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TOWARDS A PEOPLE-ORIENTED HEALTH POLICY

(A Bangladesh case study)

A reference file on Gonoshasthya Kendra,
GK Pharmaceuticals and the Bangladesh
Drug Policy.

Background resource material prepared
for Dr Zafarullah Chowdhury's visit to
Bangalore on 1st December 1983.

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sources

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- No.3 Development Dialogue 1978, No.1 & mfc Bulletin No.57, September 1980
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introduction

Dear Friends,

The work of the Gonoshasthaya Kendra (People's Health Centre) of Bangladesh under the leadership of Dr Zafarullah Chowdhury is well known. Soon after independence the Gonoshasthaya Kendra was established in Bangladesh and it went ahead step by step to organise the Community Health Program, the Women's vocational Centre (Nari Kendra), the People's Workshop (Gono Shilpalaya), the People's Shoe Factory (Gono Paduka), the People's School (Gono Patshala), the People's Farm (Gono Krishi Khamar) and the now famous Gonoshasthaya Kendra Pharmaceuticals. During these years, the Kendra also organised training programmes for the para-medics of Savar, and health workers (IRDP & UNICEF) and field programmes for undergraduate medical students and post-graduate doctors. Since 1982, the GK Project has been exploring the possibilities of evolving an alternative medical curriculum more suited to the health, socio-political and cultural realities of countries like Bangladesh. In March 1983, there was a special conference held in Dacca entitled "People and Health" organised by the Kendra and Jahangir Nagar University (Bangladesh) at which recommendations for a more people and health oriented curriculum were made.

1982 has also witnessed in Bangladesh the government's bold decision to ban 1707 hazardous and irrational drugs, fix fees for doctors, stop construction of eight new medical colleges and enforce a five year compulsory rural work before permanent registration of doctors--all these steps hopefully towards a more people-oriented health service.

Dr Zafarullah Chowdhury will be visiting India (Pune, Bombay, Trivandrum, Bangalore, Delhi and Calcutta) from 24 Nov to 4 Dec 1983 in response to invitations by the Indian Academy of Paediatrics, voluntary Health Association of India, Medico Friend Circle, Lok vidnyan Sanghatana (Maharashtra), Kerala Sastra Sanitya Parishad, NISTADS, FMRAI and other organizations.

He will be in Bangalore on 1st Dec 1983 and will deliver two public lectures here (St John's Medical College - 9 am to 9.45 am) and Indian Institute of science (3.30 pm to 4.30 pm) apart from having group discussions with medical teachers and health and development activists and

trainers. This file has been prepared as a background resource material for all those who are keen to know more about the GK Project, the GK Pharmaceuticals and the Bangladesh Drug Policy. We are grateful to OXFAM South India Office for their assistance in preparing this file.

Materials and information here may be reproduced freely in media/handouts for public awareness giving specific sources (mentioned in each article) due acknowledgement. We hope this file will help in focussing the relevance of such effort for the Indian situation as well.

medico friend circle
Indian Social Institute
Science Circle (Indian Institute of Science)
Bangalore

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GONOSHASTHAYA KENDRA
(PEOPLE'S HEALTH CENTRE)
DACCA, BANGLADESH

OBJECTIVES

1. To provide adequate health service in the rural area of Savarthana
2. to increase the independence and bargaining power of women, and
3. to bring about a change in the infrastructure and thereby allow for the economic and social development of poor villagers, i.e., 90 percent of the population of Bangladesh.

ACTIVITIES

1. A health programme which encompasses
 - a. training of paramedical workers, basic health workers, medical students and doctors in rural health care delivery,
 - b. curative care through a system of sub-centres which are staffed by paramedical workers and backed by a main centre which is staffed by doctors, technicians and paramedics, and which offers OT, sick-room, pathology, x-ray, and dental care facilities,
 - c. preventive care including immunization programmes, mother/child clinics, pre-, and post-natal care, nutrition, hygiene, and basic health education carried out through regular programme of village visiting,
 - d. family planning which provides contraceptives (pills and injection), sterilizations, and abortions, while carrying out a programme of motivation and follow-up,
 - e. an insurance scheme for users of the health care services,
 - f. pharmaceutical plant which manufactures drugs under their generic names (this is in the initial stages of operation), and
 - g. publication and distribution of literature to assist medical practitioners in effective health care delivery in rural areas.
2. A vocational training programme for villagers in which both men and women are instructed and employed in all of the following areas:
 - a. agriculture,
 - b. jute handicraft manufacture for export,
 - c. shoe manufacture and sale,

- d. metal work including welding, etc.,
- e. woodworking and finishing, and
- f. management of canteen which caters to a sizable public clientele.

3. Education

- a. classes in literacy and conscience-raising for village women and staff members, and
 - b. experimental school for children of landless combining practical training with formal study.
4. Credit unions providing loans for marginal and landless farmers.

CRITICAL ANALYSIS

1. Health Programme. "Some success of the primary service have been ascertained by surveys of sample villages and also by more random observation of disease incidence. Thus, there has been a dramatic fall in incidence of serious diarrhoea with dehydration. This is probably due to our intensive teaching of oral fluid therapy to mothers of small children, who now give the 'shortbut' to their infants as soon as they notice the first symptoms of diarrhoea. Since diarrhoea in children is still the commonest cause of death in Bangladesh as a whole, our success with preventing serious cases may well account for the lower overall death rate in our area which has been established by a sample survey (12/1,000 as opposed to the national average of 17/1,000). There has also been a marked decrease in scabies and other forms of skin diseases. Care of at-risk pregnancies, especially of women with symptoms of pre-eclampsia, has resulted in nil maternity deaths for the last year in the area fully covered by our service!"

2. Women. "Out of a total project staff (including subcentres) of 114, forty six are female; and on the health side, women outnumber men. Apart from nightguard duty, there is no single task which women have not been engaged in on equal terms and on equal pay with their male colleagues, it the daily agricultural labour, health work, welding in the technical workshop, teaching, or office work. In the vocational training programme women are taught blacksmithing, carpentry, whitewashing, and varnishing

"A much talked-about event occurred on May 1, 1977, when 23 women from the project cycled all the way to Dacca to demonstrate solidarity with women's movement all over the world

"While behavioral ^u changes and increased self-confidence made possible by economic independence and experience of work outside the home is most striking in the women closely connected with the project, there has also been a discernible change in the attitudes of women in our area in general. Burkas (veils) have almost vanished from sight among patients both at

the main centre and the subcentres, recruitment of female workers for those types of work and training which do not require much school education, no longer poses a problem; indeed, we have to send many home for lack of places, and during our recent procession to the Shimulia subcentre to commemorate the first death anniversary of Nizam (see below), many village women, as well as men, joined the ranks of the project staff.

"Nationwide, our work with women has contributed to Government decisions to recruit women for village work in family planning and as female primary school teachers."²

However, though as individuals there is a noticeable liberation among women, with certain barriers having come down, as a group, they yet remain unorganized.

3. Infrastructure. "Nizam was 25 years old. He had been with the project as a paramedic since its inception, and when a paramedic subcentre was to be set up at Shimulia he was the one arranging the final details of the land. He knew the coming of the centre to Shimulia would threaten the fraudulent practices of a good many people, including illegal possession of government lands, smuggling and selling health centre drugs. Among those involved in the illegal activities was the only qualified physician in the area, who was making a handsome profit by over-charging patients. Nizam did not realize just how great a threat the new centre was. In collaboration with local officials, i.e., the union chairman and a union member, the physician hired a group of thugs to have Nizam murdered, confident that he could make the necessary payments to the proper people, allowing him to continue his illegal work, along with his cohorts, and ensuring that the centre would not become a permanent fixture in Shimulia. Nizam lost his life, and now an almost incredible struggle for simple justice seems to be availing nothing. We have come face to face with the village. We have reached, it seems, our limit. Do we carry on with our small struggle or are we sustaining a system that would (and should) crumble, sooner without our gallant efforts. And even if we choose to work on, can Gonoshasthaya Kendra last in its present form? How viable can a body remain when it is alien to the system in which it operates?"³

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SOURCE:- Towards a People's Science Movement

Kerala Sastrasahitya Parishad

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II THE PARAMEDICS OF SAVAR: AN EXPERIMENT IN COMMUNITY HEALTH IN BANGLA DESH

INTRODUCTION

The People's Health Centre (Gonoshasthaya Kendra) is situated at Savar, some 30 miles from Dacca. The centre at Savar has gained an international reputation as an example of integrated development; none of the familiar problems (health, family planning, food, even poverty) are dealt with an isolation. Health, however, dominates the activities of the Centre. Most of the Centre's 44 paramedics are women. One of the Centre's founders was Dr Zafrullah Chowdhury. Chowdhury's team has achieved remarkable success as well as deserved recognition. But it has not been without its setbacks. In 1976, a key paramedic was murdered in one of the local villages - illustrating the kind of opposition to pioneering health that exists among the wealthy elite, not least among the quack doctors, in the villages. Here Dr Zafrullah Chowdhury describes the work of the Centre.

The poor health in our rural areas is a consequence of under-development. Malnutrition is a problem not for the physician, but for the agronomist, the teacher and the community organizer. A strictly medical approach cannot produce a healthy community, and without the involvement of the community, anything that is produced will have a questionable value.

Originally, the Bangladesh Hospital came into being during the war of liberation in 1971. At the close of the war it moved into the rural area of Savar thana, which had no health centre. Health services for the heavily populated rural areas are virtually non-existent. It was on remedying this that the Bangladesh Hospital, now named Gonoshasthaya Kendra, set its sights.

When we came to Savar in 1972, we held numerous meetings both with villagers and students in the area, to try to determine the best methods for bringing service to the people. We decided upon a centre base, which would act as referral point for a number of subcentres. Initially we recruited 100 part-time volunteers from among the students, to carry out the vaccination and health education programmes.

From the beginning, we made efforts to ensure that Gonoshasthaya Kendra would be a People's Health Centre, rather than a 'community death and disease centre.' Preventive programmes were emphasized and integrated with other areas of life that had a bearing on health, such as nutrition, agriculture and family planning.

THE PARAMEDIC:

In time, we discovered that the part-time volunteer workers were not able to fulfil the demands that the project work was making on them. We came to realize that a full-time paid worker was needed.

It was at this time, in 1973, that we developed the concept of the paramedic. This has continued to evolve, although we still define the paramedic as 'a worker who brings community development services to his own village.' From the beginning, we realized that a majority of girls would be needed if we were to reach the women of the area. The paramedics are drawn from the area which the project serves, so they are working in a familiar locality where communications are at their best. They range from 17 to 25 years. Their training is carried out in the field, where they take part in the delivery of services, carefully supervised and supported by the doctors. Some theoretical classes are given in the evenings, but the greatest strength of the paramedic is his or her closeness to the village, its unspoken needs, its wisdom and its ways.

Paramedics must show understanding and sensitivity to the life of the village. They do not preach vitamin A capsules, but rather local green vegetables. They do not ask the mothers to go (usually some distance) to a tubewell for bathing, but they are pleased if the tubewell water is used for cooking and drinking. Unlike the doctor who doled out two to six large piperazine tablets to be taken at home, the paramedic had the child take the required treatment in front of her. She is aware that a mother would hesitate to give a large dose of medicine to a child at one time.

It was also the paramedics who questioned the wisdom of the antenatal clinics. Among the people being served in one sub-centre area (15,000 to 20,000) there would be approximately 800 pregnancies in a year. Out of this number, no more than 15 to 20 percent would be 'risk' pregnancies. Gathering all the women and having them sit unnecessarily was neither an efficient use of their time nor of the clinic's. An alternative was to have the paramedics pay regular visits to those pregnant women who are most likely to have difficult labour or other pregnancy problems, and give them the necessary examination and instruction. The result is that we have had no maternal deaths in the area.

The selection of the paramedics involves the villagers, which leads to a greater responsibility for the programme on both sides. Members of the community chosen to interview the new recruits are older villagers, but from among the poorer class.

If the delivery of the service, distance is always a problem. We sought to overcome it by the use of bicycles. Though quite acceptable for boys, girls on bicycles was a revolutionary step. It took little time to win over the villagers, but the more 'educated' and 'religious' leaders balked at the idea. Nevertheless, the plan went ahead - and not only does it solve the problem of transportation, but it is also a definite step forward in the liberation of the women.

The degraded social position of the women in the villages was what first moved us into the field of education. We felt that if they could receive some training which would provide them with a marketable skill, they would eventually gain a certain

economic independence and respect.

FAMILY PLANNING: Demand and Obstruction

When we started our project, we became aware that demand for family planning services existed in the villages. The source of supply was lacking. So we began to offer a family planning service, but always within an integrated programme. Without real efforts at assuring parents that their young children would reach adulthood, we felt we could not with justice deny them the right to sons and daughters of their own. The programme has therefore made efforts to provide the needed health care, educating the parents in birth control methods and family planning to motivate them properly. Once the method has been chosen, clients are visited at home regularly.

The dai has also been successfully incorporated into our programme. Remaining in the village, she works on a part-time basis, distributing pills, checking for side-effects, assisting where possible and referring to the centre or sub-centre where needed. She is also taught to spot pre-eclamptic patients and other possible labour and birth difficulties and to instruct the mothers in regard to child care. Because the dais are village based, their drop-out rate is lower than that of the paramedics.

Since the beginning of the programme in 1972, we have noticed a steady pattern of clients moving towards a more permanent method of contraception; once family planning has been accepted. In 1974 we began to offer female sterilization, performed by the paramedics, and found that a relatively large demand existed for this method. The sterilizations are performed under local anaesthesia. Paramedics, having been trained to perform these operations, have proved themselves to be quite skilled. The villagers prefer the female paramedic to the male physicians, and it has been noted that the infection rate for the paramedics is lower than that of the doctors. The reason for this may be that the doctor is usually an occasional operator, and there is doubtless a tendency for him to assume the more difficult cases.

Advice on menstrual regulation and abortion are offered at the clinic. More advanced stages of abortion are performed by the doctors, but the government attitude to abortion is somewhat ambiguous. A survey conducted in Bangla Desh regarding attitudes towards legalization of abortion found that, with the exception of engineers, physicians were the most conservative. Sixty two percent of the physicians surveyed opposed the legalizing of abortion. Being far from the village reality, they cannot or will not, accept it.

THE WATER: The Problem of Pumps

They have no king, the rivers of Bangla Desh. At whim they rise and fall, and carry the fate of 80 million people in their course. They bring destruction, drought, dehydrated bodies, disease in a myriad forms, to green fields, fish, fertile soil.

Water is the first authority in the land to whom poor and rich alike make their appeal. For want of water, or because of flood, the lands lie idle, yielding nothing.

However, this need not be. Bangla Desh has a farm labour force of approximately 19 million men, but only 12 million of them are employed. If land was used to its maximum advantage, rather than only producing just over one crop a year, there would be shortage of labour. Sixty seven percent of the land in Bangla Desh, however, requires irrigation. One deep tube-well irrigates an area of atleast 100 acres.

Yet there are numerous instances where four of five such wells are installed within the radius of a mile. Often, this results in too rapid use of ground water and local handpump wells go dry.

UNICEF has also paid attention to the problem of water, and admirably put in efforts into supplying handpump tubewells. But generally the pump has been situated close to, or within, the compound of the wealthy man, the man with power and influence. UNICEF's aim has been to supply one pump for every 200 people. Our suggestion was to make an initial payment of 25 paisa for each person using the pump. This would ensure that it was placed in a position advantageous to all members of the village. UNICEF did alter its original scheme, and decided after three years to make a charge for the pumps ... 250 taka for each pump installed, with no further payment required. Any one individual could make this payment of 250 taka. So, now the rich man could establish his full rights over the water.

Not only installation but also real availability of water and latrines for general use will contribute to the better health of the community, cutting down intestinal and diarrhoeal diseases and skin conditions. The incidence of disease is decreased by the provision of water, irrespective of the quality, and an uncared for latrine has no appreciable effect on community health. What we need is a simple construction, that can be cared for as necessary and is convenient for use.

(courtesy - Development Dialogue 1978, No. 1)

mfc bulletin : September 1980

Abhay Bang

(The last issue contained a brief overview of the Savar-project. This one gives a more detailed information from close quarters and raises very interesting questions.)

As the car was passing from Dacca airport to the Gonoshasthya Kendra of Savar, the landscape of Bangla Desh was unfolding before me. A decade ago while working as a medical volunteer in the refugee camps during the liberation war, I had seen a few glimpses of Bangla Desh by occasional infiltration. My interest in Bangla Desh dates back to that experience. The news of political upheavals and natural disasters kept on disturbing one about Bangla Desh for last one decade, but at the same time some interesting, rather sensational news of the community health work started in Bangla Desh by a group of young doctors led by Dr Zafrullah Chowdhary, their paramedic programme, paramedics doing tubectomies etc. had created a curiosity in my mind. And here was I today heading towards the famous Gonoshasthya Kendra (G. K.), passing through the main land of Bangla Desh, seeing both her beauty and ugliness.

BEAUTIFUL AND UGLY

Beautiful because of the natural greenery and abundance of water. Ugly because of the poverty, the worst I have ever seen. The per capita yearly income for Bangla Desh is 560 Rs; one of the lowest in the world. There is gross disparity even in this small average income and the lower 50% of the population has per capita yearly income of Rs.225 or less. Population density in this country of 85 millions is one of the highest in the world (1375 persons per sq.mile). 91% of the population lives in the rural area. 50% of the total population has either no land or less than half acre of land. Literacy rate is 20%, but for women it is less than 10%.

A passage from Dacca to G. K. offers sights of sharp contrast; tall buildings of American architect mushrooming on the expansive periphery of Dacca juxtaposed to and even engulfing the collapsing huts of the surrounding villages. It must be mentioned here that the most vulgar display of affluence is not only by the plethora of 'ad' agencies UN, World Food, US Aid and so on.

But as we moved away from Dacca the poverty of the rural area started showing and soon the car turned to the right to enter into the headquarters of G. K. The first to strike you are the buildings—two-storey hospital cum office building and a four-storey hostel residence for paramedics and other staff of the G. K. Total buildings cost in GK is 9 lac Rs. "Was it so essential?" one starts questioning in the mind. But same is the feeling of Zafrullah Choudhary, who later on said, "For initial 1½ year we were living in tents and temporary shades. Had no money for buildings. An armed robbery, heavy rains and inconvenience to the patients and the staff created a need for buildings. Therefore, when we received generous foreign aid offers for buildings, we were enamoured. We did the mistake of accepting the offer and within next two years these incongruous

edifices stood up."

But what is more impressive is the simplicity and the austerity of the living style of the staff and the equality in relationship. I must admit that when I met Choudhari for the first time, I mistook him for a PA or typist of Zafrullah. Except for a few families with children, all other workers live in the same building in similar accommodation. From the gate keeper to Zafrullah, all take the same, very ordinary food in a common mess. G. K. has a novel rule-reminding me of Gandhiji's Ashram in his time (not now)-everybody in the project works for 1½ hour in the morning on the farm. "This not only helps us to become self-sufficient in our food requirements, but also builds up a healthy equal relationship among us, an identification with the manual labourers of rural areas and also helps to screen and eliminate the elitists among the new recruits." All these things must have contributed in the creation of the warm, friendly and family relationship which exists in the whole team of G. K.

I shall not describe the history and all the activities of G.K. as these things have already been published in the MFC Bulletin (Paramedic of Savar: issue No 57) Instead, after a brief description of the activities, I shall try to discuss some questions and inferences from their experiences and some of the recent experiments at G. K.

THE PARAMEDICS

G.K. started in 1972. With only 2500 doctors working for the 75 million people in the rural area of Bangla Desh (1 doctor for 30,000 population) and with only 700 trained nurses in the whole country, the Western health model was irrelevant. "The purpose of our project is to evolve some system by which the medical care of the whole population of a particular area can be undertaken efficiently and effectively with the minimum benefit, with the employment of limited medical manpower." (from the original project proposal, Feb. 1972)

In the last eight years, G. K. has been able to develop such a system with the paramedic as its main health workers. There is a central 30 bedded hospital with X'ray, pathology and operative facilities. Office and training centre is attached to this hospital. The headquarters and its 4 subcentres together try to deliver primary health care to the 91,000 population of 100 villages of Savar thana.

There are in total 4 doctors and 64 paramedics at present (39 females and 25 males) - 16 paramedics in the headquarters hospital and clinic, 15 stay at the headquarters and cover the surrounding 40 villages, moving on bicycles. (Because of the high population density a large number of villages are packed in small area). Other 20 stay at 4 subcentres (5 at each) and each subcentre covers 15 villages. 13 paramedics (mostly males) are village based-living, in their own villages and serving them.

Each paramedic (except village based) cover about 2500 population (2 to 5 villages-depending up on the size of the villages.) ~~The~~

The sub-centres have a weekly OPD when a doctor from the head-quarters visits but offers emergency services all the seven days. Some subcentres, managed entirely by paramedics, have small indoor also. The head quarter hospital runs twice a week OPD. Most of the cases are seen and treated by the paramedics. Doctors mainly work as a referral persons, as trainers and as administrators.

A paramedic is usually 7th standard to SSC pass unmarried girl almost all recruited from the outside area because of the lack of educated women in the Savur area. They are given about one year's inservice training, contents being similiar to ANM training in India. They are full time workers of GK. Drop out rate is 50%.

Salama, the paramedic with whom I went to a village on bicycle to see her routine village visit covers 4 villages. So she visits each village about once a week, sometimes twice; goes house to house, covering about 25 houses in one visit, thus usually the same house is again visisted once in a month. The main assigned jobs are 1) Treatment of minor illnesses. 2) Immunisation - BCG, & Triple to all children and tetanus toxoid to all the women in child bearing ages. 3) ANC check up. 4) motivation for FP and distribution of oral pills 5) Health education 6) Detecçion and referring complicated cases, specially among pregnant women and children to the doctor at subcentre OPD or at head quarters.

The sincerity and the efforts put by Salama were worth seeing; but the response of the people and the health status didn't seem good. The causes of low health status were also obvious in the village - terrible poverty, poor sanitation (water, mud and flies everywhere), ignorance and a resultant apathy. The paramedic was struggling against these odds with her small health kit and fighting spirit. Of course, the pictures of health might have been still worse without GK or without Salama.

I accompanied Dr Kamal, to a subcentre. That was the OPD day for the subcentre. 3 girls and 2 boys paramedics, all unmarried, stayed at that subcentre - must be a sensation in the rural Muslim community of Bangla Desh. The OPD was overflowing with patients. One could observe that neither the subcentre paramedics nor the doctor were overusing antibiotics or the injections. Same experience at the OPD at the headquarters.

GK has innovated some unorthodox methods. Diarrhoea and cholera are very common in Bangala Desh. When Cholera Research laboratory (CRL) of Dacca evolved oral rehydration therapy with the electrolyte mixture, GK field workers, while applying it in the field conditions, modified it to "Lobon-Gur" that is salt and Jaggery mixture. Jaggery is easily available in every house, it is cheap, and provides sucrose and potassium. CRL later on did field trials on this "Lobon-Gur" mixture and found it almost equally effective.

Paramedics doing tubectomies at GK is famous, and now about 85% of the tubectomies are done by the paramedics with very low complication rate. Even more bold is the OPD method of tubectomy.

Patient is discharged within two hours and spends the post operative period at home. This has been found to be safe and also preferred by the patients who apprehended and avoided tubectomies because of 7 days, hospitalisation.

WHAT DO PEOPLE WANT?

The study of the coverage and health impact of G. K. activities raises some questions which offer useful lessons.

What is the coverage of the population by the project?

The total visits by patients to the curative services offered by G. K. are about 60,000 in a year. It has been estimated that if cost and distance are not the barriers, each individual seeks curative service on an average 3 times a year. So the 1,000,00 population in the project area should be seeking help 3,000,00 times. It means that 60,000 visits cover 20% of the total curative requirements of the population. Remaining 80% are either unmet or met by other health agencies (Quacks' mostly) what is the reason for this behaviour of the people?

But even more interesting is the analysis of these 60,000 visits. In the year 1975-76 the OPDs (at headquarter and subcentres) treated 48,000 patients while the paramedics in their village rounds treated only 6000 cases.

We all speak hoarse on behalf of the 'dumb' poor people of the villages and advocate a decentralised, simplified, deprofessionalised, cheap medical care, for them. But in the GK experience when a fairly well trained (approx. 1 year) woman paramedic is going to the door step only few people are availing her curative services and the majority are preferring to walk a longer distance to the subcentre or to the headquarter.

There are 2 possible reasons which could be discovered during the discussion 1) People still felt that the curative services offered at subcentre or headquarters are superior to the services of paramedic. The mystification about doctors, indoor buildings and injections influences their choice. 2) Paramedics are all ill-equipped in their curative powers. They don't have chemotherapy beyond sulfas. This has acted as an impediment in her showing good curative results to the village people which in turn diminishes their co-operation to her in the preventive activities.

These lessons should help others in planning the curative services and understanding what people want.

THUS FAR AND NO FURTHER

What is the impact of G. K. health activities on the health status of the people?

Though comprehensive statistics are not available, the one offered by G. K. shows that the infant mortality rate in GK area is about 120 as against 140 in Bangla Desh and the birth rate is 29 as against 44 in Bangla Desh. The impact is definitely

there but a point of stagnation has come, beyond which further improvement in health indices has become difficult.

I felt that whatever improvement G. K. could achieve is mainly because of cheap, effective, widely available curative services. A cure at an early stage is a major preventive force. Some improvement is attributable to lower birth rate because of family planning, oral rehydration therapy in the cases of dehydration and tetanus toxoid to mothers. But probably all these measures have reached their saturation point. Some further improvement might occur if the curative powers of the paramedic are increased and if her acceptability increases. But poor paying capacity of the people will limit their utilisation of curative services at some point. Further significant improvement will not occur unless poverty, illiteracy and poor environmental factors are changed. Improving environmental factors is a difficult thing in Bangla Desh, where most of the land is under water for 6 months in an year. Huge inputs will be necessary to change this situation, which people can't afford.

So GK offers a good case, demonstrating to what extent the health status can be improved by the health measures alone and then how an impasse comes because of socio-economic factors acting as bottle neck. Such conclusions are possible because though GK has a comprehensive vision and has economic and educational programmes also, they are too small to effectively influence the whole population and hence the main force is still the health activity.

WHAT ABOUT PEOPLES PARTICIPATION?

In GKs experience it is very difficult to achieve active community participation for health purpose. The health volunteers from the villages were inadequate. The health committees formed in the villages almost never functioned effectively. The villages are factioned and health is not the priority. The paramedics of GK mostly are recruited from outside the GK area and being unmarried girls, they stay together in the dormitory rather than in the villages. The community health programme of GK is in the Director Dr Qasem's words, "village oriented but not village based."

In Jamkhed (MFC Bulletin No 49, Jan. 1980) VHWS are from the same villages. But what about the apparent active participation by the villagers in the programmes at Jamkhed, the respect and the response the VHW seems to get there in her preventive and educative activities as compared to the not so active co-operation by the villagers to the GK paramedic? Probably the peoples co-operation at Jamkhed is not because of the health work (in fact GK paramedics are better trained than Jamkhed VHWS) but because of the massive feeding programme and the food for the work programme. If these big economic inputs are eliminated probably people won't have much enthusiasm to participate only for 'a health programme' at Jamkhed also.

G. K. has tried to achieve economic self reliance by a health insurance scheme. But the maximum they have been able to

achieve is 50% economic self reliance. This was in spite of the fact that the project got vaccines and FP supplements at no cost. The main impediments are poverty and hence the poor paying capacity of the people (specially in Bangla Desh) and the project not adopting unethical curative measures to satisfy people and complete with the quacks.

Some of the conclusions thus drawn may seem negative. But these are the hard facts of community health work and anybody jumping into this field would better learn these lessons from the G. K. experiences rather than having illusions about massive people's mobilisation through health work, economic, self reliance and improving health by health measures alone. I have found friends at GK very open and honest in accepting and discussing their limitations also. This is a rare quality in a successful project and this increases the educative value of GK very much.

(To be concluded)

mfc bulletin: October 198.

IV

ESSENTIAL DRUGS FOR THE POOR : MYTH AND REALITY

IN BANGLADESH*

by

Z. & .S. CHOWDHURY

The drug scene (controversy) has been headline news in Bangladesh for the past five months. The supply of medicine in this country has for years been characterised by high prices, making drugs unavailable to the poor, by the sale of unnecessary and useless drugs and by the continued marketing of drugs identified as harmful and banned elsewhere.

Most people would agree that WHO's list of essential drugs (1) covers most diseases afflicting the world, but the fact remains, these are not the drugs being produced in quantity - in Bangladesh or elsewhere in the Third World.

In India, a big drug producing as well as consuming nation, tonics, vitamins, "health restoratives" and enzyme digestives (most of which are alcoholic preparations), "spin" money and account for three-quarters of drug production there, leaving scant resources for "essential" drugs (2). With tuberculosis and leprosy major health problems in that country, the Indian Council of Social Science Research had to report in 1981 that the production of anti-tubercular drugs was only one-third the minimal requirement, while that of anti-leprotic drugs was only one-fourth the minimal requirement (3).

An excellent example of demand being stimulated for non-essential drugs in poor countries is the case of Vitamin B12. Used in developed countries for the treatment of pernicious anaemia and similar B12 deficiencies, in Bangladesh the same B12 is advertised to doctors by Glaxo (UK) as useful in a wide range of treatments including "poor appetite", "poor growth" and "sterility" (6).

While 8 formulations containing B12 are listed in the UK MIMS, there are 126 on sale in India and 160 on the Brazilian market (7). 106 of the preparations available in Brazil range in dose from 5,000 to 30,000 micrograms per millilitre (2 of these formulations are sold by British Glaxo). In Britain, the highest recommended dose of injectable B12 is 1,000 micrograms per millilitre (8).

Most third world countries are now doubling their expenditure on drugs every four years while their Gross National Product (GNP) doubles only every 16 years and, according to WHO, "... for developing countries, importation of pharmaceuticals is one of the fastest growing drains on hard foreign currency" (9).

*The article is the abridged version of one part of a paper presented by the authors at the Primary Health Care Symposium No. 3 in Liverpool, UK in April 1982.

The Bangladesh scene before June 1982 and the new policy guidelines:- A waste of resources

In 1981 Bangladesh spent an estimated 1250 million taka on allopathic drugs (approximately 63 million US dollars). Only a negligible portion of this was available free of cost at Government Health Centres. The rest was sold commercially. In a country with one of the lowest per capital incomes in the world (70 US dollars per year), this means that after food, clothing and shelter, medicines are a major part of the remaining expenditure. Often a little medicine is bought in extreme need, but not enough to cure the illness. The public are left in ignorance as to the detrimental effects of breaking off treatment prematurely and the drug companies thrive on the need for repeated prescriptions. Most important, due to poverty and the high cost of drugs, only 15% of the population at a maximum estimate, are able to buy modern medicine.

Inadequate information and the common habit of self-prescription (because doctors are unavailable or too expensive and all drugs can be easily bought over the counter) have led to a situation where 70% of the annual drugs sales are on drugs described as useless or therapeutically insignificant by the British National Formulary, the National Research Council (USA) or the Federal Drug Administration (USA). An apt example is seen in two British companies manufacturing in Bangladesh - Glaxo and Fisons. The Glaxo Bangladesh Limited Medical Reference List of March 1980 listed 51 products, of which only 17 are available in Britain according to the UK MIMS of February 1980. Only one-third of Glaxo's products on the market in Bangladesh appear on WHO's list of essential drugs. In the UK MIMS of January 1982, Fisons had only five drugs listed out of the 31 products available in Bangladesh and 17 of these 31 were combinations of vitamins and minerals. The "hottest" item of the West German manufacturers, Merck on the local market has been Neobion (a combination of vitamins B1, B6 and B12). This one item alone accounted for over 68% of the total market in neuro-tropic preparations and their 1980 Marketing Plan stated: "Our objective will be to achieve at least 75% of the market share by intensifying our promotional effort". They were also concerned that Government could prove a threat and so instructed their company in Bangladesh to ".... maintain a very good relations with Government officials in Health and Commerce Ministry to guarantee importability of our products" (11).

Drugs worth an average of 150 million taka are imported annually into Bangladesh by local firms as well as voluntary and UN organizations. The remaining medicines, worth about 1100 million taka are produced in the country. 890 million taka worth, or 80% of the drugs produced in Bangladesh are manufactured by 8 multinational companies. The rest is shared by 22 of the larger local companies, with or without third party licensing arrangements with multinationals.

The Expert Committee, set up by the Government on 27th April 1982 to evaluate all the registered/licensed pharmaceuticals then available in the country, found about 4170 brand name drugs

containing over 150 different active ingredients. Only about 250 of these (less than 1%) are therapeutically significant or essential. The rest have been promoted solely for the purpose of financial gain. In a country like Bangladesh the situation is acute because it diverts desperately scarce resources and many people will deny themselves food in the hope that some aggressively advertised, but useless tonic will do them more good. But it is not only a confidence trick - substances which have actually been identified as harmful and banned in developed countries have continued to be manufactured and marketed in Bangladesh.

Mr A Wahid, Managing Director of Fisons (Bangladesh), sums up well when he says, "we are businessmen first. First of all we went profit we are oversensitive about reports from WHO. Restrictions on drugs and pesticides imposed in the US and Canada should not be applied in our country because our people are ethnically and biologically different from others" (15).

Quality Control and price Fixation

Up to this point in time, manufacture and marketing of medicine has been regulated by the Ministry of Commerce and Industries and the Ministry of Health. Drug Administration, a department of the Ministry of Health, tests the quality and composition of drugs produced and imported. Each drug and its price has to be approved by this body. On paper this sounds very good and this formal machinery is cited by drug companies to argue that nothing much can be wrong with their practice under such "stringent" a system. However, to perform their vast task, which includes testing every drug on the market in Bangladesh as well as inspecting 160 pharmaceutical Companies and thousands of registered and unregistered pharmacies and 7 inspectors. It is clear that supervision and control of manufacturers and retailers can exist only on paper with a system of this sort. In this connection, the Expert Committee which, after reviewing the drug market, formulated the new drug policy, recommended, that the Directorate of Drug Administration be expanded and adequately staffed with experts in medical and pharmaceutical sciences. They further recommended that all drug control laboratories be brought under the control of Drug Administration and that a properly staffed and equipped National Drug Laboratory with appellate facilities be set up as soon as possible.

The maximum retail price (MRP) of each drug is fixed by the Director General of Prices, Supplier and Market Intelligence, Ministry of Commerce at about 200% of the cost and freight (C & F) value of the drug which includes the value of raw and packaging materials. This mar-up on C & F price includes 20% for insurance, bank charges, etc .., 30% for distributors and retailers and only about 15/20% profit for the manufacturer. In actual fact, it is estimated that the real profit has been between 70/100%. One manner of obtaining this excessive profit is to buy raw materials at prices higher than international competitive rates. Pfizer, for example has a binding clause in its agreement with Government that its head office in the US will have to approve of any raw materials that it purchases. This allows Pfizer (Bangladesh) to buy raw materials at exorbitant prices from its sister companies abroad and thereby

transfer profit out of Bangladesh in the name of production costs. Many other companies have similar clauses in one form or another. Nationals as well as multinationals are out for table profit. Two local as well as the transnational company Glaxo are all buying from the same source, yet all quote different prices. It is interesting that 3 years later (1982), in spite of tremendous inflation, GPL was able to buy from a West German firm at a price less than that paid, by any other company in Bangladesh. It would also be false to claim that Pliva Pharmaceuticals (Yugoslavia) is of questionable quality since Pliva products have been approved by Federal Food and Drug Authority of the US as being of standard quality and usable in the US.

Packaging to increase profit:

The mystique of the name is supported by other promotional features, especially packaging. Consumers naturally tend to identify brand name tablets, capsules and syrups by their distinctive bottle or packeting. Packaging is promoted with reference to better hygiene and customer appeal. Foil-wrapped products offer much more to visual perception than the same product which comes out of a bulk tin and is wrapped in a twist of paper or non-descript container. In a country like Bangladesh where something like foil must be imported, there is a ready-made excuse for increasing the price of the product since the MRP allowed by the Government is two and one-half times the cost of raw and packaging materials.

Fortunately the new drug policy has taken steps to curb these practices also. All manufacturing companies must now purchase their raw materials at competitive international prices so this will automatically bring down the prices in this area for a number of companies. The mark-up price, previously done on a basis of 100/150% on raw materials and packaging should be curtailed so that the mark-up is only the price of the raw materials and no mark-up allowed on the actual cost of packaging materials. The immediate effect of this would be a much more even-scale price range for similar products manufactured by different companies.

GONOSHASTHAYA PHARMACEUTICALS

Gonoshasthaya Kendra (People's Health) Charitable Trust original objective of establishing a preventive and primary health care service in a rural area of Bangladesh gradually developed into a broader community development programme and not surprisingly, we began to consider how to provide our service area with quality and inexpensive medicine.

A project of the Gonoshasthaya Kendra Charitable Trust (Gonosasthaya Pharmaceuticals Ltd). GPL is designed to supply 15-20% of the present Bangladesh market in essential drugs. It aims to produce high quality, essential and generic drugs only, at the lowest possible price through responsible marketing practices. GPL is registered with the Joint Stock Companies under the Companies Act of 1913 and as such, is subject like any other company, to the usual customs, taxes and other duties. Unlike other companies, however, there are no private shareholders. The entire stock is owned by the Trust which, by its charter, limits profits to 10-15% after payment of duties and bank charges. About 50% of the profits must be ploughed back into the factory and 50% spent for research and charitable purposes.

The Board of directors has nine members - five from GK Trust and the rest representatives from the Ministry of Health, Directorate of Industries, Bangladesh Shilpa (Industrial) Bank and NOVIB, a Dutch non-government organisation. This structure was adopted with the hope that GPL would combine the advantages of private industry with its freedom of decision making for management with the character of a public enterprise oriented to the consumer and avoiding profit motives.

Funding came in good part through foreign voluntary organisation donations directly to the GK Trust for this (GPL) project. A break-down is shown at the end of the second column.

Technical expertise was provided by the Internaatinal Dispensary Association (Holland) who helped to organise additional training for managers and procured machinery and raw materials. Professor J Polderman, Expert Committee Chairman of the European Pharmacope... has been sponsored by NOVIB as our Producing Advisor. All managers of the factory are Bangladeshi.

Establishment of GPL, needless to say, met with problem areas. The first of these was infrastructure. Any attempt to establish a high technology project in an underdeveloped country will suffer from lack of infrastructure and problems arising from having to import much of the necessary equipment. Our main problems here were in the lines of architecture, electrical supply and assembling and maintenance of machines/equipment.

The second area of concern was personnel. Skilled workers in all categories, but especially maintenance technicians are extremely difficult to hold in Bangladesh due to migration to the Middle East where wages are much higher. Unskilled labourers, we were determined to recruit from among the really needy, maintaining the emphasis of the whole of Gonoshasthaya Kendra on developing women's skills. Since this was our objective, a good deal of basic functional education was necessary before the

women could begin working in factory. For most of our recruits, it, meant functional literacy classes as well as learning pharmaceutical terminology and familiarisation with the machinery they would be using.

NOVIB (Holland)	US	2.62	million
OXFAM (UK)	" "	0.33	"
CHRISTIAN AID (UK)	" "	0.22	"
COMMUNITY AID ABROAD (Australia)	" "	0.05	"
EUROPEAN ECONOMIC COMMUNITY (through Novib)	" "	0.20	"
Bangladesh Shilpa Bank, GK Trust and Others	" "	1.50	"
(this is strictly a loan to GPL)			
	US dollars	4.92	million

The social and political climate cannot be ignored either, when beginning a new industry in a country like Bangladesh. The government's policy is to encourage industrial development, especially in such a thing as essential drugs. However, anyone who intends to produce or market in Bangladesh has to cope with the corrupt practices which pervade the industrial and commercial life of the country. For those who have been in the business, GPL's conditions for doing business come as a surprise which they often cannot fully understand, since everyone knows bribery is part and parcel of the way of life in this country.

Then of course, there is the problem of moving into an already well-established market. Considering that our aim is to supply quality drugs at the lowest possible price, we knew trouble would be waiting - just how much trouble has only come in bits and pieces, but it has come, especially in the field of pricing and marketing.

We believe that for the proper information of the consumer, all pharmaceuticals should be obliged to give details of their pricing policy. The table "Contrast in Drugs Prices" though not a break-down in details of pricing, compares some of GPL's prices with those of similar products being manufactured and marketed in Bangladesh.

It should be noted that as new company, as well as due to our insistence on very high quality control and social benefits for our workers, our overheads are very high. Older companies whose machines are fully depreciated will have much lower overheads. We intentionally make higher profits on drugs we consider less

CONTRAST IN DRUGS PRICES

Company Name	Product's Name	Capsule, Tablet Price	Syrup/Liquid Price
1 <u>Ampicillin</u>			
Fisons	Penbritin	Tk. 1.69/cap*	Tk. 23.80/60mls
Hoechst	Amblosin	1.80	23.80
Square	Ampicin	1.70	21.00
K.D.H.	Amplin	1.70	23.80
Pioneer	Ampicil	1.70	21.00
Albert David	Aldapen	1.30	
G.P.L.	G-Ampicillin	1.00	24.00/100mls
2 <u>Amoxicillin</u>			
Fison	Amoxil	3.00/cap	32.00/60mls
K.D.H.	Amolin	2.47	25.00
G.P.L.	G-Amoxicillin	2.25	
3 <u>Tetracycline/Oxytetracycline</u>			
Pioneer	Teracin	0.90/cap	
Pharmadesh	Oxalin	0.97	
Hoechst	Hostacycline	0.90	
Albert David	Aldacycline	1.00	
Squibb	Sumycin	0.98	
I.C.I	Imperacin	1.05	
G.P.L.	G-Tetracycline	0.50	
4 <u>Sulphamethoxazole & Trimethoprim</u>			
Burrough Wellcome	Septrin	2.30/tab	26.00/60mls
Square	Cotrim	1.98	22.00
Therapeutics	Theratrim	1.80	22.00
Opsonin	Chemotrim	1.75	16.00
Pioneer	Sephtazol	1.90	
G.P.L.	G-Cotrimexazole	1.25	2.100/100mls
5 <u>Paracetamol</u>			
BPI (May & Baker)	Paracetamol	0.25/tab	
Square	Cetamol	0.25	
Hoechst	Pyralgin	0.27	
Fisons	Fitamol	0.25	
Nicholas	Paratan	0.25	
G.P.L.	G-Paracetamol	0.15	
6 <u>Metronidazol</u>			
BPI (May & Baker)	Glagyl	Tk. 0.78/tab	
Square	Amdis	0.70	
Pioneer	Metazol	0.60	
Opsonin	Metril	0.50	
G.P.L.	G-Metronidazole	0.40	

Company Name	Product's Name	Capsule/Tablet Price	Syrup/Liquid Price
7 <u>Asprin (300mg)</u>			
K.D.H.	Asprin	0.12	
Fisons	Genasprin	0.10	
G.P.L.	G-Asprin	0.75	
8 <u>Diazepam (5mg)</u>			
Square	Sedil	0.30/tab	
Opsonin	Easium	0.25	
Peoples	Sudex	0.20	
K.D.H.	Sedalin	0.30	
G.P.L.	G-Diazepam	0.125	
9 <u>Antacid</u>			
I.C.I.	Avlocid	0.45	Tk. 23.00/225mls
Squibb	Antacil	0.25	15.20/228mls
K.D.H.	Nutrakil	0.20	16.00/228mls
G.P.L.	G-Antacid	0.20	14.00/200mls
10 <u>Fruzemide (40 mg)</u>			
Hoechst	Lasix	1.30/tab	
G.P.L.	G-Fruzemide	0.60	
11 <u>Oral Rehydration Salt Sachet (27.5 gm)</u>			
Pioneer	Oralite-D	10.00	
G.P.L.	Labon Jaler Sarbat (O.R.S.)	2.50	
12 <u>Ferrous Fumerate with Folic Acid</u>			
Fisons	Folte Tab	0.06	
G.P.L.	G-Iron with Focid Acid	0.05	

* 2 Bangladesh Taka = Approximately One Indian Rupee.

important or whose use we wish to discourage. For example we make a 6.57% profit on ampicillin and 3.2% on paracetamol (which are below our overall margin of 10.15%) and make it up with a 36.6% profit on diazepam and 85.6% on frusemide.

GPL hopes to market about 60-70% of its production to government, government agencies and charitable health services in bulk supply. This is deemed the safest, quickest way to channel the benefits of cheap drugs to people most in need. The remaining 30-40% will be sold on the open market but this involves a system of education (most, including doctors, believe the higher the cost, the better the drug) and distribution. It is difficult for even doctors to come by unbiased drug information since there is no Bangladesh National Formulary and often the product information leaflets are very different in content in

third world countries than they are in first. The only way then for doctors to keep abreast of pharmaceutical developments is through foreign medical journals, etc. and most don't have access to the foreign currency necessary for purchase of these.

In this respect, we have used our Bengali language health bulletin 'Monthly Gonoshasthaya' to disseminate various information in relation to the baby food issue, abuse and exploitation in the drug market and other vital health-related topics.

Bid for Government Tender

Each year, the government calls for a large tender for medicines for rural health centres. In 1978-79, the government after proper calculation, put pressure on the government-owned Albert David company to sell them their ampicillin at a price of 95 paisa/capsule. In 1979-80, Albert David management contended that due to rising costs they couldn't supply lower than 99 paisa. In 1981, GPL bid for the tender of 10 million ampicillin capsule at 93 paisa, basing our calculation on the raw materials price cited by one of the leading trading houses and considering our high overheads. The day after submitting the bid, we were informed by the Trading Company that they could now quote a better raw material price. The previous one had been 95-120 US dollars per kg, the new one was 89-100 US dollars. This cheaper price would have resulted in a lowering of 5-17 paisa per capsule. We later learned that the Trading House in Question is owned by the wives of the Managing Directors of three large pharmaceutical companies, one multinational and two national. Still later, we learned that some multinational and top-selling national companies had a meeting before the tender. We did not win the tender. It went to a national company which had bid at 80 paisa per capsule. The retail price of the same company's ampicillin is 159 paisa. For the government, this was the cheapest ampicillin they had ever purchased and giving credit where credit is due, some officials thanked us, requesting us to keep up the good work.

Role of UNICEF and WHO

UNICEF is the main supplier of drugs for primary health care in the rural health centres of Bangladesh, largely through their 'Drug and Diet Supplement' (D & DS) kits. The drugs are purchased through a general tender, mainly from East and West European countries, packaged in Copenhagen and then shipped to the recipient countries. We are pleased to say that UNICEF is now considering GPL as a supplier for the Bangladesh rural health scene.

Since one of our aims is to encourage the sale of generic drugs, we thought the translation, publication and distribution of the Technical Report series No 641 (Essential Drugs) would be an important step. We approached the WHO office in Cacca for permission in respect of this request and, if possible some financial assistance for the project. We were informed that WHO in Bangladesh has no funds to support such a request. Then followed eight months of lengthy correspondence, at the finish

of which we were informed that since Gonoshasthaya Kendra is not a government organisation, permission could not be granted for us to translate, publish and distribute on our own. (We later learned that there is no need for any permission as WHO publications are not subject to any copyrights). This is a vital document which should have wide distribution in all third world countries, yet little has been done by WHO in Bangladesh to see doctors, pharmacists, etc, informed about the guidelines, they themselves have established to help us reach the goal of 'HEALTH FOR ALL by 2000', in fact, when the Expert Committee was sitting earlier this year and requested eight copies of the booklet, it could not be found in the country and had to be sent for (by which time the Committee had already submitted its report).

Relevant here is an article which appeared in the Monthly Review (December 1981) by Trushen and Thebaud who argued, "..... medical aid, like food aid, is a weapon of foreign policy wielded by donor nations, and it provides an easy entry to vast third world markets for multinational corporations - in this case the pharmaceutical industry. In the past decade, drug companies have increased their influence on WHO through participation in three new programmes: human reproduction, tropical disease research, and essential drugs for primary health care. The drug industry's penetration is indicative of WHO's continuing reliance on technological and industrial approaches to problems that are economic, social and political. Rather than promoting 'Health for All', isn't WHO furthering the medicalization of underdevelopment?"

Furthermore, the politically neutral attitude of WHO prevents it from directly denouncing various forms of domination such as colonialism and neocolonialism which are at the root of many health problems. Trushen and Thebaud have rightly pointed out, "WHO's technocratic approach is a refuge: It permits the organisation's doctors to identify a disease and describe it scientifically without calling into question the economic, political and social mechanisms that ensure its development and transmission."

And that very approach prevents essential drugs for the poor from becoming a reality. Establishment of rights of the oppressed is always an up-hill struggle.

VI

D-9/334.(J:1) THE BANGLADESH BAN ON HAZARDOUS AND IRRATIONAL
21.10.1982 DRUGS

Its Review and the present Status

- 28th April 1982: An 8-member expert committee commissioned to evaluate all the pharmaceutical products in Bangladesh and draft a rational Drug Policy - met for the first time.
- Important outcome: 4140 products in the market were evaluated. 16 criteria were laid down for evaluation. (12 criteria selected on scientific grounds).
- Based on these, 1707 products were recommended to be banned. These were divided into 3 categories or Schedules as follows:
- Schedule I - This included 265 locally manufactured and 40 imported drugs regarded as positively hazardous to be banned immediately.
- Schedule II - included 134 drugs which required reformulation and were to be banned after a period of 6 months.
- Schedule III - included 742 locally manufactured and 526 imported drugs. These drugs either had little or no proven therapeutic value or could easily be manufactured by local drug companies - instead of the multinationals producing them at higher costs, thereby depleting the country of much needed foreign exchange.
- 12th May 1982: The Expert Committee submitted its report to the Government.
- 29th May, 1982: The Chief Martial Law Administrator and his Council of Minister approved it. The date of the ban of Schedule I was changed from 1 to 3 months and the banning dates of Schedule III drugs from 6 to 9 months.
- 7th June 1982: Formal declaration of the new policy was made.
- 12th June 1982: The Drug Control Ordinance was promulgated.
- June 1982: Reported pressure exerted on the Government by the Bangladesh American Ambassador on behalf of the US multinationals to have

21.10.82: a

the policy amended. The negative stand of the USA regarding WHO's International Code against unethical marketing practices of milk food is well known.

The British, Dutch and the German Embassies joined to exert pressure on the government. The anti-government campaign having failed, the focus then turned to the Expert Committee which had recommended and pushed the drug policy

July 1982

The 4-member Expert Scientific Committee of various pharmaceutical manufacturing companies was brought by the US Embassy to further pressurize the government to reconsider the ban.

19th August 1982:

In Washington Post it was reported that the US State Department spokesman had acknowledged: "that the Pharmaceutical Manufacturers Association, a trade organisation the drug industry, asked it to bring pressure on the Bangladesh government to delay implementing the law pending discussions with the manufacturers". He added: "The State Department has a statutory responsibility for assisting American interests abroad. In this particular case, the US Government is also concerned that these regulations may inhibit further foreign investment in Bangladesh's US \$ 30 billion market in the developing countries would be at stake if other countries followed suit.

12th August 1982:

Report submitted by the Review Committee constituting of 6 military doctors set up to re-examine the matter in view of the pressure mounted by the multinationals and their respective governments.

6th September 1982:

The Drug (Control) Ordinance Amendment announced by the Government after studying the Review Committee's Report.

AMENDMENTS

SCHEDULE I:

Ban lifted from only 1 item of importance - Imodium (an anti-diarrhoeal).

Six other misused/abused dental remedies reinstated.

TOTAL BAN OF SCHEDULE I DRUGS will remain EFFECTIVE 3 month period as decided earlier all harmful drugs to be destroyed by 12th September 1982.

SCHEDULE II

4 eye preparations containing anti-biotic and steroid combinations allowed (contradictory to the Expert Committee's recommendation).

Heptuna plus a capsule containing iron folic acid, Multivitamins and minerals produced by pfizer (very strangely) allowed to remain.

Ban withdrawn of total 7 drugs in Schedule II. Time limit extended according to the amended ordinance from 6 months to 12 months for the drugs listed in Schedule II.

Lobbying for this so called necessary ante-natal drug for the under-nourished anaemic pregnant woman was done by the country's gynaecologists headed by the President of Bangladesh Medical Association, shareholder and member of the Board of Directors of Pfizer, Begum Feroza.

Facts about the Bangladesh Drugs Scene in Brief:

- Bangladesh is the third poorest country in the world with a per capital income of US \$ 70 a year.
- That 70% of annual drug sales are of drug described as useless or therapeutically insignificant by the British National Formulary, the National Research Council, USA and the Federal Drug Administration, USA.
- Out of 51 products of Glaxo available in Bangladesh market in 1980, only 17 are available in the UK and only $\frac{1}{3}$ are present in WHO's list of essential drugs.
- Of 31 products of Fisons available in Bangladesh, 17 were combination of vitamins and minerals. And only 5 of these drugs were available in the UK. 60% of Bangladesh's health budget is spent on drugs.
- In 1981 about 1250 million taka was spent on allopathic drugs in Bangladesh, but due to poverty and the high cost of drugs less than 15% of the population was in a position to buy modern medicines.

SCHEDULE III - 28 drugs (manufactured under the third party licence) were allowed to remain. Time limit extended from 9 months to 18 months effective from 12th June 1982 - date of promulgation of drugs.

SCHEDULE IV - Under this new schedule, 88 balms and vapours of small national companies were to be allowed to be manufactured for 18 months with effect from 12th June 1982.

WHAT'S NEW?

All hazardous drugs of Schedule I were to be completely destroyed by 12th September 1982.

There is a move on by the drug companies to apply for

licence to export them to Saudi Arabia, Western Africa, etc, via Europe. These applications were made on 10th September with the support of Secretary of Health. The Drug Controller has refused and the matter has now been taken up with the Industrial Ministry. The Drug Controller has recommended that if this move should go through, all these products should be previously labelled saying the drugs was recommended to be destroyed in Bangladesh by 12th September 1982.

The failure of Sri Lanka and Pakistan to have a progressive drug policy has been quoted by the multinationals to subvert the attempts of Bangladesh Government to ban hazardous drugs.

What is probably the most humiliating comment on the social consciousness of Indian health personnel is that our drug policy is being quoted by the multinationals to criticize and condemn the Bangladesh ban. Here it would not be out of place to quote from a medical journal from Bangladesh, 6th September 1982.

In India, 43606 drugs are registered and sold. Even these have not upset their possibilities of further industrialization in spite of their technological advance and poverty" (sic).

The above information is based on newspaper reports from Bangladesh and elsewhere and the personal communications from socially concerned health personnel in Bangladesh like Dr Zafrullah Chowdhury.

Availability of supply of essential life-saving drugs for the majority at reasonable cost, should come before profits of the drug companies. If these profits derive from the sale of hazardous and irrational drugs or drugs with little therapeutic value, they need to be curtailed, and policies which allow drug companies to continue producing them need to be seriously questioned. We want a rational, people-oriented drug policy, and any effort in this direction anywhere has our support.

As mentioned in our handout "In Support of Bangladesh Ban" we repeat "Sabotage of this ban at this stage by the application of pressure or by money power will be a blow to all those who sincerely believe in socially relevant and socially just health care. Consequently, this is not a question of Bangladesh's fighting a 'Bangladesh problem'. It is in fact a question of a higher premium being placed on profits than on the welfare of human beings - if the ban is withdrawn under duress. This is therefore a move against which the public opinion of all nations, particularly the developing countries should be raised. It is a cause worthy of global support specially from those involved in health work.

What would we do if we knew that the sale of hazardous and irrational drugs would continue because of the pressures and marketing strategies of the Drug companies? Would we continue stocking them in our pharmacies and prescribing them? We request our readers to boycott such hazardous products, because a Government ban on them may come too late, or never come because of vested interests.

SOURCE:- Low Cost Drugs & Rational Therapeutics.

CURBING DRUG MULTINATIONALS

Will India follow Bangla example?

- by Sumanta Banerjee

Little Notice has been taken here of a momentous decision taken by the Bangladesh Government recently. In a sweeping new drug policy, the Government has clamped an immediate ban on 237 largely harmful medicines, and has recommended the removal of another 1500 unnecessary drugs by the end of 1982.

Quite predictably, multinational drug manufacturers have taken umbrage at the decision, and have succeeded in pressurising the US Government to ask Bangladesh to "reconsider" the new national drug policy. Apart from inhibiting their future foreign investment in Bangladesh in particular, they fear that other developing countries might follow Bangladesh's example. World wide drug sales to developing countries by these companies exceed \$30 billion a year. It is no wonder that they are unhappy at the Bangladesh decision.

The new drug policy of Bangladesh bears important lessons for other developing countries and India in particular which shares in common with Bangladesh a number of problems pertaining to the pharmaceutical industry and people's health. According to Bangladesh's Health Minister, Maj Gen Shamsul Huq, the Government had to adopt the new policy because "incomplete transfer of technology, restrictive business practices, and purchase of raw materials by the multinationals at inflated prices from tied sources" were "detrimental to our national economy".

The stakes which the multinationals have in the Bangladesh drug market can be measured by some figures. The Experts' Committee which drew up the new drug policy revealed that 75 percent of the Bangladesh market was controlled by just eight multinational companies--Fisons Glaxo, ICI, May and Baker, Pfizer, Hoechst, Squibb and Organon. Pfizer dominated the market with more than \$10 million in sales in 1981, while Squibb sold around \$5 million in the same year. Nineteen Pfizer drugs appeared on the list of drugs to be banned immediately including its Stericol capsules which contain Clioquinol. Among the 22 Squibb products listed are Quizaline tablets and suspensions, both of which also contain clioquinol.

The Chairman of the Experts Committee, Prof. Nurul Islam, noted that banning of these products would help to improve health care and added: 'Nobody will die because of the want of medicines in the country if we stick to only 250 essential drugs, including 100 life-saving medicines'. In fact this conforms to the WHO report of 1979 which identified about 237 basic drugs and about 303 single ingredient formulations of these drugs which were considered as most needed for health care of the majority of the population.

(However, at the request of the US administration, Bangladesh has since revised the law by removing 41 drugs from the list of 237 harmful ones and extending for 18 months the production, sale and distribution of 71 others).

The reaction of the foreign multinationals is significant. The Pharmaceutical Manufacturers Association (PMA), a trade organisation for the drug industry of the US has described the new drug policy of Bangladesh as "precipitous" and prejudicial to public health. It has warned that blocking the flow of drugs from its member companies could open the market in Bangladesh to uncertified and potentially impure drugs from other sources.

How far is the fear justified? The Bangladesh Government has announced, while banning these drugs, its policy to encourage local industries to achieve self-sufficiency in the manufacture of essential drugs. The multinationals are expected to move out of the production of the simpler preparations and use their technology and resources to provide the more complex and innovative drugs which may be necessary.

A local organisation, Gonoshasthya Kendra (People's Health Centre) has already established a limited company, Gonoshasthya Pharmaceuticals Limited, which in 1981 began production with two of the 33 most essential drugs for primary health care--ampicillin and paracetamol. By 1982, they were producing six more drugs. It is essential that more and more such local industries are encouraged to manufacture drugs to replace the ones sold by the multinationals.

Groundless fear

Besides, contrary to the fear propagated by the multinationals that a drug scarcity is round the corner in Bangladesh, it must be emphasised that the Government has not banned all foreign manufactured drugs, but only those considered harmful and unnecessary. Alternatives are available for each of the drugs that have been banned, including cough or pain relievers.

It has to be admitted at the same time that the new drug policy in Bangladesh goes only some way towards strengthening the local industry, and still leaves many questions unanswered. In a developing country like Bangladesh (which is the third poorest country in the world, with the lowest per capita income, the lowest life expectancy and the highest infant mortality of all the developing countries), more curative measures however indigenous and inexpensive that might be are not enough. A preventive approach that will aim at removing the basic causes of diseases (poverty and malnutrition) forms the basis for primary health care in such a situation.

One still ought to recognise that the Bangladesh Government has taken an important first step curbing the hold of the multinationals and seeing to it that resources are not wasted on inessential drugs. One wishes that our government takes courage in both hands and at least implements the recommendation made by the Drugs Consultative Committee to weed out 22 fixed dose combinations as an immediate step, and narrow down the number of drugs to 116 (as recommended by the Hathi Committee).

extracts from DECCAN HERALD dated 16.9.1982

BANGLADESH POLICY UNDER U.S. PRESSURE

US asks Bangla to relax ban on drugs

- by T.V. PARASURAM
Express News Service

Washington Aug 20:

The United States has urged Bangladesh to reconsider a new national policy designed to ban hundreds of drugs, though 70 percent of the banned drugs are considered by the US Federal Drug Administration and its counterparts in Europe to be dangerous or worthless.

The State Department acknowledged Wednesday that its intercession with Bangladesh was in response to an appeal from several multi-national drug companies which fear that other developing countries will follow the lead of Bangladesh and this could undermine their 30 billion dollar world market.

Bangladesh is playing it in a low key. The economics attache of the Bangladesh embassy in Washington said the Bangladesh law was a good step forward, but the review requested by the State Department "is normal and not important". The US consumer groups do not share this benign view of the US government's intervention and have blasted the administration.

The Washington Post noted in a front page despatch that among the drugs Bangladesh wants banned are several that are not permitted in the US, including clioquinol, a chemical that is known to cause serious damage to the nervous system.

A State Department spokesman acknowledged that the Pharmaceutical Manufacturers Association of the United States (PMA), a trade organisation of the industry, asked the department to bring pressure on Bangladesh to delay implementing the law, pending discussions with the manufacturers. The spokesman defended the US intercession by saying "the State Department has a statutory responsibility for assisting American interests abroad. In this particular case, the US government is also concerned that these regulations may inhibit future foreign investments in Bangladesh.

The Carter Administration had drugs or pesticides banned in the USA would not be allowed to be exported abroad. One of the first acts of the Reagan administration was to overturn that rule with the result that drug

companies can now export from the US any item banned here. There was never any ban on the manufacture of such drugs abroad.

The US action has been condemned by several international and US charity and consumer groups. About the latest State Department action requesting Bangladesh to review the ban on certain drugs, a spokesman for War on Want said in London, 'encouraging this review is certainly not helping the people of Bangladesh'.

The Public Citizen Health Research Group, a Washington based organisation in a letter to Secretary of State George Shultz called the department's action 'unconscionable'. It said: 'Perhaps you are unaware that many of the US based multinational drug companies are foisting on innocent people in the developing countries drug which our own medical authorities consider worthless and unnecessary'. The group expressed 'dismay' that the State Department had allowed itself to be used by the giant multinational drug companies to promote and protect their exploitation of the impoverished citizens of underdeveloped countries.

The Bangladesh government announced the new law, prohibiting the sale of over 1700 drugs and immediately banning 237 products which are considered dangerous, in June. Among the US drugs affected are some made by Merck, Pfizer, Squibb, Searle and Upjohn.

According to the members of the committee that drew up the new Bangladesh policy, eight multinational companies including Pfizer and Squibb share 75 percent of Bangladesh's 100 million dollar a year drug market. Pfizer dominates the market with over 10 million dollars in sales in 1981. Squibb sold five million dollars worth the same year.

Nineteen Pfizer drugs are on the list of drugs banned in Bangladesh immediately. They include sterical capsules, which contain clioquinol. Among the 22 Squibb products affected are quixaline tablets and suspension (Q and S caps), both of which also contain clioquinol. Neither Pfizer nor Squibb would comment on the new Bangladesh law or the drugs named in it. They obviously prefer to deal with the matter through the state department.

However, a spokesman for the industry's Pharmaceutical Association, which recently led a delegation to Bangladesh in an unsuccessful effort to secure reconsideration of the law, described the new law as precipitous and prejudicial to public health.

PMA argued that blocking the flow of drugs from its member companies could open the market in Bangladesh to uncertified and potentially impure drugs from their sources.

Approximately 60 percent of Bangladesh's health budget is devoted to the purchase of drugs compared to less than 10 percent in the USA. Because of that Bangladesh is eager to bring its drug outlays under control and to begin to produce some of the less complex drugs immediately.

The Bangladesh committee acknowledged "with appreciation" the role of the transnationals but urged them to devote their "machinery and technical know-how" to producing important and innovative drugs and leave the production of simple and cheap drugs to the domestic companies.

source: INDIAN EXPRESS of 21.8.82

reading list on drug issues

<u>Bangladesh situation</u>	<u>Source/Available at</u>
1. Gonoshasthaya Kendra - a program report	LINK Vol.1, No.1, May-June 1981 (Asian Community Health Action Network Newsletter)
2. Gonoshasthaya Kendra - a progress report (Aug, 1980)	Handout available from VHAI, New Delhi
3. Bangladesh finds the right prescription	Health for the Millions (VHAI Bimonthly) vol.VIII, No.6, December 1982 SPECIAL ISSUE.
4. Drugs in Bangladesh	LINK Vol.2, No.3, Aug-Sept 1982 (Asian Community Health Action Network Newsletter)
5. In Support of Bangladesh Drug Policy	Handout of VHAI Cell on Low Cost Drugs and Rational Therapeutics.
6. The War against Bangladesh - Claude Alvares	A Rustic/VHAI publication
7. Bitter Pills--Medicine and the Third World Poor - Dianna Melrose	OXFAM publication 1982.
<u>Indian situation</u>	
1. Report of Committee on Drugs & Pharmaceuticals Industry (Hathi Report)	Ministry of Petroleum and Chemicals, Government of India, April 1975.
2. Medicine-as if people mattered	Special Issue of Health for the Millions, VHAI, New Delhi, April-June 1981.
3. Aspects of Drug Industry in India - Mukaram Bhagat	Center for Education and Development, Bombay
4. Insult or Injury - Charles Medawar	Social Audit, England, 1979

- | | |
|---|--|
| 5. Health for all - an alternative strategy | ICMR/ICSSR group
VHAI, New Delhi |
| 6. Health Care Which way To Go | medico friend circle,
VHAI, New Delhi |
| 7. Bulletin of Sciences--
Special Issue on Drug Policy | Science Circle, Indian
Institute of Science,
December 1983, New Delhi. |

for further information contact -

- | | |
|--|--|
| 1. Gonoshasthaya Kendra
P.O. Nayarhat
via Dhamrai
Dacca, Bangladesh | 2. Low Cost Drugs & Rational
Therapeutics Cell
Voluntary Health Association
of India
C-14, Community Centre, SDA
New Delhi 110016 |
| 3. medico friend circle
50 LIC Quarters
University Road
Pune 411016 | 4. Asian Community Health
Action Network (ACHAN)
Flat 2A, 144 Prince Edward
Road, Kowloon, Hongkong |
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DRUG ACTION NETWORK NEWS

- 1) Drug Action Network is a growing informal network of people, professional groups, projects, consumer education groups and activists who are keenly interested in drug use and misuse and drug policy issues in India.

Members of the network have been and are involved in various drug issues including campaign against EP forte preparations; misuse of anti-diarrhoeals, **anabolic steroids**, **clioquinol**, paediatric tetracyclines; banning of dangerous drugs; need for a code of ethical marketing for companies; popularising event in Bangladesh including new drug policy, anti-TB drug shortages and so on.

For more information please write to:

Low Cost Drugs and Rational Therapeutics Cell,
Voluntary Health Association of India
C-14, Community Centre, Sardarjung Development Area,
NEW DELHI 110 016

- 2) November 1983 is Drug Campaign Month

Various individuals and groups, part of the Drug Action Network and others in India will be launching a concerted campaign this month on Drug and Drug policy issues. For further information contact:

- | | |
|--|--|
| a) <u>Medico friend circle</u> ,
50 LIC Quarters
University Road
PUNE 411 016 | b) <u>Centre for Science and Environment</u>
807 Vishal Bhavan
95 Nehru Place
NEW DELHI 110 019 |
| c) <u>Arogya Dakshata Mandal</u>
2127 Sadashiv Peth
PUNE 411 030 | d) <u>Consumer Education and Research Centre</u>
Near Law College
Ellis Bridge
AHMEDABAD 380 016 |
| e) <u>Centre for Education and Documentation</u>
3 Suleman Chambers
4 Battery Street
BOMBAY 400 039 | f) <u>Lok Vidnyan Sanghatana People's Science Movement</u>
18 A Jagjivan Nivas
Behind Arora Talkies
Matunga
BOMBAY 400 019 |
| g) <u>Kerala Sastra Sahitya Parishad</u>
Parishad Bhavan
Trivandrum 695 001 | h) <u>Federation of Medical Representatives Association of India</u>
General Secretary
IE Rajendra Nagar
PATNA 800 016 |

OXFAM publication on drug issues

Bitter Pills: Medicines and the Third World Poor
Dianna Melrose
OXFAM Public Affairs Unit
October 1982
£4.95

Medicines can cost the poor many times their daily wage. Many people do not have access to drugs which could save their lives. Yet in Third World countries sale of tonics and multi-vitamin preparations are high.

This report examines the relationship between health problems and the sale of medicines. It produces evidence from Oxfams field experience and calls for greater international control of pharmaceutical sales and promotion.

.....

The Great Health Robbery
Baby Milk and medicines in Yemen
Dianna Melrose
OXFAM (PAU), 1981
£1.30

A study of the tragic, frequently fatal, effects of the marketing of baby foods and medicines in the Yemen Arab Republic. The Yemen case illustrates a problem which exists throughout the Third World where Western manufacturers exploit new markets without consideration of the context in which their products will be used.

To get publications

Send current rupee equivalent of the cost of book/s by MO to OXFAM, South India Office, 59 Miller Road Benson Town, BANGALORE 560 046 - along with order.

BIODATA OF
Dr. Zafrullah Choudhary,
Director, Gonosasthya Kendra,
People's Health Centre
Savar, Dhaka, Bangladesh

BORN 27th January 1941

- 1964 Passed MBBS with Distinction in Surgery.
- 1965-71 Trained as general and vascular surgeon in England. Returned to Bangladesh to join the liberation struggle and helped establish the Bangladesh hospital for the War victims on the war front.
- 1972 Bangladesh hospital transformed to Gonosasthya Kendra, also known as the People's Health Centre, or the Savar Project, in Community health circles of which he was the Coordinator/Director.
- 1974 Awarded the Swedish Youth Peace Prize.
- 1978 Awarded the highest Bangladesh National Award — The Independence Award.
- 1982 Jan. Along with his team in GK organized an international Conference on "Transfer of Technology" and inaugurated the famous "GK Pharmaceuticals" producing reasonably priced, essential quality drugs - run by a cooperative.
- 1982 June As member of the "Bangladesh Drug Expert Committee" was instrumental in formulation and passing of the internationally acclaimed National Drug Policy - based in its entity on WHO's recommendations and concept of Essential Drug List.
- 1983 April Along with GK team organized an international workshop on 'Alternative Medical Education' to focus on the need for appropriate need based medical education for a third world country like Bangladesh. The aim being initiation of an innovative alternative medical school in Bangladesh. Both these conferences were also aimed at bringing together like minded groups and individuals from the third world together, for building mutual support systems for demands for Rational Drug Policies and relevant medical education.

Member British Medical Association and Bangladesh Medical Association.

Has contributed actively to international scientific and social journals - a few of the outstanding papers being, "Research-a method of Colonization", "Tubectomy by Para-professionals", "under the law in Bangladesh". "Essential drugs for the poor - a myth and reality in Bangladesh."

Gonoshasthaya Kendra
P.O. Nayarhat via
Dhamrai
Dacca, Bangladesh

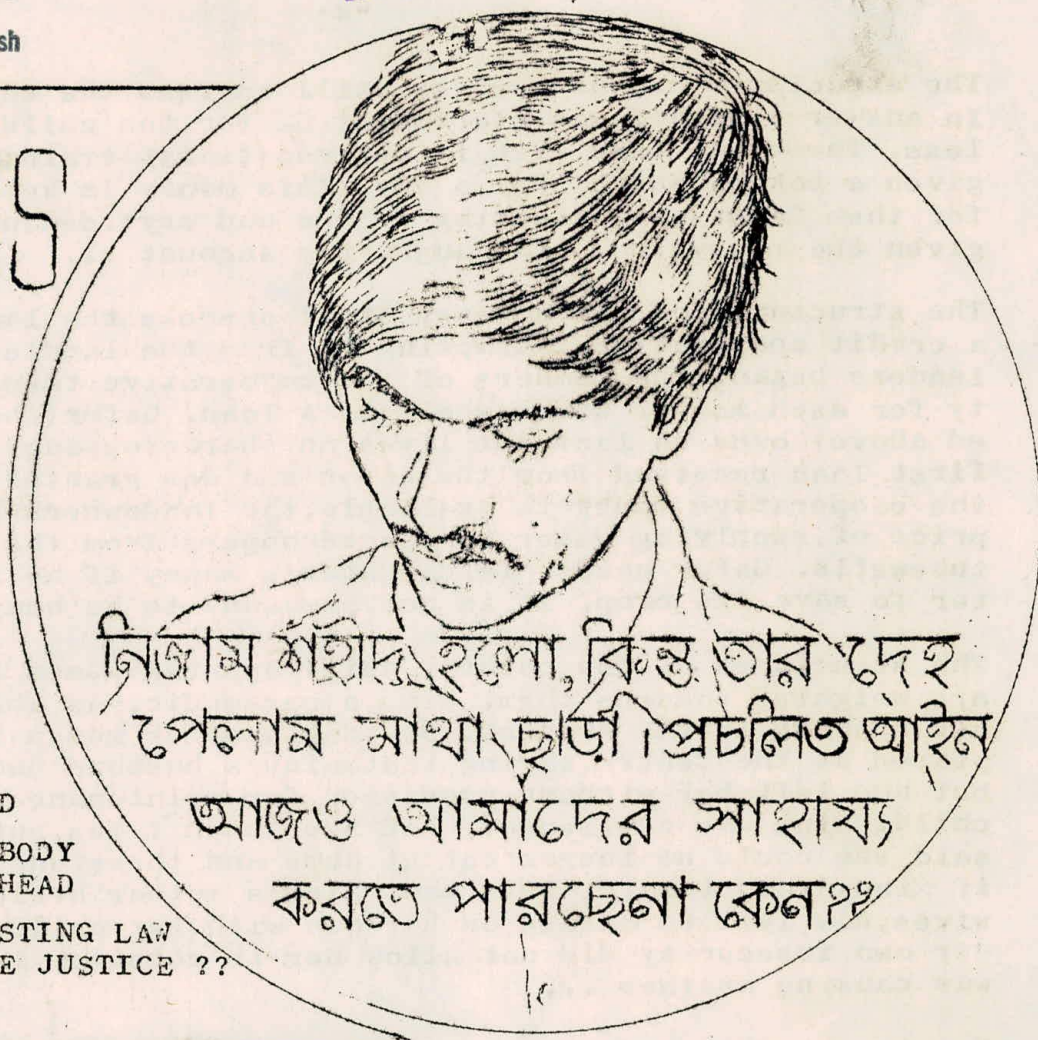
Voluntary Health Association of India
C-14, Community Centre,
Safdarjang Development Area,
New Delhi-110016.

PROGRESS

REPORT

NO. 7

AUGUST. 1980



NIZAM WAS MURDERED
WE RECOVERED HIS BODY
WITHOUT THE HEAD
WHY CAN'T THE EXISTING LAW
PROVIDE JUSTICE ??

DEDICATED TO:

THOSE WHO HAVE DIED FOR

and

THOSE WHO CONTINUE TO FIGHT ALONG WITH THE PEOPLE

INTRODUCTION:

Gonoshasthaya Kendra (hereafter referred to as GK) came into being with the birth of Bangladesh and its development cannot be separated from the life struggle of the country itself.

Since independence, Bangladesh has been the recipient of an increasing amount of foreign aid, while at the same time, the number of landless peasants has considerably increased. (1) The price of food has risen sharply. In a country where 70-80% live below subsistence, this does not mean denying oneself some delicacy, it means that there are millions of families who go one or two days a week without anything to eat. In an agricultural country, a farmer without land is a discontented man, but a man whose wages no longer buy enough to feed himself and his family, is a dangerous man.

The restlessness is on every side. No programme seems to succeed. The growing deterioration shows itself in increasing banditry (reported mainly in the Bengali language daily), in frequent strikes, rioting and in a general lack of will. Consequently, 30.5% of the total revenue budget is now spent to "maintain" law and order and "defend" the people !! (2)

GK's ideas and ventures have often been a response to different problems in the country as they came to be perceived in the course of its work.

The structures of the country still oppress the children of the poor. In answer a school was started at GK for the children of the landless. Those who take part in the vocational training programme are given a taka (about US 7¢) a day. This money is kept in an 'account' for them. Gafur came creating a 'hue and cry', demanding that he be given the money from his daughter's account ...

The structures of the country still oppress the landless. In answer, a credit cooperative attempting to free the landless from the money-lenders began. The members of the cooperative themselves stand surety for each man or woman who gets a loan. Gafur (the same man mentioned above) owns no land but lives on sharecropping. He paid back the first loan received from the co-op and was granted a second. Knowing the cooperative money is available, the landowners have raised the price of supplying water to sharecroppers from the "government" deep tubewells. Gafur needs his daughter's money if he is to get the water to save his crop. It is not pleasant to be hungry ...

The structures of the country still oppress women and GK's programmes are weighted towards them. Minu, a paramedic, was able to get work for her husband in the Project. One day another woman and her child appeared at the Centre, saying that Minu's husband had married her first, but had left her without provision for maintenance for herself and child. Minu was challenged. Had she known? Yes, but her mother had said she could no longer eat at home and threatened to commit suicide if Minu did not marry this man. Minu's mother herself, is one of three wives, now left to manage on her own with her children - all girls. Her own insecurity did not allow her to consider the insecurity she was causing another ...

Yes, the structures of the country still oppress, and it seems that each solution GK attempts has a built-in flaw, but the attempts have not met with failure - only difficulty after difficulty, sometimes causing frustration to mount very high. That is why there are moments when we wonder about the validity of the work - about the risk.

HEALTH PROGRAMME:

More villages were included in the intensive health programme during the last 2½ years. Mirerchangaon sub-Centre began functioning (see Progress Report No. 6) and the village-based health worker was introduced. Previously workers served the villages using either the main Centre or a sub-Centre as their base. During this period the village-based approach was added whereby the worker stays in his/her village home, providing health services from there, reporting in at intervals to the main or sub-Centre.

The Village-Based Worker: 14 paramedics began to work out of their village homes, and this has resulted in a closer relationship between the resident worker and the villagers. Three of these paramedics resigned when they realized village-based work was not an extended holiday. They came from middle-class background and as such, felt that by staying in the village, their prestige was somehow reduced.

Even with the 11 remaining village-based paramedics, the interest and enthusiasm displayed when they were working from the main Centre was lacking, but with increased supervision this was remedied. The environment, life-style and experience of group living are elements of the main Centre which exercise a strong attraction. However, those who have been based in the village for over a year have found satisfaction being involved not only in health care, but also agricultural and educational work, thus bringing new inspiration to themselves and the villagers.

Sub-Centres: There are still only four sub-Centres in operation, but the population/area they cover has been increased. Each sub-Centre has two beds for emergency patients and facilities for minor surgery including tubal ligation, menstrual regulation, etc.

Based on the concept of a community centre, activities are aimed at drawing the villagers into active participation in various programmes - health, agriculture, vocational, educational, etc. A combined staff of 22 health workers operate out of the four sub-Centres - 12 boys, 10 girls, providing services to people in their homes in the surrounding area.

Sub-Centre staff are encouraged to use their initiative in implementing their preventive programme. The paramedic-in-charge of Jorun now has her team giving health/nutrition instructions in three nearby Government primary schools every week.

We are in the process of looking for land for two more Centres. With our basic theme being the establishment of a 'community centre', a previous criteria has always been that the people of the area donate the land for the Centre themselves. Experience has shown that unfortunately, the rich man is usually the one who donates the land to his advantage and the subsequent disadvantage of the poor whom we really aim to reach with our services.

This is well illustrated with the example of Mirerchangaon. The donor of the land for this sub-Centre has 16 acres of arable land (he actually belongs to the country's 10% of very rich farmers who usually have more than 50 acres, but they have transferred the title deeds to their wives, sons and other relatives to comply with the law), plus a jack-fruit orchard from which he earns over one-hundred thousand taka annually selling fruit. He has 3 wives, who along with his brothers and other relatives, own almost the whole village and as such, virtually control the whole community since the landless are dependent on him for their livelihood.

When construction was being done on the mud-houses for staff quarters and clinic area, he attempted to force us to purchase earth from his highland, though earth was being offered free of cost by another party. He next requested a tubewell free for the exclusive use of his family from our village cooperative tubewell programme which is meant to be exclusively for the poor with 20-25 families sharing one tubewell.

The power struggle was well and truly on with this man making it extremely difficult for the staff to deliver services to the poor. He wanted his children's tutor appointed as paramedic. When this failed, he embarked on a course of harassment trying to obstruct the paramedics work, being especially rude and aggressive towards the girls. To this purpose he used the poor village men, telling them that unless they did as he told them, they would have no land to work. With the memory of Nizam's fate still very strong in their minds, many of our senior paramedics are reluctant to remain under this strained situation and we have had to change staff several times. We are however, encouraged by the fact that as a result of our presence, some of the village people do speak out occasionally at village meetings.

Seven years ago, tired of the tyranny, a group of local school students beat this man and burned his and his relatives houses in protest against his oppressive measures. However, he continues to thrive on his 'steam-roller' rule in much the same way as the Union Chairman described in 'Under the Law in Bangladesh' (previous GK publication).

Though Panishyle and Jorun sub-Centres have also had difficulties, they are not of the magnitude of what has been faced in Mirerchangaon. There is hope that, if these poor families can see that we offer some alternative to this 'one-man rule', they will themselves organize to protect the Centre and its staff in their own interests.

On 27 July 1979, there was a dacoity in the Panishyle Centre. 10-12 dacoits came in the middle of the night apparently to take the cycles and Narikendra sewing machine, these being the only valuable items in the Centre. Because of the spontaneous, large-numbered response of the villagers on hearing the first cry from the Centre, nobody was hurt and the bandits got nothing. For two weeks following the incident, the villagers guarded the Centre to boost the morale of the workers. Villagers later caught 2 of the bandits and handed them over to the police. They were subsequently bailed out, free to roam at large, enjoying life in much the same manner as those responsible for Nizam's murder.

Insurance Scheme: Our new health insurance programme is gradually expanding. In our last Progress Report, we mentioned having modified the old scheme. The new method divides the service population into three groups of people, according to economic condition. The first priority group is those families who cannot afford, from any source, two meals a day throughout the year for family members. The second group is those who have up to 5 acres of land (not necessarily arable) and the third group includes those who have more than 5 acres of land.

The members of the first group receive registration card free and pay 50 paisa (about US 3¢) per patient/visit. Other charges such as pathology, operations, x-ray and admission are included in the 50 paisa.

For members of the second group, the registration card is 12 taka and 10 taka/year for renewal. They pay 2 taka per patient/visit and also bear the subsidized cost of other services.

Members of the third group registration charge and renewal is the same as for the second, but they pay 5 taka per patient/visit as well as bearing the cost of other services at a higher rate than does the second group. This system assures that the poor will get health care at a minimum cost, which is our main concern. In 1386 (April '79-'80) 47% of the recurrent expenditures of our health programme were met by insurance fees.

Preventive Service: Preventive medicine (vaccines, etc.) is given free to all. Most villages in the Project area have less than 60% coverage of BCG, DPT and Tetanus immunization, but a small number of paramedics have reached 70% in their work area.

All sub-Centres do not have facility for storing vaccines. At Shimulia and Panishyle we have our own kerosene refrigerators while in the other two Centres we take advantage of occasional refrigeration facilities of the nearby Government agriculture centre. However, these are not always in good functioning condition. This means that the paramedic must then cycle to the main Centre (in one case 18 miles one way) to collect the vaccines and then return them at the end of the day. Another problem affecting the vaccination programme recently has been the frequent change of workers. Our paramedic training programme is highly regarded in the country and at least 20% of our workers leave GK annually to work in either Government or private organizations. The programme was also hampered for quite a while due to shortage of vaccines available in the country.

Our Tetanus immunization of women in child-bearing age has met with difficulties (see Bhatsala section of this report). In one survey area where we had 1115 pregnant mothers, there were 14 deaths from neonatal tetanus. Of these, 2 expectant mothers had had 2 doses and 1 had had 1 dose of tetanus vaccine. The vaccines were not expired and according to reliable studies, even one dose should protect mother and child. This is confusing to health staff as well as villagers.

However, we continue to keep close records on all pregnant women with a special programme of visiting those at risk. They are checked in

the village for blood-pressure,urine, signs of anaemia, toxemia, oedema and advised accordingly. 146 cases of eclampsia and delayed/difficult labour were referred by the village midwives for hospital management last year. Of these, there were 11 deaths.

Over population is a manifestation of poverty and therefore family planning cannot be isolated from other social and economic problems. In our insurance area, 25.4% of married couples are active users of modern methods of family planning such as Depo-Provera injection, pill, menstrual regulation and sterilization. Equally important are the traditional methods of withdrawal, abstinence and breast-feeding which account for another 10-12%. Consequently our growth rate is one of the lowest in the country.

Sterilization and menstrual regulation are done almost exclusively by our paramedics with a failure rate of 0.26% and 1.7% respectively. Menorrhagia has proven a major delayed complication of tubectomies.

It has been our observation that villagers are using abortion as a method of family planning far more than we (or planners) realize. Last year 76 cases of incomplete abortion were admitted to our sick room. Over 80% of these used herbal sticks while the remaining used quinine and hormonal preparations, etc. During the past year we had no prostaglandin so most cases in their second trimester were refused. In a few selected cases, we used the catheter method.

Since beginning the use of Depo-Provera at GK in 1974, we have had 7,358 acceptors. This was to test the suitability of the drug for Bangladeshi women. During the period of use, our findings were consistent with the observations reported in the British Medical Journal of "menstrual chaos" (3) and in just the past eight months, we had 11 cases of severe P/V bleeding which actually required hospitalization. One of these needed blood transfusion and subsequent hysterectomy. However, histologically, the tumour was found to be chorian carcinoma.

We became worried by some of the questions raised by Steve Minkin regarding immuno-suppression and effects on child growth in Depo-Provera users (4). Also to date, there have been no scientific studies done measuring the prolactin to decide the issue of increased/decreased lactation in these women.

With no clear answers on these questions and in view of Bangladesh Government's decision to start a national programme (as a result of international aid pressure) in which there are bound to be abuses, a meeting of our health workers in mid-November 1979 decided to stop Depo-Provera in the Project area.

By withdrawing this method, we don't know if we have helped our women or not. Despite the various side-effects, they still prefer Depo-Provera to the pill or IUD whose complications they must now face. Because of past mis-use and no follow-up care with the IUD, there is tremendous resistance to this method. However, we are trying to re-institute its use. Despite insertion in the main Centre under sterile conditions of 27 coils, there were 4 complications with 1 having to be removed.

Curative Service: In 1386 (Bengali year) a total of 66,948 patients were seen in our out-patients clinic (this is excluding treatment given by paramedics in their village work). 1,090 were admitted to our sick room giving a bed occupancy rate of 97.4%.

In spite of our concentration on Group 1 insurance card holders, they haven't taken proportionate advantage of our clinic services. Traveling to clinic and waiting to be seen, etc., takes up several hours of their working day which they simply cannot afford. However, they account for 30% of our sick room admissions, indicating they come for treatment only when they can't work any longer.

The socio-economic oppression of women is leading to increased incidence of attempted suicide with insecticides in our village society. Last year we admitted 24 cases. Since the oppressed have no 'right' to revolt or take their lives, but only to suffer in silence, every suicide case must be reported to the legal arm of the oppressor, the police. Therefore our statistics represent only a small number of the actual incidence.

The following is a breakdown of some admissions to our sick room (1386). The large number of admissions from 'outside-Savar' is due to the fact that the thana boundary is only ½ mile from our Centre.

	<u>Poisoning</u>		<u>Diarrhoea</u>		<u>Tetanus</u>	
	<u>Admissions/Death</u>	<u>Admissions/Death</u>	<u>Admissions/Death</u>	<u>Admissions/Death</u>	<u>Admissions/Death</u>	<u>Admissions/Death</u>
Savar Insurance	10	1	50	5	9	4
Savar Non-Insurance	2	1	6	1	2	1
Outside Savar	12	3	25	2	9	2
Total	24	5	81	8	20	7

	<u>Abortion</u>		<u>Eclampsia</u>		<u>Preg. Problems</u>	
	<u>Admissions/Death</u>	<u>Admissions/Death</u>	<u>Admissions/Death</u>	<u>Admissions/Death</u>	<u>Admissions/Death</u>	<u>Admissions/Death</u>
Savar Insurance	24	-	12	-	11	-
Savar Non-Insurance	15	-	7	4	5	-
Outside Savar	37	1	18	6	10	1
Total	76	1	37	10	26	1

Water and Sanitation: Water, considered a 'natural' element by most, is unavailable to many in rural Bangladesh. Drinking water is mainly from wells, tanks and rivers which are usually contaminated. There are an estimated 633,000 acres of land lying in derelict ponds throughout the country.

Our lobon-goor sorbhat (common salt and molasses) programme has reduced the death rate from diarrhoea among children, but not the incidence of diarrhoea due to the absence of clean water and sanitation facilities. In our effort to supply both clean water for consumption and increase production of fruits and vegetables around the house by irrigation, the hand-pump tubewell programme came into being as part of the agriculture extension.

In liaison with UNICEF, Government has given hand-pump tubewells to many villages. However, the majority have been situated on the rich man's property, resulting in limitation of its use. Also, no reliable provision was made for maintenance resulting in a common item in the Bengali daily papers being the fact that a large number are out of order.

In our programme one tubewell is to serve 15-25 families (none of these having either private or Government tubewells on their homestead). The tubewell is donated by UNICEF but the digging and platform expenses (not more than 500 taka) are borne by the family members the well will serve. A committee, made up of the various family members is responsible to see that 100 taka is deposited (and this sum maintained at all times) in either the bank or post-office for the maintenance of this tubewell. All who use the tubewell must contribute equally to this fund, otherwise we are likely to run into the same system we are trying to overcome of one (rich) person bearing the expenses and thus holding the power over who can use the water supply.

We provide a wrench and training for small repairs to one of the members and money for necessary spare parts is taken from their 100 taka fund. None of these tubewells are allowed to remain out of order for more than 48 hours except in the case of resinking necessitated by a shallow water depth. So far we have helped install 12 tubewells on the above conditions.

There is also a dilemma regarding the type of latrine suitable for village environment. Both the pit and the water-seal latrine have difficulties and limitations. The pit must be dug to the proper depth, otherwise it is merely a breeding ground for fly-borne disease. The water-seal type needs adequate (2 gal.) water for flushing and in most places this needs to be carried a considerable distance.

As far back as 1958, WHO reported the unsuitability of this type of latrine (" they are often used as chicken coops or grain silos") (5), yet UNICEF continues to promote its use in Bangladesh. Previously they used the concrete slab method, but more recently have imported 4,000 highly flammable plastic-type latrines. If they are going to continue using it, a better alternative would be jute-plastic which would be cheaper and more durable.

For the last 2 years we have been experimenting within our Project compound with a type of latrine which is commonly used in Vietnam (6). The purpose of this type of latrine is to make use of human excreta as a manure fertilizer. The object is to keep the waste matter dry, adding ash and leaves to the box contents at the end of the day to create anaerobic conditions. When properly done, this waste becomes black in 3-6 months and can be used as fertilizer. However, if dry conditions are not maintained during use, the box fills with maggots and flies. We have used the manure from two of our latrines in our agriculture fields this year for growing vegetables with good results.

We have 8 such latrines in our Project, situated in such a way as to be utilized by a variety of workers and we have observed the maintenance of the latrines is according to the health consciousness of the various workers. The main problem lies in the cultural tradition of using a good deal of water to wash the buttocks. With this latrine, the cleansing cannot be done over the same hole where defecation has taken place. Our experience is, a good bit of health education is necessary for people to understand the principles involved in the use of this latrine.

The Chinese have adopted a modified version of this latrine (7) which may become the ideal for use in rural villages. We plan on introducing a modified version of the Vietnamese latrine into the villages where our extension co-ops are operating. Sanitation has to be done in conjunction with water supply. We feel the ideal programme will be to provide a hand-pump tubewell within a few yards of whatever form of latrine is used, otherwise a truly hygienic situation will not exist when carrying water great distances is involved.

TRAINING PROGRAMME

Some years back GK began to consider the possibility of utilizing its staff, buildings and health programme as a field practice training centre, the intent being to bring greater relevance to medical training in the country. It was not until 6 May 1978 that the Syndicate of the University of Dacca finally approved the programme and due to further delays originating in the Institute of Post-Graduate Medicine, alternative programmes involving groups ranging from illiterate grass-roots workers through graduate physicians holding Government posts were inaugurated.

I.R.D.P. Co-Operative Health Worker: 303 thanas (an administrative unit comprising 150,000-300,000 population) are under Government's Integrated Rural Development Programme (IRDP). 28 of these have women's co-operatives. One course was designed (8) to train 120 women of these co-operatives from 12 thanas. At completion of the course they were to act as health workers in their respective villages.

The first programme began in August 1978 with 10 women coming to Savar GK and 10 to Bhatsala GK (our Project in Jamalpur) for an initial one months training period. Instruction during this time included general health with emphasis on maternal/child health and the treatment of four diseases commonly found in Bangladesh villages - worms, scabies, diarrhoea and simple fever. On completion of this months training, the women returned to their villages for 5 months to put into practice what they had learned. During this 5 months they were evaluated by a team of GK staff, usually 2 paramedics, or 1 doctor and 1 paramedic when this was possible. The object of this was to see how much the women retained, to identify the particular problems they had to contend with and arrange the subsequent training accordingly. It was encouraging to note that though 54% of these women were completely illiterate, they retained 80% of the material they had been given.

Returning to the Centres for a further months instruction period there was review of what they had been taught previously as well as introduction of 2 more common diseases. This was again followed by 5 months in their villages. The third and final months training was then given in the various sub-Centres. Familiarization with the vaccine programme as well as another 2 common diseases were incorporated into this period.

Most trainees were married women between the ages of 17-50 with a mean average being 31 years. They had 0-8 living children (average 3). These women were enthusiastic about the training and about learning to ride bicycles. This indicates that given time, certain orthodox social barriers may be broken.

Needless to say there were problems to contend with. In the process of selecting which women would receive training, it was again the families of position and power who dictated. They realized the relatively substantial training period attached to the work gave it a certain importance and prestige and there was also the small remuneration to be borne in mind. Consequently they promoted candidates who, though more obscure and oppressed in the villages, were nonetheless often their relatives.

There was also a reluctance on the part of IRDP's supervisors to go into the field to do their supervisory activities. They (supervisors) had only one week's training for the entire women's programme and usually gave priority to interests other than the health programme. A lack of interest in and understanding of, the problems facing these trainees can result in serious problems. Such was the case of one young trainee from Gopalganj thana.

Rumours were started to discredit her moral standing in the community which finally led to the Advisor to the Women's Programme from Dacca undertaking an investigation to find out the actual facts.

The IRDP worker, Nurjahon was a lively, outgoing young woman from a poor family. Her father was an old man and there were no brothers to earn wages to keep the family. Nurjahon had been married to a day labourer from the local mill who was eventually approached by his foreman with the proposition to marry his (foreman's) daughter in exchange for an assurance of a permanent job. Naturally this meant leaving Nurjahon and her two children on their own and she, as the woman, was immediately presumed guilty. "If her husband left her, she must be a loose woman". To supplement her IRDP volunteer work, she found it necessary to obtain paying employment. Because of her training, she was able to get part-time work in family planning. Unfortunately, the IRDP Project Officer regarded this as something a 'respectable' woman would not be doing. Neither had Nurjahon taken her 'permission' for work other than IRDP.

When questioning the village elders as to Nurjahon's behaviour, they informed us that not only did she not wear her sari over her head, she didn't even step off the road for them when they were passing her! Apparently her experience at GK had led her to believe that they also might give way sometimes.

The facts of the case then were: Nurjahon was poor, her husband had left her with two children and she was doing family planning work. However, because she was poor, she should have been cow-toeing to others and in defending herself, became a 'loose' woman.

Eventually her innocence was proven (9), but undoubtedly she will retain her 'title'. Thus a programme designed to liberate women seems to have brought further oppression, setting them against one another. This will surely not be an isolated case in the annals of IRDP and who is going to travel the country investigating and rectifying even the relatively few instances reported?

The question was raised at one GK staff meeting 'who does the IRDP really benefit?' Sadly enough, "... it (IRDP) does little for the landless and near landless who comprise nearly 50% of the rural population" (10), seems to be a quite accurate response.

Medical Students' Field Programme: A further training was offered to the undergraduates of three Medical Colleges in groups of 12-15 (curriculum available at GK). Initially the Health Ministry, which has close control over medical education, did not include female students for fear that they "wouldn't be able to manage life in the villages". However, at our insistence they were included in the 10 day period (which we felt to be frustratingly brief).

In the mornings, students made visits to the villages and interviewed people regarding their health problems. Afternoons were spent discussing the visits and possible methods of treatment for common diseases. At the conclusion of the course, each group was of the opinion that the education they were receiving in Medical College is not designed to equip them to deal with the diseases of rural Bangladesh. The 15 groups who did the course, have since established study circles at their respective colleges. One particular group challenged the idea of the annual 3-week tour of establishments in the country which is part of the college curriculum (usually found to be an extended picnic). They suggested that instead, students be divided into small groups and spend the entire period in an area of the country which had a specific health problem, such as the tea gardens, mills, etc., coming together later for an exchange of experiences. However, their idea was not accepted.

Though the curriculum had been submitted before the course started to the Health Ministry, once the programme was completed, complaints began arising from the teachers of the Medical Colleges. Students, they said, were asking too many questions. Initially, some of the students also complained of being 'brainwashed' by the GK training staff, though this 'brainwashing' consisted of nothing more than a realistic exposure to

the health situations of their own country - who receives treatment ? who cannot receive it ? why ? Does the background of medical students make their effective involvement in change impossible ?

The training formally started on 28 October 1978 with the following number of fourth year medical students involved:

Dacca Medical College	51 male	28 female
Rajshai Medical College	31 male	19 female
Salimulla Medical College	29 male	10 female
	<hr/>	<hr/>
total of <u>168</u> students	111 male	57 female

Post-Graduate Doctors Field Programme: From February through May of 1979, the field practice and dissertation section of a course leading to a Diploma in Community Medicine was conducted (curriculum available from GK). The course itself is run by NIPSOM (National Institute of Preventive and Social Medicine). 10 graduate physicians, some health administrators, others clinical medical officers in hospitals, attended. They came with the impression that by studying material available in our library, previous case studies on rural health in Bangladesh and interviewing our health workers, they could fulfill their research work/obligations. Using this method, they could commute daily from Dacca. However, after discussion of methodology, etc., they realized the value of remaining in the Centre and working out of it to obtain their information. The first week, they found the life-style of the Project difficult to adjust to and 2 actually left. The rest persevered. In the introductory week they were taken to the villages to become acquainted with the situations there. After this, they discussed their possible choice of thesis topic with Dr. Colin McCord, Dr. Qasem Chowdhury, and others responsible for the GK section of their course. Mornings they spent collecting data from the survey areas and evenings discussing health needs of Bangladesh.

As a whole, these post-graduate students found the course useful, but if it is to result in more than an award-giving ceremonial, adding another paper to their 'qualifications', the Health Ministry and those directing the course at NIPSOM must be convinced of its value so they can be supportive in following up and translating what has been learned into practice.

It was agreed before-hand that the NIPSOM Professors would spend at least 1-2 days with the students both here at the Centre and accompanying them to the village. However, only one or two Professors actually ever came and this only for a few hours one day. This is probably due in part to a lack of interest and partly to low teaching salaries forcing them to take on private practice in the afternoon/evening. It seems imperative that if a programme of this type is to be successful, the teaching doctor must receive a salary enabling him to devote his full attention to that one job.

Having seen the fate of the first group, only 2 students of the same course for 1979-80 are training here at present and will be with us for four months. Students pursuing other courses at NIPSOM are coming for variable periods to get experience in specific areas.

UNICEF Health Workers Programme: In a recent seminar, one senior Bangladesh Government official rather sarcastically remarked that thanas are rented out to International Agencies for 'development'. So, UNICEF is working throughout the country in 20 district-level offices. In connection with their nutrition programme, 40 workers, selected from 20 villages were trained to provide primary health care in addition to nutrition education. These trainees, mostly young men of middle-class background, came in groups of 20 and were given a 3 month training course from May to November 1979. UNICEF is carrying out the supervision of their work and GK is not involved.

To link up with the health/nutrition programme, 16 traditional midwives from the same villages as the UNICEF trainees have just completed a training course at the Centre. 50% had never attended a delivery in their life (see Table below) which fits with the UNICEF tradition of so-called TBA (Traditional Birth Attendant) training in the country.

<u>Number of TBA</u>	<u>Total Number of Deliveries</u>
8	nil
2	less than 20
6	more than 20

For the last year the Health and Family Planning section of UNICEF has been conducting training with the allurements of special "dai" (TBA) kits, expensive colour brochures and an allowance. As we were aware of the fate of UNICEF's past training programme (1960's), we gave our unsolicited opinion of what was likely to happen with this approach. Unfortunately, they organized the programme in such a way as to include the rich man's wife and daughter who are often more concerned with dressing well than with the service they are to deliver. When this happens, we ask ourselves, 'what are organizations like UNICEF, who have a universally respected reputation, really working towards in our country?'

Adequate and appropriate reference material to fall back on is also an important part of any training programme. In this respect we are indeed indebted to Dr. Jack Lange of Lange Publications, Dr. Charles Spencer of Australia and Inter Pares of Canada for their generous contributions to our medical library.

NARIKENDRA - CENTRE FOR WOMEN'S VOCATIONAL TRAINING

When GK's vocational training programme began, we decided that one unacceptable argument would be that which depicts women as creatures with greater limitations than men. Narikendra activities are based on a simple philosophy that includes fundamental literacy classes and other teaching in broader terms which can help them understand the causes of their own underdevelopment and what to do to bring about change. Unless this happens, they will still be tied to a male-dominated, class society. Now, with the programme well underway, the young women involved in our Narikendra have proven themselves to be equally capable with men in all work, manual and mental. The many visitors who have come as unbelievers filled with traditional arguments in regard to women's work, have gone away with a new perspective and hope.

With the growing Government policy of exporting skilled labour, Bangladesh is gradually finding itself in need of craftsmen. Narikendra has capitalized on this need and initiated a number of training programmes with primary emphasis on young women. These include a metal-working shop, carpentry, sewing (still much the field of men in Bangladesh), shoe-manufacture and a bakery.

Gono Shilpalaya (People's Workshop): The metal workshop has 22 trainees - 17 female and 5 male. The trainees are classified as skilled and unskilled. Skilled workers can cut, straighten and weld. They are also able to understand the drawings enough to follow the measurements, etc. themselves. In short, they could earn money with the skill.

The workshop has been supplying the nearby army Cantonment and Atomic Energy establishments with various construction items. Now our workers at the monthly meeting have questioned the validity of this, but the workshop staff felt their own needs - the possibility of contracts meant work, pay and further opportunities to perfect their skill. They were not secure in the belief that more work would come if this was turned down, so continued - probably using the same logic that allows a landless sharecropper to work for the oppressive landlord.

The staff can produce for competitive marketing: hospital beds, simple operation tables, revolving chairs and pipe frame chairs, electrical junction boxes, window frames and grills, steel racks and certain agricultural implements.

For the successful transfer of technology from our Centre to the village it will be necessary to have the workers exceptionally well trained and this takes time. It is one thing to learn a skill well, but another to run a competitive business. Therefore the expansion of our workshop programme has been deliberately delayed to assure that the workers, once fully competent in their trade, will be able to face competition in the open market.

There are a number of polytechnical schools located throughout the country. However, since their funds to purchase materials for practical work are very limited, the curricula have become increasingly theoretical which makes it difficult to use these 'graduates' as trainees in our shop.

For the expansion of industry into rural areas, even on a small scale, there will have to be a clear-cut Government decision in its support. While developing such, Government will have to give preferential treatment to the poor and find ways to involve them in management and ownership of these industries, otherwise any rural industrial programme will be simply another tool for widening the gap between rich and poor.

This will be picked up by aid agencies to stabilize the hold of the elite who, in the words of Alexander Hamilton (a founding father of the US constitutional government), "must maintain control over the 'turbulent masses'". At present USAID has initially committed 3 million dollars to a rural industries programme in Bangladesh. The beginning of the green revolution in a different shade?

Other Narikendra Activities: Wood-work was added to the programme in 1979 and is already growing. Now in 1980 there are 2 trainers with 6 girls and 1 boy training. 2 village women also come daily to learn this skill. The products include all types of wood furniture with the necessary cane work and finishing. We hope to expand this programme as skilled carpenters are badly needed and it could be a good source of earning for women.

At present the market for juteworks within the country is very limited and this unfortunately means we have to depend on foreign outlets. The future of jutework is at the mercy of Government and unless they promote cottage industries within the country itself, there is little chance of progress in this field.

In view of the above it is understandable that there is not always a demand for the jute products we could be producing and this in turn means less income for those skilled in this field. However, financial gain is not the aim of the programme being promoted and we have seen these women make great strides in other directions as a result of their exposure to Narikendra.

Amena, the daughter of a poor man, the wife of a callous, even cruel husband and the mother of 3 children came to Narikendra to find work. She was trained in jute handicrafts and sewing and received classes in literacy, family planning, health/nutrition and child care. She received a small salary. In the meantime her husband, a rickshaw puller, gambled his own pay, gave nothing to the household and beat his wife. Rather than crumble under this, the potential of Amena was realised. She decided to leave her husband and return to her father's. Since he is a poor man, she left her children in her husband's house, giving half her salary (100 taka) each month for their care and the remainder to her father's household.

One day Amena approached us to say that there were a number of women in her village anxious to receive training as she had. What could be done for them? The distance from the village to the Centre made it impossible

for the women to come to us, but we gave Amena the assurance that if she could organize and instruct them, we would guide and assist her. With this support, Amena proceeded. She now has 50 women in this group, training them not only in handicrafts, but also motivating them to self-awareness and self-respect.

In 1979 Amena with 22 other women of Dapushai village branched out into bamboo craft. Bamboo is locally available and, unlike jutework, also locally marketable. With GK backing, they started their own co-operative, running it themselves and marketing their own goods. The idea was thought crazy at first and some of the local men objected and tried to make trouble. However, those who were benefitting by the women's work banded together to take care of the trouble-makers. The bamboo co-operative is now a going concern with advance orders.

These women's paths will continue to be filled with obstacles for in this society they cannot move easily, but they are meeting opposition with courage and purpose.

GONO PADUKA (people's Shoe)

GK's shoe factory, a venture in rural industry, started in early 1978 as a joint co-operative of skilled workers. It was a response to 5 young men, skilled sandal-makers from Bhairab in Mymensingh District, approaching us for something different after having worked nearly 13 years in the trade. The joint co-operative between workers and GK Trust offered them the opportunity to become managers in their own business.

Oxfam(UK), through GK Trust, provided the initial capital and recurrent expenses. Once profits were forthcoming, they would be used 1/4 for repayment of the loan, 1/4 divided to the workers and the remainder back into capital.

Included in the programme was a plan to train 5 villagers, women among them, in the skill. These could be considered 'skilled' after a minimum of 2 years training and thus be eligible for inclusion in profit sharing.

A number of difficulties have arisen since the initiation of the programme. First we came up against the trade practice of retailers who, though quite willing to pay the given price for shoes, would only buy if the receipt recorded a smaller amount than actually paid. This was to evade Government excise duties. Gono Paduka workers felt we should go along with this accepted marketing (mal-)practice and found it difficult to accept when we did not. In an attempt to sell, we put a display shop outside the GK compound next to the Canteen. Though we can't claim any great financial success, it has spread the reputation of Gono Paduka!

Though they had agreed to train villagers beforehand, the workers found a problem in accepting girls as co-workers. Then too, these trainees meant a potential wider distribution of profits! There was also agriculture work, a must for all GK staff. Though they were all from agricultural backgrounds, they felt that possession of a skill lifted them above such 'degrading' work.

Another difficulty was in the type of shoe manufactured. Our aim has been to make an inexpensive sandal for a rural population. This also meant a market of limited spending power, while the workers were accustomed to producing a more expensive shoe for a rich, urban population with hopefully more profit.

Initial enthusiasm dwindled as these various problems presented themselves and solutions were not seen eye to eye. Eventually these 5 workers began to doubt if this was what they had intended. 3 left to find regular work elsewhere, a fourth, who was co-signatory of the bank account slipped away one night taking far more than his share of the funds. In spite of the odds, Gono Paduka is struggling on - destination uncertain at the moment.

GONO PATSHALA (People's School)

One of the reasons for the low rate of school attendance among children in Bangladesh (Government statistics say 40% never enrolled) could well be due to the fact that parents do not want to lose the valuable contribution that even little children can make to the home through manual labour, particularly by caring for younger family members and watching the family's animals. Like children of Java and Nepal (10a), Bangladeshi children spend up to 8 hours of their day in domestic activities, girls spending more time and starting younger, than boys. Often the four-year old is responsible for minding the two-year old as well as seeing that a fox doesn't harm the chickens. At the same time he/she may have to keep an eye on the rice that is cooking as the mother is busy elsewhere grinding spices for wives of rich farmers.

Our school began 3 years ago, selecting its students from among the children of poor and marginal farmers and offering a curriculum relevant to their needs (see Progress Report No.6). For each child who attends the school, a real effort must be made, both by the child and parents. Tasks that were being handled by the new student must somehow be picked up by another family member, but often this is not possible. So the child must manage to combine his family chores with his school work - carrying along to class a three-year old sister/brother, or collecting cow dung on his way back home. Reaching there, more jobs will be waiting. As the child gets older, tasks at home increase and the chance of having to leave the school is greater.

If we want these children educated (and their future and that of the country depend on this), we have to acknowledge that the time they spend at class is of value to their economic situation and must be compensated for. Therefore their lunch is provided as well as a nominal remuneration to those engaged in vocational training.

At the school, classes are held 5 days a week instead of 6 as at the Government schools. This is so teachers may spend 1 day conducting classes in the villages. Older students are also obliged to hold classes in the village for those who cannot come to the school site. Perhaps this is an indicator of the form that the school will gradually assume - the building may serve as the initial training ground with some students staying longer than others, while the village becomes the accepted site of a regular school programme.

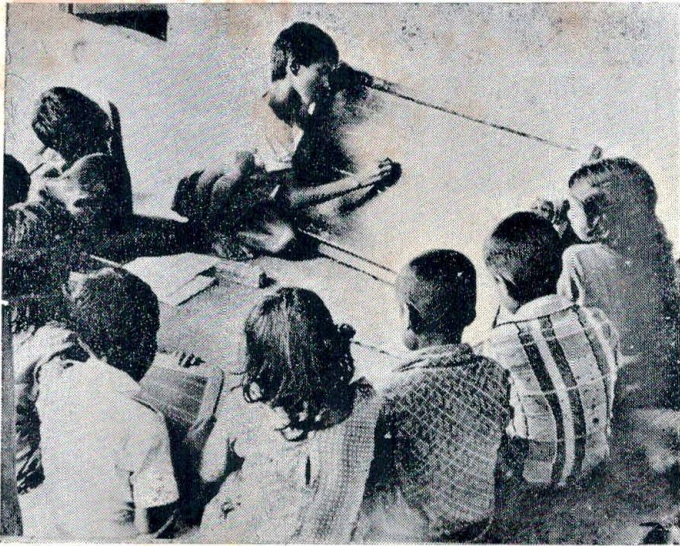
The philosophy from which the school operates is one of educating the children for their own community. At the school, individuals are members of a group and proceed at the pace of the group, helped by it when they drag behind, or helping if they are ahead.

The school is specifically for the children of the landless and marginal farmers who otherwise have no opportunity for education. Because of this, admission was refused to the children of the wealthy families in one village in the area. When refused, they put economic and social pressure on the families of the poor whose children were attending, resulting in 7 having to stop coming. Why do these rich families want their children to attend when they know well the only participants are of the poorest class, they must all do agricultural work, eat together and the classes are not run on a formal graded system, but functional basis ?

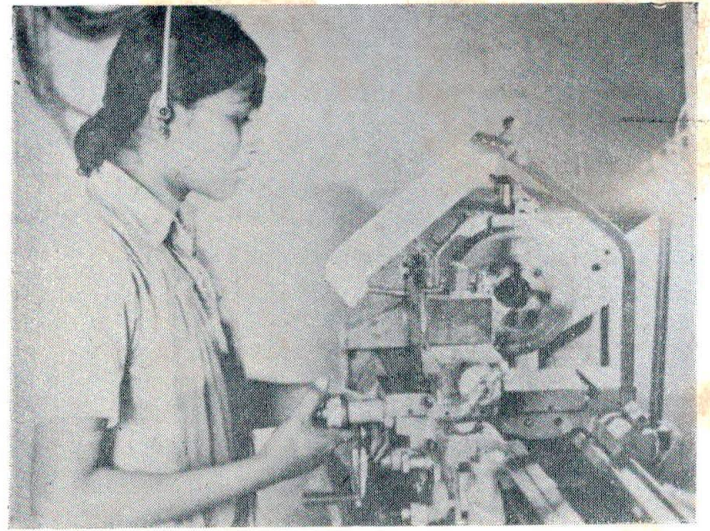
All Government schools are controlled centrally from Dacca rather than locally. This results in very poor teacher-attendance as no one bothers to check what is happening. So, Gono Patshala, with all its seeming drawbacks, does at least have the attraction of teachers on the job.

10-12 year olds in the school are introduced into vocational training for 2-3 hours per day. Presently 4 are in carpentry and 6 in metal works. After 2-3 months training, they are capable of doing effective/productive work and this is acknowledged by a small remittance which is kept in their own savings fund.

DECADE OF WOMEN

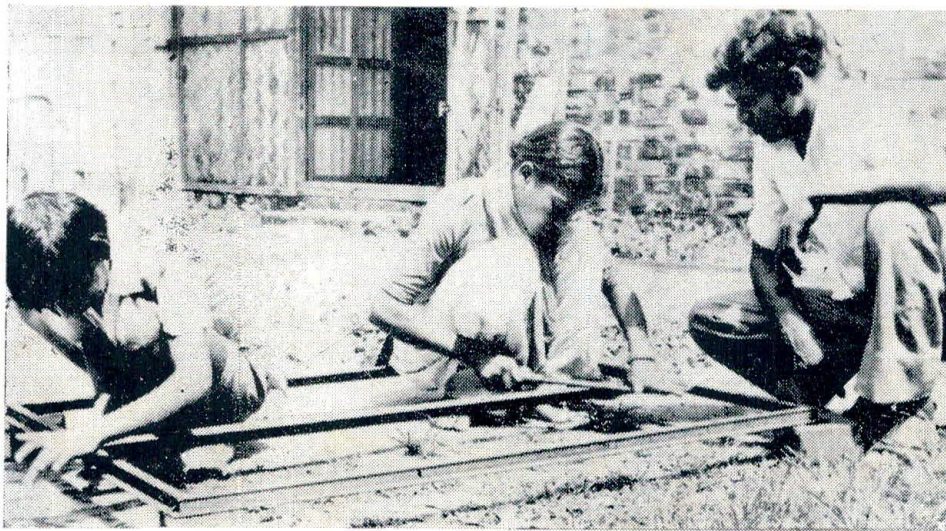
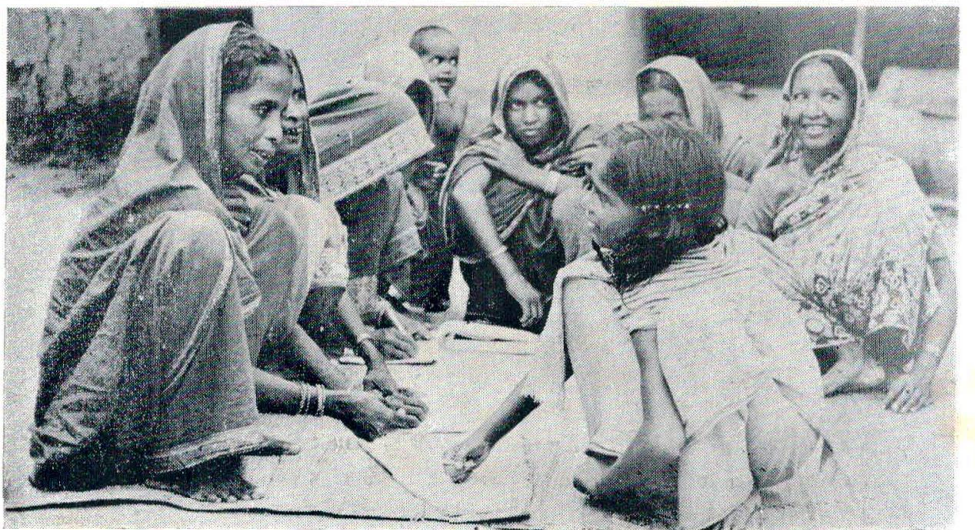


Students help each other

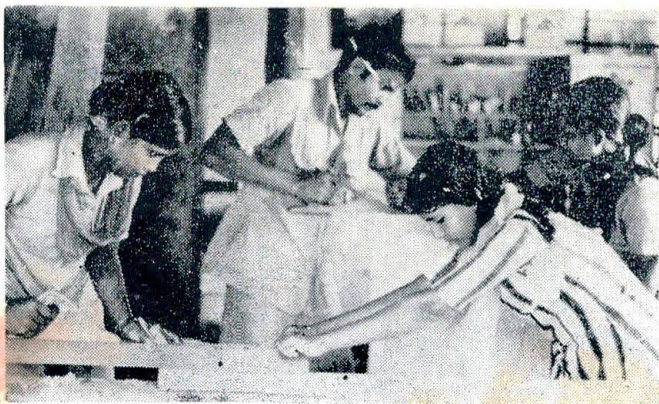


Skilled worker of Gono Shilpalaya

Literate child shares
with mothers



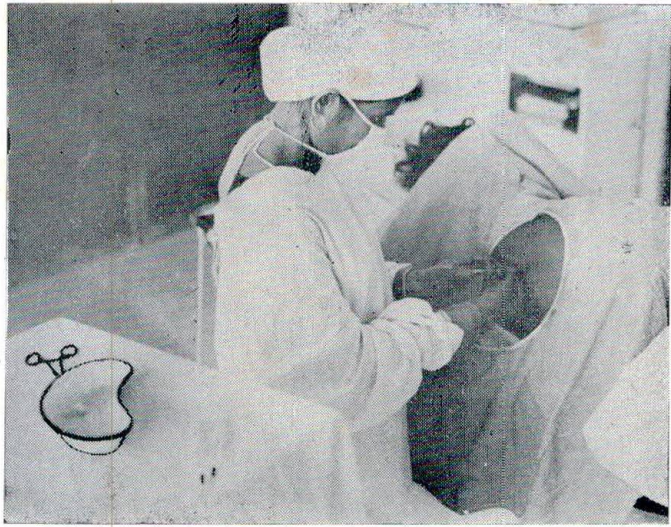
Vocational training as
part of Gono Patshala



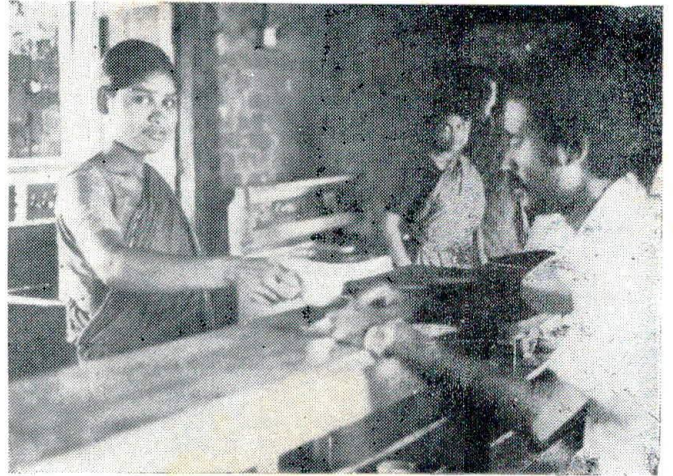
Narikendra girls at work



Passing on health education



Paramedic giving spinal anaesthesia

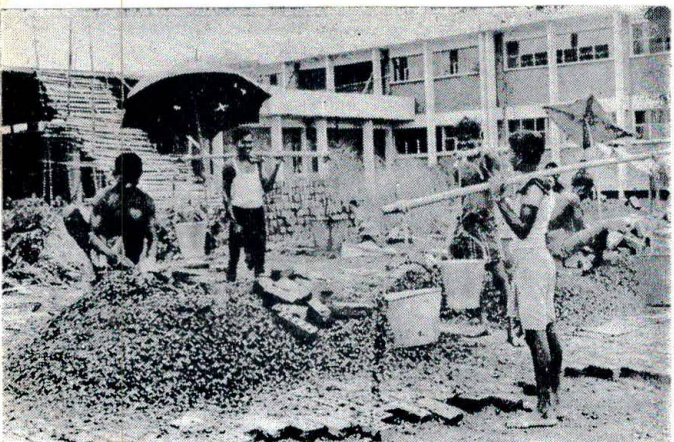


Our Canteen is also staffed by girls

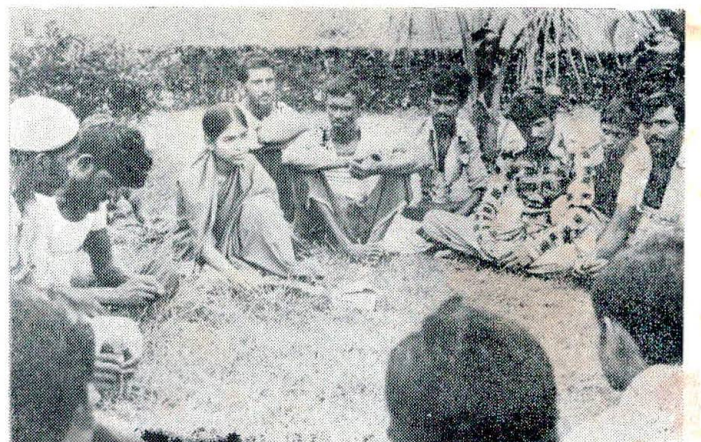
Depashai bamboo
co-operative members



Gono Paduka
"struggles on"



Groundwork for fight against drug exploitation



Agriculture extension meeting

Another project they are engaged in is poultry breeding. Foreign bred hens, while laying more eggs, need special food and are less disease-resistant than locally bred. The children are presently using an 'Austro cock with a locally bred hen. Eventually these birds will be 25% foreign-75% local breed mixture which, while having an increased egg production of 30-50%, will still be able to live on local feed.

The children are taking the new chicks of about 12 weeks home to raise on the condition that when their chicks hatch, they will return 2 to the school for other students. This also encourages in them a spirit of co-operation which is so essential in village life.

To date the school has had 218 admissions with 46 drop-outs, detailed in the following Table:

1384-1386(B.S.) April 1977 to April 1980	Total Admission		Continuation		Drop-Outs			
	Boys	Girls	Boys	Girls	4-8 years age		9-12 years	
					Boys/Girls		Boys/Girls	
	103	115	89	83	1	6	13	26
Total	218		172		7		39	

Land Holding of Continuers and Drop-Outs

	Continuers (172)	Drop-Outs (46)
No Homestead	14	5
Homestead only	81	29
Under 50 decimals *	47	6
51-67 decimals	15	4
67-100 decimals	10(2 from Project)	2
Over 1 acre	5(all from Project)-	

* 100 decimals = 1 acre

Fate of the Drop-Outs

	Boys	Girls
1. Care of domestic animals, firewood & cow dung collecting, looking after home & small children	2	17
2. Became servant	8	1
3. Day labourer/assistant	3	-
4. Watering paddy in the rice husking mill	-	3
5. Got married	-	3
6. Working in Narikendra	-	4
7. Miscellaneous activities	1 *	3
8. Death	-	1

* working as a cowboy at GK

In spite of dropping out, 17(5 boys and 12 girls) still continue occasional classes in the village and are in touch with the school. Another 4 girls working in Narikendra attend functional literacy classes conducted for GK staff.

The school links up with problems/struggles of the daily life of these children. Ours is a pilot scheme going on with an as yet, unwritten curriculum. We are still using standard textbooks which in sections are quite irrelevant. The writing of our curriculum and textbooks is now important as there is an interest in the system in the country. However,

one of our main difficulties has been in attracting and holding teachers capable of working with this new approach. 16 have come and gone since the school's inception. Since the school itself seems determined to succeed, we have hope that this difficulty will, in time, be rectified.

GONO KRISHI KHAMAR (People's Farm)

85% of the people of Bangladesh make their living on agricultural pursuits. It is therefore, not an exaggeration to say that the fate of the country depends on agriculture and for this reason, agriculture continues to play an important role in our development activities.

The relation between the land owner and the producer is a main source of conflict and any programme to bring about change cannot function without acknowledging this conflict. To understand this and participate in a transformation of these relations, is the basic aim of Gono Krishi Khamar.

Many fail to understand that agriculture is a highly skilled technology. The farmer (along with his wife and children's contribution) is extremely underpaid for providing this vital technology. We feel the only way for those not actively engaged in this task to understand to some degree the exploitation involved, is by a programme of minimal participation. This is the rationale behind the mandatory participation by all GK staff in the Projects internal agriculture programme. An additional aim is to try and develop new ideas for improving production and labour technique.

The Project cultivates HYV (high-yield variety) rice, vegetables, nursery seedlings and has 3 ponds for fish cultivation. Our average paddy (rice) yield over the past two years has been 51 maunds (27 maunds = 1 ton) per acre, but last years crop was not up to expectation due to draught.

A once green Bangladesh is rapidly becoming barren and we are trying to promote re-forestation. Apart from our own use, our nursery sold over 1500 seedlings to local farmers last year.

On an experimental basis at the Centre, we have 1 large and 2 small ponds for fish cultivation. We initially tried to cultivate Rumi fish in these ponds, but with frustrating results. After consultation with the Fisheries Department, we are again trying to raise Rumi and Migel species. Neither has our production of Nyloica fish been up to expectations. We are now trying to cultivate Nyloica fish and paddy in the same field. More than 1/3 of our land, due to the level it lies at, is suitable for only one crop a year. However, if this land is dammed up, it can be used during the rainy season for a second rice crop and it is in this field that we are putting our 'third' crop - fish. If this proves successful, we will try to introduce it into some of the villages in Savar Thana next year.

For cultivation of HYV rice, a good deal of fertilizer is required. This involves us in the controversy of chemical versus organic methods. Ecology groups promoting natural fertilizers are going to the extreme of likening the use of chemical methods to cancer being introduced into the soil. Chemicals also pollute the water making it hazardous for human use and killing fish. Then too, developing countries are dependent on multi-nationals for the supply of chemical fertilizers and this further extends the chain of exploitation of the poor who cannot afford purchasing this without borrowing from the money-lender.

On the other hand, organic methods not only improve the soil, but make use of waste, thus improving the environment. The problem with this method lies in the amount of composting needed, the resources for which simply are not in the hands of the poor. Thus it has been necessary for us to experiment with the use of natural fertilizing in our Project cultivation before we can promote it in the villages.

Last year we did a trial on a 4 bigha (1.33 acre) plot of HYV rice using only natural composting. The yield of this plot was 15.5 maunds/bigha as

compared with 16.7 maunds with chemical fertilizer, so it definitely compares favourably yield-wise. We have not yet analysed this grain to see how it compares in caloric/nutrient value. The kernels appear bulkier than that fertilized with chemicals, but there is no difference in the taste. The question is how to make this a practicable method for the poor.

When using chemical fertilizer, 60 kilo/bigha is required as well as insecticide. Natural fertilizing requires 1000 kilo of composting and 1000 kilo green manure (cow dung), but no insecticide, for the same area. Compost is bulkier than chemical fertilizer and due to its lower concentration of plant nutrients (nitrogen, phosphorus and potassium content of chemical fertilizer is several times that of natural) needs a much larger quantity. However, it is estimated that up to 1/3 of the chemical nutrients are lost by leaching to the water, whereas the nutrients of the natural fertilizer are gradually released into the soil. This means that with repeated use, in 4-5 years time the amount of natural fertilizer required should be much less.

In the final costing analysis of our trial, the chemical method (including insecticide) amounted to 150. taka/bigha whereas the natural method was 425. taka/bigha (375. taka being labour cost). The natural method was costlier, but weighing in the balance is the improvement in soil quality and employment possibility when one considers that for 5-7 months of the year, many labourers in Bangladesh are un/underemployed. We feel there is no question the natural method should be promoted. The question is 'how' in the present land ownership situation? Where does the marginal farmer and sharecropper get the necessary materials, access to water sources and space needed to do this composting?

When our paramedic (late) Nizam was starting our loan programme (early 1976), opposition was not unexpected, it was merely a question of what form it would take. The first group to accept our offer and terms numbered 11 men. A few days before they were to sign the papers and receive the cash, a young man (the son of a rich farmer) who had been a volunteer in the early days of the Project came to call. He told us what a fine thing we were doing, but didn't we realize the people we were giving the loan to were so poor they would probably spend it immediately on food and there would be no crop and no return of the money? It was in this regard he would like to offer his 'assistance'. We could give the money directly to him. He would stand collateral and be responsible for collecting what he could on the loan when a crop was in, but the amount he didn't realize would be his 'contribution' to the programme. Just one other small point - he would like to add another two names to the list of loan recipients.

A number of the Staff on first hearing, thought his offer most generous. On further discussion they realized it would be an excellent means of perpetuating control over these poor men and the inclusion of his additional 2 recipients (relatives with no need of this type of loan) would give him the necessary 'in' to the co-operative decisions.

The following day we went to the village to have the papers signed and give the money, but no one turned up to accept! The stories the villagers had been told, came together in pieces - "GK runs a health programme, not an agriculture one and while they might give you money this time, what is the guarantee there will be a second time? The money-lender is always here and it's best not to offend him by turning down his assistance, even this once." "GK has already acquired land for their Project which they say they want to expand further. They want you to put your thumb print to a piece of paper which you cannot read. How do you know they aren't out to acquire your land also?" "We villagers are one community and should stick together without letting outsiders interfere in our affairs." And the final assault - "Who helped you bury your father when he died? It wasn't GK, was it?"

Needless to say, it was not until the next year, having learned some valuable lessons, that our loan programme began! It is now well into its third year and aims at helping the marginal farmer and sharecropper

through inputs of cash, seed fertilizer, technological and organizational advise, to understand the anatomy of exploitation which keeps him subject to the dictates of the landowner and money-lender.

We are working to conscientize them to the reality that the present social system has created and perpetuates their problem and only by uniting and organizing themselves against the rich minority can they force a lowering of rates for land rent and water 'rights'. Even though Government has set the price for necessary commodities such as seeds and fertilizer, these are available to the poor only at a price controlled by the minority elite.

Not only is lack of land a major problem for these people, but also the method of distribution among the sharecroppers. Often a landlord will give a sharecropper a virtually unproductive piece of land to work. After a years labour of moving earth, fertilizing, etc. to make the land useable/productive, the sharecropper will be given another similar piece of land the following year (provided he has any money left to apply). However, as the other land still needs to be cultivated, the landlord rents the previous years improved plot to another sharecropper at a higher price, thus causing friction among the sharecroppers, which is all to his advantage.

It is impossible to develop a programme that will help these oppressed people without land reform and redistribution and these reforms will never come unless the poor themselves organize and put pressure on Government planning.

Sometimes a landlord will forcibly take the crop a sharecropper has produced. In the village of Kalma, a women's group took a 200.taka loan to cultivate egg plant. They harvested the first crop, but met with interference by the landlord when time came to harvest the second crop. Although the women's group went in full strength to the landlord, they ultimately lost the crop as he filed a case against them at the police station and they had no clear contract and no funds to fight the case. In spite of the fact that they lost monetarily, it was a valuable lesson for them on how they can be used by the rich so they will take steps to guard against this happening again.

To assist these marginal farmers and sharecroppers, fishermen and women's groups, our loans continue on the same terms as described in Progress Report No.6. The utilization of loans to date is tabulated as follows:

Total Co-op Members = 529
 Total Co-op Groups = 47 (34 male, 13 female)

Table 1: Groups by Membership

Members per Group	5-9	10-14	15-19	20-24
Number of Groups	21	13	10	3

Table 2: Members by Land Holdings

	Amount of Land	Number of Persons
1.	Landless(not even homestead)	80
2.	Homestead only	50
3.	6-17 decimals of land *	98
4.	18-33 decimals of land	72
5.	34-66 decimals of land	104
6.	67-100 decimals of land	90
7.	101-166 decimals of land	35
Total		529

* 100 decimals = 1 acre

Table 3: Loan Utilization in Relation to Land Holding

Times Loan Taken:	1-3	4-5	6	7	Total/Percentage
<u>Land Holdings:</u>					
up to 1 bigha	200	62	11	9	282 (61%)
up to 2 bigha	58	17	2	4	81 (18%)
3 bigha	48	22	5	2	77 (17%)
4 bigha	3	8	2	3	16 (3%)
5 bigha	4	2	-	-	6 (1%)

We are encouraged by the above figures to realize that the majority taking advantage of our loans scheme are really those with least resources available.

The rich man is also the fertilizer dealer, so if the poor farmer is going elsewhere for his cash, he can still be caught in the trap here. We received a special dealership from the Ministry of Agriculture permitting GK to supply directly to the farmers without a middle man.

To discredit our sale of fertilizer, a group of Union members and fertilizer dealers used the clever scheme of opening the bag, removing 1-2 kilo of fertilizer, resealing the bag and selling it at 3 taka less than the fixed Government rate which we were using. When some of the farmers confronted us and complained about our price, we sent them back to the dealers with instructions to weigh the bag they bought and also request a receipt of payment. In many cases the weight was less than it should have been and in no case could they obtain a receipt of sale.

Water is vitally important in an agricultural country and control of water resources is another means of controlling the people. The Government introduced deep tubewells into rural areas for HYV's and multiple cropping. These wells were provided, installed (on the premises of the rich farmer) and maintained at a cost of 0.25 million taka each by the Government.

Recently Government started a new policy whereby they charge a minimal rent of 1200 taka/year and the maintenance of the well is turned over to those using it. The rich farmers have formed co-ops with their family members to control the sale of water to the small farmers and sharecroppers. The current rate is 300-500 taka/acre to irrigate (50% profit to the rich farmer) and is likely to increase. After all, he tells the poor farmer - your loan is cheap because no bribes are necessary to obtain it, but I have to provide the diesel, maintenance, etc., and these are not always easy to get, without 'hidden' expenses.

There is nothing we can do about this but try in our village education classes to encourage these landless people to become members of the co-op (water) so they can have a say in the costing, etc. Government is now ready to sell the tubewells at a subsidized price (bank loan available), but again, who can afford this? Obviously the price of water will go up again and what are we to do to help our credit members against Government's support of the rich?

When facing situations like these, we are reminded of what Robert Tresselt wrote as far back as 1906 ... "Under the present system the majority of the people have really no right to be in the country at all. Under the present system, the country belongs to a few. The majority work hard and live in poverty in order that the minority may live in luxury without working at all. Whether it can be altered or not, whether it is right or wrong, landlordism is one of the causes of poverty. ... It (poverty) is caused by 'private monopoly' - that is the present system. They have monopolized everything that it is possible to monopolize. They have got the whole earth, the minerals of the earth and the streams that water the earth. The only reason they have not monopolized the daylight and the air is that it is not possible to do it." (11)

BHATSALA GONOSHASTHAYA KENDRA

When Savar GK had met with some success, we repeatedly faced the question from both local and international circles - could this type of programme be duplicated? Our basic, simple philosophy has always been that ordinary people, given responsibility and some training, can very effectively meet a challenge such as this and Shapmari has proven this theory.

Bhatsala, our 'daughter' Project 120 miles to the north, situated in the village Shapmari, Jamalpur District, has been in operation for 3 years now. Gita Chakraborty remains the Directress, ably assisted by her senior staff members in running this Project. Originally begun as a health care programme, it too is branching out into other areas of development in trying to help people raise their social, economic and educational status.

In spite of the fact that they had Savar experience to draw from, Bhatsala has not been without its 'birth-pangs', due in large no doubt to the seeming affront to male dignity and supremacy that a team of young women could move in to organize and run something of this nature in a still male-dominated society.

We had been requested by the villagers of Shapmari to set up a programme in their area. When Gita and Eva met with them to explain the aims and methods to be used, they were in total agreement and set up a local committee to assist and advise as needed. Unfortunately, it has not always been the type of 'assistance' which one would have hoped for!

Once the son of one committee member brought his daughter to the Centre for an injection. When the paramedic on duty requested his 2. taka fee, he was loud in his protest that it was 'his' hospital and he therefore had no reason to pay. When Gita, attracted by the noise appeared on the scene, he left. Evidently he had been unable to face two young women on his own as he returned a short time later with a group of about ten young men and challenged Gita to 'come out and talk'.

One day a young man (a son of the man who donated the land) came along with the proposal for a new committee made up of the young men in the village. As Gita was not there at the time, he approached Eva, her assistant, and requested that she relay this information to the Project's Central Office in Savar without delay. Naturally Eva refused. On Gita's return, she also told the young man that his proposal was not proper and if he wanted to do something about it he would have to discuss it with the existing committee and villagers and come to a decision together. This apparently ruffled the young man's calm as he proceeded to label her an 'Indian agent' (Gita being of the Hindu minority), 'communist', 'anti-government activist' and threatened to strangle her. A suggestion to the committee member that he might try and control his son's behaviour met with a strong denial that his son 'could ever have done a thing like that'.

Numerous times, the paramedics (girls) as they went about their work were harassed by the young boys speaking and acting in a disrespectful manner. Gita finally called a meeting of all village leaders and committee members and informed them that this had to stop. The villagers tried hard to cover up for their sons and assure the staff that nothing would happen again.

Despite their many assurances, history repeated itself with the arrival of the IRDP trainees, especially when they took their bicycles out for village work. Groups of young men tried to forcibly take their bicycles.

Gita and her staff knew that any meeting called would be controlled by the rich and any solution reached, their decision. The staff therefore did some 'homework' among the poor villagers, mostly members of their agriculture extension programme. Did they think the Project was fulfilling a need in the area? Did they think it was worth teaching others (IRDP) to carry this type of programme to other parts of the country? Did they

realize how the rich men's sons were treating the girls/women? Did they intend to see that something was done to stop it? - An emphatic "yes" to all questions.

A meeting was called. Gita told the people that if the harassment didn't stop immediately, she had two options - to go to the police or close the Centre, both courses equally damaging to the reputation of those responsible for the misconduct. The poor among the villagers were united and loud in their demand for support of the Project. The rich trouble-makers (or their fathers) had no choice but public apology and promise of amending their ways.

By coincidence, the IRDP local Director and SDO were present at the time of the meeting and were very favourably impressed with all that transpired.

The problem is solved for the moment, but no doubt further instances will arise. The Project offers preferential treatment for no one, regardless of 'status' and this is hard medicine for some to swallow.

Bhatsala now has a staff of 12 girls and 4 boys with an intensive coverage of 19,034 population and service available to an additional 10,000. The main thrust of the programme is the same as Savar GK - preventive health care, nutrition education and family planning. There is a theatre for minor operations, a few beds for emergency patients and out-patient clinic is conducted twice weekly at the Centre. There is a doctor, living about 5 miles from the Centre, who assists part time at the clinic and is available for difficult cases. He also participates in their training programme.

The paramedics train mothers to treat diarrhoea, scabies, etc. in the home. They also bring health and nutrition education to the villages with special emphasis on pregnant mothers - looking for possible pre-eclampsia by closely checking the urine, blood pressure, etc. The maternal death rate for Bangladesh is 8/1000, but Shapmari has their area down to 2.7/1000. 50% of all children in the Project area have had 3 doses of DPT and 50% of women in child-bearing age are covered with tetanus toxoid.

Our Projects (Bhatsala and Savar) are being faced with a serious non-acceptance of the tetanus toxoid vaccine programme. The village women we are trying to cover are convinced it is another 'contraceptive' injection and many refuse it.

If already pregnant, they are sure that if we have an injection to prevent pregnancy, we also have one to kill the already living foetus. We have also had cases of unmarried girls receiving tetanus vaccine and after having been married 2 years without conception, are convinced it was "that" injection (tetanus), responsible.

The paramedics have often tried showing both tetanus and Depo-Provera vials together, but the women, usually illiterate, insist it is merely another company's bottle, thus the different shape, printing, etc., Unfortunately, as previously mentioned, there are neo-natal deaths in spite of tetanus toxoid and this confirms the women in their conviction.

Bhatsala also began an agriculture extension programme (the same as Savar GK's) to assist those farmers who were totally dependent on the landowners and money-lenders. To date 16 co-operatives have been formed with 122 members. 37 people have taken 1 loan; 75 people 2 loans; 10 people 3 loans and 5 people, though belonging to one of the co-operatives, have taken none. 65% have repaid within the stipulated time period and the other 35% are in the process of repaying.

In spite of the tensions and personal indignities these young girls have had to put up with in getting this programme underway, their spirit remains one of dedication and optimism as evidenced by the following excerpts from the report recently submitted by the Bhatsala Directress -

" - good health is necessary for good living and is the moral responsibility of each individual ... the question is 'how best to serve the rural people ?' and the only answer is, 'amid them', that is - bring the health service and education to the village. Our people die of simple diseases and these must be removed, but it doesn't require a MBBS (medical graduate) to carry this out. Good health is rather the responsibility of the village health worker and the villagers themselves.

- so far we have treated 21,369 in the out-patient clinic at Bhatsala and an even larger number have been tended in their village homes by the paramedics. It is necessary to train the mothers to recognize and treat simple diseases themselves - diarrhoea with lobon-goor mixture, scabies and other simple ailments. One result of the village programme is that our Project area can now boast that scabies are eradicated.

- in this male-dominated society, the woman needs her husband's permission to practice family planning. We are convinced that the only successful family planning programme is in connection with social and economic change. In 1386 (mid-April 1979-'80) 22% of our Project area were active family planning users. Besides these, a good number (10%) are also using conventional methods such as coitus interruptus, rhythm and of course, we vigorously promote breast-feeding.

- the problem of education for the children of the poor faces us in our Project area ... the parents were keen on their children learning and after discussion with them it was decided to conduct evening classes at the Centre ... we had few materials and when the class first started they wrote with chalk using the cement floor of the clinic as a slate. Our efforts in this direction have met with some opposition from the landowners (if the children are up late at night, how will they carry on their work the next day?). In their efforts to discredit the school attempt, they have told the children that visitors have come and given gifts (biscuits, soap, etc.) for the school children, but that the staff at the Centre have kept these things for themselves. In spite of the odds, we hope to see this programme grow.

- the poor feel that lack of food is the root of their health problems. A change in the ability to produce enough food is necessary for any change in the health status ... this is why we initiated our agriculture loan scheme.

- we feel that Bhatsala is well-known in the Jamalpur area for its good work and is appreciated by the people. We are also grateful for the support it has with the local authorities.

- the people of Kazirchar in Lasmanpur Union, having seen the work at Bhatsala, requested us to start a Centre in their village. Land has been procured and we are beginning to build."

GONOSHASTHAYA PHARMACEUTICALS LTD.

Patient 'A' was brought to GK by his relatives complaining of a burning sensation in the chest and a feeling of suffocation and impending death. His relatives explained that he had taken some of his 'medicine', become irritable and started shouting at people. After this he took some more 'medicine', then developed his complaints.

The man, 40 years old, works in the Government Family Planning section of a Rural Health Centre. He told us that about 5 years ago, he consulted a doctor because of fatigue, occasional liver pain (pain in the right hypochondrium) and a lack of interest/enjoyment in family life.

The doctor prescribed 4 medications, 3 of which he couldn't remember the names. The other was Polytamin Syrup (a vitamin tonic with 27.5% alcohol content). 15 days later he saw the doctor again and reported that he was feeling better and more cheerful, especially when he took the 'syrup'. This being the case, his doctor agreed it would be a good idea to continue

the syrup as vitamins are a vital element for good health (no advice was given on nutrition in his daily diet).

During the subsequent 5 years he continued with Polytamin, 3-4 teaspoonsful after meals, increasing the dose when he needed to 'feel good'. The previous night he had taken 1 cup (50cc) of the preparation. It was at this point that we made his acquaintance.

Patient 'B' is a 30 year-old sharecropper. He consulted a doctor with evening fever, occasional abdominal pain and general body weakness. The doctor prescribed Combiotic (combination of Penicillin and Streptomycin manufactured by Pfizer) and calcium injections. When the fever did not settle, this was changed to Terramycin (Pfizer), Becosules (Pfizer) and Verdiviton tonic (Squibb). The fever went down but the weakness returned whenever he stopped taking Verdiviton. He hadn't the means to keep purchasing Verdiviton, but he couldn't work without it and sometimes the pain in his abdomen became severe. It was at this point that he came to our clinic. He needed a cheaper substitute for his 'tonic'.

The cases in question illustrate one of the most startling and insidious forms of exploitation associated with health care services and particularly the drug industry - the misrepresentation, overpricing and dumping of worthless drugs in third world countries.

To take Bangladesh as an example, there are over 150 drug companies registered in the country including 3 multinationals and about 22 national companies. Most of the remaining 120 exist only on paper.

The 3 multinationals and their subsidiaries control 80% of the drug market with the remaining 20% held by small and medium-sized nationals. Government's expenditure is about 10-15% (including 16.7 million taka worth of drugs provided by UNICEF for rural health services) of the drug market's 1 billion taka business.

Pharmaceutical Companies are considered essential industry and therefore pay reduced duties on imported raw and packaging materials. For example the raw material magnesium stearate imported by a pharmaceutical manufacturing company will have a nominal tax of 25% while the same talc imported by a cosmetic company will be taxed at 150-300%. Similarly packaging material such as paperboard, art paper, imported by a printer or publisher will have a tax of up to 150%. In actuality, many drug companies instead of producing drugs are selling either the goods or the import licence for the goods. A lucrative business with no work involved!

30-40% of the drugs marketed in developing countries are vitamins and tonics. Another 15-20% are banned in developed countries (combination drugs, out-dated cough mixtures and elixers and unnecessary preparations). Only the remaining 40-50% are useful drugs and these are sold at exorbitant prices.

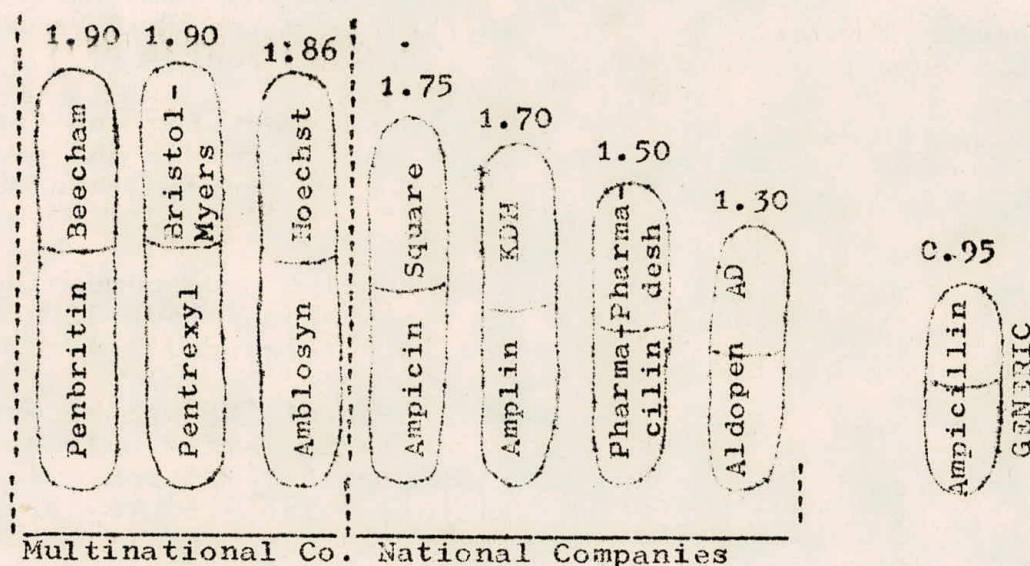
Although Government members are included in the drug-pricing committee, it is virtually controlled by the multinationals. They decide what they will produce and at what price. Bangladesh Government had to 'beg' them to produce distilled water, which though necessary, has not as much profit as Verdiviton (Squibb), Polytamin (Hoechst), BG Phos (MSD) or Combiotic would fetch.

Exploitation of this type has led to such publications as "Who Needs Drug Companies?" by Warren Want; "Insult or Injury" by Charles Medwar and ultimately a list by WHO of 200 essential drugs for primary health care in developing countries.

The question is how to go about introducing the use of 'essential generic drugs only' to a population exploited into the belief that only multi-treatment with the most expensive drugs on the market is effective? The trial in Pakistan met with an early death blow. In India, a serious attempt by a Socialist Minister resulted in only 11 generic drugs being introduced just prior to his removal from Office. The fate of 'essential drugs only' is still unknown as the multinationals continue to control

the entire drug market and in their own language, "You must understand the reason multinational companies try to grab back as much profit as possible out of the less developed countries is frankly because they are suspicious of the future stability of their operations there. I would just be talking rubbish if I were to say that the multinational companies were operating in the less developed countries primarily for the welfare of those countries. They are not Bishops, they are Businessmen." (12)

An extenuating problem is that the national drug companies have learnt their lessons from the multinationals and they too are purely "Businessmen" engaged in the same exploitation of their fellow countrymen as can be seen in the following example: of 250mg. Ampicillin capsules produced by various companies with their price variations:



Beecham has no factory of their own in Bangladesh. Penbritin is produced by Fisons under a third party licence. Bristol-Myers also have no factory and Pentrexyl is manufactured at the Albert David factory and sold at 1.90 taka while Albert David's Aldopen, containing the same properties, sells at 1.30 taka.

Society cannot let this situation go unchallenged. A Dutch friend, Jan Willem van der Eb and GK have been planning, since early on in our involvement in primary health care, how to provide drugs under generic names at low cost. It took 3 years to complete the 'footwork' of collecting the necessary Government approval, documents, etc. By 1978 we had clearance in order and in November 1978, construction began on our building. Today a factory, one of the largest in the country, with 42,000 sq.ft. of floor space is ready to go into production in October with Quality Control and Production Development Laboratory of the highest calibre.

The building design, central air conditioning installation and equipment set-up has been done entirely by Bangladeshi. Specialized top management have been recruited within the country and sent abroad for refresher courses. We have also attracted highly qualified Bangladeshi who left their jobs in developed countries to join the fight.

The factory will be 'different' not only in its production of quality generic drugs at low cost, but in keeping with GK philosophy, a large sector of employees will be rural women. Some of these have already been recruited for basic training in their work and literacy as necessary. Another distinctive characteristic is that all labelling and explanatory literature will be in Bengali.

Gonoshasthaya Pharmaceuticals Limited is organized under the Company's Act like any other manufacturing industry in the country with one major difference - there are no individual share-holders. It is 100% owned by the GK Charitable Trust and by its' charter, 50% of the profits will be ploughed back for factory expansion and the other 50% to help volunteer programmes in the country with emphasis on social sciences and indige-

nous herbal medicine research.

This programme is funded by NOVIB of Holland, Bangladesh Silpa (Industrial) Bank, OXFAM and Christian Aid.

GONOSHASTHAYA PUBLICATIONS

The cases of Patients 'A & B' previously described, illustrate how persuasive marketing shadows the minds of even highly qualified medical persons and ultimately leads to unscientific and unethical medical practice. Their lead is followed by the numerous unqualified village doctors, who in actuality, are consulted for treatment by the vast majority of the rural population.

No medical textbook would recommend prescribing an antibiotic without definite infection. Neither are B-complex vitamins recommended as routine in conjunction with one course of broad-spectrum antibiotic. MIMS (Monthly Index of Medical Speciality) for developed countries clearly notes the contra-indication of such vitamin-tonics as Polytamin and Verdiviton, which contain a high alcohol content, in cases of hepatitis or other liver involvement. A large number of the Bangladesh population suffers from liver affliction due to both amoebic hepatitis and nutritional cirrhosis.

Medical education doesn't include instruction in the economics of drug production/marketing and its social implications. Consequently, patients are deprived of nutrition education which should be given instead of alcohol-addicting vitamin tonics. A poor man will often pay as much as 1/3 his weekly wage to obtain a drug that could well be harmful to him and at most, is probably useless or unnecessary. Our estimate of the ratio of Drug Representatives/Doctor in Bangladesh would be 1:7. In Tanzania it is 1:4 while in Britain 1:20 (13). These marketing representatives are guilty of 'conning' doctors and consumers alike into identifying the healing properties of drugs with brand names (and therefore higher prices). This is made all the more easy by the fact that the only promotion material available is provided by the drug company and is usually in a language which is foreign to the person prescribing as well as to the person buying. To stop such exploitation the health profession needs continued education and consumers need access to the 'restricted' information about the drugs they are prescribed to take. To this end, our publications department came into being about 2 years ago.

66,000 villages of Bangladesh were included in the departments research programme, collecting information on how many qualified/unqualified persons are practicing medicine in the country, what their practice habits are and what information they would find of value in carrying out their work.

With this information at hand we have now published the second of our monthly health bulletin - Gonoshasthaya Monthly - (completely in Bengali) designed to give information on all aspects of basic health care. It will also be used to promote the use of quality, generic drugs. To help instruct primary health care workers, the excellent book by David Werner "Where There is no Doctor" is being translated and printed.

There have been some fine exposes done for the first world on the way the poor in developing countries are 'used' by multinational marketing, but this information is not equally available to the people of developing countries, again due to language barrier. We propose to translate and print such information and are currently working on the War on Want publication "Baby Killer Scandal".

The publications department will also develop teaching aids and curriculum for our village education programme as well as our primary school and medical training programmes. The work of this department is being financed by EZE.

POST SCRIPT

Organization: Gonoshasthaya Kendra is a Charitable Trust, registered with the Bangladesh Government. It is a non-Government Voluntary Organization, dedicated to the promotion of rural health and community development. It has a Board of Trustees, of which the Projects Co-ordinator is a member, that annually overviews the programmes run under the Project Director and Managers.

The Project programmes are partially financed by the Trust resources, local donations and the health insurance scheme. For the remainder, apart from those Organizations already mentioned, we gratefully acknowledge the contributions of Oxfam towards the health programme; Inter Pares - the health and vocational training; Terre des Hommes - the school; War on Want and a private French group "Comite de Soutien au Centre de Sante Populaire de Savar" - the agriculture extension; and Bread for the World - the Bhatsala Project.

The Project (excluding Pharmaceuticals) has three categories of workers (apart from the trainees). The first includes those who are totally illiterate up to ones who may have as much as 10 years of education. Their monthly salary scale is 300-1500 taka. The second category is professionals with a salary scale of 1200-2500 taka and the third category includes the Project Co-ordinator, Director, etc. in a 2000-3000 salary range. In 1978 the workers made provision for an annual increment of 50.taka/person, irrespective of category, if the person's work remained satisfactory.

Everyone contributes 10% of their salary to the Staff Welfare Fund. In the case of the workers with a salary up to 600 taka/month, their contribution is matched with 10% by the Project. For those in the 650-1200 taka salary range, the Project contributes 5% and for those above 1200 taka, 2% is contributed. This Welfare is refundable to any worker who remains up to three years in the Project service.

Breakdown according to Category:

	<u>1st. Category</u>	<u>2nd.</u>	<u>3rd.</u>
Total number of persons	114	4	2
Usual starting age	16 yrs.	25 yrs.	32 yrs.
Annual increment	50./=	50./=	50./=
Special increment at completion of 4 & 6 years work in Project	50./=	nil	nil

Mess contributions are scaled to salary, but everyone gets the same food. Housing is according to need (single, married, married with family) irrespective of salary. Health insurance/benefits are the same for all. Literacy classes are available to illiterate workers. Training in various skills is available according to the abilities/interests of the workers at the Project's expense. Presently one boy is studying under the electrician, another man is learning mechanics and another driving. Similarly cashiers and storekeepers have been trained for their present jobs.

All Project workers are divided into mixed (education/salary) groups for weekly discussions dealing with problems, policy making of the Project and various articles which they have read which will help improve their social awareness. There are regular monthly meetings in which all Project members participate and at which major decisions are taken. An executive committee to organize and conduct these meetings is elected by the workers for a 1 year term.

Nizam's Murder: In November 1976 our senior paramedic, Nizam, was murdered by elites seeking to protect a corrupt village structure (see Progress Report No.6 and "Under the Law in Bangladesh"). Villagers told us that if the murderers were not brought to trial within a month, we would never see justice done. At the time, we doubted the truth of their comment. Now,

almost four years later, the self-confessed killers remain free, and though the prestige of the Project have us access to the highest power in the country, this local village elite proved to be outside every control.

Minu's Death: On 8th May this year we were saddened by the death of another paramedic. Minu (the same one mentioned in the introduction of this report) was cycling from her work in the village to a paramedic meeting at the main Centre when she was struck from behind by a bus (which did not stop). She managed to stand up and push her bicycle to a nearby village shop where she collapsed with injuries due to fractured spine. She was paralysed from the neck down and died five days later.

Internal Disruption: In late February of this year one of the young workshop girls (married before and left by her husband) informed us of her intent to marry our security guard recruited about two weeks previously (and known to have a wife and children). A GonoPaduka girl was engaged (through a marriage arranged by her parents) to a man who already had one wife. One young female paramedic had a fight with one of the male paramedics over a trivial matter. This combination of situations led some of the senior female staff to call a meeting for the purpose of discussing appropriate female conduct. On the evening of 1st March 1980 they gathered. The older staff members argued for greater discretion both for their own and the Projects reputation. During the confrontation the workshop girl who wanted to marry the guard was struck by her sister, a senior paramedic. This led to a scuffle with further blows and hairpulling.

It was a clash of generations and changing cultural attitudes with the younger ones resenting the interference and restrictive attitude of the older workers. They decided to sit again the following Tuesday evening and decide on a code of conduct agreeable to all. All felt that it was a problem to be sorted out among themselves without involving the male members of the Project.

The next day started as usual with agriculture followed by many of the paramedics and extension staff leaving for their village work, the rest preparing for Sunday clinic and a group of expected visitors.

In the publications department, the male translator jokingly asked the young typist what had transpired at the previous night's 'rioting'. The research scientist, listening in, rushed to the Project Manager to demand a revolt at such 'an intolerable situation'. They were now joined by the dentist (who has since gone to West Germany) and started pushing the young girls to call others to an emergency meeting. There was a sudden commotion and cry to stop work and by 10:30 the Construction Supervisor and Research Scientist had closed the main gate to patients and visitors. Cleverly utilizing the name of the Project Manager of the publications department, they assembled workers in the main hall to demand action against the senior girls responsible for the previous nights scuffle. However, the scope soon widened and the meeting became a free-for-all of speeches and airing of pseudo-grievances. Speakers argued that the Project was oppressive and exploitative of its staff and a number were extremely abusive and insulting about senior staff.

The meeting concluded with the formation of a committee which would fight for greater security and shorter working hours. Work resumed that evening, but the 'strike' was followed by some bizarre events.

A group of the main agitators had tape recorded the proceedings of the meeting with a view to taking the story to the press. Most of the committee members refused to allow this. At this point the Project Co-ordinator, who had been in Dacca during the day, returned. He individually questioned the supposedly 'aggrieved' girls to see what had really happened and was surprised to find that none of the newly-formed committee members had asked even one of these girls what had happened to them personally! It was only then, as they tried to put all the facts together, that the girls realized how they had been used. The Project Co-ordinator then requested to listen to the tapes before discussing the committee's demands. Four of those agitating for the story to be taken to the press

then left for Dacca with the tapes. This alarmed most of the participants of Sunday's meeting and some went out to search for them. The four later 'gave themselves up' along with a copy of the tapes.

When the four 'absconders' were questioned as to their motives, it became clear that at least the translator and research scientist had joined the Project with the intention to disrupt it. Employed in the publications department, both were highly qualified individuals coming from the wealthier class, but willing to work for small pay and take part in all the Projects 'common' activities.

The translator was a member of a left-wing political party which felt the GK 'counter-revolutionary' work, because of its effectiveness in bringing some relief to the poor, would subsequently forestall the inevitable and necessary 'Revolution'. The research scientist claimed to have had experience with herbal medicine and said he wanted to make his contribution in this area. To gain employment with us he had played on the sentiments expressed by the Project Co-ordinator in his article "Research: A Method of Colonization" by stating his disillusionment with his own experience of employment with Johns Hopkins and the then Cholera Research Laboratory.

We will never learn exactly who sent and paid them, but we found concrete evidence of industrial espionage among the belongings of the research scientist including photocopies of documents from the pharmaceutical files and listening devices. Also among the possessions of the organizers, who cast themselves in the roles of champions of women's liberation and worker's rights, we discovered lewd rhymes about some of the female staff.

A further general assembly recommended 4 persons to be sacked for their role in the disruption and another 2 asked to be released. We have not increased security nor shortened working hours. We feel that our main responsibility is towards the general population, and that we have a duty to make our limited funds go as far as possible. Most of the staff are privileged by education and a reasonably paid job in an organization which has a more truly democratic structure than most other bodies in the country. A certain dedication must be expected from them if the Project is to have any meaning.

However, the strike has crystallized some issues which have become important at this stage in the history of the Project. The first is the 'generation' problem - old staff members are bound to each other by the shared experience of pioneering days of struggle, individual courage and insecurity. They feel that this gives them the right to set the tone for conduct and work performance. The new members see the older ones as arrogant and fear for their own chances of promotion and recognition. The growth of the Project has naturally limited personal contact between the Project leaders and the large number of new staff and they feel powerless in a seemingly powerful organization in spite of the various departmental meetings which are often dominated by the articulate and confident few.

New members are also by necessity different types of individuals. They joined an established organization which has become famous within the country and abroad. They are no longer dreamers and pioneers, but people competing for a decent job in a country with approximately 30% unemployment. This alienation showed itself in the ease with which so many workers joined the strike. This came as a shock to some of the leaders who believed that the workers considered the Project their own and themselves as part of a team.

Each person, as a result of that day has had to look deeply into his/her frustration, lack of courage or insight, own what he/she saw, assess it and in the learning, recommit or go another way. Some have left. Now for the rest of us, that Sunday morning, like Nizam's grave, remains with us - a challenge to what we are and what we are not.

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25 previously published/unpublished articles by Staff members are also available (some in English, some in Bengali). Readers interested in helping defray the charges of cyclo-styling, picture printing and postage of this Report are welcome to make their contributions.

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D-9/334.(J:1) THE BANGLADESH BAN ON HAZARDOUS AND IRRATIONAL DRUGS
21.10.1982

Its Review and the present Status

28th April 1982:

An 8-member expert committee commissioned to evaluate all the pharmaceutical products in Bangladesh and draft a rational Drug Policy - met for the first time.

Important outcome:

4140 products in the market were evaluated. 16 criteria were laid down for evaluation. (12 criteria selected on scientific grounds and 4 on politico-economic grounds).

Based on these, 1707 products were recommended to be banned. These were divided into 3 categories or Schedules as follows:

Schedule I - This included 265 locally manufactured and 40 imported drugs regarded as positively hazardous to be banned immediately.

Schedule II - included 134 drugs which required reformulation and were to be banned after a period of 6 months.

Schedule III - included 742 locally manufactured and 526 imported drugs. These drugs either had little or no proven therapeutic value or could easily be manufactured by local drug companies - instead of the multinationals producing them at higher costs, thereby depleting the country of much needed foreign exchange.

12th May 1982:

The Expert Committee submitted its report to the Government.

29th May, 1982:

The Chief Martial Law Administrator and his Council of Ministers approved it. The date of the ban of Schedule I was changed from 1 to 3 months and the banning dates of Schedule III drugs from 6 to 9 months.

7th June, 1982:

Formal declaration of the new policy was made.

12th June, 1982:

The Drug Control Ordinance was promulgated.

June, 1982:

Reported pressure exerted on the Government by the Bangladesh American Ambassador on behalf of the US multinationals to have the policy amended. The negative stand of the USA regarding WHO's International Code against unethical marketing practices of milk food is well known.

The British, Dutch and the German Embassies joined to exert pressure on the government. The anti-government campaign having failed, the focus then turned to the Expert Committee which had recommended and pushed the drug policy.

July 1982:

The 4-member Expert Scientific Committee of various pharmaceutical manufacturing companies was brought by the US Embassy to further pressurize the government to reconsider the ban.

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- 19th August, 1982: In Washington Post it was reported that the US State Department spokesman had acknowledged: "that the Pharmaceutical Manufacturers Association, a trade organization for the drug industry, asked it to bring pressure on the Bangladesh government to delay implementing the law pending discussions with the manufacturers". He added: "The State Department has a statutory responsibility for assisting American interests abroad. In this particular case, the US Government is also concerned that these regulations may inhibit further foreign investment in Bangladesh's US \$ 30 billion market in the developing countries would be at stake if other countries followed suit.
- 12th August 1982: Report submitted by the Review Committee constituting of 6 military doctors set up to re-examine the matter in view of the pressure mounted by the multinationals and their respective governments.
- 6th September, 1982: The Drug (Control) Ordinance Amendment announced by the Government after studying the Review Committee's Report.

AMENDMENTS

- SCHEDULE I:** Ban lifted from only 1 item of importance - Imodium (an anti-diarrhoeal).
Six other misused/abused dental remedies reinstated.

TOTAL BAN OF SCHEDULE I DRUGS will remain EFFECTIVE 3 month period as decided earlier all harmful drugs to be destroyed by 12th September 1982.

- SCHEDULE II:** 4 eye preparations containing anti-biotic and steroid combinations allowed (contradictory to the Expert Committee's recommendation).
Heptuna plus a capsule containing iron folic acid, Multivitamins and minerals produced by Pfizer (very strangely) allowed to remain.
Ban withdrawn of total 7 drugs in Schedule II. Time limit extended according to the amended ordinance from 6 months to 12 months for the drugs listed in Schedule II.

Lobbying for this so called necessary ante-natal drug for the under-nourished anaemic pregnant woman was done by the country's gynaecologists headed by the President of Bangladesh Medical Association, shareholder and member of the Board of Directors of Pfizer, Begum Feroza.

Facts about the Bangladesh Drug Scene in Brief:

- Bangladesh is the third poorest country in the world with a per capita income of US \$ 70 a year.
- That 70% of annual drug sales are of drugs described as useless or therapeutically insignificant by the British National Formulary, the National Research Council, USA and the Federal Drug Administration, USA.
- Out of 51 products of Glaxo available in Bangladesh market in 1980, only 17 are available in the U.K. and only 1/3 are present in WHO's list of essential drugs.
- Of 31 products of Fisons available in Bangladesh, 17 were combination of vitamins and minerals. And only 5 of these drugs

were available in the UK. 60% of Bangladesh's health budget is spent on drugs.

- In 1981 about 1250 million taka was spent on allopathic drugs in Bangladesh, but due to poverty and the high cost of drugs less than 15% of the population was in a position to buy modern medicines.

SCHEDULE III - 28 drugs (manufactured under the third party licence) were allowed to remain. Time limit extended from 9 months to 18 months effective from 12th June 1982 - date of promulgation of drugs.

SCHEDULE IV - Under this new schedule, 88 balms and vapours of small (new) national companies were to be allowed to be manufactured for 18 months with effect from 12th June 1982.

WHAT'S NEW?

All hazardous drugs of Schedule I were to be completely destroyed by 12th September 1982.

There is a move on by the drug companies to apply for licence to export them to Saudi Arabia, Western Africa, etc, via Europe. These applications were made on 10th September with the support of Secretary of Health. The Drug Controller has refused and the matter has now been taken up with the Industrial Ministry. The Drug Controller has recommended that if this move should go through, all these products should be previously labelled saying the drugs was recommended to be destroyed in Bangladesh by 12 th September 1982.

The failure of Sri Lanka and Pakistan to have a progressive drug policy has been quoted by the multinationals to subvert the attempts of Bangladesh Government to ban hazardous drugs.

What is probably the most humiliating comment on the social consciousness of Indian health personnel is that our drug policy is being quoted by the multinationals to criticize and condemn the Bangladesh ban. Here it would not be out of place to quote from a medical journal from Bangladesh, 6th September 1982.

"In India, 43606 drugs are registered and sold. Even these have not upset their possibilities of further industrialization in spite of their technological advance and poverty...." (sic).

The above information is based on newspaper reports from Bangladesh and elsewhere and the personal communications from socially concerned health personnel in Bangladesh like Dr. Zafrullah Chowdhury.

Availability of supply of essential life-saving drugs for the majority at reasonable cost, should come before profits of the drug companies. If these profits derive from the sale of hazardous and irrational drugs or drugs with little therapeutic value, they need to be curtailed, and policies which allow drug companies to continue producing them need to be seriously questioned. We want a rational, people-oriented drug policy, and any effort in this direction anywhere has our support.

As mentioned in our handout "In Support of Bangladesh Ban" we repeat "Sabotage of this ban at this stage by the application of pressure or by money power will be a blow to all those who sincerely believe in socially relevant and socially just health care. Consequently, this is not a question of Bangladesh's fighting a 'Bangladesh problem'. It is in fact a question of a higher premium being placed on profits than on the welfare of human beings - if the ban is withdrawn under duress. This is

therefore a move against which the public opinion of all nations, particularly the developing countries should be raised. It is a cause worthy of global support specially from those involved in healthwork'.

What would we do if we knew that the sale of hazardous and irrational drugs would continue because of the pressures and marketing strategies of the Drug companies? Would we continue stocking them in our pharmacies and prescribing them? We request our readers to boycott such hazardous products, because a Government ban on them may come too late, or never come because of vested interests.

If you are desirous of more information please write.

Mira Shiva

Co-ordinator,
Low Cost Drugs & Rational Therapeutics.

94-4

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NDP GUIDELINES AND LIST OF BANNED DRUGS

This paper includes guidelines of National Drug Policy (NDP), name of the banned drugs (Schedule-1), scientific explanations behind the ban with their list of references, essential drugs list of World Health Organisation.

The technical details of National Drug Policy declared on the 12th of June, 1982 is unknown to most of the physicians and pharmacists of Bangladesh till today. No constructive step has yet been taken to enlighten and inform the physicians about the scientific reasons and explanations behind banning 1707 harmful, useless, expensive and imported drugs whose local substitute are available. This paper is an attempt to inform the physicians of the country about the scientific reasons and explanations behind the banned drugs as projected by the Expert Committee.

In accordance to the guidelines (vide infra) followed by Expert Committee the drugs to be banned have been categorised into three Schedules.

- * SCHEDULE—1 : It includes the most harmful drugs.
- * SCHEDULE—II : It includes drugs whose manufacture and sale shall be permitted only if they are registered after change in their formulation in accordance with the direction of the licencing authority.

* SCHEDULE III :

Drugs belonging to this schedule fall into one of the followings groups :

1. Combination drugs with no or trival therapeutic value and as such increased toxicity. The combination may be of drug ingredients of the same category or ingredients of entirely different categories. These drugs have no therapeutic value to outweigh the cost. (2) Drugs being marketed under a variety of names, but with only slight difference in combination. (3) Imported drugs which are already locally manufactured, thus impeding the growth of local industry. (4) Drugs which, in themselves are not harmful, but are ; a) to become the responsibility of national manufacturing companies instead of multinational companies (e. g. antacids, simple vitamin preps., etc.)

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or; b) some such drugs are produced under license from foreign companies which do not themselves manufacture in Bangladesh. This is against national interest. Some or its substitutes will be allowed to be produced under the name of the manufacturing company only (e. g. Penbritin, manufactured as ampicillin under the generic or brand name—of whichever company is producing it) with their factory in Bangladesh.

* Drugs under schedule—1, II & III should be withdrawn from the market by 3, 6 & 9 months respectively.

GUIDELINES

- i. The combination of an antibiotic with another antibiotic or antibiotics with corticosteroids or other active substances will be prohibited.
Antibiotics harmful to children (e. g. Tetracycline) will not be allowed to be manufactured in liquid form.
- ii. The combination of analgesics in any form is not allowed as there is no therapeutic advantage and it only increases toxicity, especially in the case of kidney damage. The combination of analgesics with iron, vitamin or alcohol is also not allowed.
- iii. The use of Codeine in any combination form is not allowed as it causes addiction.
- iv. In general, no combination drug will be used unless there is absolutely no alternative single drug available for treatment or if no alternative single drug is cost effective for the purpose.

Certain exceptions will be made in the cases of eye, skin, respiratory and haemorrhoidal preparations, co-trimoxazole, oral rehydration salts, antimalarial, iron-folic, etc., as well as certain vitamin preparations, allowing combinations of more than one active ingredient in a product.

- v. Vitamins should be prepared as single ingredient products with the exception of B complex. Members of vitamin of B complex with the exception of B12 may be combined into one product. B12 always has to be produced as a single ingredient injectable product. Other members of B complex may also be produced as a single ingredient product (e. g. B1; B2; B6, etc.). Vitamins will not be combined with any other ingredient such as minerals, glycerophosphate, etc. It will be allowed to produce vitamins in tablets, capsules and injectable form only. No liquid form will be permitted because of wastage of financial resources and the tremendous misuse involved. However, paediatric liquid multivitamin (with no B12, E, K and/or minerals) will be allowed to be manufactured in bottles of up to 15ml. size with droppers. Paediatric liquid preparations of single ingredient vitamins will also be allowed to be manufactured in bottles of up to 15ml. with droppers.

- vi. No cough mixtures, throat lozenges, gripe water, alkalis, etc. will be allowed to be manufactured or imported as these are of little or no therapeutic value and amount to great wastage of our meagre resources.
- vii. The sale of tonics, enzyme mixtures/preparations and so-called restorative products flourish on consumer ignorance. Most are habit-forming and with the exception of pancreatin and lactase these are of no therapeutic value. Henceforth, local manufacture or importation of such products will be discontinued. However, pancreatin and lactase will be allowed to be manufactured and/or imported as single ingredient products.
- viii. Some drugs are being manufactured with only a slight difference in composition from another product but having similar action. This only confuses both patients and doctors. This will not be allowed.
- ix. Products of doubtful, little or no therapeutic value are rather sometimes harmful, and are subject to misuse will be banned.
- x. All prescription chemicals and galenic preparations not included in the latest edition of British Pharmacopeia or British Pharmaceutical Codex will be prohibited.
- xi. Certain drugs, in spite of known serious side-effects and possibility of misuse, having favourable risk-benefit ratio may be allowed to be produced in limited quantity for restricted use. These will be prescribed by specialists only.
- xii. The same or close substitute of a drug which is being produced in the country will not be allowed to be imported as a measure of protection for the local industry. However, if local production is far short of needs, this condition may be relaxed in some cases.
- xiii. A basic pharmaceutical raw material which is locally manufactured will be given protection by disallowing it or its substitute to be imported if sufficient quantity is available in the country.
- xiv. The role of Multinationals in providing medicines for the country is acknowledged with appreciation. In view of the calibre of machinery and technical know-how which lies in their hands for producing important and innovative drugs for the country, the task of producing antacids and vitamins will lie solely with the National Companies, leaving the Multinationals free to concentrate their efforts and resources on those items not so easily produced by smaller National Companies. Multinationals will, however, be allowed to produce injectable vitamins as single ingredient products.
- xv. No foreign brands will be allowed to be manufactured under licence in any factory in Bangladesh if the same or similar products are available/manufactured in Bangladesh as this leads to unnecessary high prices and payment of royalties. In the light of this policy, all existing licensing agreements should be reviewed.

xvi. No Multinational Company without their own factory in Bangladesh will be allowed to market their products after manufacturing them in another factory in Bangladesh on toll basis.

LIST OF HARMFUL DRUGS TO BE WITHDRAWN WITHIN THREE MONTHS WITH THEIR SCIENTIFIC REASONS & EXPLANATIONS :-

Name of Products and the Manufacturing Company	Remarks
<p>1. Tetracycline Group of Antibiotic (Syrup preparation) :- Clinmycin Syrup (Glaxo), Vibramycin (Pfizer), Terramycin (Pfizer), Imperacin (I.C.I.), Restecline (Squibb), Sumycin (Squibb), Aldacycline (Albert David), Oxaline (Pharmadesh), SQ-Cycline (Square), Kedoxylene (K.D.H.), Tetracycline (GACO), Ledermycin (Therapeutics), Tetracycline (NIPA), Ledermycin (Lederle)</p>	<p>Tetracycline syrups are harmful to children (& pregnant mothers) as they disturb bony growth of children upto 12 years of age & also discolour teeth.</p>
<p>2. 8-Hydroxyquinoline Derivatives (Iodo-chlorhydroxyquin, Di-iodohydroxy quinoline etc.) Stericol (Pfizer), Fistrep (Fisons), Embequin, Nivembin and Di-iodohydroxyquinoline bulk (BPI), Quixaline (Squibb), Dysedin (Edruc), Siodoenterin and Enteroguanidine (Albert David), Ambosin, Adysin and Idoquine (Pharmadesh), Disedin (KDH), Enteroxyl (GACO), Intosept (Zaman Pharmaceuticals) Dirroquin (Syntho Laboratories Ltd.), Enterocide (United Chemicals and Pharmaceuticals Ltd), Auraquinol (Standard Lab. Ltd.), Asiquin (Asiatic Laboratories Ltd.) Diquine (Orion Laboratories Ltd.), Dioquin (Doctors Chemical works,) Entenol (Sarma Chemical works Ltd.) Presotren comp tab (Beximco), Di-iodohydroxyquin Bulk (Pharmatek chemical Ltd.), Iodo-chlorhydroxyquin Bulk and Di-iodohydroxyquinoline Bulk (Halima Kowser), Ciediform (Siba Lab Ltd.), Enterocide (United chemical and pharmaceuticals Ltd), Dependal, Entero vioform, mexaform, Intestopan, Diiodoquin, Enteroseptol.</p>	<p>Combination of streptomycin & clioquinol. Clioquinol (iodochlorhydroxy quin), vioform (Diiodohydroxyquinoline) is implicated subacute myelo-optic neuropathy (SMON) which is manifested by abdominal pain & persistent diarrhoea and it proceeds to bilateral sensory disturbances, paresthesias & dysesthesias, preferentially in the distal of the lower limbs, but upper limbs & muscle weakness are not exempted. Blurred vision & blindness; disturbances of autonomic nervous system, psychological changes & greenish discolouration of</p>

Contd.

Name of products and the manufacturing Company	Remarks
	<p>the tongue less common but present. Similar toxic effects have also been observed with other 8-hydroxyquinolines. These are severe generalized furunculosis (iodine toxicoderma), mild to severe dermatitis, itching, diarrhoea, headache, chills, fever, disturbance of thyroid function, etc. Contraindicated with patients with hepatic damage or iodine intolerance. Administration of iodoquinol (diiodohydroxyquin, yodoxin) to children for chronic diarrhoea has been associated with optic atrophy & permanent loss of vision.</p>
<p>3. Alcohol containing tonics with vitamins and minerals :</p> <p>Polytamin (Hoechst), Durol (Pfizer), Rubraton elixir (Squibb), Verdivoton Elixir (Squibb), Tonum (Albert David) Sev General Tonic (Square), Edicomalt (Edruc), Neuroplex Elixir, Neurolecithin and Neurona (KDH), Vitatone C.I.P (Zaman Pharmaceuticals), Vincaron (Syntho Lab.) Ashoka cordial (Standard Lab. Ltd.) Bilogen paediatric with Vit. A & D, Haemoffen, Stanovine and vitamin B Complex-(Standard Laboratories Ltd), Nuritone and Ext. Kalmegh (National Lab. Ltd.), Ext Kalmegh and Rouf's Compound (Bengal Techno Chemical works, Dinajpur). Micaberi's Compound (Amico Laboratories Ltd.), Neomalt and Neovite (New Light Chemical Industries) Ashoka cordial (Dawn Co. pharmaceuticals and Doctors Chemical)</p>	<p>Combination vitamin tonic including vitamin B12 & alcohol. Alcohol is contraindicated in liver ailments of which there is a high incidence in Bangladesh. One of the greatest abused drugs in the market.</p>

works Ltd.), Liverex and Ext. Kalmegh Liq. (Dawn Co. Pharmaceuticals), Evcolecithin (East Bengal chemical pharmaceutical works), Vinolecithin and Vitrone Liq. (ADDCO Ltd.), Ext-Kalmegh and Tr Nuxvomica. (Bectro Chemical Ltd), Ferritone and plexovit (Universal Pharmaceutical Ltd.) Feovit (PIP, Pabna), Ferrotone (Reman Drug Laboratories Ltd), Phospotone and Ext Kalmegh (Bengal Chemical Industries), Kalmegh Liq. Extr and Reoplex (Pephco Lab.) Vinophos, Leakoplex and Vita-S (Chemist Lab. Barisal) Wineon Tonic (Mukti Lab), Genophos (Green land Pharmaceutical), Carnovyn Elixir and Carica Peptol Liq (Carica Lab.), Zocoplex (Zaco. Lab), Bioplex (Bio pharm Lab.) Neurotone (Rangpur Drugs and chemical coop), Extr Kalmegh (Health Lab Dacca).

Zymopax, Betalax and Haemapax (Standard Chemical works), Vitfolin, Ext Kalmegh, phospholin, Khalpholin (Aman Lab) Vidivin (United Chemist Ltd.), Vinoport (Sarma Chemical Works Ltd.) Vinomalt (Easted Drug and Chemical Works Ltd.), Ext kalmagh (United Chemist Ltd.), Glypotone (Standard Chemicals Industries), Oraliron (Colloid Lab. Ltd.), B. C. Malt (Bangladesh Chemical Works), Ext Kalmegh, (Bangladesh Immunity Co. Tangail), Kalmegh, Qumareh and Compiplex (Comilla Lab.), Vitatone Forte, Ext Kalmegh and Liq. Bismuth Co-Cum pepsin (Glove Chemical Industries Ext. Kalmegh) Great Bengal Chemical and Pharmaceutical works), Ext, Kalmegh and Liq. Bismuth Compound (Glove Ltd), Livergren and Asoke Cordial (Standard Pharm.) Vinotone (Eastern Drug Co. Ltd.), Tinct. Ipecacuqura (Najat pharmaceutical Co.), Ext-kalmegh (Eastern Drug crop), Polytone (City pharmaceutical Lab], Ferrosis [OASIS Lab], Diapsin and Sipanal [SIPA pharmaceuticals], Auriotone and Elixir Vitamins B-complex [Indo Bangla pharmaceuticals], Biorona tonic and Biovita [BIOS pharmaceutical], Opsolecithin [Opsonin chemical Industries], Kalmegh liq, Asoka cordial and Livatone [Sattar and Ahmed, Ctg]. B-Bron-12 [Purbadesh Chemists Ltd], Vivalona [Heilmerk Lab-

Name of the Products and the Manufacturing Company	Remarks
Dacca.], Ext. Kalmegh [B. Pharm Lab.], Enget [Eureka Pharmaceutical], Ext Kalmegh [Jes chemical and pharmaceutical works], Kalmegh Liq [Khandaker Bros and Co.], Ext Kalmegh and Pestorine [United chemical and pharmaceuticals Ltd]. Ext. Kalmegh (Green Lab) Natioplex (National drug co), B-G phos.	
4. Multivitamin combination with Enzymes and alcohol.	Multivitamin combination with enzymes & alcohol. Dangerous for hepatic malaises.
Diaptozyme (Edruc), Celuzyme (Albert David), Banaj liver drops (KDH), Dizyme (GACO), Peptenzyme and Enzyme zP (Zaman pharmaceuticals), Dienzyme (Huqsons Laboratories), Diavita (Standard Laboratories), Decazyme (Bengal Lab. Ltd.), Prinzyme (Chemist Lab.), Zacozyme (Zaco Lab.), Zypolin (Aman Lab.), Enzyplex (Wee Pharma Ltd.), Deresol. Syrup (Seema Pharmaceutical Lab), Peramin drops (NIPA Pharmaceuticals), Fenozyme (Bios Pharmaceuticals), Citazyme (CityPharm Ltd), Acipep (Batali chemo pharmaceuticals Ltd).	
5. Appetite Stimulants :	Cyproheptadine unnecessary appetite stimulant. Contraindicated in stenosing peptic ulcer, prostatic hypertrophy, asthma, elderly debilitated patients, nursing mothers, new and pre-term infants. Known-side effects are drowsiness, somnolence, headache, agitation, confusion, visual hallucinations, epigastric distress, photosensitivity, restlessness, paraesthesia, blurred vision, thrombocytopenia and blood dyscrasias.
Heptamin (Albert David), Perigan (National Lab. Ltd.), Peridin (Bengal Chemical Industries), Cypadin (Sonear Laboratories), Cyptadin Liq (Therapeutics Ltd.), Periactin-vita, Periactin, Peritol.	
6. Cough Syrup with Alcohol and Codeine :	Cough syrup containing alcohol &/ or Codeine { causes addiction }.
Expilin (GACO), Partusis cough syrup, (Anico Lab.), Syp. Vasak (Universal Pharmaceuticals Ltd.), Keflex (Mukti Lab.), RDCCS compound (Rangpur Drugs and Chemical Coop), Broncholin (United Lab. Ctg.), Asmalex (NIPA Pharmaceuticals), Promodyl { GACO }.	

Name of products and the manufacturing Company	Remarks
7. Atromid-S { I. C. I }	Increases the incidence of gall stones & cholecystitis ; drug induced cardiac arrhythmias, cardio-megaly, increased angina, claudication & thrombo-embolic phenomena. Clofibrate also enhances the effects and toxicity of other acidic drugs, such as phenytoin & tolbutamide. Also implicated with an increased incidence of various tumours.
8. Menstrogen Tab { Organon }	Misused drug with carcinogenic & teratogenic properties.
9. Mixogen Tab { Organon }	Combination ethinyloestradiol (oestrogen) & methyltestosterone. The only indication for use is menopausal symptoms, but has more than 20 contra-indications. A greatly misused drug with carcinogenic properties. Also a risk of high blood pressure, hypercalcaemia, hypercalciuria, virilisation, enlarged clitoris, acne, menstrual irregularities, vomiting, nausea, headache, breast tenderness, mood changes, uterine bleeding etc.
10. Orabolin Drops { Organon }	Ethyloestronol. Dangerous drug for children.

Name of Products and the Manufacturing Company	Remarks
11. Baralgin Tab and Drops (Hoechst), Spasmocibalgin Tab and Inj. Buscolysin Comp Tab.	Combination analgesics with proven toxic effects; safer alternatives available.
12. Novalgin Tab and Drops, Novalgin Quinine Dragees (Hoechst),	Aminopyrine derivative (dipyrene) causes high incidence of agranulocytosis. In some, it produces sharp fall of total leucocyte count associated with chill, fever, headache, muscle & joint pain. Aggravates bleeding tendency.
13. Dytostoma capsule (Edruc Ltd),	Combination of testosterone, lohimbine, strychnine & caffeine. Common toxic effects are sustained & painful erections (of penis/clitoris), priapism, serious disturbance of growth, sexual & osseous development if given to children. According to WHO, "strychnine should only be used as a rodenticide."
14. Imodium (Square),	Loperamide has dangerous side effects such as causing excessive sedation in chronic liver disease and in children. Aggravation of spastic bowel syndrome & precipitation of diverticular, disease. Abdominal cramp is common.
15. Influenza Tab (Square), Apocodin (KDH), Citapyrin Tab (City Pher Ltd), Refagan.	Combination of aspirin, phenacetin & caffeine. Phenacetin is toxic and liable to be abused.

Name of Products and the Manufacturing Company	Remarks
16. Rejuvin pill (GACO),	Ext. Damiana yohimbine, Nux Vomica Etc. Poisonous useless and Misused Drug.
17. Gurantrop ZP [Zaman Pharmaceuticals Ltd.].	Glucuronotacton Methionine 312 Etc. Harmful & exploitation through Consumer ignorance.
18. Different Preparation containing alcohol and other harmful ingredients.	Products containing alcohol and other harmful ingredients such as Strychnine, Nux Vomica, Bismuth, Sentonin, Phenolphthalamine, Chincona, Arsenic etc.
<p>Vitaport [Hugson's Lab.], Livetone [Satter and Ahmed Ctg], Dentacure [GACO], Tooth Ache drop [Anico Lab. Ltd.], Dentine [Raman Drug Lab. Ltd.], Dentisept [Bengal Chemical Industries], Dentine [Big Benpuhermaceuticals] Person liq (GACO), Phosphovit [Orion Lab.], Lyrex [Sheba Lab.], Bioagrol [Bio Lab.], Quinigen Liq and Santopia [Standard Lab.], Tonic Apyrex [Sarma Chemical works Ltd.], Eastion's Syrup [G. M. Lab, Glove chemical industries, Popular chemical works. Green Lab. Dr. Karim's Lab.], Bittergen [Comillah Lab.], Acidak [Standard Lab.].</p>	
19. Gripe Water :	Gripe water has long been promoted as a remedy for a child with belly-ache, especially young baby with colic. One of the most plausible suggestions for the cause of colic is temporary immaturity of the nerve supply to the large intestine which causes hypermobility causing baby to draw up its knees & cry. The condition is self-limiting & harmless & no drug is necessary, Most of the
<p>Companies formulating it :- Fisons, Jayson, ZACO, Zaman pharmaceuticals. Standard Laboratories, Amico Lab., New light Chemical Industries, Dawn Co. Pharmaceuticals, Acme Lab., East Bengal Chemical Works, ADDCO Ltd. Medicos Corporation, Bengal Chemical Industries, Mukti Lab., Niramoy pharmaceuticals, Rangpur Drugs and Chemical Coop, Health Lab., United Chemist Ltd., Tropical pharmaceutical Industries, Globe Research Lab., Eastern Drug and chemical works Ltd., Pure drug and chemical works, Bangladesh Chemical works, G. M. Lab., Globe Chemical Industries, alpha Lab., Great Bengal Chemical and Pharmaceutical Works, Standard Pharmaceuticals Ltd., Janapriyo Chemical Industries, Wee Pharma Ltd., Seema Pharmaceuticals, Modern Research</p>	

Name of Products and the Manufacturing Company	Remarks
Lab., Unique Pharmaceuticals, Sattar and Ahmed, City Pharma Ltd., Unique Lab., Manners Pharmaceuticals, Bangladesh Pharmaceuticals, Siba Lab., Eureka Pharmaceuticals.	time a child cries to draw its attention for affection, food or change of nappy. Delays in providing attention, make the child cry louder & swallow more air then draw the knees towards the belly giving the impression of bellyache. The active ingredient of gripe water is sodium bicarbonate, an antacid whose

1. Gilman, A. G. Goodman, L. S. *Pharmacology and Therapeutics*, 6th Edition; Macmillan, New York, 1982.

2. British National Formulary, Association & Pharmaceutical Society, London, 1980.

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4. Lewis, J. J; *An Introduction to the Pharmacology of Drugs*, London, Edinburgh, 1980.

5. *Selection of Essential drugs*; WHO, Geneva, 1979.

6. Bowman & Rand, *Text Book of Pharmacology*, London, 1980.

7. *Extra pharmacopoeia*, Martindale, London, 1980.

8. *Physicians' Desk Reference—1982*, Montvale, N.J., 1982.

9. *Side Effects of Drug Annual-2*, London, 1980.

10. *United States Pharmacopeia*, US Pharmacopeial Convention, Washington, D.C., 1980.

Note: The scientific reasons for ban above sources.

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Some Notes ;

Note 1 ; Some of the drugs listed above are used with quite different indication and contra-indications in countries where there is adequate drug monitoring and control system ensuring sale of drugs through the prescription of qualified physician only. In the absence of similar measures and poor economic resoures such drugs have been banned in our country to avoid the dangerous hazards resulting from indiscriminate use by vast number of unqualified, unregistered quacks and self prescriptions by the consumers.

However, further addition and deletion of any drug from the list depends upon the future development of Science.

Note II 'Cough Syrup' is one of the most misused drug in Bang'adesh on being sold as 'over the counter drug', like many other drugs. Though this sort of preparations are being marketed in Britain through prescription of qualified Physicians, yet British National formulary, 1981 Published jointly by British Medical Association and Pharmaceutical Society states as follows ;

Expectorants: There is no evidence that any drug given by mouth, by inhalation or by injection has a specific action in promoting expectoration of bronchial secretion by stimulation or augmentation of the cough reflex. The retching and vomiting which can be provoked by gastric irritants, such as ammonium chloride, Ipecacuanha. and squill can certainly expel mucus from the air passage at the same time, particularly in children, but the assumption that 'subemetic' doses of these and other drugs promote expectoration is anyth. There is thus no scientific basis for prescribing these drugs although a harmless expectorant mixture may have a useful role as a placebo. It is irrational to prescribe an expectorant in conjunction with a cough. suppressant, antihistamine or bronchodilator drugs. B. N. F. 1981, P-94

Comp. Preparation : There is no advantage in prescribing a preparation containing several ingredients that have similar therapeutic properties, or in which each ingredient has a different action.

Combinations such as expectorant and cough suppressant, sympathomimetic and sedative, and any or all of these with other types of drug such as antihistamines are to be deprecated. If particular components are needed they should be prescribed separately and dosage adjusted separately. B.N.F Nov 1981, P-96

Note 111 For successful implementation of a people oriented drug policy in Bangladesh, participation of Bangladesh Medical Association (sole national organisation of doctors) in all aspect is very much essential.

ALPHABETICAL LIST OF ESSENTIAL DRUGS

In accordance to the World Health Organization technical report (series 641, Published in 1979)

A	amiloride	tion-local anaesthetic, astringent and antiinflammatory drug
acetazolamide	aminophylline	
acetylsalicylic acid	amitriptyline	
adipiodone meglumine	amphotericin B	antimony sodium tartrate °
albumin, human normal	ampicillin	antirabies hyperimmune serum
allopurinol	anti D immunoglobulin (human)	antivenom sera
aluminium acetate	antihaemophilic fraction °	ascorbic acid
aluminium hydroxide	antihaemorrhoidal prepara-	atropine
amikacin °		azathioprine

(Contd.)

B

bacitracin + neomycin
barium sulfate
BCG vaccine (dried)
beclomethasone °
benzathine benzylpenicillin
benzoic acid + salicylic acid
benzyl benzoate
benzylpenicillin
bephenium hydroxynaphthoate °

betamethasone

bleomycin

bupivacaine

busulfan

C

calcium carbonate°
calcium folinate
calcium gluconate°
carbamazepine °
carbidopa + levodopa °
charcoal, activated
chlorambucil
chloramphenicol
chlorhexidie
chloroquine
chlorphenazine
chlorpromazine
chlortalidone°
clofazimine °

clomifene

cloxacillin

coal tar

codeine

colchicine °

compound insulin zinc
suspension

cromoglicic acid °

cyclophosphamide

cytarabine

D

dapsone

dieferoxamine

dexamethasone

dextran 70

deazepam

diethylcarbamazine

digitoxin °

digoxin

diloxanide °

dimercaprol

diphtheria antitoxin

diphtheria-pertussis-tetanus
vaccine

diphtheria-tetanus vaccine

dopamine

doxorubicin

doxycycline °

E

edrophonium

emetine °

ephedrine °

epinephrine

epinephrine °

ergocalciferol

ergometrine

ergotamine

erythromycin

ethambutol

ether, anaesthetic

ethinylestradiol

ethinylestradiol + levonorg-

estrel

ethinylestradiol + norethist-

erone

ethosuximide

F

factor IX complex
(coagulation factors II, VII
IX, X, concentrate).

ferrous salt

fibrinogen

flucytosine

fludrocortisone

fluorescein

fluorouracil

fluphenazine

folic acid

furosemide

G

gamma benzene hexachloride

gentamicin

glucose

glucose with sodium chloride_e

glyceryl trinitrate

griseofulvin

H

haloperidol

halothane

heparin

homatropine

lyl; zine

hydrochlorothiazide

hydrocortisone

hadroxocobalamin

I

ibuprofen

immunoglobulin, human

normal

indomethacin

influenza vaccine

insulin injection

intraperitoneal dialysis

solution

iodine

iopanoic acid

ipecacuanha

iron dextran

isoniazid

isoprenaline

isosorbide dinitrate

L

levodopa

levodopa + carbidopa

levonorgestrel + ethinylest-
radiol

levothyroxine

lidocaine

lithium carbonate

M

Magnesium hydroxide

mannitol	piperazine	sodium calcium edetate
measles vaccine	plasma protein ^o	sodium chloride
mebendazole	poliomyelitis vaccine	sodium chlorate with
meoglumine amidotrizoate	(live attenuated)	glucose
melarsoprol	potassium chloride	sodium fluoride
meningococcal vaccine	(oral solution)	sodium lactate, compound
methotrexate	potassium chloride, par-	solution
methyl dopa*	enteral	sodium nitrite
methylthionium chloride*	potassium iodide	sodium nitroprusside
metrifonate	prednisolone	sodium stibocaptate*
metronidazole	primaquine	sodium stibogluconate
miconazole	probenecid	sodium thiosulfate
morphine	procainamide	streptomycin
N	procaine benzylpenicillin ^o	sulfacetamide
naloxone	procarbazine	sulfadimidine
neomycin + bacitracin	promethazine	sulfadoxine + pyrimetha-
neostigmine	propranolol	mine
niclosamide	propylthiouracil	sulfamethoxazole + trime-
nicotinamide	protamine sulfate	thoprim
nifurtimox	pyridostigmine	suramin sodium
niridazole	pyridoxine	suxamethonium
nitrofurantoin	pyrimethamine	T
nitrous oxide	pyrimethamine + sulfadox-	testosterone
norethisterone	ine ^o	tetanus antitoxin
norethisterone ^o	Q	tetanus vaccine
norethisterone + ethinyl-	quinidine ^o	tetracaine
estradiol	quinine	tetracycline
nystatin	R	thiamine
O	rabies vaccine	thiopental
oral rehydration salts (for	reserpine ^o	tiabendazole
glucose-salt solution)	retinol	trihexyphenidyl
oxamniquine	riboflavin	trimethoprim + sulfametho-
oxygen	rifampicin ^o	xazole
oxytocin	S	tuberculin, purified protein
P	salazosulfapyridine	derivative (PPD)
paracetamol	salbutamol	tubocurarine
paromomycin ^o	salicylic acid	typhoid vaccine
penicillamine ^o	salicylic acid + benzoic acid	V
pentamidine	senna	valproic acid
pethidine ^o	silver nitrate	vincristine ^o
phenobarbital	smallpox vaccine	W
phenoxymethylpenicillin	sodium amidotrizoate	warfarin
phenytoin	sodium bicarbonate	water for injection
phytomenadione		Y
pilocarpine		yellow fever vaccine

^o Complementary Drug

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DRUGS 94-5
MIRA SRINIVAS

LOW COST DRUGS
& RATIONAL
THERAPEUTICS
V.H.A.I

BANGLADESH: Finding the right prescription

"It is a responsibility of the Government to protect the consumers from being hood-winked into spending their scanty resources on useless, unnecessary and (at times) harmful drugs."

-- DRUG POLICY OF BANGLADESH
JUNE 1982

In June 1982, Bangladesh introduced a Drug Control Ordinance which called for the removal of nearly 1700 drugs from the market because they were useless, unnecessary or harmful. In a few short months, Bangladesh's Drug Policy has attracted world-wide interest. WAR ON WANT has prepared this briefing paper to provide some of the background to the events in Bangladesh and explain some of controversy behind the Drug Policy.

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This briefing paper was compiled by Andy Chetley, and is based on in the field interviews; press reports; War on Want, Oxfam and Health Action International materials.

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November 1982

Further reading on the Bangladesh Drug Policy:

Medicines and the Poor in Bangladesh, by Dianna Melrose; Oxfam, July 82.

The Rational and Economic Use of Drugs in the Third World; Health Action International, August 82.

In Touch, newsletter of the Voluntary Health Services Society, Bangladesh, July-August 82.

Further reading on pharmaceuticals:

The Health of Nations, by Mike Muller; Faber & Faber, May 82

Bitter Pills, by Dianna Melrose; Oxfam, November 82

Drug Diplomacy, by Charles Medawar & Barbara Freese; Social Audit, Spring 82

Who Needs the Drug Companies?, by the Haslemere Group; War on Want, 1976

- Bangladesh Ban HFM VIIA1
- Bangladesh Ban Rustic with VIIA1
- Bangladesh Ban Part 14 II VIIA1
- In Support of Bangladesh Ban VIIA1
- Review of the Bangladesh Ban situation VIIA1
- Bangladesh Land of the rich Prescription Andy War on Chetley Want
- Drug Control Ordinance Promulgated Bangladesh June 13, 1982 Observer VIIA1
- Criteria for Banning the drugs in Bangladesh VIIA1 hand

War on Want

467 Caledonian Road, London N7 9BE

November 1982

Looking ahead

THE BANGLADESH DRUG POLICY is a significant initiative in efforts to rationalise drug therapy. Health Action International, the network of non-governmental organisations active on pharmaceutical issues, notes that:

"Bangladesh has done what any health-conscious nation should do."

That includes, of course, industrialised countries. Although some efforts have been made in Britain to rationalise drugs, the latest edition of the British National Formulary lists some 500 products of marginal or questionable therapeutic value. There are likely to be other savings that could be made in Britain's drugs bill -- perhaps as much as 20% of the more than £2 billion annual expenditure.

Bangladesh has demonstrated that a rational drug policy can be introduced. It has also demonstrated that it is not an easy task. One member of the Expert Committee commented recently:

"The battle is far from over. The policy still has to be implemented in the face of continuing opposition and pressure. A vigorous doctor/consumer education campaign needs to continue in the country to counteract the deliberately planned confusion which has been created in respect of the drug policy."

If the policy in Bangladesh succeeds, it marks a major step towards ensuring that the people of Bangladesh receive quality, low-cost medicines which meet their specific needs. And if it succeeds, it could stimulate other countries to introduce similar measures.

The pharmaceutical industry is well aware of what is at stake. According to Business International, the success or failure of initiatives like the drug policy in Bangladesh

"could well determine whether TNCs will be able to retain their freedom to market a broad range of consumer and health-care products outside the industrialised world."

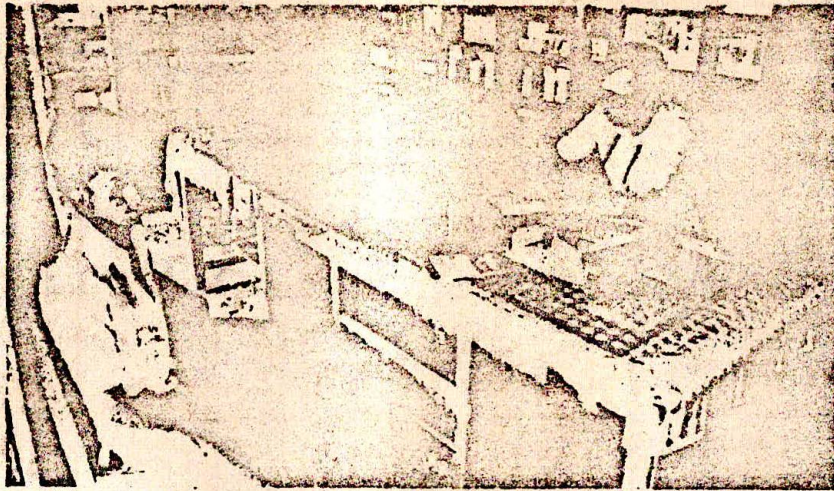
As George Teeling-Smith, Director of the industry-financed Office of Health Economics in the UK, said of the industry in 1979:

"They are businessmen, not bishops . . . If there is a hostile climate the companies must be expected to grab as much profit out of a country as they can."

And while the industry ponders its profits, and its freedom to market products which do not necessarily cater to public health needs, it is worth recalling a statement made by Dr Mahler of WHO, also in 1979:

"I have no illusions about lots of the cosmetic things going on, and I can only say that perhaps we have got the 'pharmaceutical cardinals' slightly more on their toes . . . This is not because all of a sudden they have been converted, but simply because they realise that in the kind of world in which we are living, there is a limit to indecent; and perhaps we have promoted a beginning of a platform for decency."

Perhaps, too, that is what the Drug Policy in Bangladesh has begun to do.



■ Pharmacists often double as doctors and prescribe their own wares. Many are untrained and unlicensed. Any drug can be bought without a prescription. Picture Tom Learmonth.

A tonic for Bangladesh

THE growing power of multinational companies is a matter of concern to governments and individuals alike. This is not surprising since present trends suggest that by the year 2000, 80 per cent of all world trade will be conducted by the multinationals.

The primary, if not sole, motivation of multinationals is profit maximisation. In the field of drug production this is intolerable.

The government of Bangladesh has adopted a rational drugs policy on the needs of the majority of the population in Bangladesh. The policy is need oriented rather than profit motivated and therefore a conflict of interests is evident from the outset.

It opens the door for similar initiatives from other governments who have a commitment to healthy people rather than healthy profits.

The government of Bangladesh has banned with immediate effect 237 largely "harmful" medicines and ordered the reformulation or withdrawal of a further 1505 "unnecessary" drugs by March 1983. These were the recommendations of an eight member committee of experts.

The products are marketed by 176 companies, although eight multinationals control 80 per cent of the drug market in Bangladesh.

The basis on which drugs have been banned fall into three main categories: harmful or unnecessary; drugs produced by the multinationals which require only simple technology; drugs produced under "third party" licensing agreements.

On harmful or unnecessary drugs the ordinance bans those with a combination of different antibiotics, analgesics, preparations of doubtful value such as grape water, cough mixtures and multivitamins (except the B complex).

An example of a drug in the harmful category is Orabolin. In Bangladesh malnutrition affects 97 per cent of the children. Orabolin is recommended by the manufacturers Organon in their promotional literature for use in children who are malnourished.

Orabolin is an anabolic steroid. In Britain it is used only in osteoporosis, chronic kidney failure, malignant disease and to build up patients after major surgery or serious accidents.

It anabolises and led to children the subsequent accelerated growth may be followed by premature stunting. It may also cause fluid retention and tumors of the liver.

BY JOHN CUNNINGTON

For these reasons the British Monthly Index of ethical drugs, MIMS, lists Orabolin as Not Recommended for Children.

Yet the manufacturers in full possession of the medical facts continued promotion of this drug for children in Bangladesh.

In accordance with the new policy on drugs of simple technology, the multinationals are also expected to concentrate their technology and resources on the production of complex and innovative drugs and to move out of the production of simpler preparations such as aspirin, paracetamol, vitamins and antiacids. At present 40-60 per cent of the manufacturing capacity of



multinationals has been devoted to producing drugs in this category.

The government has banned "third party" licensing — the practice whereby a company without a factory in Bangladesh licenses another company to make its brand name product. The ban comes as no surprise given the appalling record of failure to invest by the multinationals.

The new drugs policy is expected to produce foreign exchange savings in excess of £2 million per annum. This enables the government and health workers to concentrate on providing the most essential drugs to a larger section of the population.

Predictably the multinational drug companies are far from happy with the new policy. By the end of June sources in Bangladesh indicated that some of the major companies were threatening to withdraw all production facilities in the country including those for essential drugs unless the policy was reversed.

Most "new" drugs are highly questionable in therapeutic terms. For example in 1980 of the 1,087 drugs submitted to the US Food and Drug Administration for product licences, just over 2 per cent were considered to be of high therapeutic breakthrough; a little over 8 per cent were considered to be of moderate therapeutic advance; whilst the remaining 89 per cent were classed as being of little or no therapeutic advantage.

In other words 9 out of 10 drugs have little value in health terms.

They do however represent significant gains in terms of profits.

More sinister if not surprising is the move by governments, particularly the US, to get the new policy "reappraised". When Lt Gen Ershad, chief martial law administrator of Bangladesh, was in New York recently to address the United Nations he was approached by the multinationals and urged to reconsider the drug policy.

Similarly in Bangladesh the US ambassador, Jane Coon, has also approached Lt Gen Ershad and Major General Shamsul Huq, government health advisor, on behalf of the multinational interests.

With its adopted slogan of "Health for All" one could be forgiven for assuming that the World Health Organisation would back a policy which argues for putting into practice the recommendations of their "Essential Drugs List".

The list itself has undoubtedly made a great contribution to health care since it was written in 1977. It is therefore even more disturbing to note at this time that according to the WHO representative in Bangladesh replying to a question regarding the adoption of the new drugs policy "...it is not WHO's role to either applaud or condemn the policy."

The stakes are high and the multinationals have not been slow to react to the drugs policy.

The US had demonstrated previously just how far it will go to prevent sovereign governments from adopting similar policies. In Sri Lanka, when Pfizer was asked to produce more in accordance with the needs of the country and also cut the manufacture of unnecessary drugs from 40 to 25 per cent the US government threatened to stop all food aid under the PL480 agreement.

Pfizer still refused to modify production in accordance with the needs of Sri Lanka. Similarly in 1974 a contract to sell 4 million jute bags to Cuba was seen to "be prejudicial to the further commitment of USPL480 food aid."

It remains to be seen whether the government of Bangladesh can resist the pressure from multinational corporations and put into practice a rational health policy.

Or whether, under pressure, they are forced to seek ways and means of "modifying" the policy in the interests of their own survival.

■ John Cunningham is War on Wants programme officer for the Indian sub-continent.

Dangerous medicines

FOR MANY YEARS health workers in Bangladesh have been concerned about the misuse and abuse of drugs in Bangladesh. As early as 1957 articles began appearing in Bangladesh publications about the need to control the marketing of drugs in Bangladesh.

The problems that were noted were the promotion of inappropriate drugs; the expense of many drugs on the market, and the fact that they often diverted scarce resources away from less expensive and as effective remedies for basic health problems; and the presence on the market of both useless and potentially harmful drugs.

Two examples of the way in which the pharmaceutical industry treated its customers in Bangladesh are shown in the advertisements reproduced on this page.

Orabolin is an anabolic steroid, manufactured by the Dutch company, Organon. In Bangladesh the product has been advertised as a good treatment for malnutrition in children. In Britain, doctors are advised by Organon that the product is "not recommended for children" because of the potential side-effects which include stunted bone development. A leading specialist in steroids, Professor Jeffcoate comments:

"If anabolic steroids were used in Western Europe to promote growth in children, there would be a massive public outcry."

Similarly, Bristol-Myers, a US-based pharmaceutical company, showed little regard for correct information in its advertising during 1980 for CeeNu capsules -- which according to the company was a life-saving anti-cancer drug. In the US, it is only allowed to be administered by a few hundred specialist for two specific forms of cancer, because of its "limited effectiveness" and "deadly adverse reactions."


The dishonesty of the claims made for many pharmaceutical products like these was one of the factors that led to the establishment of an Expert Committee to:

"evaluate all the registered/licensed Pharmaceutical Products presently available in the country and to formulate a draft National Drug Policy consistent with the health needs of the country."

The Committee was set up in April 1982. Within 12 days, it had finalised its report, and the basis for the new Drug Policy was established.

Help the child to grow with

Orabolin




A child's world is full of joy and laughter, love and care of parents. And that is what all children need to grow healthy and sturdy. But it is not always so. Unbalanced diet, poor appetite and frequent illness often interfere with the normal growth of children.

Orabolin

- Ensures normal growth
- Stimulates appetite
- Promotes optimal weight

GROWTH IN EVERY DROP STRENGTH IN EVERY TABLET


ORGANON (BANGLADESH) LIMITED

The Orabolin advertisement appeared in a conference magazine on "The Role of Rural Doctors in Child Care", which took place in Faena's Children's Hospital in May 1981. The conference was sponsored by the World Health Organisation and the Bangladesh Ministry of Health.

Bristol Myers' 'Third World' cancer cure

While Bristol-Myers may think it can convince the citizens of Bangladesh that it's discovered a cure for cancer, consumers in the U.S. thanks to government regulations are protected from such misleading claims. In the January 31 issue of the *Bangladesh Times* the U.S. multinational trumpeted the introduction of CeeNu capsules in the country, and identified the drug as a "life-saving anti-cancer" agent, an inaccurate characterization that would not have been permitted in the U.S.

When the *Monitor* received a copy of the ad, we immediately

ANNOUNCEMENT

We are pleased to announce that our life-saving Anti-cancer drug "CeeNu Capsules" are now available in Dacca with all important chemists and druggists. "CeeNu" will be served to the patients only against doctors' prescriptions. The Controller General of Prices & Supplies, Government of the People's Republic of Bangladesh, has fixed the maximum retail price of each combination pack (containing 6 capsules) at Tk. 542.25.

BRISTOL-MYERS (BANGLADESH) INC.
Branch of
BRISTOL-MYERS COMPANY INTERNATIONAL
DIVISION
New York, U.S.A.
Facsimile of Bristol-Myers' ad

turned to the Physicians' Desk Reference (PDR), an authoritative directory of vital information on drugs sold in the U.S. CeeNu's PDR entry paints a picture far different from Bristol-Myers' claims. The drug is of extremely limited effectiveness and can generate deadly adverse reactions. In the U.S., the Food and Drug Administration recommends that specially-trained doctors, numbering only several hundred in the entire country -- administer it as a secondary therapy for two specific forms of cancer: brain tumors and Hodgkin's disease. Bristol-Myers' ads for the drug in U.S. medical journals run to two full pages, and include a detailed account of hazards associated with its use.

Milton Ellic, a Bristol-Myers official, expressed alarm at the ad. Labelling it "a little more aggressive than what we nor-

mally print" and "very inappropriate," Ellic pledged to identify those responsible, saying "I'm interested in investigating who could be running an ad like this."

Ellic explains that while Bristol-Myers operates a 100% wholly-owned subsidiary around the world, it is a "fresh new to the international drug business." Each subsidiary has free reign over marketing and does not have to launch promotion campaigns with company headquarters. "A lot of our markets are inexperienced in promoting these products," he says.

Officials at the Bangladesh Embassy in the U.S. are not moved by Bristol-Myers' "impropriety." Ambassador Iqbal Hussain has sent the ad, along with CeeNu's PDR description to Bangladesh via diplomatic pouch for review by the country's medical board. This will be taken very seriously in Bangladesh," emphasizes Mehdiul Alam, counselling officer at the embassy. *Leslie Wall*

Bristol-Myers advertisement appeared in the 31 Jan 1980 issue of the *Bangladesh Times*. Report of the incident reprinted from *Multinational Monitor*, March 1980

Irrelevant medicines

ANOTHER PROBLEM facing Bangladesh was that many of the drugs on the market were irrelevant to the health needs of the Bengali people.

In 1981, an estimated 1500 million Taka (approx. £39 million) was spent on drugs in Bangladesh. According to the Expert Committee:

"Nearly one-third of this money was spent on unnecessary and useless medicines such as vitamin mixtures, tonics, alkalisers, cough mixtures, digestive enzymes, palliatives, gripe water, and hundreds of other similar products."

One of those products, Polytamin Tonic, manufactured by the West German firm, Hoechst, was described by the Expert Committee as a:

"combination vitamin tonic including vitamin B12 and alcohol; one of the most abused drugs on the market."

Hoescht argues that:

"Bangladesh is in a chronic state of malnourishment, the vital supply of polyvitamins is essential in countries where a balanced diet is not available."

Dr Martin Schweiger who spent many years working in rural areas in Bangladesh rejects Hoechst's argument:

"Malnutrition is not treatable at all by drugs, and it is the biggest single problem -- malnutrition is treated with food. People will die from lack of calories long before they die from lack of a particular vitamin."

Doctors at the Children's Nutrition Unit in Dacca, a hospital which only admits children suffering from third-degree malnutrition -- the most severe cases, agree with Schweiger. As part of their efforts to deal with malnutrition, the doctors provide a training course for mothers of the children and encourage the mothers to stay with their children while they are in the hospital. In this way,

"the mothers see that it is food, not some medicine or drug that we give their babies to help them recover. They then see the importance of the right kind of food -- and food that they can afford."

Obviously, money spent on useless vitamins and tonics is money that cannot be spent on purchasing the right kind of food. In an industrialised country like Britain, wasting money on unnecessary drugs is merely foolish. In a country like Bangladesh, it can be a matter of life and death.

This type of waste affects not only the individual family by leading to a substitution of non-essential products for essential nutritious foods, but also has a displacement effect on the production of essential medicines. The Expert Committee noted:

"Though the multinationals have all the technologies and know-how to produce sophisticated essential drugs and basic pharmaceutical raw materials, in Bangladesh these companies are engaged mostly in formulation of simple drugs, including many useless products such as vitamin mixtures, tonics, gripe water."

As a result, 90 of the 182 essential drugs needed for the public health services are not produced in Bangladesh.

The International Federation of Pharmaceutical Manufacturers Associations (IFPMA) -- representing most of the world's major pharmaceutical companies -- states in its code of practice that all the products made by the industry should have "full regard to the needs of public health". In Bangladesh, it is clear that regard has been missing.

Expensive medicines

BAD MEDICINE inflicts a high cost on health. It also costs in monetary terms.

The pharmaceutical industry in Bangladesh constitutes a large drain on foreign exchange. Despite having 177 licensed pharmaceutical companies in the country, it was still necessary to import nearly £8 million worth of finished drugs every year. On top of this, an estimated £16 million worth of raw materials are imported each year.

Obviously, cutting back on the number of drugs -- by getting rid of those which are non-essential -- is one way of decreasing that foreign exchange drain. Another way is to tackle the structure of the industry and control some of its trading patterns.

The market for drugs in Bangladesh is dominated by just eight trans-national corporations (TNCs). They are:

Fisons (UK)	-- approx 11% of total market
Glaxo (UK)	-- approx 9% of total market
ICI (UK)	-- approx 5% of total market
Pfizer (US)	-- approx 16% of total market
May & Baker (Fr)	-- " 10% of total market
Hoescht (Ger)	-- " 9% of total market
Squibb (US)	-- approx 9% of total market
Organon (NL)	-- " 5% of total market

Together, they control some 75% of the market. This domination of the market by the TNCs leads to the opportunity for "transfer pricing" with the raw materials. In this way, the local subsidiary in Bangladesh is charged more by the parent company for raw materials than if the materials were purchased on the open world market. Squibb, for example, paid three times more than a local company to import tetracycline. ICI paid five times more for levamisole than a local manufacturer. May & Baker paid five times more to import metronidazole than local manufacturers.

The usual justification for this practice is to ensure quality. Squibb says for example:

"We buy from our affiliates because we are guaranteed the materials will conform in every particular to the exacting Squibb standards . . . We cannot risk wasting precious foreign exchange import licences on critical materials from outside vendors that may prove to be sub-standard and therefore unusable."

A World Bank study on pharmaceutical production in Bangladesh came to a different conclusion. It estimated that considerable savings could be made if the cheapest reliable sources of raw materials were used, and if local production was undertaken.

The experience of Mozambique supports this view. Mozambique tenders for drugs on the open market, buying at the best possible price. A recent report notes:

"Drug imports in Mozambique today cost the same as they did 10 years ago: about US \$1 per person. Mozambique is buying a lot more drugs for its money, simply by not wasting money on useless and dangerous drugs, on fancy packets, and on well known trade names."

Making a policy

THE EXPERT COMMITTEE had a difficult task ahead of it.

It consisted of eight members, all with expertise in pharmaceuticals -- indeed, three of the members had served on a previous Expert Committee in 1971.

Chairman of the Committee, Professor Nurul Islam, noted the commitment of the members of the Committee:

"The task was admittedly herculean. The sincerity of the members was much more than one could expect. During the entire procedure the principle of unanimous decision with up-to-date scientific logic was strictly followed and could be achieved."

The Committee first of all established a list of 150 essential drugs "considered adequate for most therapeutic purposes" and envisaged the need for a list of about another 100 drugs to deal with specialist health care needs.

After establishing the basic elements and objectives of the Drug Policy, (reproduced right), the Committee went on to draw up a set of 16 criteria for evaluating drugs on the market in Bangladesh.

Professor Islam said:

"All the criteria were scientific. No-one anywhere could challenge it. We based the criteria on the most up-to-date scientific information -- current information -- 1982 information. This is rare for a developing country. Usually the information available is years out of date -- not just one or two years -- but several."

The criteria are reproduced on the next page. Twelve of the points deal with health aspects primarily, while the remaining four deal with economic considerations.

Once the criteria were established, it was a relatively simple task to check the list of drugs on the market. Out of 4140 products examined, the Expert Committee decided that 1707 products should be removed. These products were divided into three categories:

1. Those that were positively harmful and that should be removed within one month -- 305 drugs;
2. Those that needed to be reformulated in order to stay on the market, within 6 months -- 134 drugs;
3. Those that were useless or unnecessary, either because of a lack of efficacy or because an alternative was already available. The Committee recommended 6 months for their removal -- 1268 drugs.

The report of the Expert Committee was submitted to the Chief Martial Law Administrator on 12 May 1982, and after two minor amendments -- extending the time allowed for the first category to 3 months, and the third category to 9 months, the Policy became law on 12 June.

The main elements of the National Drug Policy are as follows:

- (a) to ensure that the common people get the essential and necessary drugs easily and at a cheap rate and to ensure that such drugs are of good quality and are useful, effective and safe;
- (b) to take steps to ensure that the price of the imported as well as the locally manufactured drugs is brought within the reach of the people;
- (c) to stop in a gradual way import and manufacture of such costly drugs as are neither essential nor required for treatment and for which appropriate substitutes are available;
- (d) to provide, on a priority basis, required facilities to local drug manufacturing industries so that self-sufficiency is attained in the manufacture of essential drugs;
- (e) to prohibit the import, manufacture and sale of drugs which have been or will be adjudged useless or injurious by the experts. If any drug is specifically identified as injurious to health, the import, manufacture, distribution and sale of such drug will be immediately banned and steps will be taken to destroy its stock;
- (f) to exercise government control over advertisement so that common people are not hoodwinked by commercial advertisement on health matters and on useless, unnecessary and injurious drugs;
- (g) to exercise control on the import of drugs and raw materials so that these are made available at reasonable price. Government may establish control over the import or manufacture of packaging and container materials so that these do not lead to excessive cost of finished drugs;
- (h) to entrust the local companies with the responsibility of manufacturing those drugs which they can produce in adequate quantity and to entrust the foreign companies to gradually manufacture high quality drugs, consistent with their ability and skill;
- (i) to entrust all local/foreign companies with the responsibility of ensuring that all the essential drugs are manufactured in the country. With this end in view, the government may make it obligatory on these companies to manufacture essential drugs according to their production capacity;
- (j) to ban the manufacture, sale and distribution of bogus, adulterated and sub-standard drugs and to award exemplary punishment to persons guilty of such actions. Similarly, the production or sale/distribution of drugs prohibited as being unnecessary and undesirable, will be penalised. This measure will also be applicable in the case of Ayurvedic, Homeopathic and Unani medicines;
- (k) to constitute necessary number of Drug Courts to try guilty persons and to punish them expeditiously. Such Courts shall have at least the powers of a Sessions Court;
- (l) To strengthen the system of procurement, storage and distribution of drugs and medicines so that these are accessible to people in all areas of the country and also to ensure that there is no wastage of drugs and medicines. To achieve this, necessary administrative structure of Drug Administration, Medical Storage and the Drug distribution system may be improved; and
- (m) To take gradual steps to manufacture, distribute and sell drugs by their generic names.

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Criteria of the Drug Policy

It is unanimously decided that the following criteria will serve as the guidelines in evaluating all the registered/licensed Pharmaceutical products manufactured and/or imported in Bangladesh:

- (i) The combination of an antibiotic with another antibiotic or antibiotics with corticosteroids or other active substances will be prohibited. Antibiotics harmful to children (e. g. Tetracycline) will not be allowed to be manufactured in liquid form.
- (ii) The combination of analgesics in any form is not allowed as there is no therapeutic advantage and it only increases toxicity, especially in the case of kidney damage. The combination of analgesics with iron, vitamins or alcohol is also not allowed.
- (iii) The use of codeine in any combination form is not allowed as it causes addiction.
- (iv) In general, no combination drugs will be used unless there is absolutely no alternative single drug available for treatment or if no alternative single drug is cost-effective for the purpose. Certain exceptions will be made in the cases of eye, skin, respiratory and haemorrhoidal preparations, cotrimoxazole, oral rehydration salts, antimalarials, iron folic acid etc. as well as certain vitamin preparations allowing combinations of more than one active ingredient in a product.
- (v) Vitamins should be prepared as single ingredient product with the exception of B. Complex. Members of vitamin B. Complex with the exception of B₁₂ may be combined into one product. B₁₂ always has to be produced as a single ingredient injectable product. Other members of B. complex may also be produced as single ingredient product (e.g. B₁, B₂, B₆, etc.). Vitamins will not be allowed to be combined with any other ingredient such as minerals, glycerophosphate etc. Vitamins will be allowed to be produced in tablets, capsules and injectable form only.
No liquid forms will be permitted because of wastage of financial resources and the tremendous misuse involved. However, paediatric liquid multi-vitamin (with No. B₁₂, EK and/or minerals) will be allowed to be manufactured in bottles of up to 15 ml. size with droppers. Paediatric liquid preparations of single ingredient vitamins will also be allowed to be manufactured in bottles of up to 15 ml. with droppers.
- (vi) No cough mixtures, throat lozenges, gripe water, alkalis, etc. will be allowed to be manufactured or imported as these are little or no therapeutic value and amount to great wastage of our meagre resource.
- (vii) The sale of tonics, enzyme mixtures/preparations and so-called restorative products flourish on consumers' ignorance. Most are habit-forming and with the exception of pancreatin and lactase these are of no therapeutic value. Henceforth, local manufacture or importation of such products will be discontinued. However, pancreatin and lactase will be allowed to be manufactured and/or imported as single ingredient products.
- (viii) Some drugs are being manufactured with only a slight difference in composition from another product but having similar action. This only confuses both patients and doctors. This will not be allowed.
- (ix) Products of doubtful, little or no therapeutic value and those which are sometimes rather harmful and are subject to misuse, will be banned.
- (x) All prescription chemicals and galenic preparations not included in the latest edition of British pharmacopoeia or British Pharmaceutical Codex will be prohibited.
- (xi) Certain drugs, in spite of known serious side-effects and possibility of misuse but having favourable risk-benefit ratio, may be allowed to be produced in limited quantity for restricted use. These will be prescribed by specialists only.
- (xii) The same or close substitute of a drug which is being produced in the country will not be allowed to be imported as a measure of protection for the local industry. However, if local production is far short of needs, this condition may be relaxed in some cases.
- (xiii) A basic pharmaceutical raw material which is locally manufactured will be given protection by disallowing it or its substitute to be imported, if sufficient quantity is available in the country.
- (xiv) The role of Multinationals in providing medicines for this country is acknowledged with appreciation. In view of the calibre of machinery and technical know-how which they have for producing important and innovative drugs for the country, the task of producing antacids and vitamin will lie solely with the national companies, leaving the multinationals free to concentrate their efforts and resources on those items not so easily produced by smaller national companies. Multinationals will, however, be allowed to produce injectable vitamins as single ingredient products.
- (xv) No foreign brands will be allowed to be manufactured under licence in any factory in Bangladesh if the same or similar products are available/manufactured in Bangladesh, as this leads to unnecessary high prices and payment of royalties. In the light of this policy all existing licensing agreements should be reviewed.
- (xvi) No multinational company without their own factory in Bangladesh will be allowed to market their products after manufacturing them in another factory in Bangladesh on toll basis.

ONLY 174 PRODUCTS manufactured by the eight leading TNCs were affected by the Drug Policy. However, in financial terms, the impact could well be considerable. For example, seven vitamin and antacid products manufactured by Squibb which were banned as a result of the Policy, contributed 45% of Squibb's total turnover in Bangladesh in 1980. Certainly, as soon as the Policy was announced, the TNCs lost no time in protesting about it. The first response was a full page advertisement in all the leading Bangladesh newspapers suggesting that the policy would bring about the destruction of the pharmaceutical industry in Bangladesh. Interestingly enough, most of the truly national companies in Bangladesh, looked on the policy favourably, even though they had the most products that had to be removed. In the long term, however, the Policy offered some safeguards for the promotion of local industry -- thus most national companies could hope to derive some benefit.

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The Policy changes

AMIDST ALL THE PRESSURE, the Bangladesh government decided to establish a Review Committee to take a second look at the Drug Policy. The Review Committee consisted of six military doctors, and on 12 August it submitted a report to the government.

The report has remained unpublished. While waiting for a new decision on the Drug Policy, the TNCs began a new line of attack. Because of the support for the policy announced by War on Want and Oxfam, and because both organisations have been involved in funding the major health care project Gonoshasthaya Kendra (GK) in Bangladesh -- a project which includes a small pharmaceutical factory -- the industry decided to smear both organisations. In a one and one-third page advertisement, the industry claimed that War on Want and Oxfam were responsible for much of the content of the policy, and that our intention was to destroy the pharmaceutical industry in Bangladesh, so that War on Want and Oxfam could take over the import of drugs into Bangladesh, and so that the pharmaceutical factory at GK could have a monopoly on the production of drugs.

Both War on Want and Oxfam were attacked for being "foreign" organisations by the industry. Conveniently, the industry failed to mention that its leading corporations were foreign. It was an example of the industry failing to deal with and accept the basic arguments behind the policy -- choosing rather to attack anyone who supported it. It was a way of trying to stir up antagonism to the policy, by questioning the motivation of those groups and individuals who supported it.

Happily, that strategy failed. On 6 September, the Government announced an ammendment to the Drug Policy, arrived at after reading the report of the Review Committee and reading it in conjunction with the report of the Expert Committee. Four basic changes were made:

1. 41 drugs that were originally banned, were permitted to remain on the market. Most of these fell into the category of useless or unnecessary.
2. The time limit for reformulation of drugs in the second category was extended from 6 months to one year; the time limit for removal of the drugs in the third category was extended from 9 months to 18 months.
3. Existing third-party licensing agreements were allowed to continue until their expiry date, rather than be terminated early.
4. Some balms and ointments due for removal under the third category may be reconsidered at a later date.

Thus, despite the pressure exerted by the TNCs and by Western governments, most of the Drug Policy has remained intact. Several observers in Bangladesh have commented that, undoubtedly, one of the reasons for this has been the strong support the policy has received from around the world.

Pressure from the West

LOOKING FOR ALLIES, the TNCs turned to the US and other Western governments for support. The US responded quickly. US Ambassador to Bangladesh, Mrs Jane Coon called on the Bangladesh government and urged the amending, if not the rescinding of the policy. In late July, Mrs Coon helped arrange for a group of "scientific experts" from the US to fly to Dacca and have meetings with Bangladeshi officials. The "experts" were from:

the Pharmaceutical Manufacturing Association of America;
Squibb;
Wyeth;
Smith Kline.

In August, the US State Department admitted that the Pharmaceutical Manufacturers Association had asked it "to bring pressure on the Bangladesh government to delay implementing the law pending discussions with the manufacturers."

According to a State Department spokesman:

"The State Department has a statutory responsibility for assisting American interests abroad. In this particular case, the US Government is also concerned that these regulations may inhibit further investment in Bangladesh."

His words were virtually echoed by Douglas Hurd, Minister of State at the Foreign and Commonwealth Office in Britain:

"We are keen that the Bangladesh Government should use its scarce resources wisely. We are also keen that they should succeed in their policy of encouraging foreign investment to help with the development of an industrial economy. We, in common with other Western governments, have explained this to the Bangladesh Government through our High Commission in Dacca. It is important that in trying to achieve the aims of the pharmaceutical policy they do not discriminate against foreign owned manufacturing companies in Bangladesh and do not frighten off prospective foreign investors."

U.S. Is Aiding Drug Companies In Bangladesh

By Penny Chorlton
Washington Post Staff Writer

The United States, responding to an appeal from several multinational drug companies, has asked Bangladesh to reconsider a new national policy designed to ban hundreds of drugs that it says are ineffective, dangerous or too expensive.

Among the drugs Bangladesh wants to ban are several that are not permitted in the United States, including cloquinol, a chemical that is known to cause serious damage to the nervous system. More than 70 percent of the drugs on the list have been described by the Food and Drug Administration or its British counterpart as therapeutically worthless.

A spokesman for the State Department acknowledged yesterday that the Pharmaceutical Manufacturers Association (PMA), a trade organization for the drug industry, asked it to bring pressure on the Bangladesh government to delay implementing the law pending discussions with the manufacturers.

"The State Department has a statutory responsibility for assisting American interests abroad," the spokesman said. "In this particular case, the U.S. government is also concerned that these regulations may inhibit future foreign investment in Bangladesh."

But the U.S. action has been con-

U.S. Helps Sell Drugs in Bangladesh

WASHINGTON POST, 19 AUG., 1982

DRUGS. From AI demned by several international and U.S. charity and consumer groups. "Encouraging this review is certainly not helping the people of Bangladesh," said a spokesman for War on Want in London yesterday.

The Washington-based Public Citizen Health Research Group, in a letter addressed to Secretary of State George P. Shultz, called the action "unconscionable."

"Perhaps you are unaware that many of the U.S.-based multinational drug companies are foisting on innocent people in the developing countries drugs which our own medical authorities consider worthless and unnecessary," the letter said.

The group expressed dismay that the State Department had allowed itself "to be used by the giant multinational drug companies to promote and protect their exploitation of the impoverished citizens of undeveloped countries."

The law, which was announced by the Bangladesh military government in June, prohibited the future sale of more than 1,700 drugs and immediately banned 237 products which were considered dangerous. Among the American drugs mentioned were products made by Merck, Pfizer, Searle, Squibb and Upjohn.

According to the members of the committee that drew up the new policy, eight multinational companies, including the American companies Pfizer and Squibb, shared 75 percent of Bangladesh's \$100-million-a-year drug market. Pfizer dominated the market with more than \$10 million in sales in 1981, while Squibb sold around \$5 million in the same year.

Nineteen Pfizer drugs appeared on the list of drugs to be banned immediately, including its Stericol capsules, which contain cloquinol. Among the 22 Squibb products listed were Quixaline tablets and Suspension, both of which also contain cloquinol. Neither Pfizer nor Squibb would comment on the new law or the drugs named in it.

A spokesman for the pharmaceutical association, which led a delegation representing the drug companies on a recent week-long trip to Bangladesh to make the industry's views known, described the new law as "precipitous" and prejudicial to public health.

PMA argues that blocking the flow of drugs from its member companies could open the market in Bangladesh to uncertified and potentially impure drugs from other sources.

Bangladesh is the third-poorest country in the world, according to statistics from the World Bank, with the lowest per capita income, the lowest life expectancy and the highest infant mortality of all the developing countries. Approximately 60 percent of the country's health budget is devoted to the purchase of drugs, compared to less than 10 percent in the United States.

Because of that, Bangladesh is eager to bring its drug outlets under control, and to begin to produce some of the less complex, common drugs domestically.

The Bangladesh committee acknowledged "with appreciation" the role of the multinationals, but urged them to devote their "machinery and technical know-how" to producing

important and innovative drugs and leave the production of simple and cheap drugs to the domestic companies.

Worldwide drug sales to the developing countries exceed \$30 billion a year, however, and the multinational drug companies fear that other developing countries will follow Bangladesh's example.

The economics attache at the Bangladesh Embassy in Washington said of the new law, "I think it is a very good step forward." But he said the review requested by the State Department was normal and "not important."

It is not the first time a developing country has tried to limit the consumption of drugs produced by the multinational drug companies. The government of Sri Lanka made a direct approach to Pfizer in the early 1970s asking it to decrease the manufacture of unnecessary drugs from 40 to 25 percent.

"Pfizer refused to modify its production in accordance with the health needs of Sri Lanka," said John Cunningham, the program officer for the Indian subcontinent at London's War on Want. "What is more, the United States threatened to stop all food aid if further action was taken."

No such threats are apparently being made in connection with the new Bangladesh law, but the Interfaith Center on Corporate Responsibility in New York said that the government there was "particularly sensitive to the United States" because the United States provides substantial food aid and financial assistance to finance its development program.



Squeeze by drug lobby

by Rosemary Rightler

AMERICAN drug companies are putting heavy pressure on Bangladesh, one of the world's poorest countries, to drop plans which would make essential drugs cheaper and limit the sale of expensive medicines.

Two months ago, acting on recommendations by the World Health Organisation, Bangladesh announced legislation establishing a list of 250 essential medicines, banning 237 as dangerous, and directing that supplies of 1,500 others should not be removed.

Within days, the US ambassador to Bangladesh, Jane Coon, urged the government to reconsider. She persuaded it to set up a review committee, composed of military doctors, which is to report in the next few days.

The government, which will make its decision within 10 days of receiving the committee's conclusions, will be lobbied up to the last minute.

A group of "scientific experts" flew into Dacca last week to help the committee and to see ministers. It included a representative of the Pharmaceutical Manufacturing Association of America and executives from three corporations with stakes in the \$25-million-a-year Bangladesh market: Squibb, Wyeth and SmithKline.

A US State Department spokesman said on Friday that their meetings, arranged by Mrs Coon, had been "very useful". He said the US government became involved because it had a responsibility "to assist companies that have problems with foreign governments". Mrs Coon, he said, had been "careful to say that these are the concerns of the drug companies; we simply want a solution acceptable to both sides."

There had been no attempt to link the issue to US aid in Bangladesh. However, the State Department is considering an invitation by European governments to join them in a formal approach to the Bangladesh government. US companies dominate the Bangladeshi markets, but others are active there, including ICI, Eisson and Glaxo of Britain. The companies are trying to persuade Bangladesh to list more drugs as essential. They also object to the ruling that local companies should produce simple products such as vitamins.

They argue that the government, which was guided by experts, headed by Dr Nousoor Islam, an internationally respected paediatrician, should have consulted them.

The stakes for the drug companies are high. Bangladesh is the first country to adopt WHO guidelines. These urge governments to list drugs that will meet national health needs, ensure they are reasonably priced, and restrict the sale of unnecessary, or dangerous drugs.

Other countries could follow suit, threatening the multinational's huge and rapidly expanding Third World market.

Sunday Times
SUNDAY 22.8.1982
9 Aug, 1982

Avoiding the Policy

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1.13

THREE WAYS OF AVOIDING THE POLICY have begun to emerge in Bangladesh. First, drugs that were due to be destroyed on 12 September, have not been destroyed. These are the products termed "harmful" by the Policy. However, on 10 September, three companies -- ICI, May & Baker and Organon -- applied for export licences for their products. At first, the request was refused, but finally on 6 October, export licences were granted for their products, and for all the other products included in the first category of drugs. The three companies all intended exporting the banned drugs to other developing countries in either Africa or the Middle East.

Secondly, companies who have products which must be removed within 18 months have begun asking for permission to import some raw materials, in order to complete the ingredients required for particular drugs, and thus be able to use up existing stocks of raw materials in the country. So far, those requests have been denied, as the Bangladesh Drug Controller recognises that with careful juggling, a company could continue producing a banned drug right up to the 18-month deadline, and then appeal for more time to use up the last of the stock.

The third way of avoiding the policy is to appeal for the retention of a particular drug on the grounds that it meets some essential need. Pfizer has successfully done this with Heptuna-Plus, an iron and vitamin preparation. One leading gynecologist, Professor F. Begum -- who is also a local director of the Pfizer subsidiary -- claimed the product was indispensable for the treatment of anaemia in pregnant women.

Drug giants sell on

Products banned in Bangladesh
are to be re-exported reports
Amrit Wilson

ON 6 OCTOBER eight major drug companies whose products were banned as harmful or unnecessary under Bangladesh's new Drug Ordinance (NS 9 July) wrung a major concession from the government -- they were granted export licences for the medical preparations which were due for destruction in Bangladesh on 12 September. These preparations may now well end up in other Third World countries.

The Drug Ordinance, announced in June following the recommendations of an Expert Committee, had banned several categories of drugs, for example liquid formulations of antibiotics unsuitable for children (like ICI's Imperacin Syrup); combinations of antibiotics, of analgesics or of vitamins; and all cough mixtures, throat lozenges and gripe waters 'because they are of little therapeutic value and amount to a great wastage of our meagre resources'. In addition the Ordinance put an end to Third Party Licensing, under which multinational drug companies with no factories in Bangladesh marketed products manufactured in Bangladeshi fac-

New Statesman, 29 Oct 1982
tories under their brand name.

The drug companies responded by rallying their supporters. British, US and Dutch diplomats visited government officials and ministers to urge reconsideration. In August, while the World Health Organisation's local representative refused to 'applaud or condemn' the new policy, the drug companies themselves placed advertisements in the major dailies denouncing it as an international plot engineered by Oxfam, War on Want and Gonoshasthya Pharmaceuticals (a Bangladeshi firm which had received some funding from the charities). The Ordinance was, the companies claimed, a Christian plot against the Muslims.

In the face of these pressures the Bangladesh government has acceded to a number of specific demands -- the granting of the export licences for harmful drugs is the latest. Now, although the main principles of the drugs policy remain intact, there is a danger that special cases are being created which will re-open the door for categories of drugs which are now banned.

Pfizer, for example, has successfully cleared the drug Heptuna Plus. This is a mixture of iron, folic acid and multi-vitamins. As such it had failed the criteria of acceptability laid down by the Expert Committee. However, following the insistence of certain gynaecologists -- among them Professor Feroza Begum, a director of Pfizer -- that the drug is necessary treatment for anaemic mothers, the ban on Heptuna Plus has been lifted. Meanwhile, other drug companies are claiming to be short of just one

ingredient for some preparation which they must import in order to be able to use up stocks of the other ingredients. So far the government has held out against this.

Concessions made to the drug companies include allowing third party licences to run their terms (though they will not be renewable); and extending the time limit on certain preparations from nine months to 18 months to use up stocks. In addition, drugs categorised as harmful are now awaiting shipment from Bangladesh. According to Andy Chetley of War on Want who has just returned from Dacca:

There is nothing to stop these drugs being exported to other developing countries. ICI's tetracycline syrup might go back to England for re-export under a new label to Saudi Arabia; BPI (May and Baker) may send their drugs back to West Germany to be re-routed to West Africa; and Organon's Orabolin drops could reach Saudi Arabia and Africa via Europe.

However Jeff Holman of ICI's pharmaceutical department said: 'The drugs are not being sent back here. Where they'll go from Bangladesh is a commercial and legal question.'

Will Bangladesh's drug policy survive? Members of the Expert Committee, like Professor Nurul Islam, are optimistic. International support (from health workers and non-government organisations) has been of crucial importance, they say. The drug companies now have a new factor to contend with: 'When people are given prescriptions they are asking the doctors if any of the drugs are banned . . . the policy has changed the prescribing habits of doctors.' □

What about WHO?

THE WORLD HEALTH ORGANISATION (WHO) has been slow to offer its support for the Drug Policy in Bangladesh. At times, in fact, it has played into the hands of the TNCs by either refusing to comment on the policy, or by making ambiguous statements.

WHO's representative in Bangladesh, Dr Z. Sestack, was reported in early July as commenting:

"It is not WHO's role to either applaud or condemn the policy."

It was a surprising statement, given that WHO had developed an Essential Drugs List as long ago as 1977, which formed the basis for many of the decisions incorporated into the Bangladesh Drug Policy. More recently, WHO has initiated an Action Programme on Essential Drugs which is designed to encourage governments to pursue rational drugs policies and concentrate their efforts on providing essential drugs.

Professor Islam sees the Bangladesh Policy as being a necessary step in providing essential drugs:

"If you want to make good medicine reach the people, you must take away the bad medicine."

In order to clear up any misunderstandings about WHO's position on the Bangladesh Drug Policy, War on Want wrote to WHO Secretary General Dr Halfdan Mahler in July asking WHO to publicly support the Policy. War on Want received a response that noted that Dr Mahler would make a statement on the Policy in September when he would be in Bangladesh.

Finally, in September, at WHO's South East Asia Regional Committee meeting held in Dacca, Dr Mahler said:

"I take this opportunity of congratulating our host country on its courage in starting to put its drug house in order along the lines recently endorsed by the World Health Assembly."

Despite this statement, however, whenever Dr Mahler was questioned by the press in Bangladesh, he studiously avoided comment on the Drug Policy. This has led some observers to question whether WHO's reluctance is related to its dependence on the US for 25% of its budget.

WHO

How would you like the World Health Organisation (WHO) to ask the government of Bangladesh to make comments on your magazine? Dr Cohen, of WHO testily replied when he was asked to comment on Bangladesh's new National Drugs policy, which will ban more than 1700 unnecessary drugs by the end of this year.

Since the new Bangladesh policy was announced, WHO has been swamped with requests to make a statement on the matter. For some time the organisation has been proposing that developing countries adopt a list of essential drugs. But WHO itself is under pressure from the drugs giants.

WHO says that it is "not entitled to comment on policies of member states". But there is the suspicion that the organisation is unwilling to tread on the toes of the transnational drugs companies which have been lobbying hard to get Bangladesh to reverse its policy. Reportedly, they have pressed diplomats from western governments which have made representations on their behalf.

However, the United Nations Conference on Trade and Development (Unctad) has come out in support of Bangladesh's drugs policy. "We feel it is an excellent policy for other countries to follow", commented Unctad's Surendra Patel. "Furthermore it is directly in line with the recommendations made by the non-aligned countries in their meetings in Colombo and Cuba."

Reproduced from
South, Sept. 82

Criteria used by the Expert Advisory Committee appointed
by the Bangladesh Govt. in April 1982 to evaluate drugs
Marketed in Bangladesh

It is unanimously decided that the following criteria will serve as the guidelines in evaluating all the registered/licensed Pharmaceutical products manufactured and/or imported in Bangladesh :

- i) The combination of an antibiotic with another antibiotic or antibiotics with corticosteroids or other active substances will be prohibited. Antibiotics harmful to children (e.g. Tetracycline) will not be allowed to be manufactured in liquid form.
- ii) The combination of analgesics in any form is not allowed as there is no therapeutic advantage and it only increases toxicity, especially in the case of kidney damage. The combination of analgesics with iron, vitamins or alcohol is also not allowed.
- iii) The use of codeine in any combination form is not allowed as it causes addiction.
- iv) In general, no combination drugs will be used unless there is absolutely no alternative single drug available for treatment or if no alternative single drug is cost-effective for the purpose. Certain exceptions will be made in the cases of eye, skin, respiratory and haemorrhoidal preparations, cotrimoxazole, oral rehydration salts, antimalarials, iron folic acid etc., as well as certain vitamin preparations allowing combinations of more than one active ingredient in a product.
- v) Vitamins should be prepared as single ingredient product with the exception of B. Complex. Members of vitamin B. Complex with the exception of B₁₂ may be combined into one product. B₁₂ always has to be produced as a single ingredient injectable product. Other members of B. Complex may also be produced as single ingredient product (e.g. B₁, B₂, B₃ etc.) Vitamins will not be allowed to be combined with any other ingredient such as minerals, glycerophosphate etc. Vitamins will be allowed to be produced in tablets, capsules and imeciabile form only.

No liquid forms will be permitted because of wastage of financial resources and the tremendous misuse involved. However, paediatric liquid multi-vitamin (with No, B₁₂ EK and/or minerals) will be allowed to be manufactured in bottles of upto 15 ml. size with droppers. Paediatric liquid preparations of single ingredient vitamins will also be allowed to be manufactured in bottles of upto 15 ml. with droppers.

- vi) No cough mixtures, throat lozenges, gripe water, alkalis, etc. will be allowed to be manufactured or imported as these are little or no therapeutic value and amount to great wastage of our meagre resource.
- vii) The sale of tonics, enzyme mixtures/preparations and so-called restorative products flourish on consumers ignorance. Most are habit-forming and with the exception of pancreatin and lactase these are of no therapeutic value. Henceforth, local manufacture or importation of such products will be discontinued. However, pancreatin and lactase will be allowed to be manufactured and/or

imported as single ingredient products.

- viii) Some drugs are being manufactured with only a slight difference in composition from another product but having similar action. This only confuses both patients and doctors. This will not be allowed.
- ix) Products of doubtful, little or no therapeutic value and those which are sometimes rather harmful and are subject to misuse will be banned.
- x) All prescription chemicals and galenical preparations not included in the latest edition of British pharmacopeia or British Pharmaceutical Codex will be prohibited.
- xi) Certain drugs, in spite of known serious side-effects and possibility of misuse but having favourable risk-benefit ratio, may be allowed to be produced in limited quantity for restricted use. These will be prescribed by specialists only.
- xii) The same or close substitute of a drug which is being produced in the country will not be allowed to be imported as a measure of protection for the local industry. However, if local production is far short of needs, this condition may be relaxed in some cases.
- xiii) A basic pharmaceutical raw material which is locally manufactured will be given protection by disallowing it or its substitute to be imported, if sufficient quantity is available in the country.
- xiv) The role of Multinationals in providing medicines for this country is acknowledged with appreciation. In view of the calibre of machinery and technical know-how which they have for producing important and innovative drugs for the country, the task of producing antacids and vitamin will lie solely with the national companies, leaving the multinationals free to concentrate their efforts and resources on those items not so easily produced by smaller national companies. Multinationals will, however, be allowed to produce injectable vitamins as single ingredient products.
- xv) No foreign brands will be allowed to be manufactured under licence in any factory in Bangladesh if the same or similar products are available/manufactured in Bangladesh as this leads to unnecessary high prices and payment of royalties. In the light of this policy all existing licensing agreements should be reviewed.
- xvi) No multinational company without their own factory in Bangladesh will be allowed to market their products after manufacturing them in another factory in Bangladesh on toll basis.

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GONOSHASTHAYA KENDRA
(Formerly Bangladesh Hospital)

CITY ADDRESS

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Dacca 2, Bangladesh

PROJECT ADDRESS

Bammabari, P.O. Nayarhat
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PROGRESS REPORT JUNE TO NOVEMBER 1972

The months since our last progress report from June 20 we have not seen any spectacular successes; we had to struggle under very adverse conditions; lack of funds prevented us from establishing ourselves at our base, and apart from a small number who lived in tents the rest of us had to shuttle back and forth from Dacca, in borrowed vehicles to run our out-patient department, conduct classes for paramedical volunteers and to supervise the health survey.

The correctness of our course has been confirmed when the government published a scheme on November 3, 1972 for an integrated health and family planning scheme, which is very much in tune with our plans and we have been propagating these ideas since January, 1972.

We have been greatly encouraged by the help of numerous friends and well-wishers at home and abroad, notably a group of students in Holland and groups in Britain, France and Switzerland, and we wish to express deep gratitude to them for their efforts on our behalf.

With the help of some friends and personal resources our Project Director, Dr. Zafrullah Chowdhury went abroad for a period of two months in August and in September in an effort to raise funds from relief agencies and other groups for our project. Since relief agencies can make large sums of money available only after committee meeting decisions, we are still not absolutely certain when and whether our future will be secure financially.

STAFF AND VOLUNTARY HELPERS

The permanent technical staff of the project consists now of four fully qualified doctors, six trainee nurses, two trainee pathology technicians and one trainee pharmacist. We have come to realize that, rather than expensively trained specialists, a program like ours needs general practitioners with some specialized knowledge. Each of the doctors and hopefully the nurses will attend a fifteen day course at the Cholera Laboratory in Dacca to study diarrhoeal diseases. Two doctors have also been booked for an advanced course on the treatment of tuberculosis.

Unfortunately, none of the doctors in the team has a thorough training in gynaecology - a gap which we must fill as soon as possible. But since trained gynaecologists are exceptionally rare in this country, one of the present staff will probably have to take a specialized course. We have already come across several gynaecological problems which we find difficult to explain due to lack of facilities: women have told us that they have conceived after having given birth without a menstrual period in the interval. Another case was that of a woman who claimed to have conceived after two years without any period at all.

In Bangladesh, qualified nursing staff are much rarer even than qualified doctors, the whole country boasts only 695 (only half of this number is actually working), compared to 267,000 in the United Kingdom. It is obvious, therefore, that we have to train suitable men and women ourselves. Our training is unlikely to be recognized by the government (bureaucrats at the helm of affairs are too strongly city and hospital-oriented), but we are convinced that a certificate from us would give our nurses employment in other voluntary projects and they would also be able to work in various capacities in their respective areas.

If you have not received the "details of our Project" and "last progress report" please write to us.

As a general policy, we shall give high preference in any future recruitment of staff to applicants from Savar, since the only hope of success will come when we manage to involve the local community.

One of the most encouraging aspects of our work has been the number of people who have come forward to help on a purely voluntary part-time basis. Every Sunday we have more volunteer doctors, medical students and family planning helpers than we need. This shows that there is an enormous potential force in this country of people who want to work towards social development and are looking for an outlet for their energies and ideals. Much could be done if only those people who are already motivated towards community development work could be given tasks in a more organized and efficient fashion. One of the best examples among our volunteers is Mrs. Ayesha Rahman, a mother of nine who has for the past four months come to our Sunday clinics to act as a family planning counsellor. Since her children were grown up she has been looking for some useful activity and has found it with our project. There are many women like her in our country.

ACTIVITIES

1. Field Clinics

Since we established separate clinics for children under 12 a few weeks ago, less patients come for treatment to our Sunday clinics. But even so the attendance is between 600 - 1000. In these clinics we have been able to get an impression of the prevalence of various forms of illness and disease in our villages. In adults, these are roughly in order of frequency: 1) intestinal trouble, 2) general body ache due to rheumatism, 3) peptic ulcers, 4) skin diseases, 5) ear infections, 6) infections of the respiratory tract, 7) helminthic infections, 8) malaria and kala-azar, 9) tuberculosis, 10) prolapsed uterus and menstrual irregularities. In one clinic four frank cases of tuberculosis were detected and we are certain that many early cases of TB are being missed by our relatively inexperienced young doctor friends, since there are no laboratory aids available in Savar. Night blindness due to vitamin A deficiency has quite a high incidence. We have also come across some cases of venereal diseases which we believe to be a new arrival in our villages since due to the social structure and traditional taboos, promiscuity is extremely rare. It is possible that VD is occurring now as a result of the recent upheavals of the war. If in the villages, it would be useful if a sociologist could do some research into this problem.

In children, diarrhoea, worm infection with anaemia, malnutrition, skin diseases, and ear infections are the commonest complaints.

If we ever had any doubts, these field clinics have convinced us that however much we want to concentrate our efforts on the preventive medicine and improve through this the general standard of health and well-being among the population, we cannot completely dispense with the curative side. Only a few days ago, a little boy of two years was brought to us suffering from an advanced stage of typhoid. He died only a few hours later, but while we were making what amounted to practically a show of efforts to save him, we were able to convince his father that his son would not have caught the illness if he had been immunized. Had we no facilities at all to treat the little boy, we would have stood condemned in the eyes of the whole community. A strict separation of preventive and curative care, as practised in some East African countries is no answer to the situation in the rural areas of Bangladesh.

We believe that a completely free medical service is not the answer to health problems even with our poverty-stricken rural population, because it encourages abuse and corruption and instills the same kind of relief-taking mentality as the handing out of free food supplies.

We want to create in the people a new spirit of self-reliance and independence which is the prerequisite for social and economic development. For these reasons we charge 50 paise (2½ pence) in sterling currency) for each first consultation and 25 paise for any subsequent

ones.

If medicines are prescribed as a result of the consultation, these are dispensed free of charge. For hospitalization we charge 5 taka (25 pence) as an admission fee, but thereafter treatment, medicines and food are provided free of charge for the length of the patient's stay in hospital. In the rare cases (less than 20 percent) where people are too poor to pay these nominal charges, we waive payment in the form of a family insurance scheme: each family will pay two taka per month if they want to make use of our services. We have calculated that our whole project could be self-supporting as soon as 80 percent of the families in the thana agree to enter the scheme. We found in sample surveys in various villages that most villagers pay four to five taka per month on buying medicines and they spend more on fares to travel to the nearest towns for treatment.

2. Selection and Training of Local Volunteers

During the end of the summer we began with the selection and training of our local volunteers who will perform the bulk of our preventive work. We went to the schools of the thana and talked to student leaders and also arranged public meetings in some of the villages, explaining our work and aims. We then asked for the names of two boys to be submitted from each village who were considered suitable to undergo training as paramedical workers. However, instead of two names we initially got 8-10 from each village. In the first instance we accepted all these to spread the interest in our work. After about four classes when it became clear that the boys could expect neither money nor future jobs from us, about half of the original applicants dropped out, still leaving more volunteers than we had intended to train. After ten classes, the two doctors conducting the training set an examination for final selection of this first batch of volunteers. One hundred boys from fifty villages were taken on as future paramedical workers but the attendance of classes continued to be about 150. Apart from the school students we have been able to attract four local 'quacks' and some primary schoolteachers who are also taking part in this course, and we are particularly proud of the fact that we gained the cooperation of these 'quacks' - who were up till now the only people to whom the villagers could turn in case of illness, and to whose livelihood we could pose a potential threat. Any medical care which reaches the rural population of Bangladesh is given out by these unqualified practitioners, and whatever their medical mistakes it would be unfair and foolish to push them aside. If we antagonized them, we would create a powerful enemy who has the sympathy of the people. We want to train more of them and hope to incorporate them fully into our work.

This first batch of volunteers is being trained at our base in classes on Fridays and Sundays. For the next groups we want to go to their schools ourselves, this being a far more economical method than having all the trainees come a long way to our base. We will then hold our classes on ordinary workdays after lessons, in order to leave Friday afternoon and Sundays free for the trainees' work in the villages. The course proper started in September and the original idea was that it should continue for 24 classes with two classes each week. But during the first course we are still very much experimenting and we are learning from our mistakes. This means that we will probably have to hold more classes than intended. Next year, we will train boys from the rest of the villages in the thana. Our teaching methods and curriculum are still very much in flux and we are only slowly groping towards a better conception of how and what to teach, learning from our own experiences and seeking the advice of people who have tried similar schemes elsewhere. In particular, Dr. Colin McCord, Associate Professor of Johns Hopkins University, has helped us a great deal in this aspect of our work. For the provisional curriculum see App.

Since we are training school and college students almost exclusively, and intend to keep them on a purely voluntary basis, we will, of course, not be able to use them as permanent staff for our program, and we envisage training a new batch of volunteers each year. In this way, we will not cause any obstruction to the boys' education and

we stress during the training that their involvement in paramedical work must be done only in their spare time. After they finish schooling, some of these boys will go on to higher education in the cities or take other jobs elsewhere. Although training new village workers each year will mean a lot of work and organization, we feel that this is by no means lost when the boys stop working for our project. Their knowledge of hygiene and sanitation will stay with them and they will become more responsible and useful citizens through their experience involuntary work in this project.

In the long run, we hope to use our volunteers not only for purely medical work, but for a broad spectrum of tasks in the field of village development. In particular, we hope that we will be able to start a scheme of adult education, in which these boys could easily play an instrumental role. We believe that adults could be encouraged to learn reading and writing much more easily if they were taught by their own children.

3. Family Planning

As we mentioned in our earlier report, we have been giving advice on family planning concurrently with our field clinics. So far, our family planning activities have therefore been unsystematic and quite haphazard - reaching only those women who happened to have heard of us or come to our clinics. We have not yet begun to implement our policy of one family planning counsellor for each village. This will have to wait until we are permanently established at the site of our project. Nevertheless the results so far are encouraging. 130 women have been given the pill and although there has been nobody to advise them outside the clinics, their personal motivation has been such that not one of them has forgotten to take the pill regularly or has neglected to come to us, (often a walk of up to 15 km), for further supplies. As before we are convinced that the pill is the only method of birth control worth promoting on a mass scale at this stage of our activities. Our reservations about the use of vasectomy and tubal ligation have been corroborated by the publication on this subject (Ahmed, Ratcliffe and Duya). The second follow up 1969 East Pakistan Vasectomy Clients publication (1970), it was found that 14.4 per cent of the vasectomy clients had wives who were over 45 years old, i.e. above the reproductive age. 13% of the vasectomy clients were found to be over 70 years or more of age. The IUD is subject to the same kind of abuses as a study by M.D. Crooley and others (National IUD Retention Study in East Pakistan, Pub. 1968) shows. 34% of the women interviewed in the sample survey admitted that they did not have the IUD. Material incentive is no answer to this problem of overpopulation, but person to person contact will certainly produce better results.

4. The Survey

In the absence of any statistical data about life in our villages we decided a long time ago that it would be impossible to do any meaningful health social work, without first carrying out a survey to establish basic health data. Our questionnaire was devised to find out the following: number of family members, their age, sex, marital status, educational qualification, occupations, dates of last immunization against cholera, typhoid, TB, tetanus, diphtheria, polio etc. The survey has so far been carried out in eighty five villages. The dirty work of going into each house and eliciting the answers as well as filling out the forms was done by our local volunteers. Before we sent them to carry out the survey in each village we gave them a short training impressing on them the utility of vital statistics and the need for accuracy and conscientiousness. Random sample checks were carried out by volunteer doctors who came to help on Sunday at the clinic, and they confirmed that the survey had been done properly. We found that all the villagers were willing to cooperate with us in the survey in all its aspects except one: They were very reluctant to talk about their dead. In particular, we estimate that about fifty percent of the mothers refused to talk about abortions and the death of infants. The villagers justified their reluctance by saying that the questions about deaths were unnecessary and that one should not disturb the dead.

DEVELOPMENT IN OUR THINKING

When we first started to work out the plans for our project in Savar, we being a group of medical men were deeply impressed by the misery and ill health due to almost total lack of medical care in our rural areas. We therefore, concentrated on devising a scheme for a health service which could be implemented in the context of limited resources and scarcity of trained personnel. We derived impetus from the conviction that everything tried so far in the field of health care had miscarried because of a basic fault in a concept of medical care which had been taken over wholesale from the west, in complete disregard to the huge differences in standards of living, social structure and patterns of health and diseases. We are now more than ever convinced of the correctness of this assessment. But through our practical experience we have come to a much broader understanding of the problems in our villages: appropriate health care is of the essence, particularly the preventive side which we have been stressing all along. But had health is intimately connected with ignorance, lack of education, inadequate nutrition and lack of agricultural development. If we concentrate narrowly on health care without paying attention to education, and the production of better food, the results which we achieve today will be short-lived and superficial. For these reasons we have begun to think more in the terms of integrated community development. This can obviously not be done by medical men alone. In the first instance we have thought of encouraging the production of more nutritious food. We have found that CSM and similar protein concentrates are not acceptable to the villagers except in a time of acute famine. Fish is the most important source of protein in the diet of most Bangladeshis and the area of Savar, like the rest of the country is full of ponds which could easily be used for more systematic fish cultivations. We have been advised by a fisheries expert that the genus telepis is easy to cultivate, needs little supervision and breeds three times a year. We are intending to grow this fish in the pond belonging to Gonoshasthaya Kendra and to encourage the people to follow our example. We are also taking the advice of horticulturalists and agronomists about growing more vegetables: spinach seems a good proposition because of the ease with which it is grown and its high iron content. Our hopes of encouraging adult education through the local volunteers have already been mentioned. All our ideas regarding these non-medical fields of activity are still very tentative and amateur, but we think that, in time, we will be able to spark the interest of specialists who will be prepared to work with us in Savar.

CONCLUSION

Our greatest difficulty remains communication with the people whom we want to convince of the necessity for change and self-reliance. It is a disappointment to us that, due to lack of funds and bureaucratic holdups we have not yet been able to move to Savar permanently. At the moment a Maccha hut is going up which we hope will be completed in about three weeks time. But so far we have no water supply (water is carried to the site from a distance of one mile.), nor electricity and telephone, all of which we need to function as a health centre. To gain the confidence of the people we must live with them and be in daily contact with them. Our Saturday and Sunday clinics, useful as they may be for the people of Savar and also for ourselves, resemble too much a weekend outing of city dwellers to the countryside.

We must integrate with the rural people who make up 94% of Bangladesh, but this, in our opinion does not mean having to go back to a state of stone age primitivity.

As far as is practicable and useful we must make use of modern equipment to increase our effectiveness: We need transport to move goods and people within our project area - A LANDROVER, A MICROBUS-CUM-AMBULANCE, A MOTORBOAT, BICYCLES AND MOTORBIKES.

WE NEED BOOKS AND JOURNALS TO KEEP US UP TO DATE WITH MEDICAL DEVELOPMENTS,
WE NEED ALL SORTS OF AUDIO-VISUAL AIDS TO CARRY OUT THE TRAINING OF LOCAL VOLUNTEERS AND GENERAL HEALTH EDUCATION.

WE ALSO NEED CONSTANT RESTOCKING OF MEDICINES OF ALL KINDS, AND WE CAN MAKE USE OF DISCARDED MEDICAL EQUIPMENT FROM HOSPITALS IN EUROPE AND THE STATES.

APPENDIX

COURSE OF STUDY FOR PARAMEDICAL TRAINEES (3-6 MONTHS)

I. HEALTH SURVEY

The first classes are taken up by instructing the trainees in the importance of statistical data, methods of collecting data for the health survey, etc. This is to prepare them as soon as possible for work on this part of our program.

II BASIC HUMAN BODY AND GROSS ANATOMY

III BASIC PHYSIOLOGY pulse, temperature, respiration, water balance system of the body, shock

IV HEALTH EDUCATION 1) personal health and hygiene

2) community health

3) communicable diseases with emphasis on

local diseases: helminthic infestation, diarrhoea and dysentery, cholera, smallpox, typhoid (enteric fever), tuberculosis, malaria, measles, diphtheria, tetanus, venereal diseases

4) immunisation : vaccination, inoculation , methods and types, contra-indications and complications

5) nutrition: principles of food, basic requirements, balanced diet, food preservation, illnesses caused by deficient nutrition - anaemia, night blindness, etc.

V. ENVIRONMENTAL HYGIENE AND SANITATION

1) water-sources, impurities, collection and treatment of water

2) excreta disposal - significance, requirements and methods of sewage disposal

3) refuse disposal

4) local sanitation in emergencies and disasters

5) bazar sanitation including camp and school sanitation

6) air and ventilation - composition, air pollution, ventilation

7) industrial and agricultural health problems.

VI PROBLEMS OF OVERPOPULATION AND THE NEED FOR FAMILY PLANNING

(this will not include methods of family planning)

VII RURAL COMMUNITY DEVELOPMENT The co-operative movement, visits to dairy farms, co-operative centers, Rural Academy

VIII PRACTICALS use of microscope and stool examination, sterilization, immunization, first aid, visit to medical and paramedical centres

DUTIES FOR WHICH THE COURSE IS TO TRAIN THE PARAMEDICAL WORKER:
vaccination, keeping records of vaccinations,
keeping vital statistics of the village
organization of pure water supply and sewage disposal surveillance
curative: treatment of diarrhoea and shock

94-8

GONOSHASTHAYA PHARMACEUTICALS

INTRODUCTION

The scientists who developed the first antibiotic, penicillin, at Oxford University during the Second World War, took a clear decision not to protect their work by patents, because they believed that it was unethical to patent the outcome of pure research work, especially when it was of such great medical significance. But later, when the financial potential of penicillin became evident, it was felt that academic unworldliness had cost British industry dearly in lost profits and subsequent discoveries and developments were always patented. Professor E.P. Abraham, one of the Oxford penicillin workers, expressed this years later in his "Memoir of Lord Florey": "Thus nothing was done (about patenting penicillin), for reasons which might have been admirable in a world with different economics, but seem almost irrelevant in the society in which we live."

It was in fact penicillin and the other antibiotics which brought the modern drug industry into existence. Up to that time, very few medical chemicals were manufactured on a large scale, exceptions were aspirin, phenacetin, arsenics and, from the mid-1930's, sulfa drugs. Most insulin and vaccines were still prepared by research departments. While in the mid-1930's total sales of the U.S. drug industry amounted to 250 million U.S. dollars annually, sales had reached 8.3 billion for the first quarter of 1981 alone, and this only for the largest 15 companies.

During the 1970's, a number of studies began to draw attention to the production and marketing practises of the pharmaceutical industry, especially the large multinational companies, both in industrialized and underdeveloped countries (cf. Select Bibliography). At the same time, the World Health Organisation developed an 'essential drugs list' containing 209 items (32 of are not essential, but useful as alternatives or for rare disorders) and some Third World governments (including India, Sri Lanka, and Pakistan) tried to curb the industry by legislation. Unfortunately, the power of the drug companies and their hold over the elites of such countries was too great for these efforts to be successful, while so far WHO policy has remained a paper concept.

Observing the effect of the free hand given to the multinational drug companies in Third World countries, it seems, in hindsight, that the ethical instincts of the Oxford scientists at the beginning of the pharmaceutical revolution had much to recommend them even on a practical level.

Pharmaceuticals in Bangladesh

At a conservative estimate, Bangladesh has an annual drug market of Tk. 1250 million (approx. 83 million U.S. dollars). Only a negligible proportion of this is available free of cost in government health centres, the rest is sold commercially. In a country with one of the lowest per capita incomes in the

world (70 dollars a year), this means that after food, clothing and shelter, medicines are a major part of the remaining expenditure. Often, a little medicine may be bought in extreme need, but not enough to cure the illness, and the public are left in ignorance of the detrimental effects of breaking off treatment prematurely. Most importantly, due to poverty and the high cost of drugs, at best 15% of the people ever buy any modern medicine.

Inadequate information and the common habit of self-prescription (because doctors are unavailable or too expensive and because all drugs can be freely bought over the counter) have led to a situation where 70% of the annual drug sales go on drugs described as useless or therapeutically insignificant by the British National Formulary, the National Research Council (USA) or the Federal Drug Administration (USA). The bulk of these unnecessary medicines are vitamins, tonics, enzymes and cough mixtures.

Drugs worth an average of Tk. 150 million are imported annually into Bangladesh by small local firms and also by voluntary and U.N. organisations. The remaining medicines, worth about Tk. 1100 million, are produced in Bangladesh. There are over 150 registered drug companies, but most of these exist on paper only, having been created to take advantage of the fact that raw and packaging materials for pharmaceutical companies - which are considered essential industries - can be imported with enormously reduced customs duties and are then resold to, e.g. cosmetics factories. Tk. 890 million worth of drugs (= 81% of drugs produced in Bangladesh) are produced by eight multinational companies. The rest is shared by a number of smaller multinationals and 22 local companies. The table below shows the situation in greater detail:

	Name of Company	Annual Production in Taka
1. Multinationals:	Pfizer	200 million
	Pisons	140 "
	Billy & Becker (BPI)	120 "
	Hoechst	115 "
	Glaxo	110 "
	Squibb	105 "
	ICI	50 "
	Organon	50 "
	Others	15 "
		905 million
2. Local Companies:	Square*	70 million
	Gaco	40 "
	Albert David	35 "
	Pharmadesh	30 "
	Jayson	10 "
	Others	10 "
		195 million
3. Imported:		150 million
	Grand Total:	1250 million

*Square manufactures drugs mainly under third party license (from Janssen)

Looking at the types of medicines available, we find about 2300 brand-named drugs containing 150 different active ingredients. Only about 250 of these, about 10% are therapeutically significant or essential drugs according to the sources named above. All the rest are promoted solely for the purpose of financial gain.

Proliferation of products and their promotion is, of course, a ubiquitous feature of capitalism, but in a country like Bangladesh the situation is worse because it diverts desperately scarce resources and many people will deny themselves food in the hope that some aggressively advertised, but useless, tonic will do them more good. But it is not only a confidence trick: substances which have actually been identified as harmful and banned in developed countries continue to be marketed and manufactured in Bangladesh. The pressure that can be exerted by foreign companies on the government was shown again recently when dipyron (Hoechst brand names 'Novalgin', 'Baralgin'), which can cause fatal agranulocytosis, was again cleared for manufacture, even with an increase in the permitted quantities (Bangladesh Gazette, Pt.I, Feb. 29, 1981). The decision was taken despite strong representation from groups of local doctors and pharmacists. Other products banned elsewhere, but still available here, include phenacetin and clioquinol. A quotation from the Managing Director of Fisons (Bangladesh), Mr. A. Wahid, may sum up the attitude of the multi-nationals: "We are businessmen first, first of all we want profits...We are oversensitive about reports from WHO. Restrictions on drugs and pesticides imposed in the U.S. and Canada should not be applied in our country because our people are ethnically and biologically different from others."

This is the background to the involvement of Gonoshasthaya Kendra in the production of medicines.

GKP

Gonoshasthaya Kendra (GK) is a charitable trust which was set up in 1972 by a group of health workers who had been involved in the Bangladesh liberation struggle of 1971. The first objective was to establish a health service in Savar thana with an emphasis on preventive and primary care. In the course of this work, it was realized that health care by itself could not be an answer to the problem of poverty, and the project became involved in a wide range of community development work (cf. Progress Report No. 7).

The project experience, and especially the problem of how to get good and cheap medicines to the people, also led to thinking about a pharmaceutical factory based on four principles; viz. low prices, quality, manufacture of essential drugs only, and responsible marketing practises. The factory is a joint stock company, but all shares are owned by the GK Charitable Trust and cannot be bought or sold. Policy is determined by a Board of Directors, consisting at present of eight members, with representatives from government (Ministries of Health and Industries), the Bangladesh Shilpa (Industrial) Bank (BSB), the GK Board of Trustees, Savar GK and NOVIB, a Dutch voluntary agency.

The cost of establishing the factory has been as follows:

Building including air conditioning:	US dollars	1.2 million
Machinery and equipment:	"	1.5 "
Training of managers and business travel:	"	0.1 "
Working capital incl. raw materials for four months:		1.2 "
Transport and miscellaneous:		0.2 "
		<hr/>
	US dollars	4.2 million

Contributions from:	NOVIB (Holland)	US dollars	2.62 million
	Oxfam (U.K.)	"	0.33 "
	Christian Aid (U.K.)	"	0.16 "
	BSB, GK Trust and others	"	1.00 "
			<hr/>
		US dollars	4.11 million

Technical expertise has been provided by the International Dispensary Association, Holland, who also organised training for managers and the architect, as well as the procurement of machinery and raw materials. All managers are Bangladeshi.

GKP is designed to supply 15 - 20% of the present Bangladesh market in essential drugs once it is in full production. Retail prices will be 35 - 50% lower than those of equivalent drugs on the market, and are calculated to leave GKP with an overall profit of 10 - 15%, after deductions for all production cost, depreciation, and bank charges. Profits will be invested in expansion, medical and social research, and in new enterprises. Part of it must be spent on charitable purposes.

Marketing of GKP products will be partly through bulk purchase by the government for their rural health centres (initially 60 - 70%), and partly through a chain of special retail shops.

Conclusion

It took nearly seven years to progress from the first ideas discussed among friends to production of the first batches of the first two drugs (paracetamol and ampicillin) in May 1981. Many problems had to be overcome. The three main areas of difficulties were:

1. Problems connected with the transfer of technology - e.g. lack of infrastructure, lack of expertise among Bangladeshis from architects to refrigeration engineers to laboratory technicians
2. political: an indifferent government and hostile multinationals
3. relationship to donor agencies

A problem which we are only just beginning to face is that of distribution: how to hand on the benefits of cheap, quality production to the consumer; how to eliminate profiteering by middlemen.

To take a wider view: GK is not only interested in proving its ability to set up this particular pharmaceutical factory, but sees this effort as a learning situation for a genuine transfer of technology to the Third World. This is not achieved by multinationals bringing in complete blueprints which give no opportunity for training and experience of local manpower. Further, a genuine transfer of technology on a large scale needs a more favourable political environment than is given in Bangladesh at present. We hope that our work will demonstrate possibilities for such self-reliance and so contribute to the change needed. Most important of all, transfer of technology does not in itself mean improvement for the poor. To find ways which guarantee that industrialization can be controlled by the poor masses of Bangladesh rather than becoming an instrument of oppression, is one of the main goals of GKP.

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VOLUNTARY HEALTH ASSOCIATION OF INDIA

GONOSASTHYA KENDRA

(PEOPLES HEALTH CENTRE)

In 1971 when the liberation war shook Bangladesh there emerged a group of idealists, who believed in freedom, believed in a free independent Bangladesh and were willing to fight for it and continue working for their Bangaldesh brethren even after Independence in this venture. These idealists had vision, courage, social consciousness and concern for the deprived. Many of the doctors involved in this restructuring of health work had abandoned their studies in U.K. and other countries.

In 1972, the Bangladesh Hospital which was set up at the war front to deal with wounded Mukti Bahinis was converted as Gonosasthya Kendra or the Peoples Health Centre and moved to Savar.

The pioneers of this need-based and integrated health work were young men and women, some with formal qualifications and others with skills picked up on the job. They began their work in the rural areas of Savar about 30 miles from Dhaka. Here the base hospital was set up to cater to the referral needs of the numerous satellite sub centres and to provide health care assistance which was non-existent.

The initial health education and immunization programme was carried out by about 100 volunteers recruited on part time basis, who were senior students from school.

G.K. believed in integrating preventive programmes with activities such as nutrition, agriculture and family planning, socio economic programmes which have great bearing on health. Right from the onset G.K. was clear about its "alternative health care approach", which was not based on centralized curative oriented drug doctor disease centres called hospitals - but on decentralized demystified basic health care..

By 1973 G.K. decided to have full time paid paramedic workers, instead of part time workers, for more effective work. Most of the paramedics recruited were girls between the ages of 17-25 years, interested in health care work and from the local communities to serve the vulnerable population constituting of women and children better. Each paramedic of Savar takes care of about 3,000 population i.e. about 3 villages.

These young women are sensitive to their own people's needs and are fortunate to get the support, guidance and supervision from doctors such as Dr. Zafraullah Chowdhury and Qasim Chowdhury who believe in the potential ability of the paramedics to undertake health related tasks with greater effectiveness than many city based highly qualified doctors. This is so because unfortunately their medical education instead of providing them with the diagnostic, therapeutic, organizational and communication skills required to serve their own people and inculcation of the right attitudes do exactly the opposite and alienate them from their own people, desensitize them from their real health needs and helps in development of a value system which focusses on the commercial potential of health care rather than the service aspect, an aspect that focusses on attempts of resolution of the actual health problems.

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Selection Process: The villagers are involved in the selection of the paramedics. The village elders from the poorer section interview the candidates. Of the 44 paramedics of Savar most of them are women. The transport used by the paramedics is the bicycle - a revolutionary and a very liberating step for these young Muslim women.

Impact of Health work on the workers and the community: The work of paramedics not only provides them with an opportunity to serve their own communities but also helps them acquire certain amount of economic freedom and social recognition by the community of their work.

G.K. like any other people-oriented health programme has recognized the need for provision of good maternal and child health care services before advocating family planning.

The family planning and ante-natal care services are provided in the homes of the mothers as far as possible. This is very different from the concept of a cluttered ante-natal clinic, where women line up and wait for hours impatiently to be checked by, hussled and an equally impatient medical personnel.

The village dais are actively involved in G.K.'s work on part time basis. They deal with screening of ante natal patients requiring more specialized care and distribution of oral contraceptive pills and doing a regular follow up.

Family Planning work: In 1974 G.K. was amongst the first health institutions to use depo-provera, the controversial injectable contraceptive; it was to test the feasibility of this method for the Bangladeshi women. It was also the first to oppose it on receiving the reports of the dangers in British Medical Journal, July 17, 1976 and report by Steven Minkin. The Bangladesh Government still propagates it.

In 1974 G.K. started offering tubectomy services to the women in the community desirous of permanently limiting their families. The paramedics were trained to do these tubectomies efficiently, the result being that their complication rate was much lower than that of the doctors.

Training of Paramedics: Today most of the training of the paramedics is through an inservice training and formal lectures by senior paramedics and doctors. The paramedics are trained to deal with common health problems, diagnosing and early referral of those requiring more specialized care; and help the doctors in the base hospitals to take care of the relatively serious patients. They've been trained to do simple lab tests, such as blood, urine, sputum,

In 1976 Nizam one of the paramedics was brutally murdered in Shimulia 25 km from Savar by those whose vested interest was being interfered with by the presence of a courageous paramedic like Nizam, who was there to set up a well run sub centre. Nizam was a threat to the local quack who resorted to malpractices for profits and exploited the ignorant people. The local loan cooperative was started by the efforts of the paramedics. Nizam was beheaded and the dismembered parts of his body were found 10 days later buried in different places. The guilty even though identified roamed free, the local power structures and money influencing many things including law while the victims, their families and colleagues burnt with anger, frustration and bitterness.

No one minds a dumb health worker who doles out pills and rattles off his health messages like a parrot. - but it is when health workers begin to help communities to focus on the real causative socio-economic and political factors leading to ill health, the role of the health workers is not that much appreciated. The more effective the contribution of such health workers, the more threatened are the producers of health. Brutal murders of health workers in Guatemala, Nicaragua, Mexico, Bangladesh and Philippines give ample proof.

Insurance Scheme: This service is based on the economic conditions of the people from the community being served. They are divided into 3 groups :

Category 1 - Those that cannot afford from any source even two meals throughout the year for family members;

Category 2 - Those who have land upto 5 acres arable or unarable;

Category 3 - Those with land upto more than 5 acres.

For Category 1, registration card is given free and payment made by each patient per visit @ 50 paise (equal to 25 Indian paise), pathology, x-rays, operations, admissions are included in this 50 paise. In spite of this subsidized treatment, travel costs and loss of daily wages prevent Category 1 card holders to utilize the clinical services to the proportionate extent.

Category 2: Registration charge is 12 taka with renewal charges being 10 taka a year. Cost per patient per visit is 2 taka - the subsidized cost of other services is also borne.

Category 3: Registration charge is 13 taka. Cost per patient per visit is 5 taka and this group pays a higher rate for other services than the 2nd group.

This way the poor have to pay the minimum amount for health care services which are not entirely free. In April 1979-80, 47% of the recurrent expenditure of the health programmes were met by insurance fees according to the 1980 annual report.

Preventive Service: Immunization - These are given free to all and in 1980 the coverage of BCG, DPTX, Tetanus immunization was between 60-70 in 1980, significantly higher than other non-project areas.

Water and Sanitation: In G.K. scheme 1 tube well serves 15-25 families who have no access to private or government tube wells. Though the tubewells are donated by UNICEF the digging and platform costs are borne by the concerned family members who pay about 500 taka. A committee from amongst the family members maintains a sum of about 100 taka in a post office for the maintenance of the tube well and all the users are expected to contribute equally so that no one can because of greater financial contribution monopolize the use.

A wrench and training for simple repairs is given so that the hand pumps do not lie out of order for more than 48 hours.

Training programmes: Training of women from the Integrated Rural Development Program was undertaken by G.K.

Medical Students Field Programme: Medical students from 3 medical colleges were offered exposure to community health work at G.K. where they did village visiting the morning and were involved in discussions regarding the health needs of the people and their own competence in dealing with the common health problems of rural Bangladesh. Almost each group came to the similar conclusion that their medical education was not designed to equip them to effectively deal with the problems of rural Bangladesh.

Problems faced were complaints by the teachers of medical colleges that students were asking "too many questions". This realistic exposure to the health situation of their own country, which let the students themselves to question as to who actually benefitted from the health care and whether the different background of medical students could actually ensure meaningful services to the poor encourage them to make an effort in changing the situation.

Post Graduate Doctors Field Programme: Field practice dissertation section of a course leading to a Diploma in Community medicine was conducted in G.K. The Diploma course is run by the National Institute of Preventive and Social Medicine in Community Health.

Problems faced were in relation to NIPSCM professors not accompanying the students to the field and centre as had been agreed upon earlier: Low salaries - Professors to undertake private practice.

UNICEF Health Workers Programme: A 3 month training has been given to UNICEF trainees. Traditional midwives have also been trained to link up health and nutrition programmes.

Narikendra - Centre for Women's Vocational Training: Narikendra activities are based on a simple philosophy that includes fundamental literacy classes and other teaching; in broader terms that which can help them understand the causes of their own under-development and what to do to bring about the change.

Training programmes for the women in metal work, carpentry, sewing, shoe manufacture, bakery and help them develop skills both mental and manual so that they can do the job required just as well as men. What all this does to the women trainees themselves is significant as it is but what it does to the other women and communities they come from is more significant still. This of course applies equally to many visitors who came with a fixed concept of traditional muslim women's role in society.

Gono Shilpalaya: (Peoples Workshop)- Trainees here are mostly women and divided into 2 categories - skilled and unskilled. The workshop staff can produce at competitive prices hospital beds, simple operation tables, revolving chairs, simple pipe frames for chairs, grills, window frames, steel racks, agricultural instruments, etc.

It definitely was one of the most fascinating sights to watch a bunch of confident young girls dressed in blue shirts and payamas with white dupattas tucked under a belt, hammering away at a metallic bucket, or nailing, cutting and welding the pipe frame of a chair - with their ears plugged to prevent deafness due to noise pollution.

At carpentry workshops there were women at work making windows and door frames. The women trainees learn how to make wooden furniture too.

Handicrafts made include the use of jute in making jute bags, which have mostly to depend upon the foreign market, since the market within Bangladesh is limited. A bamboo work cooperative has also been set up by one of the trainees along with other women.

Gono Paduka (People's Shoe): In 1978 a joint cooperative of skilled workers started a G.K's rural shoe industry; there were problems e.g. unwillingness to work with women workers, unwillingness to do agricultural work at G.K., a must for all employees, preference in making stylish shoes for the rich.

Gono Paduka display shop near the canteen facing the main road is fairly well stocked with inexpensive shoes and sandals made of leather.

Gono Patshala (People's School) : One of the most innovative programmes of G.K. was started in 1977. The education for the children of the poor is a privilege denied not because of ignorance and stupidity of parents but due to the need of their contribution to family work, whether this is in minding smaller children, collecting cowdung, fire wood, fuel or water, taking cattle for grazing, washing utensils, clothes - it merely means that education is not seen as a priority. Understanding of this dual role of village children i.e. as 'Home help' as well as a 'student' has to be respected.

Classes at Gono Patshala are held 5 days a week instead of the usual 6. Older children and teachers hold classes at the villages for the children who are unable to come. The school is geared to fulfil the educational needs of the landless and marginal farmers.

The older children i.e. 10-12 years olds in school get vocational training for 2-3 hours per day and in a matter of 2-3 months they are capable of making effective contribution. The school prepares the children for their own communities.

School children are involved in poultry breeding. Local hens are cross bred with an Australian Cock and 12 week old chicken are taken home by the students. When their chicks hatch 2 of them are returned to the school for other kids.

One of the most beautiful sights during my visit in Jan. 1982 was to watch a class of little children being conducted in little groups with one of the children doing the supervision and teaching of each group, a most touching example of what children themselves can do for one another. On 2 occasions during my 2 visits to 2 different villages with Sandhya Di -Senior paramedic, Co-ordinator of Nari Niketan - and David Warner, we observed classes of a group of adult men and women involved in a learning session. What was probably the most outstanding feature was that the teacher was an enthusiastic young child from Gono Patshala.

Gono Krishi Khamar (People's Farm): Mandatory participation by all G.K. Staff in the projects internal agricultural programmes is expected. The aim is to expose those not actively involved in agriculture to understand the skills and the manual ^{work} and the level of technology, labour involved in agriculture and to realize the extent of exploitation and underpayment to the farmer for his contribution in providing this vital technology.

Reforestation is being promoted and so is fish cultivation.

Bhatsala Project is 120 miles to the north of Savar situated in Shapmari village of the Jamalpur Dist and is a 'daughter' project of G.K. working along the same lines. Geeta Chakravarty was the Director of this project in the initial years.

G.K. Pharmaceuticals: After 3 years of planning and preparation in 1978, G.K. got clearance from Bangladesh Govt to produce drugs. In Nov. 1978 the G.K. Pharmaceuticals buildings construction began. It set up a first class quality control and Production Development laboratory.

The building design, the installation of the central air-conditioning, the setting up of the equipments has been done by the Bangladeshis themselves. Top management staff were recruited from Bangladesh but sent abroad for training.

G.K. Pharmaceuticals is owned 100% by the G.K. Charitable Trust and by its charter; 50% of the profits are to be ploughed back for the factory expansion and the other 50% is to help volunteer programmes in the country with emphasis on social sciences and indigenous herbal medicine research.

Gono Publications: G.K. has translated David Werner's "Where There is No Doctor" into Bengali. It also brings out a Bengali monthly called Gonosasthya monthly - it is designed to give information on all aspects of basic health care and promote the use of quality generic drugs.

Organization: G.K. project staff are divided into mixed groups which meet every week for discussions and sharing reading reports. G.K. staff meets every month at staff meetings where major decisions are taken. The Executive Committee is elected by workers each year.

All staff contribute 10% of their salaries towards the staff welfare fund. Food is served in the mess and mess contributions is scaled according to salary but same for all.

Conference on Technology Transfer: In Jan. 1982 G.K. hosted this international conference on the occasion of the inauguration of the G.K. Pharmaceuticals. Many individuals who have made an outstanding contribution towards drugs and health work had been invited. G.K. provided this opportunity for many like minded concerned individuals to come and share, learn and contribute views and experiences related to drugs. I had the opportunity of being present there and meeting some of the most consistent supporters of our drug work.

In April 1983 G.K. hosted another international Conference on Alternative Medical Education with the aim of having a meaningful discussion by various authorities and individuals on various experiences outside Bangladesh on alternative medical education.

Dr. Sathyamala and I participated in this very educative exchange.

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RESUME: CRITERIA USED IN EVALUATING DRUGS ON THE MARKET IN BANGLADESH

- Government of Bangladesh

The Expert Committee constituted by Government Order No. S-DA/D-D-20/82/74 dated 17 April 1982 met at 10:00am on 28 April 1982 in the Office of the Director, IPGM&R, Dacca, under the Chairmanship of Professor Nurul Islam to begin evaluation of the pharmaceutical products available in the country and to draft a National Drug Policy, keeping in view the health needs of the country.

Consistent with the declared guidelines of Government to provide basic needs of life to the majority of the people through austerity and to improve economy of the country, wastage of foreign exchange through the production and/or importation of unnecessary drugs or drugs of marginal value have to be stopped.

Almost any drug may produce unwanted or adverse reactions. The combination of two (2) or more active ingredients not only makes the product costlier, it also increases the possibility of adverse reaction without increasing the efficacy over a single ingredient product. Hence, as a general rule, combinations of similar or dis-similar drugs will be prohibited.

Combination drugs could be approved if the Drug Company can give definitive, approved scientific proof (i.e. WHO publications, British National Formulary, British Pharmacopeia, European Pharmacopeia, USP or other authoritative guidelines like Goodman & Gilman's 'The Pharmacological Basis of Therapeutics', 'Current Medical Diagnosis & Treatment', etc.) of the drugs' synergistic action and increased efficacy. They also have to prove conclusively that combining the elements creates no increase of toxicity or side effects nor instability of the compound or shortening of the life of the product.

One of the greatest sources of drainage on the country's financial resources is the irresponsible prescribing and marketing and inappropriate self-use of vitamins. Another great wastage of meager resources is cough mixtures, gripe water and alkali preparations

which are of little or no therapeutic value.

It is unanimously decided that the following criteria will serve as the guidelines in evaluating all the registered/licensed pharmaceutical products manufactured and/or imported in Bangladesh. Therefore:-

I. In general combination drugs will be accepted only where no alternative single drug is available for the purpose or where the single drug is not cost-effective.

Exceptions will be made for oral rehydration salts, certain anti-malarials, co-trimoxazole, iron with folic acid for use in pregnancy, combined oral contraceptives (containing up to 35mcg oestrogen), and formulations specified by the licensing authority for a multivitamin (B Complex) tablet and paediatric drops; hydrocortisone with antibiotic skin preparations; and a haemorrhoid preparation.

II. The combination of an antibiotic with another antibiotic or antibiotic with corticosteroids or other active substances will be prohibited. Antibiotics harmful to children (e.g. Tetracyclines) will not be allowed to be manufactured in liquid form.

III. The combination of analgesics in any form is unacceptable as there is no, or only trivial therapeutic advantage and such combinations increase toxicity, especially in the case of kidney damage and overdose. The combination of analgesics with iron, vitamins or alcohol is irrational and unacceptable.

IV. The use of codeine in any combination form is not acceptable as it carries no advantage and may be subject to abuse.

V. Vitamins should be prepared as single ingredient products with the exception of Vitamin B Complex. Vitamins of the B Complex, with the exception of B12, may be combined into one product. B12 shall always be produced as a single ingredient injectable product for use by Specialists only. Other members of B Complex may also be produced as a single ingredient product (e.g. B1; B2; B6; etc.). Vitamins

will not be allowed to be combined with non-vitamins, e.g. minerals, glycerophosphate, etc. Vitamins shall be in tablet, capsule and injectable forms only. The reason why no liquid forms will be permitted is the wastage of financial resources and the tremendous misuse that has occurred. An exception will be made for paediatric liquid single and multivitamin (without B12, E, K and/or minerals) preparations in bottles of up to 15ml with droppers.

VI. No multiple ingredient cough mixtures, throat lozenges, gripe water, anti-acids etc. will be accepted (either locally manufactured or imported) as these offer no therapeutic advantages to outweigh their cost.

VII. The sale of tonics, enzyme mixtures/preparations and so-called restorative products flourishes on consumer ignorance. Most are habit-forming and, with the exception of pancreatin and lactase, they are of no therapeutic value. Henceforth local manufacture or importation of such products will be discontinued. However, pancreatin and lactase will be allowed to be manufactured and/or imported as single ingredient products.

VIII. Some medicines are being manufactured with only trivial difference in composition from other products but having similar action. Such duplication confuses both patients and doctors and will not be acceptable in future.

IX. Products whose therapeutic value is doubtful, trivial or absent and products that are judged harmful or subject to misuse will be banned.

X. Prescription medicines and galenical preparations not included in the latest edition of the British Pharmacopeia or the British Pharmaceutical Codex will be prohibited unless there is strong evidence of need and of efficacy.

XI. Certain drugs, in spite of known serious side-effects and possibility of misuse, having favourable risk-benefit ratio will be permitted for restricted use by Specialists.

needs to be subject to the interests of the TNCs pharmaceutical companies which place on the market numerous trade name drugs which they price according to profit.

This list was presented by WHO to its member countries and although most agreed with both content and spirit, few had the courage of their convictions to act to limit drug purchases and production in their own country. An outstanding example, however, of a government that chose to act upon these recommendations in Bangladesh.

In Bangladesh, the annual drug market is US\$83 million per year. Of this, 81% of drugs sold are produced by 8 TNCs. In a country where the per capita income is less than \$70 per person, at best, 15% of the people can ever afford to buy modern medicine. In an attempt to change this state of affairs, in April 1982, an Expert Committee was appointed by the government to evaluate the drug products available in the country and to draft a national drug policy which reflected the health needs of 72 million people, 80% of whom live in the countryside. The result was the Drugs Control Ordinance, 1982 which has far reaching effects on both the local and the TNC market in the country.

Essentially, the Bangladesh drug ordinance permits only the 220 essential drugs recommended by WHO to remain on the market. Explicitly, the law includes the banning of combination drugs where a single drug is available, effective and less costly, the marketing of vitamins in a combination pill or liquid with the exception of vitamin B complex; the sale of tonics which claim restorative powers but prey on the consumers ignorance and of drugs where therapeutic value is questionable; and the use of medicine except by Specialists where side-effects are known. The three schedules were promulgated in the law to dictate the time which these drugs must be off the market.

Schedule I requires immediate stoppage and includes such medicine as gripe water for babies. Schedule II are drugs requiring immediate reformulation which includes many of the vitamin

combinations. Schedule III are those that must be taken from sales by December 31, 1982 which includes cough syrups, tonics and the like.

The drug ordinance lists each drug and its manufacturer and explicitly states the reasons for its ban. For example, a vitamin tonic made by a local company is prohibited because the tonic contains alcohol which provokes liver ailments and is one of the most abused drugs on the market. Another product is said to have "no proven value; placebo effect only; waste of foreign exchange". An ointment made under license from an American TNC is called "useless". Still another drug is labelled "no therapeutic value; waste of money by the poor people of the country".

Many groups throughout the world have hailed the Bangladesh decision as a courageous attempt to come to terms with some of its most pressing health problems. The Asian Community Health Action Network, an organization based in Hong Kong comprised of several programmes and individuals working in non-government community health programmes, has endorsed this effort as a good attempt to re-allocate resources so those in poor communities have access to drugs and care. Others, health planners in England and America, recognize this policy as one which will rationalize health expenditures and provide more cost-effective use of both local resources and foreign supplies in the provision of medicines.

However, others, especially the TNCs have been less than enthusiastic. The reasons for their cool reception are easy to find. The law specifically addresses the role of the TNCs in the country. While gratefully acknowledging their assistance to date, the ordinance goes on to limit their future contribution. It states that all antacids and vitamins, a highly profitable enterprise for these companies, now will be produced by national companies. It states that no TNC medicine can be made in Bangladesh if a national company can produce the same as it leads to overpricing and payment of royalties. Finally, it says that no TNC can sell its products in the country if,

lacking its own factory in the country, it has these products made by a Bangladeshi company on a toll basis. These restriction in addition to the drastically reduced list of drugs allowed are not designed to make the TNCs happy.

The TNCs are brandishing their weapons. It has been reported that the American government has begun to use pressure on Bangladesh to modify the laws so that they prove more conducive to US business interests. The companies themselves are attempting to find ways of getting the laws changed or rescinded.

The TNCs may find allies in their efforts in the national drug people. Local manufacturers have expressed concern that their own fledgling factories also are being badly hurt by this new law. One Bangladeshi manager has said that the damage done to local industry might be the most serious consequence of this law because these companies also must limit their products. Some of those medicines which bring the highest profits necessary to run their plants are no longer allowed on the market.

The battle against the TNC drug companies is not only a Bangladesh fight. It has far reaching implications for and support from other Third World countries. India and Sri Lanka have had similar fights in their attempts to centralize drug purchasing for their countries. If the Bangladesh laws stand, many countries will have a model by which to rationalize their drug expenditures. Individuals and Third World governments are placing high hopes that Bangladesh will succeed in making good its intentions. The country that has been called world's "basket case" is now becoming a symbol of courage and conviction to those in Third World countries who suffer from an international marketing system which appears to deny them medicine to both prevent and cure their illnesses. □

BANGLADESH: The successes and failures of a small pharmaceutical firm

Gonoshasthaya Pharmaceuticals Ltd. (GPL), a small company near Dacca, is struggling to provide Bangladesh with high quality, essential drugs at competitive prices. The goal is to capture 15 to 20 percent of the Bangladeshi market. The road to the goal is proving long and rocky.

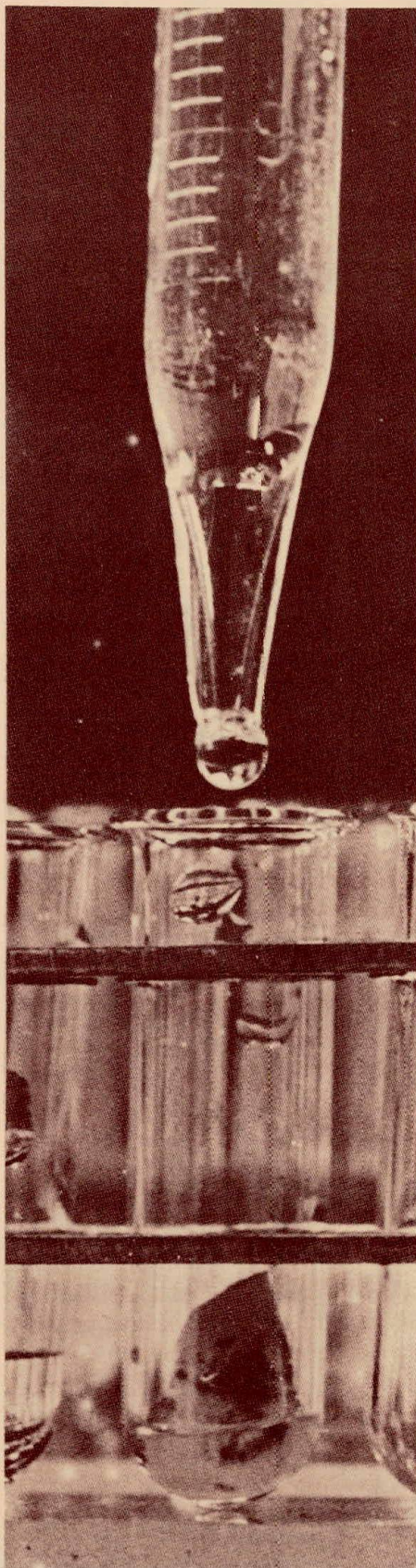
Bangladesh is a textbook case of a country that has no significant national or local production of drugs. Eight multinational companies control 80 percent of the drug market. The remaining 20 percent is shared among many small, Bangladeshi firms.

Production is heavy on antibiotics which make high profits for the companies. Companies are reluctant to produce vital necessities such as distilled water and basic drugs that bring in low profits. There are about 2,300 brand names available; 70 percent of them are judged therapeutically questionable.

To boost sales, there is an estimated one drug salesman for every doctor. (In the United Kingdom, there is one salesman for every 20 doctors.)

The number of drugs available in government health centers is negligible. Currently, legislation is inadequate to effectively control the sale of potent drugs. Many people cannot afford a doctor and self-prescribe medicine, often potent antibiotics that are sold over the counter. In a country where the average annual income is about \$70, many families go deep into debt to buy medication.

Against this background, the People's Health Center, a successful primary health care project in Savar, decided to build its own pharmaceutical processing unit. It took seven years to complete the \$4.2 million project. Funding agencies had to be convinced that such a bold idea could work and work with Bangladeshi experts and personnel—architects, chemists, managers, and plant workers. Three years



were needed to complete the feasibility and other studies required by the bureaucracy.

Now, with funding from Oxfam, NOVIB, a Dutch voluntary agency, Christian Aid, and commercial loans, GPL has been operating for one year and has made a start toward producing in bulk 30 basic drugs, preparations, and antibiotics, including aspirin, ampicillin, tetracycline, penicillin, vitamin C, sterile water for injections, and oral rehydration salts.

As planned, most of the factory workers are rural women who have received training in vocational skills and literacy from GPL. All instructions in the drug packages are in Bengali. Drugs are sold at prices 30 to 50 percent lower than equivalents produced by the larger companies. When GPL, a charitable trust, begins to make a profit, 50 percent will be reinvested in voluntary development programs.

But the first year of production has been fraught with problems. It has been difficult to find skilled personnel in Bangladesh, and GPL has had to call on more outside expertise than planned. The proper machinery has not always been available. And GPL recently lost a bid to provide the government with eleven drugs.

More problems lie ahead. GPL plans to rely on selected pharmacists to distribute its generic drugs. But will the firm find pharmacists willing to give up their profits on brand names? And will companies continue to successfully underbid GPL for big, government contracts? These are just some of the problems that face the bold experimenters at GPL.

This article is based on newsletters published periodically by the People's Health Center, and reports by Dr. Zafarullah Chowdhury, Director of the People's Health Center, and researchers Sally Bachman and John Yudkin.

HOW TO . . . teach testing for respiratory problems

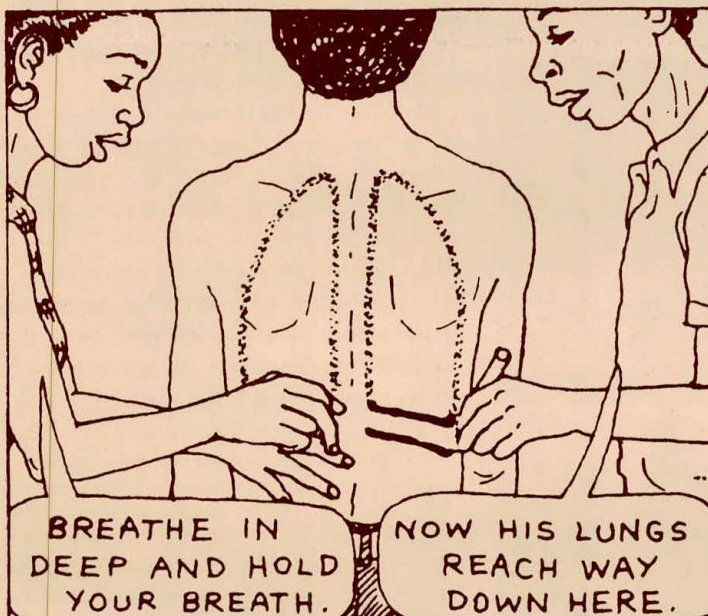
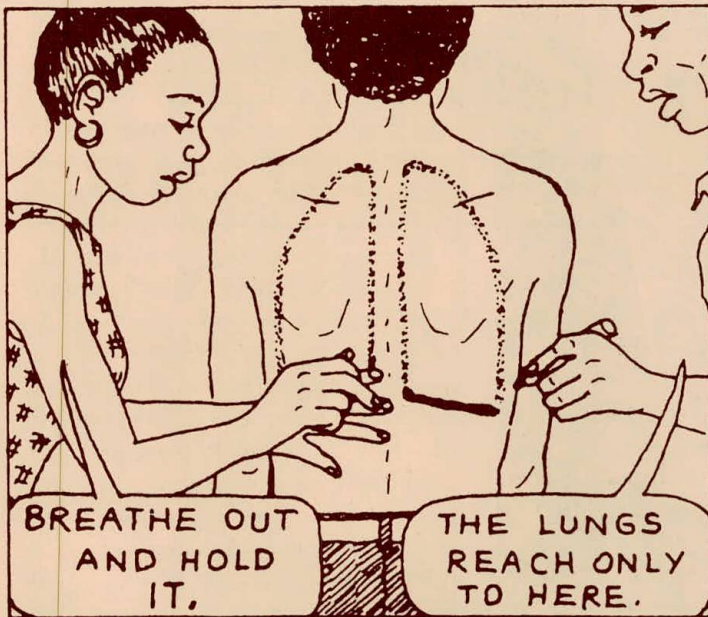
When teaching about physical exam or respiratory problems, you probably will want to explain where the lungs are and how they work. For this, it helps to draw the lungs on a student. Draw them on both the chest and the back.

To determine the size of the lungs, show the students how to thump or percuss the back, listening for the hollow sound of air in the lungs. Draw the bottom line of the lungs first when they are as empty as possible, and then when they are full. Students will see how the movement of the diaphragm (a muscular sheet below the lungs) affects breathing and lung size.

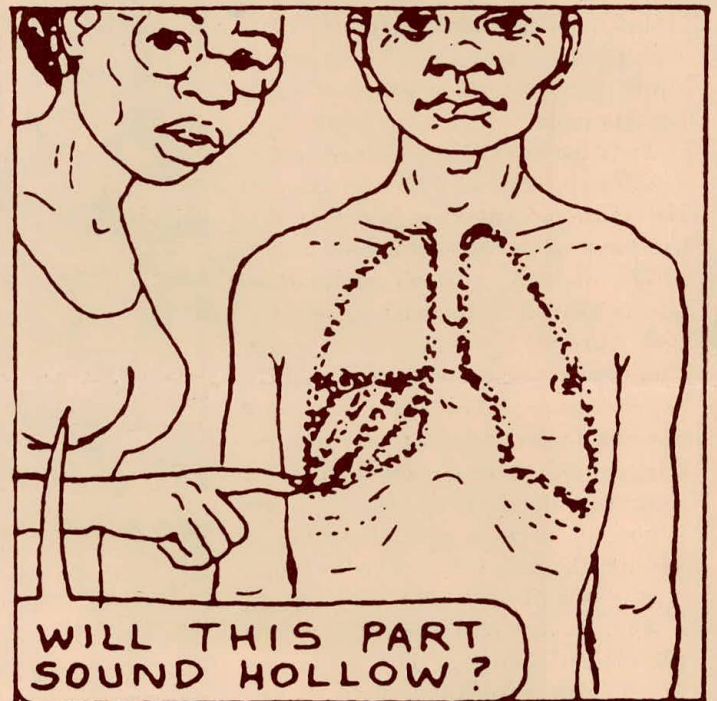
By doing this, students not only learn about the position, size, and work of the lungs, but they also learn a useful skill

for physical examination—thumping the lungs to listen for relative hollowness. This can help them spot signs of disease.

To help students understand the different sounds they hear when thumping, have them determine the level of water (or gasoline) in a large drum or barrel. Then thump the chest of a student.



Next, compare with a person who has a solid (diseased) area or liquid lung. If possible, also show the students X-rays of normal and diseased lungs.



The above article is reprinted with permission from the new book, *HELPING HEALTH WORKERS LEARN: A book of methods, aids, and ideas for instructors at the village level*, by David Werner and Bill Bower. The illustrated book is available in English (Spanish translation in preparation) from: The Hesperian Foundation, PO Box 1692, Palo Alto, CA 94302, USA. Price: \$6.50; discounts for bulk orders.

Bangladesh Drug Policy

A Comprehensive Review

(April through September 1982)

Background

An eight-member Expert Committee constituted by the present Martial Law Government of Bangladesh was commissioned to evaluate all the pharmaceutical products available in the country and draft a National Drug Policy with a view to the real health needs of the people. This committee held its first meeting on April 28, 1982.

They first laid down 16 criteria by which they intended to evaluate all products—12 of these were on a scientific basis, four on a political/economic basis. The result of their deliberation on 4140 products then available was to ban (in 3 categories/schedules) 1707 items.

Drugs from Schedule—I were deemed positively harmful and to be banned immediately and withdrawn from the market in one month's time. This Schedule included 265 locally manufactured products and 40 imported. Drugs in Schedule II required reformulation as they were combinations of similar or dis-similar ingredients (antibiotics, analgesics, steroids, etc.) and as such were of no increased therapeutic value, were a cause of possible increased toxicity and an unnecessary expense. This Schedule included 134 locally manufactured products. Six months were allowed for disposal of existing stocks and submission of recipes for reformulation. Drugs in Schedule III fell into two distinct sections—either they were: (a) again combination products with little or no proven therapeutic value or (b) they were useful products which were: (1) being manufactured under licence by a multinational company with no factory in the country; (2) imported drugs which were already being manufactured locally or; (3) simple vitamin, antacid, etc. preparations which were to be the manufacturing responsibility of local companies. The purpose of banning under Schedule III was to safeguard and promote the development of the national drug industry by not allowing multinationals to manufacture/import products either

already locally available or those of simple formulation (vitamins, antacids, etc.) which required no special, sophisticated machinery and technical know-how. In this Schedule, there were 742 locally manufactured and 526 imported drugs. The time allowed in this Schedule was six months.

The Expert Committee's report was submitted on May 12, 1982 and the Chief Martial Law Administrator and his Council of Ministers approved it (changing the banning date of Schedule I from one to three months and Schedule III from six to nine months) on May 29. The government made a formal declaration of the new policy on June 7 and the Drug (Control) Ordinance 1982 was promulgated on June 12, 1982.

Anti-Policy Activity

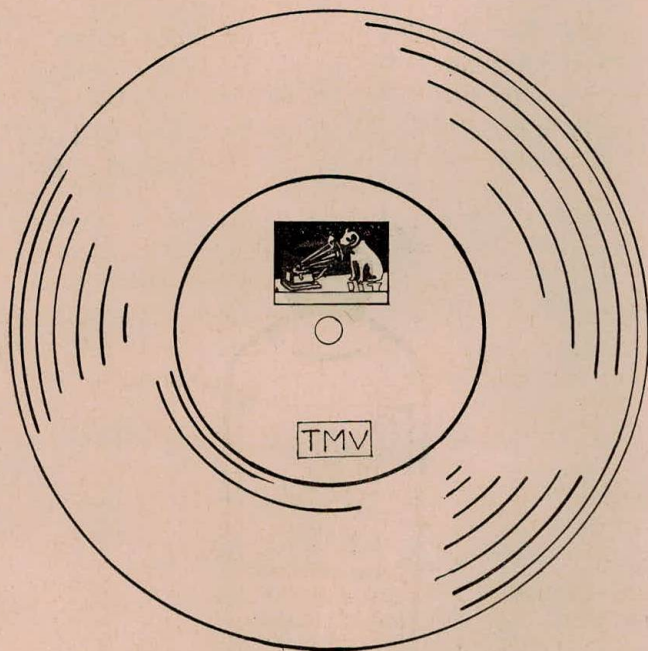
The first headline news story broke before the official government declaration (of June 7) and was the signal for beginning maneuvers by the US Ambassador to Bangladesh, Mrs. Jane Coon, on behalf of US multinational vested interests, to have the policy



"The First World Prescription"

amended if not rescinded. The drama intensified with all multinationals and some nationals mounting a campaign of anti-government criticism (punishable by 7 years imprisonment under martial law, but interestingly enough, no cases were filed in this context) in desperate attempts to sway the government from its decision. The US Ambassador was soon joined by British, Dutch and German Embassies in their pressure on the government. With apparent failure of their anti-government campaign, the multinationals turned their venomous outcry against the Expert Committee, against two members in particular.

In late July, the US Embassy brought in four members of various pharmaceutical manufacturing companies, passing them off as an 'Expert Scientific Committee.' In actual fact, they were little other than a 'trade commission' whose aim was to further pressurise government's reconsideration. The US State Department, in the August 19, 1982 edition of *The Washington Post*, openly acknowledged "that the Pharmaceutical Manufacturers Association (PMA), a trade organization for the drug industry, asked it to bring pressure on the Bangladesh government, to delay implementing the law pending discussion with the manufacturers".



Transnational Masters' Voice
also known as
"—Medical association"

The spokesman went on to say, "The State Department has a statutory responsibility for assisting American interests abroad. In this particular case, the US Government is also concerned that these regulations may inhibit further foreign investment in Bangladesh."

In this same respect, the Bangladesh Medical Association proved itself a mockery of the science it purports to practice and it was readily seen that a good number of registered doctors in the country could easily be swayed and bribed by drug manufacturing representatives.

Ordinance Amendment

With great confusion having been created by the multinationals and their concerned governments, the Chief Martial Law Administrator set up a Review Committee (consisting of six military doctors) whose report was subsequently submitted to the Government on August 12, 1982. Studying together the Expert and Review Committee's reports, the Bangladesh government, on September 6, 1982, announced the Drugs (Control) Ordinance Amendment, 1982.

Referring to the (original) Schedule I drugs, only one item of importance had its ban lifted—imodium (an anti-diarrhoeal). The other six items which were reinstated were misused/abused dental remedies/cures. The time limit for withdrawing the banned drugs of Schedule I from the market remained three months and became effective from September 12, 1982.

Of drugs in (original) Schedule II, four eye preparations were allowed which contain combination antibiotics and steroids (disallowed under the Expert Committee's criteria). Heptuna-plus, an iron supplement which fails to meet the original criteria was also allowed to remain in this Schedule. The time limit for reformulation under this Schedule was extended from 6 months to 12 months.

Under (original) Schedule III, 27 drugs (manufactured under licence) were allowed to remain, honouring existing contracts between Bangladesh government and various multinationals. A further 88 balms and vaporubs of small national companies (less than 1% of the drug market) were put into a (new) Schedule IV. These were allowed to manufacture and for 18 months.

NEWS from the states

West Bengal

Training Incentives

WBVHA has initiated a monthly training in Community Health Development for village health workers and supervisors at Seva Kendra, Calcutta, from November 1, 1982. This training will lead to the growth of "teamwork spirit". The training programme includes human relations, communications, community approach, health education, mother and child care, prevention of diseases, environmental sanitation, socio-political analysis, income generating projects and management concepts.

Field training was given at Child in Need Institute (CINI) and the Ramakrishna Mission.

Mobile Help for Bengal

The St. John's Ambulance Association has taken up the M.M.U-cum-Ambulance Project for providing medical help to a total village population of 12 lakhs through eighteen M.M.U-cum-Ambulance Units. The E.Z.E. West Germany has underwritten three-fourths of the cost.

The Government of West Bengal will pay staff salaries.

This project originated in a meeting at the Raj Niwas in Calcutta in July 1980. Dr. S.N. Chaudhuri (CINI), Mr. J.B. Singh (AFPRO) and Father Tong were present at the invitation of the then governor, Shri T.N. Singh. The governor was anxious that some of the more neglected districts of West Bengal be served by mobile medical health units. At the meeting, Fr. Tong had urged that there should be a good measure of people's participation built into the project. St. John's Ambulance Association agreed to undertake the project and to raise one fourth of the cost from local sources such as government grants and private donations.

Karnataka

New Secretary

Ms. Usha S, B.Sc., M.B.A. is the new VHAK Promotional Secretary.

A nutrition kit comprising of 5 charts and a booklet on nutrition and balanced diet is available for Rs. 35/- plus postage. Write to Hony. Secretary, VHAK, St. John's Medical College Hospital, Sarjapur Road, Bangalore 560 034.

Gujarat

Gujarat VHA Evaluated

GVHA Annual Convention and General Body meeting was held on 27th/28th November. The theme was Evaluation of GVHA with a view to planning future programmes and activities.

Bihar

Drought Crisis Shared

BVHA is on the Flood's Relief Committee to meet the crisis due to drought.

BVHA newsletter October highlights the drug menace and circulates the list of drugs which should be banned in voluntary institutions.

BVHA has been also involved in flood relief work in the state.

Madhya Pradesh

Membership Rush

Several new applications for membership are reported in the MPVHA newsletter.

Two workshops on Community Health will be held in early 1983.

A survey of extent of eye problems in the areas around Dhani, Dhar District, is completed. A special program for prevention of nutritional blindness is contemplated.

An ophthalmic nursing course giving general nurses theoretical and practical knowledge about eye surgery will be held in March 1983. At the last one conducted at Amarkantak by Dr.V.K. Ali of Christian Hospital, Shahdol, 171 eye operations were performed.

Delhi

AFORD (Aids for the Disabled) Training Programme

VHAI will work with Dr. P.K. Sethi, to formulate training programmes for the diffusion of work done at the Rehabilitation Research, Centre, S.M.S. hospital, Jaipur. A small workshop was held from November 12 to 14, 1982 to define and develop training courses at Jaipur.

Salus—India

An annotated bibliography and information system of low cost health care and manpower training, on the lines of SALUS of International Development and Research Centre, Canada, is proposed to be set up in India. VHAI and CENDIT (Centre for Development of Instructional Technology) will collaborate on this project.

* * *



**WE
NEED
YOU**

Wanted People

Wanted immediately Christian personnel to work in a rural hospital:

1. General Surgeon: M.S.
Salary —2100-100-2500-125-3125-150-3875
2. Junior Doctor: M.B.B.S.
Salary —825-50-1075-75-1450-100-1950
3. Pharmacist: D. Pharma
Salary —330-15-405-20-505-30-655-40-855
4. Male Nurses: R.N.
Salary —330-15-405-20-505-30-655-40-855
5. Staff Nurses R.N., R.M.
Salary —345-15-420-20-520-30-670-40-870
6. Auxiliary Nurses: A.N.M.
Salary —220-10-270-15-345-20-445-30-595
7. Driver-cum-Mechanic
Salary —250-10-300-15-375-20-465-30-625
8. Clerk
Salary —250-10-300-15-375-20-465-30-625

Correspondence Course in Financial Management

A 16 months correspondence course in Financial Management for Voluntary Health Care Institutions is being started by Voluntary Health Association of India. The opening seminar of this course will be from February 3rd 1983. The aim of the course is to train accounts personnel in health care institutions in all aspects of accounting and financial management. Only persons with commerce background i.e., education in commerce or working experience in the accounts department of a health care institution are eligible to apply for this course.

For the prospectus, application form and for any further information, please write to : Ravi Srinivasan, Course Coordinator FINMAN, VHAI, C-14 Community Centre, S.D.A, New Delhi-110016.

Free accommodation will be provided.

Apply to the Medical Superintendent, Swedish Mission Hospital, P.O. Khurai, Dist. Sagar, M.P. 470 117

Nurse

A qualified nurse for community health work. Must be willing to live in the village and to work with villagers. If married, husband's qualification. Apply with biodata and testimonials to Superintendent, Ashwood Memorial Hospital, P.O. Box No. 4 Daund, 413 801, Dist. Pune.

2 A.N.Ms. Apply with Biodata and testimonials to Superintendent, Ashwood Memorial Hospital, P.O. Box 4, Daund 413 801, District Pune.

Consultant

Senior/Junior Consultant for Nuclear Medicine Department equipped with computerised Tomographic Camera and Radio Immuno Assay Laboratory. Salary and terms negotiable. Apply to the Hospital Administrator ; Choithram Hospital and Research Centre P.B. No. 131, Manik Bagh Road, Indore-452001 (M.P)

PLEASE RENEW YOUR SUBSCRIPTION TO
HEALTH FOR THE MILLIONS. IT IS STILL
RS. 12/- PER YEAR.

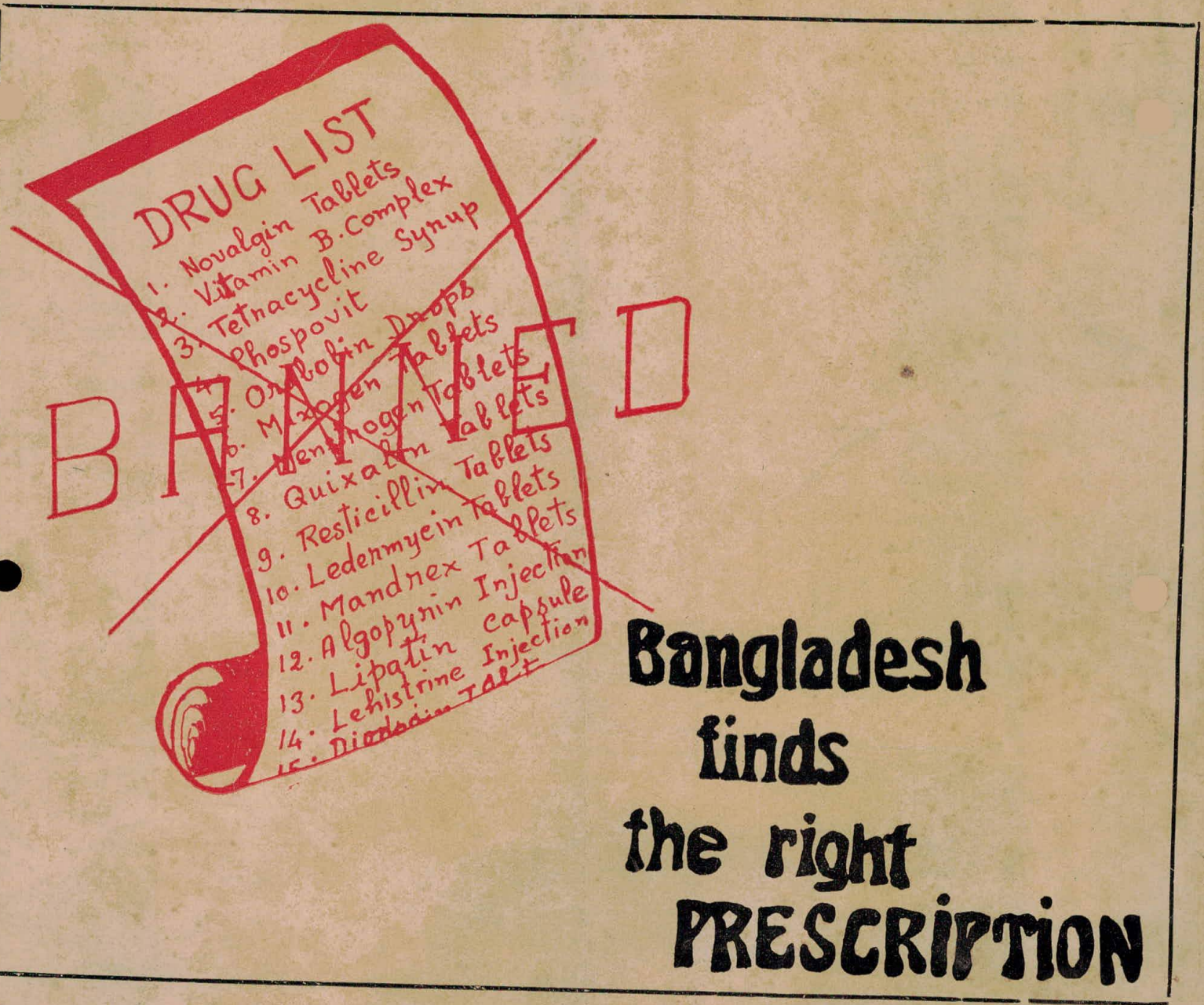
HEALTH

FOR THE MILLIONS

Vol. VIII No. 6

A Bimonthly of the Voluntary Health Association of India

DECEMBER 1982



DRUG LIST

1. Novalgin Tablets
2. Vitamin B. Complex
3. Tetracycline Syrup
4. Phospovit
5. Oxalobin Drops
6. Minoxogen Tablets
7. Menhogen Tablets
8. Quixalin Tablets
9. Resticillin Tablets
10. Ledenmycin Tablets
11. Mandrex Tablets
12. Algopyrin Injection
13. Lipatin capsule
14. Lehistine Injection
15. Diobain TALT

B
A
D

**Bangladesh
finds
the right
PRESCRIPTION**

Bangladesh Shows the Way

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Pharmaceuticals
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Project
- 12 Drugs Workshop at Jaipur
- 13 Manila Declaration
- 14 Health Workers' Convention
- 15 News from the States
- 16 Correspondence Course
- 16 We need You
- 17 Just Released

A small developing country has taken a big, bold step in the right direction. Bangladesh has banned 1707 drugs dealing with 4140 drug products. Multinational companies and their governments have expressed great resentment and resistance to this move. That is expected because they control 80% of the drug sales in Bangladesh and their market in developing countries runs into many, many millions of dollars.

The multinational and national companies affected, succeeded in pressurising the Bangladesh government to review and postpone the ban. These few months are therefore very crucial—because all kinds of pressures are being exerted to dilute the ban.

This is where all of us in India concerned with drug issues, have a vital role. We need to study all information on this issue. We published in the last issue the criteria adopted by the Bangladesh Government for the ban. In this issue, there are articles by Zafrullah, Susanne Chowdhury and Andy Chetley. Other related informations are available with VHAI. Thanks to the work of Mira and Sathya.

And then act. Write to newspapers. Write to the Bangladesh Health Minister (C/o Bangladesh High Commission, 56 Mahatma Gandhi Road, Lajpat Nagar III, New Delhi-110024). Write to Zafrullah Chowdhury, expressing solidarity and support. They need it. With lack of international support, a bold step is likely to be backtracked by the Bangladesh Government under multinational pressure.

There are some who believe that supporting the ban means supporting a military government. On the contrary, it means supporting people like Zafrullah Chowdhury and his friends—people who are working hard to promote social justice and equality in health. Supporting the ban means supporting a major decision in favour of the poor.

We need to do even better. We have to stop similar irrational and dangerous practices. We have to demand a similar ban from our own government. Write to the Drugs Controller of India, Nirman Bhavan, New Delhi-110011. It is a tough struggle to promote justice and fight oppression. But if Bangladesh, a small country which is more dependent on foreign aid for its drugs and development than India can do it, why can't we? Bangladesh has shown us the way.

—S. SRINIVASAN

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newspapers to publicize the aims of GPL.

3. Retail sale

For an efficient retail sale throughout the country, a network of depots, agents and transport has to be set up. So far, this is only in the beginning stages. At present, we sell to shops in Dacca and Chittagong. A Dacca depot is about to be opened depots for other district cities are being prepared. As we anticipated, selling through existing pharmacies has its problems. We have heard of cases where a much higher price than the MRP indicated on the package has been charged. A lack of confidence in anything that comes from Bangladesh itself is part of our sad colonial heritage, and pharmacists, having heard something of Dutch financing, charge excessive prices claiming that this is a new 'Bitali' (European) medicine. We hope that, in future, we will be able to establish our

own retail shops at least in the 62 subdivisions, which would enable us to keep a tighter control over sales practices.

4. Sales to government

Each year, the government calls a large tender for medicines to rural health centres. In 1979, the government, after proper calculation, put pressure on the government-owned Albert David company to sell them their ampicillin at a price of 95 paisa per capsule. In 1980, the Albert David management contended that due to rising cost they could not supply at a price lower than 99 paisa. In 1981, we bid for the tender of 10 million ampicillin capsules at 93 paisa basing our calculation on the raw price cited by one of the leading trading houses and considering our high overheads. The day after submitting our bid, we were informed by the trading company that they could now quote a better raw

material price: the previous quotation had been for US dollars 95-120 per kg., the new price was US dollars 86-100. This cheaper price would have resulted in a lowering of the per capsule price by 5-17 paisa. We later learned that the trading house in question is owned by the wives of the managing directors of three large pharmaceutical companies, one multinational and two national, one of the latter also collaborates closely with a multinational. Later on we also learned that some multinational companies and 3 top-selling national companies had a meeting before the tender. We did not win the tender. It went to a national company which had bid at 80 paisa per capsule. The retail price of the same company's ampicillin is 159 paisa. For the government this was the cheapest ampicillin they had ever purchased and giving credit where credit is due, some officials thanked us, requesting us to keep up the good work. □

CHART ONE

Prices in paisa (100=1 taka)¹ for drugs in Bangladesh, 1982.

Drug:	Raw material	Packaging	Overhead	Unit cost	Profits	Trade Prices	GPL	Others	
	Gonoshasthaya Pharmaceuticals Ltd.					Maximum Retail Prices (MRP)			
Ampicillin (250 mg)									
Ampicillin (250 mg)	58.3	1.5	16.7	76.2p	5p (6.57%)	85p	100	Hoechst Square	186 175
Tetracycline (250 mg)	21.2	1.5	15.7	38.4p	2p (5.26%)	42.5p	50	Squibb Pfizer Albert David	110 106 77
Metronidazol (200 mg)	9.5	8	12.5	30p	2p (6.7%)	34p	40	BPI Square	79 65
Paracetamol (500 mg)	4.8	0.7	6.2	11.7p	0.04p (3.41%)	12.7p	15	Fisons Square	24 25
Aspirin (300 mg)	1.4	0.7	3.2	5.3p	0.01p (1.88%)	6.4p	7.5	BPI Fisons	12 9
Antacid Tab	3.5	0.7	7	11.2p	4p (35.7%)	17p	20	Nicholas Albert David	27 18
Diazepam (5 mg)	0.9	1.6	4.6	7.1p	2.6 (36.6%)	10.6	12.5	Roche Square	55 30
Frusemide (40 mg)	5.2	7.2	13.6	26p	22 (85.6%)	51p	60	Hoechst	125

¹US\$1.00 = Taka 21.50

Dosages in Tender Price.

Central Medical Stores, Dacca.
 Government of People's Republic of Bangladesh

Prices in Taka per 1000

Drugs:	1980-81	1981-82
1. Ampicillin Capsule (250 mg)	Tk. 995 (Albert David)	Tk. 800 (Pharmadesh) 840 (Albert David)
2. Tetracycline Cap (250 mg)	. 440	380 (GACO)
3. Antacid Tab.	170 (Albert David)	31.5 (Fison)
4. Ferrous Fumarate with Folic Acid	39.45 (Fisons)	31.45 (Fison)
5. Frusemide Tab.	1040 (Hoechst)	510 (GPL)

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THE NEW BANGLADESH DRUG ORDINANCE - AN OVERVIEW

- Susan B. Rifkin

It is no secret that the pharmaceutical TNCs (transnational corporations) present a big barrier to the World Health Organization's (WHO) goal of "health for all by the year 2000". These companies, headquartered in the West, hold patents on some of the most effective and thus the most demanded medicines. Through a strong infrastructure of manufacturing, marketing and distribution, the drug TNCs are in a position to hold prices high thus assuring their own profits but causing hardship among consumers especially in the Third World.

The TNCs have been accused of preventing rather than contributing to good health care on several grounds. Firstly, through their hold on patents, they stop local companies from producing the same drug at lower costs. Not only do they charge the local

company much more to buy the ingredients to manufacture the medicine but also they block the company from selling the product at a lower price. In addition, TNCs sell by trade name rather than the generic (descriptive name) thus forcing the consumer to demand the higher priced commodity (i.e. asking for Penbritin - brand name - rather than penicillin - generic name). Also many drug companies market products of questionable value. They are more a result of good advertising than of good quality. These accusations as well as those related to drug dumping and marketing medicines in the Third World which have been banned in the West have focused attention on the adverse role of the drug companies in Third World health promotion.

In the mid 1970's, many groups

including the UN began to seek solutions which would allow Third World governments to counter the TNCs' control to use scarce financial resources to purchase medicines which would do the most good for the most number of people. Five UN agencies including WHO (World Health Organization), United Nations Conference on Trade and Development (UNCTAD), United Nations Industrial Development Organization (UNIDO), United Nations Development Programme and United Nations Children's Fund (UNICEF) collaborated on a strategy which, among other things, recommended a list of 190 essential and 30 complementary drugs which third world governments need to deal with their major disease problems. Armed with this list, no government

GONOSHASTHAYA PHARMACEUTICALS

— Zafarullah Chowdhury & Susanne Chowdhury¹

Gonoshasthaya Kendra (GK) is a charitable trust which was set up in 1972 by a group of health workers who had been involved in the Bangladesh Liberation struggle of 1971. The first objective was to establish a health service in Savar thana with an emphasis on preventive and primary care. In the course of this work, it was realized that health care by itself could not be an answer to the problem of poverty, and the project became involved in a wide range of community development work (of. Progress Report No. 7).

The project experience, and especially the problem of how to get good and cheap medicines to the people, also led to thinking about a pharmaceutical factory based on four principles; viz. low prices, quality, manufacture of essential drugs only, and responsible marketing practises. The factory is a joint stock company, but all shares are owned by the GK Charitable Trust and cannot be bought or sold. Policy is determined by a Board of Directors, consisting at present of eight members, with representatives from government (Ministries of Health and Industries), the Bangladesh Shilpa (Industrial) Bank (BSB), the GK Board of Trustees, Savar GK and NOVIB, a Dutch voluntary agency.

Technical expertise has been provided by the International Dispensary Association, Holland, who also organised training for managers and the architect, as well as the procurement of machinery and raw materials. All managers are Bangladeshi.

GKP is designed to supply 15 – 20% of the present Bangladesh market in essential drugs once it is in full production. Retail prices will be 35-50% lower than those of equivalent drugs on the market, and are calculated to leave GKP with an overall profit of 10-15%, after deductions for all production cost, depreciation, and bank charges. Profits will be invested in expansion, medical and social research, and in new enterprises. Part of it must be spent on charitable purposes.

Marketing of GKP products will be partly through bulk purchase by the government for their rural health centres (initially 60 – 70%), and partly through a chain of special retail shops.

1. Problems:

Any attempt to establish a high technology project in an under-developed country will suffer from the lack of infrastructure, and the problems which arise from having to import much

of the necessary equipment. During the construction phase, one of our problems was the lack of expertise in our architectural firm. Pharmaceutical factories had been built before in Bangladesh, but either they did not correspond to the rules laid down in Good Manufacturing Practise (GMP) or they were built according to blueprints brought in complete by multinational companies which had given no opportunity for local experience. We therefore sent our architect abroad for a tour of pharmaceutical factories. Our factory is connected to the general electricity supply. This is quite unreliable and production losses result from power failures. Even more serious are the current fluctuations which damage equipment and are unknown in the more sophisticated net works of industrialized countries. This creates problems of maintenance, all the more so, since the standard spare parts for machinery sent by equipments manufacturers, consist mainly of mechanical items, while we are mainly in need of electrical spare parts.

2. Personnel:

a) Unskilled

Jobs with regular incomes, however low, are scarce in Bangladesh and the object of intense competition. This applies even to unskilled labourer's jobs in factories. As a result, getting such jobs depends on the ability to give bribes, and often also on absurdly high levels of formal education. Therefore only families with some property will have members working in industry; and their wages are often a surplus cash income which is used to buy up land from less fortunate families of marginal farmers.

1 Paper presented to a Conference on Technology Transfer to the Third World, 10-12 January, 1982 at Gonoshasthaya Kendra, Bangladesh Edited Version.

The cost of establishing the factory has been as follows:

Building including air conditioning:	US dollars 1.2 million
Machinery and equipment:	US dollars 1.5 million
Training of managers and business travel:	US dollars 0.1 million
Working capital incl. raw materials for four months:	US dollars 1.2 million
Transport and miscellaneous:	<u>US dollars 0.2 million</u>
	US dollars 4.2 million
Contributions from NOVIB (Holland)	US dollars 2.62 million
Oxfam (U.K.)	US dollars 0.33 million
Christian Aid (U.K.)	US dollars 0.16 million
BSB, GK Trust and others	<u>US dollars 1.00 million</u>
	US dollars 4.11 million

PHARMACEUTICALS IN BANGLADESH

- Gonoshasthaya Kendra - Bangladesh

At a conservative estimate, Bangladesh has an annual drug market of Tk. 1250 million (approx. 83 million U.S. dollars). Only a negligible proportion of this is available free of cost in government health centres, the rest is sold commercially. In a country with one of the lowest per capita incomes in the world (70 dollars a year), this means that after food, clothing and shelter, medicines are a major part of the remaining expenditure. Often, a little medicine may be bought in extreme need, but not enough to cure the illness, and the public are left in ignorance of the detrimental effects of breaking off treatment prematurely. Most importantly, due to poverty and the high cost of drugs, at best 15% of the people ever buy any modern medicine.

Inadequate information and the common habit of self-prescription (because doctors are unavailable or too expensive and because all drugs can be freely bought over the counter) have led to a situation where 70% of the annual drug sales go on drugs described as useless or therapeutically insignificant by the British National Formulary, the National Research Council (USA) or the Federal Drug Administration (USA). The bulk of these unnecessary medicines are vitamins, tonics, enzymes and cough mixtures.

Drugs worth an average of Tk. 150 million are imported annually into Bangladesh by small local firms and also by voluntary and U.N. organisations. The remaining medicines, worth about Tk.1100 million, are produced in Bangladesh. There are over 150 registered drug companies, but most of these exist on paper only having been created to take advantage of the fact that raw and packaging materials for pharmaceutical companies - which are considered essential industries - can be imported with enormously reduced customs duties and are then resold to, e.g. cosmetics factories. Tk. 890 million worth of drugs (= 81% of drugs produced in Bangladesh) are produced by eight multinational companies. The rest is shared by a number of smaller multinationals and 22 local companies. The table below shows the situation in greater detail:

	Name of Company	Annual Production in Taka
1. Multinationals:	Pfizer	200 million
	Fisons	140 million
	May & Becker (BPI)	120 million
	Hoechst	115 million
	Glaxo	110 million
	Squibb	105 million
	ICI	50 million
	Organon	50 million
	Others	<u>15 million</u>
		905 million
2. Local Companies:	Square*	70 million
	Gaco	40 million
	Albert David	35 million
	Pharmadesh	30 million
	Jayson	10 million
	Others	<u>10 million</u>
		195 million
3. Imported:		<u>150 million</u>
	Grand Total:	1250 million

*Square manufactures drugs mainly under third party license (from Janssen)

Looking at the types of medicines available, we find about 2300 brand-named drugs containing 150 different active ingredients. Only about 250 of these, about 10% are therapeutically significant or essential drugs according to the sources named above. All the rest are promoted solely for the purpose of financial gain.

Proliferation of products and their promotion is, of course, a ubiquitous feature of capitalism, but in a country like Bangladesh the situation is worse because it diverts desperately scarce resources and many people will deny themselves food in the hope that some aggressively advertised, but useless tonic will do them more good. But it is not only a confidence trick: substances which have actually been identified as harmful and banned in developed countries continue to be marketed and manufactured in Bangladesh. The pressure that can be exerted by foreign companies on the government was shown again recently when dipyrone

(Hoechst brand names 'Novalgin', 'Baralgin'),, which can cause fatal agranulocytosis, was again cleared for manufacture, even with an increase in the permitted quantities (Bangladesh Gazette, Pt.I, Feb. 29, 1981). The decision was taken despite strong representation from groups of local doctors and pharmacists. Other products banned elsewhere, but still available here, include phenacetin and clioquinol. A quotation from the Managing Director of Fisons (Bangladesh), Mr. A. Wahid, may sum up the attitude of the multi-nationals:

up the attitude of the multi-nationals: "We are businessmen first, first of all we want profits ... We are oversensitive about reports from WHO. Restrictions on drugs and pesticides imposed in the U.S. and Canada should not be applied in our country because our people are ethnically and biologically different from others."

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VOLUNTARY HEALTH ASSOCIATION OF INDIA

C - 14 Community Centre,
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NEW DELHI - 110 016

In Support of Bangladesh's Drug Policy

On the 7th June 1982, on the recommendation of an eight-member advisory committee, the Government of Bangladesh decided to ban 1707 drugs. These constituted about half the drugs sold in Bangladesh (1742 out of 4140 products licensed for sale). The guidelines set by WHO's expert committee on essential drugs have been followed. Drugs not included in the Pharmaceutical Codex and British Pharmacopea were also excluded.

Amongst the drugs being banned are tonics, cough mixtures, elixirs, for dysenteries, restoratives, gripe water and alkali mixtures and combination antibiotics.

Not only are the hazardous and ineffective drugs being eliminated but national companies are being encouraged to produce the simpler drugs. Multinationals would be allowed to manufacture more complicated drugs.

According to Frontier dated July 1982 some of the other bold steps taken by the Government to ensure a more people-oriented health care - were:

1. Fixing of the fees of doctors ... 40 takas for the first visit (prescription and medicines excluded). Clinics and nursing homes will need licences and will have to follow standard charges.
2. Stopping construction of 8 new medical colleges and, instead, upgrading the existing medical colleges.
3. Enforcement of five years compulsory rural work before obtaining a practicing licence.

The decision was taken in the health interest of the people of Bangladesh. The policy is aimed at making essential and life-saving drugs easily available to the people who most need them. According to Professor Nurul Islam, Chairman of the Expert Committee, this action would help to improve health care. "Nobody will die because of the want of medicines in the country if we stick to only 250 essential drugs including 100 life-saving drugs"

(A. Chetley)

Bangladesh has had to import the majority of the bulk drugs paying about Taka 600 million a year - paid for in foreign exchange! a sum equivalent to 1.7 times the 1979-80 total health budget.

(Dr.H.K.M.A.Hye, Director, Drug Administration, in an interview with Diana Melrose of Oxfam).

The Expert Committee on reviewing the Bangladesh drug market concluded that "nearly one-third of this money was spent on unnecessary and useless medicines such as vitamin mixtures, tonics, alkalis, cough mixtures, digestive enzymes, palliatives, gripe water and hundreds of other similar products". The fact that three quarters of the population had NO REGULAR ACCESS TO VITAL DRUGS makes the irrelevance of the abovementioned drugs all the more jarring.

SALES OF HAZARDOUS AND UNESSENTIAL DRUGS DEPRIVE THE POOR OF ESSENTIAL AND LIFE SAVING DRUGS.

The pricing of drugs, the promotion and marketing practices, the methods of sharing of drug information have all been critically observed. These observations confirm beyond all doubt that for the drug industry, profits come before the health of the people and in the absence of a highly aware and active voluntary control by the health personnel - one has to depend on legislation.

"Under the ban, 240 products were to be immediately withdrawn following the Martial Law Ordinance issued on 7 June 1982 -

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a: 26.8.82

the rest were to be withdrawn by December 1982. Now there will be a phased withdrawal of different categories of drugs within 3, 6 and 9 months.

Diana Melrose in "Medicines and the Poor in Bangladesh".

The ban has been supported strongly by various people-oriented groups and organizations like Health Action International, the OXFAM, International Organization of Consumer Union, Penang, War on Want, UK, Public Citizens' Health Group in the USA. We in VHAI also strongly support the ban - who would not like to see the hazardous and ineffective drugs go out of the market? Probably No one except for the drug companies and those higher-ups whose pockets get lined in allowing the companies to make their profits out of the people. If this had not been so, we too would have seen some of the HATHI Commission's recommendations and other recommendations for weeding out 23 combination drugs, being put into practice long ago.

The Bangladesh Government has taken a very courageous step. The mounting pressure on it by the multinationals may result in either the reversal of the ban under pressure, or, of Bangladesh and its Government being harassed by the denial of aid and loans.

The US Government in response to an appeal made by the multinational drug companies has asked the Bangladesh Government to "reconsider the new national drug policy". This is being done "even though 70% of the banned drugs are considered by the US Federal Drug Administration and its counterparts in Europe to be dangerous and worthless", according to an Express News Service item in the Indian Express of 20th August 1982.

The multinational drug companies who control 80% of the drug sales in Bangladesh fear that other developing countries may follow Bangladesh's example and jeopardise their \$ 30 million world market.

The Public Citizen Health and Research Group, a Washington based organization, in a letter to George Schultz, Secretary of State, has said: "perhaps you are unaware that many of the US-based multinational drug companies are foisting on innocent people in the developing countries, drugs which our own medical authorities consider worthless and unnecessary".

Sabotage of this ban at this stage by the application of pressure or by money power will be a blow to all those who sincerely believe in socially relevant and socially just health care. Consequently, this is not a question of Bangladeshi's fighting a 'Bangladesh problem'. It is in fact a question of a higher premium being placed on profits than on the welfare of human beings - if the ban is withdrawn under duress. This is therefore a move against which the public opinion of all nations, particularly the developing countries, should be raised. It is a cause worthy of global support specially from those involved in health work.

To prevent the government from succumbing to pressure by the multinational drug companies, our support is needed and will be given unflinchingly

+ For the list of banned drugs, criteria used and reasons - contact us.
- Recommended reading:

- A Working Paper by Diana Melrose of OXFAM: "Medicines and the Poor in Bangladesh".
- "Frontier" July 31, 1982: "Tonic or Active Ingredient?"
- Bangladesh Bans more than 1700 Drugs: Andy Chetly - International Health Campaigner for War on Want.

Write your views in support of the ban to counter the pressure by the multinationals to:

The Chief Martial Law Administrator OR
Health Minister, BANGLADESH,
C/o High Commission for Bangladesh, Lajpatnagar III,
New Delhi

Co-Ordinator (Dr. Mira Shiva)
Low Cost Drugs & Rational Therapeutics

Title: - Bangladesh Policy under
US Pressure

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Subtitle

US asks Bangla to relax ban on drugs

By T. V. PARASURAM

Express News Service

WASHINGTON Aug 20

The United States has urged Bangladesh to reconsider a new national policy designed to ban hundreds of drugs, though 70 per cent of the banned drugs are considered by the US Federal Drug Administration and its counterparts in Europe to be dangerous or worthless.

The State Department acknowledged Wednesday that its intercession with Bangladesh was in response to an appeal from several multi-national drug companies which fear that other developing countries will follow the lead of Bangladesh and this could undermine their 30 billion dollar world market.

Bangladesh is playing it in a low key. The economics attache of the Bangladesh embassy in Washington said the Bangladesh law was a good step forward, but the review requested by the State Department "is normal and not important". The US consumer groups do not share this benign view of the US government's intervention and have blasted the administration.

The Washington Post noted in a front page despatch that among the drugs Bangladesh wants banned are several that are not permitted in the US, including clioquinol, a chemical that is known to cause serious damage to the nervous system.

A State Department spokesman acknowledged that the Pharmaceutical Manufacturers Association of the United States (PMA), a trade organisation of the industry, asked the department to bring pressure on Bangladesh to delay implementing the law, pending discussions with the manufacturers. The Spokesman defended the US intercession by saying "the State Department has a statutory responsibility for assisting American interests abroad. In this particular case the US government is also concerned that these regulations may inhibit future foreign investments in Bangladesh."

The Carter administration had drugs or pesticides banned in the USA would not be allowed to be exported abroad. One of the first acts of the Reagan administration was to overturn that rule with the result that drug companies can now export from the US any item banned here. There was never any ban on the manufacture of such drugs abroad.

The US action has been condemned by several international and US charity and consumer groups. About the latest State De-

partment action requesting Bangladesh to review the ban on certain drugs, a spokesman for 'War on Want' said in London, "encouraging this review is certainly not helping the people of Bangladesh".

The Public Citizen Health Research Group, a Washington-based organisation in a letter to Secretary of State George Shultz called the department's action "unconscionable". It said: "Perhaps you are unaware that many of the US-based multinational drug companies are foisting on innocent people in the developing countries drugs which our own medical authorities consider worthless and unnecessary". The group expressed "dismay" that the State Department had allowed itself "to be used by the giant multinational drug companies to promote and protect their exploitation of the impoverished citizens of underdeveloped countries."

The Bangladesh government announced the new law, prohibiting the sale of over 1700 drugs and immediately banning 237 products which are considered dangerous. In June, Among the US drugs affected are some made by Merck, Pfizer, Squibb, Searle and Upjohn.

According to the members of the committee that drew up the new Bangladesh policy, eight multinational companies including Pfizer and Squibb share 75 per cent of Bangladesh's 100 million dollar-a-year drug market. Pfizer dominates the market with over 10 million dollars in sales in 1981. Squibb sold five million dollars worth the same year.

Nineteen Pfizer drugs are on the list of drugs banned in Bangladesh immediately. They include its sterical capsules, which contain clioquinol. Among the 22 Squibb products affected are quixaline tablets and suspension (Q and S caps), both of which also contain clioquinol. Neither Pfizer nor Squibb would comment on the new Bangladesh law or the drugs named in it. They obviously prefer to deal with the matter through the state department.

However, a spokesman for the industry's Pharmaceutical Association, which recently led a delegation to Bangladesh in an unsuccessful effort to secure reconsideration of the law, described the new law as precipitous and prejudicial to public health.

PMA argued that blocking the flow of drugs from its member companies could open the market in Bangladesh to uncertified and potentially impure drugs from their sources.

Approximately 60 per cent of Bangladesh's health budget is devoted to the purchase of drugs compared to less than 10 per cent in the USA. Because of that Bangladesh is eager to bring its drug outlays under control and to begin to produce some of the less complex drugs immediately.

The Bangladesh committee ack-

the companies are marketing. Let's discuss briefly some of the more controversial drugs they are marketing. What sorts of drugs do they promote in Bangladesh that they would not be happy to be seen marketing in other parts of the world?

CHOWDHURY: Take the case of noblyzene—noblyzene is dipyrene. This drug was banned in the U.S. in 1963. It can still be found in Bangladesh. Two years

really feel the impact of drastically expensive drugs and high-powered promotion?

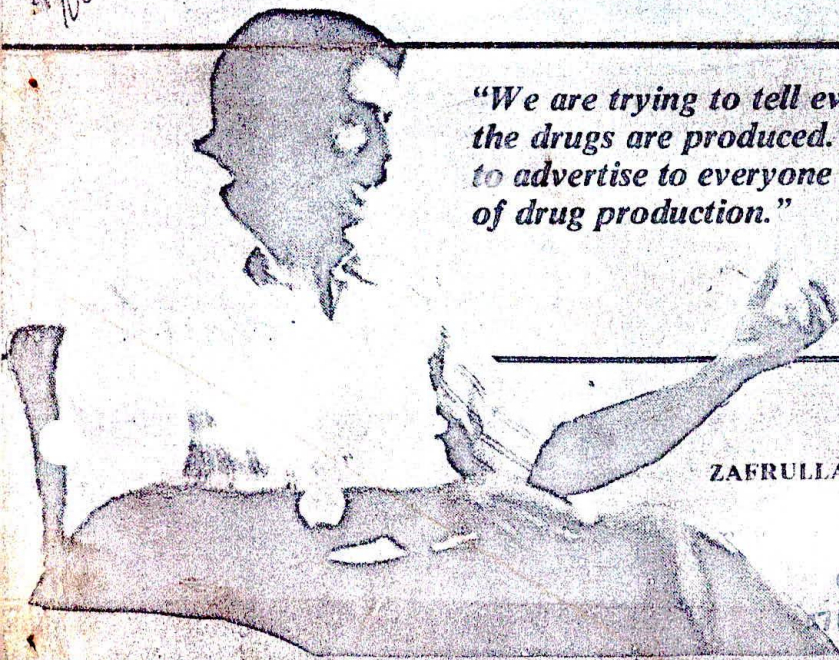
CHOWDHURY: All segments of the population are affected. You must realize that because of the exorbitant prices of drugs, only between 15 percent and 20 percent of the people can afford medicines. In the rural areas, because drugs are so expensive, people cannot possibly afford them. Number one, the

*One taka equals approximately U.S.\$07.

cannot afford food—are category A. Category B have never starved in their lives, but have never had a surplus either. They just manage on the margin. Category C has surplus food, surplus income. Under our plan, category A, the poorest have their health fully covered with one nominal fee. People in category B have to pay a fee of two taka every time they visit the health center. For people in category C, the charge is five taka. If they need to be admitted, they must pay extra money.

For the whole center, about 50 percent of our expenditures are covered by this insurance scheme. Besides our main center, we have centers for every 10 or 15 villages, each staffed by five paramedics. They are full-timers. They provide preventive care, maternal and child welfare, family planning and nutrition advice. They are also involved in education in a broader sense. The subcenters are used as community centers. We feel strongly that you cannot simply deal with health care in the narrow sense; in the rural areas, health care must be part of an overall development scheme. Our people deal directly with cultivation in the villages, they do extensive agricultural extension work. Unless you are really part of the

recognizes
of this plan
me



"We are trying to tell everybody how the drugs are produced. We wanted to advertise to everyone the economics of drug production."

ZAFRULLAH CHOWDHURY

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BANGALORE - 560 001

BORN 27th January 1941

1964 Passed MBBS with Distinction in Surgery.

1965-71 Trained as general and vascular surgeon in England. Returned to Bangladesh to join the liberation struggle and helped establish the Bangladesh hospital for the War victims on the war front.

1972 Bangladesh hospital transformed to Gonosasthya Kendra, also known as the People's Health Centre, or the Savar Project, in Community health circles of which he was the Coordinator/Director.

1974 Awarded the Swedish Youth Peace Prize.

1978 Awarded the highest Bangladesh National Award — The Independence Award.

1982 Jan. Along with his team in GK organized an international Conference on "Transfer of Technology" and inaugurated the famous "GK Pharmaceuticals" producing reasonably priced, essential quality drugs - run by a cooperative.

1982 June As member of the "Bangladesh Drug Expert Committee" was instrumental in formulation and passing of the internationally acclaimed National Drug Policy - based in its entity on WHO's recommendations and concept of Essential Drug List.

1983 April Along with GK team organized an international workshop on 'Alternative Medical Education' to focus on the need for appropriate need based medical education for a third world country like Bangladesh. The aim being initiation of an innovative alternative medical school in Bangladesh. Both these conferences were also aimed at bringing together like minded groups and individuals from the third world together, for building mutual support systems for demands for Rational Drug Policies and relevant medical education.

Member British Medical Association and Bangladesh Medical Association.

Has contributed actively to international scientific and social journals - a few of the outstanding papers being, "Research - a method of Colonization", "Tubectomy by Para-professionals", "under the law in Bangladesh". "Essential drugs for the poor - a myth and reality in Bangladesh."

The New Drug Policy of Bangladesh (June 1982) is based on 6 precepts:-

- elimination of harmful + useless medicines
- increased domestic production of essential drugs
- A public distribution system of essential drugs
- Bulk importation of pharmaceutical raw materials from different sources at competitive prices.
- The use of generic, rather than brand names
- Encouragement of locally organised applied drug research.

* 4000 different brands of allopathic drugs were available in the country. Of these, 1,700 were either useless or harmful + their production + sale has been prohibited.

* 150 essential drugs identified to serve most therapeutic purposes. Of these 12 selected for use by village level health workers for common ailments + another 45 drugs for the primary level of health care at the Upazila Health complexes. Another list of 100 drugs of a specialised nature is for use in complicated cases.

The Bangladesh Drug Control Committee uses 14 guidelines to evaluate existing drugs or new preparations:

- 1) The combination of an antibiotic + another antibiotic, or antibiotics + corticosteroids or other active substances is prohibited. Antibiotics harmful to children (eg tetracycline) may not be produced in liquid form.
- 2) The combination of analgesics in any form is disallowed as there is no therapeutic advantage. The combination of analgesics + iron, vitamins or alcohol is also not allowed.
- 3) The use of codeine in any combination form is not allowed, as it causes addiction.
- 4) In general, no combination drugs are allowed unless there is absolutely no alternative single drug. There is an exception for treatment, or if no alternative single drug is cost effective for the purpose. Certain exceptions are made in the case of eye, skin, respiratory, + haemorrhoidal preparations, co-trimoxazole, oral rehydr. salts, antimalarials, iron/folic acid, + so on as well as for certain vitamin preparations. In these cases, combinations of more than one active ingredient are permitted in a product.
- 5) Vitamins are to be prepared as single ingredient products with the exception of B complex, components of ATO

Vitamin B complex, with the exception of B₁₂, may be combined in one product. B₁₂ must always be a single ingredient injectable product; other components of B complex may also be produced as single ingredient products (eg B₁, B₂, B₆). Vitamins are not to be combined with any other ingredient such as minerals or glycerophosphate. Vitamins may be produced in tablets, capsules & injectable form only. No liquid forms will be permitted because of wastage of financial resources & the tremendous misuse involved. However, paediatric liquid multivitamin (with B₁₂, E, K and/or minerals) may be manufactured in bottles of upto 15 ml & droppers. Paediatric liquid preparations of single ingredient vitamins may also be manufactured in bottles of upto 15 ml & droppers.

- (6) No cough mixtures, throat lozenges, gripe-water, alkalis & so on may be manufactured or imported as these are of little or no therapeutic value.
- (7) The sale of tonics, enzyme/mixture preparations & so called restorative products flourishes on consumer ignorance. Most are habit forming & of little therapeutic value. Local manufacture or importation of such products is disallowed. However pancreatin & lactase may be manufactured &/or imported as single ingredient products.
- (8) Some drugs are being manufactured with only a slight difference in composition from other products, but with similar action. This only confuses both patients & doctor. It is not allowed.
- (9) Products of doubtful, little or no therapeutic value & those which are sometimes rather harmful & subject to misuse, are banned.
- (10) Certain drugs are known serious side-effects & liability. misuse, but with a favourable risk/benefit ratio, may be produced in limited quantity for restricted use. These will be prescribed by specialists only.
- (11) A drug which is being produced in the country, or a close substitute for it, may not be imported, as a measure of protection for the local industry. However, if local production falls far short of needs, this prohibition may be relaxed in some cases.
- (12) Multinational companies are not permitted to produce antacids & vitamins, which leaves them free to concentrate their efforts & resources on those items not so easily produced by smaller national companies. They are, however, allowed to produce injectable vitamins as single ingredient products.
- (13) No foreign branded products may be manufactured under licence in any factory in Bangladesh.

• If the same or similar products are available / manufactured in the country, as this leads to unnecessarily high prices + payment of royalties. In the light of this policy, all existing licensing agreements will be reviewed

(4) No Multinational company without its own factory in Bangladesh may market its products after manufacturing them in another factory under licence

- X -

Nutrient & drug interactions Japhne. A Roe. M.D.

Nutrition Reviews Vol 42, April 1984 No 4 Pp 141

Other

- X -

World Health Forum - Vol 5 No 2 1984 - Pp 103 + 107

Round Table: Tuberculosis control in the developing world; its time for a change. - J Holm.

Discussion (Dr. Nappant incl) also Traditional + Modern Medicine - is a manage possible: Mohammed Saleh Lashari.

[Science Today - Sept '84 - Pp 54
When shipella struck - Bimal Basu]

(1) Essential drugs - special issue May 1981 - a list of in Mozambique. - June 1983 + risks, quality control World Health

(2) " " Oct '83 - World trade of medicinal plants.

(3) " " Apr 82 - Industry offers.

(4) " " Nov 83 - Ration kit for Rural Kenya.

4