INFANT FORMULA PROMOTION

The marketing of milk powder based products as breast milk substitutes

Please use this form to file a report whenever you witness any infant formula promotion, or give copies to any local person (project holder etc.) who is interested in the issue and might wish to file a report.

Please attach copies of photographs of relevant materials where you can or texts, slogans or gists of texts where appropriate.

i) The monitoring applies to breast milk substitutes or bottle fed supplements, not to weaning foods, (which are foods usually cereal based and given after 6 months of age).

ii) Infant formulae are in general prepared with a good deal of care. They are good alternatives to breast milk when the latter is unavailable. In poor communities, however, it is extremely difficult to use the products safely and so are to be regarded as last resorts. It is the active promotion of these products in such situations which is wrong.

iii) The use of feeding bottles may provide a useful indicator to infant formula promotion (N.B. if formulas are used they should be via cup and spoon)

iv) Not all parts of the questionnaire will apply. Ignore if not applicable.

v) Increasingly companies are using the facilities of the health service to promote infant formulae (with implied medical endorsement) rather than direct advertising. This is more difficult to observe. Sections B, C and D, then, are most relevant but are likely to need a small amount of research to complete, rather than a chance witnessing as in A.

vi) "Mother-craft nurses" are company employed sales staff working within or alongside the health service. These may be dressed in a uniform which resembles local hospital uniforms.

OXFAM staff member _____

Product Name _____ Company name and Parent _____

Date Witnessed _____ Location _____

Date of issue of promotion (if known) _____

A) PROMOTION THROUGH MEDIA

PROMOTION MEDIUM

Newspaper Advert	☐	Billboard	☐
Magazine "	☐	Baby Show	☐
Radio "	☐	Poster, Calendar etc.	☐
T.V. "	☐	Other (point of sale display, tee shirts, feeding bottles, baby book etc - give details)	☐
Film "	☐		

If poster or calendar, etc., was this:-

In a hospital ☐
In a clinic ☐

_____

_____

Product Labels (Please send if possible)

Is the product described as "humanised" or "maternalised" YES ☐ NO ☐

Is it made clear that breast feeding is superior YES ☐ NO ☐

Is the label written in a local or national language YES ☐ NO ☐

B) PROMOTION THROUGH HEALTH PERSONNEL

PROMOTER		PROMOTION METHOD		WHERE WITNESSED	
Mothercraft nurse	☐	Giving free sample	☐	In hospital	☐
Doctor	☐	Giving bottles	☐	Clinic	☐
Midwife	☐	Other gifts (please specify	☐	Mothers Home	☐
Official nurse	☐	Suggesting product as most appropriate food	☐	Elsewhere (please specify)	☐
Other (please specify)	☐	Other (please specify) (examples may be using company wrist bands weight cards or brochures)	☐		

_____ _____ _____

_____ _____ _____

_____ _____

Does the promoter receive any inducements (commission, gifts etc.) YES | NO

Can you specify _____

If Company employee, does promoter wear a uniform YES | NO

If YES does this resemble a hospital nurses' uniform YES | CONSIDERABLY | SLIGHTLY | NO

C) PROMOTION IN INSTITUTIONS

Institution name _____

(hospital/clinic/other _____)

Does the institution automatically give newborns infant formula YES | NO

Is there a cheap infant formula sales point (milk bank) YES | NO

Is the mother offered infant formula at a lower price than local shops YES | NO

When infant formula is used, does the institution recommend: feeding bottles/cup and spoon YES | NO

ADDITIONAL INFORMATION The following details would be useful to have but might prove difficult to obtain and so are not essential. It might be that there is an appropriate local person - interested in this issues, who would research this section.

Product Name _____ Company name and Parent _____

Date Witnessed _____ Name of institution _____

Location _____ (village/town/country wide)

D) PROMOTION TO HEALTH SERVICE (HEALTH PERSONNEL)

(i.e. promotion to rather than promotion by doctors)

PROMOTION METHOD		TO	
Free sample for distribution	☐	Hospital	☐
Free sample for personal use by health personnel	☐	Clinic	☐
Commission on sales	☐	Doctor	☐
High discount for monopoly product use	☐	Nurse	☐
Gifts or grants (please give details)	☐	Midwife	☐
		Pharmacist	☐
		Administrator	☐

_____

_____

_____

E) COMPANY SALES PERSONNEL

In the country, how many 'mother care nurses' does the company employ _____

Are there ex-nurses and if not do they receive appropriate training YES | NO

Are mother care nurses' wages significantly higher than hospital nurses' YES | NO

Do Company Sales Personnel earn commission on sales YES | NO

Are there other company sales staff Numbers _____

Do sales staff have contact with: doctors/nurses/midwives/pharmacists/ hospital - administrators

Do sales staff work in: hospitals/clinics/mothers home/other _____

_____

What local laws govern sales promotion personnel _____

Other Comments: (Please write seperately and attach to this form.) Such as results of medical studies on the prevalence of bottle feeding, or on the health status of bottle vs breast fed babies. Details of breast feeding promotion programmes. Availability of infant formula and cost relative to average wage of a poor family. Marketing of products other than infant formula (such as sweetened condensed milk) as a breast milk substitute.

1) Name:

2) Occupation:

3) Drugs Recomended: 1)
2)
3)
4)
5)
6)

4) Prescribed:

OTC :- i) Patient

ii) Chemist

5) Cost of drugs:

6) Treatment duration:

7) When were drugs brought last:

8) Frequency of illness at home:

9) Money spent on drugs last year:

10) Family Income

Salaries:
Agriculture:
Misc.:

11) Annual Expt. on drugs
as % of Income.

12) Misc.:

Group Discussion on Prescribing Policy - Groups B1 & D1

Questions to be pondered about !

1. Can a Hospital devise a formulary of good quality, low cost medicines?

   Can this be common for all Voluntary Hospitals?

2. How can prescribers' compliance be ensured or is freedom of prescribing likely to make this impossible?

   Can we ensure Health Workers' compliance with their formulary (medicine list)?

   Will doctors also prescribe from this list?

   Is it possible to prevent prescriptions to medical shops being given?

3. Where simple low cost drugs will not be sufficient, how do we subsidise to all or those who need help most?

   Should all patients contribute to the cost of medicines? If so, how?

4. Will a Pharmacy Committee, including Doctors, Administrators and Pharmacists help in implementing cost control or quality control policy? (In most Hospitals medicines are the second largest item of expenditure!)

5. Have we asked our pharmacists to research costs? If so, does he know how to do so?

   Have we provided tools for the job? If so, what tools?

6. Are bulk drugs purchases possible on a group of Hospitals-base? What methods can we devise for obtaining low cost drugs either for one or many Hospitals?

7. Do we consider proper stock control, record keeping and auditing of medicines, purchase and distribution:

   a) unnecessary expenditure b) essential?

   What are our reasons for our attitudes?

8. In many Hospitals the Pharmacy is an important income producing section. Will a switch to low cost drugs raise cost or make it instead a burden on the Institution?

9. Is the production of medicines in the Pharmacy :

   a) too time consuming

   b) too costly in terms of personnel or equipment

   c) uneconomic?

   (Broadly thinking of two types: non sterile prescriptions and sterile prescriptions) How would you advise your Hospital Management?

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EMBARGO 11.00 am THURSDAY, 25 NOVEMBER 1982

THE POOR SUFFER THROUGH MULTINATIONAL DRUG COMPANIES' MARKETING PROFITABLE BUT INESSENTIAL DRUGS IN THE THIRD WORLD, ARGUES NEW BOOK FROM OXFAM

The uncontrolled sale and promotion of drugs in most poor countries means that they often do little good and can be positively harmful. Major manufacturers are acting irresponsibly in the Third World by ignoring the needs of the majority and not taking responsibility for the safe use of their products.

Dangerous double standards have resulted in anabolic steriods being promoted as appetite stimulants for malnourished children; an antidiarrhoeal drug banned in Britain, because of possible crippling side-effects, is freely marketed in the Third World and sold without warnings. Antibiotics are sold on market stalls like loose sweets, encouraging misuse and drug resistance.

For the Third World poor, the cost of basic life-saving medicines is astronomical. The price of just twenty tablets of the top-selling antibacterial drug in Mexico would provide a family of four with their basic diet for two weeks. A small bottle of an antibiotic syrup costs a poor Bangladeshi family the equivalent of £35 to a British family earning £135 a week.

In Bitter Pills, Medicines and the Third World Poor, published by Oxfam on November 25, Dianna Melrose investigates these alarming facts from the perspective of the poor, drawing on her own field research, evidence from the manufacturers involved and Oxfam's wide experience of poverty and ill-health in the Third World.

The poor suffer disproportionately from ill-health. A few dozen essential 'generic' drugs could be used to save millions in the poorest countries from unnecessary suffering and death. The know-how to make these key generic drugs has been available for decades. We take them for granted in Britain, but the majority of the Third World poor are denied them because drugs are produced and sold for profit rather than on the basis of real need. The rich world dominates

drug production. Aggressive promotion means that the most expensive brand-name drugs usually sell best. The poor are therefore forced to pay unnecessarily high prices and subsidise new drugs for the rich.

Bitter Pills documents the abuses caused by weak controls and reveals that some manufacturers - including some based in Britain - are not as scrupulous as they should be in ensuring that Third World patients and prescribers get full information on their products. Some even resist moves to introduce tougher controls in the Third World that they must comply with in Britain.

The book describes some of the positive initiatives taken at local, national and international levels to rationalise the use of drugs as part of a broader strategy for better health - recognising that disease which is rooted in poverty can only be combatted by an onslaught on poverty itself. It documents the major obstacles that Third World governments face in trying to crack down on the drug market. Rich world manufacturers and their governments have lobbied to block changes that would benefit the poor.

Practical suggestions for change are addressed to three groups: Firstly, if the poor are to benefit, Third World governments must give priority to preventive and primary health care rather than to costly hospital services. The private drug market should be controlled to safeguard health and priority given to purchase and manufacture of essential drugs.

Rich world governments should actively encourage Third World governments to adopt the WHO recommendations which, in theory, they have supported. They could help Third World governments make informed choices about drug risks and benefits by making more information available at little cost, and introducing controls to discourage exports of dangerous and inessential drugs. Official health aid should not be tied to purchases of expensive products and high-technology medical services; and voluntary agencies should strengthen community health projects which do not rely on imported drugs.

Manufacturers should take full responsibility for ensuring that their products are used safely and effectively in the Third World and respond to the real health needs of the poor by marketing low-priced essential drugs.

Dianna Melrose, 30, the author of Bitter Pills, was born in Zimbabwe and grew up in Latin America. She holds an MA in Latin American studies from the London School of Economics and worked as a translator for banking and insurance firms in the City before becoming an administrator for the British Council. She joined Oxfam's Public Affairs Unit in January 1980 and has carried out field research in Bangladesh, India and the Middle East. She conducted research for a film on the marketing of baby milk and medicines in North Yemen and is the author of the associated book, The Great Health Robbery.

Bitter Pills - Medicines and the Third World Poor, by Dianna Melrose, is published by Oxfam on November 25 at £4.95. Distributed by Third World Publications. Review copies are available on request from the Press Office, Oxfam, 274 Banbury Road, Oxford. Tel: Oxford (0865) 56777.

For more information contact Derek Warren, Oxfam Press Office on Oxford (0865) 56777.

8th November, 1982

BITTER PILLS

MEDICINES AND THE THIRD WORLD POOR

by Dianna Melrose
Published by Oxfam on 25th November, 1982
Distributed by Third World Publications
151 Stratford Road, Birmingham, B11 1RD

INTRODUCTION

Throughout the Third World millions of the poorest have no access to life-saving drugs, while drugs are wasted and misused worldwide. In poor countries those that are most needed are often the hardest to obtain, at least at prices the poor can afford. Through their uncontrolled sale and promotion in most poor countries, medicines often do little good and can be positively harmful.

1. A PILL FOR ALL ILLS?

The poor in the Third World - as in Britain - suffer disproportionately from ill-health. Disease that is rooted in poverty can only be attacked by an onslaught on poverty itself. But a small number of essential drugs could be used to save millions of the poor from unnecessary suffering and death.

2. UNEQUAL DISTRIBUTION

The Third World has three-quarters of the world's population but accounts for little more than 20% of total drug sales. In the poorest countries, annual drug expenditure averages only 50p per capita, compared with £35 in the rich world. Yet this money may represent a crucial proportion of a poor family's income. Moreover, the distribution of health services is often grossly weighted in favour of the rich town-dwellers at the expense of the majority of people living in rural areas. The poor are therefore forced to rely on untrained drug-sellers offering potentially dangerous drugs at extortionate prices.

3. PRODUCER'S MARKET

Throughout the world, drugs are largely produced and sold by private businesses whose interests are primarily commercial rather than medical or social. Third World countries are almost totally reliant on importing finished drugs and so are subject to the dramatic price increases which follow inflation. Inappropriate patterns of drug consumption are adopted, thanks to the producers' aggressive

promotion tactics. In North Yemen, non-essential drugs, tonics and vitamin pills account for an estimated 65% of total pharmaceutical imports. Only 1.3% of imports are of drugs to combat the prevelant and crippling diseases of malaria, bilharzia and TB.

4. POOR VALUE FOR THE POOR? DRUG PRICES

In Third World countries, the cost of drugs in real terms is anything up to 20 times higher than in the producing nations. Expensive brand name drugs are marketed instead of far cheaper generics. Hefty overheads for promotion and research and development into new drugs are passed on to the poor. Meanwhile only a fraction of total research spending (equivalent to half the cost of developing one new drug) is allocated to poor world diseases. Poor people are therefore subsidising new drugs for the rich.

5. INFORMATION OR DISINFORMATION? DRUG PROMOTION

Drug promotion helps to ensure that 90% of drugs prescribed by GP's in Britain are brand-name products. But at least, in drug-producing countries, advertising is monitored and doctors are supplied with objective information about cost-effectiveness. Over-the-counter sales are also strictly controlled. Such restrictions rarely apply in poor countries, where misleading or inaccurate promotional literature goes unchecked and where company salesmen may offer free samples and other sales inducements to doctors and nurses on a lavish scale. Commercial pressure can be very intense: in Nepal, Brazil and several Central American countries, there is one doctor to every three salesmen (compared to eighteen doctors for every one salesman in the UK).

6. BUYERS BEWARE - UNCONTROLLED SALES AND PROBLEM DRUGS

All too often there is a cruel contrast between advertising claims and the reality of drug use in developing countries. Powerful drugs with toxic side-effects are dispensed by illiterate traders - even by children. The dangers are accentuated by irresponsible marketing practices. Amabolic steriods have been promoted as appetite stimulants for malnourished children. Powerful antibiotics have been marketed to treat infants with "common diarrhoea." Uncontrolled marketing and sales has already led to epidemics of drug-resistant disease.

7. TRADITIONAL MEDICINE

Traditional medicine is still the major source of health care for three-quarters of the Third World population. Some important modern drugs are derived from ancient herbal remedies. WHO has urged Third World governments to plan their health systems so that modern health-workers work alongside traditional healers - with each learning from the other, encouraging patients to visit the health centres more readily.

8. TRAIL-BLAZERS - SMALL-SCALE SOLUTIONS

A number of pioneering projects have attempted to tackle ill-health in poor communities with paramedics providing preventative and curative care. The People's Health Centre in rural Bangladesh goes beyond the confines of health care to try to solve the underlying problems of landlessness, inequality and powerlessness. Other projects in a range of developing countries are specifically aimed at finding imaginative solutions to the problems of lack of vital drugs and misuse of medicines.

9. HEALTHY SOLUTIONS - THIRD WORLD NATIONAL AND REGIONAL POLICIES

Sri Lanka, Mozambique, China and other developing countries have adopted national drug policies to cater for the health needs of the majorities. A wide range of policy options are open to Third World governments to improve the use and availability of drugs. The key element needed is political will. Increasingly developing countries are exploring the advantages of strength in numbers and pursuing joint pharmaceutical policies to improve their bargaining power with the rich world producers.

10. HELP OR HINDRANCE? - THE RICH WORLD'S RESPONSE

Drug-producing nations have a controlling interest in UN agencies such as WHO that could do more to assist developing countries. The British and other rich-world governments adopt different standards for drugs for export and give little active support to Third World governments attempting to implement bold new drug policies. They back home-based manufacturers' interests - sometimes at the expense of the poor. Leading drug manufacturers have made concessions to the special needs of developing countries, but they also bring powerful pressure to bear (even involving their governments) in blocking positive new controls on the drug market

in developing countries. This concerted industry lobby is active now in Bangladesh trying to get the government's new drug policy reversed.

11. HEALTH NOW - ACTION FOR CHANGE

The principal recommendations are addressed to three groups: Firstly, if the poor are to benefit, Third World governments must give priority to primary health care rather than to costly hospital building projects. Drug imports and sales should be brought under central control, and purchases made in accordance with health needs. Training for health workers should concentrate on methods appropriate to their countries' needs and resources

Rich world governments should take steps to ensure that the WHO recommendations with which they have, in theory, agreed are implemented. They should reappraise the need for export controls and publish all available information on drugs and their safe use. Official health aid should not be tied to purchases of expensive products and high-technology medical services; and voluntary agencies should strengthen community health projects which do not rely on imported drugs.

Manufacturers should be consistent in the standards they apply worldwide and adopt higher ethical procedures in disclosing full information and marketing drugs that are essential to the needs of the poor.

RESOURCES

- Ahmed, A. Karim; Morehouse, Ward; and Shaikh, Rashid *"For Export Only: The International Trade in Toxic Substances."* Development Forum, January 1982.
- Castleman, Barry I. *"The 'Double Standard' in Industrial control of Health Hazards."* Paper presented to the New York Academy of Sciences, 4 February, 1981.
- Concern Inc. *"Hazardous Waste: A community action guide,"* May 1981.
- Dowie, Mark. *"The Corporate Crime of the Century"* Mother Jones, November 1979.
- Fazal, Anwar. *"Testimony before the Subcommittee on International Economic Policy and Trade, Committee on Foreign Affairs, US House of Representatives 5 June 1980"* IOCU Newsletter, June 1980.
- Harris, Robert. H. Keynote Address, Special Open Session on the Dumping on Hazardous Products, Processes and Wastes, 10th IOCU World Congress, The Hague, June 1981.
- Health Action International. *New "International Antibody" Will Resist "Ill Treatment of Consumers By Multinational Drug Companies"* Geneva., 27 to 29 May 1981.
- IOCU Regional Office for Asia and the Pacific. *"Forty Four Problem Drugs - A Consumer Resource and Action Kit."* May, 1981.
- Medawar, Charles. *"Insult or Injury? : An Enquiry into the Marketing and Advertising of British Food and Drug Products in the Third World."* Social Audit, Ltd., 1979.
- Newman, Barry. *"Consumer Protection in Underdeveloped in the Third World."* Wall Street Journal, 8 April 1980.
- Scherr, S. Jacob. Natural Resources Defense Council Statement to the Subcommittee on International Economic Policy and Trade of the Committee on Foreign Affairs, US House of Representatives, Concerning the Reagan Decision of the US Hazardous Substances Export Policy. 12 March 1981.
- Shaikh, Rashid; and Reich, Michael R. *"Haphazard Policy on Hazardous Exports."* The Lancet, 3 October 1981 : 740-42.
- Silverman, Milton, Lee, Philip. R. and Lydecker, Mia. *"The Drugging of the Third World."* Paper presented at the 10th IOCU World Congress, The Hague, June 1981.
- *"The Penang Declaration on the Export of Hazardous Substances and Facilities."* Consumer Currents, February 1981.
- UN Economic and Social Council. Exchange of information on Banned Hazardous Chemicals and Unsafe Pharmaceuticals. Report of the Secretary General E/1981/ 11 February 1981.
- UN Commission on Transnational Corporations. *"Role of the Information System on Transnational Corporations regarding the exchange of information on banned hazardous chemicals and unsafe pharmaceuticals."* E/C 10/90 18 June 1981.
- Weir, David, and Shapiro, Mark. *"Circle of Poison: Pesticides and People in a Hungry World."* San Francisco: Institute for Food and Development Policy, 1981.
- Wyrick, Bob. *"Hazards for Export"* Newsday, Special Report December 1981.

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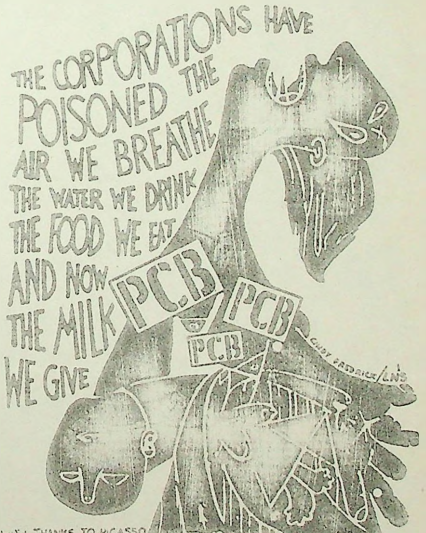

Source: International Women and Health Resource Guide

FURTHER READING

1. HATHI COMMITTEE: REPORT OF THE COMMITTEE ON DRUGS AND PHARMACEUTICAL INDUSTRY

   Ministry of Petroleum & Chemicals, Government of India: April 1975

   (Rs.17.00)

2. MEDICINE AS IF PEOPLE MATTERED

   Special Issue of HEALTH FOR THE MILLIONS.
   Voluntary Health Association of India
   New Delhi

   April-June 1981 (Rs.5.00)

3. ASPECTS OF THE DRUG INDUSTRY IN INDIA

   Mukarram Bhagat
   Centre for Education and Document
   Bombay

   February 1982 (Rs.)

4. HEALTH CARE-WHICH WAY TO GO

   Medico Friend Circle (Anthology) 1982 (Rs.10-00)

   Available from Voluntary Health Association of India, New Delhi.

5. HEALTH FOR ALL--AN ALTERNATIVE STRATEGY

   ICMR/ICSSR Study Group

   Indian Institute of Education, Pune (ICSSR, 1981).

   Available at Voluntary Health Association of India, New Delhi.

6. INSULT OR INJURY

   Charles Medawar
   Social Audit, England: 1979 (Rs.)

   Available from Indian Social Institute, New Delhi.

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7. DRUGS AND THE THIRD WORLD

Anil Aggarwal
Earthscan, 10 Percy Street
London W1 PD DR

1978 ($5.00)

8. POOR HEALTH, RICH PROFITS

Tom Heller
Spokesman Books
Bertrand Russel Peace Foundation Limited
Gamble Street, Nottingham, England

1977 ( )

9. DRUGS DISINFORMATION

Charles Medawar
Social Audit Ltd
England

1980 ( )

10. BITTER PILLS: MEDICINE AND THE THIRD WORLD POOR

Dianna Melrose
OXFAM, 274 Banbury Road
Oxford OX2 7DZ
U.K. (£4.95)

11. DRUG DIPLOMACY

Charles Medawar & Barbara Freese
Social Audit Ltd
PO Box 111, London NX1 8XG

1982 (£3.95)

12. PRESCRIPTIONS FOR DEATH: THE DRUGGING OF THE THIRD WORLD

Milton Silverman et al.
University of California Press
2223 Fulton Street, Berkeley CA 94720

1982 ($19.95)

13. DRUGS THAT DON'T WORK

Sidneywolfe, Christopher Colely and Health Research Group : 1980

Available from Public Citizen Health Research Group, Dept AC 2000
P Street N.W., Washington DC 20036, USA.

14. 44 Problem Drugs - a consumer action and resource kit on pharmaceuticals

May 1981.

International Organization of Consumers' Union Registered Office for Asia and Pacific
PO Box 1045, Penang, Malaysia.

D-10/344
LCD/a/28.2.84

Recommended Reading
For Self Education in Drugs Issue - for Social Action

1.	Insult or Injury?	Charles Medawar	Social Audit	1980	139pp	Rs.18
2.	Bitter Pills	Dianna Melrose	Oxfam Public affairs Unit	1982	277ps	Rs.80
3.	Drugs & the Third World	Anil Aggarwal	Earthscan	1978		
4.	There is gold in Pills: an enquiry into the Medical Industrial complex.	Alan Klass	Penguin Special	1975		
5.	Poor Health Rich Profits.	Tom Keller	Spokesman Books Bertrand Russel Peace Foundation Ltd Nottingham, UK.	1977		
6.	Limits to Medicine, Medical nemesis	Ivan Illich	Marion Boyars, London.	1980		
7.	The Health of Nations: A North south Investigation	Mike Muller	Faber & Faber Ltd	1982	256pp	
8.	Pills against poverty: (a study of the introduction of western medicine in a Tamil Village)	Goran Djurfeldt Staffan Linelberg	Oxford IBH, Pub. Co New Delhi.	1976		
9.	Pills Profits & Politics	Milton Silverman Lee	Berkeley University California Press	1974	403pp	

1. Highlights marketing and sales of British food and drugs products. Illustrated, easy reading.
2. A very well documented convincingly written book about the tragic drug scene in the third world and existing courageous initiatives. Initiatives that are possible around the world are highlighted, which gives us a sense of solidarity.
3. A very comprehensive overview of the drug situation in the 3rd world and the problems and causes.
4. Discloses how suppression of unbiased drug information, and the unethical marketing practices by MNC's have repeatedly taken place for greater profits.
5. Describes malpractices of MNC's in the 3rd world. Very helpful in understanding practices likes tied purchase, patent laws etc.
6. An excellent critical analysis of contemporary medicine.
7. The book deals with the disparities and the real causes of ill health and the existing health care in the third world countries. Shows how results of capital intensive western medical care were in no way superior to the indigenous traditional medical care- generally considered inferior and unscientific.
9. Highlights malpractices indulged in by Drug Companies & the role of medical personnel in propagating irrational drugs by irrational prescribing.

10. Prescription for Death Drugging of the 3rd world.	Milton Silverman Philip R Lee & Mia Lydecker	Berkeley, University of California Press	1982	186pp	A very systematically done analysis of drug promotion & drug sales practices of MNC's in the 3rd world gives suggestions as to what can be done, the book is convincing enough to demand action with its contents.
11. Drug Disinformation	Charles Medawar	Social Audit, London	1980	49pp	Shows the double standard of drug MNC's as regards the drug information given to Doctors in UK and Ireland. This is a study of MIMS UK & MIMS Ireland, gross disparities in the information between MIMS UK & MIMS of a 3rd world, country can very well be imagined.
12. Drug Diplomacy	Charles Medawar & Barbara Freese	Social Audit London	1982	119pp	Describes vividly the battle between G D Searle (the American drug company producing Lomotil) with Social Audit a public interest group demanding consumer caution & warning for use of lomotil in children. A lesson in courage, perseverence & systematic scrutiny of so called scientific studies.
13. The People's Pharmacy I a consumers guide to prescription drugs dangerous drug interactions brand name medications & money saving home remedies.	Joe Graedon	Avan Book, USA	1977		A very informative book for consumers, deleted of mystifying medical jargon. Unfortunately deals with American brands, though the drug information is applicable in our context too.
14. The People's Pharmacy II	Joe Graedon with	Avon Press	1980		Consumer guide for choosing reliable drugs, information on arthrites medications, vitamins, valium.
15. Geneva Press Conference on SMON Proceedings	Organizing Committee	Japan	1980		Discloses some of the less known facts about the SMON problem, presents the drug industry's response its apology to the SMON victims in Japan.
16. Drug induced suffering (Proceedings of the Kyoto Conference)		Japan			An impressive book about drug induced suffering, covering pharmacological, clinical & research studies. Valuable as an exposure of the medical graduates to drug related issue.

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5.	Poor Health Rich Profits.	Tom Keller	Spokesman Books Bertrand Russel Peace Foundation Ltd Nottingham, UK.	1977		
6.	Limits to Medicine, Medical nemesis	Ivan Illich	Pelican Books, London.	1980		
7.	The Health of nations: A north south Investigation	Mike Muller	Faber & Faber Ltd	1982	256pp	
8.	Pills against poverty: (a study of the introduction of western medicine in a Tamil Village)	Goran Djurfeldt Staffan Linelberg	Oxford IBH, Pub. Co New Delhi.	1976		
9.	Pills Profits & Politics	Milton Silverman Lee	Berkeley University California Press	1974	403pp	

1. Highlights marketing and sales of British food and drugs products. Illustrated, easy reading.

2. A very well documented convincingly written book about the tragic drug scene in the third world and existing courageous initiatives. Initiatives that are possible around the world are highlighted, which gives us a sense of solidarity.

3. A very comprehensive overview of the drug situation in the 3rd world and the problems and causes.

4. Discloses how suppression of unbiased drug information, and the unethical marketing practices by MNC's have repeatedly taken place-for greater profits.

5. Describes malpractices of MNC's in the 3rd world. Very helpful in understanding practices likes tied purchase, patent laws etc.

6. An excellent critical analysis of contemporary medicine.

7. The book deals with the disparities and the real causes of ill health and the existing health care in the third world countries. Shows how results of capital intensive western medical care were in no way superior to the indigenous traditional medical care- generally considered inferior and unscientific.

8.

9. Highlights malpractices indulged in by Drug Companies & the role of medical personnel in propagating irrational drugs by irrational prescribing.

17. Prescriptions for Change	Virginia Beardshaw	HAI	1983		A stimulating book of action, ideas for drug campaigners.
18. Selection of Essential Drugs	Expert Committee	WHO Technical series 615 - 641 - 685 -	1977 1981 1983		These deal with the basic principles of Rational drug therapy and Technical Report series 685 gives the modified essential drug list.
19. Therapeutic guidelines	Upunda Yudkin et al	African Medical Research & Education Foundation Nairobi Kenya.	1981		An excellent guideline for rational therapeutics giving special emphasis on the drug cost as criteria for choice of drug, diagramatically shown. Practical, simple and highly recommended for doctors and trained middle level workers.
20. Pill-fering the poor: Drugs and the 3rd world. an information & action pack	Produced by Interfaith Centre on Corporate Responsibility.	475 Riverside Drive, Room 566 New York, N Y USA 10115.			A pack of drug related informative. Articles and bibliography on drugs and the third world.
21. UNCTAD major issues in Transfer of Technology to Developing countries. A case of the pharmaceutical industry TD/B/C 6/4		United Nations Conference on Trade & Development	1975	63pp	Deals with issues related to transfer of technology, their impact and choices left to the third world countries.
22. Pharmaceutical & Health Policy: International perspectives on Provision & control of Medicines.	Blum, Andrew Herxheimer	Holmes & Meier Publishers	1981	267pp	Role of MNC, drug policies, essential drugs economies dealt within an authoritative way in a collection of excellent articles.
23. Pills that don't work	Sidney Wolffe & Coley	International Research group for Drug Legislation & Progs. New York Farrar, Straus giraux	1981	223pp	Extremely informative book, deals with ineffective highly promoted drugs in US Market itself.
24. 44 Problem drugs: a consumer action & resources kit on Pharmaceuticals.	I O C U		May 1981		Very methodically gives information about 44 problem drugs along with articles by some of the leading drug campaigners.

For Reference on Drugs and Pharmacology

1. Martindale-The extra pharmacopeia - 28th Edition The Pharmaceutical Press. Rs.700 The world's most comprehensive source of drug information in a single volume.
2. Goodman gillman - Macmillan Publishing Co. Inc, 866, 3rd Avenue, New York 10022.
3. Physicians desk reference - Medical Economics co. Inc, Oradell, N J 07649, USA.
4. Family Medicine Book - Orient Paperbacks, 36 C, Connaught Place, New Delhi 110001. Rs.30
5. Drug Interactions.

For deeper understanding of the Indian Drug Scene

1.x Hathi Committee Report 1975 Government of India (Not available reprinting [illegible] for public availability should be demanded as Hathi Committee Recommendations, the Hathi Committee essential drug list would provide the foundation for a demand for a Rational National Drug Policy.

2. Some aspects of the Indian Drug Industry . Mukarram Bhagat CED Bombay. Rs.19 (3 Sulaiman Chambers, 4 Battery Street, Behind Regal Cinema, Bombay 400039.

3. Alternative Strategy Health for all 1981 ICSSR & ICMR study Report Highlights the gap between peoples health needs & our health care delivery systems and shortages of essential drugs eg. anti leprosy and anti TB drugs.

4. The Indian Pharmaceutical Industry: problems and prospects. 1984 P L Naravana 360pp A study conducted by the National Council of applied economic Research undertaken as a response to OPPI's request to assess the present drug status, identification of factors unpending growthneeds. Other aspects covered are the Indian and International pharmaceutical industry, technology trends, price control and their impact on production and profitability.

5.x Statement of the National Health Policy 1983 Ministry of Health Govt. of India. A philosophical statement criticizing its own earlier hospital, curative care centred health policies. It discusses all the priority health issues including drugs. An important tool for the people to ensure implementation of governments own statement of the National Health Policy.

6. Pharmaceuticals: a third world experience Seneka Bibile: the Man and his work. 1978 Available from Dean, Faculty of Medicine Colombo campous University of SriLanka Colombo & Sri Lanka. 64pp. Rs.10/£1/$2
A tribute by his friends to this architecht of a courageous pharmaceutical policy in Sri Lanka, brought out in commemoration of his death on 29th September '77 in George Town Guyana where he had gone as UNCTAD pharmaceuticals advisor to help in the preparation of a Regional drug policy. His survival would have ensured major changes in the third world drug and health policies. SriLanka experience was not a failure as made out to be by the critics of rational drug policies- if there were problems they were created purposely by the vested interests. Sri Lanka experience helps us to identify them.

Drug Related Periodicals

1.	Drug Information Bulletin	W H O	Geneva
2.	The Medical Letter on Drugs and Therapeutics	56 Harrison Street, New Rochell, New York, USA 10801.	An unbiased drug information bulletin.
3.	Drugs & Therapeutics Bulletin U K	Consumers Association London	
4.	Health Action International HAI News	IOCU, P O Box 45, Penang, Malaysia.	Very informative newsletter covering world drug news of special relevance for us in the third world.
5.	The Rational Health Campaign newsletter	Rational Health, Oxfam, 274 Banbury Road Oxford OX2 7D2, UK.	Gives information about the drug action groups in UK.
6.	Consumer currents	IOCU, Penang, Malaysia.	Covers consumer issues, specially focus on MNC's.
7.	Consumer Interpol		
8.	Contact	Christian Medical Commission World Council of Churches	Available from VHAI
9.	Pune Journal of Continuing Health Education	Arogya Dakshata Mandal, 2115 Sadshiv Peth Pune, Maharashtra.	-monthly-Subsciption Rs.10/yr.
10.	Medico Friends Circle Bulletin	50 LIC Quarters, University Road Pune, Maharashtra.	monthly- Rs. 15/yr.
11.	Drug Action Network newsletter.	Low Cost Drugs & Rational Therapeutics Cell Voluntary Health Association of India C-14, Community Centre, SDA New Delhi-16	-bimonthly-so far complementary for Drug Action network only.
12.	Health for the Millions April-June '81-special issue on drugs-"Bangladesh drug Policy"	VHAI address as above.	bimonthly - Rs.12/yr.
13.	Counterfact	CED Bombay. 3 Sulaiman Chambers, 4 Battery Street, Behind Regal Cinema, Bombay 39.	Issues like hormonal pregnancy tests, depo-provera, blood trade etc have been covered.
14.	Eastern Pharmacist-Independent organ of pharmaceutical industry trade and profession.	507 Ashok Bhavan, 93 Nehru Place, New Delhi 19.	Rs.100 annual subscription. Deals with the industry related issues as well those dealing with the policyand rational drug use. Recommended for Drug Documentation centres.
15.	Health and Society	P-31, Raipur, Garia, Calcutta-84 .	

16. Monthly Index of Medical Specialities	MIMS India, 90 Nehru Place New Delhi 19.	Subscription Rs.60/yr	Relevant for Drug Action Documentation centres, for scrutinizing the Editorials, deleted drugs, new products, as well as the drugs indicluded in MIMS and CIMS, the drug information, made available by the drug Industry, to comment on their rationality of drugs and drug disinformation if any.
17. Current Index of Monthly speciality.	Bio-Card Medical Services 88/1,10 Cross, Post Box 318 Bangalore,560003.	Subscription Rs.38/yr.	

(Prepared specially for the Drug Action Network and state V H A's)

Dr Mira Shiva, Coordinator,
Low Cost Drugs & Rational Therapeutics
Voluntary Health Association of India
28/2/1984

For further information please contact:

1. Medico Friend Circle
   50 LIC Quarters
   University Road,
   Pune 411016
2. Voluntary Health Association of India
   C-14 Community Centre, Safdarjung Development Area
   New Delhi 110016
3. Low Cost Drugs & Rational Therapeutics Cell (VHAI)
   105 Rajpur Road
   Dehradun 248001
4. Arogya Dakshata Mandal
   1913 Sadashiv Peth
   Pune 411030
5. Delhi Science Forum
   J-55 Saket P.Box 4002
   New Delhi 110017
6. Society of Young Scientists
   All India Institute of Medical Sciences
   Ansari Nagar, New Delhi 110016
7. Concern for Correct Medicine
   G-16/8 Rajouri Gardens
   New Delhi 110027
8. Consumer Education and Research Centre
   Near Law College, Ellisbridge
   Ahmedabad 380006
9. Centre for Education and Documentation
   3, Suleman Chambers, 4 Battery Street
   Bombay 400039

...contd...

10. LOCOST

C/o GVHA

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Baroda 390001

11. Federation of Medical Representatives Association of India

J.S. Majumdar, General Secretary,

1-E, Rajendra Nagar

Patna 800016

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1-E, Rajendra Nagar

Patna 800016

Pharmaceuticals: Resources, Information

... The Bureau d'Etudes et de Recherche pour la Promotion de la Santé has published NOTIONS DE PHARMACOLOGIE, a handbook for nurses. Copies are available for Z4,00, CFA1200, or $5.00

Write: Bureau d'études, BP 1977, Kangu-Mayombe, République du Zaïre.

... The April-June 1981 issue of the magazine HEALTH FOR THE MILLIONS carries a discussion of drug therapy, drug colonialism, the excessive cost of brandname drugs, bulk purchasing, and other topics. Copies cost Rs. 6; $ .75.

Write: Voluntary Health Association of India, C-14 Community Centre, Safdarjung Development Area, New Delhi 110016, India.

... MANAGING DRUG SUPPLY is a valuable handbook on the selection, procurement, distribution, and use of pharmaceuticals. The 592-page, illustrated book costs $22.50, including seamail postage; airmail by special request. French and Spanish editions are planned.

Write: Drug Logistics Program, Management Sciences for Health, 165 Allandale Road, Boston, MA 02130, USA.

... The May 1981 issue of WORLD HEALTH magazine is devoted to essential drugs. Articles include background, an essay on quality control, and a model list of essential drugs. The magazine is free and available in Arabic, English, Italian, Persian, Portuguese, Russian, and Spanish.

Write: World Health, WHO, Av. Appia, 1211 Geneva 27, Switzerland.

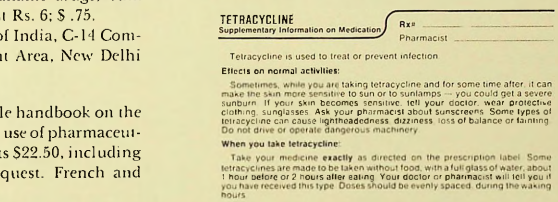
... Widespread misuse of drugs is leading to increased ineffectiveness of many antibiotics. If the trend continues, treatment of a number of common infectious diseases will be jeopardized and lives will be lost through ineffective medication. Medical costs will soar because of the high cost of alternative treatment. Alarmed at this prospect, the International Alliance for the Prudent Use of Antibiotics, a group of more than 200 medical scientists from 30 countries, is seeking data on misuse of antibiotics in developing countries.

Send materials to: Dr. Stuart B. Levy, Dept. of Molecular Biology and Microbiology, Tufts University Medical School, 136 Harrison Avenue, Boston, MA 02111, USA.

... The World Health Organization (WHO) provides information and training on quality control and drug regulation. For more information write: Pharmaceutical Unit, WHO, 1211 Geneva 27, Switzerland.

... The Canadian Pharmaceutical Association (CPhA) is developing single sheet package inserts for patients. The sheets are called "SIMS" (Supplementary Information on Medication), explain in clear language how and when to take a drug, what to do if a dose is forgotten, the side effects and precautions, and other essential information. Sample SIMS in French and English are available free on request. A full set of the 100 each of the first 12 SIMS and a filing cabinet cost $59.95, including mailing costs.

Write: CPhA, 101 - 1815 Alta Vista Drive, Ottawa, Ontario K1G 3Y6, Canada.



TETRACYCLINE
Supplementary Information on Medication

Rx# _____
Pharmacist _____

Tetracycline is used to treat or prevent infection.

Effects on normal activities:

Sometimes, while you are taking tetracycline and for some time after, it can make the skin more sensitive to sun or to sunlamps — you could get a severe sunburn. If your skin becomes sensitive, tell your doctor, wear protective clothing, sunglasses. Ask your pharmacist about sunscreens. Some types of tetracycline can cause lightheadedness, dizziness, loss of balance or fainting. Do not drive or operate dangerous machinery.

When you take tetracycline:

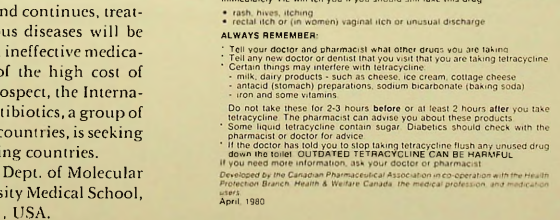
Take your medicine **exactly** as directed on the prescription label. Some tetracyclines are made to be taken without food, with a full glass of water, about 1 hour before or 2 hours after eating. Your doctor or pharmacist will tell you if you have received this type. Doses should be evenly spaced, during the waking hours.

Liquid tetracycline should be WELL SHAKEN before each dose.

Finish ALL your medication unless the doctor tells you to stop or else your infection might come back.

Stomach upset, vomiting, loss of appetite may occur. If stomach upset does occur, try taking doses with some crackers or a light snack. This effect may disappear as you get used to this drug. Mild diarrhea may also occur. If these effects get worse, call your doctor.

A SIMS patient information card on tetracycline.



If you FORGET a dose:

Take your medicine as soon as you realize that you have missed a dose. Then take your medicine at the same time as before.

What else may happen?

While taking this medication you should watch for any unwanted effects. The following signs are not common, but if they do happen, call your doctor immediately. He will tell you if you should still take this drug.

- rash, hives, itching
- rectal itch or (in women) vaginal itch or unusual discharge

ALWAYS REMEMBER:

- Tell your doctor and pharmacist what other drugs you are taking.
- Tell any new doctor or dentist that you visit that you are taking tetracycline.
- Certain things may interfere with tetracycline:
  - milk, dairy products - such as cheese, ice cream, cottage cheese
  - antacid (stomach) preparations, sodium bicarbonate (baking soda)
  - iron and some vitamins

  Do not take these for 2-3 hours **before** or at least 2 hours **after** you take tetracycline. The pharmacist can advise you about these products.
- Some liquid tetracycline contain sugar. Diabetics should check with the pharmacist or doctor for advice.
- If the doctor has told you to stop taking tetracycline flush any unused drug down the toilet. **OUTDATED TETRACYCLINE CAN BE HARMFUL**

If you need more information, ask your doctor or pharmacist.

Developed by the Canadian Pharmaceutical Association in co-operation with the Health Protection Branch, Health & Welfare Canada, the medical profession, and medication users.
April, 1980

... EL INFORMADOR, the monthly newsletter of the Asociación de Servicios Comunitarios de Salud (ASECSA), publishes information on drugs in its "fichas informativas" column. The full-page sheets offer information in Spanish on dosage, dangers, contraindications, storage, and expiration dates.

For a sample write: ASECSA, Apdo. 27, Ciudad de Chimaltenango, Guatemala.

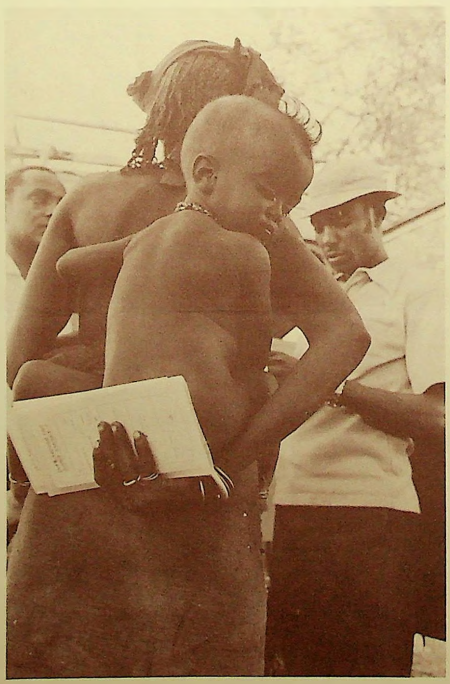
READERS' EXCHANGE

ORT in Egypt

Your front page article for January 1982 ("Egypt: Mothers cut diarrheal deaths in half with homemade treatment") makes a critical omission: the group of mothers making ORS (oral rehydration salts) at home with salt and sugar had Oralyte (full-formula) packets available to them through the nearby rural health clinics. Sufficient numbers of ill children were referred to the clinics after salt and sugar ORS was tried to have accounted for at least some of the reduced mortality in that group.

Homemade ORS is clearly an important element in community-based rehydration efforts, but many of the children at high risk of dying will require referral and more rigorous therapy if they are to be saved.

Norbert Hirschhorn, MD
The John Snow Public Health Group, Inc.
210 Lincoln Street
Boston, MA 02111, USA



Ethiopia: Holding her health record, a mother waits in line to have her child vaccinated. Photo: Blair Seitz, UNICEF.

NOTES

... "Health education methods and materials in primary health care" is the theme of the December 1981 issue of the newsletter, APPROPRIATE TECHNOLOGY FOR HEALTH. Items include a health game for children (Togo), a teaching calendar to help eradicate rats (Barbados), theater for spreading health messages (Zambia), and a discussion of illustrations in health literature. For a free copy of the newsletter, write: The Editor, ATH Newsletter, World Health Organization, 1211 Geneva 27, Switzerland.

... The London School of Hygiene and Tropical Medicine has published the results of field testing of its weight-for-height chart (Cf. SALUBRITAS, vol. 5, no. 1). For a copy of the report write: Julia Verney, Department of Human Nutrition, London School of Hygiene, Keppel Street (Gower Street), London WC1E 7HT, UK.

... A recent issue of HAITI SANTE, a new quarterly magazine published by the Centre d'Hygiène familiale de Haïti, carries an article entitled, "Your child and his dentist." The article explains the special dental problems of children: teething, oral hygiene, baby teeth, and other subjects. For a free copy (vol. 1, no. 4), write: Centre d'Hygiène familiale, 10, 1ère Impasse Lavaud, BP 430, Port-au-Prince, Haïti.

... "Women, Health and Development" and "Women and Disability" are the titles of a new series of information kits distributed by the World Health Organization (WHO). The kits contain articles, guidelines, bibliographies, and other information aimed at making the public aware of women's needs. For a free copy in English (French and Spanish editions will be available later this year.), write: The Division of Public Information, WHO, 1211 Geneva 27, Switzerland.

... The World Health Organization (WHO) is field-testing its new manual, TRAINING THE DISABLED IN THE COMMUNITY: An experimental manual on rehabilitation and disability prevention for developing countries. The manual contains training material for the disabled and their families, for policy makers and planners, local supervisors, community leaders, and teachers. If you wish to obtain a copy for field-testing purposes, write: Dr. J. Krol, Medical Officer, Rehabilitation Programme, WHO, 1211 Geneva 27, Switzerland. For others the manual is available from WHO for $20.00

... "Diarrhoea Management" is the title of a slide set that presents new ideas about oral rehydration. The set, which includes a detailed instruction sheet, is intended mainly for community nurses, hospital nurses, and other health workers. For information write: Foundation for Teaching Aids at Low Cost (TALC), Institute of Child Health, 30 Guilford Street, London WC1N 1EH, UK.

? Background

88-7

Voluntary Health Association of India

C-14, Community Centre
Safdarjung Development Area
New Delhi-110016

Telegrams : VOLHEALTH
New Delhi-110016
Telephones : 668071
668072

OUR CONCERN ABOUT DRUGS

Inspite of the green revolution, white revolution, industrialization, modernization and development, the country's increase in GNP(Gross National Profits), most of these things have not touched that man who hangs helplessly below the poverty line. The irony of all our great development is that the number of such people who are becoming destitutes is increasing.

From 27 we can now boast of 229 Medical Colleges (Karnataka is planning to make a humble contribution and add to that list). According to WHO's recommendations our doctor population ratio is above the requirement. Our Pharmaceutical Industry is amongst the best in the Third World. The state spends Rs. 9 per person per year on health. Why then do we still have such a high incidence of malnutrition? high infant mortality? Why are there still 10 million TB patients when we have crores being spent on the National TB Programme.? Why do 27 million Indians get Typhoid every year? 6 out of 100 children are in potential danger of becoming blind with Vit. A deficiency. Why is it that the great majority of our population has no access to basic health care? 80% of our doctors and our health budget cater to the needs of a small minority.

Drug costs represent 40-60% of the total health care expenditure in the developing countries (compared with 10-20% in the developed ones).

The rural urban disparity when it comes to health man power allocation expenses on drugs, vaccines and other health services is in simple words UNJUST. Only a very meagre percentage of Rs. 9 alloted per person for health expenditure reach him, who forms our 'Millions'.

VHAI believes in making health care available to those who need it most. Orientation towards "appropriate use of drugs" and non drug therapies is not merely for those who are given the prescriptions, but also for those who do the prescribing. A prescription written with the high medical standards in mind, may be highly inappropriate in a social context where the patient cannot afford to buy the drugs, or where buying these drugs for the family members means being in and out of debt with money lenders. Our prescription practices have to be modified according to the needs of the people, our choice of drugs for stocking the pharmacy have to keep this in mind and most of all the emphasis has to be on people taking self responsibility for their health and avoiding these drugs as far as possible and using those non drug therapies that have been recognized to have good therapeutic effect. Education and awareness as to how to avoid disease and then how to handle it appropriately at the lowest possible cost is the crux of our approach in low cost appropriate health care.

*DRUGS:

The marketing of most brand named drugs specially by the multinational in the Third World works against the Health of the poor: (1) Most critically - because Health Care priorities are distorted by pressure to buy expensive inappropriate drugs, which cream off limited resources, and (2) Drugs freely promoted in the absence of distribution controls can be dangerous.

(1) - The effect of promoting th expensive, branded drugs for which generic equivalents are available at a fraction of the cost (sometimes as low as 10%), is to drain limited Health Budgets unnecessarily.

COMMUNITY HEALTH CELL
47/1,(First Floor),St. Marks Road
BANGALORE-560 001

* OXFAM PUBLIC AFFAIRS UNIT (21.4.'80)

- Third World countries spend a disproportionate amount on Drugs, often as much as 55% of the total health budget (compared to 11% of NHS budget on drugs here). Bearing in mind the very limited effectiveness of drugs and curative medicine in general in tackling the major health problems - malnutrition, infectious and parasitic diseases - public funds would be far better spent on preventive health measures and the basic Primary Health Care infrastructure. For this, WHO estimate that 200 generic drugs would be more than adequate to meet Health needs.

- The promotional practices of drug companies, aimed at maximising profits, run directly counter to the health needs of the poorest. Drug company salesmen (Glaxo has 500 in India alone) concentrate their promotion on encouraging doctors to prescribe the most expensive, latest patented drugs, claiming they are great improvements on far cheaper, well-established drugs. When Beecham's and Wellcome's antibiotics and antimalarials are prescribed at public expense, instead of penicillin and chloroquine, the drug budget is rapidly exhausted. Because of existing imbalances in the health services, reinforced by marketing, the brunt of wasteful spending invariably falls on the poorest, as the rural dispensaries run short of vital life-saving drugs.

- Apart from promotion of unnecessarily expensive , but necessary drugs, doctors are also encouraged into wasteful overprescribing of non-essential tranquilisers, sympton-allaying drugs, and tonics. Onceagain, the indirect effect on the poor, is that Valium being doled out in hospitals on public funds, can mean shortages of first line drugs in the village dispensaries. Where medicines have to be paid for, (particularly when the doctor is remunerated for prescribing rather than consultation) - sales talk may lead him to prescribe unnecessary drugs e.g. several courses of antibiotics and vitamins for a sick child, costing anything up to a months wages.

(2) - Drugs freely promoted in the absence of distribution controls can be dangerous.

- The trickle-down effects of uncontrolled drug marketing in the absence of an adequate health infrastructure, trained health workers and controls on over-the-counter sales can seriously endanger the health of the poor. They are most vulnerable through ignorance of dangers and the misconception that a medicine - any medicine - will do the trick.

- When under attack for unethical marketing practices in the Third World, the drug companies argue that they stick to the letter of the law. Quite true - But, they demonstrate a total lack of social responsibility in promoting potent, potentially dangerous drugs, in countries where they know they will be freely available over-the-counter, prescribed by local practitioners and traders with little knowledge of medicine - let alone spphisticated drugs. (Whilst deaths from adverse drug reaction go unreported in the Third World - in the USA they are estimated at 30,000 per year.)

- The net effect is that the poor are encouraged to buy drugs for totally inappropriate uses and irrational self-medication - particularly of antibiotics leading to serious problems of drug resistance - can be fatal. First line antibiotics given to children with diarrhoea could mean they will die later if they get TB, because there will be no way of obtaining or paying for a second line drug.

.....3/

BRIEF OUTLINE OF VHAI'S ROLE IN LOW COST APPROPRIATE HEALTH CARE

Regarding Drug related Legislation at national level:

- Forming a lobby against unethical practices of drug companies.
- Building awareness regarding WHO endorsed code of conduct as against that drawn up by multinationals
- Seeking information and analysing national policies which may have detrimental implications, specially where drug market is concerned.
- Linking up with medical units of various consumer societies, other groups and individuals working on similar lines: eg. Medico Friends Circel, Centre for Studies in Science and Environment etc. to form pressure group.
- Use different seminars, workshops, medical and non-medical journals to disseminate relevant information.
- Questioning drug advertisements, giving incorrect information and making false claims.

Regarding Production of Generic name drugs:

- Collect information of experience regarding production of drugs and low cost health care from other voluntary groups and programmes: eg. Savar in Bangladesh, Guatimala, Philippines, Sri-Lanka, Medicus Mundi/International Organisation and seeing applicability in our Indian context.
- Encourage or collaborate in production of generic name drugs.
- Conscientize people regarding quality control and demanding it to prevent involuntarily having turning to the sophisticated drug companies.
- To identify non allopathic drugs : eg. de Chanes, Homeopathic etc. of cheaper and more effective to inform others.

Regarding Distribution of drugs: (which is the biggest problem for developing countries) (See appendix-1)

- Encouraging bulk purchase at regional levels
- Helping to organize distribution channels
- Help collect background information based on epidermiological studies, other field studies

Regarding Management of Pharmacies:

- Encouraging formation of pharmacy and therapeutics committee (See appendix 2)
- Stocking with appropriate drugs - low cost, generic, avoiding combinations trade names as far as possible
- Encouraging local preparations of liniments, ointments, syrups and mixtures (as done by compounders earlier)

...../2/

- Helping in appropriate pricing of treatment (registration, consultation and cost of drugs)

- Availability of information on all drugs dispensed with.

Regarding Dispensing of drugs:

- Limiting range of drugs in the pharmacy to essential drugs

- Use of formulary

- Encouraging use of Physicians' Desk. Reference on extra pharmacepea and not relying on the information given by drug advertisements and drug representatives.

- Helping in standardization of diagnostic and prescription procedures (to avoid unessential and limiting procedures to the most appropriate)

Regarding Education and Training of Health Personnel:

- Collection, analysis and dissemination of relevant information to health professionals (and public) regarding - use of drugs and their substitutes - role of drug industry in health services - use of non drug therapies : eg. massage, acupressure, acupuncture - investigation and use of home remedies and other indigeneous herbal medicines known to be cheaper and giving good therapeutic results.

- local preparations of commonly used ointments, syrups etc.

- planting of medicinal plants in hospital vicinity with specific therapeutic value.

Regarding Health Education of Patients :

- Emphasis on the concept of self responsibility regarding health

- Special coverage to methods of prevention of common diseases, eg: those due to poor hygiene, sanitation and nutrition.

- Information about the various govt. health programmes:
  - National TB Programme
  - MCH & FP
  - For Blindness etc.
  - Immunization Programmes

- Information regarding functions of PHC doctor, sanitary inspector, ANM etc. for people to know their rights.

- Sharing information with the people about therapies used by them

- Encouraging medically sound customs and cultural practices - eg. use of Dathun instead of colgate tooth paste and discouraging the harmful ones by giving appropriate information. eg: branding a child on the abdomen, not breast feeding a child for 3 days..

- Giving information about the misuse of - injections - tonics - steroids, bottle feeds.

.....3/

BRIEF OUTLINE OF VHAI'S ROLE IN LOW COST APPROPRIATE HEALTH CARE

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Regarding Distribution of drugs: (which is the biggest problem for develop--ing countries) (See appendix-1)

- Encouraging bulk purchase at regional levels
- Helping to organize distribution channels
- Help collect background information based on epidermiological studies, other field studies

Regarding Management of Pharmacies:

- Encouraging formation of pharmacy and therapeutics committee (See appendix 2)
- Stocking with appropriate drugs - low cost, generic, avoiding combinations trade names as far as possible
- Encouraging local preparations of liniments, ointments, syrups and mixtures (as done by compounders earlier)

.....2/

- Helping in appropriate pricing of treatment (registration, consultation and cost of drugs)

- Availability of information on all drugs dispensed with.

Regarding Dispensing of drugs:

- Limiting range of drugs in the pharmacy to essential drugs

- Use of formulary

- Encouraging use of Physicians' Desk. Reference on extra pharmacepea and not relying on the information given by drug advertisements and drug representatives.

- Helping in standardization of diagnostic and prescription procedures (to avoid unessential and limiting procedures to the most appropriate)

Regarding Education and Training of Health Personnel:

- Collection, analysis and dissemination of relevant information to health professionals (and public) regarding - use of drugs and their substitutes - role of drug industry in health services - use of non drug therapies : eg. massage, acupressure, acupuncture - investigation and use of home remedies and other indigeneous herbal medicines known to be cheaper and giving good therapeutic results.

- local preparations of commonly used ointments, syrups etc.

- planting of medicinal plants in hospital vicinity with specific therapeutic value.

Regarding Health Education of Patients :

- Emphasis on the concept of self responsibility regarding health

- Special coverage to methods of prevention of common diseases, eg: those due to poor hygiene, sanitation and nutrition.

- Information about the various govt. health programmes:
  - National TB Programme
  - MCH & FP
  - For Blindness etc.
  - Immunization Programmes

- Information regarding functions of PHC doctor, sanitary inspector, ANM etc. for people to know their rights.

- Sharing information with the people about therapies used by them

- Encouraging medically sound customs and cultural practices - eg. use of Dathun instead of colgate tooth paste and discouraging the harmful ones by giving appropriate information. eg: branding a child on the abdomen, not breast feeding a child for 3 days..

- Giving information about the misuse of - injections - tonics - steroids, bottle feeds.

.....3/

Other Activities to decrease health care costs:

- Training of different levels of health personnel to be able to handle common problems as effectively and as cheaply as possible
- Investigate role of health insurance schemes in different parts of India and their feasibility.
- Preparation of recommended reading list of books and material related to low cost appropriate health care.
- Formation of linkages with groups working on the same lines eg: MFC, Centre of Science and Environment
- Collaborating with groups to do scientific field studies on local remedies, their utility value and optimum methods of preparation (Solidarity, SIRTDO, Ranchi)

This background paper is for discussion.

--------oOo--------

Appendix 1

Distribution of Essential drugs in Developing Countries

Drug distribution was identified as a critical factor in health care and the accomplishment of a comprehensive national drug policy at the consultation and WHO Technical Discussion in 1978.

It appeared that the types of distribution systems or patterns depend largely on the political and economic system and the administrative system under which the Govt. is operating. (effective distribution of resources depends on nation's political will).

Following were the relevant factors to be considered for any system of distribution of drugs:

1. Health Care System, Demography, Health Indicators
2. Morbidity pattern
3. List of essential drugs and medical equipment
4. Adequate storage facilities
5. Administration, personnel forecasting and inventory control
6. Transportation facilities and maintenance service.
7. Packaging material standardization and labelling
8. Quality surveillance and inspection
9. Education and regular training of staff
10. Drug utilization studies

The Primary purposes of the Pharmacy and Therapeutics Committee

a. Advisory

b. Educational

Functions and Scope

The following list, which is not necessarily comprehensive, is often as a guide:

A. To serve in an advisory capacity to the medical staff and hospital administration in all matters pertaining to theuse of drugs.

B. To serve in an advisory capacity to the medical staff and the pharmacist in the selection of choice of drugs which meet the most effecitve therapeutic quality standards.

C. To evaluate objectively clinical data regarding new drugs or agents proposed for use in the hospital

D. To prevent unnecessary duplication of the same basic drug or its combinations.

E. To recommend additions and deletions from the list of drugs accepted for use in the hospital

F. To develop a basic drug list or formulary of accepted drugs for use in the hospital and to provide for its constant revision.

G. To make recommendations concerning drugs to be stocked in hospital patient units or services.

H. To establish or plan suitable educational programmes for the professional staff on pertinent matters related to drugs and their use.

I. To recommend policies regarding the safe use of drugs in hospital, including a study of such matters as investigational drugs, hazardous drugs, and others.

J. To study problems involved in proper distribution and labelling of medications for inpatients and out patients.

K. To study problems related to the administration of medications.

L. To review reported adverse reactions to drugs administered.

M. To evalutate periodically medical records in terms of drug therapy.

LIST OF RELEVANT READING MATERIAL DEALING WITH DRUG PROBLEM

1.	Drugs and the Third World	Anil Aggarwal	Earthscan Publication International Institute for Environment & Development 10 Percy Street London - August 1978
2.	There is Gold in them tharpills	Alan Klass	Penguin Special 1975
3.	Poor Health - Rich Profits	Dr. Tom Heller	Bertrand Russel Peace Foundation Ltd. Bertrand Russel House Gamble Street Nottingham 1977
4.	Social Audit Insult or Injury ?	Charles Medawar	Social Audit Ltd. 9 Poland St. London W1V3DG 1979
5.	Social Audit Drug Disinformation	Charles Medawar	Social Audit Public Interest Research Centre Ltd. November 1980
6.	Medicus Mundi Internationales	International Organization for Cooperation in Health Care. Documentation of the General Assembly (17-19 May 1980)	General Secretariat of Medicus Mundi Internationalis Mozartstrasse 1980 D-5100 Aachen, BRD
7.	Essential Drug List	WHO Technical Report series No. 641	1979
8.	Drugs and Pharmaceutical - Chapter from "Health for All - An alternative strategy"	ICMR & ICSSR	New Delhi August 1980
9.	Hathi Commission Report	GOI	1974
10.	Food First	Lappe Francis Moore and Collins	1980
11.	Medical Nemesis	Ivan Illich	

.....2/

12.	Confessions of a Medical Heretic	- Dr. Robert S. Mendelsohn Contemporary Books	1979
13.	The Medicine Men	- Vernon Coleman Arrow Books Ltd. Essex	1975
14.	Conference Proceedings	- Pharmaceuticals for Developing Countries National Academy of Science, Washington DC	1979
15.	Information Sources on the Pharmaceutical Industry	- UNIDO Guides to Info. Sources No.20 UNIDO, VIENNA	1976
16.	Pills Against Poverty (A Study of the introduction of western medicine in a Tamil village)	- Djurfeldt, Goran Lindberg, Staffan Oxford, IBH Pub. Co. New Delhi	1976
17.	In Search of Diagnosis	- Ashwin J.Patel Medico Friends Circle Gujarat	1977
18.	Planning Pharmaceuticals for Primary Health Care (The supply & utilization of Drugs in the Third World)	- Oscar jish Loretta Lee Feller	
19.	Drugging the Indian (Article in"Debanoir")	- by Shivanand Karkal	July '80
20.	The Ethics of the Drug Industry (Article in "Business India")	- by Dilip Thakore	July '80

THE PHARMACOPOEIAS

DEFINITION :

By a pharmacopoeia is meant a book published under the authority of a recognised body, generally constituted by law, for the purpose of securing uniformity of composition and strength of medicines used in the treatment of disease. This book describes most of the drugs of therapeutic usefulness and pharmaceutic necessity, withdirections for their preparation, physical or chemical characteristics, standardisation and dosage. The first B.P. was published in 1864, and the last in 1958. Other countries, as the United States, Germany, France, India, etc., also publish their own pharmacopoeias.

In the year 1955 Government of India published the first Indian Pharmacopoeia (I.P.) which includes not only all useful drugs but also many vegetable drugs of proved therapeutic value, which grow or can be made to grow in India, with definite chemical compositions and standards, and other chemical and synthetic compounds prepared in India.

The current United States pharmacopoeia (U.S.P.) was issued in 1955 and the first volume of International Pharmacopoeia was published in 1951.

The Council of the Pharmaceutical Society of Great Britain periodically publish a book called "The British Pharmaceutical Codex" (B.P.C.) which contains not only all the drugs and preparations of the British Pharmacopoeia but also many other preparations not contained in it. National Formulary (N.F.) and New and Non-official Drugs (N.N.F.) are other recognised publications.

Pharmacopoeial Preparations

Few drugs can be administered in their natural state. They are either too nauseous, too bulky, or contain some principles which are injurious to life of health. They are, therefore, submitted to certain processes prescribed by the pharmacopoeias, in order to render them fit for administration, and also to help their preservation and storing so as to maintain an uninterrupted supply during all seasons of the year.

The International Pharmacopoeia is published by the W.H.O.

The National Formulary is another recognised publication. The inclusion of drugs in the National Formulary is based on their therapeutic merit rather than the extent of use. The National Formulary includes many formulae for pharmaceutical preparations like elixirs, solutions, tinctures, pills and powders, which are in common use. National Formulary (N.F.) of India is published by the Government of India.

The British Pharmaceutical Codex

British Pharmaceutical Codex is the British counterpart of N.F. and is published by the Pharmaceutical Society of Great Britain.

...2

The Physicians's Desk Reference (P.D.R.)

This is an Americal body. The Indian counterpart is the CIMS & MIMS. Financing of this project is done by the drug companies who buy space to list their products. The information in this volume is supplied by the drug companies and is not subject to critical and objective review, although in recent years most of the descriptions are similar to the package inserts which are reviewed. One deficiency is the tendency to list or to describe more fully only new products. The publisher and the drug companies do not advocate the use of any particular product, nor is there any overt attempt to influence the therapeutic practice of the physician. On the other hand, it is only natural that a physician seeking information in this volume will be attracted to a large number of new products. One of the sections lists products by therapeutic indications. The superficial and careless physician might easily fall prey to the dozens of products listed for a particular disease or symptom without having real knowledge of the actual therapeutic possibilities or dangers and toxicities. The volume is useful and handy for finding what drugs are available, what dosage forms are made, and what drug companies manufacture the item. In the final analysis, it must be recognized that this volume represents a form of advertising.

The Merck Index

For those more scientifically inclined and desirous of knowing more of the chemistry and physical characteristics of drugs, the Merck Index is invaluable. It is not intended for therapeutic use.

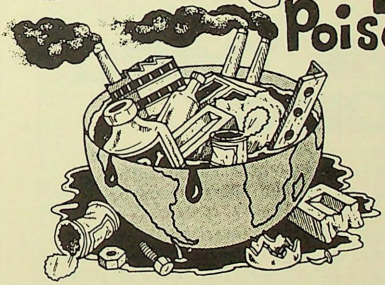
IDCU

CONSUMER INTERPOL

now you do not have to take all these hands down

Corporate Crime of the Century

Circle of Poison



Pesticides & Pills

FOR EXPORT ONLY

WHAT IS CONSUMER INTERPOL?

Consumer Interpol - If you think the name refers to a force assembled by consumers to fight international corporate crime, you are right. Rampant dumping of hazardous products, dangerous technologies and toxic wastes; countless victims (many of them disabled, dying or dead); the absence of any comprehensive effort to bring about a solution.... These have given rise to an acute sense of impatience among consumer groups and prompted action against the unconscionable deeds of some transnational corporations and 'aid' agencies. *Consumer Interpol*, set up by the International Organization of Consumers Unions (IOCU), is a dynamic entity incorporating an alert system, safety campaigns, advocacy for regulations, research and training. It aims to organize citizen action against an intolerable problem.

HOW DOES IT WORK?

IT'S GLOBAL. *Consumer Interpol*, as the name suggests, is global. At the core of the network are members of the IOCU group numbering more than 120 organizations located in some 50 countries and representing every continent. The *Consumer Interpol* is developing regional centres to support activities in every part of the world. Each of these centres will have a wide network of correspondents; the aim is to have at least one in every country. Correspondents are drawn from consumer, health and environmental groups and a wide range of knowledgeable people including journalists and scholars.

IT'S PARTICIPATORY. This information-and-action network encourages participation; it calls for a cooperative response to a shared problem. All components of the *Consumer Interpol* are two-way systems - they GIVE help and they TAKE help. The 'alert' system, for example, welcomes information on hazards from all quarters. Whatever vital information it receives will be channelled out as warnings to those who need it. Regional centres, the collection and dissemination points, will assess information received with the help of some experts.

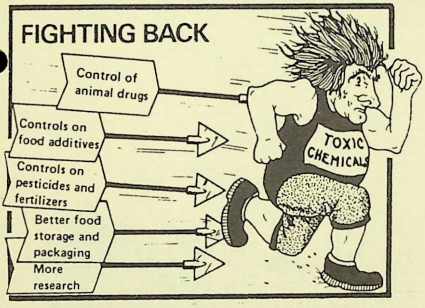
IT'S AN ADVOCACY NETWORK. The *Consumer Interpol* does not stop at issuing 'alerts.' It also takes action from time to time to ensure that the hazards are removed through legislation and other means. What the network will do is flexible and it depends on the issue at hand. A localised problem may only need a localised response with help from a few other organizations. For a global problem, *Consumer Interpol* may mount a campaign involving every concerned group that wishes to combat the problem. IOCU is not new to such international campaigns. It is playing a key part in those involving infant formula and pharmaceuticals through the International Baby Food Action Network (IBFAN) and Health Action International (HAI).

IT'S SUPPORTIVE. The supportive arm of *Consumer Interpol* is aimed at making sure the action-information balance, vital to any international campaign, is well-maintained. Research will feed the system with detailed information while training ensures that gathered information is well stored and efficiently used. A data bank with links to other documentation centres will be maintained. There will also be active links with programmes like: • the International Register of Potentially Toxic Chemicals (IRPTC) of UNEP; • the International Programme on Chemical Safety of ILO, UNEP and WHO; • the ILO International Occupational Safety and Health Hazard Alert System and • UNEP's Global Environmental Monitoring System (GEMS).

THE THIRD FORCE

"The lack of controls on the exports of toxic substances that are banned or restricted poses an undue burden on the 'inner limits' of man; it poses an undue burden on the 'outer limits' of our environment; it poses an undue burden on developing countries that have not yet the skills and resources to deal with the problem adequately. The '3rd system,' the citizens' groups in developing and developed countries, must act together because we cannot rely on the '1st system,' the governmental system or the '2nd system,' the commercial network, to deal adequately with this problem. We are concerned here with a major health issue, we are concerned with a human rights issue, and we are concerned with the protection of the environment."

— Anwar Fazal, President of IOCU, Keynote address to an NGO Seminar on the Export of Toxic Substances, New York, November 20, 1981.



Graphics : David Eaton

ACTION CHECKLIST

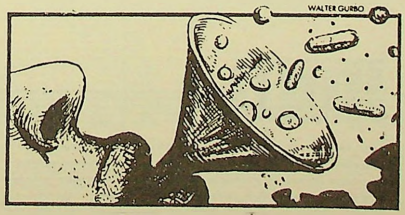
Should you receive information on any of the following...

- marketing of dangerous consumer goods like toxic foods and dangerous toys
- export of hazardous wastes
- plants that expose workers to serious health hazards
- adoption in exporting countries of new bans or strict controls over hazardous consumer goods, drugs, pesticides or industrial chemicals (this is to alert the network to the possibility of dumping)
- newly reported outbreaks of illness or death due to previously known hazardous agents

...inform the International Organization of Consumers Unions (IOCU) and we will take the appropriate action. (Our addresses are on the back page.)

DID YOU KNOW?

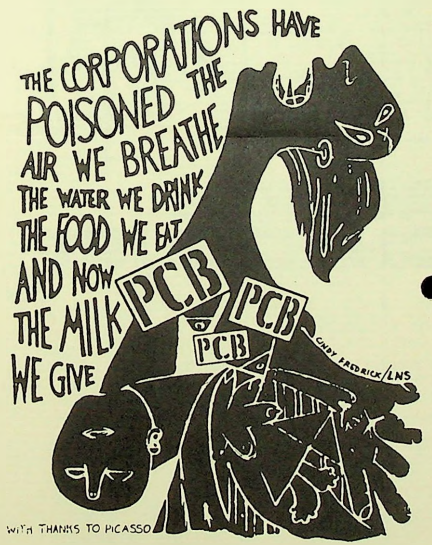
- At least 25% of US pesticide exports in 1980 were products that were banned, heavily restricted, or have never been registered for use in the United States.
- About 1.5 million people are being poisoned by pesticides every year, with half of the cases in poor countries. Some 30,000 deaths a year - three quarters of them in the Third World - are believed to be due to pesticide poisoning.
- Several million children's garments treated with a cancer-causing fire retardant called Tris were shipped overseas after being forced off the US market by the Consumer Product Safety Commission.
- Many pharmaceutical companies fail to label their products adequately regarding proper use and dosage. Often even doctors are deprived of crucial information like potential side effects.
- In India, the subsidiaries of major British and American asbestos companies operate facilities that are 50 years behind the standard of practice the firms observe in their home countries.
- The US Environmental Protection Agency estimated that in 1980 at least 57 million tons of hazardous waste was produced in the United States. There are not enough safe, secure disposal sites to handle a fraction of it.



Source: The Corporate Crime of the Century
Mother Jones reprint

RESOURCES

- Ahmed,A.Karim;Morehouse,Ward;and Shaikh, Rashid *"For Export Only:The International Trade in Toxic Substances."* Development Forum,January 1982.
- Castleman,Barry I.*"The 'Double Standard' in Industrial control of Health Hazards."* Paper presented to the New York Academy of Sciences, 4 February, 1981.
- Concern Inc.*"Hazardous waste:A community action guide,"* May 1981.
- Dowie,Mark.*"The Corporate Crime of the Century"* Mother Jones, November 1979.
- Fazal, Anwar.*"Testimony before the Subcommittee on International Economic Policy and Trade, Committee on Foreign Affairs, US House of Representatives 5 June 1980"* IOCU Newsletter, June 1980.
- Harris, Robert.H. Keynote Address, Special Open Session on the Dumping on Hazardous Products, Processes and Wastes, 10th IOCU World Congress, The Hague, June 1981.
- Health Action International. *New "International Antibody" Will Resist "Ill Treatment of Consumers By Multinational Drug Companies"* Geneva, 27 to 29 May 1981.
- IOCU Regional Office for Asia and the Pacific. *"Forty Four Problem Drugs - A Consumer Resource and Action Kit."* May, 1981.
- Medawar,Charles.*"Insult or Injury? : An Enquiry into the Marketing and Advertising of British Food and Drug Products in the Third World."* Social Audit, Ltd., 1979.
- Newman,Barry.*"Consumer Protection is Underdeveloped in the Third World."* Wall Street Journal, 8 April 1980.
- Scherr,S.Jacob. Natural Resources Defense Council Statement to the Subcommittee on International Economic Policy and Trade of the Committee on Foreign Affairs, US House of Representatives, Concerning the Reagan Decision of the US Hazardous Substances Export Policy. 12 March 1981.
- Shaikh, Rashid;and Reich, Michael R. *"Haphazard Policy on Hazardous Exports."* The Lancet, 3 October 1981 : 740-42.
- Silverman,Milton,Lee,Philip. R. and Lydecher, Mia.*"The Drugging of the Third World."* Paper presented at the 10th IOCU World Congress, The Hague, June 1981.
- *"The Penang Declaration on the Export of Hazardous Substances and Facilities."* Consumer Currents, February 1981.
- UN Economic and Social Council. Exchange of information on Banned Hazardous Chemicals and Unsafe Pharmaceuticals. Report of the Secretary General E/1981/ 11 February 1981.
- UN Commission on Transnational Corporations. *"Role of the Information System on Transnational Corporations regarding the exchange of information on banned hazardous chemicals and unsafe pharmaceuticals."* E/C 10/90 18 June 1981.
- Weir, David, and Shapiro, Mark. *"Circle of Poison: Pesticides and People in a Hungry World."* San Francisco: Institute for Food and Development Policy, 1981.
- Wyrick, Bob. *"Hazards for Export"* Newsday, Special Report December 1981.



Source: International Women and Health Resource Guide

IOCU

The International Organization of Consumers Unions (IOCU) links the activities of consumer organizations in some 50 countries. An independent, non-profit and non-political foundation, IOCU promotes world-wide co-operation in consumer protection, information and education. The Headquarters of IOCU are at 9 Emmastraat, The Hague, Netherlands. Phone (+3170) 476331, Cable Interocu Haag. Telex 33561, The Regional Office for Asia and Pacific is at P.O. Box 1045, Penang, Malaysia. Telephone 885072, Cable Interocu Penang. Telex MA 40164 APIOCU.

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appendix

MEDICAL SERVICE
OCT-NOV 1984 Dead line: 20th Sept 1984

SPECIAL ISSUE:

Drug pushers or healers?

A list of possible article/reprints: A final selection will be made based on receipt of articles within deadline as well as coordination with special issues of Health for the Millions and the mfc bulletin.

1. Editorial		
2. Drugs and the Healing Process	: A theological perspective	: Fr Samuel Ryan or Fr Cedric Rebello
3. Drugs and the CHAI vision	: the social relevance	Fr Thomas Joseph
4. Drug situation in India	: an overview	A summary from Health for All -ICMR/ICSSR Aspects of Drug in India
5. A to Z of Drug issues	: the how and why of the drug situation	Community Health Cell, Bangalore
6. Misuse/overuse	: factors/reasons	David Werner
7. Drug prescribing	: the ethical dilemma	Fr George Lobo
8. A to Z of Drug prescribing	: Banned and hazardous drugs:	Community Health Cell, Bangalore
9. Medicine as a substitute for caring		David Werner
10. A people's view of drugs		David Werner
11. To inject or not to inject		Janet Aitken
12. The crazy world of tonics		Mukkaram Bhagat
13. Learning to use antibiotics wisely		David Werner
14. Diarrhoea		Earthscan/VHAI
15. O.R.T. Options	: from dependence to autonomy	David Werner

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16. Drugs and Pharmacy regulation	: the legal aspects	Fr P D Mathew
17. In the news	: an Indian media review	Community Health Cell, Bangalore
18. Consumer Alert-Consumer Action	: Drug Action in India	Ravi Narayan (bulletin of Sciences)
19. The Kurji Case Study	: A mission hospital's efforts towards rational therapeutics	Tom Kalliath
20. LOCOST	: A low cost drug distribution service	S Sreenivasan
21. The CPA	: the CHAI experience	CHAI report
22. Drugs in other systems		Community Health Cell Bangalore
23. Non-drug therapies		

24. What can we do? Some suggestions for action

25. <u>Widening horozons and contacts</u>

a) books and journals

b) education material

c) other contacts

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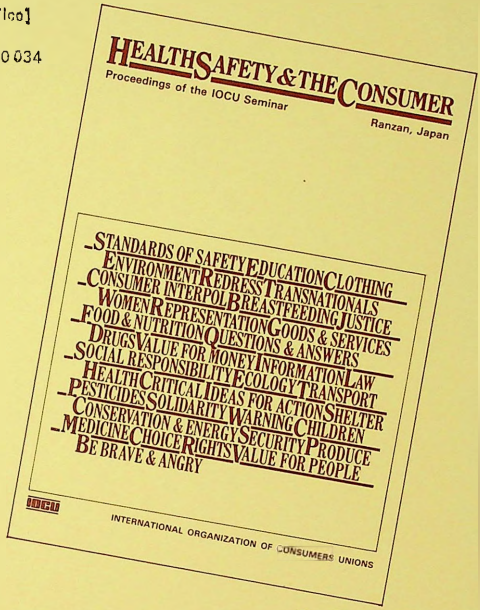
Health, Safety and the Consumer

Proceedings of the IOCU Seminar, Ranzan, Japan



Dangerous drugs, unfit food and unsafe products — these are what gave birth to the consumer movement. Angry at such threats to their health and safety, consumers in the United States around the turn of the century organised themselves and fought back. Today, consumer organisations are found in most countries, and some 120 groups are members of the International Organization of Consumers Unions (IOCU).

But safety is no longer a national concern. The global market place brings new problems, including the irresponsible export of banned or dangerous products to countries where government protection of the consumer is slack. This IOCU seminar which brought more than 300 consumer leaders, researchers and scientists together at Ranzan, Japan from April 6-9, 1983, was therefore timely.

Consumer activists and observers of the consumer movement will find this publication a useful collection of papers representing current views of the consumer movement on various aspects of product safety such as legislation, education, information and trade. The seminar also focused on two specific groups of chemicals, drugs and pesticides.

ISBN 967-9973-00-X 118 pages US$15.00 including surface mail postage

ORDER FORM

Send your order to:
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P.O. Box 1045,
Penang, Malaysia.

- I would like to order.....copy/copies of the Proceedings of the IOCU Seminar on Health, Safety and the Consumer
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  US$ 7/- for the Americas
  6/- for the Europe, Middle East, Australia and the Pacific
  4/- for Asia
- I enclose my bankdraft (drawn on any bank in Malaysia) for $....., made out to the International Organization of Consumers Unions

Name: _____

Organisation, if any: _____

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Address: _____

_____

IOCU

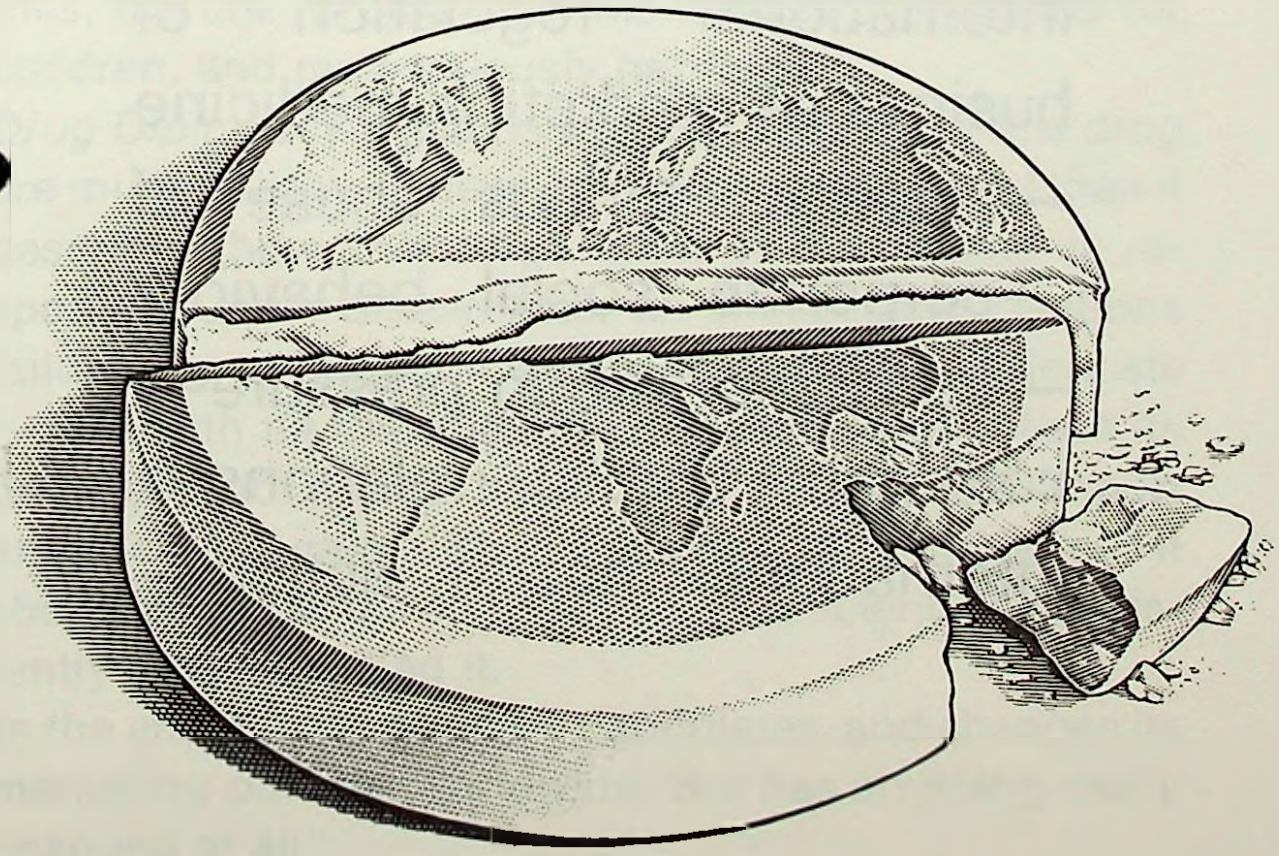
INTERNATIONAL ORGANIZATION OF CONSUMERS UNIONS

Social Audit

DRUG DIPLOMACY

Charles Medawar & Barbara Freese

Decoding the conduct of a multinational pharmaceutical company and the failure of a Western remedy for the third world



DRUG DIPLOMACY

Key words: multinational corporation—pharmaceuticals and public health—developing countries and development—international regulation of business—marketing medicine—science: serious abuse of—corporate social behaviour—consumer group pressure—corporate public relations—international health action—

Key issues: People are increasingly worried about the damage done by US and other multinational corporations in developing countries. There is special concern about the pharmaceutical industry — because double standards in marketing, and other industry practices are seriously undermining public health in the third world. There is no effective control over this — though pressure is now mounting for a World Health Organisation code of pharmaceutical marketing practice.

Drug Diplomacy shows how important these issues are by looking at the way in which a major US drug corporation has promoted one of its best-selling products in the third world. The story starts as a small British public interest group pillories the corporation for promoting this drug for the treatment of infants in developing countries. In the US and in other industrialised countries, the law forbids this: this drug is of no value for children, and may seriously harm them.

Drug Diplomacy explains why the dangers of this drug are much greater in developing countries — and then it describes how the corporation which makes it responded under attack. After an initial public relations failure, the corporation weighs in with its top scientists — and with all the scientific evidence — to defend its position and attack back. The Social Audit report analyses and demolishes the company's evidence. It shows also how the company's senior scientists consistently misinterpreted it.

In the end, the corporation capitulates, and changes its marketing policies worldwide. But has anything really changed at all?

DRUG DIPLOMACY: Decoding the conduct of a multinational pharmaceutical company and the failure of a Western remedy for the third world.

Status and date of publication: New book: ISBN 0-9503392-9-6
Spring 1982

Extent and format: 128 pages. Approx, 180 g. 210mm x 148mm (A5 size). In soft cover only.

Readership and level: Lay readers. Students — especially of development and business studies, international relations, sociology and related disciplines. Also for students and practitioners of medicine (tropical, paediatrics) and pharmacology. For corporate managements: marketing, public relations, business strategy. Also for government regulatory agency officials and senior health policy advisers.

To order: *If there is a distributor's name in the box below, it would be much more convenient for you to order through them.* If the box below is blank, please send cash with order to: **Social Audit Ltd., 9 Poland St., London W1V 3DG.**

Drug Diplomacy can be obtained at £3.95 per copy, plus postage and packing charges. Add 35p in the UK; or 55p for surface mail to all other countries. For airmail post, please add 90p per copy to Europe, and £1.80 elsewhere. *Please send cash with order. Payment must be in £ Sterling, and drafts should be drawn on GIRO or on a London bank.*

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Name and address .....

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(S.1/2/82)

PILL-FERING THE POOR: DRUGS AND THE THIRD WORLD

- Why do drug companies spend only 1% of their annual research budgets on tropical diseases which affect hundreds of millions of the third world poor, and have as yet no safe, cheap and effective drug therapies?

- Why can Africans buy over the counter, a pain killing drug, dipyrone, made by a US company, when this same drug has been banned in the United States because it is considered too dangerous for US citizens?

- Why is the real cost of drugs in third world countries often much higher than in the industrialized world – sometimes as much as 20 times more than in Europe or the United States?

Modern drugs have brought tremendous relief of suffering around the world. Research-based multinational pharmaceutical companies have made some important contributions towards improved health, discovering drugs to treat a wide range of illnesses.

Yet thousands of people die every year in the third world as a result of dangerous, ineffective or inappropriate drugs, promoted by the pharmaceutical industry.

PILL—FERING THE POOR, an Information/Action Pack provides an overview of the problems related to drug marketing in the third world. It contains articles on the need for essential drugs, on the suffering wrought overseas by some US made drugs, and on the high price the third world poor have to pay for their medicines. The pack includes an extensive annotated bibliography, basic facts and figures about the transnational drug industry, and an outline of suggestions for action on how you can get more involved in helping to stop abuses.

To order PILL—FERING THE POOR send $4.00 (+ $1.50 for postage) to: Interfaith Center on Corporate Responsibility, International Health Program, 475 Riverside Drive, Room 566 New York, NY 10115.

PILL—FERING THE POOR

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.....

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Med Service
Nov 84 28.12

V i s u a l s

Sl No	Theme	Source	Suggested positioning
1.	The World's Best Medicine	UNICEF	After editorial
2.	Living in two Worlds	Church & Social Justice (CSA)	With CHD team's article
3.	Dumping	Helping Health Worker Learn	With article Misuse/overuse of medicines
4.	Rare Himalayan herb and multi-national pill for headache	Laxman cartoon Health Care Which way to Go (mfc)	With article Misuse/overuse of medicines
5.	Vicious cycle of medicine overuse	Helping Health Workers Learn	With medication as a substitute for caring
6.	Expensive yes	Laxman Cartoon Health Care Which Way to Go (mfc)	With or before Drug misuse in our hospitals
7.	Not to be taken worthless	HAI News June 1982	With "If there are no side effects this must be Argentina"
8.	Who says lomotil has no value	Social Audit Handout (first page only)	Before "Crazy world of tonics"

COMMUNITY HEALTH CELL
47/1, (First Floor) St. Marks Road
BANGALORE - 560 001

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Sl No	Theme	Source	Suggested positioning
9.	Doctor, I have taken the tonic	Health Care Which Way to Go? (mfc)	With "Crazy world of tonics"
10.	A person who eats well does not need extra vitamins	Health for the Millions April-June 1981	With "Crazy world of tonics"
11.	What is so new about sugar-salt solution?	Health Care Which Way to Go (mfc)	With 'ORT - what are the options"
12.	Judge with pharmacology book	The Herald Review, Oct 14, 1984	With legal education
13.	Bad information means bad medicine	Social Audit (Health for the Millions, April-June 1981)	With or before "Consumer Alert--Consumer Action"
14.	Remember medicines can kill	Helping Health Worker Learn	With "Towards a Rational therapeutics".

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Copy

Voluntary Health Association of India

D-10/344
LCD/a/24.2.84

C-14, Community Centre
Safdarjung Development Area
New Delhi-110016

Telegrams : VOLHEALTH
New Delhi-110016
Telephones : 668071
668072

Drug Information - for Drug Action

The material produced by various individuals is being listed in the following pages. Most of it has been disseminated from VHAI for specific purposes namely the drug workshops, the drug campaigns, visits of Drug Campaigners eg. Dr Olle Hansson, Dr Zafrullah Chowdhury, etc.

Dissemination of the material from VHAI has in the past been limited to individuals personally known and directly involved in 'Drug Action'. With wider demand of drug material, the need to categorize, to give the date of preparation, the Central handout Code number, and authorship has been felt. The dates are important for certain handouts - eg. the Black Lists of the brands of irrational and hazardous drugs prepared in August '82 based on MIMS and CIMS enteries of that time which would have obviously subsequently altered somewhat.

Specific questions related to particular handouts can be addressed to the individual who has prepared them, many of whom are not VHAI staff.

List of Drug related material produced by Medico Friends Circle, Arogya Dakshata Mandal, Kerala Sahitya Sastra Parishad, Consumers Education Research Centre, Centre for Education and Documentation, Central Government Health Service, Lok Vigyan Sanghatna is being compiled likewise for the benefit of the newer organizations joining the Drug Action Network.

Mira Shiva

Dr Mira Shiva
Coordinator
Low Cost Drugs & Rational Therapeutics

		Date	Code	Author/Prepared by	Organization
	VHAI and the Drugs Issue				
1.	Our Concern about drugs	1981		Dr Mira Shiva	VHAI
2.	The Voluntary Health Association of India - its activities and its role in low cost drugs.	4.1.82	D-10.343	Mira Shiva	VHAI
	The Indian Drug Scene				
1.	The Drug Situation in India	5.1.82	D-10.343	Mira Shiva	VHAI
2.	A Study of Prevalent diseases in India and production of some essential drugs.	30.8.82		Dr J S Mazumdar L N Chakravorty and S Chatterjee	FAMRAI
3.	Community Health needs and Indian drug Industry.	5.12.83		Dr D Banerjee	Dept. of Social Medicine JNU
4.	Drugging the Indian.			Dr Shivanand Karkal (Reproduced from Debonair 1981)	
5.	Drugs-As if people mattered special issue of Health for the Millions	April-June 82		Guest editor-Mira Shiva	VHAI
	Rational Drug Therapy				
1.	What is Rational Drug Therapy?	April 82 (reprinted 22.11.83)	D-10/341(d)	Mira Shiva	VHAI
2.	WHO List of essential drugs for Primary Health Care.			WHO	WHO
3.	Alphabetical list of essential and complementary list.			Xerox from WHO's Technical Report Series 615	WHO
4.	Hathi Committee's Essential Drug List			Xerox from Hathi Committee Report.	
5.	Lists of Essential drugs- a comparison (Hathi Committee, WHO Sri Lanka, PGI, Echo, Action Medior and Pune Workshop)	1982		Mira Shiva	VHAI
6.	Selection of appropriate analgesic and antiinflammatory drugs.	19.10.81	D-9/334(k)	Dr Ullhas Jajoo	MFC

		Date	Code	Author/Prepared by	Organization
	Dumped Drugs and Banning of Drugs				
1.	Banning of Drugs	26.8.82	D-10.340	Mrs Chandra Kannapiran	VHAI
2.	Statement showing the categories of fixed dose combinations recommended by the sub-committee of the Drug Consultative Committee for being weeded out.			Drug Consultative Committee-Recommendations	
3.	Categories of fixed dose combinations recommended to be weeded out by the Technical Advisory Board(DTAB).	11.8.82	A-4/119	Drug Controller of India Nirman Bhawan 25.5.82	
4.	Some instances of drug dumping	Jan. 82	D-10.343	Mira Shiva	VHAI
5.	Information on some of the unwanted drugs banned abroad and dumped in the third world.	Jan. 82	D-10.343	Mira Shiva	VHAI
6.	Gazette Notification of the Drug Ban.	14.12.83	D-9/329(a)	Drug Controller of India Nirman Bhavan, 23,July 83	
	Irrational and Hazardous Drugs				
1.	Misuse of antibiotics	5.1.82	D-10/343	Dr Ullhas Jajoo	MFC
2.	The Clicquinol Controversy	19.8.82	D-9/334(a.1)	Dr Mira Shiva	VHAI
3.	Scientific Scrutiny of some over the counter Drugs	Jan 82	D-10/342	Dr A R Phadke	MFC
4.	Why amidopyrines must go	24.8.82	D-9/334(g)	Dr Mira Shiva	VHAI
5.	Using Tetracyclines for children and Pregnant women	25.8.82	D-9/334(h)	Dr Mira Shiva	VHAI
6.	Why not to prescribe anabolic steroids.	25.8.82	D-9/334(i)	Dr Mira Shiva	VHAI
7.	Some painful facts about a painkiller called amidopyrine.	23.11.83	D-10/341(d)	Dr Mira Shiva	VHAI

		Date	Code	Author/Prepared by	Organization
	The Black Lists of Irrational and Hazardous Drugs				
1.	Brands containing anabolic stercids	25.8.82	D-10-340	Dr Mira Shiva	VHAI
2.	Brands containing diphenoxylate(lomotil)	25.8.82	D-10-340	Dr Mira Shiva	VHAI
3.	Brands containing Paediatric Tetracyclin	25.8.82	D-10-340	"	"
4.	Brands containing analgin and phenacelin	26.8.82	D-10-340	"	"
5.	Brands containing hydroxyquinolines(Clioquinals)	25.8.82	D-10-340	"	"
6.	Brands containing combinations of i) Chloramphenical and streptomycin ii) Penicillin and streptomycin	August'82		"	"
7.	Brands containing irrational combinations of stercids and antiinflammatory agents	25.8.82	D-10-340	"	"
	Female Hormones and Hormonal Pregnancy Tests				
1.	Are hormonal pregnancy tests safe?	2.3.82	D-9/331(a)	Dr C Sathyamala & Dr Mira Shiva	"
2.	Dear Sister letter for the E P Campaign	11.2.82	D-10.344(c)	Dr C Sathyamala	"
3.	References on Oestrogen-Progesterone tests for Pregnancy	16.2.82	D-10.341(c)		
4.	Dear Doctor/Chemist letter	11.2.82	D-10.344(c)	Dr C Sathyamala	"
5.	Review of supportive hormone therapy in Obstetrics	5. 8.82	D-9/331(c)	"	"
6.	Brief Review of present situation of estrogen progesterone drug campaign	15.12.82	D-10/341(c)	Dr Mira Shiva Dr C Sathyamala	"
7.	A letter seeking immediate ban on high dose Estrogen Progesteron combination drugs	1.7.82	HCA-D.10	Dr C Sathyamala	"
8.	Warning Poster against hormonal Pregnancy tests			Dr C Sathyamala with Saheli Women's group.	
9.	The case against E P Forte- a review of the Controversy	1.11.83	D-10/341(1)	Dr Mira Shiva & Aspi Mistry	"
10.	Amniocentesis- for Sex determination A world without women Sex' determination tests- a technology which will eliminate women	7.9.82	D-10/342(b)	Dr Sathyamala & Amrita Chachi	" Saheli

		Date	Code	Author/Prepared by	Organization
	Bangladesh Drug Policy				
1.	In support of Bangladesh's Drug Policy	26.8.82	D-9/334(j)	Dr Mira Shiva	VHAI
2.	Drug Control Ordinance promulgated			(Reprint from The Bangladesh Observer)	
3.	The Bangladesh ban on hazardous and irrational drugs, its review and present status.	21.10.82	D-9/334/j:1)	Dr Mira Shiva	VHAI
4.	National Drug Policy for Bangladesh from expert Committee report			Dianna Melrose (extract from working paper medicines and the poor in Bangladesh)	Oxfam
5.	Bangladesh War - Part I and Part II			Claude Alvares with VHAI	RUSTIC
6.	Criteria for recommended withdrawal of products from Bangladesh market	2.11.83	D-10/341(d)	Extract from Expert Committee report Bangladesh	
7.	Bangladesh: Finding the right prescription			Andy Chetly	War on Want
8.	Essential Drugs for the poor-a myth or reality	'82		Dr Zafrullah Chowdhury & Dr Suzanne Chowdhury	Gonoshasthya Kendra
9.	Gonoshasthya Kendra-Peoples Health Centre	2.11.83	D-10/341(d)	Dr Mira Shiva	VHAI
10.	Bangladesh Drug Policy(Special issue of Health for the Millions)			Health for the Millions Editor:S.Srinivasan	VHAI
	Towards Rational Drug Policy				
1.	People Oriented Drug Policy - Mozambique	22.4.83	B-2.98	Dr Mira Shiva	VHAI
2.	Memorandum-demand for a Rational Drug Policy for India.	Jan.'84		On behalf of Drug Action Network	

		Date	Code	Author/Prepared by	Organization
	Rational Diarrhoea Care				
1.	Causes of Diarrhoea	13.8.82	D-9/334(f)	Dr Mira Shiva	VHAI
2.	Diarrhoea and significance of the problem	11.8.82	D-9/334(d)	"	"
3.	Diarrhoea and malnutrition	11.8.82	D-9/334(e)	"	"
4.	Management of acute diarrhoea	6.8.82	D-9/334(b)	"	"
5.	Low Cost drugs managing diarrhoea	6.8.82	D-9/334(a)	"	"
6.	Drugs in the treatment of Diarrhoea	11.8.82	D-9/334(c)	"	"
7.	Cost Effectiveness of the different options available and situations in which they may be appropriate.	23.8.82	D-9/334(a)	Table Reproduced from Committee on International Nutrition Programmes National Academy Press, Washington.	
8.	Antidiarrhoeals-their misuse Focus on clioquinols eg. Mexaform enterovioform and their side effect SMON	7.4.83	D-9/334(a-2)	Dr Mira Shiva	VHAI
9.	VHAI's role in diarrhoea Care	June 83		"	"
10.	Special issue of Health for the Millions on Diarrhoea.	Dec.'83		Dr Mira Shiva & Aspi Mistry	"
	Drug Industry and Consumer Action				
1.	10 Commandments of the Drug Companies	5.1.82	D-10.343	Augustine J Velliath	"
2.	Antidotes to Drug Industry	5.1.82	D-10:343	"	"
3.	What consumers can do-Social action by Consumers to deal with the drug problem	23.2.82	D-10:340	Dr Mira Shiva	"
	Drug Codes				
1.	Low Cost Drugs and Rational Drug Therapy International Codes and you	Dec.81	D-10/343	Compiled by Mira Shiva	"
2.	IFPMA Code of Pharmaceutical marketing Practices	Dec.81	D-10:343	IFPMA Code reproduced from HAI document	HAI
3.	International Codes and you (HAI reprint)	Dec.83		HAI reprint	HAI

		Date	Code	Author/Prepared by	Organisation
	Towards Rational Drug Economy				
1.	General administration of the Pharmacy			Mr Alan Cranmer MPS(GB)	CMAI
2.	Medicines Procurement and stock Control Purchase of Medicines			Note:Please contact Mr Alan Cranmer CMAI Holdsworth Memorial Hospital Mysore,Karnataka, for these as well as other material on Pharmacy management.	
3.	Low Cost Medicine Project'LOCOMP'	21.12.82	D-9-336	Dr Ashwin Patel & S Srinivasan	VHAI
4.	'LOCOST Project'-the Gujarat initiative in Bulk Purchase			Dr Ashwin Patel	
5.	WB VHA Central Drug Marketing Unit-Initiative in Bulk Purchase				WB VHA
6.	Experience of a 'Hospital Pharmacy'			Fr Mullers Hospital Mangalore(study by Mr Ed Macbert	VHAI
7.	Tablet Mission Industry Bangalore-Formulation of Essential Drugs			study by Mr S Srinivasan (contact sources directly)	VHAI
	Low Cost Alternatives				
	Home remedies and their role in reducing dependence on institutionalized medicine	4.1.82	D-10:343	Mr D P Pandey	Concern for Correct Medicine
	Tuberculosis				
1.	Rational TB Care- a priority	11.6.82	D-10	Dr Mira Shiva	VHAI
2.	VHAI's role in TB Care	11.6.82	D-10	"	"
3.	Seeking information regarding anti TB drug shortages.	25.5.82		"	"
	Drugs - Legal Action				
1.	In the Supreme Court of India -Civil writ Petition No 3492 of 1983, Under Article 32 of the Constitution of India	7.4.83		Dr Vincent Panikulangara	Public Litigation Centre, Cochin.
2.	Amendment of the above public writ petition	7.11.83		"	"
3.	A note on the legal aspects of health issues and VHAI's intervention	Nov.83		Mr Aspi Mistry	VHAI

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		Date	Code	Author/Prepared by	Organization
	Workshop Reports				
1.	Report of Drug Workshop I Workshop on Drugs Issues- seeking feasible alternatives - Pune 8-10th Jan.82	16.2.82	D-10/343	Dr Mira Shiva	VHAI
2.	Summary of the above report	24.2.82	D-10/343	"	"
3.	Report of Drug Workshop II Jaipur August 30-31st, 1982	7.10.82	D-10/343(R11)	"	"
4.	'Hazardous and irrational Drugs'				
5.	Drug Workshop follow up Information sharing	4.2. 83	D-10.344	"	"
6.	Report of the Drug sub group at the National Health Policy Seminar	April 83		Mr J S Mazumdar & Dr Mira Shiva	FMRAI VHAI
7.	Report of Rational Drug Policy discussion between Drug Activists and Policy makers	Jan. 84		Dr N N Mehrotra	MISTADS
	Drug Action Network				
	Newsletter I	Nov. 83		Low Cost Drugs Cell	
	Newsletter II	23.1.84		Dr Mira Shiva & Aspi Mistry	VHAI
	For Drug Action Networkers only				
	Minutes of the meeting with Drug Controller of India	Nov. 83			
	" " Deputy Drug Controller of Delhi	"			
	" " Mr Vasant Sathe, Minister of Chemicals & Fertilizers	3.1.84			
	Meeting of the Drug Action Networkers at VHAI in Delhi	Jan.84			
	" " " at CINI Calcutta	30.6.84			

ACTION SHEET

WHAT YOU CAN DO

OBJECTIVES:
* To draw attention to the problem of *Lomotil* as outlined in the Social Audit leaflet;
* To demonstrate that *Lomotil* illustrates the wider issues of activities of drug TNCs in developing countries.

KEY GROUPS:
* The medical and other health care professionals;
* Your drug and health authorities;;
* Other social action groups, particularly those with special interest in health and development issues.

METHODS :

Some suggestions -

* Write to the medical and pharmaceutical associations or to the editors of their newsletters and journals;
* Write to the editors of major newspapers;
* Call for a press conference.

WHAT WE HAVE DONE HERE

Included in this pack for you:

- The Lomotil leaflet by Social Audit. Use it any way you can. Re-print it. Translate it to the language best suited to your needs. Or more (in English only) can be obtained from the HAI Clearinghouse - US$6/= per 20, including airmail postage);
- A sample press statement. If you like, you can use it as a basis for your letters to the press, medical and health care groups, etc.

(S.1/12/81)

AN ENEMA FOR LOMOTIL ?

THE STORY SO FAR....

In May 1981 a British action research group released a 4-page leaflet with the words "WHO says LOMOTIL has NO VALUE" across the front page. At a glance, it looks like one of the millions of promotional leaflets the multinational drug companies send each year to doctors all over the world. But it is different. It warns doctors by quoting numerous authoritative medical sources that *Lomotil* "no value". (WHO, 1976.)

Lomotil used in the treatment of diarrhoea in children is dangerous. In the US, it is contraindicated for children under two years. Yet as the leaflet points out, *Lomotil* is indicated for children of 3 months old in Hong Kong, Thailand and the Philippines.

Following the release of Social Audit's Lomotil leaflet, a US based drug multinational launched a counter-attack. In a statement published in *Scrip* (June 3, p. 4) they claimed that the leaflet "does not present a balanced evaluation of the benefits and risks of *Lomotil* (diphenyoxlate), nor does it accurately portray the manner in which the product is marketed by Searle. The statement went on to say that "...standard medical information has been developed by Searle for all its products worldwide..." and that Searle supplies up-to-date information to doctors and other health care professionals "...regardless of whether required by local laws or government health authorities." It all sounds very slick except that in September, at a meeting in London, Searle told Social Audit that it was reviewing its labelling to indicate that *Lomotil* was not recommended for use by children under two-years old anywhere.

A victory, BUT, the issue remains - that *Lomotil* has no value for treatment of diarrhoeal diseases in developing countries. At best, it is a costlier choice; at worst, a fatal mistake. It is an inappropriate drug. Should not a product like this be demarketed?*

WHAT MORE CAN BE DONE?

Turn overleaf for some suggestions.

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* *"Demarketing refers to corporate decisions - taken because of management initiative, public pressure, or government regulation - to reduce or stop completely efforts to sell a particular product because of risks to the health, safety, or welfare of users." (From 'Demarketing Infant Formula: Consumer Products in the Developing World' by James E Post and Edward Baer, in Journal of Contemporary Business, Vol. 7, No. 4.*

Widening Horizons : on Drug issues

II Periodicals

1. Pune Journal of Continuing Health Education

   Presents scientific information and opinion on drugs and health issues to stimulate thought and further investigation.

   Annual subscription Rs.10.00 or a five year subscription for Rs.45.00 from Arogya Dakshata Mandal, 1913, Sadashiv Peth, Pune 411030

2. Drug Bulletin

   An informative monthly giving unbiased technical information on drugs and therapeutics.

   Annual subscription Rs.10.00 from Dr VS Mathur, Professor, Department of Pharmacology and Editor, Drugs Bulletin, PGI of Medical Education and Research, Chandigarh 160012.

3. medico friend circle bulletin

   A monthly which discusses issues regarding health problems, the health care system, medical education, drug issues etc., from the point of view of relevance to the needs of the majority in our country.

   Annual subscription Rs.15.00

   Write to Convenor, medico friend circle, 326, V Main I Block, Koramangala, Bangalore 560034.

4. HAI News

   A very informative bimonthly of the Health Action International (HAI), covering world drug news of special relevance for the third world. HAI is an informal network of health consumer and development oriented associationsand professionals concerned with health and pharmaceutical issues, particularly thos that adversely affect the poor.

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Annual subscription : US$10.00 from HAI Clearinghouse, regional office for Asia and the Pacific, International Organization of Consumer Unions (IOCU), PO Box 1045, Penang, Malaysia.

Special Issues:

A number of journals have brought out special issues on drugs. These may be available [redacted] on request for back issues.

1. Contact: from Christian Medical Commission, World Council of Churches, 150 route de Ferney, 1211 Geneva 20, Switzerland or VHAI, New Delhi.

   a. August 1981 No.63: 'Getting Essential Drugs to the People' with a model list of essential drugs.

   b. June 1983, No.73: 'Strengthening and regulating the supply, distribution and production of basic pharmaceutical products'.

2. Health for the Millions
   From Publications Department, Voluntary Health Association of India, C-14, Community Centre, SDA, New Delhi 110016.

   a. Medicines as if people mattered - April-June 1981

   b. Special Issues on diarrhoea and tuberculosis

3. The Journal of the Christian Medical Association of India
   From: The CMAI Office, Christian Council Lodge, Nagpur 1, Maharashtra.
   Sept 1983, Vol LX, No.9, Drugs--Fact, fallacy and fraud.

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4. World Health: The magazine of the World Health Organization, Avenue Appia, 1211 Geneva 27, Switzerland. July 1984, Essential drugs for the World.

copy

WIDENING HORIZONS - on DRUG ISSUES

Books

1. Hathi Committee: Report of the Committee on the Drugs and Pharmaceutical industry.
   Ministry of Petroleum and Chemicals, Govt of India,
   April 1975, Rs.17.00.

   [redacted] The essential drug list suggested here could provide the foundation for a demand for a Rational National Drug Policy.

2. Health for All - an Alternative Strategy
   ICSSR & ICMR, 1981, Rs.18.00 Available from VHAI.
   In focussing on a comprehensive national policy of health and a new operational strategy, the report is intended to be a basic document to initiate a nation wide debate on the subject as well as positive action towards certain radical changes to correct the present imbalances in our health caresystem. Has a very comprehensive chapter on drugs and pharmaceuticals.

3. Aspects of the Drug Industry in India.
   Mukarram Bhagat, Feb 1982, Rs.19.00
   From Centre for Education and Documentation (CED),
   3, Suleman Chambers, Battery Street, Bombay.

4. Insult or Injury
   Charles Medawar, 1980, Rs.18.00, 139 p.
   Social Audit, England. Available from : Indian Social Institute, Lodi Road, New Delhi 110003. Highlights marketing and sales of British drugs and food products. Illustrated easy reading.

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5. Health Care Which Way to Go

Medico Friend Circle Anthology II, 1982, Rs.10.00

from : medico friend circle office, 326, 5th Main, I Block

Koramangala, Bangalore 560034

Raises relevant issues regarding peoples health. Questions why is there a lack of political will to solve pressing health problems of the country. How detrimental is the alliance between medical professionals and the drug industry to people's health.

6. Under the lens: health and medicine

III Anthology of medico friend circle is due shortly and will be available from VHAI and mfc office (above).

7. Kurji Holy Family Hospital: Formulary and Therapeutic Guide.

January 1983, Rs.12.00

Available from VHAI. It is the result of the accumulated experience of senior medical staff of the hospital over the last 10 years. It gives a comprehensive list of drugs to treat 98% of hospital admissions - it also gives the generic name, dosage, indications, contraindications and main side effects in the same page. Information about comparative cost of treatment is also provided.

8. Drugs and the Third World

Anil Agarwal, 1978, $5.00

From Earthscan, 10 Percy Street, London W1 PO DR

A very comprehensive overview of the drug situation in the third world and the problems and causes.

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9. Prescription for change

Health Action Internationals guide to rational health projects, Virginia Beardshaw, November 1983, 85pp US$10.00
from Health Action International Clearing House
PO Box 1045, Penang, Malaysia.

Gives more than 40 ideas for action research projects on drugs :

- a summary of the main elements of the rational health issues and suggestions about how to campaign on it;
- advice on how to talk to drug companies and the powers that be
- a reference section that lists the main materials you need to research on drugs.

10. Pill-fering the poor: Drugs and the third world.

An information/action pack on drugs and the third world from Interfaith Center on Corporate Responsibility, International Health Programme, 475 Riverside Drive, Room 566, New York, NY 10115. US$4.00 plus postage surface mail $2.70/air mail $4.70.

It provides an overview of the problems related to drug marketing in the third world. It contains articles on the need for essential drugs, on the suffering wrought overseas by some US made drugs and on the high price the third world poor have to pay for their medicines. This package includes an extensive annotated bibliography, basic facts and figures about the transnational drug industry and an outline of suggestions for action on how you can get more involved in helping to stop abuses.

11. Therapeutic guidelines: A manual to assist in the rational purchase and prescription of drugs.

Upunda, Yudkin et al 1981, pp. 166, Rs.35.00 African Medical and Research Foundation. Available from VHAI.

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An excellent guideline for rational therapeutics, giving special emphasis on drug cost as criteria for choice of drug diagramatico format.

12. Management schedules for dispensaries: A manual for rural health workers
Peter Petit, 1983, Rs.35.00
African Medical and Research Foundatioh.
Available from VHAI.

13. 44 problem drugs: a consumer action and resources kit on pharmaceuticals.
IOCU, May 1981.
Available from HAI Clearing House (see 9)
Gives information about 44 problem drugs, along with articles by some of the leading drug compaigners.

14. A number of interesting papers to keep you upto date about the drug issue is available from Low Cost Drugs and Therapeutics Cell, VHAI, C-14, Community Centre, Safdarjung Development Area, New Delhi 110016.
(write to them for a list)

NEW SCRIPT 88 17

AUDIO - VISUAL ON THE

" DRUG POLICY OF INDIA "

PRODUCED BY CENTRE FOR NON-FORMAL & CONTINUING EDUCATION
BANGALORE 560 001

COMMUNITY HEALTH CELL
47/1, (First Floor) St. Marks Road
BANGALORE - 560 001

Slide No	Visual	Audio
1.	Sun rise	Music
2.	A villager ploughing in the field	Music
3.	Paddy fields along the road side	Villages ... India is the land of villages... housing 80% of the people of our country. India has 7½ lakh villages.
4.	A woman working in the paddy field	Mahatma Gandhi said,' Indias hopes lie in the villages. Villages have been an inspiration to many a poet and seer.
5.	A boy and a girl looking at us	Yet this 80% of the population are struggling to find their means for their existence.
6.	Barli village name board	Barli is one such village hamlet in Karnataka.
7.	Huts	Consisting of only the scheduled castes .. the deprived section of the people.
8.	People washing their vessels	The awakening dawn is disturbed by the women doing their daily routine of preparing their meals.
9.	Children tending the goats	the children tending the cattle and sheep of the landlord.
10.	Ramakka preparing ragi balls	Ramakka too gets ready the ragi balls for the family before she goes to the landlord's field for work.
11.	Sidhi, Linga and Veerabadrappa having meals	Ramakka family is a happy family ... they may have lots of trouble when money is concerned. Yet hardly there is quarrel in the family.
12.	Veerabadrappa going to work	Veerabadrappa goes to work in the morning at a quarry 2 kms away while Ramakka works for the landlord.
13.	Sidhi looking after Linga	Their daughter Sidhi, a 5 year old would be the second mother of the child Linga..the son of the family.. the light of the future.. the apple of their eye..

14.	Sidhi and Linga having food	Sidhi loves to play with her brother Linga ... she would carry him around.. feed him and put him to sleep singing songs.
15.	Dew trickling down	That day it was an unusual cold morning the dew was trickling down the palms of the hut...
16.	Linga passing loose-motion	to her surprise..Linga was passing loose motion .. she cleaned the first time ... a second time...
17.	,,	but the motion went on. That day the child was uncontrolable. He wept badly.
18.	,,	she did not know what to do... the chil would not eat.. she hoped that if her mother comes and breast-feeds the child that his hunger would be appeased
19.	Sidhi looking for her mother	she waited for her mother... and the waiting was too long for her.
20.	Ramakka coming	As soon as Ramakka arrived she was apprehensive..because of the way Sidhi looking forward to her coming.
21.	Ramakka giving money to Sidhi	on reaching inside she discovered her plight and the trouble her dear child was going through.. She immediately reached for the end of the saree and untied the only saving she had.. 10paise and gave it to Sidhi to bring the powder for diarrhoea.
22.	Sidhi coming with the powder	Sidhi went to the local man and brought the powder
23.	Ramakka mixing	Ramakka mixed the powder with milk and fed it to the child. The condition of the child remained unchanged.
24.	Linga lying near the harican lamp	she looked through the night keeping the vigil... the child remained the same.
25.	Ramakka with local dai	Next morning she called on the local dai Yellamma, the old woman of this place... when she narrated her the story of the child, Yellamma went round, pulled a few herbs and said,'Grind this herbs, pull out the juice and feed it to the child and report it to me in the evening.

26. Ramakka working in the paddy field	Rammaka went dutifully and administered the medicine. She was already late for the work that day... the food was not ready yet. She advised Sidhi to take a special care of the child and informed her if anyting serious happens please let me know and left for work.
27. Ramakka coming back home	In the evening she hurridly coming, anxious about the child and yet hopeful that the situation would have changed.
28. Linga passing loose motion	on arrival she found the situation had not changed.
29. Local dai and Ramakka	and she rushed to the local dai again and she advised her to go to temple.
30. Temple	Ramakka went to the local Gangamma temple and cried out
31. Ramakka crying	'Here is your child Gangamma...open your eye and take her sickness away... I will cut a cock and make pooja for you... please cure him of the malady. Ramakka wept at the Goddesses feet.
32. Sunrise	Next morning the situation being unchanged she mused about the wonder of the modern medicine and asked her husband to borrow money and rushed to Bethamangala 5km from this village.
33. Doctor coming	and brought the Doctor Chidambara. The doctor arrived with wonder medicine injection...
34. Doctor injecting	He dutifully administered an injection
35. Collecting rupees	collected Rs 7/- and asked Veerabadrappa to come and collect the liquid.
36. Linga lying and Sidhi sitting	Indeed the medicine worked. The baby did not have loose motion for some time and the child slept for a little while. Ramakka was relieved.
37. Linga again passing loose motion	Yet her satisfaction was short lined. The child again passed loose motion and it was unabaited. Now the sense of danger was felt by Ramakka.
38. Ramakka and Sidhi sitting at the door	She had no other go but to go to KGF big hospital 20km from her village. She did not have sufficient money nor the courage to go so far. She never visited the town.
39. Ramakka getting money	Yet she pleaded with her husband to get some money from the land lord, to be paid back after the harvest. She got the money and ...
40. Ramakka walking [illegible] the paddy field	now she wished good-bye and went across the s[illegible]nery marshy paddy fields

41. Ramakka coming out of field	Music
42. Ramakka crossing the stream	she had to cross straams before she could arrive in Bethamangala.
43. Bus going	to catch bus to KGF
44. KGF Hospital gate & hoarding	on arrival at KGF she had to look around for the hospital, requesting people here and there on the way
45. Hospital gates closed/ Ramakka looking at it	on arrival at the hospital the sign board was prohibiting her to meet the doctor
46. Ramakka pleading with the gate-keeper	she pleaded with the gate-keeper to let her in. The gate-keeper shouted 'Can't you see the board? Come tomorrow. This is not your home to come when and where you like. Sir, she pleaded My baby is very sick. I can not wait for tomorrow. I have not informed my people at home. I am coming from a long distance, please have some pity and allow me to see the doctor. "No madam, the rule for everyone is the same. You should have known about the timings of the hospital. She requested again and...
47. Ramakka giving money	He answered OK. You better pay me Rs 2/- and I can let you in.
48. Ramakka with doctor	She entered and met the doctor after some time. The doctor was too tired to attend to the patient. Looking at the condition of the child dehydrated so long, he shouted at her. "Don't you know how to take care of the child? You people have many children and yet you do not know how to take care of them. Why do you bring the child at the last moment.
49. Doctor giving the prescription	Then he furiously wrote out a long prescription. He requested IV fluids to be administered and other medicines for the baby to stop the diarrhoea.
50. Pharmacy	She carried this prescription to the pharmacy and asked for the medicine, The pharmacist billed her Rs 60/-. She had not that much of money. She had spent enough for the bus, at the gates and at

	the counter. She could not buy all the medicine.
51. Ramakka coming through the paddy field	She bought just a few tablets and went back, picked the baby and was on her way back home. She did not meet the doctor with IV fluids as she had asked her to. Because she feared another bout of scolding and another bill for administerin g the big injection.
52. Ramakka and Linga (sillohoutte)	on her way back home she discovered her baby to be limp. By this time she reached home the baby's body was cold. She screamed on realising that her baby was dead. (music)
53. Villagers running to Ramakka's hut	The people from the village came running to hear what had happened and sadness was writ large on the face of everyone. (music)
54. Villagers looking into the hut	The darling of the village was no more. After the burial, the whole house for Ramakka was empty.
55. Ramakka cooking alone	There was no cry of the child while at cooking.
56. Siddhi	For Sidhi, she no longer had her younger brother to cuddle and put to sleep.
57. Ramakka sitting near the haricane lamp	The nights were no longer troublesome, nor was it necessary to light the lamp at evening.
~~58. Cemetry~~	The light of the house extinguished. There is no longer joy pervading the house. Who can fill this vaccum? (music)
58. Cemetry	on whom shall we place the responsibility of the child's death? on their parents? on their negligence?

59	cartoon(doctor in the crowd)	shall we blame the doctors? There is only one doctor for 14 thousand rural population. Doctors are trained in big hospital atmosphere, therefore they feel inadequate to work in villages.
60	Ramakka with doctor	when the doctor spoke to Ramakka Ramakka could hardly answer because for her doctors are big people, they cannot be countered or counter answered-they are all knowing and omni potent. Indded the doctor's culture and the culture of the people are very different.
61	cartoon(a steth lying on a heap of rupees)	one can become a doctor only if he is rich and can afford good money. How will then a doctor understand that rural poor cannot even afford food.
62	Doctor with Ramakka	The baby could have been saved even at the last minute-but the long list of the doctor did the trick.
63	A prescription with lots of drugs reccomended	While prescribing the drugs-specially to the poor, the doctors need to look into maximum effeciency better safety and minimum cost.
64	cartoon	this is a rational drug use.
65	Hospital	can we blame the hospitals?
66	Hospital varanda	It's set up-it's distance...
67	Ramakka walking	People like Ramakka cannot afford to go to cities.
68	sofisticated equipments operation theatre	It is only in cities that hospitals are furnished with sofisticated modern equipment.
70	Budget or cartoon or statistics	A large percentage of government health budget goes in putting up hospitals and maintaining them. villages which house 80% of the population get only 40 percent of the budget allocation.77%of the villagers have never used the primary health centre. How can each centre serve 90 thousand population with two doctors, minimum amenities and drugs?
71	Injections	can we blame the drug industry? It's innumarable varities of drugs?
72	Pharmacy	30,000 formulations...

73	drug packets	music
74	Advertisement (Babies food)	It's profit motive...
75	close-up of a women	and the aggressive business approach...
76	essential drug list	The world healthe organisation says only with 200 essential drugs and 45 complimentary drugs all the deseases can be cured. In India the Hathi commission says we need only 116 essential drugs to cover all the illnesses.
77	Gifts to the doctors	plenty of money is spent for advertisement, propaganda and gifts to doctors by the durg companies-for unessential drugs. Here is the medical representative...
78	medical rep being interviewed	What are your basic job funtion? "to start with, at the very beginin of the day we plan our work in orde to achieve our objective-our objective is to get the maximum sales...and to get the sales we have to plan our day that what is the people I am going to see during the day, who can fulfil my requirement or my achievement for the day. And after once we leave the house, we go on planning on our way, or waiting near the particular doctor's chamber, we think in what best way we can convince the doctor so that he prescribes maximum for our compar products for which I am working or for products specifically I have gor I may probably talk to him about 5 o 6 products at a time but my interest may be to get support atleast for 2 or 3 products.
79	Tonics	Many die because there are not many essential drugs available or produce in sufficient quantities in India. 25% drugs produced are tonics which do not help in any way the health of the people.
80	Art work (statistic circle)	20% are antibiotics, but only 1.4% drugs are for TB and 1.3% for lapros
81	TB patients	of the 20 million, Tb patients in th world, 10 million are in India of them 500 thousand die every year.
82	Laprosy patients	Of them 10 million laprosy patients

		in the world 4 million are from India.
83	Blind people	out of 9 million blind 5 million are blind because of the non-availability of treatment and drugs.... 25,000 children go blind every year because of vitamin A scarcity.
84	Dr.Kulasekaran	Dr.Kulasekaran says, the life of the baby could have been saved if the mother administered boiled water, a pinch of salt and a scoop of suger mixed, time and again.
85	a child affected by diarrehea	Every year 1.5 million die of diarrehea 70% of them because of dehydration...
86	cementry	56% of deaths are avoidable, by the intervention of medicine, But there are many more siddis who die unnoticed. should we allow them to die? dont we have a part in avoiding these murders?
87	Linga with his mother	music
88	Linga with his grand father	music
89	Siddi locking after linga	music
90	Ramakka and siddi sitting at the door	music
91	acknowledgements	music
92	sound and voice	music
93	photography	music
94	script and direction	music
95	produced by	music

THE END

reading

BITTER PILLS. Diana Melrose Oxfam. Some copies of this book are available with us. The original price is Rs 100. However it can be made available at a discount for those involved in drug action.

THE CASE AGAINST E P FORTE - A Review of the Controversy. Cyclostyled note prepared by Mira Shiva and Aspi Mistry. Review of the campaign and latest views of Ob and Gynae experts on the use of these drugs in secondary amenorrhoea.

HEALTH FOR THE MILLIONS - SPECIAL ISSUE ON DIARRHOEA
Will be out in November. This issue has been designed and written by Mira Shiva and Aspi Mistry as the contribution of the Low Cost Drugs and Rational Therapeutics Cell to the Anti-Diarrhoea Campaign.

SUPREME COURT WRIT PETITION NO. 3492 OF 1983
Petition filed by Vincent Panikulangara on hazardous and irrational drugs. Available on request.

NATIONAL HEALTH POLICY SEMINAR-A REPORT VHAI
This is a fairly detailed report of a one day seminar held in Delhi on this topic. The objective was to focus the attention of the authorities on the implementation aspect of the policy document.

It emphasised the role that the voluntary health sector should be playing in policy making and implementation. At the seminar, one of the sub-groups had concentrated on drug related issues. The conclusions of the sub-groups are part of the report and the report of the drug sub-group has also appeared in the MFC bulletin.

THE WAR AGAINST BANGLADESH
Claude Alvares. Published by RUSTIC in association with VHAI. Documents and background material related to the ban on 1707 harmful and worthless drugs in Bangladesh; the new drug policy and events thereafter. (See also "Bangladesh" issue of Health for the Millions)

COURTESY : "RATIONAL HEALTH"

other activities

In August Mira Shiva and Tina DeSa conducted a 5 day workshop in school health for teachers, headmasters, wardens, community health coordinators. The emphasis was on helping school children develop self-reliance in health care and guiding them through their teachers to participate in health work. We see this as an important aspect of building a peoples health movement.

* The Kerala Sastra Sahithya Parishad (KSSP) has organised 2 jathas (science and cultural march) starting on 2 Oct and concluding on 7 November. During 37 day long march the jathas will give performances at about 300 centres. The object of the is to translate the slogan "Science for Social Revolution" into a practical programme of action. The themes of various performances in the local languages are based on contemporary social problems and unscientific approaches to various issues e.g. "War : the war against unscientific practices in the field of the drug industry".

* In November Mira Shiva will be conducting a workshop in Patna on 'clinical assessment'. The participants will be middle level field workers working in tribal areas where people do not have easy access to any other health facilities. This workshop is intended to upgrade diagnostic and therapeutic skills along the lines of "low cost drugs and rational therapeutics." The emphasis would be on striking a balance between preventive and curative health care.

* Aspi Mistry has also been working with a citizens group of Dehradun, "Friends of the Doon" who are organising against limestone quarrying in the Mussoorie hills. The quarrying activity has been gradually destroying the water resource base of the area and leading to land degradation. Through intervention in a public interest petition filed by the Rural Litigation and Entitlement Kendra, Dehradun, an interim stay order against the quarrying has been obtained from the Supreme Court.

We feel the need for health groups to be involved in health related problems like environmental problems, misuse of pesticides, lathyrism, etc. It will be recalled that such inter-disciplinary action was the topic of discussion in April when Mr Etsuro Totsuka (the Japanese lawyer who had successfully fought for SMON victims in the Tokyo court) had met a number of health, legal aid, and consumer action groups. A note on the legal aspects of health issues has been prepared by Aspi. Although it has been prepared with VHAI in mind it is equally applicable to any other health or activist group. (Available on request)

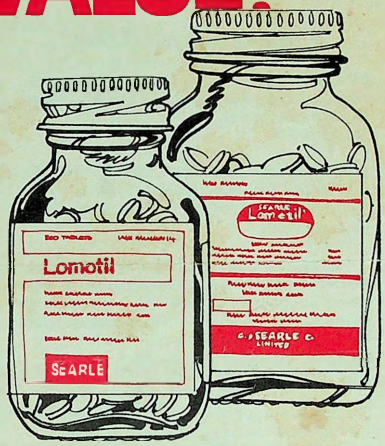
from Pg 7.

for 2-3 hours and drying it detoxifies it. This 'health education' for those with severe time and fuel constraints is meaningless; moreover the responsibility is sought to be shifted from the state and the landlord to the labourer. In the light of Dr Ahmad's study we seriously question the plans of the MP Govt to set up two par-boiling plants. The only solution is to completely ban the cultivation of khesari dal in the country.

The World Health Organization says:

"A number of medicines, which are of no value and are even dangerous, are often given to treat diarrhoea. Money and time are wasted in their use." So . . .

WHO says LOMOTIL has NO VALUE?



LOMOTIL (diphenoxylate/atropine) is made by the US multinational drug company, G.D. Searle; and promoted to physicians all over the world in terms such as "established success", "good tolerance", "excellent value" and "ideal for every situation". This leaflet — prepared and published by Social Audit Ltd., and friends* — calls into question these claims.

LOMOTIL may be of value in giving *symptomatic* relief for non-specific "travellers' diarrhoea" in adults. But experts say Lomotil — and other products like it [2] — have little or no place in the treatment of young children — especially in developing countries, where infective diarrhoeas are the major cause of death in children aged under three.[1] Lomotil's limitations include:

POTENTIAL DANGERS

"Lomotil, which is widely used in the treatment of diarrhoea in the paediatric age group, is dangerous and unwarranted . . . we urge that all physicians treating infants and children avoid the potentially dangerous use of Lomotil for the treatment of diarrhoea."
(Clinical Notes [1974])[3]

"Lomotil can relieve the symptoms of acute gastroenteritis in children, but it can also mask the signs of dehydration and cause fatal toxic reactions . . . use of this combination for treatment of diarrhoea in children is hazardous."
(The Medical Letter [1980])[4]

"Lomotil is a dangerous combination of drugs contra-indicated for children under 2 years of age and probably never indicated in childhood diarrhoea."
(Pediatrics [1980])[5]

QUESTIONABLE USEFULNESS

"The use of Lomotil as an antidiarrhoeal agent in children is difficult to justify . . . we doubt if it has any place in the treatment of diarrhoea in children."
(Arch. of Dis. in Child. [1979])[6]

"A diarrhoea that needs 4 such tablets to be cured would probably have been cured without it too. A more prolonged diarrhoea needs proper investigation and specific therapy rather than a blindly harmful stopcock."
(Leb. Med. J. [1974])[7]

ECONOMIC WASTE

Lomotil costs up to 25 times more than other widely-used symptomatic treatments for diarrhoea.
(AMREF [1980])[8]

"Lomotil (no value)." (WHO [1976])[1]

Lomotil

HOW USEFUL . . .

"The management of acute diarrhoea in childhood is essentially dietary . . . Unnecessary drug prescription for these children should be vigorously opposed."
(The Lancet [1976])[9]

. . . Against Dehydration?

"The cause of death in diarrhoea is DEHYDRATION . . . Diarrhoea is the most common cause of death in children under three years of age . . ."
(WHO [1976])[1]

LOMOTIL is not a treatment for dehydration. It may reduce the loss of fluid from the body but can also allow fluids to accumulate in the paralysed gut.

"LOMOTIL can mask fluid losses without diminishing them, and the drug itself can cause fatal adverse effects . . . there is no evidence that reduced motility diminishes the loss of fluid and electrolytes into the lumen of an inflamed intestine."
(The Medical Letter [1975])[4]

The accumulation of the body's vital fluids within the intestine can be just as dangerous as the more obvious dehydration:

"In diarrhoea, life-threatening situations are reached . . . so long as fluid and electrolytes are excessively lost into the lumen whether they are expelled from the lumen to the outside of the body or not . . ."
(J. of Singapore Ped. Soc. [1976])[10]

Small feeds of water (or a weak electrolyte solution) given frequently by mouth is the *only* first-line treatment against serious childhood diarrhoea. If this fails after 24 hours, intravenous therapy and hospitalisation may be needed.

. . . Against Infection?

"Acute diarrhoea in children is usually infective, but antibiotics and anti-diarrhoeal drugs rarely help."
(Drug and Ther. Bulletin [1978])[11]

LOMOTIL is widely and often successfully used by adults as a symptomatic treatment of bothersome, non-specific "travellers' diarrhoea" (which is rarely serious). But in children infective diarrhoea is serious. LOMOTIL prevents the child from getting rid of the infective agent and may prolong the period of infection.[12]

"In patients with infective diarrhoea, the use of constipating agents make the carrier state last longer by stopping the organism from being excreted."
(AMREF [1980])[8]

A comparison between LOMOTIL and a placebo in treatment of an infective diarrhoea reported that:

"Febrile volunteers receiving Lomotil alone experienced over a day more fever than those in other treatment groups," suggesting that "drugs that retard gut motility may facilitate intestinal infection . . ."
(JAMA [1973])[13]

HOW SAFE?

"Because of its depressant effects it is no longer recommended for children."
(Brit. Med. J. [1976])[14]

LOMOTIL poisoning in children can include atropinism, respiratory depression, coma, and even death. Symptoms can appear even at near therapeutic doses:

"Lomotil ingestion is a cause of serious poisoning in young children, especially those aged under five. It is always hard to assess the dose in patients suffering from poisoning, but it seems that young children may develop pronounced symptoms after taking only one to five tablets."
(Brit. Med. J. [1977])[15]

The difference between therapeutic and toxic dose is unpredictable:

"We were unable to find a correlation between the severity of symptoms and the dose ingested. Because of this it is not possible to predict what dose will be toxic in children, and while some may have only the mildest symptoms with relatively large doses, others develop severe toxicity on ingesting an amount near the normal dose."
(Arch. of Dis. in Child. [1979])[6]

"There is a very narrow range between allegedly therapeutic and toxic dosages, and many cases of toxicity in children have been reported."
(Pediatrics [1980])[5]

"The narrow margin between therapeutic and toxic doses, and the high incidence of atropine hypersensitivity, make Lomotil a potentially dangerous therapeutic agent."
(Clinical Notes [1974])[3]

"The dangers of this drug to children have not been well recognised. The narrow range between therapeutic and toxic doses, and also the possibility of a child being abnormally sensitive . . . may account for the severe toxicity sometimes seen with low dosage."
(Clinical Pediatrics [1973])[16]

DESPITE THE DANGEROUSLY VARIABLE RESPONSE, SEARLE'S RECOMMENDED DOSES FOR INFANTS AND CHILDREN AND THE PACKAGE WARNING INFORMATION VARY AROUND THE WORLD.

In the US, LOMOTIL is contra-indicated for children under two years old.

"This warning by the manufacturer is not because there has been inadequate paediatric testing of the drug but rather because severe life-threatening reactions (which are not rare) occur in this age group."
(Am. Fam. Phys. [1976])[17]

In Britain, however, the makers recommend it for one-year-olds; and in Hong-Kong, Thailand, and the Philippines it is offered for infants of three months old.

Special circumstances in developing countries compound the potential danger of treating infants with Lomotil in this way. In developing countries:

- children are relatively lighter than those of the same age elswhere;
- the amount of medical supervision is greatly lower;
- typically, no adverse reaction reporting systems exist; and
- drugs such as LOMOTIL (available only on prescription in the West) are in practice freely available over the counter.

HOW EXPENSIVE?

The cost of the smallest available size of LOMOTIL would for many people in developing countries be equivalent to at least one day's income. Other effective preparations for symptomatic treatment of diarrhoea[18,19] cost much less.

According to the African Medical and Research Foundation (AMREF), the cost of treatment with LOMOTIL is about twice the cost of treatment with codeine syrup orcodeine phosphate. Treatment with a kaolin mixture, which may also give relief[20], costs about 25 times less.[8]

LOMOTIL WITH NEOMYCIN (an antibiotic) is recommended by Searle for the treatment of "diarrhoea of bacterial origin." This is unacceptable:

"Antibiotic and sulphonamide preparations should be avoided for the treatment of diarrhoea even when a bacterial cause is suspected because they may prolong rather than shorten the time taken to control diarrhoea and carrier states."
(BNF [1981])[21]

"Neomycin not only can cause renal damage, but also it makes diarrhoea, dehydration, and nutritional losses worse and could interfere with oral rehydration therapy."
(Population Report , 1980)[22]

"Medicines which should not be used in the treatment of diarrhoea: . . . Neomycin . . ."
(WHO [1976])[1]

Treatment with LOMOTIL plus NEOMYCIN costs about three times more than treatment with LOMOTIL alone.

REFERENCES:

1 World Health Organization: **Treatment and Prevention of Dehydration in Diarrhoeal Diseases** (A Guide for Use at the Primary Level) (Geneva: WHO, 1976). LOMOTIL is one of 9 treatments not recommended.
2 The same preparation is sold by Janssen Pharmaceutical Ltd. and known as "Reasec". Other proprietary names: Diarsed (Fr.); Retardin (Swed.). (Source: Martindale's Extra Pharmacopoeia, 27th Edition).
3 Drake M E, & Drake M E Jr.: "Lomotil Intoxication in Pediatric Patients" (in) **Clinical Notes** (June 1974) pp. 501-2.
4 "Lomotil for Diarrhoea in Children" (in) **The Medical Letter** (iss. 25, 1975) p. 104.
5 "Delayed Cardiopulminary Arrest after Lomotil Ingestion" (in) **Pediatrics** (Jan 1980) pp. 157-8.
6 Curtis J A, & Goel K M: "Lomotil Poisoning in Children" (in) **Archives of Disease in Childhood** (iss. 54, 1979) pp. 222-5.
7 Uthman S M: "Some Complications of Diphenoxylate Hydrochloride with Atropine" (in) **Lebanese Medical Journal** (iss. 27/5, 1974) pp. 521-2.
8 Upunda G, Yudkin J, and Brown G: **Therapeutic Guidelines** (A manual to assist in the rational purchase and prescription of drugs) (Nairobi: African Medical and Research Foundation, 1980) p. 96.
9 "Drugs for Acute Diarrhoea in Childhood" (in) **The Lancet** (Nov. 20, 1976) p. 112.
10 Wong Hock Boon & Michael Toh Ho Sing: "Lomotil Poisoning" (in) **The Journal of the Singapore Pediatric Society** (April 1976) pp. 34-7.
11 "Diarrhoea in Children" (in) **Drug and Ther. Bulletin** (Jan 6, 1978) p. 2.
12 Pittman F E, "Adverse Effects of Lomotil" (letter to editor in) **Gastroenterology** (Iss. 67/2, 1974) pp. 408-9.
13 Dupont H L, & Hornick R B: "Adverse Effect of Lomotil Therapy in Shigellosis" (in) **Journal of the American Med. Assoc.** (Dec 24-31, 1973) pp. 1525-8.
14 Bell D R: "Diseases of the Alimentary System" (in) **British Med. J.** (Nov 20, 1976) p. 1240.
15 Penfold D, and Volans G N: "Overdose from Lomotil" (in) **British Med. J.** (Nov 26, 1977) pp. 1401-2.
16 Snyder R, Mofenson H C, & Greensher J: "Toxicity from Lomotil" (in) **Clinical Pediatrics** (Jan 1973) pp. 47-9.
17 Wasserman G S: "Lomotil Ingestions" (letter to editor in) **Am. Fam. Physician** (Oct 1976) pp. 27-8.
18 Smits B J: "The Irritable Bowel Syndrome" (in) **Practitioner** (July 1974) p. 43.
19 Collins C D: "Lomotil in Treatment of Post-Vagotomy Diarrhoea" (in) **British Med. J.** (Sept 3, 1966) pp. 560-1.
20 Portnoy B L, et al: "Antidiarrhoeal Agents in the Treatment of Acute Diarrhoea in Children" (in) **Journal of the American Med. Assoc.** (Aut 16, 1976) pp. 844-6.
21 British Medical Assoc. & The Pharmaceutical Soc. of G.B., **British National Formulary 1981**, No. 1, (London: The Pharmaceutical Press and the BMA, 1981) p. 40.
22 The Johns Hopkins University, "Oral Rehydration Therapy (ORT) for Childhood Diarrhoea" (in) **Population Reports** (Issues in World Health) (Nov/Dec 1980) p. 54.

*SOCIAL AUDIT AND FRIENDS

SOCIAL AUDIT Ltd is an independent non-profit making action-research unit, concerned with improving government and corporate responsiveness to the public generally. Its concern applies to all corporations and to any government, whatever its politics. Social Audit has reported and campaigned on a wide variety of public interest issues. Its interest in multinational drug companies and in development is reflected in this leaflet — with hopefully others to follow — and also in the publication of **Insult or Injury?** (An enquiry into the promotion of British food and drug products in the third world, 1979); and **Drug Disinformation** (What British and other multinationals tell doctors about their products at home and abroad, 1980).

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MINDBOGGLING

Improve your memory and intelligence with electric yellow or neon-blue brain boosters!

•SANDEEP Khurana and his wife Sheetal are apprehensive when the doctor prescribes Piracetam for their four-year-old daughter. They wonder about the effectiveness of the new drug and the fact that they had already tried out similar prescriptions to treat their daughter's learning disability

The doctor brushes away their fears by reeling off a string of impressive facts. Clinical studies, he tells the couple, has proven that Piracetam can produce dramatic improvements in verbal learning. Besides being effective in the treatment of dyslexia, it is found to help people who are recovering from a stroke and those with alcoholism, senile dementia and sickle-cell anaemia. It is also believed to enhance the brain's resistance to various injuries and boost its ability to recover from injuries.

•HIMANSHU Goyal is a bit nervous. He has an important meeting with his American business partner the following morning and has several reports to prepare, many facts to memorise and, above all, get some rest.

He visits the medical store round the block and returns home with bottles of Piracetam, Vasopressin and Hydergine. After taking the appropriate doses of each of these he goes into the study to slip on his cranial electric stimulator along with the light and sound device. He is sure that the combination of chemicals and brain machines has a synergistic effect that will create the optimal psychobiological state for the tasks that lie ahead.

An hour later, Himanshu feels different. His brainwave activity has altered, and an EEG would show that it has become more regular and has increased in amplitude in certain frequencies, causing him to feel simultaneously profoundly relaxed yet in a state of intense concentration, loose and creative as well as mentally quick and alert. He is now in the optimal state to imprint new memories, to plan new and more creative strategies, to visually rehearse every detail of his upcoming meeting.

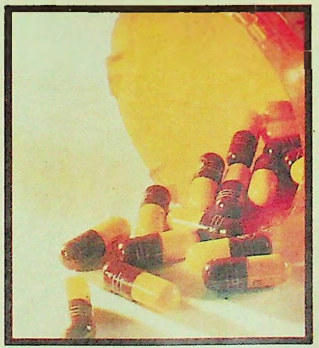
SOUNDS far-fetched? Well, both the brain machines and the cognitive enhancement compounds already exist in the United States where drugs like marijuana, cocaine and LSD are fast losing their glamour—and customers—to the new breed of brain boosters. Some of the smart drugs, as these cerebral aids are commonly called, are being increasingly prescribed by Indian doctors and demanded by customers, too. If the trend catches on, the day may not be far when brain boosters become as popular in India as they are in the west.

For now, however, it is the US and Europe that are the biggest markets for the mind magnifiers. Some of the smart drugs are high-powered pharmaceuticals; others are vitamins and nutrients, and are available as beverages at 'smart bars' in the hippest clubs of San Francisco, Los Angeles and New York.

Often called 'cognitive enhancers', these drugs are not legally available in the US, with the exception of Prozac, the top selling anti-depressant. Many of these are nothing but repackaged medications for treating various illnesses. Hydergine, for example, is used to treat an age-related decline in mental capacity. Deprenyl is used for the treatment of Parkinson's disease, a crippling brain disorder. Dilantin is widely prescribed to treat patients with epileptic seizures. The more popular of these smart drugs include Piracetam, used in the treatment of certain learning disabilities and some types of memory loss and Aniracetam, which was developed to treat loss of memory in older adults and attention disorders in children.

Pharmaceutical giants round the world just cannot resist the lure of the mindboggling profits that can accrue from the sales of the smart drugs. Millions of dollars are being spent on research by these companies, who are locked in fierce competition to develop patentable memory enhancement drugs. Since the Food and Drug Administration of the US is primarily oriented toward treating diseases in a medical context, and has not shown much interest in giving its approval to drugs that simply improve people's memories or boost intelligence, the companies have found a way out. They are directing their efforts toward gaining approval for their cognition-enhancement drugs as treatments for medical problems such as Alzheimer's disease, dementia and senility. Such cognitive drugs could quickly produce sales of well over a billion dollars a year in the US alone, and ultimately outsell antibiotics and tranquilisers.

Millions of dollars are being spent on research by pharmaceutical giants to develop smart drugs. These drugs could quickly produce sales of over a billion dollars a year in the US alone.



The 'Smart Pill race' has resulted in the creation of a new drug category called the nootropics, from the Greek words *noos* (mind) and *tropein* (turn), meaning 'acting on the mind'. Some of the nootropic drugs being tested now on humans include Vinpocetine, which speeds up learning, improves memory and seems to block the action of substances that disrupt memory; Aniracetam, which appears to be about 10 times more potent in improving and protecting memory than Piracetam; Pramiracetam, which seems to improve learning and memory by enhancing the firing of neurons in the hippocampus (a key to the formation of long-term memories), and Oxiracetam, apparently two to three times as powerful as Piracetam.

The smart-drug movement is the result of the efforts of the American 'Life Extension' gurus Durk Pearson and Sandy Shaw, who promote the use of nutritional supplements as a way to optimise mental function and neutralise immunity-destroying, age-accelerating agents known as free radicals. Hydergine, the brain enhancer discovered by the Swiss pharmaceutical firm Sandoz, shares a common source with LSD, the choice drug of the 60s and 70s. The source is ergot, the same cereal fungus. Surprisingly, it was discovered by the same scientist, Albert Hoffman, a man revered as the Daddy of Acid.

Hydergine is not the only IQ-enhancer available. The list is bigger than the generic aspirin prescriptions available worldwide. The logic behind the creators of many of these drugs is that if these formulations can help rejuvenate ailing minds, they can help enhance the performance of the healthy one too.

However, they still have no scientific proof to back their claims. Critics of smart drugs point out that Hydergine and Piracetam have been subjects of extensive research and the results are at best encouraging in animal tests, and dubious in case of humans. "There is no conclusive evidence that any drug can improve intelligence," says Dr B. Rajendran, a Kochi neurologist. Agrees Dr Satish Chandra of Bangalore's National Institute of Mental Health and Neurological Sciences: "We, in fact, do not promote the use of such drugs."

Gary Wenk, professor of neurology at the University of Arizona, claims that he's never tested a pharmaceutical for cognitive enhancement that he's found to be effective. The results, he says, are minimal at best. Raymond Bartus, chief scientific officer at Cortex Pharmaceuticals in California, believes that those with a memory deficit, particularly in the early stages of Alzheimer's disease, can be helped with the use of nootropics. "They (nootropics) are doing something, but not in all patients," says Bartus.

Many of the smart drugs may also cause minor side effects. Hydergine and Piracetam, for instance, can cause insomnia, nausea and headaches. Diapid can cause runny nose, irritable nasal passages, and stomach cramps. "Vasopressin is an alkaloid used in obstetric practice but is potentially hazardous if unsupervised," adds Dr Rajendran.

Critics say that some of these smart drugs make people forgetful and less alert. These side effects may be even worse if the drugs are taken in large doses over a long period of time, or in combination with other smart drugs. Dr James McGaugh, director of the University of California's department of psychobiology, believes that

WIDE VARIETY

NOOTROPICS

PIRACETAM: The original nootropic was developed by C.E. Giurgea (who coined the term 'nootropic') in the 1960s for the Belgium-based UCB labs. In clinical trials, it has shown to be effective for the treatment of dyslexic children and memory disturbances in people undergoing electric-shock therapy.

PRAMIRACETAM: A variation of the Piracetam molecule, it was developed by Parke-Davis as a treatment for Alzheimer's disease.

ANIRACETAM: Developed to treat age-related memory impairment and attention-deficit syndrome in children.

IDEBENONE: A leading nootropic in Japan where 1990 sales were upwards of $300 million, it is widely prescribed for cognitive enhancement as well as for Alzheimer's.

OTHER SMART DRUGS

HYDERGINE: It is the only cognitive enhancer with FDA approval. Called the 'ultimate smart pill', it is claimed to increase mental ability, prevent damage to brain cells and even reverse existing damage to brain cells.

VASOPRESSIN: Derived from a hormone secreted by the pituary gland and originally developed to treat diabetes, it has been widey researched for its effects on memory and mental alertness. A nasal spray, it goes directly into the blood stream.

DEPRENYL: Touted as the anti-ageing aphrodisiac, it was originally developed to ease symptoms of Parkinson's disease. Users claim it enhances mental functions, increases sex drive, and has an anti-depressant function.

LUCIDRIL: It breaks down to DMAE (a naturally occurring nutrient found in sea food) in the blood stream. Users claim it increases alertness, improves memory, helps in brain oxygenation and may help delay the ageing process because of its antioxidant effect.

Side effects can include insomnia and hyperexcitability.

SMART NUTRIENTS

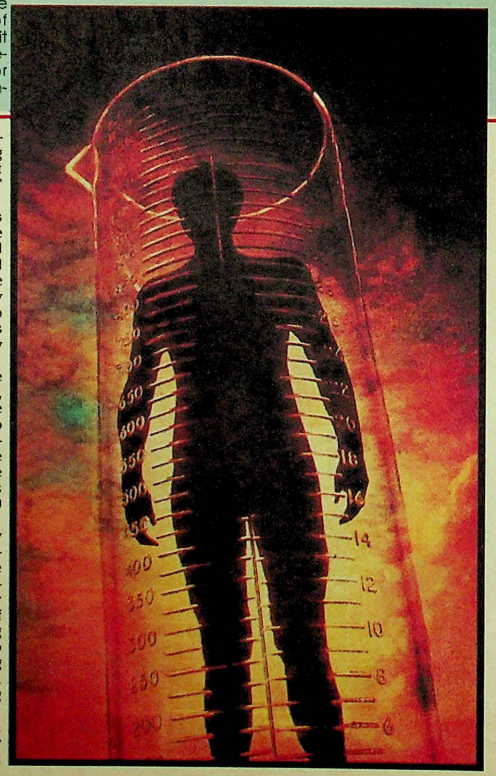
PHENYLALANINE: An essential amino acid, one that is obtained from food or other external sources. It is converted to tyrosine in the body and stimulates the central nervous system.

TRYPTOPHAN: An essential amino acid, precursor to the neurotransmitter serotonin which promotes feelings of relaxation and well-being. Users claim tryptophan has anti-depressant effects, and it has been widely used as a non addictive sleep inducer. In 1990, the FDA removed it from the market because tainted products in Japan resulted in 19 deaths.

GLUTIMIC ACID: Found in vegetables, fruits, meat, and dairy products as well as in the brain, this acid is believed to have cognitive-enhancing and mood-elevating effects.

L-CARNITINE: An amino acid that facilitates the action of the neurotransmitters acetycholine (essential for memory function) and serotonin, and may be related to the production of nerve-growth factor in the body.

ARGININE: An amino acid that causes the pituary gland to release natural growth hormone, it is said to aid in the building of muscle and the burning of fat.



the whole smart drugs deal is about as serious as astrology. "Some of the drugs being promoted as cognitive enhancers are just the opposite—they are cognitive impairers," says McGaugh.

While scientific proof is patchy, there is no stopping the growing popularity of these drugs. Many health food stores and mail order companies in the US sell amino acid supplements, claiming that they make people feel younger, more energetic, and mentally sharper. Health food bars also mix amino acid powders into smart drinks, with names like Power Punch and IQ Booster, which they claim can make people smarter.

The most popular smart amino acids are phenylalanine, tyrosine, choline, pyroglutamate, L-carnitine and arginine. The scientific validation, even in the case of amino acids, is hard to come by. In fact, these amino-acids are a bit dangerous to tamper with. One amino acid—tryptophan—was taken off the market in 1990 because its supplements probably caused 19 deaths and about 1,500 cases of a serious blood disorder.

Even Prozac has been deemed unsafe by some groups. A widely prescribed anti-depresent drug fluxetine (sold under the brand name Prozac) may trigger suicidal behavior in some patients. According to Dr Prakash Masand of the State University of New York, two patients treated with the drug began fantasising about suicide. One tried to hang himself and the other kept thinking about jumping out of the hospital window. The suicidal thoughts subsided after the drug had been discontinued for four to 10 days.

Despite the fears about the side effects, smart drugs is a growing market niche. They can be roughly divided into two categories: pharmaceuticals and health foods. The former, however, are not available in the US as readily; one can acquire these IQ igniters in Mexico or get them by mail order from Europe through a legal loophole which allows individuals to import three months' supply of their prescription pills.

The health foods, despite their name, are more dangerous as they are more freely available in the US, fuelling the so called "smart revolution". Those who want to supplement their psyches sans the anti-Alzheimer's pharmaceuticals can consume what are known as nutrients.

In their trendiest incarnations, these are packaged as smart drinks. They have market friendly names—Energy Elickshure, Psuper Psonic Psyber Tonic or Fast Blast—and come in colours which range from electric yellow or plain old mauve to neon-blue.

These drinks, which seem straight out of *Star Trek: The New Generation*, are made of a combination of vitamins and amino acids and, occasionally, a sizable dose of caffeine.

As in every other craze, the smart revolution has unleashed a new brand of entreprenuers. They are led by John Morganthaler who, along with ex-naval geronotologist Ward Dean, has written the movement bible, *Smart Drugs and Nutrients: How to Improve Your Memory and Increase Your Intelligence Using the Latest Discoveries in Neuroscience.*

Morganthaler believes that stupidity, like polio, is a disease and that he has been put on earth to help obliterate it. He is not alone in this task. Mark Rennie, a night-club owner, attorney and entrepreneur, is the man behind Smart Products, Inc., one of San Francisco's premier nutrient companies. (San Francisco, or New Brainia, as smarties call it, is the hub of the smart cosmos.) "When I think of taking smart drugs, I feel like I'm upgrading a computer. It's like going from a 286 chip to a 386," says Rennie.

Smart drinks have market friendly names—Energy Elickshure or Fast Blast—and come in colours like electric yellow and neon blue.

Who are the people who use these super chargers? Mostly the yuppies who are in search of an edge over their rivals. They treat their brains like their sports cars. But there are other users too: those slogging it out in the Silicon Valley and other high-tech colonies also indulge in these brain fuels.

However, there is also some good news which has started coming out of the smart drugs revolution. A growing body of research suggests that amino acids may provide a non-toxic, non-addictive alternative for those trying to overcome addiction to cocaine and amphetamines. Researchers at the Massachussetts Institute of Technology and Harvard Medical School have also found that the amino acid—tyrosine—may be effective in treating depression. And the pharmaceutical firm Sigma-tau is developing an acetylised version of L-carnitine, an amino acid, to treat Alzheimer's.

Hype or hip, the smart drugs are here to stay and many believe that it is only a matter of time that these find more acceptance outside the US and Europe.

Traditionalists, though, insist that the best way to reach the top is by sticking to the safer method of burning the grey cells. For, the only side-effect would probably be rising grades.

—O.P. MALIK

DR-8

The Pros and Cons of Botox

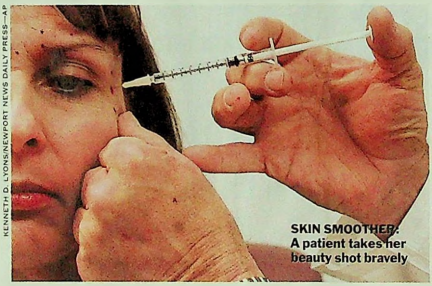
Just because the FDA has approved the anti-wrinkle shots doesn't mean that they're for you By Michael D. Lemonick

ARE YOU SUFFICIENTLY bothered by wrinkles to stick needles into your face? That's the question millions of Americans will be asking themselves once the Botox craze starts in earnest.

Botox injections, as you may have heard, are the biggest thing since nose jobs. They are already the most popular cosmetic procedure in the U.S.; about 1.6 million Americans got the shots last year—a so-called off-label use of a drug originally approved to calm twitchy eye muscles. The fact that the shots reduce wrinkles too was an unanticipated bonus; doctors were allowed to use Botox for that purpose, but the manufacturer, Allergan, couldn't advertise it to the public.

Now the company can, thanks to the U.S. Food and Drug Administration's decision last month to approve Botox for the removal of certain wrinkles. Now clinics are expected to be inundated by people yearning to be wrinkle free. Before scheduling an appointment, though, you should know what Botox can and can't do, and what the downside might be.

Botox is short for "botulinum toxin," the substance that causes botulism, a sometimes fatal form of food poisoning. It sounds scarier than it is; in small quantities, Botox merely interrupts nerve impulses to muscles in the face. The lines that furrow the forehead when you raise your eyebrows, the crow's feet that appear when you squint and the creases between the eyebrows when you frown are all caused by tension in underlying muscles, which contract and squeeze the skin like an accordion. Botox keeps this from happening.



KENNETH D. LYONS/NEWPORT NEWS DAILY PRESS—AP

SKIN SMOOTHER: A patient takes her beauty shot bravely

Fortunately, Botox is so diluted that serious side effects like allergic reactions are rare. If the doctor slips, in most cases the worst that can happen is that you will lose the ability to raise your eyelids all the way; or, if you're getting shots around the mouth, a mistake could leave you drooling. But even a perfectly executed procedure has consequences. Depending on which wrinkles you go after, you might not be able to frown or raise your eyebrows or squint.

Is this a problem? Not enough to discourage Botox enthusiasts. In Hollywood, however, the treatments are so popular that some directors complain that their leading actors can no longer convincingly perform a full range of facial expressions. The good news is that even if there's a little accident, Botox wears off after a while (which also means you have to go back every six months, at up to $500 per treatment). Slipups are pretty rare, however, as long as you go to someone who knows what he or she is doing.

That includes knowing when Botox won't be useful at all. Muscles cause some wrinkles, but many result simply from the loss of elasticity that goes naturally with aging (or, less naturally, with smoking and sun exposure), causing the skin to sag and crumple. There are treatments for this sort of wrinkle, but Botox isn't one of them, says Dr. David L. Feldman, director of plastic surgery at Maimonides Medical Center in Brooklyn, New York. "I had a patient recently who came in asking for Botox," he says. "It would have done no good at all. In fact, she might have ended up looking worse."

So Botox isn't a cure-all, and it has some pretty odd side effects. But if you don't mind getting shot up with poison and you don't mind paralyzing parts of your face—well, you've got plenty of company.

Botox questions? E-mail Michael at **michaellemonick@aol.com**

GOOD NEWS

PETER MENZEL—PHOTO RESEARCHERS

BUBBLE BREAKTHROUGH In the first clear win for gene therapy, French doctors report that they have successfully treated four boys with "bubble boy" disease, the immune-system disorder so devastating that its victims spend their lives confined in germ-free isolation. It was 2½ years ago that doctors first repaired the genetic mutation that kept the children from producing healthy infection-fighting cells, and today the kids are still thriving. It was a dramatic coup for a therapy that has had more than its share of failures.

BAD NEWS

TOM MCHUGH—PHOTO RESEARCHERS

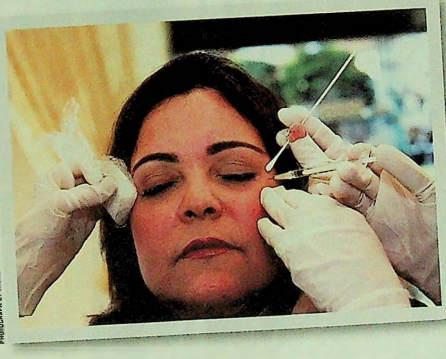
FREAKY FROGS All is not well among the lily pads. For years, frogs with missing legs or extra eyes have been turning up in ponds across the U.S. Now scientists wonder if trace amounts of weed killer in rainwater may be partly to blame. A new report shows that male frogs exposed to altrazine—the best-selling agricultural herbicide—can develop multiple male sex organs or both male and female organs. Scientists think that even low concentrations of the weed killer—one-thirtieth the level allowed in drinking water—can cause the male hormone testosterone to morph into the female hormone estrogen. Does altrazine affect humans? No one really knows. But as scientists point out, people don't spend as much time in the water as frogs do. —*By Janice M. Horowitz*

Sources: Good News—*New England Journal of Medicine*; Bad News—*Proceedings of the National Academy of Science*

Ana Figueroa

Lining Up for a Pinch of Poison

MY OBSESSION WITH BOTOX STARTED INNOCENTLY ENOUGH, WITH a routine visit to my Hollywood dermatologist. I'd always had an unsightly frown line between my eyebrows, but I used to consider it the mark of a deep thinker. Living in southern California, I had heard a lot about the cosmetic uses of botulinum toxin in recent years. Injected just underneath the skin in the form of a product called Botox, the toxin relaxes wrinkles by paralyzing the underlying facial muscles. The effects typically last three to four months. In high concentrations, botulinum toxin is a deadly poison. But Botox uses extremely diluted doses. I confessed my curiosity to the doctor, though the idea of having a potential biological weapon injected into my face made me a little queasy. My doctor assured me that the injection would take only a second. Just moments after agreeing to it, my forehead was relaxing in a state of botulism-induced bliss.



PHOTOGRAPH BY JAMES OSEWOLD FOR NEWSWEEK

A few days later I noticed a difference: the frown line between my eyebrows had disappeared! I was hooked. Now millions of other American women can be, too; the Food and Drug Administration recently approved the toxin for temporary wrinkle removal. Mind you, most women in my part of the country couldn't care less if Botox had FDA approval or not. Statistics show that more than 1.6 million cosmetic Botox procedures were performed in the United States last year, and I'll bet that most of those were in Los Angeles. Still, millions of women in America's heartland—not to mention the rest of the world—are unfamiliar with the wonders of a little shot of poison in the face.

Not me. Increasingly comfortable with the procedure, I decide to try a "Brows and Botox" event at the trendy Valerie Beverly Hills cosmetics salon. I arrive fashionably late and leave my car with the parking valet. Inside, I find dozens of denim- and Prada-clad women nibbling finger sandwiches and sipping Perrier. Alcohol is a no-no; it's hard to give informed consent to a medical procedure if you're tipsy.

First salon owner Valerie Sarnelle waxes each woman's eyebrows into McDonald's arches. Then Dr. Jessica Wu, a Harvard Medical School–trained cosmetic dermatologist, discreetly shoots up the women with Botox as they sit in a makeup artist's chair. The scene is a little jarring, like finding a Clinique counter in a methadone clinic.

Like me, most of the women have been Botoxed before but have come to sample the doctor's "technique." The buzz is that Wu's gentle touch has earned her a celebrity following. She won't give names, but discloses that before this year's Oscars, she made house calls to three female presenters to give them Botox shots in their armpits. "It eliminates perspiration," says Wu.

After Sarnelle shapes my eyebrows and graces me with fake mink eyelashes, I am ready for Wu. I worry for an instant that the good doctor might deny me my fix. After all, my last Botox shot is still working. But Wu takes one look at me and determines that I am a prime candidate. "Around the eyes," she proclaims. Wu and her two medical assistants set up tidy rows of gauze, Q-Tips, gloves and a biohazard-disposal pail. As an assistant holds an ice-filled cloth to my face, I sign a consent form. The doctor opens up two small vials, then hovers over me, needle in hand. "Smile. Relax. Smile. Relax," she instructs, trying to determine the exact latitude of my crow's feet. Two or three faint pinches on each side of my eyes, and I'm done. That's it—no stinging, no soreness. Days later I'm not aware of any new sensations—or losing any old ones.

The other women at the event gather around me for a look. "You know, you should catch the corners of your mouth before they start to droop too much more," one suggests helpfully. Joleen Rizzo, 39, an Emmy Award–winning makeup artist, frets about living in a town obsessed with looks and age. "Our standards are so much higher here," she says. "I'm sure if I lived on some farm in Iowa, I couldn't care less about Botox."

By the end of the afternoon, the Brows and Botox event evolves into one big support group. I feel oddly close to these women I barely know, as if we have shared some important rite of passage together and emerged better—or at least better-looking—for it. Collectively, we encourage Abbe Hausner, 45, to take the Botox plunge, but she remains wary. "I think for my first time, I'd rather do it in private," she says.

Not me. From now on, I'm Botoxing in public.

HEPATITIS C

THE INSIDIOUS SPREAD OF A KILLER VIRUS

Hundreds of millions are infected with the stealth virus. Most don't know it.

BY ANNA KUCHMENT

DOCTORS HAVE told Saeed Taha that he has only weeks to live. The 48-year-old electrician is sprawled on a Cairo hospital bed with tubes connected, seemingly, to every major vein and artery. A decade ago he was diagnosed with hepatitis C. Overcome with fatigue, the father of three quit his job and spent his life's savings on interferon, one of two drugs approved to fight the virus. But it didn't help. "Don't believe what is said about medicine and doctors," he says. "In this disease nothing makes a difference."

On the next bed lies Abdullah El-Shahhat, 70, who was diagnosed four months ago but already displays the swollen legs and belly characteristic of liver disease. The two are among the 15 to 25 percent of Egyptians infected with hepatitis C—the highest rate of any country in the world. Many contracted it in the same way as Taha: through a government-sponsored campaign begun in 1961 to fight the tropical disease schistosomiasis. Medical workers injected millions of Egyptians with used, unsterilized needles. Sayyeda Hassan Metwally, 54, remembers a nurse injecting her 11 relatives and four neighbors with a single syringe. The campaign ended only when an oral drug came on the market in 1982. Now the government is scrambling to control an epidemic it helped create.

This story would be tragic enough even if Egypt were an isolated case, but it's not. Hepatitis C has become a global epidemic. About 170 million people, 3 percent of the world's population, suffer from the disease—four times more than HIV. Hepatitis C doesn't kill with the virulence of AIDS, but it kills nevertheless. About 15 percent of patients mount a strong-enough immune response to completely throw off the virus. But the remaining 85 percent have the disease for life. Of those, one in five develops cirrhosis, which can lead to cancer or liver failure. What really has health officials worried is what is expected to happen in the next 20 years. Since HCV, the hepatitis C virus, can lie dormant in the bloodstream for decades, millions of people who are already infected but don't know it will start getting sick. That will boost the rate of liver failure around the world, making organs for transplant even scarcer than they are now. The demand for costly drugs to suppress the disease may skyrocket, putting them even further out of reach of poorer countries, like Egypt, whose public-health systems are already stretched.

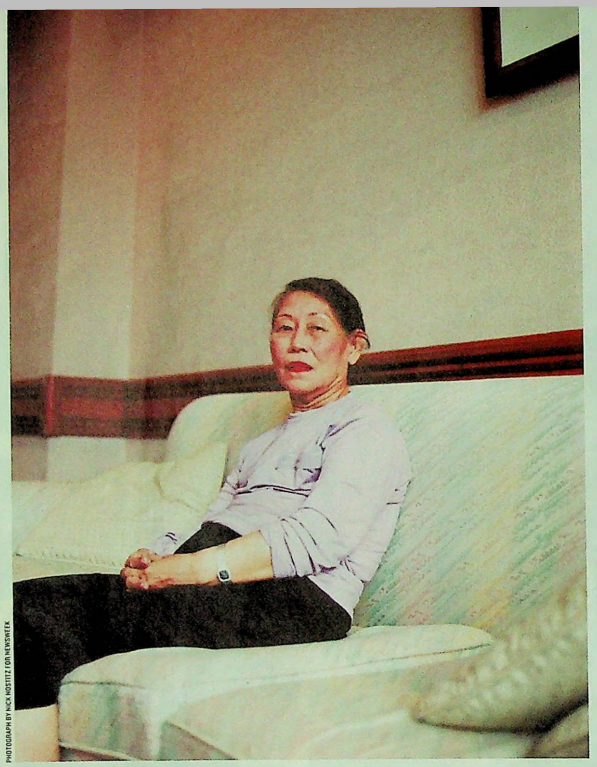
PHOTOGRAPH BY THOMAS MAITHELL—CORBIS SABA FOR NEWSWEEK

ABDULLAH EL-SHAHHAT, 70: The former minibus driver is among the 15 to 25 percent of Egyptians infected with hepatitis C

Health officials can't even begin to estimate what resources they're going to need, because even basic data about hepatitis C are virtually nonexistent. That's partly because scientists identified it only 14 years ago. By the time they developed tests to spot the pathogen, it had been spreading silently for decades. In Europe and North America, public-health officials began screening blood supplies in the early 1990s, at least eliminating the virus's spread. Developing nations, which account for the vast majority of HCV patients, have only begun to follow suit. So far only a minority, including Thailand, South Africa and Brazil, screen blood. In other countries wealthy enough to perform transfusions, such as China and India, contaminated supplies may still be infecting new patients. Carlos Varaldo, a hepatitis C patient advocate in Rio de Janeiro, calls it a "viral time bomb."

In Egypt, it's already exploded. "We wish to give free medication to all of the patients," says Sa'eed Aoun, undersecretary for preventive affairs at Egypt's Ministry of Health. "But this requires billions of dollars every year." Already more than 50 percent of Egypt's health-care spending goes toward treating patients with liver disease, most of whom have hepatitis C. The majority qualify for vouchers that they can redeem for free medicine. But to get the vouchers, hep C patients, already weak from their illness, must stand in line for hours outside the Ministry of Health. And the value of the vouchers is unpredictable—it varies from month to month, based on a patient's persistence, political connections and what the government has in its coffers. That puts pressure on doctors. "It is very difficult to decide what medication to prescribe for a patient when you know he might not be able to get the same [government] allowance each month," says Dr. Mamdooh Diaa of the Munufeyya public hospital, just north of Cairo.

In sub-Saharan Africa, which has one of the highest rates of HCV infection in the world (ranging from 1.3 to 6 percent of the population), most patients simply go undiagnosed. "Doctors aren't looking for hepatitis C," says David Heymann of the World



NVANSRI TOOMMNON, 72: Unlike most hep C patients, she can afford medication—and a private room at a Bangkok hospital

PHOTOGRAPH BY NICK NOSTITZ FOR NEWSWEEK

Health Organization (WHO). "They're looking for TB or malaria." And, say many African physicians, there's little motivation to test for a virus they simply cannot afford to treat. The situation is equally dire in Russia, where hepatitis C has increased fourfold in the past decade, due mostly to rampant IV drug use. "We are already considering this an epidemic, and there is very little we can do to stop it," says Sergey Kolesnikov, a deputy in Russia's Duma who is lobbying to start a national program to combat all forms of hepatitis. The government, he says, has imported only a limited amount of medicine, which it distributes to those who can afford it. "We are really only curing the rich," he says. Even Brazil, with one of the best health-care systems in the developing world, is struggling. Up to 5 million people are believed to be infected, but only a small minority have been diagnosed. As more and more patients develop symptoms, the government is concerned it may simply run out of drugs, which it now distributes free.

The spread of HCV is of particular concern for countries with a high rate of HIV. In the United States, it affects as many as one third to one half of all HIV patients. And the presence of one makes the other more deadly. Two recent studies have shown that co-infection with hep C leads to a more rapid progression from HIV to full-blown AIDS. The reverse is also true. As HIV knocks out a patient's immune system, it undermines the body's ability to fight off HCV, making it more likely that a sufferer will progress to end-stage liver disease. Co-infection also complicates treatment. "Hepatitis C appears to increase one's risk [for] toxicity from the HIV medicines," says Dr. Stuart Ray, an expert on co-infection at the Johns Hopkins University School of Medicine in Baltimore, Maryland.

Developed countries are equally concerned. Ironically, the virus is more of a priority in wealthier nations, which have a relatively low rate of infection, plenty of resources and fewer competing health concerns. Hepatitis C has recently grabbed headlines in the United States as celebrities ranging from former "Baywatch" star Pamela Anderson to country singer Naomi Judd have announced they're infected. "I can't go to a social event without meeting someone with hepatitis C," says epidemiologist Miriam Alter of the U.S. Centers for Disease Control and Prevention. By the end of the decade, the death toll from hep C is expected to triple in the United States. In the United Kingdom, roughly 5,000 new cases are being diagnosed each year, and the government is racing to keep up. "The epidemic is growing faster than the number we're treating," says Nigel Hughes of the British Liver Trust. That's not because the disease is spreading faster, but because increasing numbers of Britons who were infected as a result of IV drug use in the 1970s—the so-called "flower power generation"—are developing symptoms and being diagnosed. The pattern is similar in the United States, where drug use was rampant during the '60s. Why has the C virus come to light so recently, and traveled the world so fast? Consider its habitat. Unlike the A virus (which spreads via fecal matter) or the B virus (which passes easily between sex partners), the C virus can't spread unless a carrier's blood enters another person's veins. And the opportunities for such commingling exploded during the 1940s and '50s, when reusable syringes caught on and hospitals began using blood as medicine. By the late 1960s, physicians were seeing liver disease in people who didn't have either of the known hepatitis viruses. Lacking a better name for the syndrome, they dubbed it "non-A, non-B" hepatitis.

To this day, there is no reliable cure. The best treatment available is a combination of the protein interferon, which boosts immune response, and the antiviral drug ribavirin, a distant cousin of AZT. Taken together, they clear the virus in 50 to 55 percent of patients after six months to one year. But they cause such severe side effects—including hair loss and heart failure—that, in the United States, one patient in seven abandons the regimen. Bill Schwartz, 65, a retired lieutenant colonel, compares his yearlong treatment to "West Point plebe year and Vietnam combat." And it didn't control his infection.

Few people in developing countries can afford treatment. A full course of interferon costs about $20,000—the price of a small house in Brazil, or about what the president of South Africa earns in one year. For people like Nvansri Toommnon, 72, the wife of a retired Thai Air Force colonel, that's not a problem. She can afford a private room at Bangkok's Bumrungrad Hospital. But even Thai doctors would be hard-pressed to afford the treatment for themselves. "If I had to be treated, it would be almost impossible," says Dr. Sirirung Songsivilai, a professor at Mahidol University's school of medicine. Also, because the medication needs to be taken regularly over a long period of time and comes with serious side effects, a country must have a good public-health system in place to deliver the drugs. For these reasons, the WHO advises developing countries to focus on stemming the spread of new infections, rather than on treating existing ones.

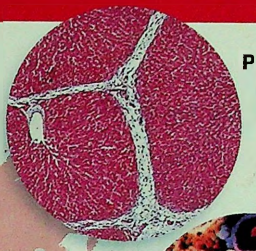
The best hope of fighting hepatitis C in the Third World, says the WHO's Heymann, is to find a vaccine. That's a cause Michael Houghton, vice president of hepatitis C research at Chiron Corp., who led a team of scientists in identifying the virus in the late '80s, is now devoted to. But he says the formula is at least five years away from U.S. government approval. Improved drugs are also in the pipeline. The market for hepatitis C treatment is now exploding, and drugmakers have several new compounds in the works. At least three companies are developing protease inhibitors, which block a key enzyme that allows the virus to replicate. And Schering-Plough, the current leader in hep C treatment, is developing molecules that could be combined with protease inhibitors to create the kind of multidrug cocktail that has proved so effective against HIV. "The parallels between these two [epidemics] are just phenomenal," says Dr. Lawrence Deyton, chief public-health officer for the U.S. Veterans Administration. "We're today in hepatitis C where we were in HIV 10 years ago, where we had only one or two drugs that were very toxic and not very effective. If a patient's liver is not in trouble, it may be perfectly appropriate to watch and wait for something better to come along."

In the meantime, many are turning to herbal remedies. Even in the United States, where most people can afford medical treatment, roughly 30 to 40 percent of HCV patients prefer alternative medicines. Dr. Robert Gish, medical director of the liver-transplant program of the California Pacific Medical Center in San Francisco, tells patients: "I have medicines that can cure you, but will make you sick. Herbalists have medicines that will help with your quality of life, but won't cure you." For the developing world, herbal remedies have the advantage of being affordable. One of the most popular herbs is milk thistle, or silymarin, which has been used to treat liver disease, or "bad bile," for more than 2,000 years. Chinese use the herbs schizandra and licorice root for the same purpose. Scientists have only begun to test many of these remedies. So far there's little evidence that they do much more than perhaps relieve symptoms such as inflammation. That's good enough for Haj Hussein, who goes to the old neighborhood of Bab El Khalk, just outside the old gates of Cairo, every couple of weeks to purchase a $3 bag of herbs. The 62-year-old, with yellow-tinged skin and dark shadows under his eyes, says the herbs work wonders. "When I know that my enzymes are OK, I can work. I can live!" For the vast majority of hepatitis C sufferers around the world, such cheap remedies will have to do until scientists and health officials can offer something better.

WITH SAMEELA ISMAIL IN CAIRO, KAREN MACGREGOR IN JOHANNESBURG, MAC MARGOLIS IN RIO DE JANEIRO, EVE CONANT IN MOSCOW, JOE COCHRANE IN BANGKOK AND BINLOT IN LONDON, ANNE UNDERWOOD AND JOHN DAVID SPARKS IN NEW YORK, KAREN SPRINGEN IN CHICAGO AND PAUL MOONEY IN BEIJING

A Viral Time Bomb

Hepatitis C can lie dormant in the body for decades before causing fatal liver damage. Worldwide, 170 million people suffer from the disease, and millions more will show symptoms in coming decades.



Global Infection Rates

Who Gets Treatment?

RICH COUNTRIES: Infected patients use costly drugs like PEG-Interferon/Ribavarin. Prevention efforts target IV drug users.

POOR COUNTRIES: Unable to afford drugs, developing nations concentrate on prevention. Blood screening and stopping the reuse of syringes are top priorities.

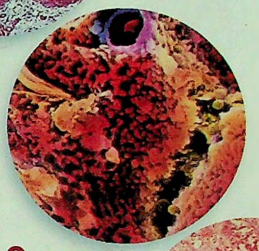
Who Is Most at Risk?

- IV drug users
- Blood recipients*
- Infants born to infected mothers
- Exposed health-care workers
- People with multiple sex partners
- People with infected steady partner

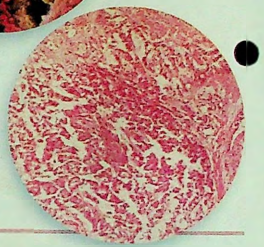
*PRIOR TO 1992 IN DEVELOPED COUNTRIES. SOURCES: MIRIAM ALTER, CDC; DR. STUART RAY, JOHNS HOPKINS SCHOOL OF MEDICINE; JOHN WONG, ET AL., AMERICAN JOURNAL OF PUBLIC HEALTH. RESEARCH AND TEXT BY JOSH YSLUCK AND JOHN SPARKS. GRAPHIC BY CHRISTOPH BLUMRICH—NEWSWEEK

Progression

1 INFECTION 15% of patients mount a successful immune response and clear the virus from their bodies within the first year.
85% of patients retain HCV, becoming chronic carriers.



2 CIRRHOSIS
80% of carriers harbor the virus for decades without suffering adverse symptoms.
20% develop cirrhosis within 20 years, which is marked by the buildup of scar tissue in the liver.

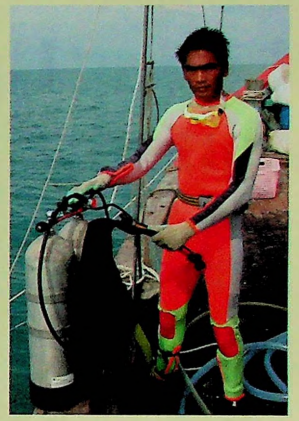


3 CANCER 75% of those developing cirrhosis suffer no serious effects from liver scarring.
25% develop end-stage liver disease, which can involve cancer, require a transplant or result in death.

CLOCKWISE FROM LEFT: MARKA—CUSTOM MEDICAL STOCK PHOTO; PHOTODISC; PROFESSORS MOTTA, NISHI, FUJITA—SPL—CUSTOM MEDICAL STOCK PHOTO; CUSTOM MEDICAL STOCK PHOTO

Race for Ruins

Malaysia's eastern waters are littered with the wrecks of ancient ships. Who will get their treasures?



COLLECTING THE LOOT: (From left) a Chinese ship from the Turiang's era, members of Sjostrand's team sort through ceramics pulled from the Desaru, a Malaysian diver at the wreckage site, a salvaged ring-handled jar from Thailand

BY LORIEN HOLLAND

STEN SJOSTRAND IS OBSESSED with wrecks. For the past nine years, the Swedish marine engineer has been scouring the waters off Malaysia's east coast for the wreckage of ancient trading ships. So far, he has uncovered seven vessels, ranging in age from the 14th-century Turiang to the Desaru, which dates to around 1830. He has not only hauled up valuable treasures but also has helped fuel a rising regional interest in just what is resting on Southeast Asia's seabeds.

Sjostrand and his team located the wreck of the Turiang—which appears to be of Chinese origin—in 43 meters of water, more than 100 nautical miles off the Malaysian coast. Although trawling nets had seriously damaged the deck, great stacks of ceramics from China, Thailand and Vietnam lay below. The cargoes were packed separately, indicating that the vessel had made several ports of call to fill its hold. And the fact that the wreck dates from the mid-14th century provides strong evidence that Southeast Asian kilns were already operating and competing with Chinese kilns before the Ming Emperor Hongwu banned private trade outside China in 1371.

There is plenty more down there. Vessels from China, Java and India plied their trade on the region's monsoon winds from as early as the 10th century. They carried everything from bowls and flatware to spices and salted fish. Already more than 30 ships have been excavated in the region, and there may be many more still undiscovered. The wrecks have proved invaluable in filling historical gaps, with each one providing a concrete glimpse of a specific moment in time. Indeed, Sjostrand's seven wrecks provide strong evidence that regional trade—as opposed to the great trade routes documented in Chinese and Arabic records—was an important business. The cargoes of the regional traders show that Southeast Asians preferred traditional pale green ceramics and were far less interested in the blue and white china that was all the rage in Europe from the 16th century on.

But marine archeologists may be running out of time. The advances in sonar technology that have helped people like Sjostrand—who shares both his treasures and his knowledge with the Malaysian government—find the wrecks mean looters also have easier access. At the same time, commercial fishing in the region—especially with dragnets that scrape the ocean floor—has intensified. The nets shave off the top of the wrecks, scattering their precious cargo and destroying the masts or protruding hulls that would help divers locate them. "Someone or something else will get to the wrecks if action isn't taken soon," says John Guy, curator of the Indian and Southeast Asian Department of London's Victoria and Albert Museum. "The result is that the pace of wreck recovery has increased dramatically, and at the same time there is an urgency that wasn't there in the past."

Pulling treasures up from the depths is no easy feat. Visibility at the wreck sites is often near zero because of high winds, and each year there are only two short periods when conditions in the South China Sea allow for deep-water diving. Merely locating the ships is a difficult task. Sjostrand—who developed a taste for ceramics more than 20 years ago while working as a commercial marine engineer in Singapore—started searching in the early 1990s. He decided on a 10-mile-by-250-mile corridor down peninsular Malaysia's east coast, in what was once one of the world's busiest shipping lanes. During the first two years, all he found were rubbish and oil pipes. Still, he had enough savings and determination to push ahead. It helped that local fishermen were often able to point out areas where they had found broken ceramics in their nets. Eventually, he got lucky. "Once you decide to do something, then you don't stop before you've finished," Sjostrand says.

To whom do the artifacts belong? Malaysia's national museum gets first pick, since most of the wrecks are in Malaysian waters. The museum gets 30 percent of the haul, while Sjostrand keeps 70 percent—an arrangement both sides seem happy with. Sjostrand is training museum staff in marine archeology, and has helped them set up an excellent exhibition at the national museum that showcases cargoes from a total of 10 shipwrecks dating back to the Turiang. "Malaysia is at the crossroads of maritime trade in this region, but our government doesn't have that much money to spend on underwater archeology," says Adi Taha, director-general of the Department of Museums & Antiquities in Malaysia. Working with people like Sjostrand is the only way to get artifacts to the surface. "Some might say this is commercialization, but I say it is commissioning," says Taha.

For his part, Sjostrand funds his underwater archeology by selling to museums and private collectors a significant proportion of the plates, jars, bowls, teapots and spoons brought to the surface. Though he retains a large collection of ceramics bought from dealers over the past two decades, the pieces recovered from the wrecks are his favorites. "For me there is far more value in a piece when you know exactly where it comes from, and you can piece together its history."

The best may be yet to come. In 1511, a Portuguese ship, the Flor de la Mar, sank in the Strait of Malacca along with its booty looted from the rich Sultanate of Malacca. An Indonesian salvage team spent several million dollars trying to locate the wreck in the early 1990s, and predicted the discovery of several billion dollars' worth of gold, precious stones and other artifacts. They found little and eventually ended the search. But the Flor de la Mar is still out there somewhere, waiting to be salvaged. Unless looters get there first. ■

FROM FAR LEFT: NO CREDIT; STEN SJOSTRAND (2); NO CREDIT