

Undergraduate Medical and Pharmacy education: the need for change and the way forward

“The Ministry of Health, Sri Lanka has requested the University Grants Commission to commence degree programs in allied health professions/supporting health staff with the objective of upgrading the health services in Sri Lanka. One such degree program is the B Pharm degree which is to have the first intake and thus begin in 2006. All funds necessary to carry out the programmes have been made available to the relevant universities”, stated Prof B. R. N. Mendis, Chairman, University Grants Commission in his keynote address at the Second International Consultation on Undergraduate Medical and Pharmacy Education.

The five day consultation was convened by Health Action International Asia Pacific (HAIAP) in collaboration with the South East Asia Regional Office (SEARO) and the Eastern Mediterranean Regional Office (EMRO) of the World Health Organization (WHO). Over sixty participants attended the consultation. Among them were Vice Chancellors, Deans, Deputy Deans, Professors, Associate Professors, Heads of Departments, Senior Lecturers and Lecturers representing thirty five Medical and Pharmacy schools in the region, representatives of the WHO,

medical and pharmacy students, family physicians, community pharmacists and civil society groups. They met at the Brown’s Beach Hotel in Negombo, Sri Lanka from the 19 - 23 September 2005 to discuss medical and pharmacy education development and the need for revisions in medical and pharmacy curricula and to share their experiences,

thereby assisting one another to design and develop curricular revisions that will enable the students to be equipped with the necessary knowledge and skills to respond to the health needs of the people they will serve with care and compassion, ethical and non exploitative.

The first International consultation was convened by Health Action International Asia Pacific (HAIAP) in collaboration with the Association of Philippine Medical Colleges and was hosted by Health Action Information Network (HAIN) in 1988 in Manila, Philippines. Since 1990, HAIAP has collaborated with its partners to convene national training workshops for medical and pharmacy educators in the following places: Savar/Bangladesh, Beijing/China, Vellore and Calcutta/India, Yogyakarta/Indonesia and Manila/Philippines.

This consultation not only invited resource persons who have proved their expertise in these fields but also other stakeholders to present their views on the present undergraduate medical and pharmacy curricula. Representatives from civil society, family physicians, community pharmacists, undergraduate medical and pharmacy students gave presentations describing

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their views on the undergraduate medical and pharmacy curricula.

Dr Joel Fernando, Member of the Governing Council HAIAP, Dr S. Puri representing the WHO country office, Dr Krisantha Weerasuriya representing SEARO of the WHO and Dr Abdel Aziz Saleh representing EMRO of the WHO delivered their welcome addresses throwing more light into the importance of undergraduate pharmacy and medical education and curricular revision. *Dr K Balasubramaniam, Advisor/Coordinator of HAIAP* giving an introduction to the background, methodology and objectives of this consultation stated that internationally both in developing and developed countries there was deep concern about the dehumanization of medical care and posed a series of questions to the audience on ethical teaching to undergraduates and the humane aspect of medical care. He added that to keep in with the changing needs of the healthcare environment a sea change was needed and hoped this consultation would be the beginning. He assured HAIAP's fullest support in terms of a secretariat/clearing house should the audience decide to set up an informal network of medical and pharmacy educators.

Shortfalls of medical education

Dr Qasem Chowdhury, Vice Chancellor, Gono Bish-wabiddyaloy, Institute of Health Sciences, Bangladesh in his overview stated that although there has been tremendous advancement of medical technology during the last decades, the health status of the majority of the people in the world has not improved but deteriorated further. Thus, we face a

global health crisis, characterized by growing inequalities within and between countries. New threats to health are continually emerging compounded by negative forces of globalization which prevent the equitable distribution of resources with regard to the health of the people and especially that of the poor.

Though the socio-economic factors like poverty, illiteracy and politics are major determinants of the health status of the people, health services still have an important role to play. A lot depends on the doctors and health workers to improve the health status of the people within the existing constraints of the socio-political system of the country.

In spite of commitment by all the countries of the world to provide health to all its people through the Alma Ata declaration in 1978, recommendations and policy formulations to reorient medical education to produce socially motivated healthcare providers have mostly remained in papers. The existing system of medical education in most of the countries still produces professionals with urban bias, tendency towards specialization and penchant for clinical practice. This is compounded by commercialization, privatization and high tech care.

Agreeably, a new type of educational programme for health personnel that will make them responsive to the needs of the majority of the population in countries is needed. Such training is most effective if it is carried out in close relation to the actual community in which health personnel are later to work. Community based education, if we may call it so, is therefore, not an end in itself but a means of ensuring that health personnel are responsive to

the health needs of the people and for improving healthcare systems through a new kind of education for future doctors.

Although curriculum in many countries has been updated several times it still fails to achieve the above goal. There is now a growing realization that medical education is teacher-centered, top down and ivory towered. It does not give enough emphasis on skills development. The communication between teachers and students is through lectures. There is an urgent need to change it to become learner-centered, student and situation driven, community oriented and geared to skills development. Due to the rigidity and resistance of the specialists who dominate the medical schools, changes in the curricula to make it more closely in line with the health needs of the majority of the people could not be achieved.

Medical education now in practice is curative and preference is given to the treatment of patients instead of prevention of diseases. Training puts more emphasis on departmental, subject centered curriculum linked with high technology. Less priority is given to community health and as a result fundamental sciences like medical sociology, medical anthropology, medical economics, environment and gender aspects necessary to understand the community are absent.

The training is mostly restricted within the four walls of the hospital. As a result the entire education had been limited to a narrow field. The graduate comes in contact with sick people usually at the terminal stage. Since the whole education is restricted within the cities in most cases, the

students are alienated from the society and they develop a different value system than that of the masses. In fact, they become physicians for the majority of the rich people and prefer to work in the urban medical centers. Students are never trained to manage problems in a peripheral situation utilizing existing facilities and resources. In reality doctors at the periphery are unable to perform their duties efficiently and effectively.

The medical institutes and hospitals involved in the medical care of patients hardly play a role in the health system of the country. As such there is no feedback given to schools regarding skills, knowledge, attitude and competency that a medical graduate will need to deliver these services. Medical education and the regular health services therefore must be more closely linked.

The need for professional training/ orientation and skill development in pedagogy to enhance the educators' role in the faculty of medical colleges has not been adequately stressed. Teachers' training is still not mandatory. Most medical college teachers continue the didactic culture of their own teachers, most of whom had not received any training either. There is a need to develop a Medical Education Unit or department in every college for the training of teachers at the time of induction, in pedagogy; aptitude testing for teaching cadre and teacher evaluation.

The evaluation system is such that it compels the students to spend long period of their training in memorizing text books rather than gaining skills in practice. Students' capacity to understand or analyze a problem is not evaluated. There is no provision for

evaluation of teachers or curricula which is very important for further improvement of education. Present education system has been instrumental in developing an attitude among the graduates who look towards health as a commodity. Graduates sell their skills to consumers. Hence, the professional success of a physician is determined by his or her success in private medical practice. As a result 'Doctors of Disease' gain priority over 'Doctors of Health'.

He also pointed out the complete ignorance of traditional medicine, although a major part of the population receives treatment with traditional and alternative medicines.

In some countries the government has encouraged the private sector to get involved in the establishment of medical colleges to supplement and create opportunity for higher education in the country. While private sector support to higher education may not be a negative trend it is now alleged that some of these medical colleges are running on commercial basis making profit and their quality of education is also questionable. Time has come to clearly differentiate between 'privatization' and 'commercialization'. The challenge ahead of us is how we can use the private sector to provide relevant and quality education in their institution for the development of the right kind of doctors for the country. Continuing education in medical science is yet again crucial to keep the health professional updated by providing technical information. Serious efforts are needed to initiate continuing the medical education process directed to all existing members of the health care service particularly Primary Health care (PHC) providers. This will help to overcome the serious

problem of health professionals being inadequately informed and inadequately skilled.

Dr Chowdhury in conclusion stated that "health for all" will not be a reality, unless medical education is reoriented to meet the healthcare needs of the majority of the people.

Pharmacy education: what is lacking

Prof Dato Dzulkipli Abdul Razak, Vice Chancellor, Universiti Sains Malaysia sharing some of his sentiments with the audience on the development of pharmacy education stated that the pharmacy practice today is a far cry from what it used to be, more so in the developed economies.

In general, pharmacists are taught about the preparation, use, composition and effects of drugs and medications. They are taught to dispense medicine prescribed by doctors and provide information to patients about the medication and their use. They are also prepared for practice in various fields of work - hospital, community and industry, other than those who choose to work as academics or continue with postgraduate studies. They are introduced to sub-disciplines such as pharmacology, pharmaceutical chemistry, pharmacognosy and pharmaceutical technology. Later, clinical pharmacy, social and administrative pharmacy, and pharmaceutical care are introduced which are relatively new to this part of the world.

Regardless of what the areas of practice are pharmacy is a professional career equipped with abilities, skills and attitudes which are necessary to achieve outcomes related to the following:

- Developing and managing medication distribution and control systems
- Managing and administering the pharmacy
- Providing pharmaceutical care to patients and clients
- Providing drug information and education to professionals and the public

However, with the introduction of a clinical dimension in the practice of pharmacy the abilities, skills and attitudes of pharmacists gradually expanded to include:

- communication skills for effective interaction with patients and with practitioners of other health professions
- knowledge integration that is necessary for clinical exposure, and application for solution of real problems
- responsibility for monitoring the drugs taken by patients and also of the general methods of diagnosis and patient care specifically related to drug therapy.

Increasingly too pharmacy education is supplemented with business and management studies so as to enable pharmacists to participate in pharmacy practice as part of business ventures, an area commonly designated as pharmacy administration. It may include aspects of pharmacoeconomics - the latest addition to the professional development of pharmacists.

All these are exciting developments in areas of pharmacy education and practice. However, by and large, the main goals are still centered around the provision of curative service essentially focused on drug therapy. Though the

profession of pharmacy has progressed by leaps and bounds in a matter of just a decade, its “curative-approach” has not changed significantly.

One of the global events that are forcing us to re-visit the realm of pharmacy, and take a hard look at how it is coping with future needs, beyond just the “curative-oriented” practice is the Tsunami tragedy of 2004, December 26, be it in Aceh, South Thailand or Sri Lanka. During calamities such as these, what is abundantly clear is that the health of the people is made most vulnerable and it faces a greater threat. This was again demonstrated by Hurricane Katrina that hit the Gulf Coast of the US. It does not matter whether you are in a very technologically advanced country or in a developing nation it is at times like these that the usefulness of pharmacy as a frontline and primary health care concern is being challenged in an unprecedented way.

Citing the relief efforts Universiti Sains Malaysia has undertaken in Aceh and to a limited extent in Sri Lanka he stated the Tsunami tragedy as the “most effective teacher” and an eye-opener for us all. The event has traumatized us all the same, that health is such a fragile thing.

Pharmacy on the whole, certainly in Malaysia, has captured the imagination of only a small segment of the population as a vibrant profession with hard-nosed public health and societal mission. For example, as HIV/AIDS is ravaging many developing countries of Asia, Africa and South America, we do not see many pharmacists taking an active role in the campaign to prevent its widespread. Likewise on junk food, SARS, “bird flu” and related issues of public health dimension we do not see

enough pharmacists championing activities directed towards its eradication. Maybe in many of these instances, there are no conclusive or effective curative regimens to talk about such that many pharmacists are not well positioned to take an active role. Yet these are the type of “dis-ease” that will take away many more lives in our part of the world as any “curable” condition would. But the pharmacists collectively remain helpless, worse still oblivious. Instead pharmacists continue to enjoy themselves in their narrow comfort zones, in the “back rooms” or behind the counter doing the pharmaceutical “thing”. To a lesser extent some are engaged with their patients in the clinical settings. Not that these are unimportant functions, but this is not what pharmacy is all about. As a result the public health role and image of pharmacy, in the sense of preventive and promotive care, continue to suffer.

In addition to this, most of us have lost the wisdom of indigenous health knowledge which by and large advocates preventive and promotive care using nature’s pharmacy as its resource. The rich traditional health practices of Asia with all its diversity is gradually being supplanted by the notion of “a pill for every ill” or at least adulterated by it. Traditional health knowledge and practices serve no more than a conduit for the discovery of more potent “modern” pills to be exploited by the marketplace. “Biopiracy” in the various megadiversities of Asia is now a growing concern as Asians themselves are unable to “scientifically” exploit their own backyard; neither can they protect them from being plundered by parties with vested interest.

He later made a suggestion that pharmacy in Asia, and developing

countries in general, to make a difference by advocating more aggressively “preventive and promotive, social-based” pharmacy. Make “pharmacy” more community-friendly as a thought process, based on age-old wisdom “prevention is better than cure” especially in the context of Education for Sustainable Development.

WHO/EMRO initiatives in pharmacy education

Dr Abdel Aziz Saleh, Special Adviser to the Regional Director, WHO/EMRO spoke about pharmacy education in a more global context with relation to health as a human right, the health for all concept, human security, health security and the Millennium Development Goals.

Speaking about the pharmaceutical care concept and the seven star pharmacist he stated that a pharmacist should be a care-giver, decision-maker, communicator, leader, manager, life long learner and a teacher. Adding further to the WHO/EMRO perspective on the role of a Pharmacist in healthcare he said, WHO strongly believes that the pharmacist is a part of the community where he or she works and is therefore ideally positioned to provide public health messages.

Good pharmacy practice involves four main groups of activities:

- Activities associated with the promotion of good health, the avoidance of ill-health and the achievement of health objectives.
- Activities associated with the supply and use of medicines and of items for the administration of medicines or for other aspects of treatment

- Activities associated with self-care, including advice about and, where appropriate, the supply of a medicine or other treatment for symptoms of ailments that lend themselves to self-treatment

- Activities associated with influencing the prescribing and use of medicines.

In 1997 WHO/EMR conducted an overview of Pharmacy Education in the EMR. The outcome of this assessment highlighted the disproportionate emphasis on the traditional pharmaceutical subjects, and the areas which are in need for improvement or updating. The findings in summary were that;

- Theoretical/teaching hours during five years ranged from 1375 to 4340.
- Student/staff ration ranged from 9.4 to 18.2.
- Interaction with society: one college scored 31 while another scored 160
- Medicine, pharmacology and toxicology were taught in 1600 theoretical hours in one college and less than 400 in another.
- There was a lack of certain topics such as community-orientation, quality assurance, healthcare and services and that there was inadequate presentation of such topics as legislation, quality control, rational use of drugs, professional ethics, etc.

It was therefore concluded that many curricula have failed to respond to the changing needs of the profession. Thus, clearly too much of the undergraduate curricula is devoted to training in the least used areas of the pharmaceutical sciences. Pharmaceutical chemistry and the chemistry of natural products were specially

identified as fields that were over studied. The amount of time spent on these subject areas should be reduced. Many curricula place insufficient emphasis on communication skills and the clinical sciences. These must form part of any core pharmacy undergraduate curriculum. The concepts of clinical pharmacy and “pharmaceutical care” must be integrated into a core pharmacy undergraduate curriculum. The potential role of the pharmacist in public health should be incorporated into the core pharmacy undergraduate curriculum. The core pharmacy curriculum must include training in management and the regulatory affairs and policy-making that reflect pharmacists’ current and future activities in these important areas. Training in management was identified as a particular deficiency.

He also stressed that all programmes must carry a mission statement, clearly set out goals and objectives and courses with clearly stated aims, objectives and assessment procedures.

What more should be incorporated into the medical education curriculum

Dr. Devanesan Nesiab, Consultant, Centre for Policy Alternatives sharing some thoughts on Undergraduate Medical Education said that a basic understanding and appreciation of Indigenous Systems of Medicine, Health Care & Nutritional Information could be imparted to medical undergraduates. By and large the relationship between the western and indigenous medical systems is unfriendly. If there is any interaction or knowledge flow, it is largely through the western system appropriating indigenous knowledge through the

development and marketing of new drugs via research laboratories and the pharmaceutical industry, or in the reverse direction through indigenous medical practitioners unlawfully prescribing western medicines of which they may have inadequate knowledge.

Prejudice against the indigenous knowledge systems inhibits comprehensive scientific study of such knowledge with a view to adapting and incorporating as much of it as appropriate into the western system, and also to facilitate the treatment of those patients who continue with more than one system. In turn, greater understanding of scientific experimental and research methodology, and knowledge of western diagnostic techniques will be of great benefit to indigenous medical practitioners.

Secondly he continued, “a seemingly ubiquitous feature of medical faculties in Sri Lanka and elsewhere is their isolation from other faculties”. It appears that there is very little exchange of teachers or contacts between the students. Medical practicals may be entirely within medical laboratories and hospitals, and this may be a reason for the location of medical faculties closer to hospitals than to other faculties. In consequence of the isolation, medical undergraduates are often less informed than others of contemporary economic, social, cultural and political issues. This isolation and lack of information may persist and even grow over the years. Perhaps it may help if the undergraduate medical curriculum is broadened and common economic and social policy courses introduced in which medical and non-medical undergraduates could interact.

“Although there is increasing awareness of the importance of primary

and preventive health much of undergraduate medical education remains focused on curative health” he explained. There are millions of people living in remote areas and plantations who are not adequately reached by our health services. Medical undergraduates need to be aware, sensitive to and concerned of the needs of such people. “Field visits” he stressed “be it in the wake of major national disasters such as the Tsunami or, rather, be an integral part of undergraduate medical training for there is always scope for mutually beneficial field visits to medically underserved areas”.

Lastly, the disparities in access to medical care are not only geographic but also economic. Many top medical specialists, like their counterparts in many other professions, serve only the rich. It is widely believed that even those who remain in state employment, specialists and non-specialists, are best reached through channelled private consultancies rather than through free services in state institutions. It is also widely believed that certain specific brand name drugs are more potent than others. Such beliefs are promoted not only by pharmaceutical firms that produce such drugs, but also by medical officers (including state medical officers) who prescribe them and pharmacists who dispense them. This is contrary to the requirement that only generic drugs and those listed in the Standard Drug Treatment Schedule of 1987 may be prescribed by state medical officers.

Family Physicians in Primary Health Care

Dr Joel Fernando, Family Medicine Course Organizer, Postgraduate Institute of Medicine,

University of Colombo, Sri Lanka
based his presentation on training family physicians for Primary Health Care oriented health systems.

Setting the background on medical education and training in family medicine he informed the audience that in the seventies the general practitioners (GPs) working in the private sector introduced continuing education in family medicine through their professional body, the Independent Medical Practitioners Association (IMPA) and later established their own academic body, the College of General Practitioners (CGP). Formal postgraduate training was started by the Postgraduate Institute of Medicine (PGIM) of the University of Colombo, Sri Lanka in 1981. The core input for this training program came from private GPs. Undergraduate training commenced in two newly established medical schools, Kelaniya in 1992 and Sri Jayawardenapura in 1993. There is no formal training in family medicine in the four medical schools established earlier.

In 1993 the Presidential Task Force on National Health Policy recommended that GP services be coordinated with government health care and the GPs be linked to the government health information and referral systems. Further, the policy recommended that all doctors engaged in primary care be trained in family medicine and private practice by government doctors be stopped within a specified time period. These attempts at change were unsuccessful. They were frustrated by the government medical professional lobby and the vested interests promoting unregulated growth of the private health industry

which favored dependence on specialists for primary care.

Sri Lanka as a result was able to train only 726 family physicians in 22 years to serve in a health system not responding adequately to peoples' health needs.

Family physicians are comprehensive generalists. They have much to contribute to teaching students the art and science of medical practice. The dual emphasis on patient centered and population based healthcare in family medicine can add value to the medical school curriculum by providing all students with a solid foundation of generalist physician skills.

South East Asia Regional family medicine scientific working group of WHO prepared a family medicine core curriculum for countries in the region in June 2003. They recommended recognition of family medicine as a separate specialty in medicine and immediate steps be taken to incorporate the recommended core curriculum in family medicine into the existing basic medical curriculum.

Medical professionals are the most influential pressure group that determine the direction of medical education and health services. Their influence on decision making is one of stabilizing their dominant control and stubbornly resisting any efforts at changing the situation. There is a need to build strategic partnerships between peoples' groups and medical professionals to diffuse such professional resistance. Politicians make important decisions on resource allocation. These decisions influence both health services and medical education.

The medical profession will have the responsibility to retrain practising

doctors in family medicine and also agree to medical specialists working within a referral system coordinated by family physicians. The profession will also have to ensure that opportunities for family medicine training are available in all medical schools. While health service users must be prepared to accept family physicians for primary care and consult specialists only through a referral system.

Community Pharmacy and pharmacy curricula revisions

S. Weerapriya, a Community pharmacist giving his views on Undergraduate Pharmacy Education in Sri Lanka commented, "In Sri Lanka, practice of pharmacy is one of the neglected areas of health services and medical practice. Both community and hospital pharmacies are in a deplorable state and although official reports have made recommendations for their improvement, nothing has been done in this direction".

He added that the introduction of pharmacy training was first carried out in Sri Lanka in the early fifties in the Medical Faculty of the Colombo. In 1957 a full time pharmacist certificate course was introduced. At present, there are four types of pharmacy certificates including, Internal Pharmacists Course leading to a Certificate of Proficiency in Pharmacy, External Pharmacists Examination leading to a Certificate of Efficiency in Pharmacy, Diploma in Pharmacy course leading to a University Diploma (suspended) and the Degree Course at the University of Colombo leading to a BSc (Pharmacy) degree.

The pharmacist training curricula needs revision to meet the changing needs of the health services. The in-

service training programmes undertaken are ad hoc and as a result of this, properly planned training is not been done and also normal services in institutions are disrupted. At present, there is little or no prospects for career development for pharmacists. There are a number of issues that have been confronting pharmacy education and some of the most important ones are stated below.

- The facilities at training centers are grossly inadequate to meet the increased demand for training
- There is an acute scarcity of qualified trainers
- The curricula are not being updated and do not suit the need of the changing job functions
- The method of assessment do not lay emphasis on what the trainees are expected to do in the field setting
- The opportunities to obtain higher qualifications after completing the basic training courses are inadequate; therefore career development is poor
- Regular in-service training courses and continuous professional development programmes are not available to update their knowledge and skills

Students have their say

Dr Ashan Abeyewardene, Research Assistant, Department of Surgery on behalf of the students of the 98/99 batch of the Faculty of Medicine, University of Colombo, Sri Lanka spoke about the new integrated and student oriented curriculum introduced in 1995 and the possible areas for further improvement.

He stated that the current curriculum since its inception has had many changes to become what it stands today, more revised and effective. It consisted of 5 terms of Introductory Basic Sciences and 8 terms of Applied Sciences covering 14 modules, which are system based. It was deemed to be a better form of learning medicine than the traditional teacher oriented system and the subject matter being integrated helped in better understanding and correlating the theoretical knowledge to a clinical setting. The understanding on community; the primary health care system, training in research, statistics and elective appointments were considered to be very useful by the students.

The main objective of an MBBS program should be to create a graduate who can function effectively as a basic medical officer and be able to refer appropriately when required, as well as have a platform for postgraduate studies. Therefore, he stressed on the prioritization of areas as to “must know”, “good to know” and “nice to know” topics to achieve this end. The first steps to competence is to have the ability to work out a problem from given core theoretical knowledge, hence be able to face many situations, and not just an isolated few and to have seen many patients and clinical situations, as well as been part of the management of the most common and important clinical diseases. Emergency medicine should be second nature to all medical graduates and emphasis on this was considered to be of paramount importance. The teaching of psychological aspects to patient care was considered useful, and thus the importance of the behavioural sciences stream in the medical curriculum.

On the effectiveness of different teaching modalities used in delivering the curriculum he stated that the students opined that with the new student oriented system the number of lectures has been decreased, but it was important that any lecture should be used only to introduce a topic and reading around the topic should be stimulated. Small group discussions, problem based learning and tutorials should be used to make sure the student has acquired the necessary knowledge outlined by the lecture, particularly giving more prominence to the “must know” topics.

On the structure of the examinations, according to him, the students have expressed that the exam questions and marking systems should be applied according to the importance of the topics with the “must know” topics consisting of at least 70 per cent of the paper. It was considered important to introduce structured essays as it was a better method of judging whether the students had actually grasped the concepts and more importantly it forces the student to learn the concept behind a particular answer than the answer itself. The students were also of the opinion that the exams should be geared to find out whether a student knows what he/she has to know and not to find out what he/she does not know. Also a review of exam questions by lecturers, after an exam was thought to be beneficial since it would give the students a second chance to learn the important core knowledge.

He concluded by stating that medical science contains an ocean of knowledge and the objectives of any medical course should be to guide the student to swim through this vast

knowledge and collect those treasures that are most important.

Prasadini Perera, Project Officer, HAIAP in her presentation commented that Sri Lanka is at a very decisive time in Pharmacy education with the first batch of graduate Pharmacists passing out in 2002, and several other universities ready to embark on B Pharm degree courses in 2006.

Giving the opinions of the Pharmacy graduates in Sri Lanka she stated that the following also should be taken into consideration when developing a Pharmacy curriculum: resource limitations, job opportunities and the extent of development of Pharmacy in the country, the needs of the country and the acceptance and the extent to which that graduate Pharmacists are provided with the opportunity to fill into these needs.

Due to the lack of resources the current degree is executed by an interdepartmental and interfaculty collaboration with the main players being the Departments of Chemistry and Pharmacology of the Faculties of Science and Medicine. Even so it was deemed important that Pharmacy be identified as an autonomous and independent discipline and that the curriculum should give precedence to what is ‘best for Pharmacy’.

In addition to the biomedical and pharmaceutical sciences the majority expressed the importance of incorporating areas such as clinical pharmacy, interactions and communications between patients and other health professionals, pharmaceutical and health policy, overview of the pharmaceutical and health sector, traditional medicine etc into the curriculum. The graduates recognized the necessity to strike a

balance between the 'science and technology' based approach with the 'community' oriented approach and most recognized that the undergraduate curriculum be geared to give the opportunity to understand 'both these worlds'. Consequently it was considered important to be given the prospect to further specialize in an area due to the multi-disciplinary nature of Pharmacy and the diverse interests among the graduates.

In conclusion, what was of fundamental importance was the imparting of core knowledge, to nurture creativity, innovativeness, adaptability, along with the ability to seek, understand and use knowledge and information.

Recommendations and Conclusions of the consultation:

During the last two days participants were divided into five working groups, two groups to work on topics related to undergraduate pharmacy education and the other three groups to work on topics related to undergraduate medical education.

Working Groups on Undergraduate Pharmacy Education

The two groups working on Undergraduate pharmacy Education listed the following as common obstacles related to Undergraduate pharmacy curricula.

- Lack of resources/funds (lecturers, supporting staff, teaching material and books, infrastructure, equipment)
- Lack of coordination between curriculum and practice and between departments within the university

- No political will/Government support/Government policies
- Lack of recognition within the healthcare system for pharmacists
- Unavailability of jobs
- Lack of experience of teachers
- Inertia/bureaucratic mindset of people
- Dependency on expatriate knowledge
- Weak enforcement on the implementation of the new curriculum

The groups then worked out possible and appropriate solutions which are as follows:

- A national political statement, its need to be translated into action and enforced
- Government policy on funding, provision to obtain experts, resources, incentives for implementers
- Active participation of pharmacists in the formulation of national health and drug policies and their implementation
- Setting up of a statutory body, pharmacy council
- Training of trainers on trends of practice and education
- Network and collaboration. Meeting of Faculties from different universities and bringing committed and motivated people together as a core group
- Adopting benchmarking and quality assurance from other countries if appropriate
- Adequate infrastructure
- Providing adequate and appropriate employment in the government

sector/recognition in the private sector/ job security

- Accreditation of pharmacists' functions
- Transparency in all steps of planning
- Identify relevant books and journals
- Access to electronic libraries of universities/use of internet
- Virtual visits
- Share resources on regional centres

In the consensus of the pharmacy groups they concluded that it was important to base pharmacy curricula on an international curriculum encompassing global roles of a pharmacist, responsibilities of the profession, ethical issues and legislations, and regional recommendations. They also stressed the necessity for four years minimum for professional courses and the importance of basing the content on health needs of the country and prioritizing according to the most important roles of the pharmacist in various work settings. Some other points the working groups noted that should be concentrated on when developing undergraduate curriculum in pharmacy are as follows:

- * Innovative and creative
- *Knowledge, skill and attitude development
- *Commitment and responsibility
- *Ethical values
- *World wide progress in pharmacy
- *New technology consideration
- *Demand and job oriented
- *Alternative medicine oriented
- *Student-oriented
- *Country, societal and domestic needs and requirements
- *client care and safety
- *Patient-centered
- *Science-based
- *International standards
- *Public health focus
- *Life long learning

Developing students cognitive aspects

The two pharmacy groups later discussed on how best to develop students' cognitive aspects including the employment of various teaching methods to impart knowledge, student presentations, communication skills, Self Directed Learning (SDL), discussion and problem solving, interactive learning, introducing an integrated curriculum, sequence and proportion of subjects, psychology and personal development, reasoning ability, increasing self confidence, community projects, extra curricular activities etc. Discussing on the subject of problem based learning (PBL) it was accepted that PBL could be applied mainly for selected courses and should be integrated towards terminal courses for instance jurisprudence and ethics, clinical pharmacy, communication skills, toxicology/dispensing, pharmacy management and drug marketing. Both Undergraduate Pharmacy and Medical Education groups agreed that social, economic and cultural (SEEC) aspects of patient care should be introduced into the curriculum; by introducing relevant courses, special topics within a course, projects and exposure in the community and the incorporation of topics relevant to the country.

International networking and collaboration

Yet another point that was stressed during the working groups was how best the national and international networking and collaboration can be developed. According to the two groups it was essential that core groups related to pharmacy or to specific subjects were developed. Communication via e-groups, joining

the Asian Association of schools of Pharmacy, organizing conferences and workshops, exchanging programs for faculty within and outside the country, giving special priority/consideration to under developed countries, forming active students groups and joining the WHO Pharmacy forum were some of the ways to develop national and international networking and collaboration. They also expressed that international networking and collaboration should take place in several lines including,

* Curriculum * Teaching *Training *Research *Students visits *Publication *Virtual library *Sharing knowledge and expertise *Networking *Assessment methods * Students and staff visits.

They also felt that they were restricted by administrative and financial resources in making curricular changes and to resolve this they recommended that the universities,

- work with international organizations to get support and resources
- conduct seminars with local and international organizations
- include expenditure in curriculum development in annual budget
- work within capacity
- prove that it is important; show outcomes; success stories
- convince administration using data and research from other countries
- start with including important topics in a course before having the whole course
- vetting and review from other experts

Quality Assurance process in undergraduate education

The two pharmacy groups also concluded that, ensuring quality in undergraduate education was vital and indicated a quality assurance process. They listed out certain factors that should be included in any quality assurance process and they are as follows:

*Good faculty *Selection of appropriate students *Socialization of students *Good infrastructure *Good evaluation system, external reviewers *Good training and clerkship *Internal and external audits *Modernizing and monitoring in learning process *Evaluation by students *Moderation of question papers *Agreeing on certain standards and accreditation process *Exit exam in final year *Syllabi workshops *Structure-Process-Outcomes Assessment and *Presentation of new curriculum to various stakeholders. It was also discussed that undergraduate education and health promotion in the globalized world should address global trends. The communication revolution in e-pharmacy, trade issues –TRIPS, GATS, regulatory control, harmonization between countries, technical cooperation, drug information, cross border services and sales, advancement in technologies, regional conflict, natural disaster, quality affordability, accessibility of pharmacy goods, hold promotion activities on health promotion (wellness programmes), drug therapy, small research, community assessment.

Business interests and pharmacy education

A few participants agreed that business interests do destroy pharmacy education. They affirmed that concentration should be on regulation, creation of an accreditation body to accredit, monitor and recommend closure of non-performing pharmacy schools, promotional ethics, quality students and faculty, fees structure, emphasis on quality of care and safety of the consumers, control number of intake, the need for standards provided by the pharmacy board and accreditation body and ensuring enough facilities. It was also voiced that community oriented undergraduate education should be provided and giving ideas on how to tackle it they stated student electives, working with primary care physicians, special courses on TB, HIV/AIDS, patient counselling in the community, at home, health education in the community, nutritional aspects, minor ailments, poison and drug information, first aid and CPR course and nursing home visits should be introduced. In this instance they also stressed the benefits of student exposure to different country practices of pharmacy (twinning program).

Human resources in pharmacy

Human resource development is one area that needs to be looked into in undergraduate education in pharmacy. The pharmacy educators in the two groups expressed that training in house as well as overseas, fellowships, collaborative research and collaborations for higher studies, promotions and personal development were important. The pharmacy educators also emphasized on limiting

the number of student intake to maintain a good staff student ratio and that student entry requirements were important to ensure that more appropriate students are admitted for courses in pharmacy. It was according to them, necessary that interviews, aptitude tests, matriculation exams, work experience with the Ministry of Health and Ministry of Education on a geographical basis were taken into consideration.

Ethics teaching to undergraduates

Another question that was posed to these working groups was how best to promote ethics teaching and improving ethics to undergraduates. The groups came up with a series of methods including case studies, debates on certain topics, seminars that would discuss a code of ethics, inculcating an appropriate culture in campus, efforts in developing appropriate course in bioethics and working with professional associations.

And lastly, they shared many good teaching practices/success stories from their experiences. In brief, they mentioned an open house project where pharmacists from all over came and visited the faculty, communicating with and carrying out activities with students, inviting practitioners from different practice settings to give lectures, setting up of student societies that conduct projects, seminars, conferences and inviting professors from overseas. Adding a note to the teachers they declared that:

*provision of objectives & course requirements at the start *student-centered teaching methods *good lesson planning *role-modelling *conducting progressive & formative assessment

*provision of feedback & counselling
*familiarity with various teaching methods
*provision of stimulating learning environment
*maintenance of good teacher-student relationship
*skill in good test construction
*utilization of effective teaching materials & aids
*presentation skills
*continuing professional development
*good classroom management and
*encouragement of self-directed learning would be important to focus on.

Working Groups on Undergraduate Medical Education

Social, Economic, Ethical and Cultural concepts (SEEC) in medical education

The three working groups on undergraduate medical education worked on finding solutions to a series of topics. Introducing the concepts SEEC aspects of patient care into undergraduate medical education was agreed essential by all three groups. Having analyzed the current situation in some countries in the region the medical educators stated that a holistic, integrated approach based on patient problems should be introduced in a classroom, community and clinical setting. Shedding light on timing it was revealed that the SEEC concept should be introduced from the first year, should have a longitudinal follow up and should be emphasized during clinical teaching. They also recommended a teaching strategy that is structured and outcome based, focused on community problems, based on real case scenarios in hospital and community.

In the final consensus they urged that curriculum developers should incorporate the following aspects to all teaching/learning activities in clinical departments; health economics/policy, traditional medicine, critical evaluation of patient management, medical anthropology, sexual behaviour, health seeking behaviour, psychosomatic illness and cultural influence on presentation of diseases and communication/language/counselling skills to strengthen the already existing community based activity and participation of many clinical teachers will assist in establishing the links. They also made note that certain teaching/learning methods should be adapted in introducing the SEEC concept such as small group discussions, lectures, role play, dramas, community attachments, case based exercises, electives, video clips, medical literature/films. Finally they stressed on the importance of assessments after the introduction of the SEEC concept with more emphasis on continuous, integrated and clinical assessments, formative assessment over a long period and that it should be portfolio reflective.

While another group concluded that there were many categories of barriers which should be addressed with some possible strategies in order to ensure students competency in SEEC issues. Barriers within

curricular:

* time – insufficient time given to SEEC issues with doctors rushing for private practice * settings – too much classroom teaching and insufficient patient contact teaching SEEC issues early and be systematized:

* too few social scientists as teachers * focus on disease and not health * focus on biomedical model of illness rather than ‘bio-psychosocial’ model *social medicine a separate department * students’ first contact with patients is with a dead patient.

Faculty:

* teachers’ background not preparing them to teach SEEC issues * teachers often not being taught to teach SEEC issues
* teachers poor role models

Student:

* students facing own social and economic problems
* students begin year one with altruism and awareness of SEEC issues but fall by year 4

Selection:

* selection of the right students * selection of the right faculty

Assessment:

* exams not made to manage common problems in a holistic way * rarely assessing competence in SEEC issues

To address some of these most crucial barriers the group developed three strategies.

Strategy one - Faculty development:

*all disciplines to be involved in teaching SEEC issues *the highest authorities to get involved *encourage faculty to use all teaching opportunities *incentive to staff to teach SEEC issues including best teacher award, sabbatical, financial rewards *mentoring *restore the GP to prominence since they are best placed to teach SEEC issues.

Strategy two – Reforming the way we assess students:

*defining knowledge, skills, attitudes and performance in

SEEC issues through regular, continuous assessment *sensitize examiners to SEEC issues *giving SEEC issues a particular weight or percentage in the final grade *requesting patients and fellow students to assess students.

Strategy three – Broaden teaching setting: *introducing a wider variety of settings to teach SEEC issues (family, clinics, hospitals)

Ethics training and improving ethics training to undergraduates

The groups also centered their discussions on improving ethics training to undergraduates. They once again analyzed the current situation in several countries in the region and identified the objective in explaining the principles of ethics to students, their ability to identify ethical issues involved during patient care and the ability to apply the principles of social, bio clinical ethics in their practice. The contents according to them should carry principles of ethics, law in relation to ethics, confidentiality, patient before self, ethics of resource allocation and research ethics. How best these can be introduced to the system was another question that sprung during the discussion. The educators stated that this concept should be introduced vertically, it should run through the whole curriculum with structured inputs, should be documented in the written curriculum, should have a separate department of bio ethics and all teachers/clinicians should be sensitized and take responsibility of training. They also added that teaching and learning activities such as lectures, case vignettes, role play, video clips, media reports would be helpful. Once again stressing the importance of assessment they said that an assessment

scheme which is initially formative later summative, moral development test and incorporation/integration into other exams as long, short cases are important. Analyzing the current situation of community based undergraduate education in some of the Asian countries was considered important. So much so that community orientation should be a must in all disciplines especially in clinical disciplines and therefore community based teaching should be encouraged in clinical disciplines. Assessments should be incorporated into clinical subjects. As with the pharmacy groups the medical working groups too commented on the need for networking; exchanging/sharing of learning resources, sharing expertise of medical education/curriculum development and increasing bargaining power with the government and between medical schools/universities, other government institutions, health activity groups international institutions and organizations.

Problem based learning as a teaching/learning tool

The educators listed some advantages of using problem based, student centered learning as a teaching/learning tool including, clinical reasoning, problem solving, critical thinking, team work and SDL. To maximize benefits on PBL it was necessary to make

students aware of the concept, change the mindset of teachers and use strategies to improve group processes. PBL according to these working groups can be integrated into the system horizontally, vertically, spirally, and could be organ-based, system-based and topic-based.

Providing ideas as to how best teaching should be integrated they stated that it can be integrated as bed side teaching, community teaching, “generalist teacher” department-less medical school and an assessment system consisting of integration of assessment and common national examination.

Quality assurance framework in education

The educators also spoke about a quality assurance framework in education for ensuring the achievement of planned education outcomes, based on performance, peer reviewed self evaluation, predetermined standards, review in three/four year cycles etc. Quality assurance programmes internally and externally with more frequent self/peer reviewed evaluation in various levels with each level feeding into the next level internally and comprehensively, based on self evaluation reports with different delegates from medical councils, universities stakeholders externally. Finally, touching on what makes a good teacher, the groups agreed that it was

necessary to brainstorm the students to acquire those qualities that make a good teacher. The qualities agreed upon and how best these could be developed were as follows:

- * good role model – faculty development/selection/recognition of good role models
- * time frame to teach – retired professors who volunteer, teaching teachers time management, protected teaching time, recruiting full and part time staff
- * enthusiastic, inspirational, motivational – often younger staff are approachable and have more time
- * experts in their subjects – best graduates may not be the best teachers
- * facilitates learning
- * facilitates questioning
- * empathetic towards students
- * integrates theory and practice
- * encourages students to be actively involved in practical care
- * good communicator

It was agreed that teachers should be trained in SDL, computer skills, critical appraisal and convince them of their importance, incorporate SDL and PBL into all teaching sessions, using multiple learning strategies and to be furnished with resources.

The final resolution

An integral element of quality assurance of undergraduate medical and pharmacy education consists of the following essential components;

- 1. Student evaluation of the Faculty*
- 2. This evaluation should initially be used formatively to improve teacher performance*
- 3. Cadre provision and teacher promotion should take into account the number of contact hours by the Faculty together with the quality of teaching as determined by student evaluation and contribution to undergraduate medical and pharmacy education and curricula.*

If you need more information on this consultation please write to prasadini@haiap.org or passanna@haiap.org

AFRICA- Kenya

Who can afford drugs in Africa?

HAI Africa, in collaboration with the World Health Organization and the Ministries of health of Ghana, Uganda and Kenya, has recently concluded country-wide surveys of medicines' prices. The work was done under the DfID-funded Regional Collaboration for Access to Essential Medicines (www.haiAfrica.org).

In carrying out the projects, HAI Africa worked with its partners: the Catholic Pharmaceutical Services in Ghana, the Coalition for Health and Social Development (HEPS Uganda) and the International Network for Rational Use of Drugs (INRUD) Kenya. The surveys were carried out using a methodology developed by the World Health Organization (WHO) and Health Action International (HAI). Data was collected on the prices of a basket of 30 medicines from a core list proposed under the methodology and an additional number which are used to treat the top ten diseases prevalent in the survey countries. The methodology relates the cost of medicines to the wages of the lowest paid government worker. This helps illustrate the affordability of the medicines. The data was collected from the public, private not-for-profit

(mission/NGO) and private for profit sectors.

Stated below are some findings:

Uganda:

In private pharmacies, the innovator brands were 13.6 times more expensive than the international reference price and were 5 times more expensive than the prices of their generic equivalents. There was a wide variation of prices for the same medicine within the private sector, wider for innovator brands than generics. It takes 36 days' wages to purchase innovator brand of ranitidine for treatment of peptic ulcer compared to 2.4 days' wages to buy an alternative treatment with generic omeprazole. For a monthly treatment of hypertension using atenolol, it takes 17 days' wages to purchase the innovator brand compared to one day's wage to buy a generic equivalent.

Ghana:

The survey revealed that, generally, the lowest paid government worker would have to work for more days to be able to buy medicines from the private retail sector than in both public and mission sectors. For example, it takes more than 10-15 days' wages to

buy 30-days' treatment for peptic ulcers using ranitidine, which is the cheapest generic medicine for this condition. Given that this is a chronic condition that may require treatment for several months, this medicine would be highly unaffordable for a large number of Ghanaians, 60 per cent of whom live on less than \$1 a day. Medicines sold by Ghana's private sector health providers cost consumers significantly more than those from the public sector. However, medicines in the public sector are not always readily available.

Kenya:

The private sector had the highest patient prices in relation to the international reference prices, with innovator brands being, on average, more than 17 times the reference price. However, it was found that public and missions' sector procurement of medicines in Kenya achieves competitive prices and could help make medicines more affordable.

The full study results will be published by the end of 2005. The affordability of medicines is of crucial importance in these countries, where over half the population lives on less than \$1 a day.

Source: HAI Africa. For more information please contact info@haiAfrica.org.

EUROPE - Netherlands

Patients' reporting of adverse reactions

Pressure to allow patients to report details of adverse reactions directly to the relevant authorities has developed following a number of cases where the response to users' evidence of harm was slow and inadequate. Calls for allowing this direct reporting reflected the concern that pharmacovigilance systems

based on reporting by professionals are failing to protect consumers from continued exposure to unsafe medicines. More broadly, there is dissatisfaction with the sometimes patronizing attitude that the authorities have towards the public and with the exclusion of patients' and

consumers' representatives from debates and decisions about medicines' policy. Medicines agencies seem uncomfortable with dealing with 'unscientific' data from patients, deeming it less 'useful' and less easy to handle in comparison with that derived from professionals' reports.

There has, therefore, been a dual motivation behind wanting to have direct reporting: firstly, that pharmacovigilance systems will be more effective if patients' reports are included and, secondly, that allowing patients to report demonstrates a necessary attitudinal change towards showing greater respect to those experiencing illness and taking medicines.

A seminar was organized by Health Action International Europe in May 2005 which brought together representatives of a range of interested groups: regulators / government agencies, consumer groups and professionals' associations. This article seeks to:

offer a critical assessment of existing systems, which includes drawing comparisons between those run by government authorities and those run by NGOs; identify ways of sharing good practice and of coordinating the use of data collected in different countries.

Five patients' reporting systems are described: Government authority-run systems

- LAREB, Netherlands (www.lareb.nl),
- Yellowcard system, MHRA, UK (www.yellowcard.gov.uk),
- Danish Medicines Agency,
- DMA (www.laegemiddelstyrelsen.dk)

Consumer group-run systems:

- DGV, Netherlands (www.meldpuntmedicijnen.nl) and
- KILEN, Sweden (www.kilen.org)

Netherlands

The DGV-run system has been operating since May 2004. It is an electronic-only reporting system which, uniquely, offers those reporting be it users, carers or health professionals the opportunity to submit information about a range of concerns related to medicines. Information can be provided about practical aspects of the medicine, such as its packaging, about the medicine's availability and

reimbursement issues, about whether the medicine is having its desired effect, as well as whether the user has experienced side-effects. There is a generic form and seven disease-specific forms, developed in conjunction with patients' organizations, which differ only in having a number of additional questions to the standard set.

The system is promoted to the public via patient and consumer organizations, through placing posters and cards in pharmacies and libraries, through commercials on local and regional radio stations and advertisements in local newspapers and the trade press for physicians and pharmacists.

The DGV system was set up in reaction to the perceived shortcomings of the official government pharmacovigilance system (LAREB), which has since 2003 received reports from patients, in addition to its existing professionals' data capture. The LAREB system is designed to capture information only on side-effects and requires reporters to provide personal information. This last point does enable LAREB to respond to reporters to seek further information, but may put off those who wish to report anonymously.

In theory, the DGV and LAREB systems are linked: data on adverse reactions reported to the DGV are forwarded to LAREB. However, there are problems both of data compatibility and data quality – LAREB sets a higher standard of proof that a reported side-effect is related to a medicine – with the effect that LAREB can only accept approximately 25 per cent of adverse reaction reports originating from the DGV system. The DGV are working on adjustments to the data entry form to enable LAREB to import data on side-effects directly to their database.

Over 2,400 reports were submitted in the first ten months of the DGV scheme, working out as an annual rate of around 3,000. The vast majority of reports relates to prescription-only

medicines and is submitted by users. Key findings include:

- 'Desired effect' – 22 per cent of reports, of which 60 per cent indicate that the medicine is working well;
- Practical aspects – 16 per cent – e.g. problems with opening the packaging or administering medicine (which could lead to errors, wasted medication and impaired self-reliance);
- Availability / reimbursement – 13 per cent – essentially complaints that the medication is not covered by the Dutch health insurance;

Specifically in relation to reports on side-effects, which make up 49 per cent of reports:

- 6 per cent reported severe side effects;
- 30 per cent of reported side effects are not mentioned in patient information leaflet;
- 43 per cent of reports relate to five classes of medicines (anti-depressants, anti-psychotics, migraine medication, anti-epileptics, non-steroidal anti-inflammatory drugs);
- 27 per cent discontinued or changed their medication;
- 7 per cent discontinued their medication without consulting their physician or pharmacist;

Presumably because the system receives forms only electronically, relatively few reports were submitted from the elderly, though this category uses most medication.

These results have been widely circulated to the government, health professionals, academics and pharmaceutical companies. Each participating patients' organization received a report on the reports submitted by their members and/or about medication that is relevant to their patients.

In the two years of LAREB itself receiving patients reports, 276 and

around 450 reports were received each year. In an article on the first year's results, LAREB stressed some key findings: "the reports from patients usually contained sufficient medical information and more frequently referred to serious adverse reactions than reports by health professionals. The reports from patients relatively often concerned psychotherapeutic agents, notably antidepressants".

United Kingdom

After a very limited pilot study in 2003, which produced fewer than 40 reports in one year, and in the wake of a 2004 review of the existing professionals' reporting-based system, the British Yellow Card scheme was extended to allow for direct patients reporting in January 2005. The MHRA had come under particular criticism for its slowness to respond to information from patients harmed by SSRI anti-depressants.

Allowing patients to complete an electronic form is "one of a number of patient reporting pilot projects and part of a process of designing systems to enable patients to report through the Yellow Card Scheme". Patients preferring to complete a paper form can either ask for one to be sent to them, or pick one up at some, but not all, GPs' surgeries. Some patients' groups do point their members and website visitors in the direction of the Yellow Card website, but promotion of the system can still be characterized as limited and ad hoc. Personal and contact details are needed – as for LAREB this is so that the respondent can be contacted for more information. Data is not forwarded to the respondent's GP without their permission.

There are no results yet of the number and type of reports submitted by users. It is possible to access Drug Analysis Prints, data of reported adverse reactions for several hundred drugs, but these do not currently incorporate patients' reports.

Denmark

The Danish Medicines Agency set up a patients' reporting system in July

2003, in part as a response to pressure organized by the Danish Consumers Council after its own research into the anti-obesity drug Letigen had shown a greater level of adverse reactions than reporting from professionals alone. As in the United Kingdom, efforts to promote to consumers the possibility to report are limited; a leaflet produced by the Agency is not widely available. Again, like the United Kingdom, the form which patients can complete is an adaptation of that already used by professionals and employs medical terminology not immediately clear to a lay reporter.

The results from the first year of reporting by patients indicated a total of 149 reports, relating to 113 medical products and 405 adverse reactions. Consumer reports amounted to 7 per cent of all reports submitted, a figure which has stayed steady in the second year of the system being in place. One-third of adverse reactions reported by consumers are not currently described on the relevant Summary of Product Characteristics (SPCs). It is not possible to search on the Medicines Agency site for results of adverse reactions for particular drugs, but this information is provided in response to written requests.

Data from users is treated in the same way as that of professionals: it is forwarded to the Market Authorization Holder, to the World Health Organization (Uppsala Monitoring Centre) and to the EMEA, in the case of the last only when 'classified as serious'. The Agency feels that the experience of allowing patient reporting "has shown that they require more time and resources compared with reports from healthcare professionals. The main obstacles appear to be less precise descriptions of the medical history. Furthermore, it is often difficult to classify the ADRs, because it is more complicated to find appropriate diagnosis in the international coding system".

Sweden

KILEN has been receiving reports from patients since 1978. Although a range of promotional techniques are used (e.g. brochures, posters, press and radio adverts), limited resources mean that many patients remain unaware of the possibility of reporting. The authorities have long been hostile to the scheme, believing it to have the effect of scaring patients and leading them to stop taking their medicine.

The great wealth of data collected by KILEN demonstrates that patients report different things in different ways and sometimes in far greater volume than do professionals. For example, between 1984-1988, KILEN received 420 reports about Lorazepam, while in the period 1980-1988 professionals' reports totalled 18. A comparison of 327 consumer reports and 437 physician reports for Setraline (Zoloft) showed that there are many side-effects reported in great number by consumers, but not at all by physicians (withdrawal reactions, electric shock feelings, dependence, suicidal ideas, apathy / lack of initiative).

KILEN is the only system where feedback is provided to those submitting reports.

Conclusions:

In conclusion the functions of collecting signals and collecting experiences are in no way exclusive. The mere fact of making regulators confront people's experiences – to see the consequences of their decisions in authorizing medicines – can prompt regulatory reviews and changes. Users can derive comfort from seeing themselves as adding to signals.

It is neither necessary nor useful to claim that either collecting signals or collecting experiences is more valuable. Both are important. Neither is it possible to identify an ideal model of patient reporting. Each system is 'work in progress'. The goal is not to plot a path towards any ideal, but to facilitate

exchange of good practice and of data, quantitative and qualitative.

There are reasons to doubt the extent of the commitment of some national and European authorities to patients' reporting. Governments may see patients' reporting as a necessary political gesture, but little more than that. The EMEA's language is non-committal, dealing with future possibilities and delegating responsibility to patients' groups. But at the same time, this is a live issue. The systems are new and lessons derived from their use still being interpreted. The opportunity exists to shape how patients' reporting continues to develop with the aim of making these systems meaningful. A culture of acceptance needs to be built among regulators about the value of patients' reporting – and also among consumers about the possibility of reporting and having their experiences listened to. Progress in the field of patients' reporting will in turn be a sign that regulators are properly focusing on health, not commercial imperatives, on realistic assessments of drug benefits versus harms, not faster access for drugs to the market, and on consumers as the centre of all regulatory decisions.

Recommendations

1. Promoting patients' reporting to consumers:

Those running patients' reporting systems should provide an assessment of which techniques to promote their systems have been most effective, with particular attention to mechanisms for encouraging reporting by the elderly;

2. Connecting to pharmaceutical company adverse reaction data:

The Danish Consumers Council should provide updates on the working group between the DMA, patients' organizations and industry of which it is a member; others should circulate the outcomes of any engagement with industry;

3. Data analysis and compatibility:

Certain core quantitative data should be pooled across different countries and future systems should be designed with such compatibility in mind. Patients' organizations should be encouraged to take on responsibility for analyzing qualitative data and should invest in systems for responding to those making reports. Europe-wide patients' organizations should facilitate exchange among their national member organizations.

4. Communicating with countries with no system of consumer reporting:

HAI Europe will coordinate outreach to groups in countries not covered in this report with a request to indicate, what existing or planned systems of patient reporting are there in their country; the extent of enthusiasm and capacity that they have for being involved in work on patients' reporting.

5. Communicating with national and European authorities:

Partner organizations should be encouraged to use this document to lobby their governments, demonstrating the value of patients' reporting systems and pressing for such a system to be developed and tested in their country.

In countries where there are no interested or engaged consumers' / patients' groups, HAI Europe will take on the task of engaging with key government authorities. The EMEA should arrange a meeting with all stakeholders about patients' reporting. Communication with national and European authorities should stress the principle of public access to pharmacovigilance data, whether from patients or from professionals.

Source: HAI Europe. For more information please write to info@haiweb.org

In the spotlight: Dr Andrew Herxheimer

Many of our readers will know Dr Andrew Herxheimer personally, and others will know his name from various publications on subjects familiar to all HAI News readers; from the early years of HAI in the 1980's, Andrew has been an active member of the network. We are therefore delighted to be able to use the occasion of his upcoming 80th birthday to highlight briefly some of his many achievements.

Andrew was trained in Clinical Pharmacology in London, and was for many years the editor of the 'Drug and Therapeutics Bulletin' in the UK, an independent source of information about medicines that has had a massive influence on improving the quality of medicines' information and on the education of prescribers' in Britain and the wider world. He helped to set up the International Society of Drug and Therapeutics Bulletins

(ISDB), and after 'retirement' played an important part in promoting evidence-based medicine through the Cochrane Collaboration, (he is an Emeritus Fellow of the Cochrane Centre, Oxford). More recently, he co-founded DiPEX (the U.K. Database of Individual Patient Experiences of Diseases), and is also involved in improving the quality of medicines' labelling as a member of the Medicines Labelling Group.

He has been an uncompromising critic of all those with responsibilities for the safety of consumers when their standards fall short. His broad knowledge, generous, humorous and energetic nature have won him a large circle of friends and colleagues throughout the world who have been - and continue to be - inspired by his values, example and support.

During the weekend of 4-6 November all these - and more – achievements will be highlighted on the occasion of his 80th birthday celebrations in London. We are sure that all of you will join us in wishing him well and thanking him for his many years of invaluable input into the HAI network.

ISDB General Assembly focuses on quality of Information, independence, sustainability & the role of bulletins in society

Therapeutic Guidelines Limited, in Melbourne, Australia, was the host for the General Assembly of the International Society of Drug Bulletins (ISDB) held from 11–15 September, 2005. ISDB is a world wide network of publishers of information on drugs and therapeutics that are financially and intellectually independent of the pharmaceutical industry. ISDB was founded in 1986 with the support of the World Health Organization (WHO) Regional Office for Europe. It is the only international body that focuses exclusively on independent drug and therapeutic information and its overall aim is to encourage the publication of independent information in all countries. Because of strict criteria the membership is numerically small but highly credible.

ISDB holds a General Assembly every 3 years to give members an opportunity to attend workshops on issues relevant to the production of independent information and also to meet with their colleagues to discuss areas of mutual interest. The recent Melbourne meeting was attended by delegates from 24 countries representing 34 different organizations. The main themes of the meeting were quality of information, independence, sustainability and the role of bulletins in society. These threads were intertwined throughout the various plenary sessions and general discussions and were the main focus of workshops where the issues were analyzed in further detail.

There were six keynote addresses. David Whitbread, an Australian

graphic designer, illustrated important design principles in a presentation based on the design work he had done for Therapeutic Guidelines Limited. He spoke about the function of design in optimizing readability and how design can convey messages to readers about the integrity and quality of information. Andrew Herxheimer drew on his wealth of writing and editing experience to offer some seemingly simple, but astute, advice on how to make best use of words. The team from the French publication, *Prescrire*, Christophe Kopp and Florence Vandervelde, talked about the importance of bulletins maintaining independence, and made suggestions on how to do this. Joan-Ramon Laporte from Barcelona gave an inspiring and fascinating account of his experience of being taken to court by a pharmaceutical company over an article published in his publication, *Butlletí Groc*. Jörg Schaaber from Germany gave a well illustrated presentation on the methods his organization, *Bundeskoordination Internationalismus (BUKO)*, uses to communicate with the public to expose and influence unethical behaviour of German pharmaceutical companies in developing countries. Rokuro Hama, Chairman of the Japan Institute of Pharmacovigilance which publishes *The Informed Prescriber* and Kusuri-No-Check, spoke about involving society as campaigners alongside bulletins.

A special highlight of the General Assembly was the launch of the joint ISDB–WHO publication, *A Practical Manual on Starting or Strengthening a*

Drug Bulletin. This manual is the result of much hard work by many members of ISDB with generous support from WHO.

Most ISDB member organizations operate on very low budgets and many individuals work in isolated and difficult circumstances. Because of generous support received from both WHO and AusAID many of these people were able to attend the General Assembly. The delegates to the General Assembly shared stories of triumphs and tribulations, talking of the difficulties they face due to their limited budgets and difficult working environments. There was strong support for the strengthening of the global ISDB network especially through the further development of regional links. There was also a call for enhanced arrangements to mentor and support bulletins in need. Delegates also spoke of the need to continue to work with the public to both inform them of relevant therapeutic issues and to encourage them to become involved with local and global pharmaceutical policies. The General Assembly is also the occasion where ISDB business is carried out, such as the election of a new Executive Committee and voting on matters related to the governance of the society. This Assembly bid farewell to the majority of the previous committee, which had been capably and tirelessly led by Professor Joe Collier (formerly editor of the *Drug and Therapeutic Bulletin*), and welcomed Dr Maria Font (from *Dialogo sui farmaci*) as the new Chairman of the Society.

Source: For more information please write to Christophe Kopp (La revue Prescrire, France), Secretary of ISDB at christophe.kopp@wanadoo.fr

Drug ad pop-ups ruled out of order

The federal drug regulator in Australia has found several pharmaceutical companies in breach of the industry's code of conduct over pop-up computer ads featuring misleading health claims, inadequate information and illegible generic drug names.

The ads, which are contained in the computer program used by about 90 per cent of Australian doctors, popped up as General Practitioners typed in prescriptions and could often be seen by patients.

One breach included an ad from Pfizer about the anti-inflammatory drug Celebrex, which claimed there was "a large body of medical evidence showing no significant increase in cardiovascular disease".

In fact, studies had indicated the drug put users at an increased risk of heart attacks and strokes, prompting the Therapeutic Goods Administration to order that the drug, when marketed in Australia, must carry warnings of cardiovascular risk.

The complaints to Medicines Australia against eight pharmaceutical companies were made by a La Trobe University academic, Ken Harvey, who

also published a study on the alleged breaches of the code in the Medical Journal of Australia (this was featured in HAI News 132\133).

Medicines Australia, the drug industry lobby group that is also charged by the Federal Government with investigating allegations of improper drug marketing, found breaches proven against six of the companies regarding seven drugs, according to a document obtained by the Sydney Morning Herald.

In most cases, the companies were simply asked to "revise their advertisements to ensure compliance with the code".

"Self regulation [of the drug industry] has been proven to fail, the fines are minuscule compared to the gains to come," said Dr Harvey, who is pushing for drug promotion on prescribing software to be banned. He was critical of ads designed to make the generic drug name illegible,

which led to consumers paying unnecessary premiums for brand names when they could use cheaper generics.

Although advertising prescription medication directly to consumers is

banned in Australia, patients could see some drug ads, because GPs were encouraged to use computers to communicate with patients about their health.

Dr Harvey said the findings highlighted the need for tough action by the Therapeutic Goods Administration.

But Medicines Australia's spokeswoman, Kay McNiece, said it was reviewing its code of practice, and had acknowledged that "technology could be running ahead of regulations".

Edmund Bateman, the Managing Director of Primary Health Care, which owns the Medical Director software, would not comment on whether he would tighten standards to ensure misleading ads were not published. "If that information is misleading or inaccurate there is legislation to cover, and enforcement should ensure that it is not likely to happen in the future," he said. Medicines Australia said it had not received any appeals regarding the findings.

Other companies found in breach include Alcon, Boehringer Ingelheim, GlaxoSmithKline, Sanofi-Aventis and Solvay.

Source: Posted on July 26, 2005 on Haianz. Originally written by Ruth Pollard, Health Reporter for the Sydney Morning Herald, 26, July 2005

The PHA 2 in search of a healthier world

1492 representatives including doctors and other health personnel together with trade union, environment, women, children and human rights activists from over 82 countries around the world attended the Second People's Health Assembly in Cuenca, Ecuador from the 17 to the 22 July to analyze global health problems and to develop strategies to promote Health for all. It commenced with a symbolic ceremony of indigenous people at the Parque Arqueológico

Pumapungo (Pumapungo Archeological Park). The gathering in the Ecuadorian city pushed for recognition of health as a fundamental human right, while calling for a full stop to "corporate abuse of health."

The first People's Health Assembly, held in 2000 in Bangladesh, was a success, drawing delegates from over 70 countries and creating an international network for a healthy world. Dr. Arturo Quizhpe Peralta, Coordinator of this year's People's

Health Assembly, said participants this year were expected to continue the debates held in 2000 in Bangladesh and consolidate the alliances for building a healthier world.

"PHA 2 is a leap forward from PHA-1" said Prof. Quasem Choudhury, Bangladesh, Co-ordinator of PHA-1 in Bangladesh "PHA 2 is making connections between the health movements in Latin America to the rest of the world" he said.

State of health analyzed

Francisco Hidalgo with the Centre for Studies and Advising on Health in Ecuador said this year's gathering was also a way to generate new forums for discussing and giving shape to an alternative form of globalization. The People's Health Assembly "in Cuenca was indeed a meeting of representatives of popular sectors, alternative scientists, and associations working in favour of intercultural, humanistic medicine who are coming together in the search for a healthier world," he said. It would be an immensely rich event due to the great diversity of the delegations, the broad scope of the debate, and because the state of health in the world today will be analyzed from different angles: as a human rights issue and in relation to ecology, military disarmament, ancestral cultures and popular wisdom. "The Assembly was part of a process that is seeking to counteract the effects of neoliberal policies that are aimed at accentuating the individualization of health, as well as the waves of privatization that further reduce access to public health services," he concluded.

The People's Health Movement, an international organization of health activists, launched a new global campaign on the right to health at its second assembly in Cuenca, Ecuador. "The campaign in its first cycle will focus on the right to health care," said Abhay Shukla, co-convenor of the People's Health Movement in India. He works with a highly visible campaign for the right to healthcare in his own country that has documented hundreds of cases of denial of access, often resulting in serious health and financial consequences. The campaign has organized several local "people's health tribunals" and regional public hearings, with the support of the

National Human Rights Commission of India. "Access to health care is becoming a burning issue world-wide," Dr Shukla continued. "It is also directly amenable to actions from within the health sector, has a single group of target decision makers, and presents an important set of clear achievable outcomes." These outcomes included strengthening universal and comprehensive healthcare systems in all countries and lobbying to change global patent and trade rules and conditions associated with the international financial institutions that presently undermine access, he said.

Assembly delegates from many countries attested to the campaign's importance. Increasing erosion in access to universal healthcare, growth of unregulated private providers, and declines in public funding are leaving millions of people without insured services. The *Global Health Watch*, an alternative world health report also launched at the assembly, cites evidence of surging medical poverty in many developing countries embracing market reforms, where lack of public health care is forcing families to exhaust what small savings they have on private treatments.

Global University

A new global university, named the International People's Health University, marked its official launch by running a five day course for health activists on primary health care and the political economy of health. The course was run at the Faculty of Medical Sciences of the University of Cuenca, Ecuador, immediately before the People's Health Assembly.

The course was attended by 61 people, from 25 countries, with a strong representation from Latin

America and other low and medium income countries. Most of those attending were doctors already involved in or committed to developing skills in health advocacy to augment their work as public health physicians, specialists in primary care, or within non-governmental organizations.

As the Convenor, David Legge, Associate Professor of Public Health at La Trobe University, Australia, talking to *BMJ* (British Medical Journal) about the aim of the course, which he and his colleagues plan to run biannually, back to back with major international meetings said "The course has been designed to stimulate, train, and link up a new cadre of health activists to join the founder members of the People's Health Movement and continue its work. It addresses issues that are poorly covered, if at all, in conventional public health courses and undergraduate courses on international health," Dr Legge said, "And we will use the experience of running this first course to develop the programme further. We will also provide details and key educational resources on the university's website so that they are widely available."

Topics covered included framing health as a human right as opposed to a need for which health services are supplied (depending on the capacity to pay for them), macroeconomics and health, primary health care, trade and health, sex issues in health, patient rights and access to pharmaceuticals, health sector reform, and health research.

Fran Baum, Director of the Community Health Research Unit at Flinders University, Australia, underlined the importance of funding community driven and community based research. "Currently, the medical

technological model dominates thinking about health and disease and defining research priorities,” she said. “Furthermore, there is no obligation on researchers to undertake research that is socially useful or to define its outcome in terms of what benefit it brings to the community. More research is needed on the underlying determinants of health and long term assessment of complex community based interventions.”

Doctors attending the second People’s Health Assembly also testified that over 100 doctors have been killed in violence against doctors and patients in Iraq during the past two years of US occupation. As a result “Thousands of doctors, many of them highly experienced have already left the country” said Dr. Salam Ismael, General Secretary, Doctors for Iraq an independent association of medical professionals that was set up in October 2003.

PHA 2 proposed to the WHO to monitor the health situation in Iraq independently. “WHO should set up a special commission for this purpose” said a spokesperson for the People’s Health Movement. “The world needs to find out the truth about what is happening to the Iraqi people under US occupation” he said while addressing a press conference. Targetting civilian population, medical facilities and personnel are blatant violations of Geneva conventions. “This is a war crime of the first order” agreed Dr. Bert De Belder of International Action for Liberation, Belgium.

“Free Trade Agreements are the number one enemy of public health today” said Dr. Eduardo Espinoza, El Salvador. “Asia can learn lessons from Latin America”, he said while referring to the disastrous impacts of unfair trade practices that has reversed the health indicators in many countries.

“What Africans need is justice and not charity” said Ms. Mary Sandasi from Zimbabwe addressing the press. She was referring to the failure of the recently held G 8 summit in affectively dealing with the debt issue.

The scheduled activities also included the international launch of the first Global Health Watch Report (GHW), dubbed the Alternative World Health Report, and the Global Children’s Forum, in which 500 boys and girls discussed, analyzed and defended issues crucial to their health, happiness and well-being. One key outcome of the Assembly was the ‘Cuenca declaration’, declared during the closing plenary on 22 July 2005. This is a brief summarization of the main concerns that emerged from various workshops and plenaries, put together rapidly by a Synthesis group (<http://www.phmovement.org/pha2>)

Sources: This article is a combination of several press coverings that appeared in the PHA Exchange. PHA Exchange 1 August 2005, originally by Tessa Richards, BMJ (30 July), IPS News Service, by Ronald Labonte, BMJ (30 July) and PHA 2 press releases of 19 July 2005.

Pharma cast as ‘bad guys’ in Hollywood blockbuster

A new Hollywood thriller featuring the pharmaceutical industry as the ‘bad guys’ has hit UK Screens in October. *The Constant Gardener* has received rave reviews from critics and is currently in the Top Ten films in the US, where it was launched at the beginning of September 2005.

The film’s tagline runs: ‘The Conspiracy is Global, The Corruption is Contagious’ and is based on a John Le Carre novel of the same name, first published in 2000. The plot revolves around a conspiracy between corrupt governments and the pharmaceutical company who are testing drugs on people in Kenya without their knowledge. Rachel Weisz and Ralph Fiennes are the film’s leads, with Fiennes’ character determined to avenge Weisz’s death and get to the bottom of the conspiracy, which takes him from London to Berlin and Nairobi.

Speaking to the BBC World Service about the role, Ralph Fiennes said the political elements of the story appealed to him. “Drug companies should be more transparent, we should know what they are doing, and how accessible are they making their drugs that will help people in third world countries. “Those are basic things that I think probably seem common, moral sense. But I was drawn to the film because of the character of Justin, really.”

Source: Haianz , October, 2005

RESOURCES

European patients' forum - secrecy and conflict of interest

The new, short report titled, "Does the European Patients' Forum represent patient or industry interests?" a case study in the need for mandatory financial disclosure by Health Action International Europe (HAIE) reveals how the European Patients' Forum legitimacy has been taken for granted despite its lack of transparency and close links to the pharmaceutical industry.

HAI Europe argues that the case of

For more details please visit www.haiweb.org

the European Patients' Forum demonstrates the need for rules on financial disclosure - who is funding NGOs and lobbyists - to be made mandatory, not voluntary. The European Transparency Initiative proposed by Commissioner Kallas must be based on clear and enforceable rules on financial disclosure.

HAI Europe also argues that the Commission and the European

Medicines Agency should reconsider their relationship with the European Patients' Forum. It is vital that the voice of patients is heard when decisions are being taken about medicines and health. The Commission and the European Medicines Agency should consult with groups which are accountable, transparent and independent of pharmaceutical industry financing.

Therapeutic Guidelines: Palliative Care, version 2

Published by:

Therapeutic Guidelines Limited

Number of Pages:

370 pages

Year:

2005

A succinct summary of the complex issues relating to the care of the patient with a terminal illness – extensively revised and expanded to include some totally new material

The need to consider palliative care early in the course of a terminal illness, not only when curative options have been abandoned, is highlighted. Also

emphasized is the need for the treatment to relate to the patient's prognosis and the goals of care.

A full listing of contents for Palliative Care 2 is given on the website <http://tg.com.au/products/pcg.html>. Some of the new material includes:

- Palliative care for patients with life-threatening illnesses other than cancer
- Communication and cultural issues, especially those related to indigenous patients

- Issues relating to travel, use of emergency departments, etc

- Bowel management, malignant ascites, dementia, pressure sores, urinary problems

- Management of distress and unrelieved symptoms in terminal care

- Revised section on NSAIDs, newer drugs, unlicensed use of drugs

- New content on dose titration, rapid dose escalation, use of opioids

- New appendix on patient assessment tools.

If interested contact: Therapeutic Guidelines Limited, Ground Floor, 23-47 Villiers Street, North Melbourne VIC 3051 Australia, Email sales@tg.com.au, Tel: +61 3 9329 1566, Fax: +61 3 9326 5632

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Implications of Some WTO Rules on the Realisation of the MDGs

Publisher:

TWN

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983-2729-48-3

Number of pages:

48

Year:

2005

Following the Millennium Summit of 2000, a useful set of references and benchmarks which governments, international and other agencies and people can look to as worthy goals to achieve, was formulated at the United Nations. They came to be known as the Millennium Development Goals (MDGs).

The realization of the MDGs has, however, been impacted upon by some of the rules, recent proposals and

developments in the World Trade Organization (WTO). This paper authored by Martin Khor, the Director of the Third World Network attempts, in summary, to show some of the effects the multilateral organization has had on the goals and targets government leaders have collectively wanted to achieve.

It begins with a brief assessment of the problems arising from the implementation of WTO rules. This is followed by an outline of the main features and effects of some of the WTO agreements and a discussion on the decision-making system and the structural or systemic aspects of the WTO. Some suggestions for improving

the situation are made for each of the topics.

Contents

1. Introduction
2. "Problems of Implementation" And the Lack of Progress on the "Development Issues" in the WTO
3. Agriculture
4. Services and GATS
5. Intellectual Property Rights and TRIPS
6. The Industrial Sector
7. Attempts to introduce new issues and agreements in the WTO
8. Transparency and participation in the WTO

To order the book visit the online bookstore: <http://www.twinside.org.sg> or contact Third World Network at 121-S, Jalan Utama, 10450 Penang, Malaysia. Tel: 604-2266159, Fax: 604-2264505, Email: twnet@po.jaring.my

Please quote your full name and address for despatch and payment details.

The Global Health Watch : an alternative view to world health

The Global Health Watch is a call to all health workers to broaden and strengthen the global community of health advocates who are taking action on global ill-health and inequalities and their underlying political and economic determinants. The global community has failed to achieve 'Health for All by the Year 2000'. New targets such as the Millennium Development goals look increasingly unachievable. Questions need to be asked about whether current policies in global health are working. The Global Health Watch for 2005-2006 looks at some of

the most important problems, suggests solutions, and monitors the efforts of institutions and governments concerned with promoting health world-wide. This report arises out of many civil society and professional campaigns and struggles for better health, and has been released to coincide with the Second People's Health Assembly, held in Cuenca, Ecuador, at which around thousand five hundred people from across the world gathered to discuss and debate strategies to overcome the political,

economic and social barriers to better and fairer health."

- Each chapter can be downloaded, or the whole document accessed at

<http://www.ghwatch.org/2005report/ghw.pdf>

- The Medicines chapter is at <http://www.ghwatch.org/2005report/B2.pdf>

- Global Health Action 2005-2006 (the associated campaign tool) is at

<http://www.ghwatch.org2005reportGlobalHealthAction0506.pdf>

Global Health Watch 2005-2006 could be downloaded from http://www.ghwatch.org/2005_report_contents.php

Olle Hansson Award

HAI News reports on developments in national and international campaigns on health for all. This newsletter highlights activities of network contacts involved in improving access to medicines, rational drug use and poverty eradication.

HAI News is produced by HAI Asia-Pacific Coordinating Office

Editors:

K.Bala, Passanna Gunasekera

Health Action International (HAI) is a network of individuals and NGOs involved in health and pharmaceutical issues.

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To recognize the work of an individual from a developing country who best demonstrates the qualities of Olle Hansson in promoting the rational use of drugs.

'It is time to act! It is time to act for all of us who believe in human dignity and justice.'

Olle Hansson

The Award is named in honour of Olle Hansson, a Swedish paediatric neurologist internationally known for his advocacy of SMON victims who were paralyzed or blinded after using clioquinol, an anti-diarrhoeal drug. Olle Hansson was a powerful campaigner against unethical promotion and marketing of drugs. In many ways, he represented the conscience of the medical profession. His influence was felt not only in Sweden and Japan, which have thousands of SMON victims, but also in Europe and developing countries. Olle Hansson will be remembered by all who campaign for the rational use of drugs.

Although he died of cancer on May 23, 1985, at the age of 49, he remains a continuing source of inspiration for public interest workers everywhere. May 23 is commemorated each year as 'Olle Hansson Day'.

The Award was first given in 1987. The recipients included Dr Mira Shiva of India, Dr Alfredo Bengzon of the Philippines and Prof Dzulkifli Abdul Razak of USM, Malaysia.

Nominations

Nominations are invited for the Olle Hansson Award. This Award for 2006 recognizes the work of an individual from a developing country who has contributed the most to:

- Promoting the concepts of essential drugs and their rational use, and
- Increasing the awareness among consumers of the dangers of irrational and hazardous drugs.

Nominations for the award, which can come from any individual or organization, should contain:

1. A one-page biodata of the candidate (including educational background, positions held, affiliations, honours and awards).
2. A 500-word statement of the nominee's qualities and achievements in the field of rational

drug use. Please provide documentation of work done.

3. A recent photograph of the nominee.
4. The nominator's name, affiliation and address.

Closing Date

Nominations will close on 30th March 2006.

Announcement

The recipient will be chosen by an international panel of judges, and named on Olle Hansson Day, May 23 2006.

The Prize

The award, which is given annually, carries a price of US\$2,000 and a commemorative certificate.

Management

The Olle Hansson Award Fund is managed by Health Action International Asia – Pacific (HAIAP) which is the Asia – Pacific arm of the HAI global network.

HAIAP is a network of organizations and individuals involved in health and pharmaceutical issues. HAIAP upholds health as a fundamental human right and aspires for a just and equitable world in which there will be among others regular access to essential medicines to all who need them. HAIAP actively promotes the concept of Essential Drugs their rational and economic use through advocacy, research education and action campaigns.

Please send nominations to:

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