A BRIEF REPORT ON THE THREE DAY WORKSHOP FOR VOLAGS ON DRUGS AND RELATED ISSUES CONDUCTED BY D.A.F.-K. with C.H.C.

08 June 89 to 10 June 89

FIRST DAY - Started with an informal round of introduction of participants and resource persons.

- took up the issue of 'TONICS' as a case study.

- the issues discussed were,

~ who consumes tonics

~ why they take them

~ role of media in promotion of tonics

~ western influence of use of alcohol as appetiser / alcohol content of tonics

~ sense of "well-being" with tonics

~ the medical dictionary definition of 'tonic' as a condition of contraction of muscles and in no way connected to its projected benefits.

~ further discussions to clarify 'tonics' was asked for by a DAF-K associate who was convinced of the useless nature of tonics.

~ contents of B-complex / Iron etc. are never near to the requirements of treatment.

— A socio-political analysis of the problem of drugs was also discussed.

The afternoon session was a discussion of bannable drugs by Dr. Shirdi Prasad Tekur. this included

~ pain killers like Analgin, Phenylbutazone etc

~ Antidiarrhoeals

~ Fixed dose combinations

~ Irrational combinations

~ Anabolic steroids

It was also discussed that there are only

Six drugs in combinations recommended by W.H.O.
- the Indian market has 70,000 formulations.
- Hathi committee recommends 116 essential drugs for India, & W.H.O. recommends 250 essential drugs the world over.

SECOND DAY:

Morning session

- the medical establishment and its close association with drug industry
- the medical education & high-tech medicine contributing to exploitative nature of medical system.

The Afternoon was devoted to interviews by groups of participants with, Chemists & Druggists, a teacher of Pharmacology at a Medical College, Drug company managers (IDPL & Unichem), consumers, and doctors. The feed back was presented on the 3rd day, the essence of which was,

(1) The teacher of Pharmacology felt that the Drug Industry misled doctors, and brainwashed them when they were doing internship, negating all that was taught as students.

(2) The chemist & druggist felt he was at the mercy of the Drug controller, who had to be bribed and also of the prescribing Doctors who insisted on different brand & names of the same drug.

(3) The Drug company managers seemed to have no problems (!) even with the Drug controller. One company claimed that even the banned drugs were of great use, but were being misused by people.

(4) The consumers interviewed were health workers in slums who were well aware of drug issues

(5) The Doctors interviewed was aware of rational therapy.

(6) The Pharmacist at a Medical College Hospital was interested in drug issues and ensured that no banned drugs were available in the in pharmacy

All possible issues were brought up and shared with the group.

THIRD DAY

Dr Ravinarayan discussed the efforts countrywide towards rational drug usage. He recalled

~ the earliest attempt by Hathori committee in 1976 towards nationalisation of multinational companies.

~ self reliance in drugs / rational therapeutics

~ 1976-81 ADM (Arogya Dabshala Mandal)
MFC
VHAI
PMRAI
efforts and stand on drug issues.

~ DSF (Delhi Science Forum) workshops and national seminars on drug issues.

~ 1984 - formation of A.I.D.A.N.

~ LOCOST - education / supply of essential drugs to VOLAGS.

~ KSSP efforts in Kerala to demystify Health as medicine

eg. KSSP translation of MFC book which sold 5000 copies

The Afternoon session was chaired by Dr CMF who clarified issues on health, and the attempt of CHAI to bring out a formulary as a first step

towards national prescription practices.

The participants shared what drug action work they could take up in their project areas.

→ ✳ continue as in Gopal's.

DR 33.2

JANUARY 1991 MONTHLY REPORT

January 1991 was the most active month in the last 2½ years. It all started during last week of December 1990 when we received a letter from FEVORD-K, inviting us to participate in a preparatory meeting at Bangalore on "involvement of people in development of degraded forest.". Though we have been working for last two years, we had no idea regarding the exact situation of Forest in Kulavalli area. So Gopal met the Range Forest Officer at Golihalli to find out regarding the same. To give an outline of our village work Gopal gave a copy of annual report, which in its introduction gives a background about the land and forest issue in Kulavalli area including giving an outline of Inamdi land and local politicians involvement, in smuggling of wood.

On 31st December 1990 the Kittur forest beat caught ten cycles of Kulavalli villagers, which were carrying wood towards Kittur, infact these villagers make livelihood by selling wood. The forest beat told these villagers "Doctor sab has given a complaint at Bangalore and told that all cycles will have to be stopped from taking wood". On 3rd January 1991, three bullock carts of Machi village were stopped by Inamdar at Kulavalli and all the Machi Villagers were forced to come for a meeting at Kulavalli.

Gangadhar sent a chit to Gopal asking him to come to Kulavalli along with forest beat. It was expected that the beat will tell the people that there is no complaint lodged. But on reaching the village the forest beat started dancing to the tunes of Inamdar and others. And what happened at the village was an eight hours drama where Gopal was surrounded by about 40 people all drunk and equipped with material for violence. Gopal succumbed to the situation and agreed to pay the ransom

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of Rs.1000/- as a compensation plus taxi fare. Next day the forest beat and constable came home and demanded Rs.800/- as they had helped in settling the issue, ultimately it was a agreed to pay Rs.400/-

On the other side Machi villagers were again called to Kulavalli and made to sit entire day and agree to the conditions that the Machi Mahila Sangha should stop functioning, Gopal and Gangadhar should no longer be allowed to the village. four days later Inamdar, Panchayat member and Prakash Marihal forcibley took the Machi Mahila Sangha members in a jeep to Bailhongal to get the Kissan Nursery money. But the RFO got wild and set them away.

BACKGROUND: There is enough reason for Inamdar and others to get upset and angry with Gopal and Gangadhar.

During the British regime, the Inamdar, had been gifted with 12500/- acres of land as he had helped the British in capturing Sangolli Rayanna a freedom fighter. Part of this land, Inamdar has leased out to Dandeli Paper mills to grow Eculyptus and this contract ends next year. Though Inamki act has been abolished the Inamdar continues the pseudo land lordship and thus exploit the ignorant farmers, by changing hands of the land repeatedly. According to our calculations Inamdar makes around a lakh rupees every year. Gangadhar on his own, was trying to educate these farmers, by asking them to take a receipt from Inamdar for land payments and also giving village maps to farmers.

All this had definately irked and made Inamdar uncomfertable. And on top of this the Machi Mahila Sangha was growing stronger and had got registered. The women had taken up certain local issues which had irked the big politicians. The Inamdar had ordered cutting down a huge tree at Machi, about five manths

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back. The Machi Mahila Sangha members decided not to give away the tree instead they took, the money into Mahila Sangha and similarly the tamarind money. The Machi Villagers were also trying to look for alternate source of income. This had also frieghtened the local politicians as they were involved in wood filling and they had to take help of Machi Villagers for this.

When the marginalised and exploited get organised, the exploitaters try to break the organised group. Probably they were looking for a chance and the copy of annual report which we had given to RFO was used as an effective tool and thus divide the village Kulavalli and Machi.

After the Incident: Machi villagers repeatedly came to Zilla Parishad members house at Kittur and requested her to allow Gangadhar back to the village, but all this prooved of no avail.

Support: It was unnatural for us to expect any support from Kittur as very close relatives of the Zilla Parishat member who stays at Kittur are involved in smuggling wood.

But the support we got from outside friends and other valuntary agencies was overhelming. Dr. Anand Kabbur of IDS Dharwad and also the present president of FEVORD - K, Sri. Dileep Kamat of SPS, Dr. S.L.Pawar from Ranebennur and Sri. S.R.Hiremath from Dharwad. Sri. Dileep Kamat introduced us to Sri.Ram Apte an advocate and trade unionist on 20th January. Dileep Kamat and Dr.Pawar attended the weekly meeting at Kittur. Dileep Kumat immediately contacted Sri. Sadanand Kanavalli who knew the Kittur PSI and Belgaum DIG.

On 31st January 1991, Dr. Anand Kabbur, Dr.Pawar, Sri,Dileep Kamat, Dr,Gopal and Gangadhar Maddimani met the DC at Belgaum and briefed him about the situation . DC assured to look into the matter and promised to visit Kittur.On 1st of February 1991 all these persons including Sri. Vasu from FEDINA Sri. Narasimha Dabade and Sri,Sadanand Kanavalli visited all three villages Machi, Ningapur and Galaginamada.

On 3rd January 1991, PSI Kittur along with Gopal, Sharada and Gangadhar Maddimani visited Kulavahili and Machi and had a nice and healthy discussion with villagers which has helped us tremendously.

Villagers from Ningapur and Galaginamada met us and promised to give us the support the Machi Mahila Sangha has started again with its weekly meetings.

Before we conclude this report we would like to thank Sri. Sadanand Kanavalli, Sri.Dileep Kamat, Sri.Anand Kabbur, Dri. S.L.Pawar Sri.Vasu, Narashimha Dabade and also local Raita Sangha leaders at Kittur who gave the needed support and encouragement at right time.

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Dear Shridr/Ravi/Thelma,

Greetings

We were in a big crises, but things are definiately improving now!

I may come to B'lore during next fortnight, I will contact you at that time.

Sincerly

Gopal Dabade

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DRUG ACTION FORUM-KARNATAKA

Sharing our Experiences

CONTENTS

P R E F A C E

These writings are an attempt to share an account of the development that took place when a group of individuals thought of forming a Forum for Drug Action in Karnataka. The 'report' is not just a recording of events; it tries to share the experiences of the group over the last three years. This is under two major heads:

1. Experiences: Relating to the group
2. Events : This highlights the important events and the attempts made.

The Report has been written for reflection and discussion by interested individuals with a view to eliciting their suggestions, comments and reactions so that future drug work may be undertaken accordingly.

We would like to thank all those who were/are associated with this Forum for their encouragement and support. Our special thanks to Community Health Cell, Bangalore, whose report of a Study-reflection-experiment inspired us to record our experiences in our efforts.

31 MAY 1989

Gopal Dabade
Kittur 591 115
Bailhongal Taluk
Belgaum District

EXPERIENCES

Two individuals involved in health and development visited various voluntary agencies in South India during November 1984, and on reflection, it was discovered that many of them gave a lot of importance to drugs in their health programmes. They got a deeper understanding of the problems related to drugs when they participated in a meeting organised by an all India body, the ' All India Drug Action Network'. A few other individuals from voluntary agencies in Karnataka who were participating in this meet felt the seriousness of the issue, thus attracting them into the fold. This resulted in the formation of Drug Action Forum-Karnataka (DAF-K). It is worth recording here that at the time of formation of DAF-K, in the dispensary of an individual, working in a rural health programme, several unwanted and hazardous drugs were stored and dispensed ubknowingly. This brought the members closer to the problem.

This group wanting to draw other's attention to the issue, in order to strengthen the body, contacted several people from diverse backgrounds like journalism, social work, medicine, health, law etc., and held a series of meetings at regular intervals in Bangalore. The idea was to form a Core group, who would be able to spare sometime from their schedule of work, and guide the course of action of the Forum with the support of other members. Since the initiators of these meetings did not want to thrust the idea of drug work on others but rather wanted the group to study and understand the issue, the formation of a Core group did not take place for two years.

However, during these two years, the larger group was adequately made aware of the drug issue through greater continous interactions with it. It may be recounted here that a funding agency introducing the discussion on drug issue, to the group of agencies seeking more funds, asked how relevant it was to spend huge amounts on drugs. This was an eye opener to many of the participants. For eg., a young medico who was to start a project for tribals had initially planned to earmark a substantial amount of his budget to drugs but on reflecting on the issues raised, he had a second thought whether it was necessary to spend such a huge amount on drugs, when social and economic programmes were of greater importance and relevance to the tribal population.

Two major advantages of organising these meetings were:

a. the group was enabled to know other groups who

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were showing interest on the issue like the Karnataka Rajya Vignana Parishad (KRVP) and others in Karnataka; and

b. Updating of knowledge/information on drug issues through reading of literature/write ups/posters and legal decisions, the resource materials on which were made available to the group by Community Health Cell, Bangalore. This was of immense help not only in knowing other like minded groups in India but in translating the information into the regional language.

By the second half of 1987, more and more agencies and individuals started showing interest in the issue. The Federation of Voluntary Organisations in Rural Development Karnataka (FEVORD-K) organised three meetings in that year to drive home the problems related to drugs. Later on another agency - Institute for Cultural Research and Action (ICRA) organised a meeting and they are now actively involved in this field by preparing appropriate material including a video cassette (In the Name of Medicine).

2. Bringing Drug Action to the General populace

It was realised that there was a lot of information on drug issues of importance existing but it was not being disseminated to the benefit of the general public. With this in mind, six articles were prepared in Kannada and sent to popular publications. The response was really encouraging. In one article a brief mention of LOCOST, Baroda (an agency engaged in the supply of certain essential drugs under generic names and educating the public of issues related to drug) had been made. The response was so enormous that we received more than two hundred letters from the readers!. This has resulted in strengthening the working relationship with LOCOST.

Later on five meetings at Dharwad, Hubli, Shimoga, Ranibennur and Bangalore were conducted with the groups/individuals who had evinced interest and the Core team of LOCOST. These meetings generated quite an amount of discussions and gave the participants a deeper understanding of the situation.

On the whole, the experiences of working with a wide range of groups confirmed our earlier impression and experience that the lay public was much more open to any new

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or scientific thought. On the other hand, the medical profession, especially the Consultants would outrightly deny or refer several scientific ideas on the pretext that "in my experience--------"!

3. Contacts with Voluntary Agencies/Other Groups in Karnataka

In our meetings with the Volags in Karnataka, we had discussed the role of drugs in community health programmes and also the importance of the drug industry in relation to its drug production pattern. Several of them internalised the idea of rational therapeutics to a certain extent with the usual starting problems. Once the idea clicked, then it was easy going later, for majority of the groups. There were, however, some groups which were totally closed to the issue of rational therapeutics, but such groups were few. In particular the groups totally closed to the idea were the local Indian Medical Association.

The relationship with Karnataka Rajya Vignan Parishad was one which has borne fruit. Two years back, when we had approached them with a request to put up some posters on drug related issues in an exhibition arranged by them at Gulbarga, the immediate response was not an encouraging one. But the next day when they gave us five minutes for a talk on the issue, a whole lot of doubts that existed in their minds cleared up, which was obviously because of the response from the people, being addressed. Subsequent to this we were invited to write articles in their bulletin, meet the members of their organisation, teachers and publish a book entitled 'Aushada Mathu Navu' (Medicine and us) in Kannada.

The other group with whom an ongoing relationship was build was Arogya Vikas Prakalpa (an organisation working for rural development in Shimoga and Sagar). Many of its volunteers were city based and doctors and hence an interesting discussion with them could take place. The action initiated by this group was so interesting that they even challenged the local chemist for selling expired drugs.

The other institutions apart from Hubli Hospital for the Handicapped, Hubli, 'Hindu Mission' hospital at Madikeri, with whom, Drug Action Forum could achieve a continuing relationship. It was this contact with Hindu Mission

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Hospital which resulted in us participating in the 'All India Hindu Mission Meet' of hospitals.

In 1984, the Community Health Cell, organised a Workshop on 'A more people oriented Drug Policy' for the members of the Catholic Hospital Association of India, when more than 400 people participated. An audio-visual slide was prepared and an exhibition and a street play on the theme was arranged during the workshop.

4. Teachers Training

A meeting of the People's Science Movement at Dharwad held about a year back led us to interaction with a group of teachers who were interested in drug issues. Following this, our coordinating working relationship increased including talks with Principals, Teachers Centre who had evinced great interest in the issue of drugs and thus a plan for the training of rural primary school teachers was evolved to be conducted on the first Sunday of every month, for six months. The venue for this programme was at the Hubli Hospital for the Handicapped and the issues discussed ranged from unessential and hazardous drugs in the market to the role of teachers in creating awareness on the drug issue among the public. The most often repeated question by teachers in this training programme was 'Why is it that the doctor prescribes these drugs? Is he/she not trained in College?'. It was also experienced that the teachers were the best persons to take up issues, as certain leadership qualities existed within them. The selection of teachers was done by the AEO (Assistant Educational Officer) Dharwad rural, the choice being made of individuals who had earlier evinced interest in social issues.

The consistant message that was stressed throughout these training sessions was that the market is flooded with many unessential drugs and we really do not require these many drugs. The presence of hazardous drugs being so freely available in the market bewildered the teachers. One particular teacher explained to the group how his wife had taken EP Forte during her early months of pregnancy consequent perhaps on which the child born is of unsound mind. It was a stunning experience for all of us. It also so happened that all these teachers who had attended the one day training programmes had earlier been given a two week intensive training by the Government Primary Health Centre, Medical Officer. They had also been

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provided with a kit containing essential drugs for Primary Health Care. With this background in health the one day training brought them much closer to an understanding of the drug issue.

It was this continuous interaction with the teachers that made us prepare a slide set entitled 'Tonics and Health' and write its script in Kannada. Several posters in Kannada on drug related issues, Oral Rehydration solution etc., were also prepared and extensively used in the training programmes.

5. Workshop with Voluntary Agencies in Health Care

The Workshops conducted for voluntary agencies were participatory in which the participants brought out the number and type of drugs that were in use in their projects. It was astonishing to note that a number of unessential drugs were being used by them. Several scientific and technical details including the WHO list of essential drugs for Primary Health Care were discussed in the workshop. Another important issue discussed was h how to evolve a programme at the village level with only the required number of essential drugs. The participants were of the opinion that any new project in health and development should be exposed to this important issue. A larger workshop for the voluntary agencies is being planned.

6. Campaigns

The members of the Drug Action Forum-Karnataka were involved in two major campaigns initiated by the All India Drug Action Network. The first campaign in which many people were involved was before the National Drug Policy was framed. The second one was against Hatch in US. Earlier some women's organisations had taken up the issue along with other groups in India of Injectable Contraceptives.

It is hoped that many more such campaigns would be undertaken in the future.

7. The Future

In the year 1988, a Steering Committee with a few

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individuals/organisations who have found sometime to spare for this issue came into existence under the aegis of DAF-K, which has recently started functioning. Experience in the past has shown that the DAF-K should concentrate their attention on grass root level voluntary agencies especially in disseminating information on drug issues for it is through them one could bring in some attitudional changes in the general public as far as drugs and its usage are concerned. It was observed that many volags were not aware of the practice of rational therapeutics. A few amongst them, even if they were aware of it, were not putting into practice for fear of losing their patients to other general practitioners.

Initiating legal action against the drug manufacturing firms who are flouting the government orders and also against the law enforcing authorities was viewed with equal importance. The story of Estrogen-Progesterone combination formulations could be taken as an example. It is unfortunate to learn that even after its ban, the firms continued to manufacture and market while the ban enforcing authorities acted as silent spectators to the audacity of these firms. It would, however, take some more time before such a step is initiated. In order to obtain a legal entity to the Forum, necessary action is under way to register it.

A two year plan of action has been outlined and is in the process of being discussed and actualised by members of the group.

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8 EVENTS

Under this head, the dates of early meetings; list of articles contributed to various Kannada magazines with a view to bringing drug action to lay persons; contact groups; and teachers training programmes conducted are presented.

I. The early Meetings:

Dates

1. 22nd February 1985
2. 19th May 1985
3. 15th August 1985
4. 13th October 1985

II. List of articles contributed to Kannada magazines with a view to bringing Drug Action to the 'Lay Person'

a. 'Jeeva Hinduva Aushadhagalu'
'Sudha' (Kannada Weekly) May 22-28, 1986

b. 'Nishadhita Aushadhagala Nirantara Prabhutva'
'Uthana' July 1986 (Kannada monthly)

c. 'Tonic Shudha Mosa'
'Taranga' (Kannada weekly) 9th November 1986.

d. 'Aushadharoopi Brahma Rakshssha'
'Sudha' (Kannada Weekly) November 1987.

e. 'Aushadhagalu Mathu Nivu'
'Hosa Diganta' 2nd November 1986.

III. Contacts with groups

1. IMA (Indian Medical Association), Dharwad, Ranebennur and Shimoga.
2. Arogya Vikas Prakalpa, Bangalore.
3. KRVP (Karnataka Rajya Vignana Parishad), Bangalore
4. ICRA (Institute for Cultural Research and Action) Bangalore.
5. CHC (Community Health Cell), Bangalore.

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6. HHH (Hubli Hospital for the Handicapped),Hubli.
7. IDS (India Development Service), Dharwad
8. SPS (Samaj Parivarthana Samudaya),Dharwad
9. BGSS (Bharatiya Grameena Seva Samiti), Hubli
10. VGKK (Vivekananda Girijana Kalyana Kendra), B.R.Hills
11. Ashwini Hospital, Madikeri
12. FEVORD-K (Federation of Voluntary Organisations for Rural Development in Karnataka), Bangalore
13. Concerned Lawyers.

IV. Teachers Training

Date of Training	Number of Participants
1. 06-09-1987	15
2. 04-10-1987	18
3. 12-11-1987	17
4. 06-12-1987	18
5. 03-01-1988	14
6. 06-02-1988	10

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C ACTION PLAN FOR TWO YEARS - JUNE 1988 to JUNE 1990

An important action to be taken by the DAF-K is to register itself as a non-profit organisation. This will ofcourse depend on the interest of the members.

The other areas around which DAF-K should work are:

a. Setting up of an information dissemination centre in Karnataka on issues around drugs and health,

b. Conducting training programmes,

c. Forming rational therapeutic cell,

d. Identifying issues which can be taken up to the Government at State level and bringing it to its notice for needful action,

e. Conduct seminar/conference by organising the various South Indian Drug Action groups,

f. Conducting studies on relevant issues.

It would be very difficult to compartmentalise all these actions, but for the sake of clarity, the plan is worked out under above headings, The difficulty being appreciated because each one is linked to one another.

a. Setting up of an information dissemination centre in Karnataka on issues around drugs

Much work needs to be done in this particular area such as:

1. Setting up a documentation centre
2. Translating it appropriately in Kannada
3. Dissemination
4. Getting Feed-back.

1. Setting up a documentation centre:

   This would consist of magazines and bulletins on drug issues by various organisations. This is to keep ourselves updated on various issues.

2. Translation should be made appropriately and major thrust will be on identifying the issue that has to be dealt, depending upon the need of the time and people's reactions.

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3. Dissemination of information will be to the following groups:

   i. Those voluntary agencies involved in integrated development projects along with health programmes.

      Member institutions of FEVORD-K.

   ii. Voluntary hospitals.

      Various voluntary hospitals in Karnataka. CHAI, CMAI and VHA-K members.

   iii. Voluntary agencies involved in non-health programmes.

      Members of PRARAMBHA, Bangalore
      Members of Karnataka Rajya Vignana Parishad.

   iv. Other mission institutions

2. Action groups in Karnataka

   i. Women Forums
   ii. Lawyers associations
   iii. Consumer Forums
   iv. Environmental groups

3. Teaching institutions in Karnataka

   i. Medical colleges
   ii. Pharmacy colleges
   iii. Other colleges

4. Professional bodies

   i. Indian Medical Association, Karnataka and its members
   ii. Expert professional bodies

The major objective of disseminating information to them will be to:

1. Internalise drug action into their institutions
2. Write issues about drugs in their own bulletins

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3. To become members of Drug Action Forum-Karnataka
4. To involve them in social action programmes.

Method of approach

As we are cutting across a variety of groups, the range being from grass root level workers to medical colleges, the information needed to be disseminated will be different.

As for groups 3 and 4 i.e., Teaching institutions in Karnataka and Professional bodies, much material has already been prepared by AIDAN in English. This will have to be linked up or to kept abreast of them or recent development.

Action Plan:

A single page bulletin every month to groups 3 and 4 which will link them up with other publications of AIDAN etc., and also keep them abreast on specific issues.

For groups 1 and 2 i.e., Voluntary Agencies and Action Groups in Karnataka, the information will need to be made more appropriate for grass root level and will need to be in regional language.

Action Plan:

A single page bulletin every month for groups 1 and 2 in simple Kannada will have to be distributed and further information in which they may be interested, may be provided.

d. Getting feed-back

The information disseminated will have feed-backs, which will be be carefully analysed and incorporated into next bulletin.

b. Conducting training programmes:

1. Training programme for health workers from various voluntary agencies:

It has been observed that voluntary agencies, themselves are promoting many unwanted and dangerous drugs, ofcourse doing it unawarely. At a training programme

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for four voluntary agencies in the first week of January 1988, it was revealing to see how the voluntary agencies used a lot of unwanted and even some dangerous drugs. A continuation of this to cover more voluntary agencies in Karnataka would be planned. Atleast two such training programmes in the ensuing two years would have to be arranged.

It may be mentioned here that the expenses towards attending the training programmes should be borne by the sponsoring organisations.

2. A similar one day training/orientation camp for social action and voluntary organisation working in other areas of development will have to be organised.

c. Forming Rational Therapeutic Cell (RTC)

It is appreciated that educational efforts would be a major stress of DAF-K, and forming a RTC would be an effort to promote awareness about the correct use of medicines. The formation of RTC would help both prescriber as well as patients.

It is a usual occurance that when patient visits doctor, he is advised a long list of drugs.

Why RTC?

When patient visits doctor, the doctor is seen as a high priest and also the patient has unquestioned faith in the power of drugs, tonics and injections. At times even reputed doctors are guilty of irrational prescriptions on the fear that 'if I do not do the same, I will lose my patients to some other doctor'.

The major reason for wrong prescription is because the doctors are misinformed by the drug companies through false advertisments. The medical representative persuade doctors to push unwanted and irrational drugs.

The RTC is an attempt to bring a balance in this gross imbalance. The patient who is the consumer is at the questioning and demanding end and hence it is a consumer movement. It is also made clear that DAF-K has no intention of putting the doctor in the spot. It aims to educate the people.

Approach of Rational Therapeutic Cell

1. The patient sends the prescription with relevant

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details to DAF-K.

2. The prescription so sent by patient would be referred to RTC who would study it and send its comments to the prescriber.

3. The RTC would consist of expert doctors from various medical specialities who are conscious of rational therapy.

The RTC members would meet every three months to evaluate the progress of work and also to exchange ideas.

The RTC would make its final comments on the prescription of the doctor.

4. The RTC would then send its studied final comment to the patient with a copy to the prescribing doctor.

Information to be sent by patient to DAF-K

The patient will be requested to send the following information:

1. Name and address of the patient
2. Name and address of prescriber to whom a copy has to be sent
3. Age, Sex, history of patient and symptoms at the time of consultation of the doctor
4. Diagnosis
5. List of medicines with dosage taken during last six months
6. Details of investigation
7. Any other relevant material
8. Photostat of prescription of doctor.

Limitation of RTC

RTC members do not have the accessibility of clinical examination of the patients, which is the most important thing in medical field before writing a prescription.

It is also made clear that RTC would not like to involve at this stage into legal battles either with doctor or drug companies. The methods of RTC are only an attempt to educate the patient and the doctor.

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d. Identifying issues which can be taken up to the Government at State level and bringing it to its notice for needful action

The State Government has its machinary, which is responsible for upholding the drug situation at State level, but it is hardly a match for the strength of the mighty drug companies. But many a time the Government is not even aware of issues that are happening even in its own neighbouring states. For example the Andhra Pradesh State Government has issued an order to all its hospitals to use only the drugs selected by WHO.

But more often it is the lack of political will on the part of the Government in which case suitable action at all levels will need to be initiated to achieve the issue identified. This will be a major thrust for the members of DAF-K, if it is for lobbying.

Apart from issues to be taken to the Government, the group should also be able to see issues which can be taken up at legal level. This will be a process of involving socially conscious lawyers. The initial step of this has already begun by keeping contact with them.

e. Conduct seminar/conference by organising various South India Drug Action groups for collective action

It is ultimately collective action which is going to pay dividend for any social action movement, and this would be the most important platform. Initially we will have to keep them informed of our activities until we identify common interests for action.

f. Conducting studies on relevant issues

There are several drug companies mushrooming up in various parts of the State and all of them have their own subtle mechanism to push the product into the market; so, a study of their products and promotional literatures could be initiated.

IN ORDER TO UNDERTAKE THE FOREGOING ACTION PLANS, THE DAF-K WOULD REQUIRE FINANCIAL SUPPORT. MEMBERS HAVE TO, THEREFORE, EVOLVE WAYS AND MEANS TO GENERATE FUNDS FOR THE PROGRAMME. IT IS CONSIDERED AN ONEROUS RESPONSIBILITY ON THE PART OF MEMBERS.

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D POST SCRIPT

It is gratifying to record here that in the last one year several individuals and groups including a consumer forum have been showing interest in the efforts of DAF-K and participating in the meetings organised by it. A group of concerned lawyers in Bangalore have come forward to extend their cooperation to the efforts of DAF-K.

The need for undertaking research in the field of drugs has been felt amongst several of us; but it should be one which would help in the campaign and not just an academic exercise. A group of scientists at the Indian Institute of Science, Bangalore have expressed their willingness to help DAF-K in this direction and the issues to be taken up for research have been suggested to them for the needful. This we are sure, would help us in a big way in our efforts and interactions with various groups.

The DAF-K used to meet every two months to discuss issues of interest apart from sending out occasional newsletters, but of late, the meeting has become a monthly feature, where issues related to certain bannable drugs are discussed.

DR 33.4

DRUG ACTION FORUM KARNATAK

24th May 1992 - Dr. Olle Hansson's Day

" Indigenous Medicine - Facts and Myths"

History of Health Culture is as old as human civilization. Every civilization has given brith to a specific health culture which in turn responded to the health needs of that area.

Variety of health problems were managed by the available local knowledge and resources. This was a totally decentralised system. People were able to adjust their inner nature to the external one i.e. people were living in perfect harmony with their environment.

Recently since last one decade there is a rekindling of interest in the traditional system of healing. The basis for this current interest as the belief, that traditional system offers a harmless, harmonious and holistic approach in contrast to the segmented and narrow vision of modern medicine. This is widely prevalent notion which has, in fact supported the forces that encouraged the commercialisation of traditional systems and their entry into the medical market.

This happened due to the "UNHOLINESS" of modern allopathic medicine which is slowly dawning upon its prosperous users as a sophisticated technology. High costs, over medicalisation and iatrogenesis pervade their lives.

The commercial market force which has engulfed the modern medicine, is looking towards other alternatives.

Ayurveda emphasise on healthy life styles (Dinacharya, Rithucharya, Ahara and Vihara). Use of herbs for curative purposes is a tiny part of this ancient heritage. Looking at the vast potential of herbs pharmaceutical companies started manufacturing commercially. This led to the compromise with quality. With the lure of huge profits spurious substandard products flooded the market in the name of Ayurveda. Pharmaceutical companies started exploiting people's psyche i.e. "anything herbal is safe".

On the one hand both Government and NGO's started giving a fillip to the promotion and development of Indigenous medicines. On the other hand pharmaceutical companies started dumping spurious indigenous herbal products.

With all good intentions to support indigenous medicine industry, the Government exempted Ayurvedic and Herbal based products from paying excise duty. This was greatly misused by the industry and started labelling anything as "HERBAL". As there is no strict quality control and monitoring system, spurious products from

P.T.O.

toffees to shampoos appeared in the market.

The Drug Control organisation is handicapped due to inadequate, and qualified manpower to supervise the pharmaceutical companies regularly. Hence there is a total failure in implementations of provisions enlisted in the Drugs and Cosmetics Act 1940 (Amendment 1964 extended to ISM's). There is only one Ayurvedic, Unani Drug Testing Unit at Ghaziabad, UP for the whole country.

Coming to the price front Ayurvedic, Unani and Herbal based products do not come under any price control. With this the prices of Ayurvedic and Herbal products are soaring and unimaginable. Moreover there is a laxity in providing licences for herbal production units. Hence hundreds of herbal units are mushrooming all over the country.

Finally, there is no policy on Ayurvedic, Unani, Herbal drugs, which has led to want on growth of herbal units.

Policy should aim at (1) clear guidelines starting from procuring herbs from its natural abode up to the finished product (2) companies should manufacture only essential products based on common disease profile of the country.

Above all it is essential to bring back the decentralised self-reliant, non-exploitative system, wherein the people start treating themselves using simple receipes for day-to-day ailments. In case of need people should use herbs grown in their home gardens and surroundings. This makes people to understand the value of using herbs grown at backyard or gardens or in pots.

There is no alternative to a healthy life more than adhering to healthy life styles.

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Dr. T.N. Manjunath
Proframme Officer
Community Health Promotion, VHAI.

GOVERNMENT OF ANDRA PRADESH
ABSTRACT

Medical Institutions - Drugs - Purchase by Government Institutions list of 200 Drugs - approved.

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MEDICAL AND HEALTH (CL) DEPARTMENT

G.O.Ms.No.386 M & H — Dated: 2nd July 1985.
Read the following:-

1. From the DME D.O. Lr.No.DME/Peshi/84, dt.3.8.1984.
2. From the Chairman, State Advisory Board on Health letter Rc.No.7/SABH/84, dt. 11.12.1984.

O R D E R:

There has been considerable increase in the recent years in the number of pharamaceutical products in the market. While judicious use of drugs can save life, indiscrimate use of drugs can be hazardous. There is enormous increase in the incidence of iotrogenic (diseases caused by drugs disorders in recent years. This matter was referred to the State Advisory Board on Health for its consideration and advice.

2. The State Advisory Board on Health had reviewed the World Health Organisation list of drugs, along with the Senior Professors of various specialities in medical colleges and submitted a list of common drugs to be stocked in the General Hospitals limiting the number to 200. The Board has also recommended that the director demanding officers (Superintendents/ District Medical and Health Officers etc.) may be instructed to strictly limit the drugs to the above list and that, as a special case, they may be permitted to buy any other drug from the rate contract items, if required for any particular disease.

3. The Government, after careful consideration, accept the recommendations of the State Advisory Board on Health and direct that the purchase of Drugs for utilisation in the Medical Institutions be limited to 200 drugs mentioned in the Annexure to this order.

4. The Director of Medical Education/Director of Health and Family Welfare is requested to identify the drugs to be purchased for Taluk Hospitals and Primary Health Centres and dispensaries out of the drugs indicated in the Annexure and communicate the same to the concerned Direct Demanding Officers.

5. If during the course of treatment, drugs outside the approved list, are required the concerned Superintendent/Medical Officer-in-charge is permitted to purchase the same from the rate contract items within the budgetary allocation. The total purchases of such medicines in a year should not exceed 20% of the budget for medicines in Medical Institutions other than Teaching Hospitals.

6. This order does not require the concurrence of Finance and planning Department.

(BY ORDER AND IN THE NAME OF THE GOVERNOR OF ANDRA PRADESH)

S.V.GIRI
Secretary to Government

To

The Director of Medical Aducation, A.P. Hyderabad.

The Director of Health and Family Welfare, Hyderabad.

The Chairman, State Advisory Board on Health, Secretariat, Hyderabad.

All Superintendents, Teaching and Non-teaching Hospitals.

Copy to all District Medical and Health Officers.

Copy to the Pay & Accounts Officer, Hyderabad.

Copy to all District Treasury Officers.

Copy to Accountant General A.P.I., Hyderabad.

Copy to P.S. to M (H.& M).

Copy to P.A. to Secretary to Government, M. & H. Department.

Copy to Liaison Officer, Publicity Cell G.A.D.

Sd/-
Section Officer
p.t.o. for Annexure

//forwarded by order//

GOVERNMENT OF ANDRAPRADESH

1. ANAESTHESTICS

1.1 General Anaesthetics

Ether
Halothane
Nitrous Oxide
Oxygen
Thiopental Sodium

1.2 Local Anaesthetics

Bupivacaine
Lidocaine.

2. ANALGESICS ANTI-PYRETICS, NARCOTICS:

Acetylsalicylic acid tables.
Paracetamol Tablets and injections.
Oxyphenbutazone Tablets
Morphine
Pethidine
Pentazocine

3. ANTI-HISTAMINES:

Chlorpheniramine 4 mg. Tablet and 10 mg injection.

4. ANTI-EPILEPTICS:

Diasepam Tablets 5 mg and Inj. 10 mg.
Phenobarbitone
Phenytoin
Phenobarbitone Injections.

5. ANTI-INFECTIVE DRUGS

5.1 Amoebicides

Metronidazole 200 mg tablets
Tinidazole 300 mg tablets

5.2 Anthelmntic drugs:

Mebendazole
Piperazine
Thiabendazole
Mephenium Hydroxynaphthoate

5.3 Anti-bacterial Drugs

Ampicillin Campsule, Syrup and Injections.
Benzathine Benzylpencillin
Benzyl Pencillin
Procaine Pencillin 4 lakh and 12 lakh
Chloramphenicol Capsules, Suspension and Injection.
Erythromycin Tables and Granules.
Gentamycin
Metronidazole (injection.)
Sulphadimidine
Sulphamethoxazole + Trimethoprim
Tetracycline Capsules and Injections.
Mandelic Acid
Nitrofurantoin

5.4 Anti-Filarial Drugs

Diethyl Carbamazine.

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5.5 Anti-Leprosy Drugs

Dapsone
Clofazimine

5.6 Anti-Malarials

Chloroquine tablets and Injections.
Primaquine
Quinine

5.7 Anti-tuberculosis Drugs

Ethambutol
Isoniazid
Streptomycin
Thiacetazone

For T.B. Hospital Only
Rifampicin
Cycloserine
Ethionamide
Pyrazinamide

6. ANTI NEOPLASTIC AND IMMUNOSUPPRESIVE DRUGS

Busulphan
Chlorambucil
Cyclophosphamide
Vincristine
Azathioprine

For Cancer Hospital Only:

Bleomycin
Fluarouracil
Methotrexate
6 Mercaptopurine
Mitomycin
Tamoxifen

7. DRUGS AFFECTING THE BLOOD

7.1 Antianaemic Drugs:

Ferrous Sulphate tablets
Iron Syrup
Folic Acid
Hydroxycobalamin (B.12)
Iron Dextran complex injections.

7.2 Anti-coagulants and antagonists

Heparin injection
warfarin tablets
Phenindione
Protamine Sulphate

8. CARDIO- WASCULAR DRUGS

8.1 Anti-anginal drugs

Glyceryl Trinitate
Isosorbide dinitrate

8.2 Anti-arrhythamic drugs

Lidocaine
Procainamide
Verapamil Tablets and injections.

8.3 Anti-hypertensive Drugs:

Hydralazine
Hydrochlorothiazide
Methyl Dopa
Propranolol

8.4 Drugs used in Shock or anaphylaxis

Dopamine
Epinephrine
Isoprenaline
Nor Adrenaline.

9. CEREBRO VASCULAR DRUGS

Levo Dopa
Trihexyphenidyl
Xanthinol Nicotinate (Complamina) 150 mg.
Cyclandelate 200 mg and 400 mg (Cyclospasmol)
Isoxsuprine Hydrochloride 10 mg (Duvadilon)

10. DERMATOLOGICAL DRUGS

Bactitracin ointment
Aluminium acetate solution
Benzoic acid + Salicylic acid ointment or cream(Whitfied ointment)
Coal tar solution
Salicylic Acid solution
Titanium dioxide
Benzyl benzoate lotion
Gamma Benzene Hexachloride Cream or lotion.

11. DIAGNOSTIC AGENTS

Radiconotrast Media

Bairum Sulphate
Sodium lothalamate
Myodil

12. DIURATICS

Acetazolamide
Furosemide
Hydrochlorothiaze-de
Mannitol

13. E.N.T.

Genticin H.C, ear drops
Chloromycetin ear drops.
Waxolen ear drops.
Oxymetazoline Nasal drops.
Acetic acid ear drops.

14. GASTRO INTESTINAL DRUGS

14.1 Antacids

Aluminium Hydroxide
Magnesium Hydroxide

14.2 Antiemetics

Promethazine
Metaclopramide 10 mg.

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14.3 Anti-spasmodics

Atropine tablets and injections
Oxyphenonium Bromide 5 mg (Antrenyl)
Hyoscine Butylbromide (Duscopan)

14.4 Cathertics

Senna Tablets

14.5 Anti-diarrhoeal

Codeine
Furazolidone

15. GYNAECOLOGICAL DRUGS

Obstetric Cream
Mycostatin Vaginal tables
Floraquine Vaginal Tablets
Ethacradine Lactate vials
Isaptent vials.

16. HARMONES

Dexamethasone or Betamethasone
Hydrocortisone Hamesuccinate
Prednisolone
Testosterone
Ethinylestradiol 0.05 mg.
Ethinylestradiol+ Levonorgestrel (Oral contraceptives)
Narethisterone 5 mg.
Hydroxyprogesterone (Prolutin)
Progesterone 5 mg.
Eltroxin
Carbimazole
Clomifene
Lente Insulin
Plain Insulin

Oral Hypo-glyclaemic Agents

Clibenclamide
Chlorpropamide
Phenformin

17. IMMUNOLOGICALS

Sera and Vaccines:

Anti-Dimmunogloblin (Human)
Antirabies Hyperimmune Serum
Anti--snake venom
Diphtheria Anti-Toxin
NCG Vaccine (Dried)
Diptheria Pertussis - Tetanus Vaccine
Poliomyelitis Vaccine
Tatanus Toxoid
Rabies Vaccine.

18. MUSCLE TELAXANTS

Neostigmine
Suxamethonium
Tubocurarine
Pancuronium

19. OPTHALMOLOGICAL PREPARATIONS:

Silver Nitrate solution
Sulphacetamide Eye ointment
Tetramyclin eye ointment
Hydrocortisone eye ointment
Iodoxuridine eye drops.
Fluoresoin

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20. OXYTOCICS

Methyl Ergonetrine Maleate
Oxytocin 5 i.u.

21. PERITONEAL DIALYSIS SOLUTION

22. HAEMODIAL YSIS CONCENTRATE

23. PSYCHOTHERAPEUTIC DRUGS

Amitriptyline
Chlorpromazine
Lithium Carbonate
Imipramine
Trifluperazine
Carbamezepine
Doxepin

24. RESPIRATORY TRACT DRUGS ACTING ON THE

Aminophylene
Deriphylene
Salbutamol

25. SOLUTIONS CONTAINING WATER ELECTROLYTE

25.1 Oral rehydration solution
For 1 lt. of water:
Sodium chloride(Sachet) 3.5 g.Na mmol/1...90
Sodium bicarbonatre (Sachet) 2.5 g HC03 mmol/1..30
Potassium Chloride (Sachet) 1.5 g K+ mmol/1..20
Glucose (destrose (Sachet) 20.0 g. glucose mmol/1..111

25.2 Parenteral

5% Dextrose
5% Destrose with sodium chloride
Potassium chloride
Sodium bicarbonate solution
Sodium chloride
Molar Lactate
Darrows
Ringer lactate
Extra Cellular replacement solution
Gastric replacement solution
Maintenance solution
Paediatric Maintenance solution.

26. VITAMINS AND MINERALS

Asorbic acid (Vitamin C)
Vitamin A
Vitamin A and B
Vitamin K
Vitamin B-complex
Vitamin B.6
Calcium Gluconate

Circulated by:
Andra Pradesh Voluntary Health
Association.

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ESSENTIAL DRUGS - W.H.O.

CRITERIA FOR THE SELECTION OF ESSENTIAL DRUGS

(WHO's Technical Report Series No. 722, 1985).

Essential drugs are those that satisfy the health care needs of the majority of the population; they should therefore be available at all times in adequate amounts and in the appropriate dosage forms.

The choice of such drugs depends on many factors, such as the pattern of prevalent diseases, the treatment facilities the training and experience of the available personnel; the financial resources; the genetic, demographic and environmental factors.

Only those drugs should be selected for which sound, adequate data on efficacy and safety are available from clinical studies and for which evidence of performance in general use in a variety of medical settings has been obtained.

Each selected drug must be available in a form in which adequate quality, including bioavailability, can be assured, its stability under the anticipated conditions of storage and use must be established.

Where two or more drugs appear to be approximately similar in the above respects, the choice between them should be made on the basis of a careful evaluation of their relative efficacy, safety, quality, price. and availability. In cost, comparisons between drugs and cost of the total treatment, and not only the unit cost of the drug, must be considered, In some cases the choice may also be influenced by other factors, such as comparative pharmaco kinetic properties, or by local considerations such as the availability of facilities for manufacture or storage.

In the great majority of cases, essential drugs should be formulated as single compounds. Fixed-ratio combination products are acceptable only when the dosage of each ingredient meets the requirements of a defined population group and when the combination provides a proven advantage in therapeutic effect, safety, or compliance over a single compound adminstrated seperately.

Guidelines for Establishing a National Programme for Essetial Drugs

In order to ensure that an essential drugs programme is adequately instituted at the national level, several steps are advised:

1) The establishment of a list of essential drugs programme is adequately instituted at the national level, several steps are advised:

1) The establishment of a list of essential drugs, based on the recommendations of a local committee, is the starting point of the programme. The committee should include individuals competent in the field of medicine, pharmacology, and pharmacy, as well as peripheral health workers. Where individuals with adequate training are not available within the country, co-operation from WHO could be sought.

2. The international nonproprietary(generic) names for drug or pharmaceutical substances should be used whenever available and prescribers should be provided with a cross-index of

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of non-propriety and propriety names.

3. Concise, accurate, and comprehensive drug information should be prepared to accompany the list of essential drugs.

4. Quality, including stability and bio-availability. should be assured through testing or regulation where national resources are not available for this type of control, the suppliers should provide documentation of the products's compliance with the required specifications.

5. Local health authorties should delineate the level of expertise required to prescribe individual drugs in a the rapeutic category. Consideration should be given, in particular to the competence of the personnel to make a correct diagnosis In some instances, while individuals with advanced training are necessary to prescribe initial therapy, individuals with less training could be responsible for maintenance therapy.

6. The success of the entire drugs programme is dependent upon the efficient administration of supply, storage and distribution at every point from the manufacturer to the end user. Government intervention may be necessary to ensure the availability of some drugs in the formulations listed, and special arrangements may need to be instituted for the storage and distribution of drugs that have a short shelf-life or require refrigeration.

7. Efficient management of stock is necessary to eliminate waste and to ensure continuity of supplies, Procurement policy should be based upon detailed records of turnover. In some instances, drug utilisation studies may contribute to a better understanding of true requirements.

8. Research both clinical and pharmaceutical, is sometimes required to settle the choice of a particular drug product under local conditions.

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DR-336

MEMORANDUM

We, the health personnel and citizens of India recognize health as a fundamental right of the people in this, our welfare state. We recognize and strongly believe that the health status of our people is more dependent on their access to adequate food, safe and adequate water, proper sanitation and clean environment.

While we support the overall perspective and approach of the new National Health Policy Statement and demand its proper implementation, we believe that a 'National Drug Policy' is an integral part of a good National Health Policy.

We therefore, demand the following:

1. We have a right to safe, essential, quality drugs which are in keeping with the health needs of the people, at costs which the majority can afford.
2. We urge our government to accept and implement the Hathi Committee Recommendations which are also in keeping with the WHO Guidelines for a Rational Drug Policy.
3. Further the national drug formulary should be revised and compiled by an expert multi disciplinary committee keeping the following criteria in mind;
   - Essentiality
   - Efficacy
   - Safety
   - Cost
   - Ease of administration
   - Availability
   - Potential for misuse.

   Such evaluation of the drugs in the market and revision of the lists should be done periodically.
4. The Essential Drugs Policy should be adopted for all health services, government and private, and priority in production, distribution and dispensing should be given to these essential drugs.
5. The public sector should produce essential and life saving drugs on a priority basis at the national level.
6. Drug production by multinationals and private manufacturers in India should also be aligned with national health priorities.
7. Bulk procurement of essential and needed drugs should be through world-wide competitive tenders and rationalization of drug purchases should govern both the public sector as well as private health sector.
8. Imports and production of non essential, specially hazardous drugs, should be strictly curtailed.
9. Drugs which have been banned from sale after being marketed for some time in one country may not be submitted for clinical trial or marketing in India. The onus of proving why a non-essential drug should be introduced or allowed to continue on the market should be with the manufacturer and such introduction should be preceded by adequate trials and evaluation by Drug Control Authorities.
10. Comprehensive drug legislation which covers areas such as price control at different levels, patents, and marketing practices should be incorporated to serve the objectives of the national drug policy and there should be no levies, sales tax or excise duty on any pharmaceutical product in the essential drugs list by the Central or State governments.
11. No technology transfer agreement shall be legal and binding which contains restrictive practices, disproportionate and unnecessary use of imported intermediaries or obsolete technologies or unfair arrangements with respect to prices, payments or repatriation of profits.
12. The National Drug Policy should state clearly the steps towards a complete abolition of brand names and as a first step use of generic names should be made compulsory in medical education, prescribing and labelling of drugs. Generic names should appear more prominently on all packagings

13. It shall be the primary responsibility of the manufacturer to ensure the quality of drug products. However, it shall be the statutory responsibility of the Drug Control Authorities to monitor the standards and ensure a minimum uniform level of government control. Consequently, the government shall take all necessary measures to enable the Drug Control Authorities to function in an effective manner and discharge the statutory duties cast upon them.
14. It shall be the statutory duty of the drug control authorities to inform health personnel and consumers of the essential drugs lists, policies, categories or brands of drugs banned for manufacture or sale, through publication in the national newspapers, magazines, medical journals with adequate explanations and details.
15. Availability of drugs required in the Governments National Programmes should be ensured on a priority basis to the government as well as voluntary and private health institutions. Quotas for anti TB, anti leprosy, anti malarial drugs, iodized salt etc should be made easily available with regularity of supply to the voluntary health institutions wherever possible, specially when their performance, in health care delivery is known to be effective.
16. In all review committees, statutory bodies and other such bodies, there should be adequate representation of consumer groups and voluntary health sector.
17. Drug companies should follow ethical marketing practices, and this should be ensured by their own organizations like OPPI, IDMA, IFPMA. We deplore the tendency of these companies and associations to get around every progressive measure of the government through recourse to technicalities of the law and through the courts.
18. The marketing code drawn up by HAI(Health Action International) should form the basis for a National Code for Marketing Practices. This should be accepted by our government and should be suitably implemented through legislation.
19. The government of India should take a lead and endeavour to influence the WHA and WHO to adopt the Code in the interests of the other developing countries and their peoples.

(IFPMA and HAI Code attached).

- Voluntary Health Association of India
- Centre for Science and Environment
- Centre of Social Medicine and Community Health-Jawaharlal Nehru University.
- Kerala Sahitya Shastra Parishad
- Medico Friends Circle
- Arogya Dakshata Mandal
- Lok Vigyan Sanghatana
- Consumer Guidance Health Services
- Consumer Education Research Centre
- Federation of Medical Representatives Association of India.

DRUG POLICIES - GOVERNMENT OF INDIA 1978

The Hathi Committee Report

The Government of India set up on February 8, 1974 a Committee under the Chairmanship of Shri Jaiskhlal Hathi and other members of parliament along with various officials and non-officials, to enquire into the various facts of the drug Industry in India.

The Hathi Committee submitted its report to Government in April 1975. The report was laid on the tables of both houses of Parliament in May 1975. After several inter ministeral discussion, and discussions with representatives of drug industry, the views of the cabinet committee was put in February 1977, but could not be considered. Final decisions of Government based on the reports were made on 29th March 1978.

Broad objects of the New Drug Policy

(i) To develop self-reliance in drug technology;

(ii) To provide a leadership role of the public sector;

(iii) To aim at quick self-sufficiency in the output of drugs with a view to reduce the quantum of imports;

(iv) To foster and encourage the growth of the Indian sector;

(v) To ensure that the drugs are available in abundance in the country to meet the health needs of our people;

(vi) To make drugs available at reasonable prices;

(vii) To keep a careful watch on the quality of production and prevent adulteration and mal-practices;

(viii) To offer special incentives to firms which are engaged in Research and Development; and

(ix) To provide other parameters to control, regulate and rejuvenate this industry as a whole, with particular reference to containing and channelizing the activity of foreign companies in accord with national objectives and priorities.

The new drug policy aims at promoting the Indian Drug Industry. At first the Hathi Committee also recommended that the Multinationals should be taken up by Government, however, since this was a drastic change, this view was not adopted. If nationalisation takes place Government would also take over Indian companies above a certain size. Certain stringencies were, however, laid down with regard to foreign companies like Small Scale Sector will be a prohibited area, formulation licences for foreign companies will be given only if they are linked with the production of ghigh technology bulk drugs from the basic stage.

Another important policy adopted was with regard to Brand names. Brand names shall be abolished in the first instance in respect of the following five drugs ;-

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Analgin

Aspirin

Chlorpromazine

Ferrous sulphate

Piperazine and its salts such as adipate, citrate and phosphate.

All single ingredient dosage form of the above drugs shall be marketed only under generic names, Drugs which are to be exported will be allowed to bear brand names.

The Hathi Committee also recommended the use of medicinal plants. Thus in the order of importance, the Hathi Committee had identified 14 plants having medicicinal value, out of which 8, namely dioscorea species, cinchona, poppy, ergot, digitalis, ipecac, dubesia (or atropa), and lemon grass are the sources for essential drugs identified by this Committee. The Hathi Committee had endorsed the recommendations of the NCST for increased cultivations of the 14 plant materials and also production of active principles obtainable therefrom with updated technology.

Recommended reading

Chemical and Medical formulary of India 1980
(Page 1)

DF-33-8

MINISTRY OF HEALTH AND FAMILY WELFARE

NOTIFICATION

New Delhi, the 23rd July, '83.

G.S.R.578(E) - Whereas the Central Government is satisfied that the use of the drugs specified in the Table below is likely to involve risk to human beings or the said drugs do not have the therapeutic value claimed or purported to be claimed for them or contain ingredients and in such quantity for which there is no therapeutic justification and it is necessary and expedient in the public interest so to do:

Now, therefore, in exercise of powers conferred by section 26 A of the Drugs and Cosmetics Act, 1940 (23 of 1940), the Central Government hereby prohibits the manufacture and sale of the said drugs namely:

T A B L E

1. Amidopyrine
2. Fixed dose combinations of Vitamins with anti-inflamatory agents and tranquillisers.
3. Fixed dose combinations of Atropine in Analgesies and Antipyretics
4. Fixed dose combinations of Streychnine and Caffeine in tonics.
5. Fixed dose combinations of Yohimbine and Strychnine with Testosterone and Vitamins.
6. Fixed dose combinations of Iron with Streychnine, Arsanic and Yohimbine.
7. Fixed dose combinations of Sodium Bromide Chloral hydrate with other drugs.
8. Phenecatin
9. Fixed dose combinations of anti-histaminics with anti-diarrhoeals.
10. Fixed dose combinations of Penicillin with Sulphonamides.
11. Fixed dose combinations of Vitamins with Analgesics.
12. Fixed dose combinations of Tetracycline with Vitamin C.
13. Fixed dose combinations of Hydroxyquinoline group of drugs except preparations which are used for the treatment of diarrhoea and dysentery and for external use only.
14. Fixed dose combinations of Steroids for internal use except combination of Steroids with other drugs for the treatment of Asthma.
15. Fixed dose combinations of Chloramphenicol for internal use except combination of Chloramphanicol and Streptomycin.
16. Fixed dose combinations of Ergot.
17. Fixed dose combinations of Vitamins with anti T.B. drugs except combination of Isoniazide with Pyridoxine Hydrochloride (Vitamin B 6)
18. Pencillin skin/eye ointment.
19. Tetracycline liquid oral prepatations.
20. Nialamide.
21. Practolol
22. Methapyrilene, its salts.

(No.X-11014/1/83-DMS & PFA)
S.V. SUBRAMANIYAN, Jt.Secy.

DR-33-9

A to Z of Problem Drugs

(A check list of hazardous, banned, bannable and dumped drugs in India.)

A = Analgin - is a potentially toxic drug and may cause agranulocytosis. Fixed dose combinations (FDC) with any other category of drug in oral dosage form are considered harmful.

Amidopyrin - was used as an analgesic anti-inflammatory agent for over 7 years. It has now been found to increase the risk of agranulocytosis and in large doses to be associated with renal tabular necrosis (Banned July 1983).

Ancoloxin - a widely used anti-nausea drug which is reported to have teratogenic potential and hence is a hazard to pregnant women. Sold in India without warning.

Anabolic Steroids - Synthetic derivatives of male sex hormone which have an androgenic and anabolic (body building) effect. It is chiefly indicated for treatment of senile and post-menopausal bone disorders and aplastic anemia. In India it is advised for malnutrition, appetite stimulant and for increasing growth. All these are foolish especially in the light of irreversible harm it can have on children's growth and sexual development. After much publicity of these side effects, CIBA Geigy has withdrawn Dianabol, one of the commonest preparations. Many more preparations continue to be marketed in India.

B = Bromides - On prolonged administration, they replace chloride ions in the body, cumulative poisoning manifests as conjunctivitis, gastro-intestinal symptoms, dermatitis and mental disturbances. It was a commonly used hypnotic of low potency but unreliable (Banned

in July 1983).

C = Chloral Hydrate - used as a hypnotic. It has been found to be an irritant of the gastric mucosa causing nausea, vomiting, flatulence and epigastric distress. It can also cause hepatic or renal damage. It should no longer be used as a hypnotic (Banned in July 1983).

Clioquinol - or hydroxyquinolines have been popularly used for prophylaxis and treament of gastro-enteritis amoebiasis and traveller's diarrhoea. Ever since the report of its association with SMON (subacute myelo-optic neuropathy) its use has been restricted or banned in many countries. In India they are supposed to be prescription drugs but are obtainable over the counter. A warning in English (small print) does occur on the product but it hardly succeeds in warning consumers.

D = Dipyrone - is the sodium sulphonate of amidopyrines having similar properties and adverse effects particularly fatal agranulocytosis. The incidence and risk of this hazard far outweighs any benefit that can be derived from its use.

E = E DP Forte - these are high dose estrogen-progesterone combinations which are dangerous for use in pregnant women because of the associated hazard of fetal malformation. In spite of the banning of production and sales of these drugs by the drug controller in March/June 1983 these continue to be misused for hormonal pregnancy

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tests and for induction of abortion.

Enzymes - A very wide range of enzymes preparations are available in India as digestives and for specific conditions. Though by themselves they are not harmful, their production in large amounts along with tonics, vitamins and health restoratives are an indication of our irrational drug policy at the cost of larger social needs. These are mostly consumed by the relatively well-fed urban population.

Ergot - is an alkaloid effective in the treatment of migraine. However fixed dose combinations with drugs like paracetamol, prochlorperazine etc., have no therapeutic advantage and hence are irrational (FDCs of ergot are banned in July 1983).

F = FDC or Fixed Drug Combinations: These are formulations where two or more drugs are combined for the following reasons: a) synergistic action; b) corrective action; c) two or more drugs normally prescribed together and taken by patient simultaneously; d) when dosage of each drug need not be individualised; e) where combination ensure better patient compliance due to convenience of administration. Conversely FDCs are irrational and should not be permitted if (a) adverse interactions occur; (b) when one of the combined drugs becomes toxic on prolonged use (c) when abrupt withdrawal of one causes withdrawal symptoms; (d) if sub-therapeutic [redacted] doses are used in the absence of clinically demonstrable synergism;

(e) when pharmacokinetic behaviour of individual agents is different. (22 FDCs were banned in July 1983 - refer Government order).

G = Gripe Water - These are popular preparations promoted for colic in children. Contain alcohol and sodium bicarbonate. Chronic use of the latter can cause milk-alkali syndrome. Uncomfortable but rarely dangerous gastric distension can also occur. Despite toxicity and side effects gripe water does a thriving business through medical and consumer ignorance (Banned in Bangladesh in June 1982).

H = Hydroxyquinolines or halogenated oxyguinoline derivatives which include iodochlor-hydroxyquinoline, proxyquinoline, halquinol, diiodohydroxyquinoline, chlorquinaldol, chiniofon). For hazard see Clioquinol.

Hormonal Pregnancy Tests - Oestrogen-progesterone combinations have been indiscriminately used in pregnant women as a hormonal test to detect pregnancy. (See EP Forte) Since there is an increased risk of foetal abnormalities and the test is false positive in one out of five women these tests should not longer be done. The Drugs controller had issued a directive to strengthen warning on packages (March 1982) and banned manufacture(Dec 1982) and sale (June 1983). Due to legal controversy, and professional and consumer ignorance it still continues to be used.

I = Injections - have played a very important role in the modern medicine and form one of its most distinctive features.

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However, it has also lent itself to a very large degree of misuse-overuse because of the mystique associated with it in the minds of the public and the temptation of the medical practitioners to pander to this need and pressure for their own economic gain.

J = Junk Drugs - these are newer formulations in the market whose only additional values are cosmetic embellishments, added flavours, elegant packing, irrational combinations - all of which help to increase its cost.

K = Kaolin - is hydrated and purified aluminium silicate, a common addition in antidiarrhoeal mixtures. Along with pectin and bismuth salts it forms a group called adsorbents, astringents and binding agents. These drugs may cause loss of electrolytes by preventing absorption through gastrointestinal tracts. If at all, they are of cosmetic value and may actually mask the severity of disease.

L = Lomotil or diphenoxylate and Loperamide are drugs whose risks of treatment outweigh their benefits especially in children. They are commonly used in diarrhoeas and the dangers of paralytic ileus leading to inaccurate assessment of fluid loss and toxaemia if associated with gut infections make them especially dangerous in pediatric practice. The use for children under six has been banned in India. In most other countries its use is banned altogether.

M = Methapyrilene and its salts (Banned in July 1983).

N = Nialamide or Niamid - a MAO inhibitor used in the treatment of depressive disorders (Banned in July 1983).

O = OTC drugs or over the counter drugs. These are drugs that are available to consumers without prescription and are mainly painkillers, anti-cold, anti-cough preparations, cough mixtures, tonics, food substitutes and protein powders. Many of them are costly compared to the benefits they render. They have some ingredients which are unnecessary or useless but helping to push up cost. They are widely advertised with false claims to push up sales. Their scientific scrutiny is a need as also a systematic campaign against their irrational ingredients or claims.

Oxyphenbutazone - these are a group of non-steroidal antiinflammatory drugs which also have mild antipyretic and analgesic properties. The dangers associated with use are bone marrow toxicity and liver toxicity. They are widely used /overused/misused group of drugs and there is great need for building professional awareness and consumer alert on this group of drugs. Recently these drugs have been banned in the U.K.

P = Phenacetin - was a commonly used analgesic/antipyretic agent which has been reported to cause kidney damage and failure and hemolytic anemia. Hence fixed dose combinations containing it are now considered outdated and hazardous. These have been recommended for weeding out by the Hathi Committee.

Phenylbutazones - another group of non-steroidal antiinflammatory drugs which give only symptomatic relief and in no way alter the course of the illness. Its main indications

are for ankylosing spondylitis and rheumatoid and gouty arthritis though they are being widely promoted and used for non-rheumatic disorders and aches, pains and fever. Bone marrow toxicity is a real danger with the use of this drug and hence its use should be severely restricted. Its present availability--freely over the counter-should be drastically controlled and its deadly combinations with amidopyrin, analgin, paracetamol, diazepam, vitamin B, dextrapropoxyphene and acetaminophen should be banned or adequate warnings in labels instituted.

Practolol (Banned in July 1983).

Penicillin - Still an important constitutent of antibacterial therapy in spite of the risk of anaphylactic reaction and allergic reactions. (Its combination with sulphonamides and its preparations as skin/eye ointments are banned from July 1983).

Q = Quinine - was the sheet i anchor of anti-malarial treatment till safer 4 aminoquinolines and 8 aminoquinolines were developed. Its use leads to black water fever and so it is restricted now-a-days for treatment of chloroquin resistant cases or sometimes in cerebral malar

R = Rational Drug Therapy - is the art/science of prescribing the best suited drugs to individuals who need them taking and not to those who merely want them. Its takes into account factors like efficiency, safety (low

incidence of side effects), cost and ease of administration. It scruplously avoids extravagant prescribing over or under prescribing, multiple prescribing or incorrect prescribing.

S = Sulphonamides - These have an important role to play in the therapy of inf ctions. The combination with penicillins is undesirable because of the antagonism of antibacterial effect when bacteriostatic and bacteriocidal drugs are given together. (FDCs of sulphonamides and penicillins are banned since July 1983).

Streptomycin - Since it is one of the most effective drugs in anti-tb treatment its use should be limited to TB treatment and mixed infections of the gut. Its combination with penicillins is undesirable since its use in small doses promotes development of resistance.

Steroids - one of the most misused drugs in general practice because of acute onset of beneficial effects. Patients are exposed to a wide range of toxic cumulative effects and adrenal insufficiency due to adrenal suppression. Its a life saving drug to be used in special circumstances. Their doses should be adjusted to the minimum that can produce the effects. Fixed dose combinations with other drugs are therefore irrational and objectionable since this individualization of the dose cannot be done. (FDCs of steroid for internal use except for treatment of asthma are banned since July 1983).

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Strychnine - This was a drug formerly used as an appetiser. Its use in tonics can induce convulsions particularly in susceptible individuals. An absolete drug! (FDCs of strychnine with caffeine, yohimbine, testosterone and vitamins are banned since July 1983).

T = Tetracyclines - One of the most commonly misused/overused broad spectrum antibiotic mistakenly thought to be free of dangers. Reports of its ability to cause discolouration of teeth, catabolic effect on protein synthesis, diarrhoea, increased intracranial pressure o in children, Fanconi syndrome (if outdated, degraded drug is used), liver damage in pregnant women have put it in the list of hazardous drugs. It should not be used in paediatric practice and in pregnant mothers. Its manufacture in syrups form for pediatric use is supposed to be banned from January 1982.

Tonics - Apart from being an economic waste, most tonics in the market contain alcohol which is the main appetite stimulant and also vitamin and mineral constituents in amounts greater than the physiological absorptive capacities of average gastro-intestinal tracts. Their overuse thus mainly help to vitaminise our sewage systems!

U = Unani and Ayurvedic drugs - These are difficult to standardise since official standardisation methods are not available FDCs of these with allopathic drugs have no therapeutic rationale or justification or proven efficacy.

(FDCs of ayurvedic and unani drugs with modern drugs have been banned since July 1983).

V = Vitamins - a typically misused/overused group of agents especially as multivitamin combinations and tonics. They are essential nutrients and ~~nutritional requirements~~ but most people get adequate amounts in a balanced diet. Specific and separate preparations are required for specific ~~di~~ deficiency states or as adjuncts to therapy. (Their FDCs with analgesics, tetracyclines, anti-inflammatory drugs, tranquillisers have no proven therapeutic effects and have been banned since July 1983).

W = Waterbury's is oneof the brand leaders in the tonic market whose main effects if any are because of the 9-10% alcohol content. It contains insufficient amounts of iron and creosates and guaicols whose role in man has not been definitively established. Like incremin, phosphomin, and hemiphos their advertised claims far surpass their actual chemical content. Advertisements of such tonics are the most symbolic of high pressure, half truths gimmicry of medical advertising.

X =

Y = Yohimbine - a drug often combined with strychnine, vitamines, testosterone, arsenic, iron and vitamins, It has been found to penetrate the CNS and cause centra excitation including rise of blood pressure, heart rate, hyperexcitability and tremor (Its use especially in such combinations is banned since July 1983).

Further Reading

1. Banned Brand Drug List
2. Hazardous Banned Bannable and Dumped Drugs
3. Rationality in Banning Fixed Dose Combinations
4. Some painful facts about a pain killer called Amidopyrine
5. Why not to prescribe anabolic steroids?
6. Irrational use of antibiotics
7. The clioquinol controversy
8. Using tetracyclines for children and pregnant women
9. Consumer Alert--Phenylbutazone and Oxyphenbutazone
10. Scientific scrutiny of some over the counter drugs
11. The case against EP Forte
12. National Drug Policy guidelines and list of banned drugs (Banghdesh)

Available from Low Cost Drugs and Rational Therapeutic Cell, Voluntary Health Association of India, C-14 Community Centre, SDA, New Delhi 110016.

DR - 33.10

Telephones: { ICSA / CMS-I Office : 869143/869244/869545
Exi. Trustee Residence : 33850

Telegraphic Address : DIAKONEIA

COMPREHENSIVE MEDICAL SERVICES, INDIA (CMS-I)

A Public Charitable Trust promoted by ICSA and Constituted by a Registered Trust Deed under the Trust Law

Chairman, Trust Board
Justice C. J. R. PAUL

Executive Trustee :
Prof. D. YESUDHAS

93, PANTHEON ROAD,
EGMORE,
MADRAS - 600 008.

October 8, 1988

Dr. Ravi Narayan,
47/1 St. Mark's Road,
First Floor,
BANGALORE 560 001.

Dear Dr. Ravi Narayan,

I have been very much impressed by your Article in the Health Action on Essential Drugs and the Indian conditions. I understand that we have to go a long way in helping the Society and the Government accept the philosophy of Essential Drugs.

With this conviction we have started a Project to manufacture the Essential Drugs stipulated by WHO. We have been able to procure all the Licences required and a dozen products are ready at the moment. We will continue manufacturing and within four weeks time we are expecting to have 24 products to be distributed to Charitable Hospitals and Voluntary Health Agencies.

I am enclosing a write-up on the Project and the Price List. Kindly introduce this wherever it is required as it is a cause for which you are also working.

Thanking you.

Yours Sincerely,

(K. V. JOSEPH)
Senior Project Executive

Encl: As stated above

Telephones: { ICSA / CMS-I Office : 869143/869244/869545
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Essential Drugs for Effective Community Health

A Project Proposal

The Comprehensive Medical Services, India (CMS-I), has proposed to manufacture selected Life-saving and Essential drugs out of the WHO List of Essential Drugs which the Hathi Commission has also identified as the basic drugs required for medi-care in our country. The Drugs produced will be made available to Voluntary Health Works at cost-price and thus kept much lower than the price prevailing in the market.

The Background

This decision is the out-come of a series of discussions with the Medical Community. The Inter-Church Service Association (ICSA) has been providing a Forum for Medical Practitioners and Health-Professionals involved in Voluntary Health Work in the city and rural areas to come together periodically for fellowship and discussion of matters of common interest. One of the concerns that emerged out of the discussions was that of the spurious and sub-standard nature of some of the common drugs in the market and the ever spiralling prices of Essential and Life-Saving Drugs which keep them out of the reach of the Poor.

CMS-I - Essential Drugs Project

Against this background the need arose to initiate a Voluntary Medical Service which will have as one of its main Objects, the manufacture and distribution of Essential Life Saving Drugs which are in short supply, or whose market-cost is prohibitive. The Comprehensive Medical Services, India (CMS-I) is promoted as a Public Charitable Trust with the exclusive Object of providing a low-cost health delivery system, with emphasis on Preventive and Promotive aspects of health, and the manufacture and supply of Essential Drugs for Voluntary Health Work.

The First Project of CMS-I will be the manufacture and distribution of Essential Drugs.

The Philosophy

The Philosophy of the Project is making available Essential Drugs at low-cost, without compromising on the quality.

The Target Group

The Target Group is the Weaker Section who cannot afford adequate Health-Care.

Project Methodology

All I.P., B.P. and U.S.P. Drugs will be manufactured and marketed under 'Generic names' to effect saving on 'Brand names'. Formulation and combination drugs are avoided as far as possible. But where they are absolutely necessary, self-evident names which are suggestive of such simple combinations have been coined. Eg. Hemo-feron for Iron and Vitamin.

A concerted effort is made to cut down avoidable expenses on extravagant packing materials, trimmings and decoration by settling for the most cost-effective, purpose-serving protective packing materials. A further effort in this direction is sought to be achieved by distributing the drugs in Hospital-Packs, Strips in Cardboard Cartons and Loose in Plastic Containers.

Drugs will be marked with the label name, CMS-I Essential Drugs Project, and shall be made available at this stage to Voluntary Hospitals and Health Agencies involved in Community Health to enable them to bring down the cost of patient-care which is on the increase, mainly on account of escalating cost of commonly used drugs.

We shall supply the products at our Cost-price. The recommended Retail Price is indicated in the Label.

Project Implementation

The Essential Drugs Project has started functioning in the leased premises of a fully equipped Pharmaceutical Production Centre in a Pharmaceutical Industrial Complex promoted by the Government of Tamilnadu at Alathur, in Chinglepet District, about 25 kms away from the city. To ensure quality at its best, the factory is well-equipped with a modern analytical Laboratory with all the latest equipments capable of analysing and assessing all our products and ensuring the standards specified by the Indian, British, and the U.S. Pharmacopoeias.

This venture will be our contribution to the Nation in its effort to provide adequate health care for all its citizens by the year 2000.

We trust our products will receive the patronage of all welfare agencies involved in community health.

Thanking you.

Respectfully submitted,

Joseph K.V

D. YESUDHAS
Executive Trustee-Director
CMS-I

COMPREHENSIVE MEDICAL SERVICES,INDIA
ESSENTIAL DRUGS PROJECT
93, Pantheon Road, Egmore, Madras 600 008.
PRICE LIST - 15.9.88

	Product	Strength		Packing		Cost - Price	
						Loose	Strip
1.	Ampicillin	250	mg	500	caps	420.00	
	"	250	mg	1000	caps	835.00	
2.	Antacid Tablets			1000	tabs	55.00	85.00
	Composition:						
	Aluminium Hydroxide	250	mg				
	Magnesium Trisilicate	250	mg				
	Symethicon	50	mg				
3.	Ascorbic Acid	100	mg	1000	tabs	60.00	
4.	B Complex c Vit C caps			1000	caps	260.00	315.00 (Blister)
	Composition: B1-10mg,B2-10mg,B6-3mg, Niacinamide 50mg, Vitamin C-150mg,Calcium D Pantothenate 12.5mg, Folic acid 1mg, B12-5mcg						
5.	Cephalexin	250	mg	100	caps	185.00	
	"	250	mg	250	caps	-	480.00 (Blister)
6.	Chloroquine Phosphate	250	mg	1000	tabs	205.00	225.00
7.	Co-Trimoxazole		S.S.	1000	tabs	335.00	360.00
	"		D.S.	500	tabs	335.00	365.00 (Blister)
8.	Dapsone	50	mg	1000	tabs	38.00	
	"	100	mg	1000	tabs	60.00	
9.	Diazepam	5	mg	1000	tabs	38.00	60.00
10.	Diethyl Carbamazine Citrate	100	mg	1000	tabs	55.00	82.00
11.	Ethambutol	400	mg	1000	tabs	365.00	
	"	800	mg	500	tabs	385.00	
12.	Fursemide	40	mg	1000	tabs		120.00
13.	Glibenclamide	5	mg	1000	tabs		110.00
14.	Hemoferon Capsule			1000	caps	220.00	287.00 (Blister)
	Composition: Ferrous Fumarate 350 mg, Vit-C 150 mg,B12-15mcg, FolicAcid 1.5mg						
15.	Ibuprofen	200	mg	1000	tabs		215.00
	"	400	mg	1000	tabs		365.00
16.	Metronidazole	200	mg	1000	tabs		170.00
	"	400	mg	1000	tabs		282.00
17.	Mebendazole	100	mg	600	tabs		96.00
18.	Nifedipine	5	mg	1000	tabs		80.00
	"	10	mg	1000	tabs		97.00
19.	Oral Rehydration salt			14.00 gm	sachet	0.75	
20.	Paracetamol	500	mg	1000	tabs	70.00	95.00
21.	Propranolol	10	mg	1000	tabs		80.00
	"	40	mg	1000	tabs		130.00
22.	Rifampicin	300	mg	500	tabs	615.00	
	"	450	mg	500	tabs	920.00	
23.	Salbutamol	4	mg	1000	tabs	82.00	120.00
24.	Tetracycline	250	mg	1000	tabs	415.00	

N.B. See overleaf for Terms and Conditions of Supply of Drugs.

Terms and Conditions for supply of Drugs

1. Supplies are confined to Christian Hospitals and Voluntary Health Agencies involved in Community-Health.

2. Prices mentioned in the List are our Cost-Price/Selling-Price. The recommended Retail Price (adding a 10% margin for handling/dispensing) is given in the label.

3. The Price List is subject to revision depending on the fluctuation in the purchase-price of Raw Materials. Supplies will be made at the rates prevailing at the time of despatch.

4. Terms of payment shall be either by Cheque (Local)or Demand Draft, drawn in favour of the CMS-I, on receipt of the consignment.

5. Consignments will be despatched by Lorry/Rail Parcel Service and Lorry/Rail Freight-Charges will be borne by the consignor. Charges on despatch by Post-parcel, if ordered, should entirely be borne by the consignee.

6. Goods are to be checked on receipt, and discrepancy if any, be informed immediately, for rectification.

7. Sales Tax will be charged as per Rules and Regulations of the Central and State Governments.

8. As per Drug Rules, Orders for Drugs should have the Name of the Doctor on the Letter-Head, or his Signature at the bottom of the Order.

9. Products are guaranteed for their quality, and the quality of the raw materials used. Copies of Quality Control Certificate for any Batch will be made available on request, specifying the Batch number.

10. While ordering Drugs please indicate:

    a)the mode of payment;

    b)the mode of transport and the nearest Rail Station or Lorry Office as the case may be.

Director, CMS-I

DR - 33 11

DRUG ACTION FORUM-KARNATAKA

57, Soni, Tejaswinagar, Dharwar-580002, Karnataka

Drug Action Forum - Karnataka is a loose group of friends spread all over Karnataka, committed to idea of rational therapeutics and has been in existence for last four years.

The various activities have been

(a) A group of people who have been committed to the idea, meet frequently on ongoing basis and discuss various issue relevant to the need of drug action. Out of several meetings during last three years a core group has evolved which is coordinating the action of the group.

(b) Writing articles about drug related issues in popular Kannada magazines. This has helped to a very great extent to take the issue to people.

(c) Preparing posters, write ups and slide-show on relevant issues and a book titled "Aushad Maattu Navu" printed by KRVP Bangalore

P.T.O

(d) Conducting training programme for rural primary school teachers (about hundred teachers have undergone one day training)

(e) Networking and conducting training programmes for voluntary agencies in Karnataka

(f) Shortly the group is to start a bulletin in Kannada on drugs and health related issue.

(g) Formation of Rational Therapeutic Cell. Bringing together a group of 9 consultants from various fields of medicine and collective action towards rational therapeutics.

Gopal Dabade
15th June 1988

English translation of Kannada article which appeared in "Sudha" dated 29 May - 4 May 1988 titled "Ewariga Vishava Aushadhi"

"THE REPORT THAT SHOCK THE DRUG WORLD"

by Sharada Gopal

Dr Gopal Dabade.

Twenty-two year young Hemant Ranade had joined recently for a job in Nagpur electricity department at Nagpur and wanted to share the happiness of his new job with his sister at Bombay. But unfortunately met with a accident in Bombay and was admitted to JJ Hospital Bombay

This incident occured in last week of December 1985. He was operated on 25th for a small injury on head. After the surgery he started showing good improvement But suddenly his kidney stopped functioning and on January 24th he breathed his last.

Seventy five year old Dawod was operated on eye at JJ. Hospital. He too was recovering but expired on 28th January almost suddenly.

And so followed the deaths of fourteen people Ramesh Shindhe, Shailandra Joshi, Laxmibai, Abdul Khader Khan, and so on. One after another, death entered JJ hospital and killed these people from 24th January to 6th February. And all these 14 were recovering from the 'illnesses' for which they had been admitted. Death created chaos and tension among the JJ hospital staff And the general public was stiff scared, after hearing the news.

What was the cause of these deaths? It was the presence of a substance

known as 'glycerol' which was administered to these patients. It was proved later that the quality of glycerol was extremely poor and it contained 'diethyl glycol' which had entered these bodies in the form of death. These fourteen deaths created news all over the country as it had occured in J.J. Hospital -- one of the best hospital in Asia, as it was known earlier on. The Government of Maharashtra came forward and ten thousand rupees towards the family members and an enquiry commission headed by one man Bhaktavar Lentin.

Justice Lentin unfolded the mystery that shrouded the death of these fourteen people and the amount of debris, cunningness, uselessness, cheating abilities, corruption that were evacuated was really astonishing, nauseating and would melt the heart of the most wicked and evil person. All this and much more Justice Lentin unearthed and brought it to the light of the people through the press media. Though it was aimed at these fourteen dead people, it also found how Maharashtra Food and Drug Administration functioned, in line with it was the industrial set-up, and following in line closely was ministerial set-up.

On 21st to 25th January 1986, seven patients died in J.J. Hospital Nephrology unit. All these deaths were because of kidney failure. On 25th January, the cause for

death was suspected on three drugs - Diamox, or Glycerol or Mannitol. Dr R. S. Chandrakapure sent a circular in the hospital instructing the staff not to use these drugs on the patients.

Seeing the existing condition in the hospital, the Dean should have moved into action. But he did not even enquire to see, if the circular that he had sent, ever even reached the hospital or not and never even bothered to visit the ward. Between 25th and 28th, a span of four days it was found that 57 bottles had been issued from the hospital store. On 27th Dawod had received two bottles of glycerol and on 28th Abdul Khader Sheikh also received. The circular notice sent by Dean had reached some wards only on 4th. This only shows how well-equipped the hospital is for emergencies.

Even those wards where it had reached the doctors and nurses did not even bother to look at it, to take some action. Some doctors even told that 'returning drugs to medical store was not the duty of doctors', but it is the duty of superiors.' The duty nurse did not inform the superior nurse. Thus even though it was realised that the drug 'present in the hospital can kill the patient, did not bother to remove it'. And even when glycerol was administered to the patient, it was not written on the chart.

It was a situation where nobody was ready to take the responsibility and

everyone wanted the responsibility to be pushed on another shoulder. This was the main reason for the deaths of these fourteen people in J.J Hospital Bombay.

Alpana Pharma is a repacking unit of drugs at Nanded They purchased drugs from Kailash and co company and after repacking they sent it to hospitals. Kailash and co, purchased drugs from H M Chemicals. H M Chemicals in turn had purchased it from Ganesh chemicals. So Ganesh chemicals is the main producer of Glycerine. Ganesh chemicals wanted to make more money by easy methods. ~~Making~~ Glycerol is costly, so they purchased second rate Sorbitol (at much lower rate) and Diethyl glycol used them to prepare Glycerol. Diethyl glycol is a deadly poison. This is used only for industrial purposes Not knowing that it was deadly poison H M chemicals and Kailash and co purchased it thinking that it is cheap. The main aim was to make maximum profit by using the cheapest things in the market. Nobody was bothered about the quality of the drug

Alpana wanted raw material for medical purposes, but Kailash & co had given them the one used for industrial purposes, And in this chain of events that followed, lead to the death of fourteen death.

If you dig again into Alpana Pharma, what is it that you get. Just more evidence that it was stinking with corruption. This company had applied for repacking licence on 13th March 84 to FDA, Maharashtra. Alpana Pharma got the licence in no time. The reason for this is Alpana Pharma's Ramanlal Sharma had a good hold and number of friends in FDA. Alpana pharma used to deposit money into the account of Dr R. D. Kulkarni JJ hospital's Pharmacology department head. And it also has come to lime-light that Rs 1,60,000 had been deposited just before Alpana got its licence sanctioned. This Dr R D. Kulkarni is a member of F.D.A.

JJ. Hospital had advertised for tender orders of Glycerol. The last date for submitting tenders was 27 April 1984. One of the most essential basic requirement for applying for tender was that the applicant for tender, should have a minimum of two years licence holding. But Alpana Pharma which had just started got the tender, even though it stood fifth in the order of selection. The only reason for its selection was that the company was 'located in backward area'. It is not just this only, but no single company should supply more than 11% of the hospital drug needs. This rule was totally overlooked and Alpana Pharma had been sanctioned to supply 33% of the drug need, though it was actually supplying 45%. If only Alpana pharma had supplied 11% of the need of the hospital, town

14 deaths would not have occured in the hospital. Alpana pharma broke several rules. It does not have a testing laboratory of its own, and the liquid preparations and powder preparations were prepared in the same room. All this because FDA had pledged full support to Alpana Pharma.

The FDA that supported this system, is responsible for giving licence to the tune of Rs 2000 crore and it has the biggest testing laboratories of our country. The organisation which could have been responsible for health of our country men, was itself a structure of ill-health. The person who headed was given full power and could not be queshoned by any one, other than health minister.

Maharashtra has 3500 drug houses and about 400 smaller ones, which work under larger companies. But 10% of these companies do not have testing laboratory of their own.

When several complaints came, as the drugs were produced of low quality, the testing of unit of FDA did not have adequate facilities, staff and requirements. Every company, companies owners, and the formulations and the repacking units should get tested twice yearly. That means atleast 19 examinations should be done every month, but in 1984, the Maharashtra FDA had inspected only 10 units!

The complaint book and the enquiry register contained only bundle of lies. Actually this book should contain the details of the inveshigations done, but this book / register contained unwanted, and irrational statements. Justice Lentin calls this book as 'Murder book'.

Sanctioning licence to useless companies taking bribe for sanctioning licences, giving bribes to top persons, if mistakes were found or if transferred requesting ministers to cancel the transfer, if a good official is nominated, then see that he is removed immediately, all these and many more such ~~actiti~~ activities were regular activities at FDA under the blessings of the ministers. The persons who fell in this line were Shalinitai Patel, Ex CM Nilgoankar, Health minister Pramila Topla, Dr Baliram Hiray, Baisawant, The FDA had stood on corrupt money and out of this corrupt money trusts were started and the President of these trust were state ministers.

Fourteen innocent lives were taken away by these callous and careless people. But it was for Justice Lentin to uncover the ~~great~~ mystery. And justice Lentin brought out inch by inch the the untold story. And today the Maharashtra government has accepted the report. The Health minister has resigned. The Dean, Professor of pharmacology, head of FDA

have all been eleminated from the j.d. and enquiries have been going on against them. Four companies licences have been withdrawn.

But still nothing has happened and the most important things that are to happen is still to be watched. Justice Jentin himself has said " we are far too civilised. Profiteers who dealt in death during the Czarist regime in Russia were sent to Siberia and in the 1930s and '40s in Europe they were put against a wall and shot. But we only hold enquiries now."

We have had several enquiry commissions and reports in our country. And the end result of several of them have been zero. In 1975 we had Haathi committee report, which had clearly stated the method of functioning of pharmaceutical industries. What has happened to it? Even copies of that report are not available now. According to its recommandations our country needs only 116 drugs. But we have 70,000 formulations in our country several drug companies. And a total lack of infrastructure, and staff to monitor these drug companies. What do we expect but choas.

Even after suspecting that the bottles contained deadly poison, 57 bottles were ~~stored~~ taken to wards. only 13 of these bottles have been returned by 7th February

So 34 bottles have been used on patients. And the patients in whom these have been used, have not died, but they must definately have developed a brain damage, a heart damage or a kidney damage. It is very easy to find out these patients, but the Government of Maharashtra is sitting silent over the issue. Why?

The greatest tragedy about Lentin commission report is that people are making it individual based and are forgetting the issues involved in it. It is for the people now to take up the issue and see that such a thing does not happen again and see to it that the reports are implemented.

From:- DRUG ACTION FORUM-KARNATAKA
Sharada Gopal
Dr Gopal Dabade
57, Soni
Tejaswinagar
Dharwar- 580002
Karnataka

15th June 1988

Supplement to Special Issue of
the Medical Service on
"Towards a People Oriented Drug Policy"

Widening Horizons—on Drug Issues

A. Books

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

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

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

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

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

5. Health Care Which Way to Go Medico Friend Circle Anthology II, 1982, Rs. 10.00 from : medico friend circle office, 326, 5th Main, I Block Koramangala, Bangalore 560034 Raises relevant issues regarding peoples health. Questions why is there a lack of political will to solve pressing health problems of the country. How detrimental is the alliance between medical professionals and the drug industry to people's health.

6. Under the lens: health and medicine. III Anthology of medico friend circle is due shortly and will be available from VHA1 and mfc office (above).

7. Kurji Holy Family Hospital: Formulary and Therapeutic Guide. January 1983, Rs. 12.00. Available from VHA1. It is the result of the accumulated experience of senior medical staff of the hospital over the last 10 years. It gives a comprehensive list of drugs to treat 98% of hospital admissions- it also gives the generic name, dosage, indications, contraindications and main side effects in the same page. Information about comparative cost of treatment is also provided.

8. Drugs and the Third World. Anil Agarwal, 1978, $5.00. From Earthascan, 10 Percy Street, London WI PO DR. A very comprehensive overview of the drug situation in the third world and the problems and causes.

9. Prescription for change. Health Action Internationals guide to rational health projects, Virginia Beardshaw, Novem-

ber 1983, 85pp US$ 10.00 from Health Action International Clearing House PO Box 1045, Penang, Malaysia. Gives more than 40 ideas for action research projects on drugs:

—a summary of the main elements of the rational health issues and suggestions about how to campaign on it;

—advice on how to talk to drug companies and the powers that be

—a reference section that lists the main materials you need to research on drugs.

10. Pill-fering the poor: Drugs and the third world. An information/action pack on drugs and the third world from Interfaith Center on Corporate Responsibility, International Health Programme, 475 Riverside Drive, Room 566, New York, NY 10115. US$. 4.00 plus postage surface mail $2.70/ air mail $/4.70. It provides an overview of the problems related to drug marketing in the third world. it contains articles on the need for essential drugs, on the suffering wrought overseas by some US made drugs and on the high price the third world poor have to pay for their medicines. This package includes an extensive annotated bibliography, basic facts and figures about the transnational drugs industry and an outline of suggestions for action on how you can get more involved in helping to stop abuses.

11. Therapeutic guidelines: A manual to assist in the rational purchase and prescription of drugs. Upunda, Yudkin et al 1981, pp. 166, Rs. 35.00 African Medical and Research Foundation. Available from VHAI. An excellent guideline for rational therapeutics, giving special emphasis on drug cost as criteria for choice of drug diagramatico format.

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

13. 44 problem drugs: a consumer action and resources kit on pharmaceuticals. IOCU, May 1981. Available from HA1 Clearing House (see 9) Gives information about 44 problem drugs, along with articles by some of the leading drug compaigners.

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

B. Periodicals

1. Pune Journal of Continuing Health Education. Presents scientific information and opinion on drugs and health issues to stimulate thought and further investigation. Annual subscription Rs. 10.00 or a five year subscription for Rs. 45.00 from Arogya Dakshata Mandal, 1913, Sadashiv Peth, Pune 411030.

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Bulletin, PGI of Medical Education and Research, Chandigarh 160012.

3. **Medico friend circle bulletin.**

A monthly which discusses issues regarding health problems, the health care system, medical education, drug issues etc., from the point of view of relevance to the needs of the majority in our country. Annual subscription Rs. 15.00. Write to Convenor, medico friend circle, 326, V Main I Block, Koramangala, Bangalore 560034.

4. **HAI News**

A very informative bimonthly of the Health Action International (HAI), covering world drug news of special relevance for the third world. *Hai* is an informal network of health consumer and development oriented associations and professionals concerned with health and pharmaceutical issues, particularly those that adversely affect the poor. Annual subscription : US$ 10.00 from HAI Clearinghouse, regional office for Asia and the Pacific, International Organization of Consumer Unions (IOCU), PO Box 1045, Penang. Malaysia. A number of journals have brought out special issues on drugs. These may be available on request for back issues.

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

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

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

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

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

   b. Special Issues on diarrhoea and tuberculosis

3. The Journal of the Christian Medical Association of India.

   From : The CMAI Office, Christian Council Lodge, Nagpur 1, Maharashtra.

   Sept 1983, Vol LX, No. 9, Drugs-Fact, fallacy and fraud.

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

BAD INFORMATION MEANS BAD MEDICINE...

Dear Doctor,

So many different brands of clioquinol recommended for the prevention or treatment of non-specific diarrhoeas. How does a doctor choose between them?

A brand of clioquinol from an unknown local firm? Or Mexaform or Entero-Vioform - world leading brands from a trusted Swiss name, CIBA?

The choice is immaterial. This is because all brands have this in common: In the treatment of non-specific diarrhoeas, their benefits have not been proven. Their dangers clearly have.

Whatever the brand - with clioquinol there is no choice. Thank you for not prescribing it.

Yours faithfully,

SO WHY AREN'T THERE MORE 'DEAR DOCTOR' LETTERS LIKE THIS?

This 'Dear Doctor' leaflet puts patients first. It was prepared and is published by Social Audit and friends.

Oral Rehydration - which method is most appropriate ?

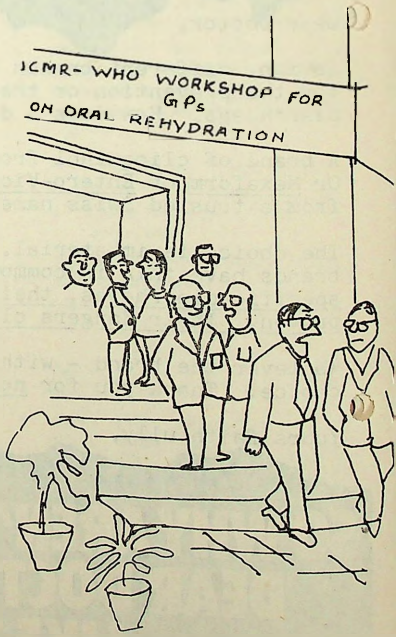
Diarrhea is one of the main causes of death in small children. However, most of these children actually die from dehydration—the loss of too much water. It is generally agreed that the most important way to manage diarrhea is to replace the liquid that the child is losing. But there is less agreement about how to do this.

A few years ago, most doctors treated even mild dehydration by giving intravenous (I.V.) solution. But this was expensive, and many children died in diarrhea epidemics because there was not enough I.V. solution, or not enough skilled workers to give it.

Today, most health planners recognize that oral rehydration—or giving liquid by mouth—is the best way to manage most cases of diarrhea and dehydration. Even in clinics, where I.V. solution is available, it usually makes more sense to replace liquids by mouth. This way parents learn how to prepare and give liquids so they can begin treatment early, at home, the next time a child gets diarrhea.

A Special Drink or Rehydration Drink can be made from water mixed with small amounts of sugar and salt. It is even better if the drink contains a little baking soda (bicarbonate of soda) and a mineral called potassium—found in orange juice, coconut water, banana and other foods.

* The salt in the special drink replaces the salt lost through diarrhea, and helps the child's body to keep liquid.
* The sugar provides energy and also helps the body absorb liquid more quickly.
* The baking soda prevents 'acid blood', a condition that causes fast, heavy breathing and shock.
* The potassium helps keep the child alert and willing the drink and eat.



What is now about sugar salt-solution ? Since ages we doctors have earned money by selling if as medicine for various diseases, though not for diarrhoea.

Courtesy—Health care which way to go MFC Anthology.

The amounts of sugar and salt in the Special Drink do not have to be very exact. In fact, there is great variation in the amounts recommended by different experts. However, too little sugar or salt does less good, too much salt can be dangerous.

The Range of Rehydration Methods for Children with Diarrhoea can be divided into two Broad Groups :

Group 'A'

1. Intravenous solution (I.V.)
2. Factory prepared oral solution
3. Factory prepared packets of rehydration salts for mixing in water
4. Bags with salts, prepared at the health centre for mixing in water.

Advantages and Disadvantages

— Control and responsibility mainly in the hands of professionals, institutions, and drug companies

— Measurement more precise and 'controlled' (atleast in theory)

— More magical; acceptance may be quicker but with less understanding

— More dependency—on high technology, on outside resources, on centralised services, and on local and international politics

— More expensive

— Easier to gather data on, and prepare statistics about

— Reaches fewer people; supply often uncertain and inadequate

— Sometimes causes delay in treatment, because special materials have to be obtained; affect is more curative than preventive

— Focus is on materials and supply (so cost goes up each year)

— May give better (safer) results for individuals treated in time, but has worse results overall since many children never receive the liquid, or are given it too late.

Group 'B'

1. Homemade drink made with plastic measuring spoons
2. Homemade drink made with spoons found in the home
3. Homemade drink made with home-made spoons
4. Homemade drink with salt and sugar measured with the fingures or by another traditional way

Advantages and Disadvantages

— Control and responsibility mostly in the hands of the family

— Measurements less precise, less 'controlled'

— More practical and easier to understand

— More self-sufficiency; uses local resources (whatever is available in the home or in stores)

— Cheaper

— Harder to gather data on, and prepare statistics about

— Reaches more people; supply is local and almost always available

— Treatment can begin at the first sign of diarrhea; more preventive than curative.

— Focus is on people and on education, so the people's capacity for self-care increases over the years (cost goes down)

— May be less safe in individual cases due to the possibility of errors in preparing or giving it, but it probably saves many more lives—since it reaches more children more quickly.

— Helping Health Workers Learn
David Werner and Bill Bower

A to Z of Problem Drugs

(A check list of hazardous, banned, bannable and dumped drugs in India).

A = Analgin — is a potentially toxic drug and may cause agranulocytosis. Fixed dose combinations (FDC) of any other category of drug in oral dosage form are considered harmful.

Amidopyrin — was used as an analgesic anti-inflammatory agent for over 7 years.

It has now been found to increase the risk of agranulocytosis and in large doses to be associated with renal tabular necrosis (Banned July 1983).

Ancoloxin — a widely used anti-nausea drug which is reported to have teratogenic potential and hence is a hazard to pregnant women. Sold in India without warning.

Anabolic Steroids — Synthetic derivatives of male sex hormone which have an androgenic and anabolic (body building) effect. It is chiefly indicated for treatment of senile and post-menopausal bone disorders and a plastic anemia. In India it is advised for malnutrition, appetite stimulant and for increasing growth. All these are foolish especially in the light of irreversible harm it can have on children's growth and sexual development. After much publicity of these side effects, CIBA Geigy has withdrawn Dianabol, one of the commonest. Many more preparations continue to be marketed in India.

B = Bromides — On prolonged administration, they replace chloride ions in the body, cumulative poisoning manifests as conjunctivitis, gastro-intestinal symptoms, dermatitis and mental disturbances. It was a commonly used hypnotic of low potency but unreliable (Banned in July 1983).

C = Chloral Hydrate — used as a hypnotic has found to be an irritant of the gastric mucosa causing nausea, vomiting, flatulence and epigastric distress. It can also cause hepatic or renal damage. It should no longer be used as a hypnotic (Banned in July 1983).

Clioquinol — or hydroxyquinolines have been popularly used for prophylaxis and treatment of gastro-enteritis amoebiasis and traveller's diarrhoea. Ever since the report of its association with SMON (subacute myelo-optic neuropathy) its use has been restricted or banned in many countries. In India they are supposed to be prescription drugs but are obtainable over the country. A

warning in English small print does occur on the product but it hardly succeeds in warning consumers.

D = Dipyrone

is the sodium sulphonate of amidopyrines having similar properties and adverse effects particularly fatal agranulocytosis. The incidence and risk of this hazard far outweighs any benefit that can be derived from its use.

E = DP Forte

these are high dose estrogen-progesterone combinations which are dangerous for use in pregnant women because of the associted fetal malformation. In spite of the banning of production and sales of these drugs by the drug controller in March/ June 1983 these continue to be missued for hormonal pregnancy tests and for induction of abortion.

Enzymes

A very wide range of enzymes preparations are available in India as digestives and for specific conditions. Though by themselves they are not harmful, their production in large amounts along with tonics, vitamins and health restoratives are an indication of our irrational drug policy at the cost of larger social needs. These are mostly consumed by the relatively well-fed urban population.

Ergot

is an alkaloid effective in the treatment of migraine. However fixed dose combinations with drugs like paracetamol, prochlorperazine etc., have no therapeutic advantage and hence are irrational (FDCs of ergot are banned in July 1983).

F = FDC or Fixed Drug Combinations

These are formulations where two or more drugs are combined for the following reasons : (a) synergistic action; (b) corrective action; (c) two or more drugs normally prescribed together and taken by patient simultaneously; d) when dosage of each drug need not be individualised; e) where combination ensure better patient compliance due to convenience of administration. Conversely FDCs are irrational and should not be permitted if (a) adverse interactions occur; b) when one of the combined drugs becomes toxic on prolonged use (c) when abrupt withdrawal of one causes withdrawal symptoms; (d) if sub-therapeutic doses are used in the absence of clinically demonstrable synergism; (e) when pharmacokinetic behaviour of individual agents is different. (22 FDCs were banned in July 1983—refer Government order).

G = Gripe Water

These are popular preparations promoted for colic in children. Contain alcohol and sodium bicarbonate. Chronic use of the latter can cause milk-alkali syndrome. Uncomfortable but

rarely dangerous gastric distension can also occur. Despite toxicity and side effects gripe water does a thriving business through medical and consumer ignorance (Banned in Bangladesh in June 1982).

H= Hydroxyquinolines — or halogenated oxyguinoline derivatives which include iodochlo-hydroxyquinoline, proxyquinoline, halquinol, diodohydroxyquino ine, chlorquinaldol, chiniofon). For hazard see clioquinol.

Hormonal Pregnancy Tests — Oestrogen-progesterone combinations have been indiscriminately used in pregnant women as a hormonal test to detect pregnancy. (See EP Forte) Since there is an increased risk of foetal abnormalities and the test is false positive in one out of five women these tests should not longer be done. Drugs controller had issued a directive to strengthen warning on packages (March 1982) and banned manufacture (Dec. 1982) and sale (June 1983). Due to legal controversy, and professional and consumer ignorance it still continues to be used.

I = Injections — have played a very important role in the modern medicine and form one of its most distinctive features. However, it has also lent itself to a very large degree of misuse-overuse because of the mystique associated with it in the minds of the public and the temptation of the medical practitioners to pander to this need and pressure for their own economic gain.

J = Junk Drugs — these are newer formulations in the market whose only additional values are cosmetic embellishments, added flavours, elegant packing, irrational combinations—all of which help to increase its cost.

K = Kaolin — is hydrated and purified aluminium silicate, a common addition in antidiarrhoeal mixtures. Along with pectin and bismuth salts it forms a group called adsorbents, astringents and binding agents. These drugs may cause loss of electrolytes by preventing absorption through gastrointestinal tracts. If at all, they are of cosmetic value and may actually mash the severity of disease.

L = Lomotil — or diphenoxylate and Loperamide are drugs whose risks of treatment outwigh their benefits especially in children. They are commonly used is diarrhoeas and the dangers of paralytic ileus leading to inaccurate assessment of fluid loss and toxaemia if associated with gut infections make them especially dangerous in pediatric practice. The use for children under

six has been banned in India. In most other countries its use in banned altogether.

M = Methapyrilene — and its salts (Banned in July 1983)

N = Nialamide or Niamid — a MAO inhibitor used in the treatment of depressive disorders (Banned in July 1983).

O = OTC drugs — or over the counter drugs. These are drugs that are available to consumers without prescription and are mainly painkillers, anti-cold, anti-cough preparations, cough mixtures, tonics, food substitutes and protein powders. Many of them are costly compared to the benefits they render, have some ingredients which are unnecessary or useless but helping to push up cost and are widely advertised with false claims to push up sales. Their scientific scrutiny is a need as also a systematic campaign against their irrational ingredients or claims.

Oxyphenbutazone — these are a group of non-steroidal antiinflammatory drugs which also have mild antipyretic and analgesic properties. The dangers associated with use are bone marrow toxicity and liver toxicity. They are widely used/overused/misused group of drugs and there is great need for building professional awareness and consumer alert on this group of drugs. Recently these drugs have been banned in the U.K.

P = Phenacetin — was a commonly used analgesic/antipyretic agent which has been reported to cause kidney damage and failure and hemolytic anemia. Hence fixed dose combinations containing it are now considered outdated and hazardous. These have been recommended for weeding out by the Hathi Committee.

Phenylbutazones — another group of non-sterodial antiinflammatory drugs which give only symptomatic relief and in no way alter the course of the illness. Its main indications are for ankylosing spondylitis and rheumatoid and gouty arthritis though they are being widely promoted and used for non-rheumatic disorders and aches, pains and fever. Bone marrow toxicity is a real danger with the use of this drug and hence its use should be severely restricted. Its present availability—freely over the counter-should be drastically controlled and its deadly combinations with amidopyrin, analgin, paracetamol, diazepam, vitamin B, dextrapropoxyphene acetaminophen should be banned or adequate warnings in labels instituted.

Practolol — (Banned in July 1983).

Penicillin	still an important constitutent of antibacterial therapy in spite of the risk of anaphylactic reaction and allergic reactions. (Its combination with sulphonamides and its preparations as skin/eye ointments are banned from July 1983).
Q = Quinine	was the sheeti anchor of anti-malarial treatment till safer 4 aminoquinolines and 8 aminoquinolines were developed. Its use leads to black water fever so is restricted now-a-days for treatment of chloroquin resistant cases or sometimes in cerebral malaria.
R = Rational Drug Therapy	is the art/science of prescribing the best suited drugs to individuals who need them taking and not to those who merely want them. Its takes into account factors like efficiency, safety (low incidence of side effects), cost and ease of administration. It scruplously avoids extravagant prescribing over or under prescribing, multiple prescribing or incorrect prescribing.
S = Sulphonamides	These have an important role to play in the therapy of infections. The combination with penicillins is undesirable because of the antagonism of antibacterial effect when bacteriostatic and bacteriocidal drugs are given together. (FDCs of sulphonamides and penicillins are banned since July 1983).
Streptomycin	Since it is one of the most effective drugs in anti-tb treatment its use should be limited to TB treatment and mixed infections of the gut. Its combination with penicillins is undesirable since its use in small doses promotes development of resistance.
Steroids	one of the most misused drugs in general practice because of acute onset of beneficial effects. Patients are exposed to a wide range of toxic cumulative effects and adrenal insufficiency due to adrenal suppression. Its a life saving drug to be used in special circumstances. Their doses should be adjusted to the minimum that can produce the effects. Fixed dose combinations with other drugs are therefore irrational and objectionable since this individualization of the dose cannot be done. (FDCs of steroid for internal use except for treatment of asthma are banned since July 1983).
Strychnine	This was a drug formerly used as an appetiser. Its use in tonics can induce convulsions particularly in susceptible individuals. An absolete drug! (FDCs of strychnine with caffeine, yohimbine, testosterone and vitamins are banned since July 1983).

T = Tetracyclines

One of the most commonly misused/overused broad spectrum antibiotic mistakenly thought to be free of dangers. Reports of its ability to cause discolouration of teeth, catabolic effect on protein synthesis, diarrhoea, increased intracranial pressure in children, Fanconi syndrome (if outdated, degraded drug is used), liver damage in pregnant women have put it in the list of hazardous drugs. It should not be used in paediatric practice and in pregnant mothers. Its manufacture is supposed to be banned from January 1982.

Tonics

Apart from being an economic waste, most tonics in the market contain alcohol which is the main appetite stimulant and also vitamin and mineral constituents in amounts greater than the physiological absorptive capacities of average GT tracts. Their overuse thus mainly help to vitaminise our sewage systems!

U = Unani and Ayurvedic drugs

These are difficult to standardise since official standardisation methods are not available FDCs of these with allopathic drugs have no therapeutic rationale or justification or proven efficacy. (FDCs of ayurvedic and unani drugs with modern drugs have been banned since July 1983).

V = Vitamins

a typically misused/overused group of agents especially as combinations and tonics. They are essential nutritional requirements but most people get adequate amounts in a balanced diet. Specific and separate preparations are required for specific di deficiency states or as adjuncts to therapy. (Their FDCs with analgesics, tetracyclines, anti-inflammatory drugs, tranquillisers have no proven therapeutic effects and have been banned since July 1983).

W =Waterbury's

is one of the brand leaders in the tonic market whose main effects if any are because of the 9-10% alcohol content. It contains insufficient amounts of iron and creosates and guaicols whose role in man has not been definitively established. Like incremin, phosphomin, hemiphos their advertised claims for surpass their actual chemical content. Advertisements of such tonics are the most symbolic of high pressure, half truths gimmicry of medical advertising.

X =

Y = Yohimbine

a drug often combined with strychnine, vitamines, testosterone, arsenic, iron and vitamins has been found to penetrate the CNS and cause centra excitation including rise of blood pressure, heart rate, hyperexcitability and tremor (Its use especially in such combinations is banned since July 1983).

Z =

(Contd. to page 20)

Prescribing Drugs

Questions to ask yourself before writing a prescription.

1. Need	Is this drug really necessary ? Is it being given to make the patient feel that something is being done ?
2. Aim	What aim is to be achieved by this drug ? What disorder of function is to be corrected ? What symptom/s have to be relieved ?
3. Knowledge	What is the approved or generic name ? What class does it belong to ? What are its characteristics ? Do I have the requisite experience or knowledge to use it ? Have I weighed the potential toxic effects against the benefit ?
4. Route and Dosage	By what route, in what dose and at what intervals is the drug to be given and why ? In what form/s does the drug come ?
5. Alternatives	Have I selected the best agent available for this particular purpose ? What other remedies might have been chosen ? How do these compare in efficacy, safety, cost ?
6. Duration	For what period of time, days, weeks or months will it be advisable to continue therapy ? When and how could a decision be made to stop ?
7. Observations	What observations can be made to judge whether the aim has been achieved ? When should they be made and by whom ? What laboratory investigation if any would help in this assessment ?
8. Elimination	How is the drug eliminated ? Will the patients illness change the usual pattern of distribution, effects or elimination of the drug ?
9. Unwanted effects	What are the side effects or toxic effects of the drug ? Are they acceptable ? How frequent are they ? How can they be modified/managed ?

10.	Precautions	Have I checked for the following : a. possible allergic risks b. possible idiosyncratic reactions c. patients drug diet which may interfere with the drug What precautions can I take to ensure continuation of therapy.
11.	Contraindications	Are there any conditions in which this drug is contraindicated ? Are these 'absolute' or 'relative' ? Are there any drugs which should be avoided when the patient takes this treatment ? Which and why ?
12.	Patients point of view	What does the patient believe about the drug ? What has he been told about it ? And what has he remembered ? Does he need additional information ?
13.	Patient reliability	Does his relative need additional information ? Is the patient reliable for this type of therapy ? Will he need/get proper supervision by relatives or attendants ?
14.	Cost	Is the drug the cheapest drug of that type ? If not could a cheaper drug do the job as well ?

15. Finally is there anything else I need to know about this drug ?

Adapted from :

i. A Herxheimer : The Lancet II 1186-1187, 27th Nov 1976

ii. Formulary and Therapeutic guide—Kurji Holy Family Hospital

iii. Prescribing drugs — MNAMS Handout, Dept of Pharmacology, St John's Medical College, Bangalore

What Can We Do ?

1. Educate ourselves	We should make an effort to avail ourselves of all the available materials on drugs. We should purchase some of the books and subscribe to some of the journals and bulletins mentioned in 'widening horizons' to keep ourselves upto date.
2. Share and Disseminate information	We should circulate all the information and resources to all our staff and to other colleagues and centres through all possible channels of communication. We could share our own initiatives and experiences.
3. Adopt essential drug list	We should draw up an essential list for our institution in which cost, efficacy, safety and quality will be important criteria (refer to WHO's suggested list) We could purchase and stock drugs in accordance with this list.
4. Adopt generic	We could use/adopt the generic drug concept during purchasing, prescribing or dispensing drugs.
5. Stop Irrational prescribing	Could stop prescribing drugs whose only advertised values are :— a. cosmetic embellishments b. elegant packing c. irrational combinations d. imitative drugs e. inadequate evidence of greater value We could weed out 'banned drugs' as well as restricted drugs. We could stop 'injection and tonic' practice.
6. Avoid Drug Industry Linkages	We could refuse to take gifs and physician samples We could avoid allowing drug companies to sponsor events/ meetings We could beware of unethical trade discounts or other forms of inducement
7. Adopt Rational : Drug Purchase	We could adopt bulk purchasing Support cooperative purchasing or production endeavours Produce drugs in your hospitals/dispensaries.

8.	Adopt open policy to non-allopathic systems and non-drug therapies	We should be open to other forms of treatment. Seek information and be willing to incorporate it in our work Share our experience with others Send our staff for training in these forms of treatment if necessary.
9.	Support networks/ organization/ consumer movements taking up drug issues.	Find out about all such groups at local, regional, state level or national level Support and participate in their activities.
10.	Promote 'Health for all' priorities.	We should actively promote the following in our work : a. simple home remedies b. herbal remedies and herbal gardens c. health education and patient awareness d. training of village level workers e. community health initiatives f. development programmes g. awareness building.

Reporting in 1956 on the excessive amount of space taken up by advertisements in Indian newspapers, the Indian Press Commission commented :

"The largest field of..... objectionable advertising which we feel should be put down by law is of drugs and proprietary medicines.....The volume of advertising of such commodities ranks next only to the volume of advertising of cosmetics.

—Use and Misuse of the Media
Sumanta Banerjee, World Health, Feb-March 1983

Learning to use antibiotics wisely

First guidelines

1. Use an antibiotic that kills bacteria rather than one that just slows them down. This usually gives quicker results, and prevents the infection from becoming resistant to treatment.

2. Use an antibiotic that causes fewer side effects and is less risky. For example, if the person is not allergic, it is safer to use penicillin or ampicillin rather than an antibiotic like erythromycin that can cause poisoning.

3. When possible, use a narrow-range antibiotic that attacks the specific infection rather that one that attacks many kinds of bacteria. Broad-range antibiotics cause more problems—especially diarrhoea and thrush—because they attack good bacteria along with the bad. The good bacteria prevent the growth of harmful things like moniliasis (fungus that can cause diarrhoea, thrush, etc.)

4. Use a broad-range antibiotic only when no other will work, or when several kinds of bacteria may be causing the infection (as with infections of the gut, peritonitis, appendicitis, some urinary infections, etc.)

Additional guidelines

5. Use antibiotics only for bacterial infections. Do not use them for viral infections, because antibiotics do nothing against viruses (common cold, measles, chicken pox etc.)

6. Be careful to give more than the recommended dose of a toxic (poisonous) antibiotic. However, it is usually not dangerous to give higher doses of an antibiotic that is not poisonous (penicillin or ampicillion). Tetracycline becomes more poisonous when old. It should never be used beyond the expiration date or in more than the recommended dose.

7. Do not use an antibiotic that slows down bacteria together with an antibiotic that kills them. The combination is often less effective than one alone. (Once the bacteria are captured or slowed, they stay hidden where the other antibiotics cannot kill them). For example, never use tetracycline in combination with chloramphenicol.

8. Whenever possible, avoid using a toxic medicine for a person with diarrhoea or dehydration. A dehydrated person's body cannot get rid of poisons as quickly in the urine. Even normal doses of a toxic medicine may build up and poison the person. (Sulfas are especially riskly for treating diarrhoea. Unless the person is making a lot of urine, sulfa can form crystals in the kidneys and cause damage).

9. Do not use toxic medicines during pregnancy—especially during the first three months. Some medicines can cause severe birth defects.

10. Use a medicine the family can afford. When choosing between medicines, always consider the relative cost, and weigh this with other advantages and disadvantages.

—Helping Health Workers Learn
David Werner and Bill Bower

Seven Steps to success in essential drugs supply

"Essential drugs ai hose that satisfy the health care needs of the majority of the people. They should, therefore, be available at all times in adequate amounts and in the appropriate dosage forms."

(1) National Drug Policy

Every country's comprehensive health. Policy should include a National Policy on Essential Drugs. WHO's role is to inform governments about the basic concept and the benefits, then to provide technical support for policy formulation,, selection of essential drugs, a plan of action, procurement, quality control, programme management and aspects such as training, evaluation and legislation. A national essential drug policy can provide more drugs to more people at the same cost or even less.

(2) Selection of Essential Drugs

Essential drugs are those that satisfy the health care needs of the majority of the population. Selections are based of the most common local disease and conditions and on the capability of the health care system. More than 80 countries have now adopted lists of essential drugs based on WHO's Model List of Essential Drugs, as have various non-governmental organizations and UN agencies.

(3) Drug Procurement

All too often countries pay more than they need for their drugs. They can get better value for money by putting out bulk orders to international competitive tender on the world market. UNICEF and WHO help countries to strengthen their procurement systems and to secure, if necessary and possible, reliable financing—internal or external—for their purchase.

4. Logistics of Supply

WHO's goal is to make sure that people can get the 20 most needed essential drugs whenever they require them, within an hour's travel. The supply chain must work: correct ordering, packing and storage; less waste through deterioration, loss or theft, regular transport to the remotest dispensary despite climatic and geographical conditions or fuel shortage. Several countries have established efficient drug supply management systems with support from WHO, UNICEF and bilateral agencies. The pharmaceutical industry also provides expertise.

(5) Proper Use of Drugs

Both health professionals and the general public are in need of better information and education about when and how to use drugs. Common problems are that the former tend to overprescribe while the latter may fail to follow the prescribers instructions or dose themselves. Drug information sheets are being considered by WHO that would give the indications, contra-indications and side effects of essential drugs. Several countries have produced their own therapeutic guides and standard treatment schedules for use by health workers. Consumer groups do valuable work among and on behalf of the general public.

(6) Quality Control

Essential drugs must be of reliable quality as well as efficacious and safe. Quality has to be assured upto the time that the drugs

are administrated by good manufacturing practices and by monitoring of products at all stages in the supply line. The IFPMA member companies provide training in quality control for nationals of developing countries. Any country lacking quality control laboratories can obtain an assurance of the quality of imported products at the time of export through the WHO certification scheme on the quality of pharmaceutical products moving in international commerce.

(7) Training

Many countries lack staff trained in policy formulation, selection, procurement, management and use of drugs, in drug legislation and regulatory control and in production and quality control. WHO is approaching universities, training schools, non-governmental organizations and the pharmaceutical industry for help with training materials and courses. At seminars and workshops, countries that have developed successful national essential drugs programmes demonstrate to others "how it's done".

from World Health, July 1984

(*Contd. from page 13*)

Further Reading

1. Banned Brand Drug List
2. Hazardous Banned Bannable and Dumped Drugs
3. Rationality in Banning Fixed Dose Combinations
4. Some painful facts about a pain killer called Amidopyrine
5. Why not to prescribe anabolic steroids ?
6. Irrational use of antibiotics
7. The clioquinol controversy
8. Using tetracyclines for children and pregnant women
9. Consumer Altert-Phenylbutazone and Oxyphenbutazone
10. Scientific scrutiny of some over the counter drugs
11. The case against EP Forte
12. National Drug Policy guidelines and list of banned drugs (Bangladesh)

Available from Low Cost Drugs and Rational Therapeutic Cell, Voluntary Health Association of India, C-14 Community Centre, SDA, New Delhi 110016.

MS-cb/D-10.340/
25.8.1982

ANABOLIC STEROIDS FOR GROWTH

BRAND & DRUG HOUSE	INGREDIENTS	COST	INDICATIONS	DOSAGE	CONTRAINDICATIONS & SPL. PRECAUTIONS
* Adroyd (Parke-Davis)	Oxymetholone 5mg	15-9.04	Underweight or asthenic patients convalescence from acute infectious diseases; major surgical procedures-pre-and post-operatively, chronic debilitating illness; osteoporosis, fractures and decubitus ulcers, severe burns	Occassionally 20-30mg daily may be required. Usually for 10-21 days but not more than 90 days. Ped. dosage: see Lit.	Prostatic carcinoma. Although Adroyd has a low degree of androgenicity, very young and preadolescent individuals are usually sensitive to the masculinising effects of androgens. Due to this, they should be under medical supervision during therapy and the drug withdrawn if masculinising effect develop. Adroyd should be used with caution in cardiac disease, hepatic dysfunction, nephritis and nephrosis.
* Anabolex B12 (Cipla)	Methandienone 2mg Vit B12 50mcg ferric amm. cit 50mg/ml	5ml-6.23	Loss of appetite and weight loss with anaemia. Growth disorders in children	5-10 drops daily for 4-6 weeks	Continuous treatment should be limited to a max. of 4 weeks with intervals of 1-2 months between courses.
*# Dianabol (Ciba-Geigy)	Methandienone 25mg	1ml-5.70	Negative nitrogen balance due to protein malnutrition, convalescence, wasting diseases, osteoporosis, growth retardation, aplastic anaemia, red-cell aplasia.	1ml-i.m. weekly. For intensive therapy 1ml on alternate days	Prostatic cancer, severe liver insufficiency, severe nephrosis, pregnancy and lactation. Should not be given continuously for persons periods exceeding 4 weeks. High doses in women may produce menstrual cycle disorders, hirutism, deepening of voice. In children, premature ossification of epiphyses and virilisation may occur

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25.8.1982

BRAND & DRUG HOUSE	INGREDIENTS	COST	INDICATIONS	DOSAGE	CONTRAINDICATIONS & SPL. PRECAUTIONS
*# Dianabol Tabs(Ciba-Geigy)	Methandienone 1mg and 5mg	1mg:2[illegible]-5.53 5mg:10-6.02	(Same as Dianabol)	Male:5mg daily. Maint.therapy:2.5mg daily. See Lit. Female:2.5mg daily. Maint:1-2mg daily. See Lit.	(Same as Dianabol)
*# Dianabol Drops (Ciba-Geigy)	Methandienone 1mg per ml	5ml-5.50	(")	Children:0.01-0.04mg/kg body wt for not more than 4 weeks	(")
# Durabolin (Organon)	Nandrolone phenylpropionate; 10mg and 25mg	10mg-13. 25mg-21.85	Protein loss following surgery trauma, burns, infectious diseases or following prolonged corticosteroid therapy, uraemia due to acute and chronic renal failure, general debility, osteoporosis, aplastic anaemia, inoperable mammary carcinoma, under weight children and fractures.	d.m. 25mg every week In acute renal failure upto 50mg weekly and in chronic renal insufficiency upto 50mg twice weekly. Children: 10mg every week	(See lit)
# Deca Durabolin	Nandrolone decanoate 10mg and 25mg	10mg:1amp -9.28 25mg:1amp 8.53	i.m. 25mg every 3 weeks. In acute renal failure upto 50mg weekly and in chronic renal insufficiency upto 10mg every 3 weeks. Children: 10mg, every 3 weeks		

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N.B. Dianabol has been deleted from the June issue of MIMS and is withdrawn by Ciba-Geigy.

BRAND & DRUG HOUSE	INGREDIENTS	COST	INDICATIONS	DOSAGE	CONTRAINDICATIONS & SPL. PRECAUTIONS
*# Evabolin (Concept)	Nandrolone phenyl-propionate 25mg Vit.E 100mg/2ml	2ml-7.06	Convalescence, to promote growth in undernoursihed children adjuvant to steroid therapy. Osteoporosis, hypoproteinaemia, Haemolytic anaemias.	2ml-4ml i.m. once weekly	Carcinoma of prostate, pregnancy, male breast carcinoma.
* Neurabol H (Cadila)	Vit B1 60mg B6 27.5mg Hydroxycobalamin 100mgg, nandrolone phenylpropionate 25mg/2ml	2ml-4.42	General debility, osteoporosis, weight loss, refractory anaemias, neuritis, neuralgias.	2ml i.m. every week	Prostatic carcinoma, pregnancy, B1 sensitive patients.
*# Orabolin (Organon)	Ethylestrenol 2mg;	20-13.34	Osteoporosis, weight loss, debility, anorexia, burns, during steroid therapy	1 tab twice daily. In serious conditions dosage may be increased	Pregnancy, prostatic carcinoma, male breast carcinoma. Severe liver dysfunction.
*# Orabolin Drops(Organon)	Ethylestrenol 2mg per ml	5ml-6.56	Body wt upto 10kg	Body wt upto 10kg: 10-20 drops. 10-20kg: 20-40 drops 20-30kg: 40-50 drops More than 30kg: 50-60 drops. All daily	
* Trinergic (Unichem)	Methandienone 5mg Vit B1 10mg, B6 10mg B12 30mcg	20-12.71	Malnutrition and under nutrition convalescence, old age anorexia nervosa, neurological disorders, extensive burns, severe injuries		Continuous treatment should be limited to a max. of 4 weeks with intervals of 1-2 months between courses.
* Trinergic Inj.(Unichem)	Methandienone 25mg Vit B12 500mcg/ml	1ml-2.96	(Same as above)	1ml once or twice weekly.	(Same as above)

* MIMS # CIMS

BRAND & DRUG HOUSE	INGREDIENTS	COST	INDICATIONS	DOSAGE	CONTRAINDICATIONS & SPL. PRECAUTIONS
*# Unabol (Unichem)	Nandralone phenyl propionate 25mg/ml	1ml-7.01	Negative nitrogen balance, old age, osteoporosis, bone fractures, during prolonged corticosteroid therapy, to promote weight gain	25mg weekly	@ Carcinoma of prostate, pregnancy, male breast carcinoma
*# Winstrol (Cosmo Farma)	Stanozolol 2mg	10-12.46	Poor protein anabolism, osteoporosis, convalescence, aplastic anaemia., during corticosteroid therapy	2-4mg thrice daily just before or with meals. Children 3-6 years: 1mg twice daily; 6-12yrs: 2mg thrice daily	Pregnancy, carcinoma of prostate, severe liver disease. Pre-pubertal children where it may lead to stunting of growth. Use lower dosage in young females to minimise androgenic side-effects. Impaired cardiac and renal function.
* Aquaviron B12 (Nicholos)	Free testosterone 25mg, VitB12 500mcg per ml	1ml-4.75	Depressed debilitated male patients	1ml i.m. twice weekly for about 6 weeks; diminish frequency as conditions improves	Prostatic carcinoma
*Aquaviron Inj	Free testosterone 25mg/ml	1ml-2.50	Male: hypogonadism, organic impotence, eunuchism, delayed puberty, premature senility Female: metropathia haemorrhagica menorrhagia, frigidity, inoperable breast carcinoma	Male: 1-2ml every 1-2 weeks diminishing the doseas patient improves Female: 1-2ml daily until bleeding stops. Not more than 200mg in one month	

* MIMS
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Drug Workshop II
Jaipur
Mira Shiva

VOLUNTARY HEALTH ASSOCIATION OF INDIA

D-9/334 (I)
a:25.8.82

C-14 Community Centre,
Safdarjung Development Area,
NEW DELHI - 110 016

WHY NOT TO PRESCRIBE ANABOLIC STEROIDS

The unquestionable, unshakeable faith in tonics and vitamins of the majority of us - Indians is due primarily to the excellent marketing strategies of the drug companies, and the compliance of the health professionals and the consumers.

The uselessness of tonics and vitamins is abundantly clear to those who care to question their rationality. Where anabolic steroids are concerned, the potential hazards associated with its intake make it a doubly black-listed product.

Anabolic Hormones -"most of them are weak versions of male sex hormones and were synthesised and introduced into medicine as agents to speed the transformation of foodstuffs into body tissues. They were originally promoted- and some still are - as drugs that could stimulate the appetite, step up body weight, strengthen bones, increase athletic ability, control a variety of emaciating diseases and in the recovery from surgery, infections, burns, fractures and severe traumatic injuries"

Ref: Prescriptions for Death" p.67
Milton Silverman.

Accepted Indications Based on objective evidence anabolic hormones are accepted for use in:

- certain kinds of (aplastic) anaemias.
- inoperable breast cancer.
- prevention and treatment of osteoporosis
- bone sofetning as seen in post-menopause of women
- senile patients.

But used as an adjunct and not as primary therapy - diet, calcium balance, physiotherapy and good general health promoting measures need equal or greater consideration.

Toxicity In large quantities, they may cause:

In Women
- masculinization
- baldness
- deepening of the voice
- hirsutism
- menstrual irregularities

(irreversible; virilization)

Adverse effect on liver - jaundice, liver tumors.
May cause sodium retention -leading to edemia and heart failure.
Can cause problems in cardiac, renal or hepatic diseases and increased or decreased libido.

In young children - Early closure of epiphyses in the bones resulting in stunted growth.

Boys - precocious sexual development.
Young girls - they can produce enlargement of the clitoris or the development of false penis.
Alteration in glucose tolerance test, thyroid function test. Electrolytes - sodium chloride water phosphates, calcium.
Liver Function Test :Serum cholesterol, suppression of clotting factors, II, V, VII & X
(Editorial: Pune Journal of Ongoing Education)

How adequately these warnings are given to the prescribing doctor

..2/-

D-9/334 (a)
a:25.8.82

by the drug company or to the consumer by the doctor - is well known!!

When the actual problem is lack of food, the solution is not tonics or anabolic steroids. When the desired action should be to look deeply into the causes of malnutrition-our major health problem - a prescription of anabolic steroids (tonics, etc) displays our ignorance or irresponsibility; apathy and indifference towards such medically irrational practices.

Different anabolic steroids are promoted in various parts of the third world (including India) for vague indications like overcoming of loss of weight, poor general health, wasting illnesses, to aid malnourished children (drug experts have emphasised that these products can help transform food to body protein only if the patient is getting enough food, patricularly enough protein and total calories).

- for treatment of debility and emaciation.
- senilfty, muscular dystrophy
- for eppetite improvement
- for pernicious anaemia, lack of energy
- poor weight gain
- reduced resistance to infection
- tiredness and debility, lack of stamina and listleasness

According to the British National Formulary"the use of anabolic steroids as body builders or tonics is quite unjustified."

According to AMA Drug Evaluations, the use of anabolic hormones to improve athletic performance is unanimously condemned. Besides the fact that there is "no increase in the size and strength and in the muscle size, there is an added risk of liver damage and interference with the testicular function".

What is more objectionable is that the "indications for use" and the "warnings about the drug" very in different countries depending on the effectiveness of the country's controlling authorities and the general awareness of the medical community and the public".

The three most popular brands of anabolic steroids are:

- Winstrol - a form of stanozol by Winthrop, USA
- Durabolin - a form of nandrolone phenpropoinate by Organon
- Dianabol - a form of methandrostenolone by CIBA GEIGY

Some of the other brands available in India, the drug houses are:

OROBOLIN DROPS - By Organon. which promoted Orbalin drops in Bangladesh "for paddiatric use in conditions like marcismus, malnutrition, poor weight gain, retarded growth - kwashiorkoi, etc.

According to Diana Melrose in her working paper "Medicines and the Poor in Bangladesh".

Durabolin and Decadurobolin"stimulate the appetite,ensures adequate food intake..checks protein depletion...resistance against infections diseases and improves general constitution and restores a sense of well being" They also cause "no fluid retention and free from harmful effects on the liver".

In the UK doctors are told "not recommended for children". Warnings include"anabolic steroids may cause fluid retention". Tumours of the liver have been reported occasionally.

Relative costs are given in the Appendix. Numerous tonics contain anabolic steroids-an exhaustive list needs to be prepared. The Pune Journal of Continuing Medical Education of June 1982 gives and editorial on CIBA GEIGY withdrawing Dianobol. We can make sure this is really done and that others follow suit.

DR-3315

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July 12, 1988

Dear friends,

You must have gathered from the newspapers dated 30th June that the high dose EP drugs have been banned.

The Gazette Notification is dated 15th June. What the reason for 15 days silence in informing the public is we don't know. In case this period was used by the manufacturers to dispose off their stocks to the druggists and chemists - in that case - ensuring withdrawl of these drugs from the market, has to be our single most imp demand and action.

From past experience we are aware that it is extremely unlikely that the drug control authorities will/can enforce an effective ban under the existing circumstances.

The amendment of the Drugs & Cosmetics Act of 1940 was brought about only when it became obvious that there was no clause as hazardous drug for banning. EP case has been a test case for us in getting a drug banned. Ensuring its total withdrawl from the market is part of our responsibility.

The Health Ministry should have informed the medical profession and public over the Radio & Doordarshan about the ban and the alternatives available.

I am enclosing :

1) DCI's letter to me dated 29th June
2) Copy of the Gazette Notification
3) Copy of my letter to the DCI.

E.P. Follow up would require :

1) Ensuring withdrawl of all stocks of high dose EP drugs from the manufacture and the market
2) Putting pressure for a deterrant punishment of the guilty by demanding payment to the Govt. of all the profits made since 1982 which should be used for setting up Adverse Drug Reaction Cells.
3) Demand for warning the health professionals & consumers at large about the drug ban.
4) Demand for making low cost simple and safe pregnancy tests available as part of MCH prog. ..... 2..

RN 19/7 JN 21/7

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5) Making efforts towards informing the medical professionals about the alternatives to high dose E.P. for the secondary amenorrhea etc.

6) Demand for expediating for endorcement of DCC's subcommittees recommendation to weed out drugs and screening of the drugs in the market known to be hazardous irrational, grossly overpriced and non-essential.

Documentation of evidence of continued sales and demand for ensuring of action for violation of the ban will need to be done.

Since mainly Menstrogen (of Organ's Infar) and E.P. Forte (of Unichem) are involved it should not be v. difficult.

Please inform all the drug enthusiasts and journalists in your area.

With regards,

(Dr. Mira Shiva)

Encl: As above

For Community Health Cell Forum Kandalkar & Drug Advocacy

रजिस्ट्री सं. डी. (डी.एन.)-127 REGISTERED NO. D. (D.N.) 127

भारत का राजपत्र
The Gazette of India

असाधारण
EXTRAORDINARY

भाग II—खण्ड 3—उप-खण्ड (i)
PART II—Section 3—Sub-section (i)

प्राधिकार से प्रकाशित
PUBLISHED BY AUTHORITY

सं. 330] नई दिल्ली, बुधवार, जून 15, 1988/ज्येष्ठ 25, 1910
No. 330] NEW DELHI, WEDNESDAY, JUNE 15, 1988/JYAISTHA 25, 1910

इस भाग में भिन्न पृष्ठ संख्या दी जाती है जिससे कि यह अलग संकलन के रूप में रखा जा सके

Separate Paging is given to this Part in order that it may be filed as a separate compilation

स्वास्थ्य और परिवार कल्याण मंत्रालय

अधिसूचना

नई दिल्ली, 13 जून, 1988

सा.का.नि. 700(अ).—केन्द्रीय सरकार का यह समाधान हो गया है कि आइस्ट्रोजन और प्रोजैस्टरोन की उच्च मात्रा विनिर्मिति के उपयोग से मनुष्यों के जोखिम में पड़ने की संभावना है और ऐसी विनिर्मिति का कोई चिकित्सीय औचित्य नहीं है तथा लोकहित में ऐसा करना आवश्यक और समीचीन है;

अतः, अब, केन्द्रीय सरकार, औषधि और प्रसाधन सामग्री अधिनियम, 1940 (1940 का 23) की धारा 26क द्वारा प्रदत्त शक्तियों का प्रयोग करते हुए, भारत सरकार के स्वास्थ्य और परिवार कल्याण

मंत्रालय की अधिसूचना सं. सा.का.नि. 578 (अ), तारीख 23 जुलाई, 1983 का निम्नलिखित और संशोधन करती है, अर्थात्–

उक्त अधिसूचना में उपाबद्ध सारणी में, क्रम संख्यांक 26 और उससे संबंधित प्रविष्टियों के पश्चात् निम्नलिखित क्रम संख्यांक और प्रविष्टियां अन्तःस्थापित की जाएंगी, अर्थात्–

"27. आइस्ट्रोजन और प्रोजेस्टिन (मौखिक गर्भ निरोधक से भिन्न) के संयोजन की निश्चित मात्रा, जिसमें प्रति टिकिया में आइस्ट्रोजन अन्तर्वस्तु 50 माइक्रोग्राम से अधिक (एथेनाइल एस्ट्राडिओल के समतुल्य) और प्रोजेस्टिन अन्तर्वस्तु 3 मि.ग्रा. से अधिक (नारेथिस्टिरोन एसिटेट के समतुल्य) हो ।" ।

[सं. एफ 11018/1/88-डी एम एस और पी एफ ए]
जे. वासुदेवन, संयुक्त सचिव

हिप्पण : भारत सरकार के स्वास्थ्य और परिवार कल्याण मंत्रालय की अधिसूचना सं. सा.का. नि. 578 (अ), तारीख 23-7-1988 का भारत के राजपत्र, असाधारण, भाग 2, खंड 3(i) में प्रकाशित निम्नलिखित अधिसूचनाओं द्वारा संशोधन किया गया, अर्थात्:–

(1) सा.का.नि. 49(अ), तारीख 31-1-1984

(2) सा.का.नि. 322(अ), तारीख 3-5-1984

(3) सा.का.नि. 863(अ), तारीख 22-11-1985

MINISTRY OF HEALTH & FAMILY WELFARE

NOTIFICATION

New Delhi, the 15th June, 1988

G.S.R. 700(E).—Whereas the Central Government is satisfied that the use of high dose formulation of Oestrogen and Progesterone is likely to involve risk to human beings and such formulation have no therapeutic justification and it is necessary and expedient in the public interest so to do;

Now, therefore, in exercise of the powers conferred by section 26-A of the Drugs and Cosmetics Act, 1940 (23 of 1940), the Central Government hereby makes the following further amendment in the notification of the Government of India in the Ministry of Health and Family Welfare No. G.S.R. 578(E), dated the 23rd July, 1983, namely :—

In the Table appended to the said notification, after serial number 26 and the entries relating thereto the following serial number and entries shall be inserted namely :—

"27 Fixed dose combination of Oestrogen and Progestin (other than oral contraceptives) containing per tablet estrogen content of more than

50 mcg. (equivalent to Ethenyle Estradiol) and of progestin content of more than 3 mg (equivalent to Norethisterone Acetate).

[No. X-11018/1/88-DMS&PFA]

J. VASUDEVAN, Jt. Secy.

Note :—Government of India Ministry of Health and Family Welfare Notification No. G.S.R. 578(E), dated 23-7-1983 was amended by the following notification published in the Gazette of India Extraordinary, Part II Section 3(i) namely :—

1. G.S.R. 49(E), dated 31-1-1984
2. G.S.R. 322(E), dated 3-5-1984
3. G.S.R. 863(E), dated 22-11-1985

PRINTED BY THE MANAGER, GOVT. OF INDIA PRESS, RING ROAD, NEW DELHI-110064
AND PUBLISHED BY THE CONTROLLER OF PUBLICATIONS, DELHI-110054, 1988

No.X.11018/1/87-D

From

The Drugs Controller (India),
Dte. General of Health Services.

New Delhi, the 29 JUN 1988

To

2. Dr.Mira Shiva,
Voluntary Health Association of India,
40, Institutional Area,
South of I.I.T.,
New Delhi-110016.

Subject : Marketingof high dose combination of Oestrogen & Progestins -

.....

Sir,

A copy of the Notification No.GSR 700(E), dated 15.6.1988 issued by the Govt. of India is forwarded herewith, for your information.

By this Notification Govt. of India has prohibited manufacture and sale of "fixed dose combination of Oestrogen and Progestins (other than Oral Contraceptives) containing per tablet 50 micrograms (equivalent to Ethenyl Estradiol) and of progestin content of more than 3 mg. (equivalent to Norethisterone Acetate).

You are requested to give wide publicity to the contents of the Notification.

Yours faithfully,

(DR.PREM K. GUPTA)
DRUGS CONTROLLER (INDIA)

Received on 4/7
Action taken
Passed on to
File No
Remarks
Signature

DR 33-16

41st ANNUAL CONVENTION

CATHOLIC HOSPITAL ASSOCIATION OF INDIA

23-26 NOVEMBER 1984

WORKSHOP THEME:

towards a people-oriented drug policy

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

---ICMR/ICSSR Health for All Report.

Venue: ST JOHN'S MEDICAL COLLEGE, BANGALORE 560034

SIGNIFICANCE OF THE THEME

THE Workshop is to help participants understand the issues relevant to drug prescribing, drug distribution and pharmacy policy in our institutions in the context of the ICMR/ICSSR warning and to challenge them to participate in the growing national response to the problem.

WHAT does the 'abundance of drugs' mean to the millions of the poor in our country who struggle in life to make both ends meet? Can they ever have access to the modern health care system which has become a business today, rather than remaining at the service of humanity at large? Do they have essential and life saving drugs at their reach within a price range they can afford?

IS our drug policy today more profession-oriented, drug industry-oriented rather than patient-oriented? Whose interests are we serving in our institutions?

HOW can we move towards a more people and patient-oriented drug policy?

THESE are some of the QUESTIONS which we shall respond to in our Workshop.

"Community Health is a process of enabling people to exercise collectively their responsibilities to maintain their health and to demand health as their right. Thus it is beyond mere distribution of medicines, prevention of sickness, and income generating programmes".

--CHAI new vision

OBJECTIVES

1. TO CREATE AN AWARENESS OF:-

   the health situation in India, the role of drugs in health care, the pattern of drug production in India vis-a-vis the people's health needs, the dynamics of the drug industry, the pattern of drug distribution and availability in the health system, the national drug policies and laws.

2. TO CREATE AN AWARENESS OF:-

   irrational use, over use and misuse of drugs by health personnel.

3. TO DISCOVER

   the social, economic, political, cultural and other factors responsible for this problem.

4. TO DISCOVER

   how all of us are part of the problem at a personal level.

5. TO CONSIDER

   the various responses at national/regional levels in the areas of :-- consumer awareness and people's movements; continuing professional education; pressure group on policy makers; search for low cost alternatives; individual/group action; institutional policy changes.

6. TO DISCOVER

   ways and means by which we can respond to this situation at individual, institutional and regional/national levels.

.....

PROGRAMME HIGHLIGHTS

Sessions on:

Understanding the problem
Drugs and the healing ministry
Towards rational therapeutics
What to do to tackle the problem
Some initiatives in the country
The people's medicine

Group discussions on:

What/why the problem in our health institutions?
What can we do to tackle this problem?

Liturgy

Reflecting on our calling and the faith dimension of our response

Exhibition on:

Socio-political dimensions of Health and Drugs
Rational Drug Therapy
Home remedies and Herbal medicines

Studies on:

Drugs for a Community Health Center
Understanding the injection/tonic culture
Use/misuse of drugs in surgery
Drug situation in small rural hospitals
Cost of treatment

Cultural Programme

Understanding the problem from the poor man's point of view.

.....

SYNOPSIS OF PAPERS

Drugs for Primary Health Care (C M Francis)

An integral part of our commitment to primary health care is the provision of essential drugs to all those who need them, in adequate quantity and quality and at affordable prices wherever the person is. The various aspects of the drug problem needing our attention include production, what drugs are required, choice of drugs, National Drug Policy, selection of drugs, drug production and procurement, logistics of supply, quality control, regulating the drug trade, drugs for immunization, drugs for cure, drugs for symptomatic relief, search for new drugs, drug information and the need for evaluation of the efficacy of primary health care including drugs.

The Ten Commandments of the Drug Industry (Augustine Veliath)

1. Thou shalt have tens of thousands of drugs
2. Thou shalt not question the price of a drug
3. Thou shalt not tamper with nature's garden
4. Thou shalt respect they doctor more than thyself
5. Thou shalt betray thy people and thy nation for petty rewards
6. Thou shalt not covet, court, or subscribe to any other system of medicine
7. Thou shalt never reveal company secrets
8. Thou shall first seek remedies for fashionable ailments
9. Thou shalt be a dumping ground for banned drugs
10. Thou shalt be a guinea pig for new and untried drugs.

The Ethics of Prescribing (George Lobo, sj)

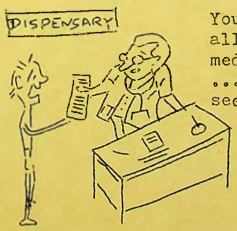
Discusses reasons for the unfortunate situation related to drugs prevalent today, viz., technological model of health care leading to manipulation of the patient, search and demand for instantaneous cure of symptoms, mystification of medicine, profit motive and 'free enterprise' of the pharmaceutical industry, a deep rooted cultural alienation from the people, exploitation of dependent developing countries, decreasing emphasis being given to preventive medicine and other systems of medicine.

The use of drugs should be regulated by the principles of totality (overall good of the patient) and of double effect (the good effect overriding any harmful effect). It suggests remedies for the development of a person-centred and holistic approach to health care.

Professionals in the Church - an introspection (George Joseph)

Serious questions have been raised about the institutional witness of the church in India, particularly its relevance in the social context of today. In the case of the Healing Ministry there is urgent need to critically look at our priorities and commitment and our style of functioning in the light of the gospel. The role of the professionals have to be reassessed as part of an overall effort to bring back the true spirit of 'Diakonia' into this ministry.

The whole issue regarding the need for evolving a 'rational drug policy' has to be seen in this perspective.



What is Rational Drug Therapy? (Mira Shiva)

Rational drug therapy means practice of socially conscious, relevant, concerned and yet scientifically sound medicine. It recognizes the non-role of drugs in certain conditions, the role of alternative systems of medicine and recognizes the limitations of Western Medicine in our social context.

It emphasises selective use of drugs based on essentiality, efficacy, safety, easy availability, easy administration, quality drugs preferably of indigenous production.

Rational Drug Therapy recognizes the concept of essential drugs and the concept of graded essential drug lists for different levels of health personnel. It recognizes the right of health personnel and consumers to drug information and its effective communication.

It is taking of a conscious decision to boycott certain drugs and use others only when needed. It means prescription with awareness, to avoid as far as possible -- iatrogenesis (drug induced problems, drug interactions, adverse drug reactions and emerging drug resistance).

It is understanding the role of drugs and rational drug therapy in the emerging health movement.

What can be done at a pharmacy level (Alan Cranmer)

(a) Management of Pharmacy Services include involving the users of the service; the Pharmacy Committee - its constitution and functions, viz., implementation of hospital policy, selection of medicines, sources of medicines, cost versus quality, basic drugs and formulations, medicines banned in India and abroad, medicines from other systems; stock control; prescribing discipline and pharmacy discipline.

(b) Good dispensing services involve need for good professional service to patients, proper presentation of patient's medicines, preparation of medicines in the pharmacy compared to purchase, medicines in the pharmacy and at clinic level.

contd.....

(c) Relationships with suppliers, ie., with representatives in the pharmacy and an assessment of products offered and their sources.

(d) Educational requirements - basic courses, legal requirements, course content, continuing education for pharmacists.

(e) Relationships with hospital colleagues.

.....

INITIATIVES IN THE COUNTRY

(1)

Arogya Dakshata Mandal, Pune has been raising awareness about drug related issues among medical professionals and the lay public since the past 8 years. They publish a monthly--'Pune Journal of Continuing Health Education'--on drug issues and are also bringing out a book 'Rational Drug Therapy' in December 1984.

They launched a movement called 'Operation Medicine' in 1977 against irrational prescription of vitamins, tonics and tinned foods.

(2)

All India Drug Action Network: A number of groups have been working in the field of drug related issues at various levels during the past 3-4 years. They have been in contact with each other and have been working informally together sharing information, putting forward a memorandum (demanding a Rational Drug Policy), participating in campaigns, lobbying with government etc. In August 1984, they felt the need to have a more organized base and have formed the All India Drug Action Network. CHAI is also a member of the Network.

(3)

Lok Vigyan Sanghatana, Maharashtra, or the People's Science Movement have launched campaigns about anaemia and irrational anti-anaemia drug preparations and also about over the counter drugs. They organize jathas, hold district/town seminars, write in the mass media etc.

(4)

Kerala Sastra Sahitya Parishad is a voluntary non-government organization consisting of scientists, doctors, engineers, social scientists, teachers, students, workers, peasants, technicians who are committed to popularising science and channelising it for social revolution. The KSSP has recently decided to take up the Drug issue and initiate a big campaign to expose the anti-people and exploitative tactics of the Multinational Drug Companies. The questions of essential versus non-essential and dangerous drugs, the inadequacy of drug safety control measures, the rising prices of life saving drugs and the non-implementation of the Hathi Committee recommendations are the highlights of the programme.

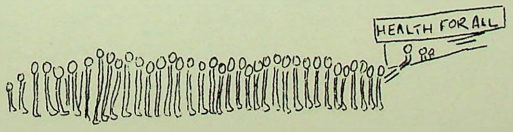
(5)
LOCOST or Low Cost Standard Therapeutics is a collective voluntary enterprise for rational therapeutics. LOCOST aims to promote low cost, scientifically tested medicine under generic names. LOCOST is a response to a growing demand and challenge of the voluntary health sector to meet the needs of the deprived sectors of the society for not only low priced but also good quality medicine. LOCOST includes procurement, quality testing and control, distribution and educational efforts, and is located in Gujarat.

(6)
Bangarapet Mission Tablet Industry in Karnataka is a successful small scale venture providing low cost, good quality formulations to some mission hospitals in the country.

(7)
Low Cost drugs and Rational Therapeutics Cell of the Voluntary Health Association of India, New Delhi, has been instrumental in bringing together various groups in India on the issue of drugs. They have been providing informational backing to these groups, organizing meetings, informally coordinating some actions etc.

(8)
medico friends circle is a group of socially conscious individuals, interested in the health problems of our people. Through their monthly bulletin, they discuss drug issues among others. They have formed a Rational Drug Policy Cell and have launched a campaign on anti-diarrhoeals.

(9)
The Kurji Holy Family Hospital Formulary is the result of the accumulated experience of the hospital over the last 10 years. It gives a comprehensive, list of drugs to treat 98% of the hospital admissions. It also gives the generic name, dosage, indications, contra-indications and side effects of these drugs. Information about comparative cost of treatment is also provided.



(10)
State Forums: During the past year drug action forums have been active in Andhra Pradesh and West Bengal. Drug Action forums are also being initiated in Gujarat and Orissa.

(11)
The Pharmacology Department of the Post-Graduate Institute of Medical Education and Research, Chandigarh, provide unbiased technical information on drugs and therapeutics through a monthly publication 'The Drugs Bulletin'.

(12)
Others: The following organizations have also been involved in drug related issues and are part of the All India Drug Action Network:

Consumer guidance Society of India, Bombay
Consumer Education Research Centre, Ahmedabad
Federation of Medical Representatives Association of India
Health Services Association, Calcutta
Delhi Science Forum, New Delhi
People's Participation in Science and Technology, Madras/Bangalore
Centre for Science and Environment, Delhi
Centre of Social Medicine and Community Health, J N University, New Delhi

W h a t w e c a n d o ?

-- Support them

-- Join them

-- Keep them informed about what you are doing

.....

RESOURCE MATERIALS

- People, Pills and Prescriptions, column in MEDICAL SERVICE since May-June 1984.
- Objectives of the Workshop, a handout.
- Understanding the Drug situation in our Hospitals, a check list.
- Towards a People-Oriented Drug Policy, Special Convention Issue of MEDICAL SERVICE (October-November 1984) and a supplement to this issue will be distributed during the Workshop.
- Drugs awareness and Action, mfc BULLETIN Special Issue No.107 November 1984.
- DECCAN HERALD Supplement on the Workshop.

.....

"What people really need, first and foremost is clean drinking water, latrines, school and land, not urban hospitals with their wonder drugs".

-- Planning Commission

AN INSPIRATION

Reading

The story of the sickman
at the pool of Bethsaida

John 5: 1-9

Reflection

The action of Jesus in bypassing the pool is an invitation to us to look more critically at our own health care system. Thanks to our emphasis on curative health care, we have grown accustomed to thinking solely in terms of the health needs of the individual rather than addressing ourselves to the community as a whole. While concentrating on the symptoms, we have failed to take into account the environment and other social factors. Poor sanitation, polluted water supply, the superstitious beliefs and taboos of the community are also related to sickness and disease.

Further, the miraculous pool in its ineffectiveness is a symbol of our own ineffective health care system despite the highly qualified doctors and nurses, well equipped private and public hospitals, medical research centres and multinational drug industry.

The poor man in the gospel story lived very close to the pool, yet he was helpless because of his poverty. In like manner the poor in our midst remain helpless in the shadow of an expensive, curative health care system that is geared exclusively to the service of the rich.

Source: The Bible: Aspirin or Dynamite
by Cedric Rebello s.j.

DR - 3317

THIS MONTH'S CIRCULATION OVER 7500

FMRAI news

Organ of Federation of Medical Representatives' Associations of India

July 1982 — For internal circulation only

Further Victory of Addco Workers

After six months continuous struggle, workers of Addco Ltd., Calcutta, once again have come out victorious by defeating the designs of the management.

Last year, Addco workers had to resort to indefinite strike for long seven months and ultimately compelled the management to enter into a settlement. At that time it was mutually agreed that complete charter of demands would be settled this year. To avoid a fresh settlement, the management imposed illegal lock-out in the factory. The employees in depots and sales offices resorted to indefinite strike, in protest. FMRAI extended all support.

A settlement was signed on 15 July last, lifting the six months' old lock-out and calling off the strike by the workers in depot and sales offices. An agreement has been signed on financial benefits also for the workers in the factory, field and for casual workers. One dismissed employee was also reinstated. On behalf of Addco Ltd. Employees' Unions, apart from other office bearers of the Union, Com. Prabir Sengupta, the Minister of State for Labour of West Bengal Government, signed the settlement as the President of the Union.

Biological E. Workers Preparing for Struggle

Biological Evans Staff & Workers Union and FMRAI are preparing for launching movement jointly. In this regard a meeting will be held at Hyderabad shortly.

Biological Evans Staff & Workers Unions has been reorganised recently under the banner of CITU. In a large attended gate meeting at the Company's Hyderabad factory, N. Bhaskara Rao, the President of the Union, declared to launch struggle in case the management refuses to settle all demands of the workers amicably. The issue of victimisation of large number of factory workmen is pending for long. Workers' legitimate claims for wage revision, the problems of contract workers and the issues of medical representatives are also to be settled. N. Sreeramamurthy, Vice-President of FMRAI, also addressed the meeting.

The Company concentrated their attacks on the field. Field workers were transferred arbitrarily, work was suspended, charge-sheets and warning letters were issued. The Company refused to pay revised financial benefits to the field workers, who are the active functionaries of FMRAI, and refused to grant leave to the council conveners preventing them from attending all-India meetings.

In the meantime, it is reported that T. V. Srinivasan has settled the issue of his termination of services with financial compensation.

The affiliated units of FMRAI and its local units from different parts of the country sent demand letters. Andhra Pradesh Medical and Sales Representatives Association has launched postering campaign. A massive demonstration was held in front of Company's conference at Kanpur and deputation met at Lucknow. A mass deputation of Maharashtra Sales and Medical Representatives Association met the Divisional Manager of the Company at Amravati and lodged protest. FMRAI already alerted its units throughout the country to prepare for intensive struggle.

In this context a joint meeting between the Union and FMRAI at Hyderabad is significant.

Neo-Pharma Refuses Amicable Settlement

In May last, FMRAI demanded of Neo-Pharma management to lift lock-out of its Bombay factory and reinstate all dismissed medical representatives. Management agreed for preliminary discussion with the General Secretary of AICAPEF. Accordingly, preliminary discussion was held at Calcutta on July 13 last. Three representatives of NPGCE Union also accompanied the General Secretary. From the beginning, it was clear that the management was not interested for a negotiated settlement. None from the head office management came to participate in the discussion. They deputed a petty officer, the divisional manager at Calcutta, to meet him. This officer of the Company also came one hour late. In this meeting, the management informed that the lock-out was lifted on 12 July and they were prepared to reinstate the medical representatives on the basis of their individual undertaking. The question of undertaking by individual field worker did not arise and therefore was rejected.

The General Secretary of AICAPEF proposed lifting of lock-out, reinstatement of victimised medical representatives; the opinions in respect of production and marketing of various products can be recorded by the Union and the management in the agreement; opinion may be sought jointly from the drug control authorities as far as the promotion of alleged misbranded drugs are concerned. The management raised the issue of refusal by the medical representatives to carry out Company's order. It was told to them that all lawful and reasonable orders of the management will be carried out by the medical representatives. However, it is

Continued on Page 2

Editorial

HOW EFFECTIVE IS THE DRUG LAW

Drugs and Cosmetics (Amendment) Bill, 1982 may come up for discussions in the current session of the Parliament. In the statement of objects and reasons, placed in the Parliament on 30 April, the Health Minister Sri. B Shankaranand admitted that "The problems of adulteration of drugs and also of production of spurious and sub-standard drugs are posing serious threat to the health of the community". But, a closer scrutiny of the proposed amendments do not show that the Government is determined to weed out this menace in the society. Further, it hardly makes any difference in the situation by mere amendments of law unless there is an effective administrative instrument guided by determination and political will to correct it.

The amendments suggest that any person found manufacturing adulterated and spurious drugs, *which when used is likely to cause death or likely to cause such harm as would amount grievous hurt within the meaning of section 320 of the I.P.C.*, is punishable with imprisonment for minimum 5 years and a fine of Rs 10,000/. It is interesting to note that simply for producing adulterated or spurious drugs will not make the manufacturer liable for such punishment unless otherwise it is proved that it actually caused or was going to cause death or it caused or was likely to cause grievous hurt. In such cases charges may be framed under existing criminal laws for more stringent punishment than what has been proposed in the amendment.

The existing situation in respect of prosecutions for manufacturing spurious drugs can best be revealed from a study reported in a paper in the seminar on drug industry held in New Delhi in November 1981. It reported prosecution proceedings under Drug Act from Madras as follows :

Year	No. of prosecution launched	Results
1978-79	One	One convicted to pay a fine of Rs. 1,500/- with simple imprisonment till rising of the courts
1979-80	Four	Only one was convicted with a lesser punishment
1980-81	One	Acquitted.

In respect of sub-standard drugs the reluctance of the Government to punish the culprits is appalling. Recently, the Deputy Minister for Health and Family Welfare, Miss Kumud Joshi informed the Parliament that on an average 17.5 per cent of the drugs manufactured and sold in the country during last three years were found to be sub-standard. On further study it will reveal that major quantity of those drugs were produced by multinationals and so-called reputed drug firms. At this rate around Rs. 600 crores of sub-standard drugs were sold during last 3 years without the knowledge of the prescribing doctors and their ailing patients. The proposed amendments in the Drug Act does not suggest any effective step to prevent this trend.

Even within the present frame-work of the Act, the manufacturer of a sub-standard drug can be prosecuted and punished

Continued on Page 2

Editorial

Continued from Page 1

upto 3 years of imprisonment or fine or both. But. not a single drug manufacturer was prosecuted or punished on these charges.

Apart from producing spurious, adulterated and sub-standard drugs, the manufacturers are happily producing drugs without valid licences which is punishable under law with 1 to 10 years of imprisonment (which is now being amended from 1 years to 3 years of imprisonment). In a written statement in Rajya Sabha on 19 July 1982, the Union Minister of State for Petroleum, Chemicals and Fertilizers, Mr. Dalbir Singh, admitted that Pfizer Ltd., the U. S. multinational, is producing 31 drugs like Becosule capsules, Multi-Vitaplex Forte capsules, Terramycin capsules etc. without any valid licence and authorisation. Glaxo Laboratories, the British multinational, is producing 26 drugs followed by Warner Hindustan, the U. S. multinational, producing 23 drugs without valid licences. The Minister further admitted that such instances had been noticed in the case of a number of other drug companies also. However, Government failed to take any effective step against these companies.

Drug peddling is not permitted under law. But, it is a common practice of the industry. Motor vehicles are often found loaded with ready stock of drugs of a particular company and moving from place to place, particularly in the villages, peddling drugs from shop to shop.

Drugs and Magic Remedies (Objectionable Advertisements) Act provided punishment, as cognizable offence, for any person resorting to advertisement directly or indirectly giving false impression regarding the true character of the drug, false claims or misleading documentation. But, it has become a common practice of the drug manufacturers to resort to exactly such objectionable advertisements. A detailed memorandum, enlisting such malpractices of the drug manufacturers, was submitted by FMRAI to the then Petro-Chemical Minister and the Health Minister in 1978. A thorough enquiry was demanded on these issues. But, the Government does not show any will to combat such situation. As per this Act oral advertisement with the help of a folder is not permissible. It is statutory obligation on the part of the drug manufacturers to place the facts in respect of a drug in printed literatures to be handed over to medical practitioners. This legal obligation is being grossly violated by most of the drug firms now, beginning in 1973 with Glaxo Laboratories. The Government refused to take notice of such developments.

Spurious and adulterated drugs are produced, huge quantity of sub-standard drugs are sold, drugs are produced without valid licence, drug peddling and objectionable advertisements have become common practice in the industry to-day. The situation is worsening day by day. Mere amendments of few clauses of some laws are not going to remedy the situation. Only powerful democratic movement involving the broadest sections of the people can alter it and bring changes for the interests of the suffering humanity for whom the drugs are supposed to be produced.

Neo-Pharma Refuses Amicable Settlement

Continued from Page 1

obligatory on the part of the management to clarify legal positions. The management requested withdrawal of all agitations during negotiations. The General Secretary replied that all industrial actions under the provisions of I. D. Act, like strike, can be called off. It may be noted that few medical representatives are on strike demanding reinstatement of their colleagues.

Though management promised to inform AICAPEF General Secretary about their opinion in respect of his proposals within 22 July, they failed to do so indicating that they are not interested for amicable settlement.

FMRAI called emergent zonal meeting of eastern zone for effective mobilisation to carry forward the struggle and will take further decision in the Working Committee meeting at Madras being held by end of July. Presidents and Secretaries of all affilated units have been invited.

FULFORD MANAGEMENT DECEIVES FIELD WORKERS

In West Bengal the field workers of Fulford (I) Ltd. (Earlier known as U.S. Schering) organised in councils and are fighting for their justified demands under the banner of WBCRU. Being alarmed, the management evolved a novel plan to cheat the medical representatives of the Company. They issued a fake circular through one N.N. Naidu asking the representatives to join a non-existent union by sending Rs. 5/-each.

Field workers, placed in distant places in the country and being eager to join their comrades for the purpose of job security and improvement in service and working conditions, often become victims of such mischievous elements. Some individuals, groups and vested interests extracted huge amounts from the field workers in the name of union and thereafter disappeared. Management also started sponsoring such fake and non-existent organisation to isolate the Company's medical representatives from the mainstream of the movement.

FMRAI coutions all field workers to remain vigilant against these mischievous elements and not to join "any union or organisation" without consulting FMRAI and its units.

TERMINATION WITH RETROSPECTIVE EFFECT

Chelsea, a small drug company of Pombay, terminated the services of a medical representative by a letter dated 17 May with retrospective effect of 31 March 1982.

NO EXPLANATION

"No explanation whatsoever you give will be accepted. Let me tell you clearly that if the sales picture is not changed within December, 1981 we will all find ourselves in difficulty."

—Quotation from a circular of the General Manager of Raptakos Brett to the Medical Representatives.

AN APPEAL

A cyclonic-storm alongwith incessant rain on 3 June 1982 caused severe damage to three coastal districts of Orissa i.e. Cuttack, Balasore and Puri. The casualities to human life has exceeded two hundred and thousands of people have been rendered homeless. There has been wide-spread damage to vast areas of agricultural land because of the inflow of tidal water. Many villages still remain water-logged.

Our Union has given a call to its members to donate towards relief fund. Rs. 1200/- has already been given from our Union's fund towards relief operations carried on by the member unions of the Cuttack City Co-ordination Committee of Unions and Associations. A team from the above organisation including two of our members and a team of doctors went with relief materials and medicines, mainly collected by our members, to some of the affected areas on 24 June. The extent of damage is such that relief work is likely to continue for months.

Under such circumstances, we appeal to all affiliated units of FMRAI to donate to the relief fund. The contribution may be sent to the General Secretary of our Union.

General Secretary
Orissa Sales Representatives Union
Kesarpur. Cuttack-753001

FMRAI PUBLICATIONS

	No. of copies available on 1-7-82	Price
1 FMRAI 12th G.C. Meeting Documents	98	Rs. 6.00 per copy
2 Closure in drug industry (a note published during New Delhi Drug Convention)	346	Re. 0.50 per copy
3 Constitutions of FMRAI	145	Re. 0.50 per copy
4 27-Point C.O.D.	38	Re. 0.50 per copy
5 Multinationals in Drugs & Pharmaceutical Industry (AICAPEF Publication)	28	Rs. 3.00 per copy
6 Legal Notes No. 1 (High Court Division Bench judgement in Andhra Pradesh holding that under Shops & Establishments Act in Andhra Pradesh, Appellate authority has the jurisdiction to adjudicate Medical and Sales Representatives issues)	16	Re. 0.50 per copy
7 Legal Notes No. 2 (Meher Tribunal Award in Maharashtra holding that Medical and Sales Representatives are "Workmen" under I. D. Act)	813	Re. 0.50 per copy
8 Legal Notes No. 3 (Kerala Tribunal Judgement holding that the Medical Representatives are "Workmen" under I.D. Act and Residences of Area Managers are establishments of the Company)	929	Re. 0.50 per copy
9 Legal Notes No. 4 (Judgement of Labour Court at Patna holding that under SPE Act, Labour Court jurisdiction is the place where the employee works. Scooter Allowances, Daily Allowances, Incentive amounts are not part of wages)	928	Re. 0.50 per copy

Send requisition to FMRAI Publication, 1E, Rajendranagar, Patna-800016 with advance payments including postage.

ORGANISATION ADVANCES

ANNUAL GENERAL BODY MEETING OF Maharastra Sales & Medical Representatives Association was held at Nagpur on 11 July last. Large number of delegates and observers from Ahmed nagar, Bombay, Kolhapur, Aurangabad, Pune, Nanded, Solapur and Vidarbha units participated in the meeting. Members from Akola and Amravati also came to attend this meeting. The General Secretary's report recorded rich and varied experiences from both national and international events. The report noted the existing situation in drug industry after 34 years of independence particularly production of non-essential drugs and cut in production of essential drugs, high profitability, multinational strangle-hold, promoting banned drugs and corrupt practices in sales promotion, sale of irrational drug formulation, spurious and substandard drugs etc. The report noted the rising voice of the workers of the industry including the medical and sales representatives against such a situation.

The report recorded significant development in respect of 19 January Strike and successful participation of Bombay unit and the members of other places in the strike. The report highlighted the demands of the N.C.C., 27 point C.O.D. of FMRAI and participation of members in pursuance of these demands.

The report was adopted unanimously with all round support of the members and resolved to make MSMRA a stronger force. The office bearers of the Association was elected unanimously with K.K. Chaturvedi as President and R. S. Rane as General Secretary.

ANNUAL GENERAL BODY MEETING OF MSMRA, **Bombay Unit** was held on 13 June with record attendance of members. The President in his address pointed out the deepening socio-economic crisis and the necessity for the working class to unite and struggle. The General Secretary of Warner Hindusthan Employees Union, Secretary of AICAPEF (Maharastra Branch), Secretary of FMRAI and the President of IMA (Bombay Branch) addressed the members. A condolence resolution was adopted on the demise of Com. Suresh Ganguly. By another resolution the meeting supported NPGCE Union in their struggle. The meeting elected R. S. Rane as the President and Subhas Para as the General Secretary.

UTTAR PRADESH MEDICAL AND SALES REPRESENTATIVES ASSOCIATION organised two days' workshop for the trade union functionaries at Gorakhpur on 2 and 3 July. Twentyfive cadres participated in the workshop. Members discussed the historical development of trade union movement in the international and national level, the contribution of the working class in the national independence movement and subsequently in the post independent period and the tasks before the working class. Members also discussed about the necessity to carry forward the struggle objectively taking into consideration the subjective realities. Discussion took place on the perspective of the movement, secterianism and the tendency of class collaboration, democratic and collective functioning. While discussing immediate tasks, emphasis was given to develop programmatic unity on the basis of declared policies. Discussion took place on the nature and forms of movement, labour laws etc.

The workshop noted that it is only a begining of self education of the cadres for converting the hetrogenous mass organisation into a well-trained cadre based organisation, unified with clear understanding of declared policies and programmes of the organisation.

The Workshop created much enthusiasm amongst the participants.

At the close of the workshop a largely attended general meeting was held, which was addressed by the general secretary of FMRAI.

UPMSRA, AGRA UNIT ORGANISED a Special Session of the General Body on 9 July last. The meeting was attended by the General Secretary and Zonal Secretary of Zone-II of FMRAI and General Secretary of UPMSRA.

ALL INDIA MEETING OF CONVENORS OF SARABHAI field workers councils was held at Patna on 6 July. Serious discussions took place and decisions were taken to organise councils in unorganised areas. Efforts will be made to organise councils in the Sarabhai group of companies.

The conference of All India Federation of Sarabhai Group Employees was also held at Patna from 5 to 7 July. Large number of units from different parts of the country participated in the Conference. The meeting elected George Verghese, Secretary of FMRAI, as the President of the Federation and re-elected S.R. Banerjee of Kanpur office as General Secretary. The meeting decided to publish a periodical journal "Sarabhai Worker".

On 6th. evening a joint meeting with FMRAI office bearers took place. It was decided to launch joint movement in pursuance of the demands of field and office workers. The field and office workers of Sarabhai will submit memoranda separately in the respective divisional office. The field workers of Sarabhai are demanding recognition of All India Grievance Committee, statutory bonus and reinstatement of George Verghese and supporting the demands of the office workers. The office workers are demanding change in distribution policy, settlement of their charter of demands and also supporting field workers demands.

Jointly demonstrations will be held in front of all Sarabhai offices in August and massive Dharna will be staged on 6 & 7 September.

AS ER DECISION OF THE ALL INDIA MEETING of Convenors, Vice-President and General Secretary of East India Pharmaceutical Works Employees Union visited Lucknow and Patna. They attended and reorganised EIPW field workers council which was attended by UPMSRA leaders. Successful council meeting was also held in West Bengal. The Annual General Body Meeting of the Union will be held at Calcutta on 15 August and the all India Convenors meeting will be held on 16 August.

ALL INDIA CONVENORS MEETING OF BOEHRINGER KNOLL field workers councils will be held at Jabalpur on 13 August.

WORKING COMMITTEE MEETING OF FMRAI is being held at Madras on 29 and 30 July. Presidents and General Secretaries of all affiliated units have been invited to attend.

SOUTH ZONE ORGANISATIONAL CONVENTION OF FMRAI will be held at Ethiraja Kalyanmandapam, Madras on 7 & 8 August in a massive scale. Zonal meeting of the field workers of 46 companies have also been called simultaneously on 7 August at 3.00 P. M. at the same place. A Convention will be held on 8 August afternoon.

BIDDLE SAWYER Management had in the month of April this year transferred Com. Ramanujam from Madras City to Gwalior, Com. Daya Prasad from

Continued on Page 4

Abbott Signed Agreement With Union for Field Staff

Consequent to reinstatement of R. G. Michel, General Secretary of Abbott Laboratories Employees Union, a settlement was signed between the management and the Union in respect of five medical representatives. M. A. Faki and R. Behl of Bombay, S. K. Roy and M. K. Roy of Bihar and V. Ramachandran of Tamilnadu refused to fall in line under pressure of the management and refused to sign any agreement imposed by the management through Abbott management's representatives council.

Clause 5 of the agreement, signed by the Managing Director and Director Personnel on behalf of the Company and the President and General Secretary of the Union on behalf of the five medical representatives, states that the five medical representatives will get the revised service conditions as applicable to other medical representatives of the Company with retrospective effect. The terms of the settlement means that these five medical representatives will enjoy the financial and other conditions of service as applicable to other representatives, without any discrimination, but their bargaining forum shall be Abbott Laboratories Employees Union as the union representated the five medical representatives and the management accepted this position through this agreement.

3 July Protest Day

Successfull programme of NCC

After 19 January successful strike, the workers of the country responded in a massive way to the call of National Campaign Committee to observe Protest Day on 8 July, the opening day of the Parliament, to lodge the protest of the working class against the anti-labour provisions in the proposed amendments in Industrial Dispute Act, Payment of Wages Act, Indian Trade Union Act and the Bill for hospital and educational institution employees. A massive demonstration was staged in front of the Parliament and gate meeting, street demonstrations and mass meetings were held throughout the country. In many places, workers wore black badges. Thousands of leaflets were distributed and massive postering was done exposing the anti-labour policies of the Central Government.

FMRAI units are already the constituents of the state and district campaign committee, Large number of field workers participated in this campaign in various parts of the country.

NEWS IN BRIEF

Demonstration Against Themis

On 12 and 13 July Themis management called a sales meeting of field workers at Patna. On 13 July a militant protest demonstration was staged by BSSR Union members. A memorandum was submitted. Earlier, protest demonstration was staged in front of distributors' office of the Company on 28 June. Themis field workers protested against increasing clerical work; they formed a council, endorsed FMRAI C.O.D. and decided to contribute to the struggle fund of Themis workers in Bombay.

Madhya Pradesh Medical Representatives' Association printed struggle coupons and contributed to the struggle fund of Themis workers at Bombay. AICAPEF, Maharastra Branch started collecting fund in support of Themis workers. Emergent council meeting was held in U.P.

Government Refuses Licence to Themis

On representation by AICAPEF, Central Government assured that no licence will be granted to Themis. The application of Themis to shift their factory from Bombay to other part of Maharastra was rejected. The Labour commissioner of Maharashtra, consequent to the failure of his effort for an amicable settlement for opening the factory, sent his report to the ministry for take over of the management of Themis by the central govt. under Industrial Development Regulation Act. The Government of Maharastra has not sent any report to the Central Government, a high official of the central Govt. informed.

Change in Leadership of B.I. Workers Union

In an election on 30 June, the discredited leadership of *Bengal Immunity Workers Union* was defeated by an overwhelming majority. Saroj Bhattacharya and Debabrata Basu have been elected as President and General Secretary of the Union respectively.

The past leadership of the Union opposed FMRAI, opposed 19 January strike and collaborated with the management openly. FMRAI is determined to carry forward struggle shoulder to shoulder with the Union for common interests of the workers.

Negotiation in Rallis

Negotiation on charter of demands of the field workers of Rallis has started on 9 July between the management and Rallis Group of Employees Union. The next round of discussion will take place in August. FMRAI extended full support to the Union in this respect.

Reinstatement in Services

Management of T. T. K. terminated the services of a probationer field workers in West Bengal. WBCRU staged a demonstration in front of the place of Company's conference at Calcutta. Consequently management reinstated and confirmed him in services.

Late Realisation by Eastern Drug

It became a common practice of the management of Eastern Drug, Calcutta to recruit medical representatives and thereafter terminate their services after few months. The field workers of the Company in Bihar organised a council to conduct their legitimate trade union activities. Management called them in Calcutta, ostracised them, terminated their services and compelled some to 'resign from council.' This infuriated the members of BSSR Union and they decided to wipe out the Company's business in Bihar. OSRU and WBCRU also extended support. Within few months the management realised this situation and met BSSR Union leaders several times. The agreement was arrived at through discussions in the BSSR Union office. The management gave assurance to the Union not to interfere in the union activities of the members, reinstated the victimised employees and settled other disputes. Union assured the management that in conducting their normal business activities they will get cooperation of the Union in accordance with its declared policies.

Grievance Committee Meeting in Bengal Chemical

Subsequent to all-India Grievance Committee meeting, State-wise Grievance Committee meeting has started taking place in Bengal Chemical. One of such local Grievance Committee meetings was held at Patna on 5 July which was attended by the head office and local management, All India, Zonal and State Conveners, Joint Secretary of BSSR Union and the Secretary of the local BCPL Union. The discussion took place objectively. Such local Grievance Committee meetings took place in West Bengal earlier and is scheduled to take place at Jaipur and Cuttack. If all public sector undertaking managements in drug industry take such a positive stand, the situation is bound to improve in public sector.

Settlement of Pfizer Workers

After protracted negotiation and struggle with historic 111 days indefinite strike, the Pfizer workers entered into an agreement with the management on 20 June last. Effective from 1-1-1982 the rate of variable dearness allowance has been raised to 5% from 2½%. This is a major gain for the workmen in the Company. A final settlement is being discussed and will be signed shortly.

Negotiation in F. D. C.

The second round of negotiations on the charter of demands of the F. D. C. field workers is taking place at Trivandrum on 23 and 24 July. The Grievance Committee meeting will also take place simultaneously.

COD of FDC Fieldworkers Settled

We have received telegraphic message from All India Convener of F. D. C. that their C. O. D. and grievances have been settled. Details are awaited.

Support to Steel And Coal Workers

National Campaign Committee decided to hold industry-wise conventions of core industries in public sector and thereafter a general convention of the public sector undertakings. Accordingly, a convention was held in Bhopal for BHEL. The steel workers met at Bokaro in a Convention on 17 and 18 July. The assembly is the biggest in the history of the united movement of the steel workers. The unions, affiliated to the Central Trade Unions in the National Campaign Committee, participated in this convention. FMRAI unit in Bihar extended all support for the success of this convention. Similarly, big prepration is going on at Dhanbad for the convention of coal workers. BSSR Union is in the reception committee and is contributing its might for the success of this convention.

Historic Strike of University Teachers

Social forces are throwing all sections of democratic people into militant struggles. The recently concluded prolonged historic strike of the University Teachers in Bihar proves the point. On 79th. Day of their strike on 29 June last 10,000 University Teachers staged demonstration in front of the Assembly. They walked in scorching sun and in heavy rain. The teachers were on indefinite strike from 12 April and started courting arrests from April 22. Never before the teachers got such sympathetic support from all sections of the people. The teachers of Bihar are joining the main stream of the democratic movement which is bound to spread in other parts of the country.

TOP 19 MONOPOLY HOUSES

1. Tata, 2. Birla, 3. Mafatlal, 4. J. K. Singhania, 5. Thapar, 6. ICI, 7. Sarabhai 8. ACC, 9. Bangur, 10. Shri Ram, 11. Kirloskar, 12. Hindustan Liver, 13. Larsen Toubro, 14. Scindia, 15. Modi, 16. TVS Iyenger, 17. Mahindra & Mahindra, 18. Chowgule, 19. Bajaj.

13TH. GENERAL COUNCIL MEETING OF FMRAI

AT

BARABATI STADIUM

CUTTACK

ON 8 & 9 OCTOBER 1982

ORGANISATION ADVANCES

Continued from Page 3

Madras City to Jabalpur & Com. Aswani Kapur from Delhi City to Nasik. Agitational programmes were taken by TNMSRA & DSMRA. A massive demonstration was held on 14th June at Delhi where the Company's conference was scheduled to be held, the Company hurriedly shifted the venue of the conference to Ludhiana. There also a mass deputation met the management and the Biddle Sawyer field workers boycotted lunch and tea in protest. Later in the joint conference of U. P. & Bihar field workers of the Company held at Lucknow a memorandum was submitted by UPMSRA in a mass deputation and the field workers of Bihar and U. P. boycotted lunch in protest. Prior to this FMRAI had held discussions with the management but the management retreated from the agreed formula. Management retreated even from the commitment of the Grievance Committee which was accepted on principle by them earlier.

It was unfortunate that when TNMSRA had taken up the issue and when the negotiations were in progress both the representatives of Tamil Nadu negotiated on their own with the management. This encouraged the management to retreat. However, FMRAI. W. C. will be discussing the issue and take up future programmes.

Published by the General Secretary of the Federation of Medical Representa tive's Associations of India from 1-E, Rajendranagar, Patna-16 and Printed by Roy Printing Works, Langartoli, Patna-4

Dr. Sathi,

DR-33-18

PANEL ON PRUDENT ANTIBIOTIC USAGE

IMA - 1990

I. ANTIBIOTIC - RESISTANCE

Microbiology

- Briefly describe How a microbe acquires resistance to antibiotics?

✓ Pharmacology

- How could we limit the emergence of resistance? - Rotation.

Pediatrics & Medicine

- What are the problem areas in current practice due to resistance microbes?

✓ Pharmacology

- How does clavulanic acid improve the efficacy of ampicillin and amoxycillin (Augmentin)?

Medicine

- Can we use this combination in place of Ampicillin/Amoxycillin on a universal basis?

Microbiology

- How has staphylococcus responded to our efforts at beta lactamase resistant penicillins?

✓ Pharmacology

- What is the significance of MRSA (methicillin resistant staph aureus) in planning therapy?

Medicine

- Compare and contrast Ampicillin/Amoxycillin in a practical sense.
- Can Augmentin be used in MRSA infections?

✓ Pharmacology

- Relative place of Aminoglycosides Gentamicin, Netilmicins and Amikacin.

3PT

JIPMER had organised this as part of their Rational Drug Therapy Sessions for GP's & PGs

RN

Drug files 2/ 3

Medicine

- Current place of NALIDIXIC ACID in therapy.

Pharmacology

- Disadvantages of quinolone drugs.
- Weakness of III gen. cephalosporins.

Medicine

- How would you rate newer quinolone and III gen. cephalosporins in clinical practice?

Microbiology

- What are the trends in microbial resistance to aminoglycoside, quinolone and cephalosporines in the west and in India?

II. ANTIBIOTICS IN PRACTICE

1. Upper Respiratory Infection

   With our limited LAB facilities, how can we prescribe antibiotics rationally in URI - (Drug, Dosage, Duration)

   - in children - Pediatrics
   - in adults - Medicine

2. How & when will you use antibiotics in LRI

   - in children - Pediatrics
   - in adults - Medicine

3. Acute UTI

   - in females of reproductive age - group
     - Obstetrics & Gynecology
   - in males - Medicine

4. Prudent management of chronic or persistent UTI
   - Medicine

5. Surgical lesions causing UTI
   - Surgery
   (What to look for & whom to screen)

6. Skin infections

   - Impetigo - Pediatrics
   - Recurrent furunculosis - Medicine
   - Cellulitis & Carbuncle - Surgery
   - Animal & Human bite - Medicine
   - Traumatic wound - Surgery

7. Surgical lesions

a) Necrotising fasciitis - Surgery
b) Diabetic foot infection - Surgery
c) Compound fracture - Surgery
d) Osteomyelitis/Septic arthritis - Surgery & Pediatrics

8. GIT

a) Does antibiotics reduce severity of diarrhea?
   - Pharmacology ~~Pharmacology~~ Paed

b) Indications of antibiotics in diarrhea
   - Medicine Paed

c) Antibiotic associated diarrhea

   - Aetiology - Microbiology
   - Therapy - Medicine

d) Resistant typhoid
   - Microbiology

   - adults - Medicine
   - children - Pharmacology

e) Is campylobacter species important in South India?
   - Microbiology

f) How will you diagnose it?
   - Microbiology

g) How will you treat it?
   - Medicine

9. Meningitis

Organism not known or identifiable - How will you manage?

   - children - Pediatrics
   - adults - Medicine

10. Antibiotic Prophylaxis

   - Surgical - Surgery and Obstetrics & Gynecology
   - Infective Endocarditis - Medicine

DR-33-19

For further information contact:-
Voluntary Health Association of India
C-14, Community Centre, Saket,
New Delhi-110016.

OUR CONCERN ABOUT DRUGS

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

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

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

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

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

*DRUGS:

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

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

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* OXFAM PUBLIC AFFAIRS UNIT (21.4.'80)

.....2/

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

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

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

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

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

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

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

...../3/

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

Regarding Drug related Legislation at national level:

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

Regarding Production of Generic name drugs:

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

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

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

Regarding Management of Pharmacies:

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

.....2/

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

- Availability of information on all drugs dispensed with.

Regarding Dispensing of drugs:

- Limiting range of drugs in the pharmacy to essential drugs

- Use of formulary

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

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

Regarding Education and Training of Health Personnel:

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

- local preparations of commonly used ointments, syrups etc.

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

Regarding Health Education of Patients :

- Emphasis on the concept of self responsibility regarding health

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

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

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

- Sharing information with the people about therapies used by them

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

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

.....3/

Other Activities to decrease health care costs:

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

This background paper is for discussion.

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

Appendix 1

Distribution of Essential drugs in Developing Countries

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

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

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

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

The Primary purposes of the Pharmacy and Therapeutics Committee

a. Advisory

b. Educational

Functions and Scope

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

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

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

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

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

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

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

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

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

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

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

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

L. To review reported adverse reactions to drugs administered.

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

LIST OF RELEVANT READING MATERIAL DEALING WITH DRUG PROBLEM

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

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

DP-33.20

Group Discussion on Prescribing Policy - Groups B1 & D1

Questions to be pondered about !

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

   Can this be common for all Voluntary Hospitals?

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

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

   Will doctors also prescribe from this list?

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

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

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

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

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

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

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

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

   a) unnecessary expenditure b) essential?

   What are our reasons for our attitudes?

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

9. Is the production of medicines in the Pharmacy :

   a) too time consuming

   b) too costly in terms of personnel or equipment

   c) uneconomic?

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

Voluntary Health Association of India

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

Telegrams : VOLHEALTH
New Delhi-110016
Phone : 652007, 652008

The Great Health Robbery

Dear Friend,

The theme of the discussions at the eighth General Body Meeting of VHAI held in Ahmedabad in April 1982 was "The Great Health Robbery".

The participants identified five groups of people who were deprived of their right to good health viz., children, women, people who need medicines and workers. They made some positive suggestions for action to be taken at the individual, the State and the National levels.

VHAI will be grateful for your attention to these valuable suggestions. Your collaboration in drawing up an action plan is indispensable.

AT THE INDIVIDUAL LEVEL

Children

Children are sensitive and perceptive; therefore, we must practise what we preach.

Women

a. Through introspection and meditation, women must become aware of the full potential of their own strength and spiritual power.
b. Women must go in for vocational skills and education and try to be economically self reliant.

People who need medicine

a. As an individual to respond sensitively to the need of another for medicine in as many ways as our personal resources make it possible.
b. The organisation of an area-wise information service to keep upto date information on location or availability of scarce life-saving medicines.

Workers

a. Workers should be recognised as individuals capable of making decisions for themselves.
b. Protect workers in our individual institutions against occupational hazards.
c. Provide them with the facility to redress grievances.

AT THE STATE LEVEL

Children

a. Adopt, adapt and carry out NANI plans vigorously.
b. Increase programmes for mother education in nutrition.
c. Projects to increase family incomes, so they could have more energy rich foods.
d. Education of doctors about the needs of children with protein calorie malnutrition.
e. Promote education on the value of jaggery, against refined sugar, as better food.

(P.T.O.)

Women

a. Organisations must provide self-employment schemes for women; greater economic freedom will bring women greater social freedom.
b. Compulsory Primary Female Education, its strict implementation is important to raise the status of women.
c. Since enhancing women's income improves her health, even part time employment can begin the process of helping her become more free. Society must make this possible.
d. Concerted drives and campaigns by voluntary organisations against social evils like dowry, obscene advertising and films denigrating the image of women, job and wage discriminations etc must be encouraged.
e. The establishment of co-operatives or trade unions of working women would help.

People who need medicine

a. To help purchase bulk medicines at regional and State levels; where possibile from the government for the national eradication programmes.
b. To provide ways and means to deal with the problems of spurious drugs by

   i. developing laboratory facilities where needed
   ii. improving the existing facilities
   iii. involving voluntary groups in the detection of spurious and adulterated food and drugs.

c. Promote appropriate health and use of drugs through seminars, literature, etc.
d. Demand code of conduct of marketing, for the pharmaceutical industry.
e. Demand more facilities for research and practise of indigenous systems.
f. Build up public opinion for shifting the licencing and pricing of drugs from petroleum to Health Ministry.

Workers

a. To press for the implementation of the minimum wages legislation so that the worker is able to obtain the required volume of calorie prescribed by the ICMR Study.
b. Creation of workers recreational outlets to minimize recourse to alcoholism.
c. Press for the provision of adequately equipped cafetaria to provide variety and nutritious foods to workers on a co-operative basis.
d. Establish stringent measures to survey work establishments for study of conditions; to use this to prevent possible hazards to which workers are exposed.
e. To develop continuous adult education process to keep workers motivated; to make them aware of their rights and responsibilities.

AT THE NATIONAL LEVEL

Children

a. Explore cinema and television as an education media.

(P.T.O.)

b. Work upon strategies for controlling infections affecting children
c. Medical curriculum must caution against unnecessary prescription of drugs.

Women

a. To give publicity to laws, which protect women from occupational, social, economic and sexual exploitation.
b. To co-ordinate information on cases of injustice and seek redress from authorities at different levels.

People who need medicines

a. Press for the use of generic names of drugs, wherever possible and include them with the brand names.
b. To use the media for expression of public opinion for a shift in the licensing and pricing of drugs cfrom the Petroleum to the Health Ministry.

Workers

a. To give publicity to the laws, which protect workers from occupational hazards and economic exploitation.
b. To co-ordinate information on cases of injustice and present them to the respective authorities at different levels.

vhai's role in drug issue

Almost all training programmes, publications and other work of the Voluntary Health Association of India, over the last decade have stressed the need for appropriate and low-cost health care. In some VHAI workshops, at present, alternative forms of drug therapy and even non-drug therapies are discussed and practised.

The voluntary sector has a beautiful example of how low-cost, good quality formulations are possible in the Bangarpet Tablet Industry. Some voluntary hospitals and institutions even have some form of tablet formulation and/or solution production units.

VHAI is currently negotiating an arrangement with a tablet manufacturer in Ahmednagar, Maharashtra. The objective is to make low cost, essential, drug formulations available to the voluntary sector under generic names.

Meanwhile feedback obtained from health workers in the field (including a series of appropriate health care workshops conducted by the Tamil Nadu Voluntary Health Association) have helped in defining what needs to be done.

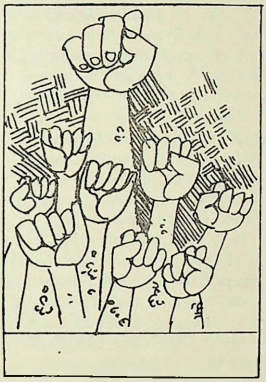
A brief outline of VHAI's role in drug-related issues follows. VHAI is already active in some of the areas identified below:

1

drug related legislation at national level

Forming a lobby against unethical practices of drug companies.

* building awareness regarding WHO endorsed code of conduct as against that drawn up by multinationals;
* seeking information and analysing national policies that may have detrimental implications, specially where drug market is concerned;
* linking up with medical units of various consumer societies, other groups and individuals working on similar lines: e.g. Medico Friends Circle, Centre for Science and Environment etc, to form pressure groups;
* use different seminars, workshops, medical and non-medical journals to disseminate relevant information.



* questioning drug advertisements that give incorrect information and make false claims.

2

production of generic name drugs

* collect information of experience regarding production from other voluntary groups and programmes: e.g. Savar in Bangladesh, Gautemala, Medicus Mundi Internationales etc.;
* encourage or collaborate in production of generic name drugs;
* conscientize people regarding quality control and demanding it (to prevent involuntarily having to turn to the sophisticated drug companies).
* identify non-allopathic drugs e.g. de Chanes, Homoeopathy, that are cheaper and more effective and inform others.

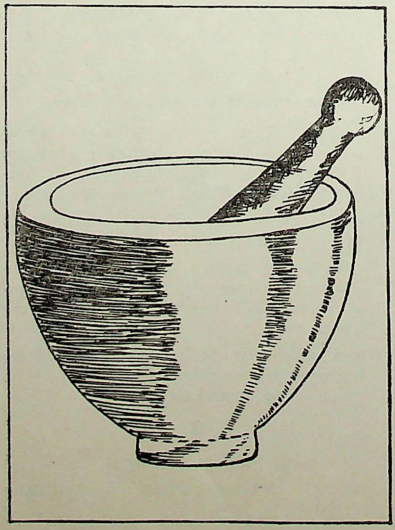
3

distribution of drugs

(which is the biggest problem for developing countries)

* encouraging bulk purchase at regional levels;
* helping to organize distribution channels;
* help collect background information based

Has Homoeopathy a treatment for all diseaeases? Yes, it has a treatment because it does not treat diseases but only sick persons. But the fact that the human organism is almost infinitely subtle and intricate and each person is a unique individual with no parallel, brings in limitations in the treatment. Even so, it is possible to treat all human ailments with the existing medicines and availability of more and more new medicines is sure to make the treatment easier. The most difficult diseases to cure are those that arise from indiscriminate use of non-Homoeopathic medicines. Surgical cases cannot be treated with Homoeopathic medicines alone. For example, the fracture of a limb or a strangulated hernia need immediate surgical intervention. Surgery is a separate branch of medicine, independent of any particular system. There is a general saying that children are easily cured by Homoeopathic medicines. This is a fact because the bodies of children have not been abused with drugs and stimulants and their minds are free from trauma.



There is an essential difference between Homoeopathic treatment and treating diseases with Homoeopathic medicines in the line of other systems of treatment. Homoeopathy aims at individualising and treating each patient as a person suffering under and from particular conditions. There is no specific medicine for a particular illness, there are only specifics for individuals. For example, ten cases of tuberculosis may require ten different medicines whereas ten different disease conditions may require the same medicine. The Homoeopathic approach to the study of diseases is from clinical standpoint. It regards clinical symptom as those that render themselves perceptible to our senses as a result of forces that are acting and reacting in and through the human organism in disease conditions.

popular in india

Most modern medicines create more problems than they solve, especially with the general tendency of doctors to overmedicate. But the medicines of Homoeopathy are comparatively harmless and they are cheap too. The low price of Homoeopathic medicines, their comparatively harmless nature and the lack of a uniform policy towards Homoeopathy throughout the country until recently, have given rise to innumerable quacks practising Homoeopathic medicine in India. This has lowered the opinion about Homoeopathy in the minds of many persons. The damage is now being slowly undone.

India is probably the country where Homoeopathy is most advanced and popular today, and the States of West Bengal and Kerala come first in this respect. There are nearly hundred institutions teaching Homoeopathy. They are recognised by various State Boards and Councils. Eight of them are government-run institutions. There is a Central Government Homoeopathic Advisory Committee. Under the Homoeopathic Central Council Act of 1974, a Central Council of Homoeopathy was set up on 8th August, 1974. It determines the minimum standards of Homoeopathic education throughout India and maintains a Central Register of Homoeopathic practitioners. In the West, after experiencing a period of decline, now there is an increasing interest in Homoeopathy.

* * *

on epidemiological studies and other field studies.

4

management of pharmacies

* encouraging formation of pharmacy committees in voluntary health care institutions.
* stocking with appropriate drugs, low cost, generic, avoiding combinations, trade names as far as possible;
* encouraging local preparations of liniments, ointments, syrups and mixtures (as done by compounders earlier);
* helping in appropriate pricing of treatment (registration, consultation and cost of drugs);
* availability of information on all drugs dispensed with.

5

dispensing of drugs

* limiting range of drugs in the pharmacy to essential drugs.
* use of formulary.
* encouraging use of Physicians' Desk Reference on extra-pharmacopia and not relying on the information given by drug advertisements and drug representatives.
* helping in standardization of diagnostic and prescription procedures (to avoid the inessential, and limiting procedures to the most appropriate).

6

education and training

* collection, analysis and dissemination of relevant information to health professionals and public regarding use of drugs and their substitutes, role of drug industry in health services, use of non-drug therapies: e.g. massage, acupressure, home remedies and other indigenous herbal medicines known to be cheaper and giving good therapeutic results.
* local preparations of commonly used ointments, syrups etc.
* planting of medicinal plants in hospital vicinity with specific therapeutic value.
* initiate new, short-term appropriate courses for unregistered dispensers of medicines.

7

health education of patients

* emphasis on the concept of self-responsibility in health.
* special coverage of methods of prevention of common diseases. e.g. those due to poor hygiene, sanitation and nutrition.
* information about various government health programmes:
  - —National TB Programme
  - —MCH & FP
  - —Blindness
  - —Immunization programmes etc.
* information regarding functions of PHC doctor, sanitary inspector, ANM etc., for people to know their rights.
* encouraging medically sound customs and cultural practices—e.g. use of *Datuns* instead of toothpaste and discouraging the harmful ones by giving appropriate information.
* giving information about the misuse of injections, tonics, steroids, bottle feeds and other drugs.

8

decrease health care costs

* training of different levels of health personnel to be able to handle common problems as effectively and at as low cost as possible.
* investigate role of health insurance schemes in different parts of India and their feasibility.
* preparation of recommended reading list of books and material related to low cost appropriate health care.
* formation of linkages with groups working on the same lines.

* * *

voluntary initiative...

The Gonoshasthaya Kendra (GK), the Bangladeshi voluntary organisation has been planning to produce and distribute generic drugs at half the price charged by the multinationals. Progress Report No 7 of GK outlines their programme:

"Society cannot let this situation (about drugs) 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 three 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 with a 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 Bangladeshis. Specialized top management have heen recruited within the country and sent abroad for refiesher courses. We have also attracted highly qualified Bangladeshis 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 indigenous herbal medicine research."

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

...and making tablets

In 1977, a study was made by VHAI of 25 items manufactured in the hospital pharmacy at Fr Muller's Hospital, Mangalore. One of the major conclusions that emerged from the study was it is profitable to manufacture drugs and related items in the pharmacy.

A VHAI study done later in 1979 also revealed the same. Using the simplest of machines and borrowed capital, the returns could be atleast a minimum of 20% on capital investment per annum. Savings to the hospital as compared to commercial products could be anything from 30% to 70% on an average. A total initial investof Rs 2 lacs would be sufficient for a tabletting unit. (Laboratory testing to be done elsewhere). In fact, the hospital tabletting unit act as a source of low cost medicines for other like-minded institutions in the sorrounding region. The savings and benefits would be higher.

However, obstacles (like in Fr Muller's) could be reluctance of medical staff to prescribe non-branded drugs.

CONSUMER ALERT - CONSUMER ACTION

- ravi narayan

the problem

THE INDIAN Council of Medical Research (ICMR) and the Indian Council of Social Sciences Research (ICSSR) have, in a joint study-group report entitled 'Health for All - an Alternative Strategy' warned that 'eternal vigilance is required to ensure that the health care system does not get medicalised, that the doctor-drug producer axis does not exploit the people and that the abundance of drugs does not become a vested interest in ill-health'. This warning is a serious indictment of the drug industry and the medical profession in the country. It confirms the growing evidence that drugs are being pushed on an unsuspecting public by devious methods which masquerade as 'sales promotion' of drug companies and 'professional prescribing practice' by doctors.

A SPATE of reports have been appearing in our newspapers and periodicals of late, on drug-related issues and a review of these highlight that many of the following practices are not at all uncommon in India:

i) Sale of drugs banned in other countries
eg: Lomotil and Clioquinol preparations.

ii) Sale of irrational combinations and formulations
eg: Hathi Committee has suggested weeding out of atleast 23 such preparations.

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iii) Sale of drugs without adequate precautionery product information

iv) Sale of drugs at a highly inflated costs

eg: It is reported that Analgin is being sold at 20 to 30 times the cost of production.

v) Promotion of drugs for indications that are neither clinically proved and are often potentially dangerous

eg: Promotion of HP forte combinations for pregnancy testing and induction of abortion. There is well documented scientific evidence that the risk of foetal deformity is increased by the use of these hormonal preparations.

vi) Sale of spurious, adulterated or poor quality drugs

eg: Turmeric powder in tetracycline capsules and poor quality, reaction producing intravenous fluid preparations have been reported.

vii) Sale of old, expired and unused drugs

There is the double danger of effects of denatured drugs as also of inadequate dosage.

viii) Over-prescription and misuse of tonics, high-protein foods, hormonal preparations and baby foods that are both superfluous and a drain on the family economy.

.....3

ix) Sale of drugs over the counter without doctor's prescriptions or the necessary statutory checks.

x) Production of drugs for profits rather than health needs of people--eg: The ICMR/ICSSR report highlights that drugs for diseases like leprosy and tuberculosis which affect millions are produced at one-third and one-fourth of actual requirements while tonics, vitamins and high protein substitutes are being produced in wasteful abundance.

IT IS evident then, that what is needed in the country today is a consumer awakening and awareness building process that will sensitise people to the realities of the drug industry, mobilise public opinion, sensitise policy makers, confront the medical establishment and challenge the drug industry. This process will have to lead to the initiation, promotion and sustenance of consumer action to ensure that the drug policy in India is more 'people' and 'health' oriented. Is there any evidence of such an awareness?

consumer alert and action

BEGINNING IN the late seventies, there is an increasing number of organisations, associations, projects and action groups who have begun to create an awareness of drug-related policy issues. These groups are predominantly if not exclusively urban-based, consisting of young professionals and intellectuals from different ideological backgrounds.

Since the Medical profession is the 'instrumental consumer' ie., they prescribe the drugs, many of these groups have directed their efforts particularly towards them. Many others are health or development associations, science popularising movements and consumer associations who are increasingly taking up drug-issues as one of their many activities. The list of groups makes interesting reading are -

Voluntary Health Association of India (VHAI), New Delhi;
medico friend circle (mfc), Pune;
Arogya Dakshata Mandal (ADM), Pune;
Delhi Science Forum (DSF), New Delhi;
Society of Young Scientists (SYS), New Delhi;
Lok Vidnyan Sanghatana (PSM), Maharashtra;
Kerala Sastra Sahitya Parishad (KSSP);
Concern for Correct Medicine (CCM), New Delhi;
Consumer Action Front (CAF), New Delhi;
Consumer Education and Research Centre (CERC), Ahmedabad;
Centre for Education Development (CED), Bombay;
Federation of Medical Representatives Association of India (FMRA); Patna;
All India Women's Conference (AIWC) and so on.

It is impossible to document all the efforts of these groups but the main types of action they have been involved in are :-

1. Publications

mfc published two anthologies of their bulletin articles 'In Search of Diagnosis' (1977) and 'Health Care Which Way to go' (1982) which included many articles on drug-policy related issues. VHAI's special issue of the bi-monthly 'Health for the Millions' was entitled 'Medicines, as if people mattered' (1981). It covered many aspects of drug use and abuse and tried to stimulate voluntary initiatives from the public and the medical profession. CED published an exhaustive, well-researched report on 'Aspects of Drug Industry in India' (1982) to stimulate further interest.

2. Meetings

These were organised by many of the groups to bring together people interested in the problem to share views and discuss action plans. The Drug Industry and the Indian People (DSF, SYS, FMRA and others, November 1981), Drug Issues and Feasible Alternatives (VHAI, Pune, Jan. '82), Drug use and Abuse (mfc, Tara, Jan. '82) were three such meetings. The Seminar on National Health Policy (New Delhi, VHAI, AIWC, CCM, April 1983) also discussed drug issues and stressed the need for information dissemination and consumer action.

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3. Educational Campaign through letters and media

AIM launched a movement called 'Operation Medicine' in July 1977 with letters to medicos and articles in press requesting for a stop in prescription of forte vitamin preparations, irrational B-complex formulations, tonics and tinned foods and boycotting of certain drugs being sold at inflated costs.

VHAI launched a campaign in March 1982 (International Women's Day) against the misuse of hormonal preparations for pregnancy testing. Letters were sent to doctors and chemists informing them about the dangers and requesting them not to misuse these products. Articles were published in leading newspapers and periodicals. The movement snow-balled and the government decided to ban EP forte combinations. The movement continues to challenge government action which has given a lag period of six months to drug companies to move stock before ban becomes effective.

mfc launched a campaign early this year about the rational management of diarrhoeas in children with a hope to prevent misuse of various available preparations that have not much therapeutic value. Press releases, informative articles and letters to drug controllers have been major constituents of this campaign.

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4. Newsletters/Bulletins

One of the best examples of continuing education of doctors on drug issues is the Pune Journal of Continuing Health Education published by AIM. This bulletin sensitises its subscribers to the half-truths of medical advertising apart from providing reliable information on latest drugs. The Drugs Bulletin of Pharmacology Department of Post-Graduate Institute, Chandigarh is another example. mfc bulletins have also regularly featured articles on drug issues.

5. Information net-work among voluntary action groups

To maintain this growing interest, VHAI has set up a special cell on 'Low Cost Drugs and rational Therapeutics'. This Cell has been keeping groups all over India informed about new problems and follow up action of campaigns. Other groups have also initiated informal network exchanges.

6. Low-Cost Drug Ventures

The Bangarapet Medical Mission Tablet Industry has been a very successful small scale venture in providing low cost, good quality formulations to a limited group of mission hospitals in the country. Recently in Gujerat a new project called LOCOST has been initiated. This is a collective voluntary endeavour for rational therapeutics through promotion of low-cost, quality, generic named medicines. An important dimension of the project will be an educational effort addressed to the voluntary sector for minimum use of drugs and the socio-economic implications of irrational therapeutics.

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7. Drug issues in Science Movements

With the growing interest on drug related issues well-known science movements in the country like KSSP and PSM have also decided to coordinate with other agencies in joint campaigns. At the All India convention of the people's Science Movements at Trivandrum convened by KSSP in February 1983, a health group was formed which drew up up a joint action programme having the following four components.

a. Ban on EP Forte combinations

To oppose the wrong arguments of drug companies being used to pressurise government to lift ban order on these combinations.

b. Campaign about Anemia in Women and irrational anti-anaemic drug preparations in the market.

PSM Maharashtra was including it as a topic for their yatra in May 1983.

c. Campaign against irrational Diarrhoea Management in Children

mfc would initiate campaign from June 1983.

d. Campaign against Multinationals in Indian Drug Industry

A campaign lead by FMRA would be organized in October 1983 to coincide with the annual Jatha of KSSP and to make people aware of the role of Multinational Corporations in India.

towards a people's movement

ALL THE above efforts are small steps towards a much more wide-based consumer movement against drug use and abuse and profit oriented drug policies. However, it must be remembered that in a country like ours when a very large percentage of people are below the poverty line and when more than 75 person have little access to a basic health service a consumer action programme only on drug matters will continue to be cut off from the needs and aspirations of the majority.

DR NORMAN BETHUNE, famous for his work in China wrote, 'The best form of providing health care and health protection would be to change the economic system which produces ill health - to liquidate ignorance, poverty and unemployment'.

ONE HOPES that eventually drug-related issues will become part of a much wider people's campaign for health development and socio-political change because at the root of the entire problem of drug production and availability lies what Ivan Illich has aptly described as 'Social-iatrogenesis - ie., health policies reinforcing an industrial organisation which generates ill-health'.

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DR-33-24

Report of Visit to the All India Missions Tablet Industry

Bangarapet - 563 114 Karnataka, India

From: Wim Faassen, Special Field Consultant, Christian Medical Commission, World Council of Churches, P.O. Box 66, 1211 Geneve 20, Switzerland

Visit Dates: 1-3 September 1984

Meeting with: Emanuel J.D. Birnur, Superintendent
H. Rathnam, Production Manager, Assistant Superintendent
Stanley G. Jogin, Analytical Chemist
S. Frederick Emmanuel, Analytical Chemist
Wilson Y. Nandihal, Treasurer

1. Introduction

In the first quarter of 1984, Bishop Elias Peter, the chairman of the Board of the All India Missions Tablet Industry, along with Major J.K. Michael, Director of CASA and Bishop Jonathan, treasurer of CASA, paid a visit to CMC and met with Dr. Ram in Geneva and requested the CMC to look into the possibility of expanding the industry to meet the growing needs of the church and voluntary hospitals and health works for essential drugs in India. Dr. Ram had previously visited the Tablet Industry in 1981 and had already indicated the possibility of further strengthening their very fine work. Dr. Ram had used their products, which are of very good quality and available at a very low cost, for 16 years of his rural health work in India and was keen that others benefit from them as well.

The visit was thus formalised by Dr. Eric Ram, Director of the CMC/WCC, by agreeing to the request of Bishop Elias Peter. CMC had their formulary and the product list. The general question was: "If they want to expand, do they need any support?"

The report will cover the following subjects:

2. History
3. Management and Personnel
4. Marketing
5. Production
6. Finance
7. Future

2. History

"Dr. Hugh H. Linn, Medical Missionary", written by his wife, Minnie V. Linn, 2 years after his death in 1948, tells that Dr. Linn was called the "pillar" of the church, because of his great Tablet Industry.

Dr. Linn started to produce tablets for missions in 1920 in Vikarabad, and soon moved to Bowringpet, which is now called Bangarapet. The aim was to enable the missionaries to help more people. Products were then sold to some 200 mission hospitals, and as many dispensaries, district missionaries and managers of schools. Tablets went as far as Arabia, Burma, China and Africa, and each package of tablets contained a tract which told about Christ. Dr. Hugh Linn's booklet "Diagnosis and Treatment of Common Diseases for Village Workers", Madras 1928, was translated into 6 Indian languages.

After his death in 1948, his son, Dr. (Pharm.) K.M. Linn took over. He retired in 1981. The production manager, Mr. Birnur, then became the superintendent.

3. Management and Personnel

The management consists of the superintendent (who also does the sales), the production manager (who is a pharmacist as well), the laboratory manager, the treasurer and a pharmacy assistant for the packaging and additional labour. There is a total of 19 people.

The company is registered as a small scale industry and charitable trust. It would lose this status if the personnel consisted of 20 or more. The consequences in such a case are that the exemption from income tax is lost, the employess would be organized in the union, and government insurance schemes would have to be followed, increasing the costs for the company.

The Methodist Church of India is the full owner of the Tablet Industry. Bishop M. Elias Peter is the chairman of the board.

4. Marketing

The range of products and the prices are given in the price list of March 1984. It contains 55 tablets, of which 6 are patent and proprietary, and 5 external applications. Furthermore, 57 formulations of other companies are offered to the clients in order to complete the range. These items are bought with 20% discount.

Prices are said to be interesting. Supplies are only made to mission institutions and members of VHV. Packaging is free. For tablets, half of the forwarding charges have to be paid by the customer, for ointments 100%. On the patent and proprietary items, an excise duty of 15% has to be paid.

The present turnover is Rs. 3.8 million, of which 2.5 million on own products (at Rs 11.5 for 1$, these amounts are $330.000 and $217.000). The main own sales consist of 75 million tablets.

Ointment sales are about 4.5 tons a year at about Rs. 200.000 (8% of own production).

Presently only 20% of the Protestant and 5% of the Catholic hospitals are supplied. The Catholic clients are mostly from Kerala. Catholic hospitals derive most of their drugs from gifts.

The marketing approach is rather passive. "Our customers are our representatives". Some advertisements are placed in mission periodicals. There are no travelling salesmen. The only care available is the 1960 8 cylinder USA Plymouth left by Dr. K.M. Linn, but to use it, the Tablet Industry needs a driver. Transport of drugs to the railways is done by cart and bullock.

The first question they asked me was: "Are there any hospitals under your control who could buy the double production?" I said that CMC/WCC has no hospitals under its control but works with more than 2,000 hospitals and many more health centers and dispensaries around the world.

Mr. Jürgen Gotthardt of WEM-Hamburg visited Bangarapet early 1984. A report has been made by him.

The Government of India (GOI) spends about 1$ p.a./p.c. on health. Most church-related medical institutions get no government grants, and have to live from the fees of the patients. The Indian government owns 2 pharmaceutical factories, the Indian Drug and Pharmaceutical Ltd. (IDPL), and the Hindustan Antibiotics Ltd. Imported drugs would be cheaper than locally manufactured ones. Customers pay 10% Central Sales Tax. WEM and CASA, according to the report, are willing to channel orders through the Tablet Industry on the "Deemed Export Scheme". Payments would be made from Germany in free foreign exchange. The Tablet Industry could then import raw materials directly, and WEM could even promote export to other countries. Also, new Indian machines could be bought under the Deemed Export Scheme, with payment in hard currency. The report also suggests that a separate production and distribution unit could avoid the troubles of officially growing beyond the 20-employees limit.

According to the people I talked to at the Tablet Industry, WEM's proposals are not acceptable, since WEM would ask 6% for these services, and an increase in the drug prices of 5% to the hospitals that are brought in contact with the Tablet Industry by WEM. The Tablet Industry cannot use 2 different price lists. Mr. Birnur did not know whether Bishop Elias Peter had already given a definite answer to WEM. Contact with Mr. Gotthardt after my return to Europe about this matter seems to be advisable, anyhow, since WEM has been thinking about various possible solutions. The Tablet Industry also said they could not afford 6% on the raw material prices, since their net profit is only 5%.

The Tablet Industry is afraid of an expansion into a separate distribution unit, since some unwanted people might be manipulated into new jobs.

Talking about possible supplies for government tenders, the constraints mentioned were: the government is not a charitable organization (I do not agree; government gives health care free; the mission hospitals are pretty expensive for the patients), tender orders are only obtained through bribes, and if payments are finally made after 1 year or more, this also happens only if you give a considerable compensation. So government orders are out.

Export sales are negligeable.

From the answers given it was not clear whether the sales are limited by the market or by the production. It was said that the same number of people could easily produce 50-100% more with better machines, and that limiting factors were the non-availability of punches for the old tablets, machines and the irregular supply of raw materials and electricity. On the other hand, one gets the impression that the passive marketing is the limiting factor and the acceptance of the "19-people limit".

Some employees are of the opinion that the Tablet Industry should produce only tablets to remain loyal to the original aim of the founder of the company.

However, on the letterhead the command "Go heal the sick" is given without limiting remarks.

There are no bad debts; sometimes it takes 1 year before clients pay, but most pay within 1-2 months.

5. Production

The building for production is sturdy and clean and certainly has possibility for expansion. The roof is high and light, the space is cool, the floors are of good quality.

Granulation and drying equipment is partially old, sometimes complete granulate is bought on the market (aspirins). Tray driers are used. Tabletting machines are:

- Manesty double rotary 27 stations England 1958
- Manesty single rotary 16 stations England 1958
- Stokes single rotary 16 stations England 1955
- Cad mach single rotary 16 stations India 1970

It is difficult, if not impossible, to get punches for the old manesty and stokes machines; for this reason the second machine is already out of operation.

It is clear that these machines would not be fully occupied for 75 million tablets per annum, if punches were available. On the other hand, the first 3 machines are already over 25 years old and they become gradually difficult to maintain.

Packaging of tablets is done by weight or by special counting devices. The labels are clear, the glue, however, is so bad that all labels look dirty. Containers are either square tins or round plastic jars.

The ointment department is hardly more than you find in a larger hospital. The same people making tablets alternatively also make some ointments. There would be room for capsule production, but the Tablet Industry is afraid to surpass the 19-employees limit.

The laboratory has enough space and looks reasonably well-equipped; a photospectrometre is lacking and wanted. Regular samples during production are taken. The state drug inspector of Karnataka regularly checks the production.

Working overtime is allowed up to 18 hours/week, at double pay.

The Tablet Industry has no license to import raw materials, so they have to buy them in the local market, mainly from brokers. Often, items are out of stock and have to be bought on the black market (mainly the imported raw materials). Vitamin C and I.N.H. are in short supply. Even if the Tablet Industry had an import license, supplies might be very irregular, because the government canalizes the raw material imports, and sets quantities and prices. Payments have to be made in advance.

Of course, gifts of raw materials via CASA e.g. would be allowed, but then the end products may not be sold, only donated.

Taxes on raw materials and packaging purchases are 4%, and if bought inside Karnataka 9.6%.

6. Finance

The Tablet Industry is owned by the Methodist Church. Per annum, Rs. 84,000 has to be paid to the church for rent for the buildings (sales department and store of finished products. The newer production hall is owned by the Tablet Industry. It seems that this rent is excessive and a source of income for the church. Without this cost, the drugs would be 2.2% cheaper. The money paid for rent to the SIRC (South India Regional Conference in Bombay) is used to support village priests.

The Tablet Industry is obliged to transfer 75% of its profits to charitable organizations to be exempted from taxes. In 1983, the net excess of income over expenditure was Rs. 84,000, of which Rs 60.000 were donated to mission schools and hospitals.

The total provision for machines and equipment as of 31-12-82 was Rs. 102.000, not enough by far to replace the old machines. Total depreciation in 1983 was nearly Rs. 12.000. The provisions are used for working capital and not even free for machinery purchases.

Of the Rs. 102.000, 60.000 was spent in 1984, so that Rs. 42.000 is left as reserve for machinery and equipment.

The Tablet Industry has written to the government to obtain permission to build up more reserves for machinery renewal.

Since the Methodist SIRC is the sole owner of the Tablet Industry and receives considerable amounts yearly, one could say that they are responsible for providing funds for any renewal of machinery. Donating amounts of Rs 60.000 annually to various charitable organizations at the cost of a sound depreciation policy does not seem very wise from a financial point of view.

The Tablet Industry has no bank debts, since it is not allowed to borrow money.

The present stock is worth about 1 million rupees, of which Rs. 600.000 is raw material. The Tablet Industry regards a stock of 1 million rupees as "normal" for an annual sales of Rs. 3.8 million, so 3.2 months' sales as stock. This is certainly modest and it is not unlikely that items will be out of stock regularly on this basis.

Personnel costs amount to about Rs. 220.000 or 5.8% of sales, again, a very modest figure.

Raw material and packaging purchases in 1983 amounted to Rs. 1,535.000, which at a sales figure of Rs. 2.5 million would mean 61.4% of sales, assuming opening and closing stocks would be equal. The factor sales divided by raw material and packaging would then be 1.63, a reasonable figure for a non-profit drug manufacturer.

The accounts receivable are about Rs. 524.000 or 1.7 months, a good performance. Accounts payable are Rs. 166.000, again an excellent figure.

In total, the financial picture of the company is sound, apart from the amounts spent on rent and charity (which could be used to build up reserves for renewal and expansion).

Budget estimates for 1984-85-86 and the audit report 1983 were received.

7. Future

The Tablet Industry would like to expand production without increasing the staff. For that they need:

a. 2 double rotary tabletting machines, 27 stations, at about Rs. 100.000 each (Indian made) - Total Rs. 200.000 - Capacity each 1500 tabs/min., or about 35 h/week and 50 weeks/annum about 150 million tabs per annum each total 300 million tablets. If the license for 6 additional tablets is obtained, the Tablet Industry expects to be able to already market 200 million tablets.

b. 1 fluid bed drier, Indian made, Rs. 70.000 (The Tablet Industry says the rest of the granulation department is adequate).

c. 1 diesel generator 100 KVA, estimated Rs. 100.000

d. 1 double beam spectrophotometer, import, Rs. 100,000

e. 1 single pan balance, Swiss, Rs. 10.000

f. 1 ointment vessel, double walled, 250 L, local made - Rs. 30.000

g. 1 standard 10 diesel van, 3 tons, Rs. 80.000

h. 1 capsulating section 20 million capsules per annum, with airconditioning, fumigation, U.V. lamp, price from Italian manufacturer unknown - say Rs. 100.000

i. installation for expansion and various Rs. 200.000

For an increased production, from Rs. 2.5 million, to say, Rs. 12.5 million. (multiplied 5 times), the working capital also should be increased 5 times (so an additional 4 times).

Assuming the present working capital (stocks, debtors and bank/cash less creditors) is about Rs. 1.6 million, the additional need would be about 4 x Rs. 1.6 million = Rs. 6.4 million.

The total estimated additional capital needs of Rs. 890.000 would be for machines, equipment and installations, according to the Tablet Industry estimate (which might be on the low side), and for working capital Rs. 6.4 million, total Rs. 7,290,000 (or at Rs. 11.5/$, about 634.000$).

Concluding remarks:

The Tablet Industry needs to formulate its own growth plans in a project proposal with better estimates of prices, capacities, personnel, etc. for submission to the donor agencies to obtain funds. My personal view is that a different way of depreciation and use of funds is also needed so that donations would not be needed after the initial grant of $634,000 for working capital or machines. For working capital the use of bank loans and/or soft loans should be investigated.

The complete address of the Methodist Church in India is South India Regional Conference - Bishop M. Elias Peter - Medical Council No. 27 (old no. 315) - 1st Main road - Cambridge lay out Ulsoor - Bangalore 560 008 (Tel. 51087).

Acknowledgements:

I owe special thanks to the management and staff of the Tablet Industry for arranging my appointment with CASA and VHAI in New Delhi, for the transport between Bangalore, Kolar and Bangarapet and for all the frank information provided. I am also grateful for the board and lodging at the Elkn Thoburn Cowen Memorial Hospital in Kolar arranged by Dr. Kaye and Dr. Keith Streatfield and Mr. Jaya Mitra, the administrator, and to Bishop Elias Peter, whom I had the pleasure of meeting briefly at the airport.

ANKURAN

अंकुरण

SELF RELIANT HEALTH PROJECT

A N K U R A N P R O J E C T

1. INTRODUCTION

ANKURAN is a voluntary non profit making secular organization registered in 1982 under Societies Registration Act 1860.

It believes that health is an important aspect of development and can act as a good entry point to overall development. For the present its work is carried on in four panchayats of Chatra Sub-division in Hazaribagh District of Southern Bihar but later it should extend to a wider area.

2. GENERAL BACKGROUND

The World Health Organization has adopted the target of " Health for all by the year 2000 ", but the present health services in Third World countries, especially in rural areas, organized on a western model are not adequate regarding the enormous problems to deal with and do not meet the fundamental needs of the population as a whole.

Realisation of this inadequacy has given rise to a new concept of health care, called primary health care by the WHO, which consists in doing away with classical schemes and replacing them with new and very decentralised structures where the doctor is no longer the central figure and treatment is milder and less expensive.

Ankuran is a registered Society under the Bihar act XXI of 1860. Office ; Gudri Mahalla - CHATRA—825401—District Hazaribagh—Bihar—(INDIA)

3. OBJECTIVES

The aim of ANKURAN is to try out in rural areas a system of health care accepted by all and accessible to all as far as possible, which should provide appropriate treatment to the poorest as cheaply as possible.

Thus in its area of operation ANKURAN proposes to set up a locally run health network based on village pharmacies, village health committees, a low cost drugs manufacturing industry, medicinal herbs gardens and a pathological laboratory. In this network stress will be put on traditional herbal medicine and preventive health with community participation which means to educate and organize people for community development, to accept the responsibility of taking care of their health.

4. ACTIVITIES

1. Village Pharmacies

The spear-head of the project is a network of village pharmacies, one pharmacy for 2000 to 5000 people. These pharmacies will be run by local retrained healers (Bare Foot Pharmacists, BFP) chosen by the population and who are motivated and qualified. Each pharmacy should be involved in varying extents in research, production, distribution and promotion. The BFP will have also to organize the population so as to allow them to take in hand the defense of the health of the community.

2) Village Health Committees

In each village, a village health committee (VHC) with 5 to 7 people including 2 village Health Volunteers (VHV) is formed to be

responsible for the villager's health and has to maintain everytime the good health through education. The 2 VHV, one male and one female (dais), regularly trained, work as preventive health agents and educate the people. They will have to keep close contact with the BFP.

3) Low Cost Drugs Manufacturing Industry

As an indispensible complement to the village pharmacies and in order to provide low cost but quality drugs to the poorest section of the community, one small-scale pharmaceutical industry is to be set up in the outskirts of Chatra. This LCDMI will produce at low cost few essential drugs from chemical and some drugs from medicinal herbs. The medicines will be distributed to the village pharmacies or sold to surrounding hospitals or institutions. Besides giving self-reliance to the project and providing cheap drugs to the people, that programme will increase also employment in the countryside.

4) Medicinal Herbs Gardens

The supply of medicinal plants for the popular pharmacies and the industry will come for the most part from local resources. For that, production gardens will be settled in the villages on a community land. They will be managed by the village health committee. One demonstration, research and production garden will also be settled on a land belonging to Ankuran at the outskirts of Chatra and will be as a reference for village crops. By promoting the growing of medicinal herbs, the employment in the countryside should also be increased.

5) Pathological Laboratory

A pathological laboratory set up in Chatra is offering its health services to the population of the subdivision. Prices adapted to the economic situtation of the patients and mobile laboratory in

the villages allow the laboratory services to reach the poorest in the villages.

5. SPONSORSHIP

For the implementation of that original health network, ANKURAN is helped and sponsored by Solidarity International (France) which has started the project, by United Nations (Geneva), European Economic Community (Brussels) and other organizations.

6. HOW TO REACH THE INSTITUTION

CHATRA is connected with Gaya (80 km) and Hazaribagh (70 km) by frequent buses and with Patna, Ranchi, Rourkela and Daltenganj by some direct buses. The premises of ANKURAN are located in the middle of Chatra town and can easily be reached by rickshaw or by foot.

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DRUG ALERT!

DRUGS FOR ARTHRITIS IN THE DOCK

On 17th May 1984, local newspapers announced that two popular drugs used for arthritis (Tanderil and Tendacot) — both oxyphenbutazone derivatives — were ordered to be immediately withdrawn, from the market in UK by a government order[1]. The action was taken on the recommendations of the Committee on Safety of Medicines (CSM). Though the manufacturer Ciba Geigy had exercised its right of appeal under the Medicines Act to stall the government's decision, which actually had been taken sometime ago, the Medicines commission had upheld the decision to revoke the licence.

400 deaths are reported to have taken place in Britain in the last two years due to these drugs[2]. The committee found them twice as dangerous as three other drugs belonging to the phenylbutazone group (Butazone, Butacodine and Butacote) which were withdrawn in March this year. The CSM had continued to receive reports of adverse reactions including fatal ones due to blood disorders, gastro-intestinal intolerance and bleeding[3].

Sidney Wolfe, Director of the Health Research group (sponsored by Ralph Nader) has estimated that world wide probably more than 10,000 patients had died as a result of taking these drugs. In his letter to the Department of Health and Human Services, he gave anaemia, agranulocytosis, leukemia, gastro-intestinal bleeding and peptic ulcerations as the leading causes of drug induced deaths. Other deaths were also attributed to hepatitis, thrombocytopenia and renal failure[4].

Interestingly in the last two years, three other non-steroidal anti-inflammatory drugs benoxaprofen, indoprofen and zomepirac and a formulation of indomethacin (osmosin) were also withdrawn. A review of a current CIMS[5] shows 20 formulations of oxyphenbutazone (Algesin-0, Aristopyrin cream, Butacortindon, Butadex, Butaproxyvon, Disiflam, Flamar-P., Ganrilon, Inflavan, Kilpane, Maxigesic, Oxalgin, Oxyrin, Oxytriactin, Reducin-A, Reparil, Rumatin, Suganril, Tendon, Tromagesic) and 8 formulations of phenylbutazone (Actimol, Algesin, Aristopyrin, Butapred, Ebeflam, Parazolandin, Zolandin, Zolandin-Alka) recommended for use by doctors in India. How many patients must die before something is done about this in India as well?

An mfc annual meet background paper in 1982 concluded that the ideal anti-inflammatory drug was yet to be discovered and Aspirin remained the agent of choice when cost-factor and benefit to risk consideration were taken into account[6]. Have events in UK endorsed this?

With such a large number of anti-inflammatory drugs in the docks, will homeopathy[7], ayurveda and non-drug therapies have a role to play in the treatment of arthritis?

— Community Health Cell, Bangalore

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VOCAL FIGURES

Our current state-wise break up of readers are — Maharashtra (212); Gujarat (63); Karnataka (36); Delhi (28); Bengal (27); Kerala (26); Bihar (19); Andhra Pradesh (17); Tamil Nadu (17); Madhya Pradesh (13); Punjab (9); Uttar Pradesh (8); Orissa (5); Goa (2); Assam, Himachal Pradesh, Meghalaya and Haryana have one each. mfc has yet to make an entry into Arunachal, Kashmir, Mizoram, Nagaland, Tripura, Manipur, Pondicherry, Andaman and Nicobar. How national are we?

Can members/subscribers/readers help us to reach out to more people by sending us names and addresses of people who may be potential subscribers and share our perspectives?

Two bulletins will be sent free to them as a trial subscription!

mfc office, Bangalore

WARDHA MEETING

The mid-annual EC/Core group meeting of mfc will be held at Wardha from 27-29th July 1984 at Gauri Bhavan, Sevagram Ashram, Sevagram (Maharashtra). At this meeting discussions will be held on organizational issues and plans for the annual meet on 'TB problem and control'.

Editorial

THE ICMR/ICSSR report on 'Health for All' has warned that "eternal vigilance is required to ensure that the health care system does not get medicalised, that the doctor-drug producer axis does not exploit the people and that the abundance of drugs does not become a vested interest in ill-health[1]". The Drug Action Network which has come together in the last two years is symbolic of this vigilance, which is growing in India. The memorandum drawn up by the participating organisations, which is featured in this issue highlights the diverse aspects of drug policy towards which this vigilance has to be directed.

THE banning of a wide range of commonly used drugs for arthritis in U.K., in recent weeks (article on Drugs alert) raises questions about the complexities of this vigilance. In countries like U. K. and U.S.A. in spite of drug safety committees, comprehensive drug laws, efficient drug control authorities, active consumer groups and socially sensitive elements in the profession — drugs continue to slip through and get used for years before their dangers get known and bans are instituted.[2] How much more difficult will it be in our country where all these elements of 'vigilance' are still only in the process of evolving?

William Osler's exhortation that one of the first duties of the physician is to educate the masses not to take medicine[3] is particulaly relevant in today's drug situation. The role of doctors in acting as watchdogs is primary — laws, controls and authorities notwithstanding. Are doctors prepared adequately for this role in India? Medical education stresses the minutiae in pharmacology and medicine without stressing the factors of cost, safety and social relevance. It also does not consciously immunize the doctors against the half-truths of persuasive medical advertising[4]. In the absence of programmes of continuing education in the country, practicing doctors continue to be informed only by the profit oriented pharmaceutical industry, thus worsening the situation.

UNLESS there is a growing realisation among medical students, young doctors, teachers, health workers, professional associations, consumer education groups and science movements that this problem needs to be tackled in the form of an organized movement very little change can be expected in the present situation. Satchidanandan's critique presents an analytical framework and background against which such a movement would have to evolve. His suggestions for a multi-dimensional campaign of demystification, conscientization, study, curriculum change and deprofessionalization could well be initiated taking drug issues as the focal point. It would, however, be important to keep in mind that over seventy five percent of the people in India have little or no access to health care. Hence an action programme only on drug matters would be cut off from the needs and aspirations of the majority[5]. However, if this became part of a wider people's movement for socio-political change, the drugs problem would be tackled at its very roots.

Please note

Subscribers are informed that due to an RMS go slow in Bangalore, clearance of the mfc bulletins in June was delayed. The bulletins must have reached in the third/fourth week. We apologise for the unavoidable delay!

In future bulletins will be despatched on the 10th of every month. Please let us know if you do not receive them by the 17th of the month (this applies to Indian subscribers only).

mfc office, Bangalore

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Views and opinions expressed in the bulletin are those of the authors and not necessarily of the organisation.

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INTERNATIONAL FEDERATION OF PHARMACEUTICAL MANUFACTURERS ASSOCIATIONS (IFPMA)

CODE OF PHARMACEUTICAL MARKETING PRACTICES

Preamble

The Statute of the Federation article 3 states that one of the objects of the Federation is "to promote and support continuous development throughout the pharmaceutical industry of ethical principles and practices voluntary agreed on and "to coordinate the efforts of its members towards the realization of the above objects".

It is believed that in keeping with the pharmaceutical industry's international responsibilities, the members of the Federation will be prepared to accept certain obligations, insofar as their marketing practices are concerned, and to ensure respect for them.

IFPMA recommends a Code of Marketing Practices to its member associations, recognizing the difficulty of setting out a simple Code which will be applicable in all parts of the world. It seems clear that national and regional conditions and legal restrictions will continue to vary to such an extent as to make a simple world Code impractical. Nevertheless, the Federation believes that it has a duty to encourage its member associations to either introduce such Codes of Practices or where such Codes already exist, to continually re-examine and where necessary revise them so that a voluntary system based on such a Code keeps pace with modern medical knowledge and changing health services and conditions.

It is recognized that many individual member associations of IFPMA have laid down their own Codes of Marketing Practices and this recommended Code is not intended to replace similar Codes or instruments already in force by members of the Federation. The following voluntary Code is therefore put forward as a model for IFPMA's member associations.

A Code of Marketing Practices of this sort should be the responsibility of member associations who should also provide guidance to their members on matters of compliance and interpretation.

Obligations of the industry

The obligations of the industry may be identified as follows:

The pharmaceutical industry, conscious of its special position arising from its involvement in public health, and justifiably eager to fulfil its obligations in a free and fully responsible manner, undertakes:

- to ensure that all products it makes available for prescription purposes to the public are backed by the fullest technological service and have full regard to the needs of public health;

- to produce pharmaceutical products under adequate procedures and strict quality assurance;

- to base the claims for substances and formulations on valid scientific evidence, thus determining the therapeutic indications and conditions of use;

.../-

- to provide scientific information with objectivity and good taste, with scrupulous regard for truth, and with clear statements with respect to indications, contra-indications, tolerance and toxicity;

- to use complete candour in dealings with public health officials, health care professionals and the public.

Suggested Code of Marketing Practices

We hereby declare our intention to voluntarily conform to the following Code of Marketing Practices:

I. General Principles

1. The term "pharmaceutical product" in this concept means any pharmaceutical or biological product intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in humans, or to affect the structure or any function of the human body, which is promoted and advertised to the medical profession rather than directly to the lay public.

2. Information on pharmaceutical products should be accurate, fair and objective, and presented in such a way as to conform not only to legal requirements but also to ethical standards and to standards of good taste.

3. Information should be based on an up to date evaluation of all the available scientific evidence, and should reflect this evidence clearly.

4. No public communication shall be made with the intent of promoting a pharmaceutical product as safe and effective for any use before the required approval of the pharmaceutical product for marketing for such use is obtained. However, this provision is not intended to abridge the right of the scientific community and the public to be fully informed concerning scientific and medical progress. It is not intended to restrict a full and proper exchange of scientific information concerning a pharmaceutical product, including appropriate dissemination of investigational findings in scientific or lay communications media, nor to restrict public disclosure to stockholders and others concerning any pharmaceutical product as may be required or desirable under law, rule or regulation.

5. Statements in promotional communications should be based upon substantial scientific evidence or other responsible medical opinion. Claims should not be stronger than such evidence warrants. Every effort should be made to avoid ambiguity.

6. Particular care should be taken that essential information as to pharmaceutical products' safety, contradictions and side effects or toxic hazards is appropriately and consistently communicated subject to the legal, regulatory and medical practices of each nation. The word "safe" must not be used without qualification.

7. Promotional communications should have medical clearance, or where appropriate, clearance by the responsible pharmacist, before their release.

II. Medical Representative

Medical representatives must be adequately trained and possess sufficient medical and technical knowledge to present information on their company's products in an accurate and responsible manner.

III. Symposia, Congresses and other Means of Verbal Communication.

Symposia, congresses and the like are indispensable for the dissemination of knowledge and experience. Scientific objectives should be the principal focus in arranging such meetings, and entertainment and other hospitality shall not be inconsistent with such objectives.

IV. Printed Promotional Material

Scientific and technical information shall fully disclose the properties of the pharmaceutical product as approved in the country in question based on current scientific knowledge including:

- The active ingredients, using the approved names where such names exist.
- At least one approved indication for use together with the dosage and method of use.
- A succinct statement of the side-effects, precautions and contraindications.

Except for pharmaceutical products where use entails specific precautionary measures, reminders need not necessarily contain all the above information providing that a form of words is used which indicates clearly that further information is available on request.

Promotional material, such as mailings and medical journal advertisements, must not be designed to disguise their real nature and the frequency and volume of such mailings should not be offensive to the health care professionals.

V. Samples

Samples may be supplied to the medical and allied professions to familiarize them with the products, to enable them to gain experience with the product in their practice, or upon request.

******

DR-33.28

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D-10/343

LOW COST DRUGS AND RATIONAL DRUG THERAPY
INTERNATIONAL CODES AND YOU !

Last year the WHO was instrumental in passing an International Code of Conduct of Marketing Practice of Baby foods.

This not only focussed the attention of the public, the health professionals on the baby food issue, but placed the concept of breast feeding from a 'rustic, old fashioned practice' to scientifically sound and recommended one. What this will do to the commercial interests of the milk food industry is anybody's guess? It is up to the aware public, the consumer associations, the journalists to ensure that the code of conduct of which India was a signatury - is firmly adhered to.

The contents of this code are being circulated for awareness and action of the health personnel and the public.

Along with it is a copy of the International Code of Pharmaceutical Marketing Practice, proposed by IFPMA (International Federation of Pharmaceutical Manufacturers Associations).

A copy of this provisional code was given to the participants of our Drug Workshop at Poona, for discussion and comments.

The code is being circulated along with extracts from the discussion document prepared by Health Action International on the code.

You are requested to read it carefully, share it with your colleagues and pass it on. Your comments and suggestions regarding the international code of pharmaceutical marketing practice are requested.

You are requested also to bring to our notice, cases of malpractice by drug companies which may be, by way of misinformation, selling of spurious drugs, unethical marketing practices, commissions for prescriptions, cut backs etc. Your participation is not only requested but is NEEDED for us and other groups and organisations to take any legal action, for malpractices to be curtailed before it is too late.

What is IFPMA ?

IFPMA is an International Federation of Pharmaceutical Manufacturers Association, a Zurich-based trade organisation, set up and supported by a number of national associations of manufacturers of prescription drugs. Altogether there are 30 affiliated national associations plus 12 affiliated through the Latin American Association of the Pharmaceutical Industry.

Why the IFPMA Code was introduced and what it aims to be?

"The Paris-based International Chamber of Commerce has published codes of advertising and marketing practice - which are meant to apply to business of all kinds. However, the IFPMA Code (which makes no reference to the requirements of the International Chamber of Commerce) is believed to be the first ever attempt to introduce an international code of marketing practice for pharmaceutical companies.

...2/-

The preamble of the IFPMA Code (Appendix) explains how its terms of reference extend to the drawing up of a voluntary code of practice. Though the IFPMA does not state why it decided to introduce a code at this time, the following factors would certainly have been important:

1. There has been considerable criticism of the activity of the international pharmaceutical industry, and it appears to be increasing. The industry has given little evidence to suggest that it accepts such criticism - but would certainly be aware, at least, that health-care professionals increasingly find it legitimate and to the point. The relative success of the campaign coordinated by the International Baby Food Action Network (IBFAN) has demonstrated the potential for international action by media, consumer, public interest and development and health action groups - particularly where developing countries are concerned.

2. The need to avoid further statutory regulation of the industry at either national or international level. The indications are that the IFPMA proposed its Code in response to the threat of a move by the World Health Assembly to work towards the setting up of a formal international code of pharmaceutical marketing practice. In the event, the threat did not materialise at the Summer 1981 World Health Assembly - but there remains the possibility of future initiative, if not through the World Health Organisation or UNCTAD, then possibly through the UN Centre on Transnational Corporations.

3. The credibility of the industry - now clearly under threat - is a vital commercial asset. Lack of confidence in the drug industry by those who regulate, prescribe or use pharmaceutical products could be commercially disastrous. It is clearly critical that the industry generally, as well as individual drug companies, is trusted and seen to 'care'.

The IFPMA has responded to these (and perhaps other) imperatives by first, issuing a statement of 'the obligations' of the pharmaceutical industry; and secondly, by suggesting a number of 'general principles' by which these obligations might be fulfilled.

It is important to recognise that, in doing so, the IFPMA is not trying to introduce its own 'simple world code'. The IFPMA specifically says this would be 'impractical' because of differences in local conditions. All IFPMA is trying to do with its Code is 'to encourage' national member organisations either to introduce or to revise their own voluntary codes."

What stage of implementation is the Code in?

"The document has not yet been formally adopted or published: it is reproduced here in the form in which it was circulated for comment to IFPMA member associations, in March 1981. Since then, the Code has been agreed by the IFPMA Council and, by the end of June 1981, it had been approved also by all of the major associations within IFPMA."

What is the purpose of the discussion document circulated by HAI?

"The purpose of this paper is

1. to draw attention to the existence and provisions of the IFPMA Code;

...3/-

2. to discuss briefly its significance in relation to controls that are needed and which might be applied; and

3. to suggest options for action by HAI participating groups. "

According to the discussion document, what are the three essential ingredients of any code of practice omitted in this IFPMA's Code?

1. Need for interpretation.

   Reference to the need to ensure that the industry makes products which have full regard to the needs of public health - appears a statement so vague that it is hard to accept it as anything much more than an advertising or public relations slogan.

2. Need for monitoring

   The question raised is 'what assurance is there, that the code will be adhered to?' Is the Code to operate on the basis of a complaints procedure? The mechanism for complaints handling and monitoring, which are fundamental to a code have not been referred to.

3. Need for enforcement

   What happens if the Code is violated?

   - who judges? industry (through its association or otherwise) or truly independent bodies.

   - whether enforcement decisions are published - or this is kept a secret? Could it be possible to establish, on the basis of past decisions, what practices are acceptable or unacceptable? And what is the record of individual companies where complying with the Code is concerned.

   - what sactions would be applied if companies break the provisions of the Code?

   - what incentive is there for firms to observe the requirement of the Code?

What are the implications and significance of this for the HAI groups?

This is useful to refer to the obligations of the industry identified by IFPMA;

Individual groups may think alternative or additional requirements which might be needed to control abuse in pharmaceutical marketing, and to consider how such requirements might effectively be enforced at both national and international level;

...4/-

Groups might also wish to collect exmaples of apparent malpractice;

Collectively, groups may find it useful to exchange information or the design and enforcement of standards under different voluntary (self regulatory) systems operating in their countries. Groups might also wish to compare and pool the evidence they obtain about apparent malpractice and to publish and publicise this evidence both locally and internationally through HAI.

HAI would like to know whether it should press for introduction of an international code of pharmaceutical marketing practice which has "teeth," and which can reasonably be expected to work through WHO/UNCTAD and national governments.

YOUR RESPONSE IS NEEDED URGENTLY

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DR-33.29

E-4/378
K/16/7/84

Background paper for

DRUG ACTION NETWORK (DAN)
Core Group Meet, Wardha,
July 30-31, 1984

From: Dr. W.V. Rane
Dr. A.R. Pachwardhan

DRUG PRICING AND PRICING POLICY

Introduction and acceptance of generic names would solve all the problems of pricing (barring a few accepted combinations). But as long as generic names cannot be accepted, it is advisable to adopt the stop-gap measures suggested hereunder.

Present system of indirect promotion of drugs to a common man through the medical profession and eventual selling through series of middlemen (distributors, stockists and retailers) brings direct and indirect burden on the consumer. The government, in order to safeguard the interest of the common man has introduced many directives - which have been ill-utilised by the pharmaceutical industry.

1. CATEGORISATION OF DRUGS: In order to make essential drugs available at reasonable rates, the government formed four categories of drugs. Category I drugs were taken as essential and a mark-up of 40% was allowed thereon. In order to cover the losses if any, the government allowed the manufacturers to charge any price on category III & IV drugs. The END RESULT: the essential drugs are not available and that the tonics, multivitamins, cough syrups, hormone combinations, anabolic steroids, ensyme etc. products are heavily promoted and within a span of one year the prices of these products have doubled or trebled and that the sales have increased. This is mainly due to indirect promotion of 'not-so-essential' drugs through the medical profession. More money and imagination is expended by the pharmaceutical companies in promoting these products. Eventual loser is the end consumer.

   How can this be remedied?:

   a) fixing leader prices of not-so-essential (Category III & IV) products by grouping them irrespective of various combinations. These groups can be: Multivitamins, enzymes steroids, cough syrups etc. etc.

   b) Imposing price control on all categories of products and even allowing higher mark-up (than the present) on group I & II products.

   c) Imposing certain restrictions on sales promotion of not-so-essential products viz no samples, no presents, no fancy packings, no lay-press advertisements and no schemes or bonus offers.

   d) Banning the visual aids-charts and strictly checking the medical literature.

2. DRUG PRICE CONTROL AUTHORITY

Drug Price Control Authority was created to control prices. This authority should review the prices every two years. No special facility should be given to any section of the industry. A few examples of gross discrepancies are given hereunder:

	Product	Composition/ tablet		Rate	Cost 100 tablets
A.	Corbutyl(Roussel)	Dextropro-poxyphene	65mg.		
		Paracetamol	650mg.	2.15/6	35.83
	Norgesic(Cipla)	Dextropro-poxyphene	32.5		
		Paracetamol	325mg.	3.11/10	31.10

How can one justify virtually the same price for exactly half the contents?

Proxyvon (Wockhardt)	Dextropro-poxyphene	65mg.		
	Paracetamol	400mg.	4.68/6	78.00
	Diazepam	2mg.		

What justification there can be for reducing paracetamol by 250 mg. and adding diazepam 2 mg. and taking more than double the ruling (of Corbutyl) prices.

B.	Mictopyrin (Nicholas)	Acetyl salicilic acid	350mg.	0.78/10	7.80
		Caffein	20mg.		
	Micropyrin-C	Aspirin	350mg.		
		Vitamin C	25 mg.	0.54/4	13.50

Merely dropping 20 mg. caffein and adding 25 mg. Vitamin C has doubled the prices.

C.	Essidrex (Ciba-Geigy)	Hydrochlor-thiazide	25mg.	0.46/10	4.60
	Arkamin-H (Unichem)	Clonidine Hcl.	100mg.	5.28/10	52.80
		Hydrochlor-thiazine	20mg.		
	Arkamin	Clonidine Hcl.	100mg.	4.20/10	42.00
	i.e.	Hydrochlor-thiazine	20mg.	1.08/10	10.80

Now when 25 mg. tablet of hydrochlorthiazide (essidrex) is available for less than 5 paise a tablets (cost of tabletting and packing included) mere adding of 20 mg. hydrochlorthiazide enabled the manufacturers to charge 11 paise for the same.

There are many such instances and these should be reviewed by the Drug Price Control Authorities.

3. MIDDLEMEN AND COMMISSION

The unions and associations of chemists & druggists have become powerful and they are now demanding 10% wholesellers commission and 20% retailers commission on new introductions. Gradually they will make these terms applicable to existing products as well which now give 5% wholesale and 12.5% retail commission. Their present demand has naturally increased the direct burden of 12.5% and indirect burden by 13.74%. This increase is due to increased excise duty and sales tax on increased prices. Take for example a product presently sold for Rs.100/- (i.e. maximum selling rate). This price will attract roughly Rs.13.00 excise duty and Rs.4.00 as sales tax.

For this price the manufacturer gets a minimum price (i.e. realisable price) of Rs.84.65. Now for getting the same realisable price of Rs.84.65, a new price structure will be as follows:

Trade rate	Rs.93.11
Maximum selling rate	Rs.111.74

which otherwise means that the end consumer has paid 13% excise duty on increased price of Rs.11.74 and he has also paid 4% sales tax on this increased price. That otherwise means that by this new method, he is paying Rs.11.74 additional to the middle men-Chemists etc. and Rs.1.53 additional excise duty to the central government and Rs.0.45 additional sales tax to the state government.

4. BENEFIT TO SMALL-SCALE INDUSTRY

Benefit of price etc. offered to small scale sector has been ill-used by the multinationals and big Indian firms. Normally a multinations is not allowed to market a new product or its combination - and even if marketted, it's price is controlled by the government. In order to bypass these difficulties, the manufacturers have created their own subsidiaries as small-scale industries and are taking maximum advantage of the benefits offered. In most of these cases the fancy products been marketted or that new combinations of old products have been introduced at fancy prices.

For example :

Walter-Bushnel	Metakelfin	Rs. 5.47/2	Rs.273.50/100
	Chymoral forte	20.58/12	171.50/100
	Amclox	10.25/4	256.30/100

Martel-Hammer, Montari, Jagson-Pal, Dolphin, Full Ford, Blue-Cross are some such firms.

Normally the products manufactured by a small-scale industry are marketted by the parent multinational. The government should now allow the multinationals and other big firms to market the products of such small firms. Before making any of their new product available to their own subsidiary, it should be made available to any other small-scale industry. The rates of all such new products should be controlled and fixed by the government.

5. ATLEAST ESSENTIAL DRUGS TO BE MADE AVAILABLE IN GENERIC NAMES

Anti-leprotic, anti-malarial, anti-tuberculour, anti-biotics anti-filarial, analgesic drugs atleast should be marketted only in generic names and their prices reduced. Once these products are converted into generic forms, these will not attract excise duty and the state governments can wave off the sales tax. The whole-sale and r tail margins on these generic products should be fixed only at 5% and 12.5% respectively. These measures will make these essential drugs available at virtually half the present prices. Leader price should be fixed and any addition of anything should not enable to increase or cross the leader price.

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DR-33-31

DIARRHOEA AND DRUGS*

IN the rich world, where the treatment of diarrhoea aims to relieve inconvenience rather than save life, a variety of drugs is used.

SINCE there are so many possible causes of diarrhoea, it is often not possible to identify the cause, let alone attack it directly with drugs. This is particularly true in poor communities, where there are few expensive diagnostic laboratories.

IN the Third World, drugs are therefore of limited value in tackling diarrhoea.

WHO, in a Manual of the Treatment of Diarrhoea, warns "A number of medicines which are of no value and are even dangerous, are often given to treat diarrhoea. Money and time are wasted in their use".

THIS advice sometimes conflicts with the hard sell of the rich world's drug companies. American pharmaceutical firm G.D. Searle has encouraged its representatives to claim that its product Lomotil has "an important role in the treatment of such diarrhoeas to help prevent dehydration."

The WHO manual on the other hand dismisses the drug as of "no value".

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*source: PRIMARY HEALTH CARE: Earthscan Press Briefing Document No 9, July 1978 pp 38-39

IN Britain and the USA, it can only be obtained with the prescription of a doctor. Yet in some poor countries, Lomotil is freely available over the counter without warning of possible dangerous side effects, particularly to children.

GOVERNMENT health services still spend money on such products. In Tanzania, for instance, a doctor found recently that $25,000 (£35,000 shillings) a year was being spent on Lomotil and other anti-diarrhoeal drugs of doubtful effectiveness. The WHO's list of essential drugs is intended to exclude this sort of wasteful purchase.

.....

mfc ms

TOWARDS RATIONAL THERAPEUTICS

Extracts of a letter from a young doctor in a small rural hospital in Madhya Pradesh.

Dear Friend,

.....About drug prescribing practices in our hospital--in the first few months of my work I had ordered many new drugs. Later I realised mainly because of financial conditions of the patients that only important essential drugs and a minimum possible list should be adopted.

Antibiotics

We use commonly Procaine Penicillin and Penidure. They used to use a lot of Streptopen, which I don't. I mainly use procaine penicillin. Then I use a lot of septran when there is double pathology, like respiratory tract infection with urinary tract infection or otitis media. We use tetracyclines very rarely. Injection Terramycin I don't use at all. So also chloromycetin. I never use chloramphenicol. If I doubt enteric fever, I start with septran. Then we have streptomycin only for TB patients. Crystalline penicillin I use only in new borns. At present I feel very confident regarding the usage of antibiotics and I don't use two drug combinations, so I have stopped using chlorostrep.

Diarrhoea

This is usually controlled with rehydration salts and plenty of oral fluids.....Slowly discontinuing lomotil and other drugs.

Cough syrups/Tonics

When I joined there were lots of varieties of cough syrups, cough/cold tablets and also lots of variety of tonics. It took me nearly a year to cut down many brands. We had 11 brands of cough syrup and 10 brands of tonics.

Now we make cough mixture in the hospital for free patients and we have 3 other brands of cough syrup.....

About tonics--it takes a lot of patience to convince patients--they don't need tonics--they can get the same benefit with proper food and milk/eggs. Now-a-days very few people ask for "Thakath ka sissi" and we have only two types of tonics....

I have kept multivite tablets, fersolate and calcium tablets. Not a single brand of costly vitamin capsules or tablets are stocked. They used to use a lot of varieties. Slowly I stopped even B-complex injections...

For TB patients we have pyridoxin. For children we have Vit A & D and multivite drops. Vit C. I hardly use--nor do I use calcium injections except in tetany.

Antacids

We had lots of brands before. Now we use Belladinal and two brands of antacids only.

.....One thing I have succeeded in proving here is that you can run a small hospital and treat patients successfully with only a handful of drugs which are cheap and good quality. Why do we insist on each doctor or specialist having his own petty brand of drugs in our large hospitals and even the medical college hospitals?.....

Yours sincerely,

L.M.

DR-33.32

ORAL REHYDRATION - which method is most appropriate?

Diarrhea is one of the main causes of death in small children. However, most of these children actually die from dehydration--the loss of too much water. It is generally agreed that the most important way to manage diarrhea is to replace the liquid that the child is losing. But there is less agreement about how to do this.

A few years ago, most doctors treated even mild dehydration by giving intravenous (I.V.) solution. But this was expensive, and many children died in diarrhea epidemics because there was not enough I.V. solution, or not enough skilled workers to give it.

Today, most health planners recognize that oral rehydration--or giving liquid by mouth--is the best way to manage most cases of diarrhea and dehydration. Even in clinics, where I.V. solution is available, it usually makes more sense to replace liquids by mouth. This way parents learn how to prepare and give liquids so they can begin treatment early, at home, the next time a child gets diarrhea.

A Special Drink or Rehydration Drink can be made from water mixed with small amounts of sugar and salt. It is even better if the drink contains a little baking soda (bicarbonate of soda) and a mineral called potassium--found in orange juice, coconut water, banana and other foods.

* The salt in the special drink replaces the salt lost through diarrhea, and helps the child's body to keep liquid.
* The sugar provides energy and also helps the body absorb liquid more quickly.
* The baking soda prevents 'acid blood', a condition that causes fast, heavy breathing and shock.
* The potassium helps keep the child alert and willing to drink and eat.

.....2

The amounts of sugar and salt in the Special Drink do not have to be very exact. In fact, there is great variation in the amounts recommended by different experts. However, too little sugar or salt does less good, and too much salt can be dangerous.

P.T.O

--Helping Health Workers Learn : David Werner and Bill Bower,

THE RANGE OF REHYDRATION METHODS FOR CHILDREN WITH DIARRHOEA CAN BE DIVIDED INTO TWO BROAD GROUPS:

Group 'A'

1. Intravenous solution (I.V.)
2. Factory prepared oral solution
3. Factory prepared packets of rehydration salts for mixing in water
4. Bags with salts, prepared at the health centre for mixing in water.

Characteristic: More dependency: control in the hands of institutions and professionals.

Advantages and Disadvantages

Control and responsibility mainly in the hands of professionals, institutions, and drug companies

Measurements more precise and 'controlled' (atleast in theory)

More magical; acceptance may be quicker but with less understanding

More dependency--on high technology, on outside resources, on centralised services, and on local and international politics

More expensive

Easier to gather data on, and prepare statistics about

Reaches fewer people; supply often uncertain and inadequate

Sometimes causes delay in treatment, because special materials have to be obtained; effect is more curative than preventive

Focus is on materials and supply (so cost goes up each year)

May give better (safer) results for individuals treated in time, but has worse results overall since many children never receive the liquid, or are given it too late.

Group 'B'

1. Homemade drink made with plastic measuring spoons
2. Homemade drink made with spoons found in the home
3. homemade drink made with homemade spoons
4. homemade drink with salt and sugar measured with the fingures or by another traditional way

Characteristics: More self-sufficiency ; control in the hands of the family

Advantages and Disadvantages

Control and responsibility mostly in the hands of the family
Measurements less precise, less 'controlled'
More practical and easier to understand
More self-sufficiency; uses local resources (whatever is available in the home or in stores)
Cheaper
Harder to gather data on, and prepare statistics about
Reaches more people; supply is local and almost always available
Treatment can begin at the first sign of diarrhea; more preventive than curative.
Focus is on people and on education, so the people's capacity for self-care increases over the years (cost goes down)
May be less safe in individual cases due to the possibility of errors in preparing or giving it, but it probably saves many more lives--since it reaches more children more quickly.

Main identity

From: "Dr Dabade" <drdabade@sancharnet.in>
To: <drugactionindia@healthyskepticism.org>
Cc: <pseumya@vsnl.net>
Sent: Sunday, November 30, 2003 9:26 PM
Attach: ATT00051.txt
Subject: Re: [drugactionindia] Hepatitis B vaccination in India

Dear Dr Panda,
Greetings.
Thanks for your comment. Can i request you to throw more light on Hepatitis C.
Thanking you
Gopal

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12/2/03

12/2/03

DR-33

District Health Action Forums (DHAF)

PREAMBLE

Whereas infections and diseases are on the rise,

Whereas the government machinery fails to address adequately the problem of ill-health,

Whereas the voluntary organizations and non-governmental developmental organizations (NGDO), though to some extent networked for advocacy on health related issues at national level, are yet to becomes joint force at the district level,

Whereas medical institutions, left to themselves and specialty, cannot measure up to the immense challenge of health for all in the district,

Whereas health calls for a multi-sided response from various sections,

Whereas representatives of people too need to be motivated in a commitment to integral health.

Whereas the WHO and related initiatives have been stressing on the district as a viable unit for health planning

Whereas for reasons mentioned above, it is beneficial to bring into one forum the various health-related concerns in the district -- whether of governmental or non-governmental or community-based organizations.

It is proposed to set up a district Health Action Forum in each district of India.

Objectives :

1. To identify the major health needs and issues in the district.
2. To plan together and initiate joint campaigns.
3. To pool resources together to bring health to all.
4. To join forces to involve people in planning and acting for health.
5. To promote health resource-mapping by people .
6. To build infrastructures for participatory action for health by people at the grassroots.
7. To promote a district-wide network of people for concerted action for health.

COMPOSITION

The District-level Health Action Forum could comprise the following:-

- District-level Health Officers of the government or their representatives, like District Medical and Health Officers. District TB and Malaria Officers, District Education Officer, etc.
- Members of Voluntary Health Association of India
- Members of Catholic Health Association of India
- Members of Christian Medical Association of India
- Voluntary organizations intersted in health environment and development.
- District level consumer movements.
- Representatives of Diocesan Social Service Societies.

ACTIVITIES SUGGESTED

1. Health Resource Mapping by people and health planning from below.
2. Organizing people at the grassroots into neighbourhood health communities and networking them through representative sructures at the levels of the village/ward, panchayat, mandal and the district.
4. Taking up district-specific health issues.
5. Preparing an action plan for a definite period of time, say for five years, and preparing annual plans accordingly.
6. Cleanliness and environmental protection.
7. Celebrating health-related days.
8. Consultation on participatory action for health (PAH)
9. Demystification of medical knowledge
10. Getting people to be growingly less and less expert-dependant.

HRM - For Resource File/Box on CHAI or start a Resource file on DHAF.

JN 6/6

On the basis of the internal changes taking place for collaborators as a result of collaboration and the type of response of the collectivity to external scenario, These are two factors important in respect to DHAF. I would like to classify the different types of inter-agency collaborations given in annexure 2 and the various perceptions of the DHAF given in annexure 3 into four major groups and I would prefer to call them major approaches to inter agency collaboration. Summarized and tabular statement on these three approaches is given as annexure 4. These are the 'conventional networking' approach, joint programming approach, engulfing approach and political approach. (The third one is not relevant for our discussion here). These are not mutually exclusive categories but are different stages of development in a continuum. The level of understanding of the present socio political scenario, the extent of commitment to effecting a real change in the living conditions of the poor and the degree of capability of the actors are the factors that help an organization or an individual to make their choice on approach.

The first approach is the easiest and the least burdensome one. This is the most commonly found type of inter-agency collaboration. It does not need a higher level of commitment and capability. In our experience, most of our DHAFs show leniency towards this direction. It is this approach is easily acceptable one because it is immediately rewarding and a politically neutral one or "harmless" one. It is non-threatening too. It is a floating approach without any proper direction.

The second approach is the one envisaged by the concept paper published by CHAI. It involves more understanding, commitment and capability. It is a burdensome business and a time consuming process. The DHAFs look at DHAF in this way. It is surprising to see that most of our collaborators including our members are not very much interested in this approach. And those who are interested are mainly excited by the possibility of getting coopted by undertaking "contracted out" schemes of the governments and acting as contracted vendors of government services.

The third is a political approach. Here a critical analysis of the emerging socio political scenario must be the starting point. It will provide role clarity to collaborators. The critique of social reality will help the emergence of different types of responses within the DHAF, which may later develop into specialized efforts or offshoots of the DHAF. Then the DHAF should always get linked up with the emerging and new movements to safeguard interests and rights of people. A good example is the possible linkage with the PHA. Very few collaborators of the DHAF understand it in this way.

The choice of Approach:

The choice of approach depends mainly on the challenge one faces from the emerging scenario and one's resolution to address them in a specific manner. Hence, in the current context, if one wants to make a choice from among the above approaches, one has to analyse the current scenario and try to position oneself. Let us try to do this and understand the ideal or the desirable approach to collaboration that the DHAF may need in the present context.

The current (external) scenario is largely shaped by globalization. The direct impact of globalisation on health is a well-discussed subject. Now for the purpose of this paper, we shall turn to some other impacts of globalization. Shrinking of the state, decentralization of power and crisis in democratic practices are the important political impacts of globalization.

The state in India after globalization is not as powerful as it was earlier. The state lost its power in terms of both autonomy and sovereignty to the market. This leads to

1. Giving up many of its conventional functions in favour of the market. Decentralization and devolutions takes place in a great way at his point of time.
2. Market forces and the rightist, reactionary divisive forces rush to occupy the spaces formerly occupied by the state as soon as the latter makes the withdrawal.

3. The democratic practices that shaped the state gradually become outdated and a crisis appears there. The organised political forces that try to control the state will have either to become mouth pieces of the market or to compromise with it and with that representative democracy will be in very serious crisis. Search for new models become inevitable.

The only hope is civil society. Activating civil society and promoting different types of civil society organisations to capture the new spaces and to pilot new democratic practices is a real solution. But civil society is virtually non existant or remains fragmented, if at all, it exists. Not only that the factors such as caste, class and so on which the segmentation of civil society takes place are also affected by globalisation and undergoing changes. It suggest that conventional organisational strategies will also become inadequate and inappropriate. On the other hand the new organisational strategies such as NHGs and SHGs proposed under globalization are proposed to make people in different to such changes but can be seen as double edged weapon.

The above anlaysis tells us that the desirable or ideal approach to collaborations in DHAF in the political one. Unless the DHAF intervenes in the political situation, the networking and joint programmes will neither be able to make any impact on the lives of the masses or be sustainable. And equally important is the implication that most of our collaborators are not adequately aware of the real nature of emerging situation.

Tasks before us:

The following are the important tasks before us.

- A well designed policy on networking and collaboration. (Networking and collaboration is to be seen separately from advocacy and lobbying. Both are not one and same. The former can be a tool for the latter; but not a tool only for the former. It has other functions too. Spell out those also in policy statement).
- Building up the capacity of our members and other collaborators is very much important. The capacity building activities of the DHAI has to address the new and emerging needs also. The ongoing capacity building activities needs a thorough revision.
- Opening up ourselves is very important. The leaders of the R.U.s and the D.U.s may have to be made aware of the inevitability and desirability of being open.

Annexure - 4

THE DIFFERENT APPROACHES TO DHAF

Sl. No	Name	Nature	Internal change	Response to external situation	Result
1.	Conventional network approach	A mere platform (sharing and discussion on health issues and concernes celebrations) watchdog And "excursion"	No internal change Extent of involvement is limited (for a change or variety or seeking support and gaining confidence)	No serious response to the external situation. Superficial responses Symbolic responses	No effect on the factors creating the scenario.
2.	Joint Programming Approach	Join planning. Joint programming Convergence Addresses the issues of long term basis Extension	Internal changes takes place (policy, planning etc) Network priorities influences internal priorities	Not deep Curative and partly preventive in nature	• Efficiency increased • Help the actors to adjust to the scenario • Compromising • Getting coopted • No influence on factors creating the structure • Stop-gap arrangement
3.	Engulfing Approach	NOT RELEVANT TO OUR CONTEXT			
4.	Political Approach	DHAF becomes a forum promoting varying responses including all the above. Flexible to accommocate different interventions at different levels. Promoting offshoots Dynamic and changing	Internal change take place (perspective, vision) "Born again" feeling. Strategies of operation shall also be changed	Deep Seek the real causes	Influence the deciding factors Open to all movements catering to the interests and needs of the poor.

DIFFERENT PERCEPTIONS OF DHAF

Project or additional programme

Simple network of NGOs

Full-fledged organisation

Platform of all stake-holders in health

Civil society response to globalisation

New paradigm of participation

Strategy to mediate with power and governance

Means to bring PHC back to forefront

Forum for advocacy and policy lobbying for health for all

Watch-dog arrangement

Instrument changing the style of functioning and
Perception of actors

Means to promote community action for health and
Hence community involvement in health

Disaster management mechanism

Arrangement for convergence of resources and hence
For cost reduction

Mechanism to help government in carrying out its functions

Political intervention in health

Joint programming forum

Arrangement for sharing of resources and responsibilities

DR-33.

ರಕ್ತ ಹೀನತೆ ಚಿಕಿತ್ಸೆಗೆ ಔಷಧಗಳು– ಒಂದು ಅಧ್ಯಯನ

ರಕ್ತಹೀನತೆ ಚಿಕಿತ್ಸೆಗಾಗಿ ಇರುವ ಔಷಧಗಳ ಸ್ಥಿತಿಗತಿಯ ಕುರಿತು ಗ್ರಾಹಕ ಸಂಘಟನೆಗಳಿಗೆ ಹೇಳುವ ಒಂದು ಪ್ರಯತ್ನ

ಲೇ: ಡಾ.ಗೋಪಾಲ ದಾಬಡೆ, ಡಾ. ಆರ್.ಆರ್. ಕಾಂಗೋವಿ, ಡಾ. ಎಸ್. ಎಲ್.ಪವಾರ, ಡಾ.ಎ.ಎನ್.ಕಬ್ಬೂರ
ಪ್ರಕಟಣೆ: ಔಷಧ ಕ್ರಿಯಾ ವೇದಿಕೆ–ಕರ್ನಾಟಕ
೫೭ ಸೋನಿ, ತೇಜಸ್ವಿನಗರ
ಧಾರವಾಡ ೫೮೦೦೦೨
ಕರ್ನಾಟಕ
ಫೋ:(೦೮೩೬)–೨೪೬೧೭೨೨

ಮುಖ್ಯ ಅಂಶಗಳು

೧. ನಮ್ಮ ರಕ್ತದಲ್ಲಿ ಹಿಮೋಗ್ಲೋಬಿನ್ ಪ್ರಮಾಣವು ೧೧% ನಿಂದ ೧೩% ರಷ್ಟಿರಬೇಕು. ಈ ಮಟ್ಟಕ್ಕಿಂತ ಕಡಿಮೆ ಇದ್ದರೆ ಆ ವ್ಯಕ್ತಿಗೆ ರಕ್ತಹೀನತೆ ಆಗುತ್ತದೆ. ಹಿಮೋಗ್ಲೋಬಿನ್ ನಿಂದಾಗಿ ರಕ್ತದ ಬಣ್ಣವು ಕೆಂಪಾಗಿರುತ್ತದೆ. ಪುಪ್ಪುಸದಿಂದ ದೇಹದ ವಿವಿಧ ಅಂಗಗಳಿಗೆ ಆಮ್ಲಜನಕವನ್ನು ಮತ್ತು ದೇಹದ ವಿವಿಧ ಅಂಗಗಳಿಂದ ಪುಪ್ಪುಸಕ್ಕೆ ಇಂಗಾಲದ ಡೈ ಆಕ್ಸೈಡನ್ನು ಹೊತ್ತೊಯ್ಯುವ ಕೆಲಸವನ್ನು ಹಿಮೋಗ್ಲೋಬಿನ್ ಮಾಡುತ್ತದೆ. ಯಾವುದೇ ವ್ಯಕ್ತಿಗೆ ರಕ್ತ ಹೀನತೆಯು ಆಯಿತೆಂದರೆ ಆದು ಆತನ/ಆಕೆಯ ಆಹಾರದಲ್ಲಿ ಪೌಷ್ಟಿಕಾಂಶದ ಕೊರತೆ ಇದೆ ಎಂಬುದನ್ನು ಸಾರಿ ಹೇಳುತ್ತದೆ. ಒಂದು ಸಮುದಾಯದಲ್ಲಿ, ಒಂದು ದೇಶದಲ್ಲಿ ರಕ್ತ ಹೀನತೆ ಇರುವವರು ಬಹಳ ಇದ್ದರೆ ಅಲ್ಲಿ ಆಹಾರದ ಕೊರತೆ ಇದೆ ಎನ್ನುವುದು ನಿಚ್ಚಳ.

೨. ರಕ್ತ ಹೀನತೆಗೆ ಕಾರಣಗಳು ಹತ್ತಾರು. ಆದರೆ ಭಾರತದಲ್ಲಿ ರಕ್ತಹೀನತೆಗೆ ಅಪೌಷ್ಟಿಕತೆಯೇ ಅತಿ ಮುಖ್ಯ ಕಾರಣವಾಗಿದೆ. ೨೦೦೨–೨೦೦೩ ರಲ್ಲಿ ದೆಹಲಿ ಹೆಲ್ತ್ ಸರ್ವೆ ಸರ್ವಿಸಸ್– ರಿಪ್ರೊಡಕ್ಟಿವ್ ಎಂಡ್ ಚೈಲ್ಡ್ ಹೆಲ್ತ್ ಸರ್ವೆಯ ಪ್ರಕಾರ ಭಾರತದಲ್ಲಿ ಹದಿಪರಯದ ಹೆಣ್ಮಕ್ಕಳಲ್ಲಿ ೯೫% ಹುಡುಗಿಯರು ಮತ್ತು ೫ ವರ್ಷದೊಳಗಿನ ಮಕ್ಕಳಲ್ಲಿ ೯೩.೩% ಮಕ್ಕಳು ರಕ್ತಹೀನತೆಯಿಂದ ಬಳಲುತ್ತಾರೆ. ರಕ್ತಹೀನತೆಯು ಮಕ್ಕಳ ಬೆಳವಣಿಗೆಯ ಮೇಲೆ ತೀವ್ರ ಪರಿಣಾಮ ಬೀರಬಲ್ಲದು.

೩. ಈ ಅಧ್ಯಯನದಲ್ಲಿ ರಕ್ತಹೀನತೆ ಗುಣಪಡಿಸಲು ನಮ್ಮ ಡಾಕ್ಟರುಗಳಿಗೆ ಪೇಟೆಯಲ್ಲಿ ಎಂಥ ಔಷಧಗಳು ಲಭ್ಯವಿವೆ ಎಂಬುದನ್ನು ಅಭ್ಯಸಿಸಲಾಗಿದೆ. ರಕ್ತಹೀನತೆಗೆ ವೈಜ್ಞಾನಿಕವಾದ ಒಳ್ಳೆಯ ಔಷಧಗಳಿವೆ ಎಂದು ಯಾರಾದರೂ ನಿರೀಕ್ಷಿಸಬಹುದು. ಆದರೆ ಹಾಗಿಲ್ಲ. ರಕ್ತಹೀನತೆಗೆ ಸರಿಯಾದ ಔಷಧವೇ ನಮ್ಮ ಪೇಟೆಯಲ್ಲಿ ಲಭ್ಯವಿಲ್ಲ.

೪. ಈ ಅಧ್ಯಯನದಲ್ಲಿ ಡಾಕ್ಟರುಗಳು ಬಳಸುವ ಮಾರ್ಗದರ್ಶಿಕೆ ಪುಸ್ತಕ, ಸಿಮ್ಸ್–ಎಂದರೆ ಕರೆಂಟ್ ಇಂಡೆಕ್ಸ್ ಆಫ್ ಮೆಡಿಕಲ್ ಸ್ಪೆಷಾಲಿಟೀಸ್ ೨೦೦೫–೨೦೦೬–ರಲ್ಲಿರುವ ಎಲ್ಲ ರಕ್ತ ಹೀನತೆಯ ಔಷಧಗಳನ್ನೂ ಪಟ್ಟಿ ಮಾಡಲಾಗಿದೆ. ಆದರಲ್ಲಿ ಒಟ್ಟೂ ೩೩೮ ಔಷಧಗಳಿವೆ. ಅವನ್ನು ಔಷಧ ಶಾಸ್ತ್ರದ ಪುಸ್ತಕದಲ್ಲಿ ಹೇಳಿರುವ ಆಂಶಗಳೊಂದಿಗೆ ಹೋಲಿಸಲಾಯಿತು. ಹಾಗೆಯೇ ವಿಶ್ವ ಆರೋಗ್ಯ ಸಂಸ್ಥೆಯ ಅವಶ್ಯಕ ಔಷಧಗಳ ಪಟ್ಟಿಯೊಂದಿಗೂ ಹೋಲಿಸಲಾಯ್ತು.

೫. ಈ ಎಲ್ಲಾ ೩೩೮ ಔಷಧಗಳ ಪ್ರತಿಯೊಂದು ಔಷಧವನ್ನೂ ಹೋಲಿಸಿ ನೋಡಿದಾಗ ಆವು ಹೊಂದುತ್ತಿವೆಯೇ? ಇಲ್ಲ, ಕೇವಲ ಒಂದೇ ಔಷಧ, ಫೆರಸ್ ಫ್ಯುಮರೇಟ್ ೨೦೦ ಮಿ.ಗ್ರಾಂ. ಮಾತ್ರ ವಿಶ್ವ ಆರೋಗ್ಯ ಸಂಸ್ಥೆಯ ಅವಶ್ಯಕ ಔಷಧಗಳ ಗುಣಕ್ಕೆ ಸರಿ ಹೊಂದುತ್ತದೆ ಎನ್ನುವುದು ಕಂಡುಬಂದಿದೆ. ಈ ಔಷಧದ ಬೆಲೆ ಒಂದು ಮಾತ್ರೆಗೆ ೧೩ ಪೈಸೆ. ರಕ್ತಹೀನತೆಯನ್ನು ಗುಣಪಡಿಸಬಲ್ಲ ಸರಿಯಾದ ವೈಜ್ಞಾನಿಕ ಔಷಧದ ಒಂದು ಮಾತ್ರೆಗೆ ಕೇವಲ ೧೩ ಪೈಸೆ. ಆದರೆ ದುರಂತ ನೋಡಿ. ಈ ಅಧ್ಯಯನ ಕೈಗೊಂಡಿರುವ ಧಾರವಾಡ ನಗರ ಪ್ರದೇಶದಲ್ಲೆಲ್ಲ ಸುತ್ತಾಡಿದರೂ ಫೆರಸ್ ಫ್ಯುಮರೇಟ್ ಔಷಧವು ಯಾವುದೇ ಔಷಧಂಗಡಿಯಲ್ಲಿ ಲಭ್ಯವಿಲ್ಲ. ಯಾಕೆಂದರೆ ಬೆಲೆಯೇ ಅಷ್ಟು ಕಡಿಮೆಯಿರುವಾಗ ಅದಕ್ಕೆ ಲಾಭ ಆದೆಷ್ಟು ಬಂದೀತು ಎಂದು ಯಾವ ಔಷಧ ವ್ಯಾಪಾರಿಗಳಿಗೂ ಆಸಕ್ತಿ ಇಲ್ಲ.

೬. ಹೀಗಾಗಿ ಗ್ರಾಹಕನಿಗೆ ಅವೈಜ್ಞಾನಿಕವಾದ, ಸರಿಯಾದ ಸಂಯುಕ್ತವಲ್ಲದ, ಆನವಶ್ಯಕ, ಬೆಲೆ ಹೆಚ್ಚಿರುವಂಥ ಔಷಧವನ್ನೇ ರಕ್ತಹೀನತೆಗೆ ನುಂಗಬೇಕಾದ ಅನಿವಾರ್ಯತೆ. ಅವುಗಳಲ್ಲಿ ಕೆಲವು ಹಾನಿಕಾರಕ ಕೂಡ.

೭. ಸರಿಯಾದ ವೈಜ್ಞಾನಿಕವಾದ ಔಷಧವೇ ದೊರೆಯದ ಕಾರಣ ಡಾಕ್ಟರುಗಳಿಗೆ ಅವೈಜ್ಞಾನಿಕ ಔಷಧ ಭರಿಯದೇ ಬೇರೆ ದಾರಿಯೇ ಇಲ್ಲದಂಥ ಪರಿಸ್ಥಿತಿ. ಅವರು ಹೆಚ್ಚು ಬೆಲೆಯ, ಔಷಧ ಶಾಸ್ತ್ರ ಪುಸ್ತಕದಲ್ಲಿ ಬರೆದಿಲ್ಲದಂಥ ಔಷಧಗಳನ್ನು ಬರೆದುಕೊಡುತ್ತಿದ್ದಾರೆ.

೮. ಸಿಮ್ಸ್ ನಲ್ಲಿ ಪಟ್ಟಿ ಮಾಡಿದ ಔಷಧ ಸಂಯುಕ್ತಗಳ ಬೆಲೆಯನ್ನು ಪರಿಶೀಲಿಸಿದಾಗ ಅವುಗಳಲ್ಲಿ ಹೆಚ್ಚಿನವು ಬಹಳ ದುಬಾರಿ ಎಂಬುದೂ ಕಂಡು ಬಂದಿದೆ.

೯. ಸರಕಾರಿ ಆಂಕಿ ಅಂಶಗಳ ಪ್ರಕಾರ ನಮ್ಮ ದೇಶದಲ್ಲಿ ಇರುವ ಔಷಧ ಕಂಪನಿಗಳ ೨೦೦೩–೨೦೦೪ ರ ಒಟ್ಟೂ ಉತ್ಪಾದನೆ ೫೦,೦೦೦ ಕೋಟಿ ರೂಪಾಯಿ. ನಮ್ಮ ಅಧ್ಯಯನದಿಂದ ಕಂಡುಬಂದಿದ್ದೇನೆಂದರೆ ಭಾರತದ ೧೦೦ ಕೋಟಿ ಜನರಲ್ಲಿ ಅರ್ಧಭಾಗ ಅಂದರೆ ೫೦ ಕೋಟಿಯಷ್ಟು–ಜನಸಂಖ್ಯೆ ರಕ್ತಹೀನತೆಯಿಂದ ಬಳಲುತ್ತಿದೆ. ಅವರಿಗೆಲ್ಲ ಚಿಕಿತ್ಸೆ ಕೊಡಿಸಲು ೫೮೫ ಕೋಟಿ ರೂಪಾಯಿಗಳು ಬೇಕು. ಅಂದರೆ ಔಷಧ ಕಂಪನಿಗಳ ವಾರ್ಷಿಕ ಉತ್ಪಾದನೆಯ ಕೇವಲ ೧.೧೭% ಹಣವನ್ನು ತೊಡಗಿಸಿದರೂ ಸಾಕು, ನಮ್ಮ ರಕ್ತ ಹೀನತೆಯ ಸಮಸ್ಯೆಯನ್ನು ಇಲ್ಲವಾಗಿಸಬಹುದು.

ಮುಂದೇನು?

ಪ್ರತಿ ಔಷಧ ಕಂಪನಿಯೂ ವಿಶ್ವ ಆರೋಗ್ಯ ಸಂಸ್ಥೆ ನೀಡಿರುವ ಮಾರ್ಗದರ್ಶನದ ಪ್ರಕಾರ ಕಬ್ಬಿಣಾಂಶದ ಮಾತ್ರೆಗಳನ್ನು ತಯಾರಿಸಲೇಬೇಕೆಂದು ಪೆಟ್ರೋಲಿಯಂ ಮತ್ತು ರಾಸಾಯನಿಕ ಮಂತ್ರಾಲಯವು {ಔಷಧ ಸಂಹಿತೆಯನ್ನು ರೂಪಿಸುವ ಮಂತ್ರಾಲಯ} ಆಜ್ಞೆ ಮಾಡಬೇಕು. ಅದೇ ರೀತಿಯಲ್ಲಿ ಪ್ರತಿಯೊಂದು ಔಷಧ ಅಂಗಡಿಯೂ ಕೂಡ ಕನಿಷ್ಟ ಒಂದಾದರೂ ಕಬ್ಬಿಣಾಂಶದ ಔಷಧವನ್ನು ಅವಶ್ಯಕ ಪ್ರಮಾಣದಲ್ಲಿ ಯಾವಾಗಲೂ ಇಟ್ಟಿರಲೇಬೇಕೆಂದು ರಾಜ್ಯ ಸರಕಾರವು ಆಜ್ಞೆ ಮಾಡಬೇಕು. ಗ್ರಾಹಕ ವೇದಿಕೆಗಳು, ಜನಪರ ಸಂಘಟನೆಗಳು ಈಗಿರುವ ಸ್ಥಿತಿಯ ವಿಷಯವನ್ನು ಕೈಗೆತ್ತಿಕ್ಕೊಂಡು ನೀತಿ ಸಂಹಿತೆ ರೂಪಿಸುವ ಸರಕಾರ, ಮತ್ತು ಕೈಗಾರಿಕೆಗಳ ಮೇಲೆ ಒತ್ತಡ ತರುವ ಕೆಲಸವನ್ನು ಮಾಡಬೇಕು. ಆಂಥ ಒಂದು ಕಾರ್ಯಕಾಗಿ, ಚರ್ಚೆ ಮತ್ತು ಸಂವಾದಗಳನ್ನು ಆರಂಭಿಸಲಿಕ್ಕಾಗಿ ಈ ಪುಸ್ತಕವು ಉಪಯುಕ್ತವಾಗಲಿದೆಯೆಂದು ಕರ್ನಾಟಕ ಔಷಧ ಕ್ರಿಯಾ ವೇದಿಕೆಯು ಹಾರೈಸುತ್ತದೆ.

ಆಮೆರಿಕಾದಲ್ಲಿ ಅತಿ ಕಡಿಮೆ ಜನಸಂಖ್ಯೆಗೆ ಅತಿ ಅವಶ್ಯವಾಗಿ ಬೇಕಾದ ಔಷಧವನ್ನು ಒಂದು ಕಂಪನಿ ಉತ್ಪಾದಿಸುತ್ತಿದ್ದರೆ ಆ ಕಂಪನಿಗೆ ಸರಕಾರವು ತೆರಿಗೆ ವಿನಾಯಿತಿಯನ್ನು ನೀಡುತ್ತದೆ. ಅಮೆರಿಕಾದ ಈ ಮಾದರಿಯನ್ನು ನಮ್ಮ ಸರಕಾರಗಳೂ ಅನುಸರಿಸಿ ನಮ್ಮಲ್ಲಿಯೂ ಕೂಡ ಅವಶ್ಯಕ ಮತ್ತು ವೈಜ್ಞಾನಿಕ ಔಷಧಗಳು ಅತಿ ಕಡಿಮೆ ಬೆಲೆಯಲ್ಲಿ, ಲಾಭಾಂಶವಿಲ್ಲದೆಯೂ ಲಭ್ಯವಾಗುವಂತೆ ಮಾಡಬಹುದು.

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ಈ ಅಧ್ಯಯನ ವರದಿಯು ಶೀಘ್ರದಲ್ಲಿಯೇ ಒಂದು ಪುಸ್ತಕ ರೂಪದಲ್ಲಿ ಹೊರಬರಲಿದೆ. ಒಂದು ಪ್ರತಿಯ ಬೆಲೆ: ೧೦ ರೂ ಮಾತ್ರ. ಆವಶ್ಯಕ ಔಷಧಗಳ ಲಭ್ಯತೆಗಾಗಿ ಆಂದೋಲನದಲ್ಲಿ ಭಾಗಿಯಾಗಲಿಚ್ಛಿಸುವವರು ಮೇಲೆ ಕೊಟ್ಟ ವಿಳಾಸವನ್ನು ಸಂಪರ್ಕಿಸಬಹುದು.

೨೫.೦೮.೦೬
ಧಾರವಾಡ

DR-33.

ಭಾರತ ಸರ್ಕಾರದ,

ಔಷಧ ನಿಯಂತ್ರಣಾಧಿಕಾರಿ

ನಿಷೇಧಿಸಿದ ಔಷಧ ಸಂಯುಕ್ತಗಳು

Fixed Dose Combinations of Drugs Banned

By the Drug Controller of India

ಡ್ರಗ್ ಆ್ಯಕ್ಷನ್ ಫೋರಂ – ಕರ್ನಾಟಕ,

೫೭, ತೇಜಸ್ವಿ ನಗರ,

ಧಾರವಾಡ ೫೮೦ ೦೦೨.

ಫೋನ್ ೨೪೬೧೨೨

ಬೆಲೆ : ರೂ. ೫/–

ಭಾರತ ಸರ್ಕಾರದ, ಔಷಧ ನಿಯಂತ್ರಣಾಧಿಕಾರಿ ನಿಷೇಧೀಸಿದ ಔಷಧ ಸಂಯುಕ್ತಗಳು. 1

Fixed dose Combinations of Drugs Weeded by the Drug Controller of India.

1. Amidopyrine.
2. Fixed dose combinations of Vitamins with anti-inflammatory agents and tranquillisers.
3. Fixed dose combinations of Atropine and Analgesics and Antipyretics.
4. Fixed dose combinations of Strychnine and Caffeine in tonics.
5. Fixed dose combinations of Yohimbine and Strychnine and Testosterone and Vitamins.
6. Fixed dose combinations of Iron with Strychnine, Arsenic and Yohimbine.
7. Fixed dose combinations of Sodium Bromide/Chloralhydrate with other drugs.
8. Phenacetin.
9. Fixed dose combinations of anti-histamines with anti-diarrhoeal.
10. Fixed dose combinations of Penicillin with Sulphonamides.
11. Fixed dose combinations of Vitamins with Analgesics.
12. Fixed dose combinations of Tetracycline with Vitamin C.
13. Fixed dose combinations of Hydroxyquinoline group of drugs except preparations which are used for the treatment of diarrhoea and dysentery and for external use only.

57. Fixed dose combinations of Haemoglobin and fixed dose combination of Pancreatin or Pancrelipase containing amylase, protease and lipase with another drug (stayed by Government with effect from October 20, 1999)
58. B1, B6 & B12 combinations.
59. Astemizole.
60. Terfanadine
61. Multi – ingredient products that contain Astemizole, Terfanadine or Phenformin are also banned.

ಹೆಚ್ಚಿನ ಮಾಹಿತಿಗೆ ಕೆಳಗಿನ ವಿಳಾಸಕ್ಕೆ ಸಂಪರ್ಕಿಸಿ:–

ಔಷಧ ನಿಯಂತ್ರಣಾಧಿಕಾರಿ – ಕರ್ನಾಟಕ,
ಆಂಬೆ ಪೆಟ್ಟಿಗೆ ಜಿಷಿಒಒ,
ಪ್ಯಾಲೆಸ್ ರೋಡ್, ಬೆಂಗಳೂರು ಜಿಟಿ ೦೦೧
ಫೋನ್ ಒಒಒಒಳಳಒ

Drug Controller of India,
Nirman Bhavan,
New Delhi 110 001.

ನಮ್ಮ ದೇಶದ ಔಷಧ ಸ್ಥಿತಿ ಹೇಗಿದೆ?

ಇದು ನಿಮಗೆ ಗೊತ್ತೆ?

- ವಿಶ್ವ ಆರೋಗ್ಯ ಸಂಸ್ಥೆಯ ಪ್ರಕಾರ ಆವಶ್ಯಕ ಔಷಧಿಗಳ ಸಂಖ್ಯೆ ಕೇವಲ 375.
- ಆದರೆ ನಮ್ಮ ದೇಶದ ಮಾರ್ಕೆಟ್ಟಿನಲ್ಲಿ 80,000 ಔಷಧಿಗಳು ಲಭ್ಯ ಇವೆ!
- ಇವುಗಳಲ್ಲಿ ಅತಿ ಹೆಚ್ಚಿನವು ಅನಾವಶ್ಯಕ ಹಾಗು ಹಾನಿಕಾರಕ.
- ನಮ್ಮ ದೇಶದ ಅತಿ ಸಾಮಾನ್ಯ ರೋಗಗಳೆಂದರೆ ಕ್ಷಯ, ಮಲೇರಿಯಾ, ಕುಷ್ಠ, HIV/AIDS. ಆದರೆ ಈ ರೋಗಕ್ಕೆ ಸಂಬಂಧಪಟ್ಟ ಔಷಧಗಳ ಮೇಲೆ ಬೆಲೆ ನಿಯಂತ್ರಣ ಇಲ್ಲ.
- ನಮ್ಮ ದೇಶದ ಔಷಧ ಸಂಹಿತೆಯನ್ನು ತಯಾರು ಮಾಡುವವರು ಆರೋಗ್ಯ ಮಂತ್ರಾಲಯವಲ್ಲ, ಪೆಟ್ರೋಲಿಯಂ ಮತ್ತು ರಾಸಾಯನಿಕ ಮಂತ್ರಾಲಯ.
- ನಮ್ಮ ಔಷಧಗಳ ಬೆಲೆನಿರ್ಧರಿಸುವವರು ವಾಣಿಜ್ಯ ಮಂತ್ರಾಲಯ.

"ಆಧುನಿಕ ಔಷಧಗಳಲ್ಲಿ ಅರ್ಧದಷ್ಟನ್ನು, ಕಿಟಕಿಯ ಹೊರಗೆ ಬಿಸಾಕಿಬಿಡಬಹುದಾಗಿತ್ತು, ಆದರೆ ಪಕ್ಷಿಗಳು ಅದನ್ನು ತಿನ್ನಬಹುದೆಂಬ ಹೆದರಿಕೆ."

ಮಾರ್ಟಿನ ಹೆನ್ರಿ ಫಿಶರ

14. Fixed dose combinations of Cortocosteroids with any other drug for internal use.
15. Fixed dose combinations of Chloramphenicol with any other drug for internal use.
16. Fixed dose combinations of crude Ergot preparations except those containing Ergotamine, Caffeine, Analgesics, antihistamines for the treatment of migraine headaches.
17. Fixed dose combinations of Vitamins with Anti-TB drugs except combinations of Isoniazide with Pyridoxine Hydrochloride (Vitamin B&).
18. Penicillin skin/eye ointment.
19. Tetracycline liquid oral preparations.
20. Nialamide.
21. Proctalol.
22. Methypyrilene, its salts.
23. Methaqualone.
24. Oxytetracycline liquid oral preparations.
25. Demeclocycline liquid oral preparations.
26. Combinations of Anabolic Steroids with other drugs.
27. Fixed dose combinations of Oestrogen and Progestrin (other than oral contraceptive containing per tablet Estrogen content of more than 50 mg (equivalent to Ethinyl Estradiol) and of progetin content of more than 3 mg (equivalent to Norethisterone Acetate) and all fixed dose combinations injectable preparations containing synthetic oestrogen and progesterone.

28. Fixed dose combinations of Sedatives/hypnotics/anxiolytics with analgesic – antipyretics. 3
29. Fixed dose combinations of Pyrazinamide with other anti-tubercular drugs except combinations of Pyrazinamide with Rifampicin and INH as per recommended daily dose given below:-

Drugs	Minimum	Maximum
Rifampicin	450 mg	600 mg
INH	300 mg	400 mg
Pyrazinamide	1000 mg	1500 mg

30. Fixed dose combinations of histamine H2 – receptor antagonists with antacids except for those combinations approved by the Drugs Controller, India.
31. The patent and proprietary medicines of fixed dose combinations of essential oils with alcohol having percentage higher then 2% proof except preparations given in the Indian Pharmacopoeia.
32. All Pharmaceutical preparations containing Chloroform exceeding 0.5% w/w or v/v which ever is appropriate.
33. Fixed dose combinations of Ethambutol with INH other than the following:

INH	Ethambutol
200 mg	600 mg
300 mg	800 mg

34. Fixed dose combinations of antihelmenthic with cathartic/purgative except for Piperazine.

35. Fixed dose combinations containing more than one antihistamine. 4
36. Fixed dose combinations of Salbutamol or any other bronchodilator with centrally acting anti-tussive and/or antihistamine.
37. Fixed dose combinations of laxatives and/or anti – spasmodic drugs in enzyme preparations.
38 Fixed dose combinations of Metoclopramide with other drugs/or anti-spasmodic drugs in enzyme preparations.
39 Fixed dose combinations of centrally acting anti-tussive with antihistamine having high atropine like activity in expectorants.
40. Preparations claiming to combat cough associated with asthma containing centrally acting anti-tussive and/or an antihistamine.
41 Liquid oral preparations containing glycerphosphates and/or other phosphates and/or central nervous stimulant and such preparations containing alcohol more than 20 percent proof.
42. Fixed dose combinations containing Pectin and/or Kaolin with any drug which is systemically absorbed from GI tract except for combinations of Pectin and/or Kaolin with drugs not systemically absorbed.
43. Chloral Hydrate as drug.
44. Tooth paste/Toothpowder containing Tobacco.
45. Dover's Powder/Dover's Powder Tablets.
46. Antidiarrhoeal formulations containing Kaolin or Pectin or Attopulgite or activated charcoal.
47. Ant diarrhoeal formulations containing Phthalyl Sulphathiazole or Sulphaguanidine or Succinyl Sulphathiazole.

47 Antidiarrhoeal formulations containing Phthalyl Sulphathiazole or Sulphaguanidine or Succinyl Sulphathiazole.

48 Antidiarrhoeal formulations containing Neomycin or Streptomycin or Dihydrostreptomycin including their respective salts or esters.

49 Liquid oral antidiarrhoeals or any other dosage form for paediatric use containg Diphenoxylate or Lopermide or Atropine or Belladona including their salts or esters or metabolites Hyoscyamine or their extracts or their alkaloids.

50 Liquid oral Antidiarrhoeal or any other dosage form for paediatric use containing halogenated hydroxyquinolines.

51 Fixed dose combinations of antidiarrhoeals with electrolytes.

52 Fixed dose combinations of modern drugs with Ayurvedic drugs belonging to any other system of medicine.

53 Fixed dose combinations of Penicillin and Streptomycin.

54 Fixed dose combinations of Oxyphenbutazone/Phenylbutazone with any other drugs.

55 Fixed dose combinations of Analgin with any other drugs other than antispasmodics.

56 Fixed dose combinations of Dextropropoxyphene with any drug other than non-steroidal anti-inflammatory drugs (NSAID).

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ಫೋನ್ ೭೭೬೭೮೪

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ಮಾರ್ಟಿನ ಹೆನ್ರಿ ಫಿಶರ