ESSENTIAL MEDICINES IN PRIMARY HEALTH CARE

Editorial
Understanding Essential Medicines and Primary Health Care

Personal review
Essential Medicines-Still A Convincing Concept

Feature
Medicines and Primary Health care: Challenges and Hopes in the Church Health Systems

Commentaries'
Medicines and Primary Health Care: where are we?

Free Trade Agreements, Primary Health Care and Medicines: Impact on Women and Children

Call for action
Essential Medicine for Children: A Need for Action

Experiences
Getting Drugs Closer To the People

Bible Study
Does God Have Strategy For Health To All?

Resources
Medicines are crucial health care products in the Primary health care system. An important function of any health care system is to deliver appropriate health products and services in an equitable, reliable and efficient manner. The quality of a primary health care system is usually judged by patients on the basis of appropriate medical staff and availability of needed medicines.

Essential medicines as defined by the World Health Organization (WHO) are those that satisfy the priority health care needs of the population. They are selected with due regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness. Essential medicines are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality and adequate information, and at a price the individual and the community can afford.

The idea of defining essential medicines – and establishing a list of them – was developed from a report made to the 1975 World Health Assembly. These efforts were aimed to increase the range and availability of medicines for populations with poor access. An Expert Committee on the Use of Essential Medicines was established to assist member states to select and procure essential medicines. In 1977, the first report of the Expert Committee was published which included:

(a) criteria for determining if a medicine fit the definition of an essential medicines
(b) the first model Essential Medicines List (EML)

Since then WHO has updated the model EML every two years. In 2007, thirty years after introduction of the essential medicines concept, a model EML for children was also introduced.

Primary Health Care

It was unanimously adopted by all WHO member countries at Alma-Ata in the former Kazakh Soviet Republic in September 1978.

PHC visualized universal coverage of basic services such as education on methods of preventing and controlling diseases, promotion of food security and proper nutrition; adequate safe water supply and sanitation; maternal and child health, prevention and control of endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential medicines.

The emphasis changed from the larger hospital to that of community-based delivery of services with a balance of cost-effective preventive and curative programs. The approach was intersectional, involving agriculture extension officers, schoolteachers, women’s groups, youth groups and religious leaders, etc.

The community, through its leaders, was to be involved in the planning and implementation of its own health care services through community primary health committees.

Governments adopted PHC Concept. Goals and targets were set for achieving Health for all by the Year 2000. these goals include:

- At least 5% of gross national product should be spent on health;
- At least 90% of children should have a weight for age that corresponds to the reference values;
- Safe water should be available in the home or within 15 minutes’ walking distance, and adequate sanitary facilities should be available in the home or immediate vicinity;
- People should have access to trained
personnel for attending pregnancy and childbirth; and
• Child care should be available up to at least one year of age.

A recent WHO report titled Primary health care – now more than ever, found striking inequities in health outcomes, access to care, and what people pay for care. Many health systems have lost their focus on fair access to care, and the report called for a return to primary health care.

Primary health care tackles the root causes of ill health, and attacks threats to health. As the report noted, better use of existing interventions could prevent 70% of the global disease burden.

This issue of the Contact magazine gives practical examples on the importance of essential medicines in primary health care.

Various authors have reviewed the concept of essential medicine. Richard Laing reviews the concept 30 years after it popularizations and wonders whether it is still a convincing concept.

The issue also highlights the challenges of implementing primary health care in Faith Based Organisation (FBOs) Institutions. Jane Masiga looking at successes of access in the last three decades, gives a historical perspective on how much has been achieved on the availability of medicines within the primary health care.

In addition the issue highlights free trade agreements, primary health care and medicines and how they impact on women and children.

Essential medicines for children is a big issue and concerted effort is needed to ensure that medicines for children meet the standards expected for medicines available for adults.

We hope you enjoy reading this issue of the contact magazine whose theme is Essential Medicines in Primary Health Care and that the experiences and knowledge shared in this issue will motivate you to take a positive action towards scaling up access of essential medicines in primary health care.

Next Edition

The World Health Organisation defines the six building blocks of health systems as:
• Service delivery
• Health workforce
• Health information systems
• Medical products and technologies
• Financing systems
• Leadership and governance.

It also emphasizes the values and principles of primary health care, including equity, solidarity, and social justice, universal access to services, multi-sectoral action and community participation as the basis for strengthening health systems. The theme for the 2009 Contact is: Health System Strengthening: Focus on church institutions and pharmaceutical service provision

The following are specific topics you could contribute in, however they are not restrictive.
• Maintaining a viable health system in an economic meltdown: The case of a system or hospital
• Challenges of training pharmaceutical professionals
• A successful FBO private partnership
• Investing in pharmaceutical Quality Control
• Mainstreaming HIV and AIDS
• Running a viable drug supply organization amidst poverty and civil strife

The articles should be between 800 - 1000 words in simple language since the readership is diverse - all over the world including areas where English is not a first language.

Please include a short profile of about two to three sentences of the author and organization including contact details for acknowledgement purposes. We would appreciate hearing from those interested in writing by May 29th 2009. In case of any further clarification or any questions do not hesitate to contact us.

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PERSONAL REVIEW

ESSENTIAL MEDICINES: STILL A CONVINCING CONCEPT

In 1989, Contact No 107 was titled “Essential drugs - a Convincing Concept.” The special edition contained a major article by the then Pharmaceuticals Adviser Christel Albert. It also contained a list of useful publications, the CMC Guidelines for Donors and Recipients of Pharmaceutical Donations and the 5th Model List of Essential Medicines. I used this publication as the main resource for training courses and meetings all over the world. Now 20 years after this publication and 30 years after the first Essential Medicines List in 1977 and the Alma-Ata declaration of 1978 it is worth revisiting the original concept and identify what has changed, what developments there have been and what remains the same.

The Concept

Clearly the original concept that a few well chosen essential medicines reliably provided and rationally used could ensure the effective therapy of the sick world-wide remains a convincing concept. Millennium Development Goal 8E includes the essential medicines concept. In fact, we see many developed and transitional countries and institutions such as health insurance providers or Health Maintenance Organizations using this approach. But there have been many developments and I will identify from a personal position what the most important of these have been.

Selection

For the first 25 years of the Essential Medicines movement selection was on the basis of experience. In 2003, WHO introduced an evidence based approach with public sharing of information. The key document in this process is the Application form. This form identifies 15 questions that should be answered prior to adding or removing an item from the Essential medicines list. Any country or organization could adapt this form to meet their needs. Many countries have adapted the WHO Model List to be a levelled list which defines which medicines should be provided at which level of the health system.

Procurement

In 1989, the dominant means of procurement was by Open Tender or in World Bank language Open Competitive Bidding. Since then the World Bank and many international organizations including the Global Fund for AIDS, Tuberculosis and Malaria and some countries have moved from this unsatisfactory approach to use either Restricted Tenders, ideally with performance monitoring or direct procurement from non profit suppliers such as MEDS in Kenya, or JMS in Uganda or other international procurement agents such as IDA or Action Medeor.

The reason for this change is that in Open Tender price is the primary determinant of supplier selection while quality assurance and supplier reliability are clearly more important. A key development during the 1990s was the publication of the MSH International Drug Price Indicator Guide. Since 1977, there have been a number of attempts to establish pooled procurement systems. When these have been within a country, particularly when hospitals or missions have combined their requirements and ordering, major savings have been obtained. However, when this approach has been attempted internationally the results have been disappointing, with one...
notable exception. The Eastern Caribbean Pharmaceutical Procurement Service (PPS) have run a successful service for more than 25 years.

Distribution

In this area progress has remained slow and has been bedevilled by multiple supply channels created by donors or vertical disease control programmes. In 2003, Marthe Everard and Marlon Banda working with many colleagues from EPN member organizations undertook an innovative study of medicines storage and distribution systems in church related organizations in Africa. This innovative study paired investigators from one country with those from another country and exchanged visits completing a standard study document.

The key findings of the study related to the need to improve quality assurance of the procedures being used, the better management of medicines donations, more effective use of pricing information combined with updated financial management systems and a focus on customer satisfaction.

Later a similar study was undertaken of government supply systems and while this report has not yet been published similar findings were obtained with a clear conclusion that the most efficient national system was likely using a semi-autonomous model.

The issue of donations has continued to be a challenge. In April 1988, the Christian Medical Commission published their guidelines on pharmaceutical donations. In 1989, WHO published Interagency Guidelines, which have been widely accepted and used even by major pharmaceutical companies. However, problems still arise when well-meaning individuals or organizations rush to send medicines in crises. The Inter Agency Donation Guidelines have stood the test of time and should be fully implemented. This means that both donors and recipients should define specific guidelines for their own situations.

Rational Use

Here there has been great progress since 1989. At that time there was a widespread perception that medicine use was often inappropriate due to a lack of training of health workers. The
INRUD network was established to study the issue and one of their first activities was to develop a method and manual on “How to Investigate Drug Use in Health Facilities.” This widely used method showed that medicine use varied widely from good to very poor.

The method has also been used to evaluate interventions and we now know a great deal more about how to improve rational use. A key publication describing how to establish Drug and Therapeutic Committees was published in 2003. Improving medicine use in the community was rather neglected until the mid-1990s when the Amsterdam group led by Anita Hardon and Catherine Hodgkin with support from Daphne Fresle from WHO began organizing courses on Promoting Rational Medicine Use in the Community.

This resulted in two useful manuals on investigating and changing medicine use in communities. A continuing challenge to rational use is the inappropriate promotion of medicines, which is as much a challenge now as it was in 1977. In 1988, the Ethical Criteria for Medicinal Promotion was published by WHO. This remains the standard that industry and national codes are judged against. Unfortunately very few medical or pharmacy students are aware of these guidelines.

**Financing and Medicine Pricing**

The major developments in financing of medicines have been the emergence of Global Health Initiatives for Vaccines, AIDS, Malaria and TB. Though GAVI, GFATM, PEPFAR, PMI and GDF have been focused on diseases these initiatives have brought an enormous amount of new money into medicines purchases. Unfortunately chronic diseases such as heart disease, diabetes, asthma and depression do not yet have such global health initiatives and struggle for funds. As a result many patients continue to purchase medicines out of their own pockets, usually from the private sector and often at 5-10 times the international price.

The major development on medicine pricing has been the WHO/HAI medicines prices and availability project. This project brings together consumer NGOs, Ministries of Health and WHO to measure medicines availability, prices, affordability and price components in a standard way allowing comparisons across countries and over time. The HAI Africa group have used information from the many surveys to undertake price and availability monitoring reporting.

**Quality Assurance and Regulation**

When the essential drugs concept was first enunciated little emphasis was placed on quality, quality assurance or regulation. However the importance of regulation and ensuring the quality of essential medicines has become clear. WHO has been a leader and supporter of country activities aimed at improving regulation through the production of technical standards and guidelines and the provision of country support.

In addition, the WHO prequalification of medicines programme has allowed many producers of ARV’s, Malaria and TB medicines to prequalify to be eligible to receive Global Fund purchases. What is striking about this new approach is the transparency of the process in which nearly all relevant information is posted on the prequalification web site. Recently quality control laboratories have begun to be prequalified.
What's New?

Over the past few years two new approaches to improving medicine systems have been the Good Governance for Medicines (GGM) Initiative and the Medicines Transparency Alliance (MeTA). These two complementary activities aim to improve medicines availability by attacking corruption (GGM) and promoting efficiency through transparency. Both projects are undertaking pilot projects and are likely to become integral parts of essential medicines programmes. A new approach that is being used successfully in a number of countries has been the human rights approach to claiming a right to medicines. Court cases have been successfully fought in a number of countries in which the constitutions or national law guarantees the right to health or health care 13.

The Future

In the 1989 Contact on Essential Drugs Christel Albert stated “The essential drugs concept is now well established and is basic to achieving more justice in health care.” As the world changes with populations aging, the emergence of chronic diseases and new health systems, the importance of having the few well-selected, quality assured essential medicines universally available and rationally used will remain. Ensuring that people everywhere and at all times have these medicines remains the goal!

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References

1. Application form containing information to be included with an application for inclusion, change or deletion of a medicine in the WHO Model List of Essential Medicines. Available at: http://www.who.int/selection_medicines/committees/expert/17/application/EML17_AppForm.pdf
3. The Organisation of Eastern Caribbean States (OECs) Pharmaceutical Procurement Service web site: http://www.oecs.org/pps/about.html
12. The WHO Prequalification Programme web site: http://healthtech.who.int/pq/
Since the declaration of Alma Ata (ex Union of Soviet Socialist Republics) in 1978 on Primary Health Care, developing countries have given a lot of effort into increasing primary health care services in terms of training of health workers, allocation of resources and the important reorganisation of the health system in order to increase health coverage.

Churches in Africa are a significant and indispensable government partners with regard to health care coverage. But what can be expected from implementing primary health care? And what is the role of medicines in this process?

Primary Health Care are health services which are accessible and which meet health needs of individuals and the community and represent the first level of contact with the health care system. The focus lies on both financial and geographical accessibility for the community so that both urban and rural areas are adequately served and hospitals serve as referral facilities. Appropriately trained

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**MEDICINES AND PRIMARY HEALTH CARE: CHALLENGES AND HOPES IN THE CHURCH HEALTH SYSTEMS**

David Radoli
health services professionals responsible for this work are necessary. There is a close partnership between the health workers (working as a team) and the local community.

The components of PHC include prevention and curative services, rehabilitation and health education. To ensure these services are properly carried out, practitioners, including the faith based services, must evaluate themselves and regularly assess not only the quality of health services which they offer, but also how accessible their primary health care services are to the community.

The implementation of primary health care requires a minimum of preconditions as follows:

- Availability of a sufficient number of qualified human resources for health
- Availability of adequate infrastructure according to the guidelines/norms
- Availability of financial resources
- Availability and accessibility of affordable quality essential medicines.

The Church Health Services face a number of challenges in implementing primary health care including:

**Human capital:**

This is a vital resource, essential for implementing primary health care activities. Inspired by the teaching of their faith, these must be qualified men and women, who are engaged and compassionate in their work as they deal with the different health problems of the community. Unfortunately, brain drain of the qualified human resources from the church health services strikes a deadly blow every now and then! The support of the health professionals through for example, training and regular refreshers is important and has to be taken into account during the facility’s planning.

**Financial resources and infrastructure:**

This is an area of particular difficulty for church health services. While finances are always limited, there are always needs for regular equipment maintenance and periodic renovations of the infrastructure, necessary to maintain the required standards of care.

**Affordable quality essential medicines:**

The availability of medicines is a centre piece of primary health care. The supply and management of medicines in order to guarantee their availability and their accessibility for the population in terms of prices, is a major challenge that church health institutions must deal with. There have however been commendable efforts with regard to addressing some of these problems. However much still need to be done as many health institutions still face supply difficulties. In addition, in many countries, one has to also have to deal with the phenomenon of street medicines and also fake, counterfeit and substandard products in the market.

**Primary Health Care: a case study from Assemblées Chrétiennes au Tchad (ACT)**

In spite of the limitations, there are some successes, where the availability of medicines and other support services at the primary care level, have had significant positive outcomes. The example of ACT highlights this.

Facing great needs and numerous
health problems experienced by the population, the Assemblées Chrétienes au Tchad have succeeded in mobilising the community to take care of their health. First a hospital (Hôpital évangélique de Koyom) with a capacity of 100 beds was put in place in a rural area and it serves as referral centre for 32 health centres founded by local churches. These centres are actively involved with the community, supporting them to reflect on their health problems and helping to put in place activities that respond to identified priorities. These health institutions are working on the implementation of primary health care with some notable improvements on the field.

1. Prevention
Prevention includes all actions which were implemented in order to avoid or reduce the number or severity of diseases or accidents. There are three parts to be distinguished, namely primary, secondary and tertiary prevention:

- **Primary prevention**
Primary prevention means to fight against the risks before the appearance of the problems - risks in terms of individual risky behaviour and risks from the environment or the community.

A project to promote basic health has been carried out in 10 health centres coordinated by the l'Hôpital évangélique de Koyom. This project aims at reducing the morbidity and mortality of vulnerable populations – children under 5 and pregnant women – by providing basic health care and promoting health education and purification and use of drinking water. Matrons have been trained with regard to the activities to protect mothers and infants. They do consultations every week at health posts in all the villages in the areas they are responsible for. In total this reaches a population of 134 431.

The achievements in primary prevention in 2007 are as follows:

- 17 275 children under 5 (92%) were treated systematically with Albendazole tablets against parasites twice a year;
- 44 442 persons (12.9%) educated about HIV and AIDS and importance of voluntary counselling and testing, they were also taught how to prevent and treat malaria and the importance of good hygiene.
- 53% of pregnant women (3005) benefited from free Iron and Folic Acid tablets to prevent anaemia and 1000 of them received an insecticide treated bed-nets;
- 60% of children below the age of 11 months are fully vaccinated;
- The prevalence of intestinal parasites among children under 5 was reduced from 7% to 3.05%;
- A utilisation rate of antenatal consultations of 78% in the 10 health centres was clearly higher than the national average of 50%.
- The drilling of wells with manual pumps at 9 health centres to provide drinking water to the community in order to prevent certain diarrhoeic diseases.

- **Secondary Prevention**
Secondary prevention stands for testing, this means the discovery of an infection to prevent the development or the worsening of a disease. In the context of this project, 1093 voluntary tests for HIV were carried out in 2007 in the area served by 10 health centres. Those tested positive are receiving
care at the Hôpital évangélique de Koyom.

• Tertiary Prevention
Tertiary prevention aims at preventing the relapses or complications. It includes a medical, psychological and social readjustment. In the context of following-up with people living with HIV, this involves mainly the prevention of opportunistic infections with Cotrimoxazole tablets and of anaemia with Iron/Folic Acid tablets. A total of 52 people are involved in this program in the context of caring for people living with HIV/AIDS.

2. Curative services
These services include the active taking care of patients during their medical consultations. In this program the attendance rate rose from 20% to 22% in 2007. There is hardly any change. This is most likely due to poverty hence limited accessibility to the faith-based health institutions.

3. Health education
The aim of health education is to enable the patient contribute himself to maintaining or improving the quality of his life and his health status. Health education is given regularly during vaccination, medical consultations, care for people living with HIV/AIDS and mass mobilization.

The role of medicines in this primary health care project
It will be difficult to separate medicines from primary health care. In this case study for example, except for health education, medicines played a crucial role among the other components of primary health care. This important
place occupied by medicines in the implementation of primary health care, requires a minimum of competence of the health professionals to ensure rational use of medicines.

In 2007, an epidemiological profile from 29 of 32 health centres within ACT was carried out. Eleven (11) essential medicines (in generic form) were chosen to indicate the rate of availability of medicines during the last 6 months in 2007 i.e. a period of 180 days. The results showed that:

- Five health centres had an availability of these medicines of less than 90%.
- Eight had an availability rate of 90 to 96% during this period;
- Finally 16 health centres had an availability of more than 96%.
- Stock outs were experienced in all centres now and then.

These stock-outs were due partly to the little knowledge concerning management of medicines by the nurses who were responsible for the health centres (e.g. no keeping of stock cards, no order were based on real consumption? figures) and also to the difficulties in procurement due to unavailability at the source and/or lack of financial resources.

children fetching water at the health centre in Békourou
Why there is hope for the future

In the face of many difficulties, to remain hopeful takes much courage. But there is hope! For example, the workshops for the responsible staff of FBOs which are organised by the Ecumenical Pharmaceutical Network (EPN) already gives hope. This capacity building for health professionals in the area of transparency, proper management and rational use of medicines, standard operating procedures etc are important steps which can be replicated by the beneficiaries in their settings. The policy of setting up contracts with the state in some countries gives hope with regard to subsidizing activities of faith-based health centres. Finally the development of partnerships with donors offers an opportunity which should not be neglected.

Conclusion

Health is, according to WHO, a state of complete physical, mental and social well-being. It does not mean the simple absence of illness or disability. Behind this romantic definition are so many hidden inequalities, in terms of geographical and financial impacts on health. It is obvious today that there is a relationship between poverty and health, how else could one otherwise understand that there are many sick people in the South and medicines and equipment are in the North?

Health is a major problem for the population in Africa and justifies the important role the church is playing in terms of primary health care services. Health indicators like maternal and infant mortality being still high in our countries, show that the perfect level of primary health care (in terms of preventive, curative, promotion and environment) has not yet been reached. The needs and health problems within the community are important and the state alone will not manage to resolve and satisfy them in an appropriate and continuous manner. In order to improve the coverage of primary health care services for our communities, it is therefore necessary to consider ways to tap into all available resources, including financial resources, both within the country (public, private) and also externally.

These stock-outs were due partly to the little knowledge concerning management of medicines by the nurses who were responsible for the health centres.

Djékadoum Ndilta is a Medical Doctor and the head of the Evangelical Hospital of Koyom, a district hospital established in the rural south of Chad. Dr. Ndilta regularly supervised promotion of the health care activities among the church’s health centres, a responsibility he has carried since 2001. Dr. Ndilta is an EPN Board Member and he holds a Master in Public Health (MPH).
Primary health care was defined at Alma Ata in 1978 and was then seen as the vehicle for achieving health for all. It is a fact that majority of the population in developing countries, especially in the rural areas depend on primary health care systems for their health needs. It is also a fact that many diseases that cause death and disability in developing countries can be prevented, treated or their effect reduced with cost-effective essential medicines. It is therefore important that essential medicines are available at this lowest level of health care.

**Concept of Primary Health Care**

Primary health care is a term used for the activity of health care provider who acts as a first point of consultation for all patients. Generally health care clinicians who may be physicians, nurses or various other workers trained for the purpose, are based in the community as opposed to the hospitals.

While there are many definitions of primary health care, the principles of accessible, comprehensive, continuous and coordinated personal care in the context of family and community are consistent.

The concept of primary health care was defined by World Health Organisation (WHO) in 1978 as both a level of health care delivery and an approach to health care practice. It is estimated that 75-85% of the population seek care at this level yearly. It provides both the initial and majority of health care services of a person or the population. This is in contrast to tertiary health care which is consultative, short term and disease oriented for the purpose.
of assisting the primary health care practitioner. In developing countries, tertiary care is generally reserved for patients with unusual illness requiring highly specialised services.

Countries with better provisions for primary health care have better patient satisfaction at lower cost and better health indicators. The WHO World Health Report 2007 deals with access to primary health care as an essential pre-requisite to health. It acknowledges the importance of Alma Ata declaration of 1978 which called for integrated primary health care as a way to deal with major health problems in communities and for access to care as part of a comprehensive primary health system.

Need for medicines
The care of chronic diseases such as diabetes or AIDS, the provision of preventive care services such as immunisation and family planning, and health education are to a large extent handled at this level. It is no wonder therefore that there is great need to equip this level with sufficient resources to handle such needs.

Medicines are indispensable and necessary for the health needs of the population. They should be available at all times, in the proper dosage forms, to all segments of the society including the lowest level. A primary health care system without medicines is therefore like a river without water. Availability of medicines in primary health care system promotes trust and encourages participation in the health care system within the population.

This does not rule out the fact that some ailments do not require medicines and can be managed with home remedies, adequate rest or change in life style. The importance of medicines is such that patients leaving the health facilities will rate the clinicians on the services provided, of which medicines form a major component of this service. It is for this reason that studies for health care services must include availability of medicines. The importance of medicines cannot be overemphasized as they save lives and improve health.

Essential medicines were defined by WHO in 1975 as those medicines that meet the health needs of the majority of the population. This concept advocates for a selection of a list of medicines that satisfy the need of majority within the population and should be available all the time and at affordable prices.

Progress
There has been substantial improvement in the availability of medicines within primary health care. Looking at the successes in access of medicines in the last three decades, one cannot help reflecting on various factors which have made this possible including the Essential Drugs Concept which has been widely promoted by WHO in the developing countries.

In 1950s and 60s many developing countries faced an overwhelming task in providing the western based model based on hospital medicines and high technology. In the late 1970s, it was estimated that 60-80% of people in the developing countries lacked regular access to even the most essential medicines. A different model of care emerged which recognised that the health of populations was determined by factors other than medical care and that these factors could be controlled by communities themselves. By the

A primary health care system without medicines is therefore like a river without water.
By the 1970s the WHO recognised and formulated this model and declared at Alma Ata “Health for all was achievable through primary health care by 2000”. Governments in sub-Saharan African embarked on processes to align their health policies and indeed implement them within the primary health care framework. Primary health care in Africa was seen as an overall strategy for achieving health for all, rather than just as the first level of care. Thus countries restructured their entire systems and framework of primary health care rather than focus on the first level of care only.

Over the last 30 years a wide range of developing countries have successfully developed a model of primary health care promoted by the WHO. This is based on the idea of essential health care based on practical scientifically sound and social acceptable methods and technology, made universally accessible to individual and families in the community, through their full participation and a cost that the community and the country can afford to maintain. It differs fundamentally from the primary health care systems that may be found in developed countries e.g in UK which relies more on technical and curative care than the community oriented approach.

In the late 1990s with the emergence of HIV/AIDS scourge, the workload at all levels of health care increased drastically and the higher level facilities became burdened by high bed occupancy by these patients for long periods. Transportation of patients to the higher level facilities became expensive especially if it has to be done on monthly basis for prolonged periods. It became evident that chronic management of these patients is better done at the primary level. Home based care was enhanced and this finally evolved to cater for other ailments as well. It has reached a stage where diagnosis and initiation of treatment may be done at a higher level but monitoring of the patients and re-fill of the prescriptions for these medicines can now be done at primary health level.

Many ministries of health have made structural and regulatory adjustment to accommodate this need. The essential drugs lists in many countries have been restructured to reflect the medicines that can be used at the primary health care level. Even community health programmes have been allowed to handle a limited number of medicines, and are now included in the home based kits.

Challenges

Although much has been achieved in the last decade, many challenges still remain. The mid 1980s to the end of the decade saw worsening economic performance which was followed by enforcement of structural adjustment programmes, political instability, man-made and natural disasters and the beginning of HIV/AIDS pandemic. All these wrecked havoc on plans countries had for implementation of primary health care. Within this context, elaborate policies and plans are not fully implemented. Furthermore there appears to have been a general under estimation of the resources required. Though there was some initial progress in improving health status as shown by some parameters, health for all was not achieved by any of the countries.
The proportion of primary health care varies from country to country, for example about 80% in Great Britain, 32% in United States of America. Considering all sources of primary health care, there is still a lack of primary health care providers in many developing countries particularly in the rural areas.

Achieving financial sustainability within the primary health care systems remains one of the major challenges. The challenges in making medicines available are numerous and include inadequate budgetary allocation, irrational use and wastage. In addition there is limited ability to change the behaviour of providers, patients and the public to promote effective, safe and economical prescribing, dispensing and use of medicines. Furthermore medicines are still costly for individuals households and many countries. This is illustrated by fact that in most developing countries, medicine expenditures represent one-third to two-thirds of total public and private health expenditures (WHO/DAP 1996).

**Conclusion**

More than ever, the dream of achieving health for all and universal access to medicines must remain a key health target. We may not have achieved the goal of having health for all by the year 2000, but with the current focus on primary health care, we are moving in the right direction.

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FREE TRADE AGREEMENTS, PRIMARY HEALTH CARE AND MEDICINES: IMPACT ON WOMEN AND CHILDREN

Neoliberal globalisation presents us with new threats to health such as, among other, an increase in trade in unhealthy commodities, international trade agreements that are promoting the penetration of transnational corporations into the health sector, patent rights being used against the dire health needs of poor people, and unfair rules in the international trade of agricultural products that devastate the livelihood and health of poor peasants. All of them seriously undermine the ability of poor countries to adequately support Primary Health Care systems. Global inequities also result in poor countries being left with too few resources to sustain funding for health systems overall, thereby becoming reliant on external sources of funding.

The poor, the marginalized and the disempowered households are least likely to participate in or benefit from FTAs.

Free trade agreements (FTAs) do have a major impact on the lives of poor families. In an FTA between a developed country and a developing country or countries, the latter are in a weaker bargaining position due to their weaker negotiating strengths. It has been observed that many trade-related measures benefiting developed nations, which have been rejected or subjected to flexibilities at the World Trade Organisation (WTO), are now being imposed upon developing countries through the plethora of FTAs signed, especially with the US. Joining FTAs, as well as joining the World Trade
Organization (WTO) has proven to result in increasing income inequality and social disparities both in poor and rich countries.

FTAs make some groups in a society benefit while others lose; they affect not only the households' welfare, but also the welfare of individuals within. Households that are unable to adjust rapidly enough to the new economic conditions are the ones that suffer. FTAs also generate reallocations in household spending which have foreseeable health impacts that are often difficult to trace. Vulnerable groups, especially children, will be affected in a variety of ways depending on the intra-household distribution of power and resources.

By reducing import tariffs FTAs affect tax revenues and consequently the provision of primary health care services by the government. Domestic prices of medicines and services are affected due to their direct links to international prices that FTAs and trade liberalization bring about. In case of disease in the family, changes in medicine prices force changes in the allocation of intra-household resources, affecting household consumption patterns, and ultimately disposable household income.

Impact on women and children

Women’s and childhood poverty and hence their access to medicines and to Primary Health Care services cannot be simply deduced from household poverty data overall; it is also shaped by the intra-households distribution of power and resources. Although there has been little research on the effects of FTAs on Primary Health Care and particularly on mothers and children, they are none the less, indeed susceptible to the negative effects of FTAs as it impacts the power and resource distribution. The poor, the marginalized and the disempowered households are least likely to participate in or benefit from FTAs. So family members of these households, in which the women and children are least empowered, are the most at risk from the negative effects.

Restricted access to medicines is one such important effect. For example, maternal and child health (MCH), a pillar of Primary Health Care, is affected by the degree to which the government is willing and able to fund essential medicines and primary health care. Any impact on this budget, affects MCH. In the case of children, we know that vulnerabilities often divert children from school to work. In a cascading effect, this affects

a) The allocation of children’s time between work, school and play,
b) Their access to health services, and

C) Their consumption of food.

Coping with the impact of FTA

Complementary Primary Health care and social protection policies are thus needed for women, children and other vulnerable groups in the society. Though not many options exist there are some areas open for explorations including:

- A contingency fund for use in cases of negative impact: losers are identified and appropriately helped and compensated.
- Cash transfer programs to redress liquidity constraints resulting from shocks induced by FTAs.
- Incentive mechanisms to reduce existing gender imbalances especially in access to reproductive health services, medicines and particular attention to the girl child.
- Increase in the number of publicly-funded daycare centers with a negotiated access to PHC and essential medicines.

Conclusion

FTAs are not the way to reduce poverty and inequities. Households’ consumption patterns of medicines and food are affected by changes in prices of goods; Of particular concern are modifications in the households’ food basket, as well as families’ ability to access health care and the impact on Children.

Moreover, if FTAs-induced tax reductions lead to decreased coverage of commune health centers, increased reliance on private care is the only option left. Then, poor children’s health will for sure be negatively affected. The other side of the coin is: As family resources decline, they may have to increasingly rely on public health services, i.e. a possible shift in demand from private to public health services so that these services will face higher demand while their funding is being reduced. Therefore, increases on the pressure on government staff and budgets must be addressed: The question is, have we done so?

Finally, decision-makers not only from health, trade and economics ministries, but also those responsible for social development need to take concerted action for mothers, children and youth so that the negative impacts of FTAs are at least minimized.

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References

Meditines for children are frequently unavailable, impractical to administer or difficult to use well, and unsafe and unaffordable. Action is needed to ensure children’s medicines meet the standards expected for medicines available to adults. All children are affected, but the impact is most acute and the needs most urgent in poor countries, where the proportion of children in the population is highest and health services are weakest.

Four challenges require attention in the short-term: absence of scientific data; lack of products that are practical to administer; lack of usable information about existing medicines; and market failure for paediatric medicines.

**Absence of scientific data**

Scientific evidence is essential to ensure appropriate use and access to medicines for children. Fewer than half the products used to treat children have been properly developed. Pharmacokinetic studies defining optimal doses for children in relation to age or weight are often not done. Much of the treatment offered to children lacks a scientific basis, i.e. is ‘off-label’, and estimation of doses and treatment effects are based on studies in adults. This wrongly assumes that children metabolise medicines in the same way as...
adults without taking account of maturity of the liver, kidneys and enzyme systems. The result can be under- or over-dosing, leading to inefficacy or toxicity.

**Insufficient appropriate dosage forms**

Medicines are needed in forms that are appropriate for use in household and clinical settings. In addition to being available and affordable, paediatric medicines must be palatable and acceptable to the child, stable and practical to use in difficult conditions, packaged appropriately, and accompanied by information that parents can understand and use. Many are now unpleasant to taste, difficult to administer, and costly. In some diseases several drugs have to be taken, making fixed-dose combinations a practical solution. Impractical dosage forms result in inefficiencies in busy clinical settings, waste money and have poor health outcomes.

**Weak pharmaceutical markets for paediatric products**

Without scientific data, the registration of products in countries is inhibited. Weak competition among available products leads to high prices. In the absence of suitable products, there is no real demand and new manufacturers are reluctant to enter the market.

**Why has this situation arisen?**

The difference in standards for children’s and adults’ medicines stems partly from the perceived risks of conducting studies in children. There has been lack of demand for appropriate medicines and information. Higher expectations have resulted from recent developments including: the new paediatric medicines’ legislation in the European Union (2007); identification of essential medicines for children – the WHO Essential Medicines List for Children (EMLc 2007); and pressure from AIDS, tuberculosis and malaria public health programmes.

**What are the priorities for better products?**

For better products, more research and development of medicines is needed.

Globally 1000 children under five die every hour. HIV/AIDS, TB, malaria, neonatal sepsis, pneumonia and diarrhoea cause most of these deaths and serious illness. Products appropriate for children in all age-groups are needed to treat these diseases, including:

- Appropriately packaged antibiotics to treat pneumonia and neonatal sepsis;
- A palatable and easily used formulation of zinc in combination with Oral Rehydration Salts for treating diarrhoea;
- Effective pain relief; in many countries access to simple oral morphine is denied;
- New fixed-dose combination medicines for tuberculosis in children;
- Better dosage forms of existing products, including fixed-dose combinations for malaria and HIV/AIDS; and
- More easily administered dosage forms - such as sprinkles, small or scored tablets, drops etc.

**Support is needed**

Progress on WHO’s World Health Assembly Resolution 60.20 “Better Medicines for Children” will be reported to the 2009 WHO Executive Board in January 2009. WHO has developed and updated the Essential medicines List for Children, commissioned work to identify ideal fixed-dose combination products for tuberculosis, undertaken preliminary surveys of availability of key medicines for children in Africa, and begun to define the optimal dosage forms of medicines suitable for children of all ages. This work provides a framework for global support for better research into children’s medicines, which if implemented will enable progress toward MDG targets.

It is now necessary for the entire public health community - governments, donor agencies, academic research units, regulators, the industry and all who have a duty to care for children - to recognize the need for safe and appropriate medicines for this population.

A start has been made, but without sustained commitment by all concerned during 2009 (the year of the Rights of the Child) and beyond children will continue to be disenfranchised: their rights to adequate health care, as well as the global agenda for health, will be undermined. It is time for action.

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GETTING DRUGS CLOSER TO THE PEOPLE?

CASE STUDIES

Primary health care services are vital for a healthy and productive society. This can only be achieved where there is political will to spend money for the service, transparent procurement and distributions of medicines and availability of in the right quantities and in right formulae. The availability and affordability of essential medicines cannot be over emphasized; this is why essential medicines should be part of primary health care. The case studies below illustrate some of the common problems of access at the community level.

CASE ONE

Mary Makezi,* a female aged 42, married with four children started taking ARVs in 2005 when her CD 4 count at the time was 78/mm$^3$. She takes Trimune 30. Though ART has considerably improved her life, she still face huge difficulties adhering to the regime.

She has to travel 50 kilometers from her village to the nearest clinic every month. Mary starts her journey in the morning either on foot or if she is lucky, she finds a van which she pays an equivalent of 8USD to and fro. Upon arrival at the clinic she usually waits in the queue for 5 to 6 hours and occasionally finds some food to eat which costs her an equivalent of 2 USD.

She finally get to see the doctor, who takes less than ten minutes to do routine check ups. Usually she gets no chance to ask questions, and too often the doctor is already overworked and moody. Furthermore, she may need to have liver tests and others investigations done, which cost a lot of money”.

Access means not only the availability of drugs at the health care institution, but also the ability of the patient to physically get them. Transport, meals, diagnostic tests and other related costs, act as barriers to access for many in the community. Furthermore adequate human resources to ensure patients receive adequate attention is a major factor in the success of treatment. Therefore though delivery of drugs and supply to the community is a major issue for the success of PHC, this must be accompanied by other supportive services.

CASE TWO

John Bowa, * male aged 36, married with two children, tested HIV positive 5 years ago. In November 2008, John’s CD 4 count dropped below 200 and was required to start ART. The drugs made him develop severe side effects which included swelling of the legs and this caused him severe pain that he could hardly sleep.

He went to a public hospital where the doctor prescribed him a strong pain killer and advised him to visit a private clinic. He visited the clinic and he was in shock to find that the clinic belonged to the doctor who prescribed him the medicines in the public hospital.

“I was re-examined with some simple test and the doctor told me that I have to take the very pain killer he earlier prescribed.” He says. The price of the medicines was about USD 200. He was forced to use the money he had reserved for rent since he was desperate.

“After learning more about essential medicines, I discovered that the pain killer I was given at the private clinic was on the country essential medicine drug list.” He says.

John feels that the only way to ensure transparency is by government involving the consumers from the time of procurement to the time of distribution. Patient’s should know which medicines are on the national essential medicines in primary health care and advocate for more availability and affordability.
A non-functioning health care system can lead to unscrupulous practices. In addition a lack of understanding of what drugs are essential and therefore should be available at all times can be costly to the patients. Other common problems are related to the proper storage and maintenance of drugs. Greater empowerment and participation of the community in PHC can minimize these problems.

How have people tried to address these limitations?

There are different roles to be played by the health care worker and the community members. Innovative ways can and have been found and used. In drug distribution for example, locally available resources can be used as illustrated by the use of camels in areas where there are no roads, as shown in the photo.

Keeping drugs cool can be supported by use of shading of walls where drugs are kept with palm leaves or similar materials; use of paraffin refrigerators on solar powered equipment. The list is not exhaustive but points to the need to explore sustainable solutions to support PHC at the community level.

The use of medical list geared for different health care levels, and training of health care workers, facilitates the proper forecasting of needs and storage of drugs. And the support of community in supporting those on drugs, increases adherence and the likely positive outcomes of treatment. In the section under resources, we give reference to some useful documents to address these issues.

Case studies submitted by Casco Mubanga, HIV and TB activist, working as I.E.C & advocacy officer for the network of Zambian people living with HIV and AIDS (NZP+) Lusaka chapter. His major advocacy work among others has been advocating for access to treatment and scraping of user fees for TB treatment and diagnosis tests for people living with HIV.

* Not his/her real name
In 1978, the member countries of the WHO adopted the Primary Health Care as a strategy to achieve an acceptable level of health for all people by the year 2000.

But long before the declaration of Alma Ata, an apostle of Jesus Christ, St John in writing to a disciple, Gaius, indicated God’s desire for all his people: “I wish above all things that thou may prosper and be in health, even as thy soul prospers” 3 John 1:2. Three things stand out in this passage:

1. Health of body
2. Health of soul
3. Prosperity in secular affairs

If God has a set goal for the health of his people, then he surely must have a strategy by which this status will be achieved. Indeed, God has a strategy and in this article I will try and outline four strategies found in scriptures for our consideration to achieving God’s health for all.

The first strategy in achieving a healthy status in God’s economy is nutrition. When God created man, he gave
specific instructions regarding his diet: He said “I have provided all kinds of grain and all kinds of fruit for you to eat” Gen 1:29. This dietary instruction was put to the test when Daniel and his friends in the Kingdom of Babylon chose vegetables and water as against meat and wine provided by the King. The result was a far more superior health status for Daniel compared to the others who had what was thought to be the ‘best’ meal. Huge portions of grains, vegetables, fruits and water in our daily meal will tremendously improve our health.

The second strategy in achieving a health for all in God’s economy is cleanliness. In the book of Leviticus, God gave detailed regulations to the people of Israel, regarding how to keep themselves and their environment clean in order not to be contaminated with disease. The Israelites lived in camps in the wilderness, and these instructions were required in order to prevent epidemics due to uncleanliness of person or environment.

The third strategy in achieving health for all in God’s economy is treatment of ill health with medicines by physicians. In Jeremiah 8:22, the prophet asks a question about the people of Israel, “Is there no balm in Gilead? Is there no physician there? Why then is not the health of my people recovered?” What this passage indicates is that balm (medicines) prescribed by physicians and applied appropriately by the people should lead to recovery from ill health. If for whatever reason, a person becomes sick, the availability of medicines and health professionals is a critical component of God’s plan in bringing health to his people.

The fourth strategy in achieving health in God’s economy can be seen in the story of King Asa. Even though it is stated as the fourth strategy it is the foundational requirement for the achievement of the other strategies. The strategy is the acknowledgement of God as the Healer, and not relying only on medicines and physicians without recourse to God for His blessing. In 2 Chronicle 16:12, it is stated that “in the thirty-ninth year of his rule, King Asa got a very bad foot disease, but he relied on doctors and refused to ask the Lord for help.

The bible says of Jesus when he was on earth that he went about doing good and he healed all (Acts 10.38). When we fail to recognize that God is the healer and we trust in the ability of men to heal us the Lord says we are cursed. In Jeremiah 17:5 God specifically states that “I have put a curse on those who turn from me and trusts in human strength”.

God has a clear strategy for achieving health for his people. The strategies are not much different from the Alma Ata primary health care strategies - nutrition, local endemic disease control, essential medicines, treatment of common disease - except in one, acknowledgment of God as the source and giver of health, and the need to continually rely on him as we carry out the activities.

As the world seeks to rediscover primary health care – now more than ever, we as faith-based providers should follow the footsteps of Christ who went about doing good and healing all, relying on the power of the Most High God. Only the reliance on God will lead to the success of primary health care as the strategy for health for all.

Questions for reflection

1. Does God have a strategy for health to all?
2. Have our hearts become deceitful? as it was with King Asa?
3. Do we trust in God when we have nothing else to trust to and only when need drives us to him?
RESOURCES

Guidelines for the storage of essential medicines and other health commodities
The USAID/IDELIVER Project offers guidelines for those involved in setting up a storeroom or warehouse. It contains written directions and clear illustrations on receiving and arranging commodities; special storage conditions; tracking commodities; maintaining the quality of the products; constructing and designing a medical store; and waste management; as well as additional resources.

WHO Model List of Essential Medicines for Children
The 1st WHO Model List of Essential Medicines for was developed by a sub-committee in July 2007, and then endorsed by the 16th Expert Committee on the Selection and Use of Essential Medicines in October 2007. It can be downloaded from
http://www.who.int/childmedicines/publications/EMLc%20(2).pdf

Recommendations for pharmacy management and the dispensing of Anti-Retroviral Medicines in Resource-limited settings
The document by FIP Working Group proposes a guidance that sets out principles and guidelines for procurement and dispensing of HIV/AIDS medicines. It provides examples of procedures and practical advice as well as offers many links for securing more information and advice. Pharmacists are invited to explore and adapt this guidance to their specific environments.

Who Killed Primary Health care
How the ideal of ‘health for all’ was turned into the reality of worsening health for the world’s poor. First appeared in 1995 but still relevant
http://www.healthwrights.org/articles/who_killed.htm

How to estimate warehouse space for drugs
The guideline is targeted to those responsible for planning and organizing pharmaceutical purchasing at national and regional levels. It describes a method for establishing the necessary minimum size of pharmaceutical stores and for estimating transport volumes
http://whqlibdoc.who.int/HQ/1993/WHO_DAP_93.3.pdf

Integrating Primary Health care
This book by Paul Thomas and Kurt Stange combines models, theory and practical advice that guides clinicians, managers and facilitators to lead integrated primary health care. Using case studies and real life examples, the practical sections are cross-referred to theoretical sections that show how theories of whole system learning and change can be applied in different situations. This book is perfect for those who lead or teach change in health care institutions such as primary care organisations, in small organisations such as general practices, and through networks. In particular practitioners and managers who wish to make sense of complex interacting factors will find it of great benefit.
http://books.google.co.ke/books?id=4Jd2LPWP5z4C&dq=primary+health+care&source=gbs_summary_s&cad=0

Thirty years of essential medicines in primary health care
The article presents the conceptual need for and rationale of essential medicines, from its beginnings until now. Essential medicines, as an integral component of the PHC philosophy and system, are explained and developments in the essential medicines approach over the past 30 years are traced.
http://www.emro.who.int/publications/emhj/14_S1/PDF/14_s1_08.pdf

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