Book Review
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Dermatological Preparations for the Tropics

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Skin diseases are a major source of morbidity in tropical countries. In Nepal, a developing country in South Asia, infectious skin diseases like scabies remain a common source of morbidity. In these countries patients mostly pay for medical treatment from their own pocket. Dermatological disorders often do not receive the attention they require and medicines for these conditions are expensive and often not easily available.

Recently, the science shop at the University of Groningen in the Netherlands has brought out a second revised edition of the book *Dermatological Preparations for the Tropics*. The book is a formulary of dermatological preparations with background information on therapeutic choices, dispensing and prescribing.

In his preface, Dr Hans Hogerzeil describes how dermatological preparations are easy to manufacture and can serve as a good start for industrial production of medicines in many countries. In many tropical countries however these medicines are not easily available and hence the value of this book which provides information on the preparation of these medicines. The book is divided into three parts. The first part deals with pharmacotherapy of skin diseases, the second with small scale local production and the third provides brief monographs on common preparations and raw materials. Local production of dermatological preparations is important to reduce cost and improve availability. The selection criteria for dermatological preparations are need, benefit/risk ratio, benefit/cost ratio, vehicle, stability, preparation, raw materials and packaging. Each chapter ends with a brief list of references. We especially liked the brief list of indications and preparations mentioned in Chapter 3.

Chapter 4 examines the treatment of common skin conditions while Chapter 5 looks at common vehicles used in skin preparations. Vehicles play an important role in delivering appropriate amounts of the medications to their site of action. Chapters 6, 7 and 8 deal with different issues related to local manufacturing of dermatologicals. The important issue of stability of these preparations, and a list of terms related to dermatology and dermatological preparations are mentioned in subsequent chapters. The monographs deal with contents, formulation, preparation, packaging, storage, therapy and additional information. The appendix deals with the important issue of water quality used in dermatological preparations.

The language used throughout the book is simple and easy to understand. The book is well produced and is available free on the internet from http://beta.wewi.eldoc.ub.rug.nl/root/2012/formulary/ or from http://irs.ub.rug.nl/dbi/4fed64994b40a.

The book can be used to train primary health care workers, pharmacists, pharmacy students, medical and nursing students to provide low cost care for common skin diseases in a resource limited setting.

About the book:
Bakker P, Woerdenbag H, Gooskens V, Naafs B, van der Kaaij R, Wieringa N. Dermatological preparations for the tropics. Beta Science Shop, University of Groningen, the Netherlands, 2012.

The Access to Medicine Index 2012

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Access to medicines has been recognised as a fundamental human right internationally. However, even today a significant percentage of the population, especially in developing countries, lack access to medicines. Cost has been recognised as a major factor limiting access in many studies. This index examining initiatives of the world's 20 largest pharmaceutical companies to promote access to medicines in the developing world is published every two years by the Access to Medicine Foundation. The foundation aims to encourage the world's major pharmaceutical companies to make their products more widely available, affordable and accessible to people in the developing world.

The 2012 report which has been recently published examines the activity of the world's 20 largest pharmaceutical companies in seven key areas. These are overall management of access to medicines programs, public policy and market influence, research and development, pricing policies and supply chains, patents and licensing, enhancing capacity of developing nations in

product development and distribution, and product donation and philanthropic activities. The index covers 103 countries and 33 diseases. The key findings of the report are GlaxoSmithKline (GSK) remains at the top of the list as in 2010 but two new companies, Johnson and Johnson and Sanofi have moved into the top three. Many companies are devoting up to 20% of their development pipeline to products needed in developing nations. Tiered pricing schemes are increasingly being used. Medicines are sold at market prices in the private sector but are made available at reduced cost to economically weaker families and often free of cost at public health facilities. The major area of concern remains the fact that companies exert little real influence on contract research organisations (CROs) which conduct trials on their behalf. Recently this issue has raised a lot of concern and many countries including India have modified their guidelines for clinical research.

Companies are putting in place centralised strategies to improve medicine access in developing nations. It is heartening to note companies are following more ethical marketing standards and have put in place more robust systems for monitoring and enforcing compliance of employees and others with these guidelines. GSK and Bayer have publicly committed to stop making political contributions in Index countries where they operate. Many governments are putting in place tougher guidelines for doctor-industry relationships and a number of medical councils have addressed this issue in their policies.

The 2012 index uses a more refined methodology based on stakeholder feedback with the methodology followed being described in the Appendix. The abridged summary of academic and technical sources used in methodology development and analysis will be useful to researchers. The definition of terms is helpful. The graphs, figures and boxes help assimilate the information easily while the many figures highlight the human element of medicine access and affordability.

With all the negative publicity surrounding 'big pharma' it is heartening to read this book highlighting industry initiatives towards promoting access to medicines. The book will be interesting reading for all involved in promoting access to medicines in the developing world. The report can be downloaded from the Access to Medicines Index website (http://www.accesstomedicineindex.org/).

World Malaria Report 2012

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The World Malaria Report 2012 summarises information received from 104 malaria endemic countries and other sources. It updates the analysis presented in the 2011 report. It highlights the progress made towards the global malaria targets set for 2015 and describes the current challenges for malaria control and elimination.

The report is structured with eight chapters and regional and country profiles. Chapter 2 highlights policies strategies, goals and targets for malaria control and elimination. The WHO Global Malaria Programme, in keeping with its normative role for malaria prevention, control and elimination, embarked on a major review and redesign of its policy setting process in 2011. The conclusion of that process was the creation of Malaria Policy Advisory Committee (MPAC), which came into operation at the start of 2012. MPAC advises WHO on appropriate malaria policies, standard, initiatives, and major issues and challenges.

Chapter 4 – Malaria prevention through malaria vector control, emphasizes most powerful and most broadly applied interventions; long lasting insecticidal nets (LLINs) and indoor residual spraying (IRS). Achieving universal coverage with effective vector control requires a sustained programme of vector control delivery operations which are carried out by combinations of delivery system like mass distribution campaigns, through antenatal services and immunisation clinics. IRS is applicable in many epidemiological settings, provided the operational and resource feasibility are considered in policy and programming decisions.

Chapter 5 - preventive chemotherapy for malaria describes the two recommended strategies, intermittent preventive treatment (IPT), and seasonal malaria chemoprophylaxis (SMC). IPT is the administration of a full course of an effective antimalarial treatment at a specified point of time to a defined population at risk of malaria, regardless of whether they are parasitaemic with the objective of reducing the malaria burden in the specific target population. IPT with sulfadoxime-pyremethamine in pregnancy at each scheduled antenatal visit and in infancy at immunisation clinics along with DPT2, DPT3 and measles vaccine is recommended in countries in Sub Saharan Africa with moderate to high transmission. SMC is the intermittent administration of full treatment courses of an effective antimalarial

medicine during the malarial season to prevent malarial illness in children aged between 3 and 59 months, with the objective of maintaining therapeutic drug concentration in the blood throughout the period of greatest malaria risk.

Chapter 6 – diagnosis and treatment of malaria recommends prompt parasitological confirmation by light microscopy or alternately by rapid diagnostic tests in all patients with suspected malaria before treatment is started. Uncomplicated P.falciparum malaria should be treated with artemisinin based combination therapy (ACT). P.vivax malaria should be treated with chloroquine in areas where the drug is effective; an appropriate ACT should be used in areas where P.vivax resistance to chloroquine has been documented. Both chloroquine and ACT should be combined with a 14 days course of primaquine for the radical cure of P.vivax to prevent relapses. Severe malaria should be treated with injectable artesunate and followed by a complete course of an effective ACT as soon as patient can take oral medication. Continuous monitoring of the efficacy of and resistance to antimalarial drug is important to feedback treatment policy and ensure early detection of changing pattern of resistance.

Chapter 7 highlights malaria surveillance. The design of malaria surveillance system depends on two factors, the level of malaria transmission and the resources available to conduct surveillance. In the control phase in areas of moderate to high transmission, there are often so many malaria cases that it is not possible to examine and react to each confirmed case individually; rather analysis must be based on aggregate numbers, and action taken at a population level. In a low transmission setting, it is possible and necessary to track and respond to individual cases. In the elimination phase, malaria programmes need to detect each infection, whether or not it is symptomatic and conduct an investigation of each case to ascertain whether infection was imported or locally acquired and undertake appropriate control measures.

Chapter 8 discusses goals and targets for malaria control and elimination. The World Health Assembly (WHA) and Roll Back Malaria (RBM) targets for 2015 are to reduce malaria cases by 75% from the 2000 level and reduction of malaria deaths to near zero by 2015. Fifty countries including nine countries in African region are on track to meet the WHA & RBM target. Of 99 countries with ongoing malaria transmission 58 submitted sufficiently complete and consistent data on malaria cases between 2000 and 2011 to enable an assessment of trends to be made. However these 58 countries account for only 15% of estimated cases worldwide. The surveillance system is weakest where the malaria burden is highest. There is critical need to strengthen malaria surveillance, so that programmes can identify and direct resources to the populations most in need, respond to outbreaks of disease and assess the impact of control measures.

WHO launched a new initiative called T3: Test- Treat – Track on World Malaria day 2012. It urges malaria endemic countries, donors and the global malaria community to scale up diagnostic testing, treatment and surveillance for malaria. The initiative calls to ensure that every suspected malaria case is tested, that every suspected malaria case is treated with a quality assured antimalarial medicine and that every malaria case is tracked in a surveillance system.

The report is complemented with regional and country profile. In conclusion, the report portrays the current status of global malaria and emphasizes the need of strengthening the surveillance system, data reporting, and T3 strategies.

About the book:

WHO. World Malaria Report 2012. Geneva: WHO; 2012. ISBN:978 92 4 156453 3
Available online from http://www.who.int/entity/malaria/publications/world_malaria_report_2012/wmr2012_no_profiles.pdf