MEDICAL SERVICE

the building of networks for consumer protection ● drugs in small rural hospital—a preliminary investigation ● drugs used for killing and planning ● legal education 12—crime and criminal procedure ● chai news and notes ● only a true cultural choice can effectively oppose euthanasia

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contents

EDITORIAL

A True Partnership

"Collaboration with non-governmental organisations in implementing the global strategy of Health For All by 2000 AD", was the topic for the technical discussion during the thirty-eighth World Health Assembly held at Geneva on 10th-11th May 1985. In this issue we have given the outcome of this historic meeting i.e. the final resolution passed at the W.H.A., as the first item of the CHAI NEWS NOTES column, for your ready references. No doubt this is a very important and valuable document which contains enough and more guidelines to organise ourselves i.e. governments at various levels and any number of voluntary organisations spread all over the country. This resolution has special significance for us in our country, because India has not only accepted this but also was one of the six countries who originally proposed the resolution. By this certainly we have assumed an added responsibility of implementing the various suggestions in the resolution. This has to be seen in its full seriousness by all concerned, if we are really sincere and serious about implementing the global strategy of Health For All by 2000 AD.

Those of us who had the opportunity to take part in the discussion cannot forget the enthusiasm of the participants representing more than five hundred non-governmental organisations from all over the world at the national. regional and international level. There was a general concensus that the non-governmental organisations are in a better position to implement the strategy because of their missionary commitment and closeness to the masses. Welcoming the participants in the technical discussions, the WHO Director General, Dr. H. Mahler, said that "non-governmental organisations had shown themselves to be strong advocates for people's concerns and agents for change". "It is not the question of governments *using* non-governmental organisations and their resources", he continued, "rather it is governments *facilitating* the work of non-governmental organisations who have a wealth of experience to put primary health care into effective action".

The free and frank discussions in the groups and in the plenary session on the second day were indications of dawning of a brighter furture as far as the relationships between governments and non governmental organisations were concerned. What is required is a true partnership in the real sense of the word between governments and non governmental organisations in the spirit of mutual trust and respect. In a country like India, no government, however fast and efficient it may be, can meet the challenges and problems that facing us, without the help of voluntary organisations. Both the governments and voluntary organisations will have to work hand in hand

keeping primarily the interest of the masses in mind, but at the same time keeping each one's identity. What is to be avoided by all means is any "holier than thou" attitude from the part of both the governments and non governmental organisations.

Let us all hope and pray and act so that what has been laid down by the World Health Assembly Technical Discussion may pave way to A TRUE PARTNERSHIP between the governments and voluntary organisations at various levels to build a more just society in our country and elsewhere.

CHANGE OF TELEPHONE NUMBERS

With effect from 1st July 1985, the new telephone numbers at the CBCI Centre will be :

344 470
344 453
344 695
344 615

As our office is at the CBCI Centre we can be contacted by these numbers also, besides our direct number : **310 694**

— EXECUTIVE DIRECTOR

The building of networks for consumer protection*

— Eva Lachkovics

When you look at a fisherman's net you will see a lot of small knots linked together either directly or indirectly. In this way little material can cover a considerable area and hold rather heavy weights. Because of the knotted texture the net is very flexible, it can take any shape and wrap all sorts of objects. It is light and not cumbersome. And once it floats in the water you can hardly see it and grap it only with difficulty. These qualities are indeed very useful for the fisherman. These same qualities can also be very useful for the consumers when they have to deal with "big fish".

The 'knots' of a network

Consumers and citizens all over the world have already woven a big net, they have tied those little knots and linked small centres to each other either directly or indirectly. They have covered the whole globe and formed this flexible structure that is so hard to attack because of its net-qualities. We call it network because actually it consists of overlapping nets and more complicated linkages than a fisherman's net. The bridges can reach very far and very near, and can cross each other and come back to the origin after a few diversions. This makes the network even stronger and more effective.

I am talking about the contacts between consumers' and citizens' groups, information centres, universities, government institutions, development agencies, a lot more other categories of organizations and of course individuals criss-cross all over the world. The majority of the groups involved are officially called non-governmental organizations, NGOs. The Perak Consumers' Organization is such an NGO. But if you call them people's organizations it is probably much more to the point because they represent the people, as consumers in the case of consumer organisations.

Significance of a network

What significance does a network have for these NGOs, for the people's groups, for the consumers?

If we talk about consumer protection, we have one crucial tool we can use against malpractices of the manufacturers—information. Finding, spreading and making use of information becomes the essence of consumer protection. That is where the network comes in because it opens an immeasurable potential of channels for information flow. If one link of the network needs a piece of information, that another one has or can easily get hold of these channels are activitated. Facts, figures, experiences, opinions are exchanged through them with only little effort and little loss of time.

International contacts are of special importance when we are dealing with transnational companies. They are present in many different parts of the world and by the help of the network we are too, keeping a close

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This paper was presented by Ms Eva Lachkovics, project Officer, International Organization of Consumers' Unions (IOCU), Coordinator, Health Action International (HAI), at the 'Consumer Rights Seminar' organised by the Perak Consumers' Association (PCA) at the Tun Razak Library, Ipoh, Malaysia, on April 1, 1984.

watch on them. If, to give you an example, a decision is taken in the US that effects Malaysia—it could be concerning the export of a banned pesticide—our US contacts might send an urgent telex to the IOCU office in Penang. On receiving it we might pick up the phone and call IOCU's various member consumer organisations in Malaysia to notify them—the Perak Consumers' Association (PCA) would be one of them. The consumer groups, fortified with "hot" news, might contact the authorities immediately, who might not yet be aware of the imminent danger, which gives the consumers a very strong position. With united strength, reinforced by publicity, the Malaysian consumer groups might be able to prevent the import of a dangerous pesticide thanks to a well functioning international network.

Another approach an international network makes possible, is to compare a particular situation, for instance the availability of hazardous products, in Third World and industrialised countries and publicise the results. Such a study can be used to put pressure on authorities and industry to remedy a double standard situation revealed in the study. From the various information centres, universities and government sources we can get expert information which is essential to back up any case or demand. Facts and figures speak with a very loud voice and usually do not fail to impress even bureaucrats.

The exchange of experience is also essential. We can learn from other groups new techniques and strategies to tackle our problems. Other groups' activities can act as sources of new ideas, stimulation and encouragement. Furthermore, knowing about other groups' programmes, we can link and coordinate our actions, contribute to the efforts of others and receive their contribution to ours in return. Concerted action increases each group's strength and confidence and has a most powerful impact on the target.

Imagine a Malaysian consumer protection network: Little voices all over the country demand at the same time with all sorts of different means, for instance the ban of a dangerous and unnecessary drug group, anabolic steroids. (Anabolic steroids were in the Malaysian papers recently as you will remember).

If coordinated the little voices will become quite a thunderous chorus. The media will report about the various activities designed to achieve the ban. People will become conscious and wary of anabolic steroids. They will start asking, why these dangerous drugs are on the Malaysian market, what security measures are taken for the consumers, who has controlled the safety for use in Malaysia of these drugs, and so on. The authorities will have to react. So will the medical profession and the manufacturers, if the consumer protest is strong enough. A single voice once in a while can easily be drowned. A well coordinated chorus cannot be neglected.

Even at regional e.g. South-East Asian, and global levels a network makes coordination possible. IOCU's Consumer Interpol network for instance, coordinates action at a global level. Whenever one of its members gets hold of information on a dangerous or defective product the information is sent to the Consumer Interpol centre at the IOCU office in Penang. From there a Consumer Altert giving details on the product, the problem and recommended consumer action is sent out to all the international contacts without delay. And the issue will be raised in many different parts of the world within a very short time of the detection of the particular hazard for the world's consumers. This is a very effective mechanism for consumer protection.

Building of a network

How does such a network come about? In fact, everyone can develop one. Everyone

has friends, colleagues, knows people working in the same field with similar attitudes, concerns and aims. So you start talking to them, find out more about what aims you have in common. You put these people in touch with each other simply by mentioning them to each other. Finally you come together to discuss the problems all of you are concerned with and decide to do something about them, what to do, how to do it together and how to coordinate it. You and your new group will be drawn to publications dealing with the subject of your concern. You will collect information on it and quite naturally addresses of people or institutions who have published this information. You will start writing to them learning more about them. They will put you in touch with yet other groups and individuals and your network is growing and growing. Sooner or later you will arrange for a bigger conference. It will be the manifestation of the network and will again mark the start of concerted action on a bigger scale. But the growth does not stop there. A network develops its own dynamics of growth. Once it becomes known people will approach it to becomes participants. A consumer protection network will not stop growing until the reason for its existence, the consumer problem, is rooted out.

History of the Health Action International network

As an example I will now outline the history of the network I am involved in the one I know best. It is called Health Action International or just HAI. One of the nuclei of its development was the International Organization of Consumers' Unions, (IOCU). IOCU had become more and more aware of the problems arising from indiscriminate marketing of drugs hitting Third World countries especially seriously. As a consequence IOCU conducted studies on the marketing of problematic drugs and produced a consumer action resource kit on 44 Problem Drugs.

During that period many people and groups in many different countries became aware of the same problems. Single voices were heard everywhere through media and publications. Naturally IOCU wanted to get in touch with these single voices knowing already how important and effective it is to join forces. IOCU represented already a very well developed network of more than 120 member consumer organisations in some 50 countries and had no difficulties in reaching out to the various "voices" or being reached by them. Letters went back and forth around the world, opinions and experiences were exchanged. IOCU started collaborating with several groups outside its membership on the issue of pharmaceuticals. As the contacts and the enthusiasm to start action grew, it was decided to bring them all together and combine the efforts for improvements, and the International NGO Seminar on Pharmaceuticals took place, in Geneva, 27-29 May 1981. It was co-sponsored by IOCU and the W. German Federal Congress of Development-Political Action Groups, BUKO, another network, namely that of grassroots groups in the Federal Republic of Germany concerned with development issues in the Third World.

At this conference the HAI network was consolidated and given its name. Its purpose was defined: "to resist the ill-treatment of consumers by multinational drug companies". The roots of the drug problems were diagnosed : "the multinational drug industry is deeply implicated in the trade in hazardous, useless, inappropriate and often unconscionably expensive drugs". It was a very diverse group representing some 50 organisations from 26 countries, which nevertheless agreed on such crucial principles.

Diversity is another strength of networks. It allows manifold and unusual approaches and prevents attacks for being one-sided or narrow-minded. Every group of the network retains its original profile and self-reliance.

Nobody has to divert from their mandates. Furthermore nobody becomes dependent on anybody else's action or inaction which is another asset of networking. Whoever wants to and can contribute does so, whoever does not, does not impair the network's dynamics either. Such was the accordance at the Geneva NGO conference. Nothing more formal than a simple press statement confirmed the groups' pledges. The network kept the flexibility of a fisherman's net and all its other assets.

One of the immediate action plans of HAI was the setting up of an international clearing house for information on the relevant issues. The HAI clearing house was and still is based at the IOCU Regional Office in Penang, Malaysia. It is of utmost importance for a network, especially for a huge international one like HAI, to have a centre for pooling information. Otherwise the information flow, which makes the network what it is, cannot be upheld. This will become obvious when I will explain the functions carried out at the clearing house.

The regular vehicle for the information flow, apart from mountains of correspondence was introduced about half a year later. It was the bimonthly network newsletter, HAI News, carrying current outstanding news on members' activities, drugs, drug regulation and policies, drug industry and health in general.

Almost exactly one year after the Geneva conference a special coordinator for the clearing house arrived in Penang, because the work that was to be done was not just a little side job. It slowly but steadily became quite substantial. Well, the coordinator that arrived was I.

At the pulse of networking

Now what do I do as a "professional networker?" What is networking all about?

When I came to Penang I first of all had to make myself acquainted with the already existing network—participants, their activities and their interests. Some of them I had already met personally in Europe. Personal acquaintance or even friendship invigorates a contact considerably. That is why conferences and seminars are so important. You can relate to people much better if you know them personally. And you have to relate a lot in a network. I slowly grew into the network and started relating to people.

Everyday a lot of information and letters land on my desk either from contacts or through the many magazines our library is receiving regularly. I have to scan the information as to its usefulness in relation to our work. If I get a piece of news on a particular issue which I know a certain group is working on, I send it to them right away. If a particular item is of great interest to the whole of the network I write a short summary and carry it, together with the source, in our newsletter, HAI News. If somebody is interested to know more about this item they can contact the source directly. A network newsletter is a convenient means not only to spread information but also to link up groups. I also tie new knots myself. If I cannot answer an information request myself, I usually refer to another group, information centre or anybody who might be able to help according to what I know from my previous correspondence.

Answering information requests is not just a mechanical job. As I already pointed out, it is important to *relate* to people. By sending a few accompanying lines with the informational material you can encourage the groups and give them the kind of moral support that helps against frustration. The mere thinking of a person acts already as encouragement. I recently had an enthusiastic letter from a Filipino lady working on medicinal plants thanking me for all the information I had sent to her—information, that I had received

and considered useful to her. This information was indeed useful to her and encouraged her to write an article, which again I asked her to share with the whole network.

When I get letters from people who are interested in HAI or want to participate I have to categorise them a bit, in order to use my time efficaciously. Is it a short formal letter that refers to information more or less "for the file" only? Can you read commitment to our cause between the lines? Does enthusiasm literally jump out of the paper? Is it a business letter? And so on. Usually you can tell a lot from one letter. You get a notion on whether the person wants to do serious work on the subject or is just a busybody, whether he or she has experience or needs guidance and many other little things. If the contact seems promising I will spend some time thinking how I could help best and writing a stimulating letter. If the letter looks vague and undecisive asking just for any information without saying why and what for, I would not waste much of my time on it and send just general material on HAI. If the persons are serious they will come back for more.

Some time ago I received a letter from a Pakistani medical student who seemed full of energy and real concern for drug abuse, mismarketing and double standards in Pakistan. I was impressed and replied at length. Soon more detailed questions came. I answered, sent him lots of materials and put him in touch with other HAI members who could be of further assistance. And immediately he started single-handed a newspaper campaign demanding the ban of the dangerous anti-diarrhoea drug, clioquinol, which was banned in Malaysia in 1982, by the way. He was successful. Clioquinol was banned in Pakistan on July 28, 1983. But Syed, my contact, was not content. He wanted the immediate stop of sale and the ban of some other dangerous drugs. By now he has become a very active and faithful HAI participant. I published his success in HAI News and keep supporting his actions with information and advice as much as I can. He in return contributes a lot to the information pool of the HAI clearing house.

Another one of my functions is trying to connect isolated activities in one country with similar ones in others. For example recently I got a letter from a contact in Australia who wanted help for a study on painkillers. So I sent him, apart from informational materials, some addresses of groups who, as I knew, had already done or were doing research on painkillers. I hope some collaboration will result from this.

A survey on anabolic steroids which I have already briefly mentioned was coordinated from the HAI clearing house last year. It served on the one hand to collect information, on the other to activate and stimulate several Third World groups and strengthen the HAI network in the developing world. Seventeen field workers in twelve different countries were asked to carry out a survey on marketing and promotion of these potent drugs, which are totally inessential and can cause horrible side-effects, such as sex changes in little girls, stunted growth in children and liver damage. The information, put down in a comprehensive report, was later used to make a case against irresponsible marketing practices of certain drug manufacturers. This information was of course channelled throughout the HAI network, stimulating the whole network and strengthening the links between the field workers and HAI.

Results of individual actions of other groups are also channelled through the network, either using HAI News as a vehicle or by sending out the reports, publications or announcements directly to the contacts.

Continuous growth of a network

All these activities contribute to the continuous growth and development of the HAI network. The HAI clearing house is the main catalyst of this growth, but not the only one. Last year, for instance, IOCU and other HAI participants sponsored two persons' travel through Latin American countries in order to make new contacts for the network. Later they were linked to the HAI clearing house in Penang, where we now have a staff member, who speaks Spanish and Portuguese and can help me with these contacts. By now HAI-Latin America is already starting to sprout and blossom. The same is now underway for Africa. A doctor, sponsored by IOCU, just returned from his "African Safari" on behalf of the HAI network.

As for this region, last November, an ASEAN workshop on Pharmaceuticals and Health Policies took place in Penang, hosted and coordinated by IOCU together with the Quakers International Affairs Program's (QIAP) regional office based in Bangkok. It was meant to strengthen the HAI network in this part of the world and form the nucleus for some concerted action in the area. It was highly successful and brought about the establishment of a sub-HAI-network, the ASEAN Health Action Network. HAI's successes are rather substantial although not always noticeable at first sight. I'll give you just a brief outline : HAI or rather HAI's many participants have managed to raise worldwide awareness of the drug problems caused by mismarketing and of possible remedies such as essential drugs lists, rational pricing schemes and preventive health care measures. Doctors and government officials appreciate and consider HAI's efforts and publications. HAI has contributed to restrictions and bans of many hazardous drugs in many countries and companies have changed labels, writhdrawn certain advertisements or even some of their products because of the heavy concerted consumer criticism. HAI has published a Draft International Code on Pharmaceuticals as a discussion document which has attracted wide attention of consumer and health groups as well as medical associations, governments, industry and international bodies like the World Health Organization (WHO) and the United Nations Conference on Trade and Development (UNCTAD). The draft, a manifest of consumers' demands with respect to drugs, is being internationally discussed. This means the consumers and their needs are seriously taken into consideration thanks to the HAI network.

Uniting Forces

I explained all this at length to give you a concrete example of the development of an already existing, huge, well functioning consumer protection network. It is well known and respected at the relevant international body, the World Health Organization (WHO), and equally well known and feared by the pharmaceutical industry. It shows the various aspects of networking and gives an account of the impact consumers can have if they unite forces. Apart from HAL, IOCU is involved in two other comparable global networks, the International Baby Food Action Network (IBFAN) an the Pesticides Action Network (PAN).

You have come here to unite forces too. You are consumers who are concerned with consumer protection. No matter which area you are particularly worried about, be it drugs, pesticides, food, infant formula, etc, if you want, you can become part of a powerful network and get all its support and backing up here and now. You can work with the Perak Consumers' Association (PCA), which is a member of the Federation of Malaysian Consumers' Association (FOMCA) and thereby a member of IOCU too. What you need is concern with a consumer problem and the firm determination to do something about it.

The next important thing is information. Collect some information about the problem of your concern and link up with friends with the same interest. PCA can give you advice on how to proceed further with your information. And already you are part of a network, which will give you more confidence. You won't feel alone and helpless anymore, which will even enhance your commitment and enthusiasm. Action will involve you more and more once you have started.

When you have collected any information on your particular issue always ask yourself some crucial questions:

* How can I use it most effectively?
* Who could help me spread this information?
* Who could have information matching mine and leading further?
* Who could need my information to build on it?
* Who is working in the same area whom I could collaborate with in the future?

These are networking questions, questions which I ask myself everyday. They are the lubricant for the smooth running of a network. In fact they are the lubricant for any action that is to be taken in the consumer interest, because isolated action is an isolated voice which might not be heard. Therefore, the aim must be not to leave it isolated. The first answer to these questions might be PCA, but later on you might indulge in networking on a larger scale in the consumer interest.

The references below will help you to get acquainted with the mentioned networks and will give you ideas for action.

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Drugs in small rural hospital —A preliminary investigation

G.D. Ravindran

This study was conceived after we came to know that the theme for CHAI convention was on drugs, and drug policy. We wanted to study the drug situation in the small hospitals. We prepared a questionaire consisting of 31 questions covering the following topics:

1. General description of the hospital
2. Drug availability
3. Drug selection
4. Dispensing/Prescribing practice
5. Drug information and continuing education
6. Adverse reactions.
7. Drug Budget
8. Treatment of Malaria, TB, Diahorrhea
9. Additional information regarding the changes made by doctors working in these hospitals.

St. John's has a rural placement scheme for its doctors. All the hospitals under this scheme have 25-50 beds. So we selected the hospitals and sent the questionaire to the students who are working in these hospitals.

A preliminary report based on the first ten responses was presented at the CHAI convention in November 1984.

Statistically speaking this number may be insignificant for an analysis, but the issues raised by the analysis are significant and call for some introspection.

High lights of the Study

1. Smaller the OPD load larger the no. of drugs that were stocked in the pharmacy.

No. of patients attending OPD	No. of hospitals	No. of drugs
5000	3	110-175
5000-10000	2	60-198
10000-15000	2	235
15000-20000	2	105-277
20000	1	154

This raises an important question why should hospitals which are being used by fewer number of people have large number of drugs in their pharmacy.

2. Injections constituted 14-33% of the total drug.
3. 10-20% of the drugs consisted of tonics most of the hospitals had one brand of Iron tonic, one brand of B Complex and one brand of calcium.
4. Though malnutrition was one of the major disease, none of the hospitals stocked food substitutes which augur well for our institutions.
5. Many of them stated that they came across steroids being used for all conditions in the general practice—prescriptions that they received. Only 3 types of steriods were being used in the hospitals they were (1) Bethamethasone, (2) Dexamethasone, (3) Prednisolone. This also shows that less of steroids are being used.
6. One area of concern is the different types of antibiotics that are being stocked in

our pharmacy. It ranged from 2-14 types. Is it necessary to use so many antibiotics? One saving grace was that Gentamycin and Cephalosporidine were not yet stocked by the hospitals.

7. 50% of hospitals had more than one brand of Ampicillin, Septran or Erythromycin. Is this because of the inducements and aggressive tactics of medical representatives?

8. Lomotil was stocked in 5 pharmacy. According to the doctors they did not use it in their practice.

9. More than two brands of phenylbutazone and Oxyphenbutazone were stocked in 50% of the pharmacies.

10. Different brands of antipyretics and analgesics were stocked in all the pharmacies.

11. Selection of drugs.

a. Medical Officer	3
b. Medical Officer + Administrator	3
c. Administrator trained	2
d. Administrator untrained	2

The conclusions that can be drawn are in 40— of the hospitals Medical Officer is not consulted. This gives rise to a lot of friction between the medical officer and the management.

a. It would be easier for the hospitals to stock low cost drug because the administrator decides.

b. In the 3 hospitals where the doctor and the hospital administrator decide about the drugs a beginning of the pharmacy council can be seen.

12. Criteria for selection of drugs.

cost factor	5
Local company	4
Profit for the hospitals	3
Efficacy	2
Expiry date	2
Patients acceptability	2
Reputable company	1
Whims and fancies of Administrator	1

Many comments were made—one person wrote that the company helps the hospital in finding doctors for its hospitals. Hence the company drug was being prescribed in the hospital irrespective of cost and efficacy.

50% of them were cost conscious. Except 2 none of them mentioned the efficacy of the drug.

13. Though all the hospitals had laboratory technicians only 3 had trained pharmacist. According to the new rule every hospital should have a pharmacist. We have a great dearth of pharmacists. The study brings out the importance which the hospitals give to the pharmacist.

14. PRICING
No standard criteria was followed. The pricing was very arbitrary. It ranged from charging cost price or retail price marked on the drug or the whole sale drug price + tax + many levels of profit which ranged from 5% — 50% the cost price of the drug. Is this ethical?

15. Except one doctor no one knew the amount spent on drugs or the status of the pharmacy financially. Most of them were saying that the administrator were not forthcoming with further details.

16. In a small hospital we expect more drugs to be prepared by the hospital. Carminative mixture was prepared in all the hospitals. 50% of hospitals mentioned that they also prapared Glycerin Magsulf paste. In most hospitals other than these nothing else was being prepared.

17. There was no consistent rule about expired drugs. They are used between 6 month — 1 year after expiry in some hospitals.

18. 3 hospitals mentioned that they had a formulary.

19. 3 other hospitals had an essential drug list.

20. 4 hospitals had a standard regimens.

21. Only one hospital had all the above components (18-20).

22. To gain knowledge about use of drug, doctors used MIMS and textbooks.

23. 7 of the doctors were aware of banned drugs. One person did not know about it.

24. Very low incidence of adverse drug reach were mentioned. These involved pencillin and B-Complex. No other reactions were mentioned. This reflects the awareness that our doctors have about adverse reactions.

25. We choose 3 diseases to study the drug regimes followed in our hospitals. The criteria being the variety of treatments that are available and also the importance.

Tuberculosis

We found that all hospitals follow standard regimes of streptomycin/INH/Thiactazone. Two hospitals used Rifanpicin and Ethambutol. 3 hospitals referred the patient to sanitoriums. One made the bold confession that in their hospitals poor patient got only INH & thiactazone and streptomycin was withheld due to nonpaying ability. (a shocking example of our preferential option).

Malaria

Not a single person wrote about the use of primaquine for radical treatment of Malaria. Many were aware of the use of primaquine. But primaquine is not available in the market.

Diarrhoea

Only two hospitals made a constructive effort to use ORS fluid therapy in practice.

26. To the question what changes that they have brought about in their pharmacies

    (1) 90% of the doctors state that they have been using generic names for antibiotics in their hospital practice.

    (2) All of them state that they have reduced the number of tonics & injections.

The important suggestions which were featured in the answers were :-

1. The hospitals should have a clearly written drug policy which should be known to everybody working in the hospital.

2. CHAI should arrange regional workshops to continue medical education for the senior nurses/pharmacists working in rural dispensaries.

Overall impression

Though the situation looks outdated, misinformed and, irrelevant there are many signs of hope of a new awakening, a new sensitivity and a search for greater relevance.

Drugs used for killing and planning

—Dr. J. Iype

Drugs are manufactured by pharmaceutical companies for PRESERVING OR PROLONGING LIFE or for relieving suffering of humans and animals. Until recently the MOTTO was this all over the world. Now there are drugs manufactured for KILLING; many drugs are also used by the medical profession by its LETHAL (killing) dose, *legally* to kill human beings at different stages of existence.

"I will not give a person a homicidal drug to kill. I will not give to a woman a pessary to procure abortion. I have become a physician to PRESERVE life and not to destroy life". Now this whole Hippocratic oath is reversed, and EXTERMINATION is considered as a great service to the nation. Doctors directly kill in euthanasia or mercy killing; they exterminate normal babies, in the name of medical termination of pregnancy, even though there may not be medical causes. The noble medical profession. has become ignoble

I. Drugs manufactured for killing unborn babies

Prostaglandins are a group of naturally occurring hormones, one form of which, produces strong contractions of the uterus. This form PROSTIN was approved by the Food and Drug Administration, originally, for *one purpose only* and that was termination of mid-trimester pregnancy. Since then two other forms of the drug have been approved; they also are *primarily used for killing in the middle three months or later.*

One complication of the drug, mentioned in the Upjohn Companies' literature, is that the baby occasionally is *BORN ALIVE* (a mistake?) The remedy for this complication not mentioned in the literature, has commonly been to let the baby die from lack of attention. The Upjohn company has become known internationally as the 'death peddler' because of this drug, since it is the first major drug house to make a *drug,* whose only major purpose is to kill living human beings. Nation wide protest has come in America and a wallet size card has been distributed to the millions throughout the world. It asks if you want to support the only company that is producing a drug, whose only major purpose is to kill.

II. Abortifacients:

Are available in the market both in modern medicine and in indigenous medicines for killing the unborn babies. Ergot preparations and oxytocics used in delivery cases are also used as abortifacients.

III. Drugs used for killing in euthanasia or mercy killing

Any drug can be used this way to kill by its LETHAL (killing) dose. Euthanasia bill was in the parliament of 'Ahimsa' India twice and the same bill with some modifications is now with the government of Gujarat. Whatever be the terminology used or whatever be the mode of killing by drugs, *killing is killing only.*

IV. Drugs used in human experimentation

There was international furore over the Indian monkeys being used for experiments in laboratories and space ships. Hence India prohibitted export of monkeys. Babies procured by wilful abortion are used for experiments as guinea pigs even today in grand

scale, and surprisingly there is no voice raised against it!

Hitler used human live adults for experimentation and world construed it as horrible and condemned it. It may be a new drug to be experimented on the baby or an old drug for a new effect found out by accident. It may be a virus or bacteria injected to the baby to produce a disease and, in the end, by the same poison or organism baby is killed.

V. Drugs used for Family Planning

When eostrogen was given to the cows it yielded more milk and accidently it was found that the cow was also not becoming pregnant. Doctors tried it on women and found that women also did not become pregnant with the hormone eostrogen. Hence this one and other combinations are used now as the pills for contraception. Later it was found that eostrogen is producing immense problems in the cow's body and the law has come preventing the drugs being administered to the cows. Surprisingly women are asked to continue to consume them in plenty all over the world even though they are producing adverse effects and complications.

Medical literature is flooded with real reports and statistics regarding the complication of the pills. Many have started questioning the safety of the pills. It is carcinogenic for the uterus, breast etc. It is diabetogenic, thrombus forming and if it occurs in the heart. it results in heart failure.

LEGAL EDUCATION—12

Crime and Criminal Procedure

(Due to space limitation we could not continue the column on legal education during the past few months. With this issue we are continuing this column.

—Editor)

—P.D. Mathew

A crime is an offence against the community or society at large. It is the responsibility of the State to prevent crime and to punish criminals. A criminal can be punished only in conformity with the requirement of law. The Indian Penal Code, Central and State laws define various types of crimes or offences and prescribe definite punishments. The Code of Criminal Procedure 1973 (New Code) lays down specific provisions with regard to the judicial procedure to be followed in the investigation of offences and the trial of the accused. A great majority of the Indian citizens are ignorant of the provisions of criminal laws. Ignorance of law, legal rights and duties often result in individuals violating these laws or not exercising their legitimate rights. Sometimes the authorities concerned with the prevention of crime and the punishment of criminals seem to exceed their legal powers or use illegal means in dealing with the accused persons. The ignorance of law among the weaker sections is sometimes exploited by the custodians of law and other powerful elements in society for their vested interests. It is the duty of every citizen to know his legal rights and obligations, so that he can behave in a responsible manner and render assistance to the authorities where necessary and if called upon to do so. It would, also help him in preventing his exploitation by fellow citizens, police, bureaucrats and members of the legal profession and the judiciary.

This is to promote legal literacy among the ctizens. It deals only with the concept of crime, the structure of criminal courts, F.I.R. provisions of the Code of Criminal Procedure with regard to investigations by the police and complaint.

What is crime ?

A crime is an act of commission or omission contrary to law. It is presumed to be an act against the community or society at large. The State has power to punish a person committing a crime if he is found guilty. In other words, crime is an act which is declared punishable by the State. In India various acts of crime are defined in the Indiad Penal Code (Sections 109 to 511) and other Central and State laws.

Presumption of innocence

In Criminal law it is generally presumed that an accused person is innocent until the contrary is proved through a judicial process.

The Code of Criminal Procedure

The Code of Criminal Procedure 1973 (New Code) lays down the judicial procedure to be followed in bringing of a person accused of a crime to justice. It also provides for a machinery for the punishment of offenders and a procedure to prevent crimes.

What are the objects of the New Code?

The objects of the New Code are:

1. to ensure the accused a fair trial in accordance with the principles of natural justice;

2. to ensure the accused a fair trial as of right without needless and harmful delay; and

3. to simplify trial procedure so that the poorer sections of society get justice easily and expeditiously.

What are the kinds of offences defined by the Code ?

There are mainly 3 kinds of offences:

1. bailable and non-bailable

2. cognizable and non-cognizable

3. compoundable and non-compoundable

Bailable and non-bailable offences

There is a column in the Schedule to the Code which lays down a list of offences which are bailable and those which are not bailable. Bailable offences are less serious than non-bailable ones. In bailable offences the accused has a right to get bail. But in non-bailable offences granting of bail is left to the discretion of the Court.

Cognizable and non-cognizable offences

Cognizable offences are offences for which a police officer can arrest a person without a warrant. They are more serious than non-cognizable offences. In non-cognizable offences the police cannot arrest the offender without a warrant from the Court. Cognizable offences are listed in the Schedule of the Code of Criminal Procedure. Certain offences punishable under other Central and State Acts are sometimes made "cognizable" for effective implementation of the provisions of these Acts.

Compoundable and non-compoundable offences

The Code lays down a complete list of compoundable offences in Section 320. Compoundable offences, less serious in nature, are those offences which can be compromised with or without the permission of the court by persons mentioned in the specified sections. A compromise petition, after it is filed cannot be withdrawn. A case can be compounded, before judgement is pronounced, even in revision.

The accused is acquitted if the case is legally compounded. On the filing of a compromise petition signed by both the parties in respect of an offence, for which no leave of the court is required, the Magistrate is in duty bound to order an acquittal.

Criminal Courts

Structure of Criminal Courts

Supreme Court	— National level
High Court	— State level
Sessions Court	— District level (Divisional level)
Judicial Magistrate of the first class	— Sub-divisional level (Taluka—Tehsil level)
Judicial Magistrate of the second class	

Note

* The State governments can declare a city or town which has more than one million population as a metropolitan area. Bombay, Calcutta, Madras and Ahmedabad are already declared metropolitan areas. In metropolitan areas the Judicial Magistrates are known as Metropolitan Magistrates whose jurisdiction is limited to the metropolitan area.

* In every district there is a Court of Session. It is presided over by a Judge

appointed by the High Court. If necessary the High Court may appoint additional Sessions Judges and Assistant Sessions Judges.

* In any district the High Court may also appoint a Judicial Magistrate of the Fitst Class as the Chief Judicial Magistrate.

* If requested by the Central or the State Government the High Court may appoint, for a specified period, an experienced person in legal affairs as special Judicial Magistrate to deal with a particular case or a class of cases.

* The Sessions Court has an overall control over its subordinate courts, viz. Courts of the Chief Judicial Magistrates, Magistrates of the first class and Magistrates of the second class.

* The State Government appoints Executive Magistrates one of whom is District Magistrate and others Executive Magistrates subordinate to the District Magistrate to perform executive or administrative functions and specified judicial functions etc.

* The State Government may, if required, confer the power of the Executive Magistrate on a Commissioner of Police.

* Every Judicial Magistrate as well as Executive Magistrate is given a specified area in which he can exercise his territorial jurisdiction.

* The Supreme Court situated in Delhi is the highest Court of the nation and it is the final authority to deal with appeals in criminal cases. It has also original jurisdiction (jurisdiction to deal with a case without referring the same to a court subordinate to it) to deal with criminal matters under Articles 32 of the Constitution.

* A person convicted for capital punishment (death) may file a mercy petition to the President of India if his appeal is rejected by the Supreme Court.

Powers of Criminal Courts

The Indian Penal Code defines crimes and prescribes specific punishment. The types of cases each court can deal with are specified in the Schedule to the Code. As for example, a murder case cannot be tried by a Court of Judicial Magistrate of first class or second class, it must be tried in a Sessions Court. Thus Judicial power given to each Court in dealing with cases and passing sentences is limited. The following table may help you to understand the power of each Court in relation to passing of sentences on convicts.

1. **High Court**

Any sentence authorised by law : Section 28(1)

2. **Sessions Judge or Additional Sessions Judge**

Any sentence—but a sentence of death shall be subject to confirmation by the High Court: Section 28(2)

3. **Assistant Sessions Judge**

Any sentence except —

(a) a sentence of death, or

(b) imprisonment for life, or

(c) imprisonment for more than 10 years: Section 28(3)

4. **Chief Judicial Magistrate**

Any sentence except —

(a) a sentence of death; or

(b) imprisonment for life; or

(c) imprisonment for a term exceeding seven years: (Section 29(1).

5. **Magistrate of First Class**

Any sentence of imprisonment not exceeding three years or of fine not exceeding Rs. 5000 or both: Section 29(2).

6. **Magistrate of Second Class**

Any sentence of imprisonment not exceeding one year or of fine not exceeding Rs. 1,000 or both: Section 29(3).

Notes

* A Magistrate cannot award a sentence in excess of his jurisdiction.
* If an accused is convicted for several offences in the same trial, the Court is empowered to pass several sentences for such offences prescribed by law. But generally the Court directs that several punishments to be inflicted on the convict for several offences must run concurrently i.e., during the same period.
* Children below 16, who have committed an offence not punishable with death or imprisonment for life, may be tried by a Court specifically empowered under the Children's Act 1960 or under any law providing for the treatment, training and rehabilitation of youthful offenders. If the Children's Act is not in force in any State, then a Chief Judicial Magistrate can conduct such a trial.
* Where a fine with imprisonment is imposed on an accused and if the fine is not paid he can be given a further term of imprisonment in addition to one already awarded. Rules regarding the same are explained in Section 71 and 72 of the Indian Penal Code and Section 31 of Code of Criminal Procedure 1973.

POLICE OFFICERS

Powers of Police Officers

There is a hierarchy of Police Officers beginning from a constable to a Superintendent of Police in a district.

Usually the office-in-charge of a police station is called the Station House Officer (S.H.O.). He and his Superior Officers can exercise power within the local area to which they are appointed. The commission of a criminal offence is to be reported to the police station within whose jurisdiction the offence has taken place. This is called the First Information Report (F.I.R.).

What is the duty of the Citizens to assist Magistrates and Police ?

Every person is bound to assist a Magistrate or police officers when they reasonably demand his help in preventing (i) the escape of a person being arrested; (ii) breach of peace; (iii) and any damage to railway, canal, telegraph or other public property (Section 37 Cr. P.C.).

What is the duty of the Public to give information to the Magistrate or Police Officer ?

Every person, who is aware of the commission of any of the following offences is bound to give information forthwith to the nearest Magistrate or police officer (Section 39 Cr. P.C.).

1. Conspiracy to overthrow the Government
2. Offences against the public order and public peace
3. Taking of bribes by a public servant
4. Adulteration of food and drugs
5. Murder
6. Theft accompanied by preparedness to cause injury
7. Robbery and Dacoity
8. Criminal breach of trust by a public servant
9. House trespass
10. Counterfeiting of currency notes etc.

Note

* Failure to give information of the above offence without any reasonable excuse is considered an offence under section 202 of the I.P.C.
* The burden of proving the failure to do so is on the person aware of the commission of such offences.

Information to the Police and Their Power To Investigate (Sections : 154-173 of Cr. P.C.)

When an offence is commited, any person (whether he himself is agrieved or not) who know about it can give information to the police officer of the nearest police station to investigate the case. The offence committed may be cognizable or non-cognizable. In cognizable cases the police can investigate upon information received without a Magistrate's order. In non-cognizable cases the police cannot investigate without a Court's order. In such cases the police will refer the matter to the Magistrate to obtain an order to conduct investigation.

What is FIR?

F.I.R. (First Information Report) is the first information given to a police officer regarding the commission or occurrence of an offence.

What must be the essential contest of F.I.R.?

The F.I.R. must contain the following points.

1. The name and address of the accused
2. The date, place and time of the occurrence of the offence
3. Particulars regarding the offence viz., identifying details of property where it is a "property crime," or motive if it is a crime against person, etc.
4. Identity of the witnesses, if any.

Note

It is not necessary to mention all the details of the offence. The F.I.R. must be lodged as early as possible. Undue or unreasonable delay in lodging the F.I.R. inevitably gives rise to suspicion, which puts the court on guard to look for possible motives and the explanations for the delay.

Note

* Any person aware of the commission of an offence can give information to the police officer.
* It must be given to the officer in-charge of the nearest police station.
* It can be given orally or in writing.
* If given orally, it must be written down by the police officer.
* It shall be signed by the informant.
* The substance of the information must be entered in the "Station House Register," (Section 154(1) Cr. P.C.).
* A copy of the information as recorded (F.I.R.) must be given to the informant free of cost (Section 154(2) Cr. P.C.).

What is the remedy if F.I.R. is not recorded by the police officer ?

On refusal to record the F.I.R. by a police officer the aggrieved person may send the substance of the information in writing by post to, or approach in person, the Superior Officer of the Police Station Officer, i.e. Sub-Divisional Officer or the Superintendent of Police (D.S.P.). If in the opinion of the latter a cognizable offence has been committed, he may either investigate the case himself or direct a subordinate officer to investigate it.

Has F.I.R. any evidentiary value ?

The F.I.R. is an important document as it is the starting point in an investigation. Hence,

the obligation to speak truly and to avoid exaggeration or falsehood. By itself, it is not substantive evidence in a trial to prove the guilt of a person. Yet the first information is a document of considerable importance in criminal trial. It can be used to corroborate (support) or to contradict the testimony of the Informant witness, by the accused. In case where the informant dies before the trial and the F.I.R. is recorded on his statement, it may be considered a "dying declaration" and it may be used to establish the cause of his death. To sustain a conviction, "first information" must be corroborated by other evidence.

What is the procedure to be followed by the police in non-cognizable cases ?

If information of an offence is given to a Police Station Officer which is a non-cognizable offence committed within the limits of the police station, the police officer must record the information in the Station House Non Cognizable Register and then refer the informant to the Magistrate (Section 155).

Note

* In the case of non-cognizable offences the Police officer has no power to arrest a person or to investigate the matter without the order of a Magistrate.

What is the power of a Police Officer to investigate cognizable offence ?

An officer in-charge of a police station can investigate without the order of a Magistrate any cognizable offence comitted within the local limits of that police station (Section 156(1)).

What is the procedure to be followed for investigation?

1. From the information received, if the Police, Officer suspects the commission of an offence, he, either in person or through his subordinate officer, investigates the facts and circumstances of the case.
2. The Police Officer must send his report, i.e. a copy of the F.I.R. to the Magistrate empowered to take cognizance of the offence.
3. If necessary, the Police Officer may arrest the offender.
4. If it appears to the officer in charge of a police station that there is no sufficient ground for investigation or the offence reported is not of a serious nature, then he may not investigate the case. In this case the Police Officer must communicate the reason for non-investigation to the informant (Section 157(1) & (2)).
5. The Magistrate on receiving the police report may either ask for further detailed investigation or proceed with the case and dispose of it in the manner provided in the Code of Criminal Procedure. This scheme keeps the judiciary informed and enables it to exercise a supervisory role.

What is the power of a Police Officer to require attendance of witness?

A Police Officer who is investigating a coginizable offence has the power to send an order in writing to any person, who is acquainted with the facts and circumstances of the case, to appear before him. Such a person has a duty to attend before the Police Officer and answer all the questions relating to the case put up to him.

Note

* To obtain information from women and children below 15 years, the Police Officer must go to the place where they reside. In other words, for purpose of an investigation they must not be compelled

to meet the Police Officer in any place other than the place where they reside (Section 160(1) Cr. P.C.).

* It is obligatory for the Police Officer to pay reasonable expenses of every person attending the investigation at any place other than his residence (Section 160(2) Cr. P.C.).

Examination of witnesses by police

The Police Officer empowered to investigate the case may examine orally any person acquainted with the facts and circumstances of the case. A person examined in the course of a police investigation is obliged to answer truly all questions put up to him except questions which tend to expose him to a criminal charge or penalty (Section 161 Cr. P.C.).

Is the witness who makes the statements to a Police Officer bound to sign the document or report written by the Police Officer ?

A person making statements to a Police Officer during the course of an investigation is not bound to sign the document.

Note

* The statement of a witness can be used during trial by the accused and, also, by the prosecution (with the permission of the trial court) to contradict the witness (Section 162 Cr. P.C.)
* Statement includes both oral and written statements.
* The first information report (F.I.R.) recorded against the accused is not a "statement" in the legal sense as it is not made in the course of an investigation.
* The accused person is entitled to get the copies of the recorded statements of the witnesses for the purpose of cross-examination.

Has the Police Officer any authority to torture a witness or an accused so as to induce him to make a particular statement ?

Section 163 Cr. P.C. prohibits any Police Officer from making any inducement, threat, or promise for the purpose of obtaining a statement.

Neither can he prevent by warning or otherwise any person from making a statement which he may be disposed to make on his own free will, i.e. a person is free to make a confessional statement if he so desires.

The Police Officer has no authority to assault, or to confine a witness or an accused in order to obtain a statement or to extort a confession from him.

CONFESSION

During an investigation, an accused person may like to make a voluntary confession of the truth of the facts of the offence. A confession obtained by threat or violence is not a valid confession and it will not be admitted as evidence at the trial. An accused person is not bound to make a confession. The confession made by an accused to a Police Officer has no evidentary value i.e. it cannot be used during trial against the accused. The Criminal Procedure Code, Section 164, has made special provisions regarding the manner of recording a valid confession by a Magistrate.

What is a confession ?

A confession is a voluntary disclosure made by an accused person that he has committed an offence.

Who is authorised to record the confession ?

Only an authorised Magistrate can record the confession of an accused person. A

confession cannot be recorded by a Police Officer. The confession may be recorded either during the investigation or before the commencement of the trial.

How is the recording of a confession to be made ?

1. The Magistrate before recording any confession from the accused must explain to him that he is not bound to make it and that it may be used as evidence against him (Section 164(3) Cr. P.C.).

   He must not record the confession unless he has reason to believe that it is made voluntarily.

2. Every question and answer must be put down in full (Section 281(2) Cr. P.C.).

3. The record shall be shown or read over to the accused or interpreted to him (Section 281(A)).

4. The accused must be at liberty to explain or add to his answers (Section 281(4) Cr. P.C.).

5. The record must be signed by the accused and the Magistrate (Section 281(5) Cr. P.C.).

6. The Magistrate must make the following memo at the foot of the record and sign it: "I have explained to Mr. X that he is not bound to make a confession and that if he does so, it shall be used as evidence against him and I believe that his confession was voluntarily made. It was taken in my presence and was read over to the person making it and admitted by him to be correct, and it contains a full and true account of the statement made by him," (Section 164(3)).

   (Signed) AB
   Magistrate

7. The Magistrate after recording the confession in the above manner must forward it to the Magistrate by whom the case is to be tried. The recording Magistrate may not be the Magistrate having jurisdiction to try the case, (S. 164(3)).

Note

* After the recording of the confession the accused person may retract his confession.
* The Bombay High Court held that a retracted confession if proved to be voluntarily made can be admitted along with other evidence.
* Even if a Magistrate makes certain technical errors like not writing the memo etc., in recording the confesion it can still be accepted as evidence if the error does not cause damage to the defence of the accused.
* It can be revoked only when there is some written record which is defective.

Has the Police Officer power to search in the course of investigation ?

During the course of investigation if the Police Officer has sufficient reason to believe that any material related to the offence is hidden in any place within the limits of his police station, he himself may make a search of that place to obtain the material or appoint a subordinate officer to search for the thing in a specific area. (For legal provisions regarding search warrant please refer to legal education series No. 2).

What is the procedure when investigation cannot be completed in 24 hours? (Section 167 Cr. P.C.)

* If the accused is in police custody and if it appears that the investigation cannot

be completed within 24 hours and the accusation is well-founded, then the Police Officer must forward the accused along with a copy of the entries in his diary to the nearest Magistrate.

* The Magistrate may authorise the detention of the accused in police custody for a period of not more than 15 days at at a time.
* After every 15 days, the Police Officer must produce the accused in person before the Magistarate to obtain permission for further detention in judicial custody. The total period of detention may be 60 days depending on the nature of the offence(s) being investigated. On completion of this period, the accused has to be released on bail if he is prepared to furnish bail.
* When the Magistrate refuses to grant permission to the police to detain the accused in police custody he either be detained in jail-custody or released on bail.
* The Magistrate authorising detention in the custody of the police under section 167 Cr. P.C. must record his reasons for doing so.
* If an investigation is not completed within six months from the date on which the accused is arrested, the Magistrate can issue an order to stop further investigation into the offence, unless the Police Officer gives special reasons for the continuation of the investigation beyond six months. If the investigating officer feels aggrieved by this Order, he can apply to the Sessions Judge for having it vacated.

What are the grounds for remand in Police custody ?

1. There is sufficient evidence to believe that the accused has committed the offence.
2. Further evidence may be obtained by a remand.

What is the procedure to be followed when evidence is deficient ?

If the evidence is not sufficient, the Police Officer may release the accused from custody on his executing a bond to appear a Magistrate if required (Section 169 Cr. P.C.).

What is the procedure to be followed where the evidence is sufficient ?

If there is sufficient evidence, the Police Officer:

1. forwards the accused under custody to a Magistrate competent to try him or if the offence is bailable and the accused is willing to give security, takes security from him for his appearances before the Magistrate;
2. sends to the Magistrate any weapon or other article necessary to be produced before him;
3. requires the complainant and the witnesses to execute a bond to appear before the magistrate to give evidence;
4. delivers a copy of the bond to one of the executants and sends the original with his report to the Magistrate (Section 170).

What is the nature of the police report made at the end of investigation?

This report is known as "charge sheet."

It contains:

1. the name of the parties,
2. nature of information,
3. names of witnesses and
4. whether the accused is forwarded in custody or released on his bond with or without sureties.

Note

* Complainants and witnesses on their way to any court are not required to accompany the Police Officer.
* They cannot be subjected to unnecessary restraint or inconvenience.
* They are not required to give any security for their appearance other than their own bond.
* If any witness or complaint refuses to attend or execute a bond, the officer-in-charge of the police station may forward him to the Magistrate who may detain him in custody until he executes the bond (Section 170 Cr. P.C.).
* These provisions are intended to indicate while there is a civic duty on persons acquainted with the facts of the case to assist the State (Prosecution) during the trial no unnecessary restraints are placed on witnesses by the police.

What is a "Police Diary" ?

Every police officer making an investigation must daily enter his proceedings in a diary (Case Diary). It must record:

1. the time at which the information reached him;
2. the time at which he began and closed his investigation;
3. the place or places visited by him; &
4. a statement of the circumstances ascertained through his investigation (Section 171(1)).

Note

* The object of keeping "case diaries" is to enable the Court to be informed of investigation by the police to aid it during trial.
* It can be used by the Court and the Police Officer and the accused under certain circumstances (Section 172(3)).

What are the documents an accused person is entitled to get before the commencement of his trial?

Before the commencement of his trial, the accused is entitled to get from the Police Officer a copy of the first information report, police statements of prosecution witness during the initial investigation and all other documents or relevant extracts on which the prosecution proposes to rely in the trial.

Note

* A criminal case (police case) always begins with the giving of a "charge sheet." It gives all the particulars of a case and, if a witness is examined and his name is not on the charge sheet, one may draw the attention of the Court to it if the accused feels that the police are "improving" upon the case. The prosecution, however, are not prevented from applying to the trial court for summoning additional witnesses not cited in the charge-sheet. It is for the court to summon them if the cause of justice so requires.

What is to be done by the Police Officer at the completion of the investigation?

* Every investigation is expected to be completed without unnecessary delay.
* As soon as the investigation is completed the Police Officer must forward the report to a competent Magistrate in a prescribed form.
* Along with the report the police must forward to the Magistrate all documents and relevant extracts and the statements of prosecution witnesses on which the prosecution proposes to rely.
* Even after forwarding the above documents the Police Officer may continue the investigation if he obtains further evidence on the offence committed

and forward the report to the Magistrate (Section 173).

What is the procedure to be followed in case of suicide, murder, accident, etc?

* When a Police Officer receives information regarding the unnatural death of a person (death due to suicide, murder, accident etc.) he shall immediately give intimation to the nearest District or Subdivisional Magistrate to hold an inquest i.e., a judicial inquiry to ascertain the cause of a person's death (Section 174-176 Cr. P.C.).

* Then he must go to the place of the incident and in the presence of two or more respectable neighbours make an inquiry and draw up a report on the injuries on the body and of the apparent cause of death. This report must be signed by the Police Officer and two witnesses.

* If there is any doubt about the cause of death, he must, if possible, send the body for examination to the nearest Civil Surgeon or other qualified medical man appointed by the State Government.

* He may, if necessary, summon two or more persons for the purpose of investigation and any other person acquainted with the facts of the case and every summoned person is expected to answer truely relevant questions put up to him.

What is the procedure of investigation in case of death in police custody ?

When a person dies while he is in police custody, the nearest Magistrate competent to hold the inquest must hold an inquiry into the cause of death, either instead of, or in addition to, the investigation conducted by the Police Officer. During the investigation he must record the evidence taken by him, according to the procedure prescribed and the circumstances attending the death. If required, he himself may examine the body and cause the dead body to be disinterred to ascertain the cause of death (Section 176 Cr. P.C.).

Note

When an inquest is made by a Magistrate, he must, whenever practicable, inform the close relations of the deceased and allow them to be present at the inquiry (Section 175(4) Cr. P.C.).

COMPLAINT

What is a complaint ?

It means an allegation made orally or in writing to a Magistrate with a view to initiation of action, that a certain person (known or unknown) has committed an offence.

Note

* This is the second way by which legal action against an accused person can be taken.

* This is a remedy for initiating action in a non-cognizable offence or when the police officer does not take action on the basis of the F.I.R. in a cognizable offence.

* The object of the complaint must be to move the Magistrate to take action against an accused person.

* Neither the FIR nor the police report on the conclusion of an investigation is considered a complaint.

* The legal action taken by the Magistrate against the accused must be according to the Code of Criminal Procedure 1973.

Who can complain to a Magistrate ?

In a criminal case, the prosecutor is always the State because a crime is an offence against society. Hence, a complaint need not necessarily be made by the person injured or aggrieved. In some cases the victim is not even able to speak. A complaint can, therefore, be made by any person aware of the offence. But, in some cases this right to complain is restricted by legislation; for example, in an offence of adultery the husband alone has the right to complain. Under section 195 of the Cr. P.C. or in cases of contempt of the lawful authority of public servants only the concerned authority is allowed to complain. If they do not, no one else can complain.

For further information in Legal matters contact :

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Lodi Road, New Delhi 110 003.
Tel : 622379; 623135
Gram : INSOCIN

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Resolution of the world health assembly

The Thirty-eighth World Health Assembly,

Recalling resolution WHA 34.36, and reaffirming its commitment to the implementation of the Global Strategy for Health for All by the Year 2000 through the solemnly agreed, combined efforts of governments, people and WHO;

Mindful that the attainment of the goal of health for all by the year 2000 is an integral part of international social and economic development as well as a direct contribution to world peace;

Emphasizing the crucial need for a real partnership between governments, nongovernmental organizations and WHO in order to achieve the goal of health for all by the year 2000;

Recognizing the commitment of nongovernmental organizations and the complementarity of the resources which they can mobilize for the achievement of strategies for health for all;

Taking into account the conclusions and recommendations of the Technical Discussions held during the Thirty-eighth World Health Assembly on "Collaboration with nongovernmental organizations in implementing the Global Strategy for Health for All";

1. APPEALS to the global family of nongovernmental organizations to support the strategies for health for all, and calls for their involvement and the increased use of national and international resources towards this end;

2. CALLS on the national nongovernmental organizations:

(1) to commit themselves in practice to the implementation of the strategies for health for all by the year 2000;

(2) to establish close collaboration with governments, in a spirit of partnership, for the implementation of national health for all policies and programmes;

(3) to encourage and support in all ways self-care and self-help groups at the community level for the effective implementation of primary health care;

(4) to establish appropriate national coordinating mechanisms, such as natinal councils of nongovernmental organizations, to provide a focal point for nongovernmental activities in health and health-related fields;

3. URGES international nongovernmental organizations:

(1) to take appropriate measures to further the collaboration between national nongovernmental organizations and Member States in the implementation of health for all strategies;

(2) to collaborate with WHO and other international organizations in providing support and cooperation in health for all activities;

(3) to coordinate their activities to ensure mutual support and cooperation in health matters;

4. CALLS on Member States:

(1) to promote, foster and support the partnership approach by involving nongovernmental organizations in policy formulation, planning, implementation, and evaluation of the national health for all strategies;

(2) to encourage and support the establishment of self-help and self-care nongovernmental groups at the community level, giving particular emphasis to women's groups, in order to implement primary health care approaches effectively;

(3) to stimulate the active involvement of youth and student organizations, since these represent the generation that will be responsible for the world's health in the year 2000;

(4) to encourage and support the establishment of nongovernmental coordinating or other appropriate mechanisms at the national level to facilitate mutual dialogue and close consultation on health matters;

(5) to utilize the expertise and experience of nongovernmental organizations through consultation, and for this purpose prepare inventories of their resources, skills and collaborative health activities with governments;

(6) to facilitate the mobilization of adequate resources for the work of national nongovernmental organizations for health work;

5. REQUESTS the regional committees to consider ways and means of strengthening the involvement of national and regional nongovernmental organizations in the implementation of regional and national strategies for health for all;

6. REQUESTS the Executive Board to review the existing framework of WHO's collaboration with organizations from the nongovernmental sector, together with the existing rules and procedures, with a view to strengthening it and making in more effective;

7. REQUESTS the Director-General:

(1) to pursue his efforts to promote the involvement of international nongovernmental organizations in the Global Strategy for Health for All;

(2) to promote and support partnership activities of Member States, WHO and nongovernmental organizations for the implementation of strategies for health for all;

(3) to review periodically the progress made in promoting and fostering collaboration between governments and nongovernmental organizations.

Sixteenth plenary meeting, 20 May 1985
A38/VR/16

The passing away of a crusader, A health campaigner and a friend of the third world

On 23rd May 1985 in Stockholm passed away one of the most courageous men. His name was De. Olle Hansson, professor of Paediatric Neurology in the University of Gotenberg, Sweden. He died of cancer.

Since 1965 he had single handedly fought against the unethical practices of pharmaceutical companies. He was the first person to report in 1965 that clioquinols (mexaform, enteriovioform, etc. were *absorbed* from the gut) and were associated with blindness (optic atrophy).

He fought against Ciba Geigy's "denial of facts", e.g. absorption of the drug, association

of mexaform like drugs with SMON, (Subacute Myelo Optic Neuropathy) which in simple words means paralysis, loss of baldder control; burning pain in the limbs and blindness.

Dr. Olle Hansson stood as a witness on behalf of the SMON victims in the Tokyo Court, where the SMON case was fought for 8 years. His contribution as an expert who was willing to take the side of the people against one of the most powerful multinationals is exemplary. He had the courage to stand against the medical establishment which continued to perpetuate the lie that SMON was caused by 'virus' and as a genetic disorder of the Japanese. It was his effort along with that of other socially conscious laywers, doctors and journalists that led to the benning of mexaform in Japan way back in 1971.

His efforts in Sweden led to the diagnosis of 43 cases of SMON in Sweden itself.

In 1976, Dr. Olle Hansson proposed a boycott of all Ciba Geigy products for continuing sales of their products mexaform and enterovioform in the third world countries. Doctors from Sweden, Denmark and Norway joined in the protest. They wrote in the medical journals, newspapers, etc. By 1981, Ciba Geigy had lost 25 percent of their market in Sweden. And by mid 1982, one third of their market was lost. Dr. Olle Hansson insisted that the drug industry knew only economic arguments and protest by prescribers and consumers in boycotting their products was a major tool in our hands.

Dr. Hansson's efforts helpd SMON victims in Japan obtain compensation—a percentage of which was set aside by the victims themselves to fight against drug induced suffering elsewhere. Similarly 38 individuals afflicted with serious side effects in Sweden, sued Ciba Geigy and they were paid 1.8 million Swedish Kroners in an out of court settlement.

Last year it was Dr. Olle Hansson who informed the Drug Action groups worldwide about Tandril and the association of deaths due to agronulocytosis. Consumer Alerts were immediately sent off. Ciba Giegy realizing that facts from their own internal documents were now known by the public, were forced to decide to withdraw the product by the 3rd quarter of 1985.

Dr. Olle Hansson was at this time not merely fighting Ciba Geigy but fighting cancer, which had already begun to spread.

The fight that Dr. Olle Hansson was involved in was against malpractices and deliberate misinformation. He believed that informed public could resist their being manipulated and exploited in the name of medical science by profit oriented commercial interest in connivance with vested interest within the medical establishment and bureaucracy.

Dr. Olle Hansson was one of the pillars of Health Action International, which is an informal co-operating network of health groups, consumer groups and public interest groups worldwide.

Health Action International (HAI) networkers have been fighting for safe, rational and economic use of pharmaceuticals in their own countries and also worldwide.

Dr. Olle Hansson was a source of information and inspiration to individuals, groups and organizations involved in drug action. His work and life depicts what a single person with a purpose, awareness, courage and concern for the people could do. He fought a lonely battle against pharmaceutical malpractices since 1965. It was only in the eighties that his contribution was beginning to be appreciated by the people in the third world for whom he had been fighting. His experience in fighting unequal battles against

malpractices of the powerful drug lobby has been of special significance to our country.

India is on the threshold of formulating its national drug policy. For the first time,the common man is going to demand that his/her interest be safeguarded and given a higher priority than the so called growth of the drug industry.

The growth that Dr. Olle Hansson fought against was increased production and exports of irrational and hazardous drugs; greater profits for drug companies; more commission for chemists, drugists and more revenue for the state, at the cost of the consumer.

The fight has been for the right of every individual to essential and life saving medicines which are available not merely in posh nursing homes or city hospitals, but in the remote areas where the other Indians live. The demand for essential drugs is associated with the demand for an immediate withdrawal of medically known hazardous and irrational drugs, from the markets. Total ommission of this aspect from the National drug policy draft prepared by the Steering Committee of the National Drug and Pharmaceutical Council is very disturbing.

Dr. Olle Hansson stood for 'right to information by the consumers and prescribers'. He insisted that the people should know about the medicines they consume. Tandril (sold under any other name) could 'shut down' the bone marrow. His dose of estrogen progesterone drugs which are still being used for pregnancy testing can lead to abnormal babies being born (thanks to the stay order obtained by Organon, Nicholas and Unichen from Calcutta and Bombay High Courts against the Drug Controller of India's ban order on the product in 1983) their sales continue—flaunting drug control flaunting rules of ethical marketing practices.

He fought for effective drug control at the national and international levels.

India's Hathi Committee report inspired the Bangaladesh Drug Policy. Will it inspire our own New Drug Policy? When Bangladesh decided to adopt WHO recommendations on essential drugs, there was an uproar; the policy has stayed despite the pressure and so have the multinationals. 130 new drugs which are essential have since been registered by them while 170 hazardous drugs have been withdrawn. The total number of drugs withdrawn under Drug Ordinance of June 1982 were 1707.

While all over the world various intellectuals, scientists, doctors, consumer groups, human rights groups involved in the health and drugs issues share the sorrow of Dr. Olle Hansson's passing away, his death challenges all of us to continue this unequal fight between Davids and Goliaths, between concerned individuals and cooperate powers and their supporting bureaucracies and political patrons.

Dr. Olle Hansson was not merely an expert in his field. He was a true teacher, whose quiet tenacious struggles taught us how to fight for others and for truth and justice; how to persevere, be consistent and single minded.

In Sweden and world over he is a hero and considered a legend. For us he was a friend, we needed and valued.

Dr. Olle Hansson visited India in April 1983 as a guest of VHAI. During this visit he addressed a public meeting at the All India Institute of Medical Sciences on the role of antidiarrhoeals (with focus on clioquinols—mexaform and enterovioform). Meetings were arranged with some of the leading neurologists, the Drug Controller of India, health activitists and legal experts.

It was due to his untiring efforts that Ciba Geigy was forced to issue a statement regard-

ing the withdrawal of mexaform and enterovioform from the international market by March 31st, 1985. (It is ironical that while the leading producer of hydroxyquinoline has been forced under international pressure from medical professionals and consumer groups, to a decision to withdraw its leading product. our Drug Control authorities and our doctors continue to want it). His efforts forced Ciba Geigy to decide about withdrawal of Tandril from the world market.

VHAI shares its grief with thousands of others across the world. VHAI is fighting along with other drug action groups who are part of the All India Drug Action Network, namely:

1. Arogya Dakshata Mandal, Pune
2. Consumer Education and Research Centre, Ahmedabad
3. Centre for Education and Documentation, Bombay
4. Drug Action Forum, West Bengal
5. Drug Action Forum, Andhra Pradesh
6. Drug Action Forum, Karnataka
7. Medico Friends Circle, Pune
8. Federation of Medical Representation Association, Patna
9. Foundation for Research in Community Health, Bombay
10. West Bengal Voluntary Health Association, Calcutta
11. LOCOST, Baroda
12. Catholic Hospital Association of India (CHAI)

for a Rational Drug Policy.

In the Monsoon session of Parliament will be decided how many hazardous and irrational drugs will be allowed to be dumped on our people. How many Indians will or will not have access to essential and life saving drugs? Whether their distribution, availability and prices, will or will not be taken care of. It will be decided here, how unbiased drug information will be made available to our health personnel and our people to help in rational decision making.

VHAI along with others will continue to fight for peoples health. Ensuring that our people get 'people oriented national drug policy' would be our greatest tribute to Dr. Olle Hansson. He has not merely shared with us valuable information but has provided a sense of solidarity. He recognized the need for medical professionals to take public stand on issues related to peoples health when justice is being denied. Swimming against the current has always required great moral courage.

Dr. Olle Hansoon stood as an epitome of moral courage and deeply valued it in others.

It is not merely the passing away of one of the most experienced drug activists but the passing away of a great teacher: a teacher of moral courage, of selfless struggle; it is the passing away of a rare friend of the common and under privileged people.

Dr. Mira Shiva
Coordinator, Low Cost Drugs & Rational Therapeutics and Convenor, All India Drug Action Network.

May 29, 1985

Report of the Seminar for Village Health Promoters conducted at Junwani from 25th to 27th Feb. 1985

A 3 days local seminar from 25th to 27th of February was organised for Village Health

Promoters by the medical association of the diocese under the guidance of Sr. Jyothi and the consignee Fr. Gerald Almeida and his co-workers to prepare better health workers in rural areas. 45 selected women attended the seminar.

Fr. Gerald inaugurated the session. The saying "prevention is better than cure" was emphasised. He invited the women to know their role as good mothers and explained to them the necessity of personal cleanliness and keeping their homes and surroundings clean. Thus he made known to them the very purpose of calling each one of them for this seminar. The idea was further explained and deepened by a role play and followed which there was a group discussion at length. All the groups stressed the need for personal attention to keep things clean.

The selected women were then enlightened on their role as health workers in the village. They would work as intermediaries between the nurse and the villagers both for health and moral support. They are instructed to submit their monthly reports to the sister of the dispensary and work in collaboration with her. At the time of breakout of epidemices they are to keep the authorities informed. Along with personal hygiene the leaders were instructed to give special attention in the matter of use of water. The theme was made quite vivid by group discussion and slide shows. As the wells and lakes constitute the main sources of water supply the emphasis was laid on the necessity of keeping these wells and lakes clean so as to prevent any contamination. The use of potasium permanganate, bleaching powder, filteration boiling of the drinking water etc. were advocated as safe approach to be accepted in this respect.

Apart from physical health mental hygiene also go a long way in building up human persons. Various mental sicknesses and their consequences were explained in the group. Fear, doubts, guilty conscience, worry etc. effect the wholesome growth of the persons.

Finally the necessity of following a balanced diet with the right amount of carbo-hydrates, fats, protein and vitamins was dealt with, making clear to the participants the deficiency diseases that can arise in the absence of such a diet. A lesson on cooking without loosing vitamins, was taken by one of the local women who had done a health worker's training earlier.

The seminar ended with a variety of entertainments presented by the participants on the topics of the seminar and the participants went back with the conviction that they are the agents of health. Surely the group is a promise to effect such and many other programmes in future that will endorse the human society to grow to its fullness.

—Sr. Elsy Mary SMMI

St. Joseph's Leprosy Hospital, Tuticorin: Brief Annnal Report for the year 1984

The hospital has given high priority to the antileprosy campaign. In this respect it has conducted a series of surveys which include general survey, epidermiological survey, school survey and healthy contact survey.

The facts arrived at are the following:

The total no. of known cases of leprosy patients	2881
Total no. of registered cases for treatment	1892
Total no. of patients released from control	879
Total no. of patients released from control in 1984	200

Regarding the impatients service, a total of 451 patients have received admission in the hospital. In the physiotherapy room 320 patients have received physical exercises. The hospital has supplied 405 patients with micro cellular rubber sandals and two patients with spring shoes and other artificial aids.

The hospital caters to the occupation therapy and rehabilitation of the cured ones. Inpatients who are on stabilization of antileprosy treatment and are able to work and those patients who are cured and rehabilitated earlier, work in mat making, weaving, in the poultry and dairy farm, candle making, sewing, cycle repair and as helpers in the farms. The number of these patients are decreasing as the hospital tries to rehabilitate them at home rather than in the hospital premises. A total number of 30 patients have been helped with loan under GLRA scheme.

The hospital is interested in the promotion of health education. It imparts continuous education to individuals and groups of patients, their families and the public using various methods.

A leprosy week was observed holding public meetings and staging dramas, depicting the early signs of leprosy, giving the message to the masses that it can be cured and that it is not a hindrance to social life.

Seminars and meetings for the staff are being conducted from time to time to re-equip them with the latest know how in the treatment and rehabilitation of the patients.

1. Brief Report on Community Health Activities of Diocese of Rajkot

Diocese of Rajkot is an infant mission diocese formed in the year 1977. This diocese is concentrating its activities more on rural apostolate. As a part of this goal, community health activities are given due importance.

Medical Apostolate of the Diocese:

Community Health Promotion activities are being carried out through 12 mission stations of the Diocese. They are in Bedi, Rajkot, Chachana, Nanikhakkar. Porbandar Junagadh, Morvi, Ribida, Merubagh, Hapa, Gogha and Mithapur.

Nature of activities of the health centres in Bedi, Chachana, Nanikhakkar, Morvi, Ribida, Merubagh and Gogha is almost the same. These health centres are situated in rural areas of the Diocese. There is one qualified religious Sister in each health Centre. She provides medical aid to the local people in the health centre upto noon. In the afternoon, she visits surrounding villages, with the help of other Sisters, with medical kit and provides medical aid to the local people on the spot. They discuss about various aspects of health and preventive aspects of diseases with the local people especially with the house-wives. In four stations viz. Ribida, Merubagh, Gogha, and Chachana the village working girls, who are appointed by the Diocese to assist the religious in the village work help the qualified Sister to visit the surrounding villages. They often use charts, posters etc. during the village visit for the health education of the people.

Occassionally the religious organise medical camps for the poor people of the surrounding villages generally with the co-operation of govt. doctors. During the camp, quite a lot of village people undergo thorough medical check-up. Then, the serious cases will be referred to or admitted in the hospital. For minor cases the doctors prescribe medicine and the nurse sisters do the follow up treatment.

For example, we organised an eye camp in Ribida on 17th of May for benefit of village

people of Ribida and surrounding seven villages. More than 150 patients benefitted out of the camp. We organised this camp in collaboration with the opthalmology section of General Hospital, Rajkot. They provided free medicine to about 100 eye patients during the camp, and more than 30 patients were given spects from the hospital after the camp. Sixteen cases were referred for operation fixed to be conducted on 7th of June, in the General Hospital.

In Gogha, Chachana and Morvi, the religious have got mobile health units to organise the health promotion activities. With the help of mobile health units we are extending medical aid to a large number of patients. Health centres in Hapa, Merubagh and Porbandar are newly started ones and will be initiating activities in line with the old ones as described above.

We started immunization programme in all stations except in Junagadh and Satadar. CHAI helped us to purchase medium size fridges to these stations to preserve vaccines.

In Junagadh, the Sisters have been working in a Government Leprosy Hospital for the last 30 years. The dedicated service of the missionary sisters is widely appreciated by the local people. In Satadar, a village which is situated in Gir Forest area about 60 km away from Junagadh, there are 60 leprosy patients staying in a housing colony of 30 houses. The sisters go to Satadar once in a week to dress up the wounds of the patients and to give the medicines. We have provided a milk goat each to all the families. We are thinking of other rehabilitation measures as well for these patients.

In Mithapur religious are working in the Tata Hospital of Tata Chemical Ltd. and in the T.B. Sanitorium. A few sisters are visiting nearby villages and provide medical aid to the local people.

2. Community Health Orientation Programme in Rajkot Diocese

The Diocese of Rajkot (Gujarat), on the initiative of Sr. Isabella Mary, the Diocesan Health Coordinator, organised an orientation programme in Community Health on 2nd and 3rd of May for the sisters working in rural health centres. Fr. Thomas Joseph of Catholic Hospital Association of India conducted the sessions.

Bishop Gregory Karotenbrayil, in his welcome address, stressed that the healing ministry of the Church should render relevant and meaningful service to the poor rather than entering into a profit making business through institutionalised approach. The Diocese, with its small dispensaries spread in the rural areas, has adopted this as a policy.

Through deliberations and reflections that followed the whole day, the participants came up with the realization that diseases have their deep roots in the socio-economic, political and cultural imbalances. While dispensaries are busy with curing illnesses, 70% of the diseases are preventable for which the services of doctors are not needed but a process of enabling the people for adequately handling their health. Community diagnosis of a simple disease diarrhoea (but a major child killer!) made clear the point that health and development are interrelated.

These analysis, added with the good will of the participants, paved the way for some creative future planning which includes advanced training of personnel in Community Health and formulation of a Master Plan for promotion of Community Health in the whole Diocese.

3. Diocese of Trivandrum

A meeting of the hospital directors and administrators of Trivandrum Archdiocese was

held on 13th of March. Twenty Two persons participated in it. His Grace the Archbishop the Most Rev. Benedict Mar Gregorios presided over the meeting. The Diocesan Director, Fr. George Purathoot welcomed the Archbishop and the participants. His Grace in his inaugural address stressed the importance of the healing ministry and expressed that all our efforts must be motivated by the love of Christ and that there must be collaboration and understanding in all our activities. He promised all kinds of help for the promotion of health care activities in his diocese.

The main aim of the meeting was to make the CHAI health policy a reality in the CHAI unit of Trivandrum Archdiocese. The Diocesan Director, Fr. George, shared on the theme of the "People Oriented Drug Policy" and thus the main theme of the convention was highlighted to the participants during his talk.

The plan of action presented by the Kerala groups in the CHAI convention in Bangalore was intimated to the members in the meeting.

The urgent need for a CHAI diocesan unit was proposed by the director. All the members unanimously agreed to the proposal and the Board of Directors of the CHAI Diocesan Unit was elected.

The members shared their experience through open dialogue among the participants and the infrastructure of the diocesan hospitals and institutions were made known to all concerned.

"Health for a million" programme is effectively being carried on throughout Trivandrum Archdiocese. It is an on going programme in the diocese. Another important programme in the diocese in the M.C.H. programme. In both these programmes emphasis is given to health education training programme.

Before the meeting broke up a plan of action based on the broad outline of the regional planning was also drawn for the diocese.

—Fr. George Purathoot

4. Orientation Programme on Community Health in Jabalpur Diocese

In an attempt to activate the existing Community Health Programmes in Jabalpur Diocese, the Diocesan Social Service Society organized a one week Orientation programme from 13th to 17th of May for priests and sisters involved in Community based activities. The Community Health Department of Catholic Hospital Association of India, represented by Fr. Thomas Joseph and Sr. Mariamma Antony conducted the sessions.

The sessions started with defining a comprehensive vision of health — situating ill health in the context of socio-economic and political imbalances of the society and arriving at a philosophy of health that it is a state of total well being and not merely the absence of disease or infirmity. Social analysis, community diagnosis showing the link between physical illness and social illness, awareness building education, communication methods, planning, importance of right attitudes in development work, etc, were some of the major topics dealt with. Faith reflection sessions and the liturgy helped the group to see the message of Gospel in relation to the social realities of today. Some concrete plans were chalked out for the future which includes mainly developing a team of trained personnel in the Diocese. A follow up of the present meeting was also planned for November 1985.

Only a true cultural choice can effectively Oppose euthanasia

(On Thursday, 6 September, at Castel Gandolfo, Pope John Paul II spoke to members of the Catholic University of the Sacred Heart's 54th Cultural Renewal Course concerning the value of life and the need for the Christian community to affirm it and to work for a true, educated choice for life within the family and society. The following is our translation of the Pope's speech.)

Dearest Brothers and Sisters,

I am particularly happy to greet each and every one of you, participants in the 54th Course of Cultural Renewal of the Catholic University of the Sacred Heart. I address my greetings especially to the organizers of the meeting, and above all to the Rector Magnificus, Adriano Bausola, whom I thank for the respectful words with which he opened this informal meeting.

The theme which you have chosen for the summer course this year—"The value of life"—is as important as ever. You have had occasion to analyse its religious, ethical, psychological and social aspects, emphasizing how life maintains its value in its every stage and condition and how the possibility for each one to give meaning to his own personal experience depends, in large part, on the firm commitment of everyone, even if life is tried by the limitations of sickness or the weight of old age, which is the inevitable prelude to the mysterious "passage" of death.

Among other problems, you have confronted one particularly debated today, that of euthanasia, examining it in the context of questions deriving from, the intangibility of human life.

Repeatedly confirmed and developed

This intangibility is a logical corollary of the Christian conception of life, of the lordship of God over life and death, of man's belonging to Christ, both in life and in death (cf. Rm 14 : 8). This is an explicit teaching which occurs again and again in the Bible, beginning with the first pages of Genesis and the "Thou shalt not kill" of the Decalogue (cf. Ex. 20 : 13 and Deut 5 : 17), up to the First Letter of John (cf. 3 : 11-15); this is unanimously expressed in the Tradition of the Fathers, beginning with the most ancient written record, which is that of the *Didache*, and it has been confirmed by penitential practice which from the earliest times has sigmatized homicides one of the gravest sins. This teaching has been repeatedly confirmed and developed in our time by the Pontifical Magisterium and by conciliar and episcopal documents.

In the light of these teachings the believer must acquire and ever greater consciousness of the intangibility of every innocent human life and give proof of inflexible firmness in the face of the pressures and suggestions of the dominant cultural environment, decisively standing against every attempt to legalize euthanasia, and also to continue the struggle against abortion.

An irreconcilable conception of life

But the real problem to be confronted, in regard to the outlining of a growing social acceptance of euthanasia, seems to be a different one. As has already been seen in the case of abortion, the moral condemnation of euthanasia remains unheard and incompre-

hensible to those who are imbued, perhaps unconsciously, with a conception of life which is irreconcilable with the Christian message or rather with the very dignity of human person, correctly understood.

To find proof of this, we need only consider some of the negative characteristics more in vogue in the culture which abstracts from transcendency:

— the habit of disposing at will of human-life as its source;

— the tendency to appreciate personal life only to the degree that it can provide riches and pleasures;

— the valuing of material wellbeing and pleasure as supreme goods, and consequently, the concept of suffering as an absolute evil to be avoided at all costs and by every means;

— the concept of death as the absurd end of a life that could still have given enjoyment, or as the liberation from a life still continuing although already "deprived of meaning", because it is destined to continue in pain.

All this in general accompanies the conviction that man, leaving God out of the question, is responsible solely to himself and the freely established laws of society.

It is clear that where these attitudes have taken hold, in the experience of persons and social groups, it can paradoxically appear logical and "humane" to "gently" put an end to one's own or another's life, when it could hold only suffering and serious impairment. But this is in reality absurd and inhuman.

The commitment that is demanded of the Christian community in such a socio-cultural context is more than a simple condemnation of euthanasia, or the more attempt to block the road towards its eventual spread and subsequent legalization. Basically the problem is above all how to successfully help the men of our time to become aware of the inhumanity of certain aspects of the dominant culture, and to rediscover the most precious values which have been obscured by it.

The emergence of euthanasia, as a further resort to death after that of abortion, must therefore be taken as a dramatic appeal to all believers and to men of good will to move with urgency to promote with every means and at all levels a true cultural choice for our society's future.

Therefore of particular importance are, above all, a presence and a decisive action of Catholics in all those places and organizations, national and international, in which decisions of extreme importance for the direction of society are made.

Likewise the same must be said concerning the vast field of the social communications media, on whose importance in relation to the formation of public opinion it is superfluous to insist.

But it is no less important and necessary to spread the awareness that everyone, simply with his own life style, contributes to reaffirming the Christian concept of life, or to constructing a different one.

It is urgent, therefore, that all who are reached by the Church by word and action be helped :

— to become aware of the diversity which has often become established between faith and life, as a consequence of an uncritical practical acceptance of hedonism, consumerism, and other concepts underlying a certain life style;

— to discover the genuine Christian concepts concerning life, suffering, death, and the true scale of values of life, con-

ceived of as a vocation and a mission, for which everyone is responsible before God;

— to build anew on these concepts one's own individual, family, and professional existence, not fearing to go against the current with Christian firmness.

Renewal of authentic Christian feeling

Essentially, the problem of euthanasia requires and demands with dramatic urgency a serious and constant commitment to a real and personal renewal of authentic Christian feeling. Further decays and negligence could result in the suppression of an incalculable number of human lives, and in a further and grave degrading of all society and human life in general to ever more inhuman levels.

Finally it can be added that the principal subject of all this commitment cannot be other than the family. This finds justification above all in the same motives that support affirmations of general importance concerning the central role of the family in evangelizing mission of the Church (cf. *Familiaris Consortio*, n. 65) and for the future of humanity (cf. ibid., n. 86). But there are additional specific motives in relation to the problem of euthanasia and the commitments required of the Christian community for its solution. In fact, the sector most consistently opposed to the risk of becoming victims of euthanasia is composed of the elderly, especially the invalids and those who are no longer self-sufficient. A different attitude, of acceptance and love, has in the family a privileged ground to take root and to spread (cf. *Familiaris Consortio*, n. 27).

Proper attitudes, contrary to those outlined above concerning life, suffering, and death, which prepare the ground for euthanasia, can ordinarily assumed and convincingly carried forward only on the basis of an appropriate family education.

One can therefore conclude that it is principally through the family that there can take place an effective renewal of the Christian message on the value of life, of every human life, even if seriously handicapped, weakened by age, or torn by suffering.

Stimulating and impelling discussion

I am pleased that the Catholic University of the Sacred Heart has dedicated these days of study to such a stimulating and at the same impelling discussion, which has given you a way to examine the anomalies of present-day society, which is so contradictory but also so desirous of authenticity and sensitive to the problems that trouble mankind. I am sure that you, combining the sensitivity of intellectuals with the will to verify events in the light of the Gospel, will recognize the duty to be in this society the light that shines on the lampstand and the salt that gives flavour and preserves from corruption (cf. Mt 5 : 14). For that matter, the themes developed during the Congress clearly tesify to your concern and your generosity.

I am confident that you will give particular attention to the points that I have thought useful to touch upon, even if rather briefly, and that you will be able to find the way to continue to take an interest in this question in order to make your contribution in clarifying it. I accompany your efforts with my prayer, while I cordially impart to everyone my affectionate Apostolic Blessing.

Courtesy : *THE VOICE OF THE CHURCH*