provision. A study showed that 11 out of 12 countries in which successful court cases in support of access to medicines took place where there were supportive constitutional language and in the 12th, international treaties ratified by law automatically acquired status of national law.

Opportunities to update a country's constitution present a chance to align national values and aspirations with international human rights standards.

Good governance in medicines

Corruption within the pharmaceutical sector is of increasing concern because it denies many people access to medicines. It is estimated that between 10% and 25% of global spending on public procurement is lost to corruption. The UN Secretary General in 2009 stated that corruption represents one of the biggest impediments to the worldwide efforts to achieve the Millennium Development Goals.

Examples of corruption in the pharmaceutical sector can be collusion in the procurement process, falsification of efficacy and safety data, price-fixing by cartels, and leakages and diversion in the distribution chain. The consequences of corruption tend to be more apparent in developing countries where legislation and regulations are not effectively enforced due mainly to resource constraints.

WHO launched Good Governance for Medicines Programme GGM in 2007 to support countries deal with issues of corruption. The approach is first to conduct a national assessment of the level of transparency and potential vulnerability to corruption of the national pharmaceutical system. Then a national GGM framework through a consultation process involving key stakeholders is developed. The framework usually includes: an ethical framework and code of conduct, regulations and administrative procedures, collaboration mechanisms with other good governance and anticorruption initiatives, whistle-blowing mechanisms, and sanctions for reprehensible acts. Once this framework is adopted, it is then implemented with support from civil servants, civil society and other key stakeholders in the pharmaceutical sector. Ghana is one of the countries implementing this program.

Pharmacy education issues

Most countries in the sub-region do not have any written statement of nationally determined competencies to be exhibited by products from pharmacy schools which would meet the needs of their national health systems. In most cases, the schools copy models of pharmacy education from other countries without appropriate adaptation to suit local needs and circumstances. In addition, there is no national guidance on expectations for a pharmacy graduate which is agreed by all stakeholders including employers of pharmacy.

Tertiary education in Africa has been criticized as being

unresponsive to the labour market and the requirements of the society. The self assessment of Pharmacy Schools conducted by the Federal Ministry of Health in collaboration with the World Health Organisation in 2009 confirms that key stakeholders who can help to bridge the gap between the curriculum and the country's needs are excluded in decision making process at the school level. The panacea is the needs based education approach which is determined in collaboration with all key stakeholders including employers of pharmacy graduates in the country.

Another important factor may be a general inadequate capacity of the schools to ensure translation of competency objectives to professional capabilities required in practice. Of particular importance is the development of valid and reliable evaluation instruments as well as a feedback mechanisms that will ensure utilization of results for improvement. There is now growing consensus that academic professional training does not confer teachers with the skills required in teaching. It is important that the faculty in pharmacy schools should be exposed to training that would ensure curricular and learning effectiveness. There is thus a need to ensure some staff development in the area of teaching in order to improve curricular effectiveness and teaching.

Operational research

Without the generation of evidence, people are generally not taken seriously as anecdotal evidence cannot ensure the development of policies to address critical national issues. The Federal Ministry of Health in Nigeria in collaboration with WHO provided support to University of Nigeria Teaching Hospital to develop a Drugs and Therapeutics Committee. The clinicians felt that patients were generally non compliant and therefore required more expensive medicines to improve adherence. We conducted a simple study in which we measured the number of diabetic patients who were able to leave the hospital with the full complement of their medicines. Only 36% of the patients fell into this category. Their socioeconomic profile showed mostly retired men and women, petty traders, subsistent farmers, the unemployed, students etc who were not only poor but had other dependants. Most procured their medication through gifts by friends and relatives. When the report was presented to the committee, they were dumbfounded and voluntarily revised their Essential Medicines List to include affordable medicines.

There is usually a lot of talk within the pharmacy circle that substandard and counterfeit medicines are being found mainly with informal providers. I have searched literature and I could not find one study which justified such an assertion. However, literature is replete with evidence of the role of informal drug sellers in the distribution of medicines such that there is more evidence to include them in health programs than pharmacists. This should give us food for thought.

In conclusion, national drug policies are key to developing the pharmaceutical sector. Therefore, their development, implementation, monitoring and evaluation should be of utmost importance to pharmacists in the sub-region if they have to make available quality assured, affordable, safe, effective medicines to reduce illness, suffering, death and poverty in the populace.

Thank you.

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