MEDICAL SERVICE

rational drug therapy ● locost: good quality, low cost generic medicines ● workshop recommendations on towards a people oriented drug policy ● comparative study of brand name drugs and generic name drugs ● drug use and misuse in surgical practise ● role of traditional medicine in primary health care

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contents

EDITORIAL

Big task ahead

With this issue of our Journal, most of the convention and the welcome workshop proceedings are made available to our readers. According to the opinions expressed by the participants of the convention and workshop held at Bangalore last November, that was a very useful convention. Such remarks were made by the participants regarding conventions in the past too. Every convention ends with a number of resolutions and recommendations. During this convention too there were resolutions and recommendations. In the previous issue we had already given the concern expressed by the delegates over the health situation with particular reference to the drug issues, and also the resolutions. In this issue we are giving the recommendations at various levels as a result of the workshop discussions. From all these one thing is very evident i.e. the task before the health care institutions in the future is a very big one.

We have been very prompt in making recommendations and resolutions during convention after convention. However, when the question of implementation comes we fall back. If we go through the recommendations and resolutions of our last convention, we can see there are a number of very practical suggestions to be carried out from individual level to national (CHAI) level. Let us make a deliberate attempt to do something concretely and positively on this.

The basis of all these proposed activities and action programmes is our motto, i.e. "Love of Christ Compels Us". It is in the field of health care that this love can be manifested in the best way. There should be an urge from within us to come to the aid of the sick, the poor, the oppressed, the under privieged etc. It is not enough for us to provide certain services even in the most efficient way or even free of cost for those who can not afford to pay. We need also to analyse the situation in which majority of our people are.

We are treating millions of sick people through our institutions every year. On analysis we may find vast majority of them are suffering from infections, diseases due to malnutrition, lack of safe drinking water, proper sanitation, etc. Yet we know most of these could be prevented. The requirement is proper nutrition, sanitation, safe drinking water facilities, increased purchasing power of the common man etc.

Thus we see the task ahead of us is a gigantic one in our country and also a challenging one. Let us all summon our courage and pool our resources together and go ahead as we have no other option because "Love of Christ Compels Us".

Rational Drug Therapy

—DR. MIRA SHIVA

Rational Drug Therapy is use of *effective.*

— *safe*

— *reasonable cost*

— *quality control standard drugs*

— for there is a *specific therapeutic need.*

in right doses, for right duration, for the right patient with effective communication of the right information which is followed by rational consumption of drugs.

Main *actors involved*

Policy makers — who can allow flood the market with irrational and hazardous drugs in the name of scientific and pharmaceutical progress at the cost of essential drugs.

Drug producers— Interested in producing and selling drugs not necessarily filling health needs having high market value, with inadequate or biased drug information, drugs which ensure irrational drug use.

Pharmacists— The first point of contact for many consumers buying OTC drugs 46% according to NIN studies with majority of pharmacists being untrained and unqualified.

Health personnel— who form the major components of the medical industry complex and who have to rely on the drug industry for samples, ongoing education, sponsoring of their conferences, grants for research etc..

Consumers — mainly ignorant, illiterate, poor and sick with preventable health problems, They often believes in the modern day superstitions i.e. Western medicine is scientific and developed and therefore at alone has the answer 'There is a pill for every ill'.

While talking of Rational Drug Therapy the questions cannot be addressed to the prescribers along since its all the various other dimensions that makes Rational Drug Therapy possible or not. To ensure rational drug use, the matter has to be dealt at all levels.

Believing in and implementing Rational Drug Therapy requires a certain philosophy i.e. practice of humane ethical, medically sound medicine which puts 'people' before 'profits'. Alleged belief in rational drug use and commercialization, profitering from medicine don't mix. Theoritical knowledge of what Goodman Gillman 'Martindale' and all the medicine Text books say in absence of the above attitude cannot ensure rational use. Like anything else requiring swimming against the current, rational drug therapy requires *knowledge* of the principles of Rational Drug Therapy and an attitude which permits its implementation.

Principles of Rational Drug Therapy

Appropriateness and Relevance— Use drugs which fulfil the main health needs of your people.

Prioritization— Give priority to essential over non essential these drugs providing our symptomatic relief.

Cost Consciousness— Avoid costly brands if cheaper drugs therapeutically equivalent drugs are available.

Boycott and challenge— Boycott irrational and hazardous drugs.

Communication of information— Provide patient with adequate information about the drug use.

Healing and caring — Communication of concern — Let your interaction having a healing effect.

Use drugs that :

— Offer *significant therapeutics* benefits

— meets *real medical needs*

— have a *satisfactory risk-benefit* ratio i.e. low risk and greater benefit.

— provide acceptable therapeutic value for money.

Avoid using drugs which

— may be therapeutically sound but not needed

— drugs with one or more ingredients of no value in sub therapeutic doses.

— the drug or its ingredient have an unacceptably high risk

— in a particular formulation not permitting effective and appropriate intake

— which doesn't allow the most appropriate route of intake or work as effectively.

e.g. Buscopan (hyoscine butyl bromide) is used to relieve stomach spasms— poorly absorbed from gut according to some experts. It is effective only as injection (Turner P Volanse G N 1980 pg. 3) Oral B-- (Cynacobalamin or hydroxycabalamin is futile (BNF No. 5 1983 pg. 275) Painkillers, antihistamine, creams are more effective when taken orally.

Many paediatric syrups medicine contain about 60% sucrose and not children's teeth if taken in long doses.

Avoiding avoidable risk-

— side effects are predictable and unavoidable

— adverse reactions are unexpected and unusual

— certain drugs may be risky for children eg. Paediatric tetracyclin, cholompheni-col for infants.

— certain drugs may create problems if used for long (therefore need to be used only for a short period)

— some drugs are particularly prone to abuse and can be dangerous when abused (Pethedine, exytocic steroids)

— certain drugs have a low therapeutic margin eg. lomotil for infants, digexin

— risks may be created due to inadequate provision of information (eg. phenylbutazone, oxyphen butazone, amidopyrines, pain killers and their impact on BM anabolic steroids)

Certain ingredients in formulation increase risk. eg. fixed dose combination of steroids, analgesics, tranquillizers. Risks when certain drugs are formulated in certain ways. Certain ingredients lead to sensitization to certain products leading to reaction when used in greater doses. e.g. neomycin and Betnovate, antibiotic ear drops.

Fixed dose combinations are justified in WHO's 250 drugs, only 7 are FDC—

1. if the ingredients enhance each others action
2. combination and cost
3. if willingness of patient to take the drug improves significantly, therefore of a single preparation.

Many combination drugs are like Swiss Army penknieves. They are exotic and versalite, very convenient and compact their only real disadvantage apart from cost is that they are very inefficient.

Some irrational combinations

1. antibiotics as only diarrhoeals—chloro-strep, STMP
2. expectorants and cough— suppresents together
3. Steroids

N H S Sainsbury Report 1967

2200 prescribed drugs categorised.

Effective drugs 50% of the total

Rational Combinations 8%

Unclassified 7%

(Pharmaceutically active but of unproven therapeutic value or safety)

Undesirable irrational, ineffective, 'superseded or absolute drugs or preparations.

U.K. joint formulary Committee recently identified 20-24% of 2000 and branded drugs as less suitable for prescribing BNF No. 6 1983.

Why are fixed dose combinations made?

1. Extension of product range
2. Can get patent protection
3. reduces price competition
4. Convenient
5. May be cheaper.

In 1982 £ 150 million spent on drug promotion. In U.K. about £ 4000—£ 5000 on each G.P. i.e. 50 drug advertisements/day 1 : 20 1 : 3—4

provides professional, political support, sponsoring, research, journals, conferences, free medicines.

Drug information—Panorama BBC-TV series 17-1-83.

I remember a study involving chickens. It was a carcenogenesis study—a study to determine whether or not the drug caused cancer. The report to FDA said the test drug caused cancer no more often than placebo, or a sugar pill and in fact that was true. What they failed to tell us was that half the chieckens died of heart failure. That's putting your best foot forward.

Innovation

VIC Department of Health and Social security—204 new chemical entiters studied which were granted license between 1971-80. NCE's were mainly for disease—common cronic and and occur principally in Western Society. Only I was a new C.E. For treatment of odri-stogomases, oxamniquine (guffin JP, Diggle GE '81.)

NCE's in U.S. 1982, 28 new drugs approved.

Class	*Degree of therapeutic gain*	*No. of NEC's*	%
A	Important	4	14
B	Modest	5	18
C	Little or none	19	68

Analgesis of product licenses between 1973-77 done by Drs. Guffin and Diggle.

Fully innovative	4 NCE's	4%
Semi innovative	32 „	31%
Non innovative	67 „	65%

(DHSS-Department of Health & Social Security)

Greenfield report 1982 — Informal working group on effective PRESCRIBING.

Sainsbury 1967 — Medicines Commission—Association of British

Pharmaceutical Industry

no control of medication

no confidence in product quality

decreased patient compliance and confidence

loss of support for errors and problems
loss of information and technical services
U.K. based medical research discourage

Placebo effect

Beecher 1982 patients. Placebo effect in angina, rheumatoed and degenerative arthritis, pain hay fever, headache, phtic ulcer and essential hypertension.

Psychiatric · patients anxiety— psychotherapy, (Benson 4 Epstern M 1975)
Causes of overprescribing

— to play safely and legally if unsecure
— to terminate consultation when busy tired or bored
— to impress or mystify
— patients or role play as a proper doctor
— prescribing on instruction from superiors
— compliance to patients demands
— sheet habit
— justify consultation and make it official
— to impress the patient and keep him hooked.

Realizations about Drug therapy

— Different patients respond differently to drugs
— need to avoid drugs in pregnancy
— recognition of catrogenise and nature of drug interaction
— recognition of the role of suggestion and therapeutic effect of the prescribing process
— recognition of the desirability of not using drugs when not needed.

Sources of information which most influence general practitioners prescribing habits.

Source	*percent*
Drug firm representatives	29
Recommendations from consultants	27
Articles in journals	12
Drug firm literature	10
Professional contacts with doctors	8
Advertisements in journals	1
Drug firm meetings	1
Other sources	10
Dont know	2

(Source Sainsbury Committee enquiry. 1967)

Quality of prescribing

Of 25 most prescribed drugs in U.S. 1976, 8 were authoritatively considered to be pharmacologically and therapeutically questionable (Knapp. D E 1978)

Prescriptions for children random samples 72 GPs in Wessics 1% i.e. 80/6331 could legitimately be called into question on the basis of current modern specialist leading 42% of doctors used drugs that have recently been considered hazardous or undesirable (Calford J 1980)

750,000 leading hospital prescription indicated over one in 8 was over medication.

Recognition of ingredients

Best known 23 combinations correctly identified by only 2/3 prescribers, 7/23 not even one physician answered correctly. (Report of plot survey among 60 Montreal physician in DTB, '80) Over half of repeat pres-

criptions were in appropriate for Sainsbury Report 1967

1/4 prescriptions for painful osteo arthritis were for Butazolidin. About 20% of prescription were for drugs with no anti inflammatory effect eg. codiene, paracetamol. Antidiarrheals—about 40% of prescriptions were for antidiarrheals, now discredited or considered hazardous.

Consumer compliance

Two out of 5 patients never take prescribed drugs as directed (Parish 1982 pg 10).

Over 200,000 tablets were collected by chemists during a 3 week medicine amenesty in Dudluy in 1976. 3 years later —300,000 tablets turned. In 1982, 140,000 tablets collected. (Source Inglis B in Health Services-'82)

4/10 cannot read railway time table. One in 4 adults cannot work out the change they should receive from £ 5 note after purchasing single article. Nearly 1/3 cannot handle multiplication, division or percentage (News item Numeracy week Guardian 1983).

Royal college of G P's 1977.

Typical GB seeds

— 600 people with cough and colds

— 300 suffering from depression and anxiety

— 100 with chronic rheumatism

— 50 with High B P

— 8 with heart attacks

— 5 with chronic appendicitis, strokes.

Campaign poster—be prepared to leave this clinic chamber empty handed. The doctor may not give you a prescription. His advice may be all that you need. You can be sure that is you really need one you'll get one.

Locost: Good Quality, Low Cost Generic Medicines

—S. SRINIVASAN

Our former Vice President, M. Hidaytullah once made an interesting observation:

"Why have milk prices gone up so much? In the olden days, the mothers milked the cows, the daughters set it out in pans to separate the cream, one of the sons sold it in the market.

Today, the agricultural department is mobilised, the cow sheds are sterilised, the cows are immunised, the milk is homogenised, the supplies are motirised, the dairies are organised, the milkmen are unionised, the milk exports are subsidised, the political leaders are energised.

The result? The Indian consumer is victimised."

We, in LOCOST are not exactly in the milk business but we have been concerned with the drug (medicines) problems in our country and decided to launch out a small project called LOCOST, to distribute generic based medicines that are not only cheaper but scientific in their constitution and specification.

Our small effort has had its initial problems, obstacles, and challenges. There were even moments of anxiety. But we cannot deny that the support LOCOST received from interested health and management professionals, from partners or purchasers has given us cause to look forward.

LOCOST (Low Cost Standard Therapeutics) is a collective voluntary enterprise for rational therapeutics. LOCOST aims to promote low cost, scientifically tested medicines 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 society for not only low priced, but also good quality medicines.

History of LOCOST

In the last few years, voluntary agencies have been sensing an urgent need for a rational drug therapy structure. Some of the main reasons that led to this sense of urgency were: widespread irrational prescription practices with no social accountability; the unethical practices of the drug industry; the lack of a formal structure and network for low cost and quality medicines.

Despite seminars, commissions, research studies and journalistic expose's, there was no adequate implementation as a response compared to the magnitude of the problem.

Interested voluntary health sector members discussed the issue and finally sowed the first seeds of LOCOST in a nebulous form. In 1982, a team of experienced professionals in the field of community health got together and drew up a list of the essential drugs based on the Hathi Commission, the WHO recommendations and other such documents. A search for competent and dedicated personnel finally led to a modest infra-structure for LOCOST.

The initial bottleneck LOCOST encountered was the problem between prices and orders. Small scale manufacturers, whose credibility was not doubted, refused to quote a price unless they had firm orders. The partners (or target purchasers from small health cen-

tres) did not want to place orders until the prices were quoted. LOCOST was badly in need of finances for its working capital, running expenses and non-recurring capital requirements.

Taking a plunge however, LOCOST secured a few loans from individuals to the tune of Rs. 55,000/- and asked OXFAM for a grant of Rs. 40,000/- to explore the viability of the idea for the first few months. Fr. M.A. Urrutia, was able to raise a further grant of Rs. 55,000/- and LOCOST was launched.

Registered as s public trust at Baroda in November 1983, the first supply of LOCOST drugs was despatched in October 1983. Subsequent visits to health institutions only underscored the need for rational therapeutics. LOCOST is now well on its way to establishing a small step, but in the right direction, in the field of social justice in health.

How LOCOST Functions

1. Procurement : LOCOST has contacted a number of reliable low cost drug manufacturers on the Bombay-Thane and Ahmedabad - Baroda - Surat regions whose integirity and credibility have not been doubted.
2. Some of these manufacturers supply the drugs specifically ordered by LOCOST.
3. Quality testing and control : LOCOST's responsibility is to ensure a regorous quality control of these drugs before despatch.
4. All the drugs distributed by LOCOST are under generic names and adhere to the principles of rational drug therapy as chartered by the World Health Organisation, the Hathi Commission and other authentic studies.

LOCOST's range of products has increased from the initial 19 to 25 to 45 at present. LOCOST plan ultimately to distribute 72 drugs based on the WHO and Hathi Commission recommendations which will be added on to the LOCOST price lists as the financial base gets more secure. One of the options of LOCOST is to increase its nominal profit margin and or to cater to private profit making institutions. However LOCOST feels this will vitiate and hamper its original aims and objectives, namely to cater to the rural poor and urban slums.

Educational Efforts

LOCOST tries to create an awareness about the unethical and irrational practices of both the health professionals and the drug industry through visits, literature, seminars, etc. This enhances the scope for rational drug therapy.

A rational drug therapy cell has been formed under the auspices of LOCOST. The cell consists of interested physicians, academicians and practitioners from the field of medicine, pharmacology and management from Bombay and Baroda. The cell has had to two meetings to date—one at Bombay and one at Baroda. The cell will, among other things, do the following:

1. Critically review and examine existing drugs and therapeutic agents available in the Indian market with respect to their scientific constitution, the claims made by their marketing agents, and the harms, uses and misuses in the light of actual experiences in India.
2. Pool in adverse drug reactions.
3. Conduct research and study wherever needed.
4. Find ways and means to educate users at various levels and act as a guide to users especially in rural areas.
5. Start publications and educational materials to support the rational drug therapy effort.

Conclusion

LOCOST is slowly taking off towards more stability not only in services rendered and in management functions but also in awareness building of rational drug therapy. It would be appropriate here to thank all the partners for their support and involvement without whom this venture would not have reached where it is today. LOCOST thanks each one of its partners and hopes that a constant dialogue will help both parties fruitfully.

For price list and for further information, please contact :

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Annexure I

Why LOCOST?

Several independent studies have revealed the following facts:

1. There are approximately 30,000 formulations going on in the market under various brand names. Most of these are unscientific.
2. All these formulations can be reduced to about 200 in number. Their compositions can be simplified thus enhancing the relevance for rational drug therapy.
3. Marketing them under generic names can further reduce their costs to the consumer.
4. Granting a reasonable profit margin, the present on going rate of profits can be lowered considerably.
5. It is possible to ensure a high quality of drugs at low costs.

It was widely believed that quality drugs cannot be made available at low costs. Yet there was a pressing need from health professionals working with the poor and marginalised sections of society for low cost quality medicines.

LOCOST was launched as a response to the above situation.

Annexure II

Comparison between LOCOST prices and prices of cheapest brands/generics currently at Khushalchand Charitable Drug Store, S.S.G. Hopsital, Baroda

		Form & strength
1. Ampicillin (LOCOST)	57.00 per 100	250 mg Cap
Ampicillin (Lyka)	80.00 per 100	-do-
2. Ampicillin Syp (LOCOST)	4.00 per 40 ml	125 mg Syp 5 ml
Ampicillin Syp. (Cipla)	6.20 per 40 ml	-do-
3. Chloremphenicol (LOCOST)	30.00 per 100	250 mg Cap
Reelor (Sarabhai)	43.00 per 100	-do-
4. Chlorpromazine (LOCOST)	0.36 per 10	25 mg Tab
Chlorpromazine (Intas)	2.00 per 10	-do-
5. Cotrimexazole Tab. (LOCOST)	2.76 per 10	80+ Tab 400 mg
Septran (B.W.)	6.20 per 10	-do-
Bactrim (Roche)	6.20 per 10	-do-
6. Codein phosphate (LOCOST)	1.10 per 10	10 mg Tab
Codein phosphate (Indon)	2.30 per 10	-do-
7. Chloroquine phosphate (s.c.) (LOCOST)	2.04 per 12	250 mg Tab
Lariago (IPKA)	3.80 per 12	-do-
8. Cotrimexazole Syp (LOCOST)	3.00 per 50 ml	40+ Syp 200 mg per 5 ml
Septran (B.W.)	7.00 per 50 ml	-do-
Bactrim (Roche)	7.00 per 50 ml	-do-
9. Diazepam (LOCOST)	0.57 per 100	5 mg Tab
Tancolorim (Torrent)	5.25 per 100	-do-
10. Ferrous sulphate (LOCOST)	7.20 per 1000	200 mg Tab
Ferrous sulphate (Roopes)	6.00 per 1000	-do-
11. Frusemide (LOCOST)	0.69 per 10	40 mg Tab
Lasix (Hoechst)	2.00 per 10	-do-
12. Mebendazole (LOCOST)	0.69 per 6	100 mg Tab
IDIBENA (IDPL)	1.75 per 6	-do-
13. Metronidazole (LOCOST)	0.84 per 10	200 mg Tab
Metrogyl (Uni.)	2.00 per 10	-do-
14. Paracetamol (LOCOST)	0.66 per 10	500 mg Tab
Paracetamol (Paran)	1.00 per 10	-do-
15. Prednisolone (LOCOST)	1.00 per 10	5 mg Tab
Deltacortil (Pfizer)	2.00 per 10	-do-
16. Salbutamol (LOCOST)	0.80 per 10	4 mg Tab
Bronkotabs (Biddle Sawyer)	2.75 per 10	-do-

N.B.

1. Khushalchand price data courtesy Raju Gaekwad.
2. Please note that Khushalchand gets discount at a special rate from the drug companies. Their actual prices to the public could be anything from 40 % to 100 % higher.

Workshop Recommendations on Towards a People Oriented Drug Policy

at the CHAI annual convention in Bangalore
from 23-26, Nov. 1984

[Following are some of the important suggestions made by various groups of participants at the above mentioned workshop. Each group had given a number of valuable suggestions. What is given here is only a summary of them which I hope will reflect the thinking of the various groups. The suggestions were at four different levels i.e. Individual, Institutional, Diocesan and National —*Editor*]

I. Individual Level

1. All health care personnel should be aware of drugs which are essential, banned, hazzardous etc.
2. Prescription of drugs should be rational in every respect. Doctors should take special care in this.
3. Prescription should be legible and explanation should be given in vernacular.
4. When dispensing medicines clearcut instruction should be given in vernacular regarding dosage, use, timings, etc.
5. Educate the patients by explaining to them about the side effects of certain medicines, advantages of natural food over tonics etc., rational use of injections etc.
6. Not to fall prey to the salesmanship of medical representatives in ordering substandard drugs and sometimes even spurious ones. No gift in any form should be accepted in this regard.
7. Promote herbal medicines and home remedies and also promote non-drug therapy like yoga, exercises etc.
8. Use of audio-visual aids in educating people on various illness, their possible prevention, simple remedies etc.
9. Doctors and others concerned should avoid any unnecessary investigations, even if this will lead to a cut in the income of the institutions.
10. Study of the local social and cultural practice of the people.
11. Sharing of the informations and knowledge received at the workshop with others connected with the health care services, such as, doctors, nurses, administrators, pharmacist, Parish Priests, etc.
12. Write in journals like "Medical Service" etc. about your experiences, case studies, good or bad effects of drugs etc. for the information and benefit of others.
13. Be a good listener to the patients and others and spend time in explaining to them the various aspects of illness and their remedies.
14. Be a promoter of rational drug therapy by joining hands with anyone who is working in this line.
15. Promote the use of drugs with generic names.
16. Attend refresher courses, workshops, etc. on matters pertaining to better health care in a rational way, as a part of continuing medical education.
17. Cultivate the habit of reading.
18. Avoid over/under/self/multiple prescriptions.

19. Share informations, journals etc. with others concerned in the institution.
20. Help in the preparation of a formulary and follow it strictly.
21. The good of the patients should be kept as priority number one by all concerned.
22. Adhere strictly to the principles of medical ethics.
23. Have respect for other systems of medicines and promote the use of them whenever necessary, more useful and possible.
24. Promotion of Inter personal relationship with all the health care personnel in the institution.

II. Institutional Level

1. Every institution should have a drug formularly to be strictly followed.
2. There should be a pharmacy committee in each institution (hospital) comprising of the administrator, pharmacist, medical officer etc. The number of members in this committee will depend on the size of the institution.
3. Drugs should be dispensed only on prescription.
4. Certain common medicines should be prepared in the institution itself to ensure quality and make it cheaper eg. preparation of carminative mixture etc.
5. Have a pharmacy budget and preference should be given to life saving and essential drugs.
6. Remove all the banned drugs from the pharmacy.
7. Stock sufficient quantity of life saving drugs.
8. Display a list of essential drugs and banned drugs at the dispensary and at the OPD of hospitals to educate people.
9. Promote Community Health Programme and non-drug therapy.
10. Identify and review the goals and objectives of the institution.
11. Inter personal relationship should be built up in the institutions.
12. As far as possible build up a good library.
13. Request CHAI for organising courses for health care personnel in the member institutions (administrators, nurses, doctors, pharmacists and other paramedicals) on various topics.
14. Medico Legal Cases should be attended to in our institutions even if this would involve some inconveniences as human life is more important than any inconvenciences.
15. There should be fixed time for meeting medical representatives.
16. Imparting health education on topics, like oral rehydration, NFP, prevention of illness etc. should form an integral part of our institutional activity.
17. As far as possible institutions should cooperate with government at various levels.
18. Every institution should have a qualified pharmacist.
19. Primary health care should be taken on a priority basis by all our institutions.
20. Healthy inter-professional interaction should be promoted.
21. Avoid unhealthy competition among institutions and to be stopped at all cost in doctor-snatching.
22. Positively promote other systems of medicines and nondrug therapy.
23. Join hands with other institutions and professional bodies to create public opi-

nion and pressurise the Government to change policies for the good of the people at large.

24. If need be even to initiate action against doctors who go against institutional formulary and policies.

25. Send informations to CHAI Central Office on new experiences, initiatives, innovations etc. to be published in our journal "Medical Service" for the information and knowledge of others.

III. Diocesan Level

1. There should be a coordinator in every diocese to coordinate various efforts in the health field.

2. Orientation, workshop etc. should be organised in the diocesan level (sometimes also regional level) on various topics connected with a rational health care.

3. Institutions in a diocese, or even in a region, should come together to form certain common policies based on the situation of their area.

4. They should also organise bulk purchase of drugs and other materials.

5. There should be regular flow of communications between the diocesan units and CHAI for better service and efficiency.

IV. National (CHAI) Level

1. CHAI should prepare list of banned drugs (preferably with reasons for banning), and essential drugs for the use of various types of institutions.

2. CHAI could prepare a model formulary for different types of institutions.

3. CHAI should establish a quality control lab as soon as possible on a priority basis.

4. CHAI should eventually go for production of essential and life saving drugs for the benefit of all. Consult Lisie hospital, Ernakulam, LOCOST, Baroda and Bangarapet Tablet Factory for this purpose.

5. Continuing medical education should be taken up by CHAI which should include other systems of medicine. Our journal "Medical Service" could also be used for this purpose.

6. CHAI should take initiative in reorientation of Medical Education also in terms of value formation. A start could be made with St. John's Medical College itself.

7. CHAI should organise training of Community Health workers at a reasonable cost.

8. Informations on compounding drugs should be provided through our journal "Medical Service".

9. Information materials on drugs and other such subjects should be made available in regional languages either directly by CHAI or by diocesan/regional unit of CHAI.

10. Collaborate with and support other like-thinking organisations at the national, regional and local level.

11. Use counter advertisements.

12. An evaluation through a survey regarding the follow up of this workshop should be done before the next convention.

13. CHAI should provide a list of pharmaceutical firms producing drugs with generic names.

14. CHAI shall mobilise public opinion and approach the central and state governments to solve problems related to production, distribution, etc. of drugs at all levels.

(Contd. to p. 17)

What/Why the problem in our Hospitals and Dispensaries

(A summary of the Factors/Problems identified by 15 groups through small group discussion)

National

Life saving drugs not available in sufficient quantities.
Too many formulations.
Lack of a rational drug policy.
Lack of quality control.
Inadequate price control.
Essential drug prices rising.
Unnecessary taxation.

Institutional (Professional)

Belief in standard companies.
Highly individualised prescribing.
Improper communication with both patient and pharmacist.
Habit to prescribing powerful drugs.
Not open to other systems or non-drug therapies.
Lack of continuing education.
Lack of knowledge of banned drugs or policy issues.
Professional associations do not advocate rational drug policy.
No encouragement to local compounding.
Struggle for existence.

Institutional (Pharmacy)

Have become income generating unit of hospital.
Decrease in local compounding.
Use of expired drugs.
Continued use of English in labels and instructions.
Lack of bulk purchase.
Cost only criteria in drug selection.
Buying from local, substandard companies.

Institutional (Administrative policies)

Lack of communication and team work. (between administrators, doctors and pharmacists)
Lack of rational drug policy.
Lack of standardised formulary.
Profit motive and commercialization.
Charging for donated medicines.
Selling of vaccines obtained free from Government.
Inefficient administration.
Building mania and institution development.
Refusal of emergency or medico legal cases.
Inter institutional competition.
Doctor/staff snatching from one church institution to another.
Lack of involvement with government agencies or health services.
Screening of drugs/policy issues by untrained superiors/administrators.
Lack of institutional goals.
Lack of understanding of peoples needs.
Lack of commitment to christian/human value system in the institution.

Medical Companies

High pressure advertising.
Misinformation.
Package deals of inessential drugs.

Offer of unethical 'perks' or 'discounts'.
Offer of resources to institutions.
Drugs treated as an industry.

At the level of people/patients

Pressure for injections and tonics.
Faith in costly medicines.
Faith in foreign medicine.
Expectation of free treatment.
Ignorance about drugs.
Poor purchasing capacity.
Over the counter purchase.
Self-medication.
Psychological dependence.
Increasing drug culture.
Inadequate consumer awareness or action.

(Contd. from p. 15)

15. CHAI should prepare/make available audio-visual materials for educating the health care personnel and the public.

16. A signature campaign could be undertaken by CHAI demanding from the drug controller, Supreme court and others concerned for a speedy implementation of the existing legislation on drugs and also for bringing further legislation to ensure availability of life saving and essential drugs and also banning of hazzardous drugs.

17. CHAI should work in closer collaboration with other national organisations like VHAI, CMAI, All India Drug Action Net work etc.

18. CHAI should help resolve problems in various hospitals which may emerge when they start implementing these policies.

19. CHAI should organise a strong National Drug Committee for research on drugs, study on harmful effects of drugs etc.

20. Research should be undertaken into the systems of medicines other than Allopathy for better and cheaper health care more in line with the values and culture of our people.

[The above mentioned suggestions are of great importance for all of us concerned with the health of our people, particularly the underprevilaged. Hence I request all concerned at various levels to go through them carefully and seriously and try to implement them. As suggested we shall try to make an evaluation before our next convention.

— Executive Director]

A Comparative Study of Brand Name Drugs and Generic Name Drugs
(on the basis of cost and efficacy)

A. John Berchmans

Introduction

The study was conducted at the Ozanam Free Dispensary, located in the camps of St. Joseph's College, Tiruchirappally-620002, Tamil Nadu.

A Brief History

The Oznam Free Dispensary was opened on 23, April 1978 with a motto to give Medical care to downtrodden and forsaken section of the society without any discrimination of caste or creed and is run by the Tiruchirapalli Particular Council of the *Society of St. Vincent De Paul*. It is open between 4.30 p.m. and 6.30 p.m. on Mondays, Wednesdays and Fridays. One Lady doctor and two male doctors visit our dispensary on the above said days on the honorary basis. Registration fee of Re. 1/- is collected for administening injections and 50 paise for oral medicines from the patient. Apart from this, donations are collected from the generous hearted local parishners, viz, business men, professors, etc. and sometimes financial aid from CHAI, which help us to keep the dispensary afloat.

The Study

Till a year ago only brand name drugs were prescribed and dispensed in our dispensary. Then on the suggestion of Medical practitioners who prescribed generic name drugs we began to purchase, prescribe and dispense generic name drugs but quality drugs in our dispensary and studied the cost and efficacy of the generic name drugs and brand name drugs. Here we present the result of our study.

	Brand Name	*Price*	*Generic Name*	*Price*
1.	Tenamycin, Inj (Pfiza)	For 10 ml Vial Rs. 3.45	Cexytetracycline Microbe Gufic	For 30 ml pack Rs. 4.70 Rs. 4.75
2.	B_{12}-Inj. Alembic	For 10 ml pack Rs. 3.25	Cyanocobalamin	For 10 ml pack 1DZ Rs. 7.00
3.	Neurobion Inj. Merck	For 2 ml pack Rs. 2.50	($B_1+B_6+B_{12}$) Zobromin	For 10 ml pack Rs. 4.00
4.	Flagyl 200 mg Amezole	40ps per Tab 35ps/Tab	Metronidabole 200 mg	14ps/Tab
5.	Crocin, Metacin	35ps/Tab	Paracetamol	10 ps/Tab
6.	Cel—100 mg (Vit. C)	8ps/Tab	Ascorbic acid	3ps/Tab
7.	Sulphadiazine	25ps/Tab	Sulphadiazine	18ps/Tab

As the above study shows the generic name drugs are less costlier than brand name combination drugs none the less they are as efficacious as the latter. In the future we shall purchase, prescribe and dispense generic name drugs, but quality drugs for all the essential drugs and help the poor by giving necessary medical care for a lesser charge and give the medical care *freely* for those who really deserve it.

Drug Use and misuse in Surgical Practise

Dr. Srinath Dore

There are about 1,600 officially recognised drugs and drug combinations listed in the mothly index of Medical Specialities a monthly publication which is a Pharmacological index used in most hospitals as a source of reference to the Medical Profession. Out of this long list probably only 50 drugs are essential and in use in Surgical Practice at this Hospital. At the outset it brings to light the gross discrepancy between the number of essential drugs reuqired and the number available for the practitioner to use.

In the Analgesic and Antipyretic group of drugs there are about 54 brand names of drugs which are basically combinations of Paracetamol, Analgin etc, starting from Actimol, Avamol to Zimalgin. Among the huge list of 54 we use only 6 drugs which are Baralgan tablet and injection, Novalgin tablet and injection, Fortwin tablet and injection, Crocin tablet, Injection Mol, Injectine Pethidine and Injection Morphine. The Companies marketing these drugs vary from known companies to relatively unknown companies with no proper quality control and testing.

In the Sedative and Tranquilliser group there are 25 brand names with common names like Calmpose to drugs like Nervo Vitamin 4 being advocated for Cardiac Sexual Neurosis and psycho Neurosis. The price range varies from 7 paise a tablet to 40 paise a tablet. In this long list we use only Calmpose tablet and injection.

In the Non Steroid Anti Inflammatory groups, most brand names are combinations of Phenylbutazone, Oxphenbutazose, Ibuprofan and other derivatives, all drugs with potent side effects if misused. Indications listed vary from inflammatory conditions like Rhematoid Arthritis, Non Traumatic inflammations and inflammations associated with Obstetric and Gynaecological conditions. In the list of 35 drugs we mainly use Brufen and Dolocaps.

Antibiotics:

These group of drugs forms one of the most important list of vital drugs which are essential at the same time there is a gross tendency for misuse. Misuse of Antibiotics has led to the hospital resistant infections which are fast becoming a problem in most hospitals and Peripheral Centres. The policy of to shoot a fly with a double barrel gun has unfortunately become the trend. The drugs used are Ampicillin, Gentamhcin, Crystalline Pencillin, Strepto Pencillin, Eroythromycin, Septran, Cloxacillin, Cephalexin and Metranidazole. Each of these drugs are marketted by 15 different Companies under their own brand names with varied combination and price ranges. The Industry churns out different antibiotics as their profit margin is high. A course of Ampicillin for seven days would cost Rs. 40/-whereas the same course with Streptopencillin having similar range of properities would cost half as much. Thus most essential antibiotics are quite out of reach of the common man.

Drugs acting on the Gastro Intestinal System :

Ranging from Antacids to Laxatives and Antispasmodic agents we use ten drugs in

the list of 80. The prominent ones are Gelusil, Dygiene, Cimetidine, Buscopan, Perinorm, Dicyclomine, Dulcolax, Liquid Cremaffin and Glycerin Cuppository. These group of drugs are most commonly prescribed and hence one needs to view them with seriousness. Apart from the essential drugs we have a long list of enzyme preparations like Zynebio, Molzyme, Merizyme, Enzar which have relatively minimal utility but pushed and sold in the market because of a high profit margin.

The Endocrine preparations used in Surgery are mainly in Thyroid disease where Eltroxin and Potassium Iodide is used and in Diabetes where Insulin and Lente Insulin are used.

The Anti Tuberculosis and Anti Leprosy Agents are the essential group of drugs namely INH, Thiacetazone, Rifampicin, Etnam Butol, Streptomycin, Pyrizinamide, Dapsone and Clofazime. There are very few companies marketting these essential drugs as compared to the Companies, marketing tonics and vitamins. The reason is obvious. These drugs don't form a very big financial and commercial prospective.

Tonics, appetite stimulatants mineral and nutritional additives. This is the money spinner of the pharaceutical industry and has unfortunately a most prominet place in drug therapy. These form the least important group of drug from a therapeutic point of view. The conditioning is so deep rooted that the first medicine the patient wants for his ailment is a tonic rather than drugs for Tuberculosis. In a prescription of five drugs the patient may first buy the tonic and leave out the rest for want of money. We have a record of two hundred and forty brand names of drugs with exotic names like Glutomalt Tonomalt, Tenophos, Bitahext, Bitopheral, Berin, Sclerobich. The list is endless. The listed indications vary from general tonic, general debility, stressful conditions, nocturnal muscle cramps to nervous exhaustion. They come in varied palatable flavours and attractive containers with complimentary gifts. Price range is limitless. We have thus have a list which is relatively non essential but with so called maximum range of indications to suit our large population. The ones really used are tab. Macrofolin with Iron Tab. B.C. glaxo, and Berocin C.

In conclusion it seems that the drug industry is fast reaching a stage where essential drugs are being side lined to make room for the relatively unessential drugs. The new Practitioner is faced with a long list of drugs and indications that he is unable to prescribe and choose the right drug. With the drug industry bringing out different combinations of drugs using technical jargons like increased efficacy, better patient compliance it becomes imperative for the practitioner to be aware of the list of drugs which are essential and of proven efficacy.

Finally I would like to emphasise that in St. John's Medical College Hospital (which is one of the largest hospital in the Catholic Hospital Association of India) out of a list of 1,600 drugs available, in our Dept. of surgery we use only 50 which are essential.

Role of Traditional Medicine in Primary Health Care

Dr. T.N. Manjunath

Traditional system of medicine are deeply rooted in the civilization of Asian region and India in particular has recognized systems of traditional medicine which have continued to flourish upto modern times. Practitioners of traditional systems of medicine in like manner have remained a part of the community they serve. Being sensitive to the traditions, believes and customs of the people they exert considerable influence within the community in relation to health and health related practices.

Recognizing this health man-power potential in the delivery of primary health care services the joint UNICEF/WHO study recommended to mobilise and train practitioners of traditional systems of medicine for primary health care services.

Traditional medicine is the sum total of all the knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social imbalance and relying exclusively on practical experience and observation handed down from generation, whether to generation or verbally in writing. 2.

The traditional systems of medicine practised in our country recognised by the Government include the Ayurveda, Sidda, Unani, Yoga and naturopathy systems. In our country today there are 4,50,0003 traditional practitioners out of which, 3,41,408 are traditionally trained. This includes herbalist, bonesetters, spiritual healers and traditional birth attendants and there are another 1,08,592 institutionally qualified practitioners in various systems of traditional medicine.

It is unfortunate that a large number of these practitioners are in the field but largely working outside the National Health Service system. The manpower potential available may be utilised for primary health care services for achieving the goal of health for all the year 2000.

A comibation of traditional healing and modern medicine appears to be the most promising and appropriate for the health problems facing the developing countries. Ayurveda or the "Science of Life" countributes much in this direction as majority of the Ayurvedic preparations are cost-effective non-toxic and can be prepared locally.

It is well known that in many aliments of functional origin like consitipation dispepsia, indigestion and cases that have proved refractory to modern medical treatment good results have been produced by the Indigenous system. Yoga practice and meditation, forms the part of the indigenons system. They were once considered only as a subjective experience. These practices have been objectively assessed and their physiological effects and possible clinical application in many anxiety disorders are being recognised.

The practitioners of Ayurveda normally prepare the medicines needed for the patients in their own clinics from simple decoctions to powder. The physicin also advises the patient to prepare them in their own homes, from locally available herbs. For example

Paper Presented by Dr. T.N. Manjunath, Assistant Medical Officer, (ISM) CHAD Programme, CMC Vellore at the workshop on "Towards a People-oriented Drug Policy" at St. John's Medical College, Bangalore from 23rd to 25th Novembe, 1984.

in villages combination of Thulasi leaves juice, pepper powder and honey for cough is used which is inexpensive, effective and also easily available in rural areas. However in urban areas the practitioners give prescriptions for patent drugs which are available at Chemists and Drug shops. The large scale production of Ayurvedic drugs is now undertaken by many pharmaceutical companies like Himalaya Drug Company, Baidya-nath Company and Indian Medical Practitioners Co-operative Pharmacy and Stores Limited (IMCOPS) Madras using modern pharmaceutical technology. These products include patent, proprietary and classical preparations. Every state has got its own drug standardisation centre which supervises and maintains standard of Ayurvedic drugs. There are as many as 4500 pharmacies which produce these drugs in South-Eastern Asia. Statutory controls over the manufacture of Ayurvedic drugs are also enforced in some countries.

Ayuredic pharmacopers contains 8000 receipes. Besides these there are large number of receipes which have not been documented but which are used by the community in every day practice.

Ayurvedic medicines are prepared in the form of distiletes (Arka) fermented preparations (Asava, Arishta) linctus (lehya) incinerated minerals, shells (bhasma) powder (Choorna) ghee (Ghritham) Tablets, pills (vati) decoction (Kwatha).

The Community Health and Development (CHAD Programme of the Community Health Department of Christian Medical College) is studying the feasibility of incorporating the traditional practitioners in the Primary Health Care. The CHAD Programme provides services for the entire block of Kaniyambadi with a population of 80,000. This study is being conducted in a population of 15,000.

Availability of Ayurvedic, Allopathic and Accupuncture treatment under the same roof is a unique feature of the CHAD health programme and is a definite step towards integration.

The objective of the study is to identify the constraints which prevents the effective involvement of practitioners of traditional medicine in primary health care programme and evolve strategies for their greater involvement in promotion of Family Planning. Maternal and Child Health (MCH) and immunization programmes. It also includes their orientation, training, monitoring and supervision and identify areas where integration is possible. It also aims to identify possible linkage between the practitioners of traditional systems of medicine and national health care system.

11 Practitioners have been identified in the 15,000 population. These practitioners were interviewed, and their willingness to practicipate in the programme determined. The practitioners are visited by the Assistant Medical Officer of Indian Systems of medicine of the CHAD Programme and their activities are supervised every week. During which he tries to establish a good rapport and get their participation in the health programmes.

Initially they were reluctant to share their knowledge and practices. After gaining the confidence in the programme through the repeated visits of the health team they slowly started sharing their knowledge and techniques. They were also afraid that their practices may be asked to be stopped or controlled. This overcomes by assuring them that their practices which are good and helping the community will be maintained and strengthened. They were also informed of the unhealthy practices like branding and persuaded to discontinue them.

They had misconception that vasectomy affects their general health and makes man very weak and he is suspectible to diseases. This was removed by continued education by all categories of health workers of the programme.

Initially they were treating even those conditions which were not responding to their treatment and after education they are convinced that certain conditions like high fever, of 3 days duration, bleeding should be referred for modern medical care.

There was no proper reporting system regarding the type of cases treated. They were asked to maintain a record in which they have to register the Name, Age, Sex, Complaint, Treatment, Response and referral. This will be scrutinized and supervised.

In the early stages there was over reporting of case by the practitioners. This was cross checked by surprise visits when they were asked to show the cases. Following this over reporting came down.

It is observed from the preliminary studies that the traditional practitioners by virtue of their close association with the community plays a key role as educator and change agent on matters relating to health and family welfare. He, as a part of health team, actively involves himself with national health programmes both as a practitioner and as a commnnity leader they are heavily used in the Tuberculosis, bilariasis, RF'RHD, Malaria eradication programmes.

Diarrhoeal diseases which causes high morbidity and high infant mortality needs promotion of oral rehydration therapy, which would make an impact particularly on the infant mortality. The traditional practitioners have been educated on the correct use of oral rehydration salts and its practical application in the treatment of actue diarrhoeas with the ultimate goal of making oral rehydration therapy for treatment of diarrhoeas a routine practice in the community.

ORS packets are distributed to them repeatedly and they are taught to prepare ideal oral rehedration solution in the abscence of readymade packets in which they have shown a definite improvement in the management of diarrhoeas.

These traditional practitioners are educated on various health and health related problems in their own village and in their own language. Oral hydration for the child with diarrhoea has also been accepted with enthusiasm in preference to the crude cauterisation or branding. This is really a change brought about by their education, helped changing their attitude regarding some beliefs which does not have any basis

The high cost of drugs and inability of many developing countries to purchase such drugs have prompted several countries to look forward for local products in the form of medicinal plants and herbal medicines that have proved to be effective, safe, in expensive and culturally acceptable.

In this direction a herbal garden is grown in CHAD Campus as a means of home remedy for common ailments and also encouraging traditional practitioners to identify locally available an d commonly used medicinal plants and herbs and make use of them in their treatment. The community is being educated regarding herbs in the Mahila Mandal (Women's Group) as a means of home remedy to make people become more self reliant and make herbal medicine as people's medicine.

A few low-cost effective remedies taught at Mahila Mandal (Womens Club) meeting and used by the community.

1. For cold inhalations of eucalyptus oil in boiling water helps much relivi-

(Contd. p. 29)

The Drug Action network a people's response to the Drug's issue, VHAI's role and responsibilities

—Dr. MIRA SHIVA

VHAI's very inception was as a response to the health care needs of the majority. With a handful of visionaries, VHAI attempted to propagate the concept of community health and primary health care in late 60's. VHAI did provide a leadership role in alternative health care with a very clear commitment to its philosophy of reaching out to the best deprived sections of society. Initiative alone with professional expertise was the strength of VHAI. This loose federation of about 3500 membership of non profit making non government health institutions did represent a significant part of the Voluntary Health sector which provides 20% of the primary health care in India.

VHAI and Drugs

The Drug cultures and modern myths

April-June 1981 special issue of HFM 'medicines as if people mattered' was on Drugs. Long before that some of us had begun to realize the negative impact of the 'Drug culture' or the 'Drug Pollution' of the mind of an increasing number of a literate, illiterate, urban and rural health personnel and consumers alike. We felt that this *unshakable faith* and *implicit trust* in drugs was being created skillfully and being taken advantage of by the medical industrial complex. The myth that there was a *pill for every* ill was a modern day superstition, a medical myth which was being created, fed propagated by vested interest. There was just no reason why irrational useless costly and often hazardous drugs should be flooding the market, and find place even on the shelves of our service oriented voluntary health institutions and be dispersed and prescribed without any one questioning the rationality of their very existence.

Our initial efforts have been geared to our own VHAI members and in our various training programmes whether they were clinical assessment workshops, community health, OD seminars school health workshops or holistic health workshops, misuse of drugs and the issues involved have been discussed.

By the end of 1981 itself we realised that in a society where giving of long prescriptions with the latest 'wonder drug' had such a value. It was difficult for health personnel in the voluntary sector to bring about a significant change in the preception of rational drug use in loolation. Even though many health institutions and health personnel accepted the concept of essential drugs, and rational drug therapy, they found the market pressures very difficult to deal with.

By this time we were beginning to recognize the *shortages* of *essential and life saving drugs eg;* for TB and leprosy in the field. We also realized that most of our health institutions were not very well informed about the drugs and health policies. Had they been they would never allow some of the decisions which would not be in the interest of the public to be passed so easily. The need for health personnel, the people and consumers to participate and force their participation in decision making in matters affecting them and their work was strongly felt.

On 8-10th January in Pune, VHAI organized an intense workshop 'Drugs issues seeking feasible alternatives' when representatives of consumer organizations, health organizations, socially conscious doctors, pharmacologists, journalists met. The objective was to take stock of the existing drug situation, the trend, identify our own roles and responsibilities and coordinate our efforts.

It was here that the decision to take on the issue of EP drug on campaign basis for Women's day was taken. EP drugs were being prescribed for pregnancy testing inspite of their not being recommended for such a purpose because of foetal malformation. In the case of the EP campaign women's groups, journalists, other peoples organizations started coming together. A net work was spontaniously being built.

In August '82 at Jaipur many of the drug enthusiasts met again, the focus this time was 'Hazardous drugs'. Handouts providing the unbiased drug information from medical about Amidopyrines, Paediatric tetracyclines, EP update, hormonal preparations, clioquinols, anabolic steroids were specially prepared by us and circulated.

January and MFC annual convention at Tara was held with drug use, misuse as a theme and the anti diarrhoeal campaign was launched with the various groups pooling in. In February '83 KSSP for its bianneal 'peoples science movement convention focussed on drugs'.

In April '83 Dr, Olle Hanssen visited us. We were aware of his contribution in fighting SMON while preparing the clioquinol material in '82 itself. He was the first medical doctor to report the association of optic neutrits with clioquinol (Mexaform, enterovioform etc) please note this was in Sweden and not Japan; he had fought single hanpedly against the powerful Ciba Giegy, challenging their 'false drugs information' that the drug was not absorbed from the gut. Dr. Hanssen had gone as a witness to help support the SMON victims in their legal battle against Ciba Geigy Takable Tanable the manufactures of clioquinol (hydroxyquindine products) and the State. He had led the boycott of 3000 doctors and in Sweden against Ciba Giegy. Their continued sales of clioquinols in third world of Dr. Hanssen's inset was a big boost to us, his public meeting at AIIMS later with the Drug Controller of India, leading neurologists of Delhi, various journalists etc. proved one point—to fight against Drug colonolism, support would have to come from people's organizations and socially conscious individuals. Expecting medical associations and medical persons to fight for peoples cause was really expecting too much. Drugs issues were a sensitive issue and a strong stand by VHAI has meant treading on many toes, occasionally on the toes of some of our own institutional members.

Fighting against myths, superstitions and malpractices of a highly organized medical industrial complex is a task that demands committment creativity and courage and consistency. Eventhough the legal dimension of the drugs issue has been long recognised the need to be involved in public litigation against the vitimizers on behalf of the people is long overdue. Today the matter related to generic names, the banning of EP drugs and some of the other durgs in DCI's gazette notification multivitamines etc. is in the High Court or Supreme court. It is no longer being fought or therapeutic and rational grounds but on legal grounds, existing legal cases eg. Vincent Panikulangara's case against DCI, DGHS etc. for allowing sales of banned and hazardous drugs have succeeded in creating public consciousness about the matter. Drug Action networkers who have organized regional seminars and public meetings in Bombay, Trivandrum, Madras, Bangalore, Baroda and Delhi.

Mr. Etsuro Totsuka's of Japan a socially conscious lawyer from Japan who had fought for the SMON victims and who was been actively involved in informing other 3rd world groups about mexaform Drug toxicity and legal action, also visited us in '83. A meeting with alternative health workers, public litigation lawyers and journalists was held—to discuss health issues urgently requiring legal intervention. During the one day National Health Policy seminars organized by VHAI a drug sub group met, discussed and gave some recommendations.

In December '83 Dr. Zafrullah visited India for the paediatric Conference in Pune, VHAI coordinated his tour so that Dr. Zafrullah could meet the State VHA's. A Drug Action Forum has emerged drug action networkers in Pune, Bombay, Trivandrum, Madras, Bangalore, Delhi and Baroda where public meetings, discussions and seminars were organized. This sharing of experience at Gonosasthya Kendra of the Bangladesh drug policy helped in getting numerous others concerned and involved with drugs issue.

A lot has happened since then, AP VHA organized its General Body meeting with the theme 'misuse of Drugs' in February '84 16-20th November '84, AP VHA organized a workshop on 'Rational Drug Use' for health personnel. In their G B meeting where health and consumer groups as well as the state Drug Control authorities attended the seminar on drug misuse which has met with the Government authorities in their planning sessions for the 7th five year plans.

WB VHA organized a public seminar with Maximiller Bhavan in March '84 on 'Drugs Vs People'. WB VHA has initiated the Central Bulk Purchase Unit to make essential quality generic drugs at reasonable price. The second catalogue giving price lists is an educational tool, providing the essential drug list, list of banned drugs as well as principles of rational drug therapy. WB VHA's contribution in the WB epidemic has been dealt within HFM.

Gujarat VHA along with other individuals and organizations has initiated the bulk purchase initiative called LOCOST (low cost Standard Therapeutics). Drug education forms an important part of drug supply. MP VHA since past 3-4 years has been organizing clinical assessment workshops for upgrading of diagnostic therapeutic skills of middle level health personnel.

Kerala VHA organized a seminar on 'Low Cost Health Care' and another meeting on drugs is being planned for February.

Orissa VHA is planning its Drug meet sometime next year.

During Dr. Zafrullah's visit, some of the Drug Action network Core group members met in Delhi and also attended a meeting with the Policy makers organized by NISTADS on 'Health Pharmaceutical Policies'.

A one day meeting of Drug Action networkers took place in CINI on 31st January '84 to discuss certain specific issues eg. dilution of Fera companies and their impact, Vincent's case and out stand, Banning of Drugs etc.

On 30-31st August at the Drug Action network Core group meeting in Wardha, the All India Drug Action network formed and its organizational structure formalized.

Representing Organizations Profile of All India Drug Action Network Coordinating Committee

ADM	CERC
CGHS	CHAI
DSF	SAF
FMRAI	FRCH
KSSP	LOCOST
MFC	Log Vigyan Sanghatna
VHAI	

Material produced by VHAI and Drug Action network members in course of Drug and DAN meetings.

- — Strong medicine
- — Prescription for change
- — IOCU Anabolic steroids
- — Bitter Pills
- — Hathi Committee Report
- — Recommended reading
- — Photostat cover of Pharmaceutical Policies—Andrew Herxheimer
- — Contact
- — Wrong Kind of Medicine
- — Drug hand outs—eg. Essential drugs list, Banned Brand drug list, Essential drugs—a prioritization, E P update, Banned, Bannable, hazardous drugs etc.

National — National Drug Policy—Technical Expert Committee.

- — M. P's questions in Parliament about banned drugs.

State — State VHA's

Members — Seminars, Workshops, training programmes on Rational Drug use, clinical assessment and rational therapeutics.

International — G.K. Drugs & Health Policies — 1982 January. Drugs & Pharmaceutical Policies—IOCU — HAI Sweden.

On 25 - 26th November an emergency core group meeting was called for to discuss All India Drug action network's stand for the Technical Expert Committee meeting on 29th November.

Many VHAI members have contributed towards drug work in various ways. Kurji Holy Family Patna after much internal dialogue amongst its senior doctors and management has slashed down the number of drugs in its formulary.

Morning Hope Addikavidu has taken a policy decision not to stock irrational and hazarious drugs in its Pharmacy. It has also incorporated various non drug therapies in its routine medical work.

From several places reports have come of dialogues, discussions, counter questioning of the medical representatives many of whom are found to be totally unaware of some known facts about the drugs. (A Number of medical representatives have been reported to have quit their jobs after realizing how they are being used as puppets, fed with half truths, to push down the throats of their people—drugs that need to be thrown in the sewage.

Padhar Hospital, a 200 bedded hospital in Betul district during a 'Diagnostic study' conducted, there was found to be using around 100 drugs, the average number of drugs prescribed from the OPD ranged between 50-60 drugs. This hospital provides padeiatric, maternity, surgical, eye, orthopedic and rehabilitation services; besides community health work and socio economic, programme.

Deen Bandhu, Tamilnadu has pioneered the use of herbal medicines and has been conducting several training programmes for grass root workers in community health training programme and its community health work.

Bengal Rural Welfare Society is running a community health programme in various villages outlying Culcutta based on homeopathy. It has now moved into provision of integrated medical services from different systems of medicines from under one roof.

RAHA had been bulk purchasing drugs for it 30 or more health centres for being to cut down costs. RAHA health centres today combine some aspects of traditional medicine in their community health work.

WANTED

I. The Voluntary Health Association of India needs an Executive Director:

The main goals of the Association are community health for the lowest economic levels of society, with emphasis on health education, promotion and maintenance of health.

Applications or information helpful toward finding a suitable person, will be appreciated. There is a staff of thirty people plus related State level associations.

Write to:

The Executive Director
Voluntary Health Association of India
C-14 Community Centre, SDA
New Delhi 110 016.

II. Retired Christian doctor MBBS 60 yrs. looking for wholetime job in small mission Hospital/Health Centre.
Kindly address:

D.M. Saha
69 Defence Colony
Alto Porvorim
Bardez, Goa 403 521

III. Dr. A.K. Mitra, 74 Sree Ram Dhang Road,
Salkia, Howrah 711106
Seeks suitable employment. Those institutions interested may contact directly.

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nig could or fumes of turmeric powder.

2. Pomergranate skin dry powder in buttermilk helps in certain cases in reliving dysentry.
3. Decoction of oman seeds helps in reliving tummey ache in case of idigestion.
4. For fresh cuts and wounds fresh ginger paste with Jaggery helps much in healing and stops formation.
5. Scabies paste of margosa leaves mixed with turmeric helps much.
6. For scorpon stings rubbing a piece of onion on the site of the sting and refer to hospital.
7. For intestinal worms seeds of papaya works effectively.
8. Clove oil application for tooth ache.
9. For certain diabetic cases in the community bitter gourd has helped much in bringing down blood sugar level.

References :-

1. Primary Health Care : Report of the International Conference on Primary Health Care, of WHO Geneva Health for all series No. 1,1978
2. Promotion and development of Traditional medicine, WHO Geneva Technical reports series 1978,
3. Gunaratna V.T.H., Voyage towards health, New Delhi, Mc Grawhill, 1980.

Recommended Journals

During the last convention of November 1984, at Bangalore many of the participants asked to publish a list of journals pertaining to Health and Development. Following is the list of few of them with addresses.

Journals	*Address*
1. Social Welfare	Central Social Welfare Board, Jeevan Deep, Sansad Marg, New Delhi - 110 001
2. Swasth Hind	The Director, Central Health Education Bureau (Directorate General of Health Service), Kotla Marg, New Delhi - 110 002
3. Medical Friend Circle bulletin	Dr. Mrs. Thelma Narayan, 326, Vth Main, 1st Block, Koramangala, Bangalore - 560 034
4. Contact	Christian Medical Commission, World Council of Churches, 150, Route de Ferney 1211 Geneva 20 Switzerland, through VHAI, New Delhi.
5. Centre Calling	The Editor, 'Centre Calling' Temple Lane, Kotla Road, New Delhi - 110 002
6. Health for Millions	Voluntary Health Association of India, C-14 Community Centre, SDA, New Delhi - 110 016
7. Assignment Children	UNICEF, Palais des Nations, 1211 Geneva 10, Suisse.
8. Herald of Health	G-S Peter Son for the Owners Oriental Watchman Publishing House, Box No. 35, Pune - 411 001
9. Home Science	The Editor, Home Science, Directorate of Extension, Pratap Bhavan, 5, Bahadur Shah Zafar Marg, New Delhi - 110 002.
The Naturopathic Monthly	
1. Health Herald	Institute of Naturopathy and Yogic Science, 16th Thumkur Road, Bangalore - 560 073
2. Swasta Jeevan	All India Nature Cure Federation Rajghat Colony Delhi - 110 002.

HOSPITAL SUNDAY CELEBRATION

Sunday, 17th March 1985

Theme : "Towards a People Oriented Drug Policy"

All our institutions are requested to celebrate this day with due importance as a follow up of our convention in Bangalore last November and as per the recommendations and guidelines.

— EXECUTIVE DIRECTOR

Seminar cum Retreat on

Spiritual and Personal Growth through Clinical Experience

Course I.	For Sister Nurses
Date :	April 15—22, 1985
Course II.	For X-ray, Lab Technicians etc.
Date :	April 23—30 1985
Course III.	For Hospital Administrators
Date :	May 2—9, 1985
Resource Persons :	Fr. Felix Podimattom OFM (Cap) and his team.

Venue (for all the 3 courses)

Amarjyothi
Portiuncula Capuchin Ashram
Kattappana PO 685 508
Idikki Dist, Kerala.

No. of seats : Only 30 for each course (Apply soon)

Last date to receive registration form :

Course I	March 31, 1985
Course II	April 8, 1985
Course III	April 15, 1985

For further details and registration form etc. Please write to :

The Executive Director
Catholic Hospital Association of India
CBCI Centre, Goldakkhana
New Delhi - 110 001.

Management Seminar for Pharmacists

Venue :	All India Institute of Medical Sciences, New Delhi.
Date :	6th— 13th April 1985
Participants :	Qualified and/or registered pharmacists, pharmaceutical chemists, Drug Inspectors, Chemists and Druggists, Medical Store Keepers etc. from Government or Voluntary Sector.
Tuition fee :	Rs. 250/-

For Further information please write immediately to :

Dr. P.N. Ghei
Indian Hospital Association
C-II/72 Shahjahan Road
New Delhi - 110 011.
Tel : 382602

Only 14 out of 59 analgesic preparations found scientifically justified

Dr. Jamie Uhrig and Dr. Penny Dawson of Medico Friend Circle have analysed 59 preparations listed as analgesics and antipyretics in the July '84 issue of MIMS, India and found 45 of these 59 preparations to be irrational on some ground or the other.

Basing themselves on the latest authentic text books, Dr. Uhrig and Dr. Dawson rigorously studied each of these preparetions and graded them into the following categories :

A. Use of the product is justified-14 preparations for example: Plain paracetamol, Aspirin etc. . . .

B. The combination is not proven to be superior to single ingredient preparation and hence not recommended. . . . 17 preparations. For example—Equagesic, Fortagesic, Malidens, Micropyrin, Optalindon. . . . etc.

C. The combination has been proven to be inferior to single ingredient preparation and should be withdrawn. . . . . 11 preparations. For example—Apidin, Carbutyl, Dolopar Plus, Norgesic, Parvon-N Parvon-P, Proxyvon, Spsame-proxyvon, Sudhinol-N C. . . . . etc.

D. The preparation contains analgin and should be banned. . . . 17 preparations. For example—Codosic, Dolopar, Novalgin, Ultragin, Sedyn-A forte, Spasmizol etc. . . . . .

Medico friend circle appeals for socially conscious medicos to ask for withdrawal of all the preparations belonging to category B, C and D.

Five Viral Diseases Discovered by Indian Scientists

Five Anthropod—borne viruses

1. Kyasanur forest disease (KFD)
2. Ganjam
3. Chandipura
4. Wanowire
5. Bhanja

have been identified for the first time by Indian scientists. Till 1952 only two dengue and sandfly fever were known from India, but today 41 arboviruses have been identified In India, of which 28 are new to science. Major arboviral diseases in India are those spread by mosquitoes and ticks.

Information VHAI

US $550 Billion A Year is Spent on arms Whilst

2,000,000,000	people do not have safe water to drink
450,000,000	people suffer from hunger or malnutrition
250,000,000	people live in urban slums or shanty towns
12,000,000	babies die every year before their first birthday
130,000,000	children are unable to attend primary school
870,000,000	adults cannot read and write
500,000,000	people are unemployed or underemployed
42,000,000	people are blind or nearly so

Information, VHAI

A Brighter Future

Predictions at a recent World Health Day ceremony indicate that the next ten years will likely to see the most dramatic breakthroughs of all time for the health of people of the Third world. Among developments anticipated :

* Availability of an effective vaccine against malaria.
* Development of an effective vaccine against leprosy.
* Widespread use of oral rehydration therapy which will have the lives of millions of children through reduction of deaths from diarrhoea.
* Massive immunization programs against the six major infectious diseases from which children die in the developing world : measles, polio, diptheria, whooping cough, tetanus and TB.
* Global eradication of guinea worm.
* Dramatic increase in the availability of clean water and sanitation especially in Asia.
* Implementation of widespread programs to reduce the preventable blindness caused by vitamin A deficiency, onchocreciasis (river blindness) and trachoma.

Information, VHAI