In 1985, the World Health Organization defined the rational use of medicines as requiring that “patients receive medications appropriate to their clinical needs, in doses that meet their individual requirements, for an adequate period of time, and at the lowest cost to them and their community.”

Selecting a limited number of essential medicines can lead to better supply, appropriate prescribing, and lower costs. Essential medicines are those that satisfy the health care needs of the majority of the population. Selecting essential medicines begins with defining a list of common diseases for each level of health care. The treatment of first choice for each health problem forms the basis for the list of essential medicines and the standard treatment guidelines. The pharmaceutical system should then assure the availability of the medicines at all times.

Irrational medicine use occurs in all countries and in all health care settings, from hospitals to homes. It involves cases in which no medicine is needed but is prescribed; cases in which the wrong medicines, or ineffective or unsafe medicines, are prescribed or dispensed; cases in which effective and available medicines are not used; and those in which medicines are used incorrectly by patients. These actions negatively affect the quality of medicine treatment, raise health care costs, and may cause adverse reactions or the development of antimicrobial resistance.

Although prescribers play an essential role in the choice of medicines, the role of the consumer is equally important. Public knowledge, attitudes, and perceptions regarding the use of medicines influence the decision whether to seek health care, from whom, and whether to follow the recommended treatment. In addition, an increased focus on treating chronic diseases in developing countries, including HIV/AIDS, has resulted in research designed to promote long-term treatment adherence. A major concern regarding poor adherence to treatment for infectious disease is the development of antimicrobial resistance (AMR); poor adherence to any medicine is also costly in terms of the patient’s quality of life, the subsequent increase in health care expenditure, and reduced productivity.

MSH helps develop and implement activities to promote appropriate medicine selection and use and to control AMR from the global to the community level. For example, we have worked to assess pharmaceutical-use patterns in hospitals; investigate reasons for irrational use; and design, implement, and promote interventions to improve pharmaceutical use and treatment adherence. In addition, MSH works with countries to formulate AMR advocacy and containment strategies and promotes the establishment and effective function of national- and facility-level Drug and Therapeutics Committees.