

A DRUG CAMPAIGN NEWSLETTER

mfc Rational Drug Policy Cell

DECEMBER 1985

Dear Friends,

This is to keep you informed about recent events, various issues and current developments about Drug Action and campaigns with which we have been associated. To make our interventions more meaningful, we need your active interest, time and Commitment. Please write to Anant Phadke at our rational drug policy cell, 50 LIC quarters, University Road; Pune 411016 if you would like to participate in and support the campaigns. A lot could be done in the New Year if you are willing to join the ongoing efforts.

Eternal vigilance is required to ensure that the health, care system does not get medicalised, that the doctor-drug producer axis does not exploit the people and that the 'abundance' of drugs does not become a vested interest in health.

- ICMR/ICSSR Health for All Report, 1981

INSIDE

| | |
|----------------------------------------|----|
| A letter from the AIDAN Coordinator An | 3 |
| AIDAN press release | 4 |
| Imported Drugs: poor quality | 5 |
| A Buko-Pharma campaign | 6 |
| Vitality and Energy through Hoechst | 7 |
| A live saving directory | 8 |
| Keeping Track | 9 |
| Action Alerts | 9 |
| Health Care in India-i-book review | 10 |
| Annual Meet - 1986 | 11 |
| Drug Campaign News | 11 |
| Double Standards | 12 |

Fighting for A People's Drug Policy

- The KSSP Experience

Dr. B. Ekbal*

The Kerala Sastra Sahitya Parishad, the People's Science Movement in Kerala intervenes in areas like Health, Education, Ecology and Problems of War and Peace. In the field of health, KSSP is very strongly questioning the relevance of the present day health delivery system which is curative oriented, individualised institutionalised and highly costly and catering to the needs of only a wealthy minority. KSSP feels that a People's Health Movement alone can change the health delivery system in favour of the rural poor. KSSP has been striving for the last few years by various means to initiate such a movement in our country. With this purpose KS8P is at present 'organising health camps, health education classes, people's theatre forms and audiovisual campaigns and field studies on an extensive scale.

Although granting that drug's and hospitals have only a minimal role to play in achieving a healthy living for the poor, we felt that exposing and fighting the anti-people and exploitative tactics of the drug companies should play a major role in the campaign for a People's Health Policy for Our country. The aim is twofold, on the one hand we should demystify pharmaceutical products as far as the people at large are concerned and on the other hand this can be used as an entry point into the medical profession so as to conscientise the doctors and medical students on the wider health issues.

KSSP started its campaign for a Peoples Drug Policy from the World Health Day, April 7th, 1984. With one and half years intense campaign we could make the drug issue a subject of public debate, make people aware of the unethical marketing practices of drug companies and also could identify and organise a number of doctors and medical students who are socially conscious and are ready to wage a fight for a People's Drug Policy.

We started the campaign with a few major demands. These are demands for the production and distribution of essential drugs, banning of non essential, irrational and dangerous: drugs, better quality control of drugs-and implementation of the Hathi Committee Recommendations like, nationalisation of the drug industry, strengthening of the public sector, and introduction of generic names "genericnamesand updating of the national formulary. Through the campaign these demands are explained in detail to

the people with the help of documented facts, figures and authentic governmental and non governmental resource materials.

The campaign started by conducting seminars simultaneously in all the 14 districts of Kerala on the World Health Day. The theme paper was presented by a KSSP activist doctor. Representatives of doctor's organisations, medical representatives and pharmacist organisations and eminent personalities took part in the discussion. Later 45 zonal conferences were organised taking the campaign still further forwards. By the end of the year, most of the 600 units of KSSP evenly distributed throughout Kerala organised seminars attended by hundreds of doctors, and thousands of people.

Apart from lectures and seminars a number of articles on the various aspects of the drug issue were published both in KSSP journals and in other popular magazines. Two books were published and the studies done by Medico Friends Circle on Analgesics and Antidiarrhoeals were reprinted and popularised among doctors. We are at present summarising the Hathi Committee Report which will be published by the end of December 1985. Through the Rural Science Forums of KSSP, about 2000, wall news papers explaining the various aspects of the drug issue were displayed in the rural areas. Thus the message was communicated to the rural people.

The Science Cultural Programme organised by KSSP is a powerful medium for the popularisation of ideas on various issues. Every year Science Cultural March will be organised from one end of Kerala to the other end taking the message of science to the people in a big way. A few items on health issues including drugs were included in the last two jathas which attracted the attention of the people.

KSSP units are at present functioning in the Medical Colleges also. With the help of these units seminars and discussions are regularly conducted in the medical colleges. A number of articles have already appeared on the drug issue in the medical college magazines. Recently the Trivandrum Medical College students opened Dr. Olle Hanson, corner to sell books on drug issues at the, All India Paediatric Conference conducted in the Medical College campus. KSSP activist doctors, who are also members: of professional bodies like Indian Medical Association and Kerala Government Medical College Teachers Association and Kerala Government Medical Officers Association and Medical Students Organisation have made the drug issue a live subject of discussion in these bodies 'and could make their professional bodies take a positive stand on this issue on many occasions.

We coupled our campaign on the Bhopal Genocide with the ' Drug campaign effectively. Bhopal as the inevitable out-come of the multinational exploitation of the MNCs including that in the pharma-

ceutical sector could be focussed during the Bhopal campaign.

We are at present organising an All India Seminar on 'Drug Industry: A decade after Hathi Committee' to mark the occasion of the 10th Anniversary of the publication of Hathi Committee Recommendations. Since we have a public sector pharmaceutical company in Kerala (Kerala State Drugs and Pharmaceutical Industry) supplying about 45 % drugs to the Kerala Health Service a call to strengthen, KSDP is already made so as to make it capable of producing all the essential drugs for the Health Services. With this end in view a seminar on 'A Drug Policy for Kerala' will be organised in January 1986.

What 'are the concrete results of the KSSP campaign so far?

1. The drug issue has been already developed into a subject of public debate.
2. People from all walks of life are now aware of the various issues involved, like essential versus irrational and dangerous drug, exploitative tactics of the MNCs and the indifference on the part Of the Government in implementing the Hathi Committee recommendations.
3. A, number of doctors and medical students sympathetic with our views are identified and organised.
4. The prescription habits of doctors are slowly but definitely changing.
5. The sale of irrational and dangerous drugs is coming down.

*** President, Kerala Sastra Sahitya Parishad**

Please Note

mfc organisational changes

From 1st January 1986 Convenor:

Dhruv Mankad

**mfc office address: 1877 Joshi Galli
For Future Nipani591237
Correspondence Belgaum dist,
Karnataka**

A letter from the AIDAN coordinator

Needed Intervention in the National Drug Policy

Dear Friends.

Most of you are already aware of the exploitative functioning of the pharmaceutical companies in third world countries.

You are also aware that the National Drug Policy is under formulation. The outcome will be mainly decided by the pressure and influence of the drug industry's foreign sector and the national sector.

The National Drug & Pharmaceutical Development Council (NDPDC) which was formulated in 1983 to look into the drugs issue - has looked into the mere pricing and production aspects of the drug problem and that too from the [point of view of the drug industry.

There is a strong possibility that the National Drug policy will be like the Textile policy.

It is crucial that the people's interest is safeguarded. The drugs are supposed to be produced in their interest after all.

Our demands are very rational and fundamental.

—Availability of essential and life saving drugs (i.e. adequate production and streamlined distribution) to the peripheral areas.

—Withdrawal of hazardous and irrational drugs. Availability of unbiased drug information to health personnel and consumers.

(This would include updating of our National Drug Formulary which has not been done since 1977 and provision of therapeutic guidelines as in British National Formulary. Provision of Consumer Caution in regional languages—for problem drugs).

—Adequate Quality Control and Drug Control (so that every 5th drug in the market is not substandard as it is at present according to Government's own figures, and an improvement in the existing drug control mechanism has to be ensured).

—Drug legislation reform needed to prevent drug companies from misusing legalistic loopholes against the people.

If you can spare sometime and concern (not because you lack it, but because you are already involved with other things) please alert your friends, your organisations network, and request them to take whatever action they can take—from writing protest letters to the policy makers involved, to editors, and holding meetings. Since medicines deal with health and lives of people and no matter what, area, of work

you all are involved in — if you could drop a letter concerning your views about a people oriented drug policy to

— Mr. R. K. Jaichandra Singh Minister of State for Chemicals & Petrochemicals, Shastri Bhavan -New Delhi - 110011

—Mrs. Mohsinha Kidwai Minister Ministry of Health & Family Welfare Nirman Bhavan New Delhi - 110011
Dr. D. B. Bisht Director General of Health Services Ministry of Health Nirman Bhavan New Delhi - 110011

—Dr. Vaidyanathan Ayyar Development Commissioner (Drugs) Ministry of, Chemicals & Fertilizers. Shastri Bhavan. New Delhi - 110011.

with a copy to me, your contribution would be deeply appreciated and would make a great difference.

Since the National Drug Policy; is in the parliament — it would be a pity if inspite of all of us knowing about it, we let an anti-people drug policy be passed unchallenged.

In no other country are matters related to drugs dealt by the Industry Ministry and not. Health Ministry — the' priorities and influences are obvious.

Warped growth pattern of the pharmaceuticals, flooding of the market with irrational and hazardous drugs, total confusion about essential and non-essential drugs is not in the interest of our people.

The Banned and Bannable Drug list with information about these drugs being produced by VHAI is in the press. It is another attempt at focussing attention of the people on what is going on in the name 'of health care, and why they must speak up and safeguard their' own interest.

'The issue related to withdrawal of hazardous drugs, availability of drug information, ensuring drug distribution has been totally and conveniently omitted from the Drug Policy recommendations by the NDPDC — inspire of these being the chief problem areas from the' peoples point of view and even according to WHO criteria of a Rational Drug Policy.

With the involvement in Bhopal issue, the drug policy issue has received a very low priority from many of the groups involved in Drug Action itself,

(Continued on page 12)

All India Drug Action Network

A Press release

22, August 1985

Mr. Veerendra Patil, the Minister of Chemicals and Fertilizers told the delegation of the All India Drug Action Network which met him yesterday to submit a memorandum about the new drug policy and AIDAN's alternative Rational Drug Policy. AIDAN is a body coordinating the drug related work of different organizations working in the field of health, science policy, consumer and people's science movement from different parts of the country.

In its Rational Drug Policy Statement, AIDAN has drawn attention to the fact that unless unscientific, useless drug combinations which constitute the majority of drugs available in the market are withdrawn, enough resources would not be available for the production of lifesaving and other essential drugs. The delegation pointed out that some of these irrational drugs are even harmful and the Government is doing hardly anything about it. Out of a number of bannable drugs, Government had banned 22 categories of drugs in an order on 23rd July, 1983. This ban order is not properly implemented. The Minister replied that this implementation is beyond the purview of his Ministry. Too many of the demands related to the Rational Drug Policy, ms. response "was that these concerned the Health Ministry. It thus appears that there is no proper-coordination between "different ministries and the existing drug policy is only, concerned with licensing and price regulations.

In its memorandum, AIDAN has pointed out that the very approach of the report of the Steering Committee' of the National Drug and Pharmaceutical Development Council (NDPDC) is mistaken from the point, of view of the needs of the people. It is not based on the disease pattern in our country but is meant, to put in its own. words; "to decide on the selectivity of price regulation," Instead of progressing beyond the Hathi Committee report, the Steering Committee report is regressive in character This is because of the very method of the constitution of the NDPDC (with no-representative from the people, its terms of reference and method of functioning. The report contains no reference whatsoever to, the question of essential drug is as recommended by the WHO, no reference to the question, of irrational, and hazardous drugs. It deals only with different demands about profit-margins, price regulations coming from different sections of the industry, and hence is irrelevant to the needs of the people the Minister was told. The list of essential drugs

given in the appendix of this report is grossly inadequate and meant only to reduce the basket of price -- controlled drugs".

The Minister was unable to respond to all these questions related to the selection of drugs and suggested that a joint meeting with the Health Ministry is required to sort out these issues.

AIDAN has, after indepth analysis and many intense discussions formulated an outline of a Rational Drug Policy which was submitted to this Ministry in November 1984. The Rational Drug Policy Statement which sums up this outline was submitted to the Minister today. Apart from the central question of essential drugs and irrational drugs, this statement emphasizes the need for proper, continuing education of doctors, other medical personnel and consumers; stoppage of misleading promotional literature of drug companies, the necessity to adopt "The International Code for Ethical Marketing of Pharmaceuticals" as detailed by the Health Action International, proper drug distribution to the poor and the needy, through Governmental channels, abolition of taxes on priority drugs, plugging the specific loopholes identified by AIDAN in the import of drug technology and in the licensing policy to ensure self reliance, adoption of the 1975 Helsinki (Mark II) Declaration on ethical drug trial on human subjects... etc. It points out that all these measures cannot be planned unless the Government is keen on a Rational Drug Policy and not a drug pricing policy and unless profit making ceases to be the primary criterion for the drug industry.

Correspondence, meeting various officials and even the minister has failed to bring about any change in their concerns. AIDAN has therefore decided to take these issues to the people and also show by way of demonstration, how things can be done. Member organizations of AIDAN are publishing lists of brands of banned and bannable hazardous drugs. Two pilot studies to assess how many drugs in different categories (antidiarrhoeals, analgesics) are irrational have been completed. Prioritized essential drug list is being finalized and studies are being launched to calculate the drug needs of certain essential drugs based on the actual incidence of diseases. A critical analysis of the drug industry in India is already being circulated in regional languages and likewise aspects of alternative strategy would also be circulated. Member-organizations of AIDAN have recently launched such a mass movement and have received a good response from the people as well as many doctors

Imported Drugs: Poor Quality

The African Experience Dr. P.

S. Patki *

Most of the countries in the tropics may be referred to as developing countries and they do have certain features in common'. These countries lack sufficient skilled man power, and orthodox scientific' medicine is relatively young. Medical technology is under developed and hence they import most of their drugs from the advanced countries. Dr. K.K. Adjepon-i-Yamoah a pharmacologist from University of Ghana Medical School, has undertaken an extensive study to evaluate the quality of the drugs which are being imported in his country. The findings of his studies are quite astonishing.

In Ghana 90% of the drugs used in clinical practice are imported from Western countries. Secondly drugs may be imported as semi-finished raw materials and then formulated into, various dosage forms. In 1978 there were 328 official drug importers in Ghana and each importing firm had its own favourite exporting country and company! The number of different proprietary drugs is large and there are many brand names containing the same pharmacological agent. For-example the market survey revealed 15 different brands of ampicillin from different sources.

Now the major questions to be answered in relation to drugs are (a) Quality (b) Efficacy (c) Safety and (d) Quantities to satisfy national needs.

Quality:

The great diversity of the sources and types of proprietary drugs available in many tropical countries necessarily means that there are likely to be wide differences in the chemical and biological properties of imported drugs belonging to the same pharmacological class.

A disturbing feature which has been noticed on a number of occasions is that inert substances are packed into capsules and sold as specific drugs. These could be termed 'counterfeit' drugs. In 1972, a random sample 'of procaine penicillin in a government hospital was found to contain no antibacterial activity. A large consignment of calamine powder was shipped to Ghana in 1976 and chemical analysis Later revealed no calamine in the powder. In another study a sample of imported fortified procaine penicillin was found to contain one part of procaine penicillin and five, parts of penicillin G, the official requirement is the reverse ratio. A systematic analysis was conducted in the Ghana Government Regional Medical Stores between July and December 1972. Penicillin, Streptomycin, Tetracyclines, Chloramphenicol; antimalarials and analgesic antipyretics were studied.

The result indicated that a, large number of sub-standard drugs were circulating in the hospitals. (See Table I.)

Table-I

Drugs analysed during a quality control programme

| Drug | Total No. of samples | Samples found unacceptable% |
|--------------------------|----------------------|-----------------------------|
| Antibiotics | | |
| 1) Penicillins | 24 | 50 |
| 2) Streptomycin | 68 | 11 |
| 3) Tetracyclines | 26 | 34 |
| 4)Chloramphenicol | 11 | 18 |
| Analgesic - Antipyretics | 17 | 41 |
| Antimalarials | 25 | 12 |

Penicillin content of some of the preparations was as low as 22% and streptomycin content in one sample was as low as 5 %.

One should remember that the comments on imported drugs apply to the locally manufactured drugs also.

Apart from the accelerated physical and chemical degradation of -drugs, poor storage facility causes some of the drugs to get contaminated. Thus it was found that, 30 % of 50 random samples of stock solutions of drugs for oral and topical applications contained over 100,000 organisms/ml- E. coli Pseudomonas and Salmonella were among the organisms identified. Suchcontaminatlans are therapeutically undesirable and dangerous. In another study it was found that a low degree of contamination was, present in eye drops, nasal and ear drops and a high degree of bacterial contamination was found in mouth washes, dusting powders and creams.

Undoubtedly many of the drugs imported have' been of great therapeutic value. There have been many instances of failure of therapy in the tropics. While the same may be due to drug resistance, many are attributable to poor quality of drugs. Treatment of a caste of infection with a 'counterfeit' drug or degraded drug is dangerous and causes therapeutic disasters. Another factor is the, rate at which drug combinations 'of an undesirable nature are found in the tropical countries. Examples are that of Amidopyrine + Phenylbutazone, Phenylbutazone + Aminophenazone, Drugs like phenylbutazone are being pushed into tropical countries in large amounts. Why is it so?

There are a large number of proprietary preparations in the tropical' countries sold in the name of 'tonic' blood 'tonics', drugs for 'vitality', neuro-

* Reader in Pharmacology. B, J. Medical College, Pune,

tropic drugs etc. Most of them are of doubtful or unproven therapeutic value. Phenacetin is now a restricted drug in advanced countries but in the tropics it is available freely. Arsenic is hardly used in the developed world as a drug but in Ghana arsenic pessaries in the name of stovarsol is available in plenty.

Financial considerations

Ghana spends around 10% of her ~budget on health; between 30-50% of the health funds are spent on drugs. In spite of this there is shortage of essential drugs such as vaccines, chloramphenicol, antihelmenthics, and antimalarials. In the face of these shortages market places are full of an array of fast moving drugs-such as tonics, vitality drugs and aphrodisiacs and so on. There appears to be very little relationship between the drugs that are available and the real health needs of the deve-

loping world.

To sum up, the developed worlds have a major obligation to the developing countries in the transfer of technology and good drugs. Most important is that the developed countries should pass laws which will prohibit the export of drugs which have not met their local registration requirements.

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A Drug Alert Campaign!

Dear Friend,

Essential drugs could be an important part of a rational health policy. Although the concept of essential drugs and primary health care is accepted as the right solution, very little happens in reality. Most countries are flooded with hazardous, irrational and expensive brand drugs. This is especially true for developing countries which are a growing and very little controlled market for pharmaceuticals.

The Pharma-Campaign of BUKO, a network of more than 200 Development Action Groups in West Germany, is fighting since five years' against the harm and waste produced by the irrational marketing of drugs by multinational companies. BUKO is the co-founder of 'Health Action International' (HAI), a network of some 50 groups in more than 30 countries worldwide.

The most powerful drug companies are based in a few industrialized countries. Development Action and Consumer Groups in these countries think it is their duty to campaign against the global malpractice in drug marketing in the 'home countries: of the drug multinationals. The world's biggest pharmaceutical manufacturer Hoechst is based in the Federal Republic 'of Germany. As 'the biggest' sets a lot of the bad standards all companies practice, BUKO and HAL decided to start a campaign against dangerous and irrational Hoechst drugs.

The campaign was launched in West Germany in September with the public announcement of an "Examination of Hoechst drugs by Development Action Groups". We promised to present every month a Hoechst problem drug till the shareholders meeting mid-1986. We began with the multivitamin - preparations RECRESAL, VITAHEXT and FESTA-VITAL (see article that follows). We, inform our member groups, interested doctors and the press

about these problems drugs and ask for action: to make information meetings, to write letters of protest to Hoechst, to inform the public and to lobby politicians.

To make this campaign a success, we need strong international support. Hoechst drugs are sold nearly everywhere. Hoechst has agencies or subsidiaries in most countries of the world. So everybody is affected by Hoechst. And everybody can support the campaign:

Research: Advertisements, package leaflets, reports on bad marketing are needed primarily from developing countries, but are useful from industrialized countries too.

Action: To maximize the pressure on Hoechst it is important that groups and doctors from as many places in the world as possible protest against the Hoechst marketing malpractice. We will supply you every month with background information on a Hoechst problem drug and ideas for action.

We ask you to:

- * Write letters of protest to your local Hoechst subsidiary and/or Hoechst AG, D — 6230 Frankfurt, West Germany
- * ask doctors and pharmacists to write similar letters
- * inform the public wherever possible
- * ask experts for support
- * start a Hoechst campaign in your own country

It is very important for us, that you report us your activities and the response you get from Hoechst. Your support is important for a successful campaign against Hoechst and for better health!

Sincerely yours

Jorg Schaaber and Rudiger Kettler

For further information, please contact: BUKO
Pharma-e-Kampagne
August-Bebel-Str-62,
D-4800 Bielefeld 1, Fed. Rep. Germany

VITALITY AND ENERGY THROUGH HOECHST?

It's an easy job for pharmaceutical companies to sell multivitamins in developing countries. Many people fear to get not enough vitamins in their food, and pay a lot of money for vitamins and tonics brewed in the laboratories of the chemical industry of the North. Nevertheless a sufficient and complete diet would be the right and cheaper solution. The pharmaceutical industry knows that people give their last money for drugs - even when the pills don't work. The world's biggest pharmaceutical company Hoechst is involved in this business with the poor. In Germany no multivitamins and tonics are sold under the name "Hoechst". In the developing countries the same company sells several "cure alls".

Vitamins — A 'Healthy Business

A big part of pharmaceutical sales in the Third World is made with absolutely irrelevant or irrational products. One example are the heavily promoted multivitamins and tonics. In Brazil, Venezuela and Pakistan vitamins are the second-most sold products; (1) Most of the vitamin preparations, are multi ... ingredient products.

The German multinational company E. Merck earned most of its money in Bangladesh by selling multivitamins. They dominated the market for the irrational vitamin B combinations with a share of 68 %. To sell even more of those products the Merck manager decided to promote their vitamins to "fresh graduates and quack doctors in rural markets". (2) The managers were aware of the vitamin and tonic image of Merck and asked the parent company: "To remove this 'vitamin' image from the mind of the doctors and chemists; Merck should forcefully introduce essential products like antibiotics etc. immediately." (2) This sort of business is no longer possible in Bangladesh due to the strict new drug policy, but still exists in most developing countries.

Hoechst and Vitamins

The World's biggest pharmaceutical producer Hoechst takes' its share of the vitamin and tonic market. The company based in Frankfurt, West Germany manufactures the preparation VITAHEXT (in Africa sold as RECRÉSAL) and FESTAVITAL. Experts call such mixtures "expensive placebos" (3).

Recresal and Vitahext

RECRÉSAL/VITAHEXT is a mixture of the vitamins B1, B2, B6, B12, caffeine; phosphates, sugar and alcohol (5% to 20%). Indications for this irrational combination are: physical and mental fatigue, lack of appetite, disorders of nutrition and metabolism. (4) Hoechst promises that the "combined action of all ingredients stimulates the appetite; activates the metabolism and strengthens the formation of blood; the nervous and cardiovascular system. (5) The "pleasantly flavoured syrup" (4) is claimed to "enhance physical and mental

performance" (4) to "eliminate despondency, premature fatigue, lack of concentration, apathy and lack of appetite quickly." (5).

Irrational, expensive, dangerous

The B-Vitamins included in RBCRESAL/VITAHEXT are in a sufficient quantity in an ordinary meal. But even in the case of vitamin deficiency the patient does better in spending his money for food.

In India or example the consumer of VITAHEXT pays up to 7 US\$ a month if he adheres to the dosage given on the package. A big amount of money compared to the income of many Indians.

RECRÉSAL/VITAHEXT can even do harm to the consumer. Hoechst has added vitamin B12 in the form of Cyanocobalamin instead of the today normally used hydroxycobalamin. This antiquated form of vitamin B12 can mask the degeneration of the spinal cord and can damage the optic nerve. (6; 7) The long-term use of Phosphates may lead to extra skeletal calcification and to disorders in the mineral metabolism. (8).

Festavital A curious mixture

Hoechst's marketing of FESTAVITAL is absolutely irresponsible. FESTAVITAL is an unbelievable mixture of digestive enzymes, dried ox bile, the vitamins H1, B2, B6, some, other vitamins of the B-group, vitamin C and E, methionine, hesperidin and some trace elements. Hoechst's indications for FESTAVITAL in Third World countries are "Overstrain, pregnancy lactation". (9)

There is no medical justification for such an irrational mixture. Hoechst even takes the risk to harm consumers with this product. The folic acid component (a B-vitamin) in FESTAVITAL can promote damage of the nerves, as no vitamin B12 is added. The Martindale warns: "The inclusion of folic acid in multivitamin preparations may be dangerous." (10) The long-term use of vitamin A can lead to a vitamin A poisoning with many health problems. (7, 11) No responsible acting company should therefore' add vitamin A in (the any way irrational) multivitamin mixtures.

West Germany: A developing country?

FESTA VITAL is available in Germany under the name VITAFESTAL and sold by the Hoechst subsidiary Casella med. The indications are absolutely different to those in the developing countries. In Germany VITAFESTAL should help against "digestive disorders". (12)

RECRÉSAL has been available in West Germany till 1983. Both products are registered under the old drugs law which did not ask for proven efficacy and safety.

Buko asks for withdrawal RECRÉSAL/VITAHEXT and FESTAVITAL are unnecessary products; there is no justification to sell them any longer. These products speculate

(Continued on page 8)

A LIFE -SAVING DIRECTORY

Turning the tide on trade in Hazardous Products

WHAT IS THE "CONSOLIDATED LIST"?

A new directory published by the United Nations and known as "The Consolidated List of Products whose Consumption and/or Sale Have Been Banned, Withdrawn, Severely Restricted or Not Approved by Governments" is a first step in the direction of resolving some of the life — threatening problems caused by the largely unregulated trade in banned and restricted products.

The "Consolidated List" contains critical information on regulatory decisions, restrictions and bans taken by national governments on harmful pesticides, dangerous pharmaceuticals hazardous consumer products and toxic industrial chemicals. Sixty countries contributed data on more than 500 products for the first edition.

The Hazards-some examples

DDT, DBCP; PARATHION These and other pesticides poison at least 575,000 people every year. Most of this poisoning occurs in the Third World; where; day after day, farmers and their families are exposed to toxic chemicals banned in the industrialized world years ago.

CHLOROFORM Many countries have now recognized chloroform to be a cancer-causing agent and have prohibited its use in medicines. Nevertheless, a women's group in Bombay, India, reports that a popular cough syrup containing the dangerous chemical is still available Over-the-counter. The label reads, "Keep bottle tightly closed to avoid loss of chloroform".

DALKON SHIELD The manufacturer withdrew this Dangerous Intrauterine Device (IUD) from the U.S. market in 1974. In 1983, U.S. government officials warned that the device should be removed from all women still using it. But the manufacturer admits that the Dalkon Shield was inserted in women in some 79 countries. Many of those women have not been warned of the hazards of serious infection. They are still walking around with a time bomb in their bodies. Because of a lack of information, women are becoming sterile, some are even during.

HOW DID IT COME ABOUT?

The directory is the outcome of years of concern within the United Nations about unrestrained trade in products that are, for health and safety reasons, strictly regulated or even prohibited in some countries. In 1982, the United Nations General Assembly adopted a resolution calling for the preparation of a directory listing the hazardous products and describing regulatory actions that had been taken on them.

WHO /CAN USE THE DIRECTORY?

Non-governmental organizations (NGOs) have found the U.N. directory to be an invaluable re-

ference on hazardous products. NGOs are presently using this resource to draw attention to the 'double standard' that exists between developed and developing countries in the area of hazardous pesticides and unsafe pharmaceuticals. NGOs see the directory as a powerful tool to make governments and consumers more aware of the problems caused by the increasing international trade in toxic substances.

For government officials, the directory serves as useful handbook to identify potentially hazardous products in the international marketplace. Use of the handbook can lead to regulatory action to control damages that could be caused by those products.

Order a copy for your organization to use. You can get one free by writing to:

Mr. Luis Gomez
Assistant Secretary General
United Nations DIESA-PPCO
DC 2, 18th Floor New York N.
Y 10017 USA

Ask for a copy of the "Consolidated List"

Source: A flyer on the consolidated list from UN — recently received by us.

(Continued from page 7)

with the fear of poor people to get not enough essential vitamins, although better nutrition is the right solution. The marketing of these multivitamins is unethical. We asked Hoechst to withdraw RECREAL and FESTA VITAL worldwide.

First reactions

In a first reaction Hoechst admitted that our critique on the indications and warnings for FESTA-VITAL are right. Hoechst won't withdraw this product and has only promised to standardize the information. (13) Hoechst did not respond to our critique on RBCRSAL VITAHEXT. H.S. / JS.

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- 2) Merck Marketing Plan Bangladesh 1980-1982
- 3) G. Kuschinsky, Taschenbuch der modernen Arzneimittelbehandlung, Stuttgart 1980, p. 378
- 4) e.g. in the package leaflets in Ruanda and Kenia 5) PLM Colombia p. 337; since 1984 the composition of VITAHEXT in Colombia is changed, in all other countries. We referred to VIT AHEXT is still sold in the composition described in the text above. 6) Martindale, The Extra Pharmacopoeia, London 1982 p 1644 7) When overdosed. This may easily occur in Third. World countries, especially children are in danger. 8) Martindale op cit., p. 641 9) e.g. MIMS Africa 4/1985 p, 87 and MIMS Middle East 4/85 p. 123 10) Martindale op. cit, p. 1647 11) Ibid. p. 1636 12) Rote Liste 1985 13) "Hoechst weist Vorwurfe zuruck, Frankfurter Rundschau 6.9.1985.

Source: PHARMA BRIEF campaign newsletter
BUKO Pharma-Kampagne Number 1 October 1985

(1) Locost Handouts

The following handouts have been prepared by Locost during the year.

i) Analgesics (Painkillers) by pr Bal ii) Antidiarrhoeals drugs-e-symptomatic measures by Dr. Y.K. Amdekar, iii) Haematinics -Part 1 pharmacological aspects by Drs Sagun Desai and Rajul Desai iv), Haematinics- Part II— Some clinical aspects by Dr Anita Srivastava v) Haematinics part III— Preparation of commonly used Haematinics vi) Haematinics- Part IV - A survey of formulations in available in India vii) Product information sheets on Ampicillin, Atropine, Paracetamol and Mebendazole.

If you are interested in copies please write to LOCOST, (Low-cost standard therapeutics), GPO Box - 134, Vadodara-390001

(2) Antidiarrhoeals- A rationality Study: by Dr. Shishir J. Modak for Rational Drug Policy Cell, mfc. Now reprinted by Kerala Sastra Sahitya Parishad. Price Rs. 2/-. Available with-mfc, AIDAN and KSSP offices.

(3) Analgesics and Antipyretics-a Rationality Study by, Drs Jamie Uhrig and. Penny Dawson .for- Rational Drug-Policy Cell of mfc:

"Now reprinted by Kerala Sastra Sahitya Parishad: Price: Rs. 2/- Available with mfc, AIDAN and KSSPS offices.

(4) AIDAN Handouts: The All, India Drug Action Network has circulated the following handouts this year.

i) Graded Essential Drug list, ii): Priority Drug list of NDPDC, iii) the Hatch Bill, iv), AIDAN press release v) New Drug Policy and AIDAN Steering Committee Recommendations vi) Banned brands list (in print)

Those interested in copies please write to Mira Shiva, AIDAN Coordinator, C-14 Community centre, SDA, New Delhi-110016.

(5) Ramakka's story and the Drug Policy of India an audio-visual .set, (120 slides and cassette) price Rs. 450/- Produced by Centre for Non Formal, and Continuing Education, Ashirvad 30' St . Mark's Road, Bangalore-560001.

(6) Towards a people oriented Health Policy a reference file on Gonoshasthya Kendra, G.K. Pharmaceuticals and the Bangladesh Drug Policy.

Prepared by mfc, Indian Social Institute and Science Circle Bangalore. (1983)

(Price Rs. 5, 00). A few copies still available with mfc office, Bangalore,

1). The Hatch bill

Senator Orrin Hatch introduced a bill no.

S. 2878 in the U. S. Semite last year. The passing of this bill would allow export of U. S. FDA unapproved drugs to other countries. It should be noted that the existing American Law embodied in section 801 of the 1938, Food, Drug and Cosmetics Act; prohibits the export of drugs which have not been approved for use in U. S.

When the bill was introduced last year, protest came from all over the world against the retrograde amendment - from Thailand, Srilanka, India; HAI associated groups 'and public interest groups in the US. After all the public outcry, the bill was Dot voted' upon. The bill has been recently reintroduced with some modifications. Basically it will allow for export of pharmaceuticals not approved for use in US A to countries with regulatory and drug enforcement procedures considered adequate by F. D. A. ***The problem for the Third World Countries will be that the re-export of these products from the above mentioned countries cannot be regulated. We need to protest about this.***

2) **Watering down of UN consolidated List**— of hazardous drugs and chemicals

There is a move to exclude the brand name and the manufacturing data, and also to exclude drugs that .were recommended for being weeded out because of their therapeutic usefulness. Far countries with poor drug controls and gross lack of availability of unbiased drug information any such dilution of information related to hazardous chemicals and pharmaceuticals is unacceptable. These changes are being contemplated because of pressure from certain sources.

All such instances of double standards pertaining to health, industrial and safety matter need to be opposed.

*For further details and action plans write to Mira Shiva, AIDAN coordinator, C-14 Community centre SDA, New Delhi - 110016.

(7) Pills, Policies and Profits

by Francis RoIt Published by War on Want. Price £ 2.95 + postage.

The book examines commercial, political and professional reactions to Bangladesh's Drug policy, both within the country and internationally. It explains the way in which the policy-has -been obstructed and the difficulties of trying to improve the health of the majority in a poor, Third World country.

(Available from Third World Publications, 151 Stratford Road, Birmingham, B11; IRD; U. K.)

Book Review

HEALTH CARE IN INDIA: George, J6seph, John Desrochers, Mariamma Kalathil, Centre for Social Action, Bangalore. pp 148; Rs. 4.00.

Doctors, health planners and other professionals working in the field of health, often feel frustrated by the slow pace at change in the health situation of the Indian people. This leads one to become cynical about the utility of trying out alternatives in health care, On the one hand. On the other hand, it leads one to become smugly satisfied about the 'small achievements within one's area of work, not bothering about the general situation at all. There is 'a third alternative: to integrate the work at a micro level with a correct perspective of the macro-situation, thereby simultaneously contributing, in however small way, towards change in the health situation of the country.

HEALTH CARE IN INDIA is written for those "action oriented persons and groups who work at the local level... and are searching for an over all perspective". The book makes a commendable attempt at an overall analysis of health care in India looking at its socio-economic and political aspects.

The authors begin by tracing the history of the development of health services in India. After devoting a few lines on the traditional systems of medicine, this chapter focuses mainly on the mode] of health care based on 'modern' medicine develop-ed from the British period till the Health for All document (ICMR/ICSSR report). They correctly state that the model that the British developed, showed their concern for their "own, political and economic gains". But the preceding analysis fails to clearly bring this out. In fact, the 'conclusion the authors reach after describing the public health measures taken by the British between 1864 and 1946 is incorrect and contradicts the earlier statement quoted above. The British enacted these laws not, as the authors conclude, because the "increasingly recognised the State's responsibility for public health" but because the British were aware of the disastrous consequences of the spread of epidemics as a result of bad sanitary conditions, on the British Army and bureaucracy (1) That is precisely why, the British did not usher in a Sanitary Revolution which' they did in their own country during the 19th Century.

Using a wealth of statistics and information based upon the reports of various committees appointed by the Indian Government as well as the Five Year Plans (FYPs), the authors have been able to show the yawning gap between the pronouncements of the planners, policy makers and politicians and the actual achievements. The glaring failures in establishing a, model of egalitarian, rural biased and preventive health care have been bro-

ught out well by the authors. They go on to show on the basis of the expenditure outlays for rural health and water-supply during the V and VI FYP that during the latter,' there has been a significant change in favour of rural health. But given the general direction of the book's contentions, one is almost surprised at the conclusion the authors reach regarding the impact of this apparent shift in priority during the VI plan. The authors claim that "this limited but significant shift of policy and expenditure has also produced some results". Then they enumerate the increased number of-Primary Health Centres opened, subcenters upgraded and Community Health Volunteers trained, in support. Was this the result that the planners had promised? Or the authors had expected? One is certain that it was not so. One had expected to see significant changes in the people's health status. Has that happened? Unfortunately, the authors have been unable to cite a single parameter to show such an improvement.

Next, the authors analyse the National Health Policy (NHP) of 1983 in light of the IGMR/ICSSR report on Health for All. They emphasise the character of the ICMR/ICSSR report. They allege that some of the important issues raised by the ICMR/ICSSR report have been totally neglected by the NHP statement. The report lays down alleviation of poverty, removal of social economic inequality, and spread of education us essential pre-requisites to achievement of Health for all by 2000 A.D. But the NHP conveniently overlooks these aspects, and talks only of minor reforms in health care services. The authors pinpoint the flaws in the policy, quite effectively. What they fail to note, however, is that the ICMR/ICSSR report itself is a diluted version of the reality. The report has failed to analyse the real socio-economic cause behind the poverty, inequality and lack of education of Indian people and therefore the solution it has offered remains at best, mere wishful thinking.

One would like to add one more shortcoming of the National Health Policy which the author's have overlooked. With the over flooding of the drug market with irrational drug formulations on the one hand and shortages: of priority drugs on the other hand, there is an overwhelming need for a National Drug Policy. NHP is totally silent about this extremely grave problem.

The book brings out very lucidly the deteriorating health situation of the Indian people with the help of population mortality and morbidity statistics. The population growth rate runs high, though slowing down the Infant Mortality Rate still is one of the highest amongst the developing nations, though cl10hraepidemics are rare its incidence is still high, TB and leprosy are rampant, malnutrition in children and anemia in women have reached

an alarming proportion. All the indicators reflect a dismal state of affairs.

In an excellent analysis of these failures, the authors correctly conclude that, "a health care system functions within the broader socio-and political and cultural-or ideological system.... Though enjoying a limited autonomy and freedom of operation, the health care system basically 'Corresponds to and reflects what happens in the society. It is therefore normal that the health policies of the Indian Government betray the same class bias as its economic policies ...". For those who may be doubtful or resentful of this 'ideologisation' of health problems, the authors elaborate further on the social forces, and vested interests who shape the health policy and its implementation. They include private enterprise in health, health professional's and drug companies. Here, one would have expected a more thorough analysis of these forces-the political economy of health care in India. But though the vested interests within the health sector are adequately discussed, the role played by the 'politics and economies' of the Interests outside the health sector-of classes and class struggles' is not discussed.

In the end, the authors strike a hopeful note.

There are forces within the present system which are trying out alternatives. In a very informative chapter, these various alternatives are discussed. The authors cite from the: experiences of the developed capitalist countries to show the role played by improved nutrition, living conditions as well as wide public health measures in improving the health standard of the people. Further they cite the example of Vietnam, China and Cuba to show how, removal of poverty and inequality along with establishment of an egalitarian, and prevention oriented health care system can bring about rapid and dramatic changes in the health status of the people. The authors also show how giving importance to preventive and promotive health mea-

ANNOUNCEMENT

mfc annual meet 1986

Venue: Khandala (Maharashtra)

Dates: 27-29 January 1986

Theme: Issues in Environmental Health —
a case study- of pesticides

For further information, registration details,
travel information and background papers,

Write to:

Annie George, mfc
Foundation for Research in
Community Health
84-A, R.G. Thadani Marg Worli,
Bombay 400018,
Maharashtra

ures and the spread of the education have contributed to the higher health status of the people of Kerala.

Based on these experiences, the authors enumerate various possibilities of 'relevant health action'. The spectrum ranges from setting up a curative network to conscientization and political action. The report then focuses upon the debate on the relative importance 'of community health care, community development and conscientization/political action alternatives.

The critical review of this debate and the authors' position would form a theme of a separate article. Therefore, we need not go into it. One would like to state however, that all the three approaches become irrelevant and status quoist if the 'ultimate' aim—the emancipation of the people from the oppressive reality is overlooked.

In conclusion, one would like to observe in agreement with the authors that "the possibilities of meaningful involvement are clear enough to' all to come out of their indifference, lethargy and discouragement and to rediscover a new sense of direction and purpose."

In all, the book deserves the critical attention of all those involved or interested in health issues with a broad perspective of a total social change.

References:

1. Radhika Ramasubban, The colonial legacy and public health system in India-Socialist Health Review vol. 1. No.2 pp 6-12.

-Dhruv Mankad, Nipani

Drug Campaign News - 1985

Recent events

1. Protecting -the child consumers:— a workshop on irrational medication and infant foods organised jointly by the Consumer Guidance Society of India and the Indian Academy of Paediatrics at Gorakhpur (U. P) in September,
2. A Drug Action Forum was launched in Orissa in October.
3. Towards a people oriented Drug Policy: — a workshop organised by Catholic Hospital Association of India at its 42nd National Convention in Lucknow (D. P) in November.
4. A Decade after Hathi Committee: — an all India seminar on the Drug Industry organised by the Kerala Sastra Sahitya Parishad at Trivandrum in November. The seminar was cosponsored by the Department of Science and Technology and the Indian Council of Social Science Research.
5. The Drugging of Asia: —Pharmaceuticals and the Poor:- A seminar organised by the International Organisation of Consumer Unions, the Voluntary Health Association of India and Asian Community Health Action Network in Madras in December.

DOUBLE STANDARDS

The examples given below show how inappropriate medicines are promoted and marketed in Third World countries—very often with inadequate information. These examples only hint at the extent of the problem, which involves drug proscribers, users and regulators as well as the companies that produce them. What it amounts to is the wholesale importation of a system of medicine incapable of addressing the real health needs of the developing world: —

Expensive broad spectrum antibiotic drugs like CLAFORAN (Hoechst/Roussel, FRG /France), BAYPEN (Bayer, FRG), and AUGMENTIN (Beecham, UK) must be used very carefully. Indiscriminate use encourages the growth of antibiotic resistant bacteria, and furthermore, these drugs are extremely expensive. CLAFORAN costs about \$US 10 per gram, and a daily dose is between 2 and 6 grams. Ideally, broad spectrum antibiotics should be used only when safer, cheaper, narrow spectrum antibiotics have failed. In East Africa, however, these drugs are being promoted among general doctors, who are given the impression that by prescribing these expensive drugs they are giving their patients the "best".

In Kenya and elsewhere glossy posters of expensively dressed men and women promote TONOVAN, a testosterone-based potency drug from Schering (FRG). This drug and E. Merck's PASUMA STRONG and Organon's ANDRIOL are just some of the products sold by European companies in East Africa to treat impotence. Male anxiety about sexual performance creates a ready market for, seemingly scientific potency drugs. Most can be purchased over the counter, without a prescription. Clinically, however, hormone-based drugs can treat only 2 % of all impotence. In effect these drugs are an expensive and dangerous placebo, for the great majority of the men who take them. Testosterone can cause liver damage and many of the drugs are irrational combinations of other ingredients. TONOVAN and PASUMA STRONG, for example, contain Yohimbine (an aphrodisiac), strychnine, and vitamin E as well as testosterone. Yohimbine and strychnine, in particular, have potentially serious side-effects.

Merck, Sharp and Dohme's PERIACTIN is advertised in Pakistan and other developing countries for "natural weight gain" for the growing child; for the adolescent who is underweight— and for the convalescent who needs good appetite". This US - based company with extensive European holdings promotes PERIACTIN as a tonic in countries where child malnutrition is rife. But appetite, stimulants do no food, since malnutrition can only be effectively treated by food, and other causes of weight loss is a symptom — not a disease in itself. Drugs like this are an, expensive distraction from children's real health needs; one course of treatment with

Sandoz's appetite stimulant MOSEGOR costs around US \$ 10.00. And a double standard is involved as well. In the developed world Sandoz markets a chemically identical drug for migraine treatment.

Product literature for this drug notes that "a slight increase in body weight is observed in some patients" PERIACTIN has not been promoted as an appetite stimulant for children in the US since 1971, because the US Food and Drug Administration considers the evidence for the indication to be inadequate.

ENCEPHABOL (E. Merck, FRO) and ARC: A", LION ZOO (Servier, fr .) are just two of the irrational "brain tonics" marketed by European companies in Africa and Latin America. ARCALION 200 — a vitamin B1 derivative — is promoted for "mild depression and anxiety, psychogenic impotence of recent onset, impairment of memory and concentration and reactive asthenia". Adults, and children are supposed to benefit from it if they suffer from "tics, stammering, enuresis; difficulties at school". There is little or no clinical evidence to support these claims. In Africa, glossy promotional brochures advertise ENCEPHABOL as treatment for male "mid life 'crisis's" while in Latin America school children take, it, to improve 'brain performance, concentration and sociability.

Source: Promoting the essentials Virginia Beardshaw. Special Report: Drugs and Agrichemicals HAI, PAN, ICDA, BEUC March, 1985.

(Continued from page 3)

Following my meeting with Mr. Jaichandra Singh, Chemicals Minister on 4.11.1985 it is clear that contribution from the Health Ministry by way of drawing up a clearly defined essential drug list for the nation for guidance of both public and private sector has not come.

These should include — drawing up an updated national formulary with therapeutic guidelines and — a list of drugs that are hazardous and irrational.

Failure in monitoring exact mode of drug use misuse and drug shortages will prevent identification of problem areas and formulation of functional strategies that are required.

In view of the urgency and in view of the seriousness of the nature of the Drug Policy, your intervention is needed.

With sincere regards,

Yours sincerely, (DR.
MIRA SHNA)
Coordinator
Low Cost Drugs & Rational
Therapeutic and Convenor
All India Drug Action Network