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The Network's NEWSLETTER Rx
Association for Rational Use of Medication in Pakistan

The Network s mission is to promote rational use of medication and essential drugs concept in Pakistan in order to optimize the usefulness of drugs and help bring equity in their access.

Science of commerce

Contrary to the opinion of all recognized international authorities on the subject, immunotherapy is being promoted as the first line therapy for bronchial asthma and allergies in Pakistan. This unscrupulous campaign is not being run by a company with vested interests but by an institution which is the custodian of the nation's health and is financed by the tax payers' money — the National Institute of Health (NIH). The NIH's immunotherapy enthusiasts are pushing poor arguments quoted from dubious sources. Usually, the job of distorting scientific facts for commercial gains is considered the companies' domain but the advocates of immunotherapy are using the name and facility of a public sector institution for pushing forward their own vested interests. (See page 4 to 7)

The NIH Allergy Centre is not in a position to even ensure that the warnings given by the so-called experts of immunotherapy are followed properly. For example, the Centre in no way can make sure that resuscitation apparatus is available where the patient is being given the vaccine shot outside the Centre. The institution after conducting the allergy tests, dispenses 12 doses of the prescribed vaccine in a vial and expects the patient to store it at +4°C to +8°C in his/her home refrigerator. The patients get the weekly vaccine shots by a neighboring GP or a dispenser who do not have resuscitation apparatus and are generally not trained to treat anaphylactic shocks.

We believe that this is yet another gimmick of the medical practitioners to make a quick buck as the beneficiaries of this kind of treatment include, most importantly the doctors themselves. This practice is exposing patients to un-called for health risks which may even be life threatening besides creating a lot of inconvenience for the patients and robbing them of their money. This also points towards an acute need in our country to set standards of ethical practice and a system of accountability for the profession. The consumer, who is gullible and vulnerable, must also be informed about how they are bereft by those in whom they put their trust, what are their duties and rights to safe guard their health and wealth.

DrugNews

Chlormezanone withdrawn - but not in Pakistan

A survey, reported in the New England Medical Journal, conducted between 1988 and 1995 in Europe has shown chlormezanone, an anxiolytic/tranquilizer, to have serious safety problems. According to summary of the survey, 153 cases of toxic epidermal necrolysis (a condition characterized by widespread bubbling and then sloughing off of the skin resulting in large areas of skin loss) have been linked to chlormezanone, including 13 cases of Lyell's syndrome out of which seven patients died.

Keeping in view the limited therapeutic value of the compound compared to the severity of potential side effects, the worldwide manufacturer Sanofi Winthrop has withdrawn this product from a number of developed countries. It was withdrawn from France in October 1996 and from the US market on 15 November 1996.

The Network wrote the five manufacturers/importers of the product in Pakistan and the health ministry to also withdraw/ban the drug in Pakistan but received no response. All the five brands (Baserol by Sanofi Winthrop, Samerol by Sami, Novorol by Krka, Dolgesic by Progressive and Muscerol by Pharmatec) are freely available in the market. The Rawalpindi/Islamabad area distributor (International Brands Limited) of Sanofi Winthrop informed us over the phone that Baserol was freely available and in fact was being supplied in bulk quantities to medical institutions in Rawalpindi even during March 1997.

The Network briefed the press about the issue and only then the Ministry decided to respond. Surprisingly, it informed the press that it had taken 'the appropriate step' much before it hit the newspapers by asking the companies to withdraw the drug and the companies also had complied with their instructions. This has been done under a new rule which says that any drug banned in any of the developed countries for safety reasons will be banned in Pakistan automatically.

But perhaps our drug regulators don't know that even to make things happen automatically you have to make some effort. The drug is still widely available all over the country!

More on Furazolidone

After the publication of "Furazolidone: Dangerous and obscure" in the drug news section of The Network's Newsletter, Vol. 5, No. 3, we have received a detailed feedback from Lt. Gen. (Retd.) Mahmud Ahmad Akthar. He has taken a different position as opposed to Dr Leo Offerhaus' by arguing that since cholera epidemics are very common in our part of the world and vibrio cholera is becoming increasingly resistant to tetracycline, furazolidone offers a good alternative.

He argues that of course quinolones are effective but these are very expensive for majority of our people and government institutions and also because of the fact that some patients cannot tolerate quinolones. Furazolidone is very cheap and its toxicity is far less as compared to many other anti-microbials including cotrimoxazole. In the USA, it is recommended as an alternative to tetracycline in pregnant women.

Like wise he informs that furazolidone is a drug of second choice for giardiasis. Standard text books on the subject recommend furazolidone as a first choice for giardiasis in children.

For resistant type of salmonellosis of course first choice are quinolones but again their high cost and intolerance by some people surely provide a place to this drug in the treatment. We have to keep the affordability factor in mind while making selection of drugs in poor countries. Furazolidone also offers an alternate for Shigellosis and Travelers Diarrhea, even in the USA.

He concludes by saying that "for all the above mentioned reasons furazolidone has been included in the essential drug lists of Pakistan, India and Bangladesh. One has to keep drugs of second and even third choice in the lists. There are many patients who do not tolerate metronidazole, does that mean we should not treat these patients. I have personal experience of prescribing this drug to my patients for a number of years and also of holding clinical trails in typhoid fever. There were never any serious reactions which are quite often seen with other anti-microbials like penicillin, cotrimoxazole, quinolones, amino-glycosides, cephalosporins etc.

Child survival programs need resuscitation

According to a report carried by daily "The Nation" of March 6, 1997, Acute Respiratory Infections (ARIs) control program being run by the Government of Pakistan with the help of WHO, Unicef and other donor agencies has been unable to achieve its objectives. Its performance has been "unsatisfactory" and the program is a "total failure". The assessment was done by an eight member team of consultants including four from Pakistan. Acute Respiratory Infectionsare responsible for one third of all infant deaths in our country and this program has failed to make any change in the situation even after 10 years of its existence.

The ARI and other similar programs like Control of Diarrheal Disease (CDD) program have not succeeded in our country despite investment of colossal amounts of aid and tax payers money and investing decades of time. It is no surprise that our infant mortality figures are amongst the worse in the world. An earlier review of the CDD program carried out in 1992 very clearly pointed out that the main obstacle in the way of successful implementation of this program was the prevalent irrational use of drugs (cough and cold remedies and anti-diarrheals). Standard treatment guidelines for ARI and CDD programs explicitly reject cough remedies and antidiarrheals, but the government continues unabatedly to register more of these drugs for manufacture and sale in the country.

According to a survey conducted by The Network last year (reported in our Newsletter's March 1996 issue) there were 275 cough syrups, marketed by 140 companies, and 64 antidiarrheals, marketed by 48 companies, registered and available in the market until late 1995. The figure would be higher now after one and a half year of reckless registration of drugs. These drugs are harmful if used in these indications and are responsible for the failure of these child survival programs and are resulting in unimaginable suffering of babies and their families in our country. We have been demanding that these products which serve no one but the profit hungry pharmaceutical industry should be banned immediately.

We would like to advise the Unicef consultants and others involved in the ARI program that besides training doctors, paramedics and parents in proper case management, it would be worth while to press the government to deregister all the products which are hindering the success of the program.

US pharmaceutical industry asks IMF to stop loans to Pakistan

The US pharmaceutical industry association, PhRMA, has asked the International Monetary Fund not to grant a series of new loans to Pakistan unless the new caretaker government improves intellectual property protection and relaxes its controlled pricing policy for pharmaceuticals.

These measures should be prerequisites for further lending, PhRMA suggests. It notes that the new government is thought to be receptive to the problems of industry.

PhRMA has been complaining for some time about the environment for pharmaceuticals in Pakistan, against the background of strong lobbying from local consumer organizations over what they regard as high prices in the country.

PhRMA regards the country's intellectual property rights protection legislation - which does not include product patents - as unclear and rarely enforceable. Taken in conjunction with price controls, the levies applied on imports of raw and packaging materials are punitive, PhRMA says. The policy that international firms can only register pharmaceuticals which are already on sale in the country of each firms incorporation is "discriminatory", because domestic companies can register products from any source. The policy of insisting that the generic name of a drug should be as prominent as the brand on labeling is "an infringement of proprietary rights ", it claims.

SCRIP 2194/5 January 2/7 1997 p16 quoted from CPA Newsletter of Commonwealth Pharmaceutical Association, February 1997, Number 46.

The Network sifts through the scientific evidence to assess the worth of the much talked about specific immunotherapy or desensitization

Immunotherapy: professional expediency

Over the recent few years there has been a lot of controversy generated in Pakistan by a new 'specialty' of doctors treating bronchial asthma and other allergic conditions through immunotherapy.

Scientific literature is unanimous that at very best this type of therapy has a limited role in asthma treatment and should be reserved only for those patients who do not respond to drugs. The British Thoracic Society does not recommend immunotherapy under any circumstances. British National Formulary (BNF) warns against use of immunotherapy as it is likely to develop severe adverse reactions including anaphylaxis.

But come spring season and one finds banners all over the country announcing fantastic products and magical results for asthma patients on offer at special allergy clinics. There appears to be a great competition going on amongst these clinics to make the best out of the 'allergy season' and they are using all sorts of gimmicks to get attention - from friendly advice to editorial prescriptions published in PMRC's Pakistan Journal of Medical Research.

While such clinics have opened in all big cities, Islamabad offers the scoop of the season thanks to the abundance of pollen due to heavy forestation here. But perhaps the biggest irony is that this sly practice has been started at the National Institute of Health in Islamabad. And theirs is the most effective marketing campaign so far. The Allergy Centre of the NIH, situated at the outskirts of Islamabad, receives from 200 to 250 patients a day throughout the year except during the two monsoon months. The patients flocking from around the country pay Rs 400 at their first visit — Rs 200 for the (skin pricks) allergy test and another Rs 200 for the first dose of vaccine. The clinics registers show that on 13th March, 1997, 238 patients visited the clinic while on 15th March 231 persons came for the vaccination.

Considering the money that the NIH is minting by promoting this unscrupulous practice, one can easily appreciate the scientific (or is it economic?) evidence that the proponents of this therapy are so vociferous about. Most of the doctors working at the NIH Allergy Centre are also running their private evening clinics and they are for obvious reasons the vocal advocates of this new found therapy. It was confirmed from one such clinic that the vaccines made at the NIH are dispensed by the doctor but we could not ascertain whether the NIH subsidizes these supplies or sells these at commercial rates.

The proponents of this therapy are pushing lame arguments and quoting weak references in their bid to establish the effectiveness and safety of the so-called specific desensitization.

Almost all the renowned and authentic medical sources are doubtful and unsure about the effectiveness of this therapy but are sure about its potential risks. The consensus report on diagnosis and management of asthma of the National Institute of Health, USA recommends that allergen immunotherapy should be considered ONLY when asthma is poorly controlled with drug therapy or when it is impossible to avoid allergens. For more references see box on page 6 and 7.

The NIH USA guidelines issue a strong warning that specific immunotherapy may be dangerous. All books of scientific medicine are unanimous in this respect. Davidson's Principles and Practices of Medicines 17th Edition 1995, says on page 341: Hyposensitization is not without risk of producing an acute anaphylactic reaction. Resuscitation apparatus must be present in

Almost all the renowned and authentic medical sources are doubtful and unsure about the effectiveness of this therapy and are sure about its potential risks.

the facility where the patient is being administered the vaccine.

The patients visiting the Allergy Centre at the NIH, Islamabad are given the first shot in the facility and a vial of vaccine enough for 11 more injections is handed over to the patient along with a printed instruction sheet. The patients who also come from very far away and remote areas are then supposed to store the vaccine at +4°C to +8°C in their home refrigerators for the next three months! On 21st March, 1997 of the first 40 patients of the day at the NIH Allergy Centre 7 had come from Lahore, 4 from Shiekhupura, 3 each from Dir, Faisalabad and Khanewal, 2 each from Gujranwala, Islamabad, Sahiwal and Banu and one each from Tank, Mardan, DG Khan, AJK, Toba Tek Singh, Abbottabad, Chechawatni, Bahawalpur, Batkhela, Attock and Afghanistan. The patients are also supposed to take the vial to their doctor (who could be anybody: a quack, a nurse, a dispenser or a qualified doctor) every week and get the shot. Whether all these people giving the patient the vaccine shot have resuscitation apparatus at their facilities is not the NIH's headache. All that the national institution could do is give a written instruction that to cope with an anaphylactic shock a cortisone injection should be at hand.

To top it all the NIH is dispensing mixtures of vaccines for multiple sensitivities. Hyposensitization with a mixture of allergens is irrational and cannot be recommended. In past days this type of therapy was used in Pakistan in Civil and Military hospitals also but with the advent of effective and safe therapies (lately inhalers) it has also been largely abandoned.

There are also questions about the quality of vaccines produced by the NIH. A doctor working in the facility told The Network that the institution is currently manufacturing 113 different vaccines. Whether the institution follows Good Manufacturing Practices (GMP) and Good Laboratory Practices (GLP) is another question with no clear answer.

The information contained on these pages is contributed/collected by Prof Mushtaq A. Khan, Dr Zafar Mirza and Zia-ur-Rehman. Some parts are attributed to an E-mail message from Dr Osman Yusuf. The report is compiled by Tahir Mehdi.

Tips for allergy patients

- First of all try to find out the source of your allergy.
- Depending upon the source, try to protect yourself from it e.g. if you know that you are allergic to pollen then take all the protective measures to reduce your exposure to pollen during the spring season which includes the following:
  - before start of the season it is helpful to start prophylactic medication with the advice of your doctor (usually oral antihistamines)
  - keep your windows and doors closed during the season
  - avoid fresh air as much as possible especially during early morning
  - wear masks to cover your nose and mouth when going outdoors
  - avoid dusting, if inevitable then use moist cloth
  - regular steam inhalations and gargles with warm salt water are very useful
  - do not dry your clothes outdoors, they will catch pollen
  - adjust your routines to get maximum rest as allergies get worst during fatigue and mental stress
  - if you have allergic asthma, it is important to know that anti-inflammatory (corticosteriods) inhalers are the most effective therapy. Consult your physician for it. Inhalers are superior than other formulations and modes of treatment e.g. injections, vaccinations etc. (See also box on page 7)
- Please, note the following before you consider the vaccination.
  - Major professional authorities highly suspect the efficacy of this treatment and many do not recommend it. (See Opinion pool on page 6&7)
  - these vaccines can have their own fatal side effects, patient can go into severe shock after receiving the shot which if not managed properly can lead to death.
  - if you still decide about receiving allergy vaccination please make sure of the following three points:
    - that you are seen by a properly trained doctor.
    - that s/he has quality vaccines available.
    - that s/he has proper arrangement for management of anaphylactic shock.
    - that s/he has taken the proper history of your allergy and has made sure that you have already tried the other treatments. If s/he suggests vaccination straight away then you should be suspicious.
    - Last but not the least, you should know that vaccination has its own limitations and only few can be fully benefited from it, so don't have high expectations from this treatment.

Be aware of so-called specialists

Allergy specialists abound all over the place these days. Many of these are self-claimed "Messiahs" with no professional credentials to support their heavy titles like "allergy specialist", "consultant physician", "allergy consultant" etc. Their practices are true reflections of their fake entitlements. Before deciding for immunotherapy, please double-check the expertise of your doctor and the basis for his/her hefty claims. As a patient it is your right to ask for this kind of information. Choosing an appropriate health professional and proactively participating in your health care decisions is your prerogative. Only as a well informed patient with critical thinking you can get the best out of the health care profession. Not having the correct information about the treatment and about those who offer it makes you more vulnerable to be harmed and looted.

The **National Asthma Council** of Pakistan has developed these guidelines through a national workshop.

Guidelines for the management of bronchial asthma

Introduction

"Asthma is a chronic inflammatory disorder of the airways. Chronically inflamed airways are hyperresponsive; they become obstructed and airflow is limited (by bronchoconstriction, mucus plugs, and increased inflammation) when always are exposed to various stimuli, or triggers".

The major change over the recent past has been of the fact that asthma is a chronic inflammatory disease rather than purely bronchial spasm. This has implications in the management of bronchial asthma. Unfortunately this disease continues to be treated with bronchodilators and very limited use of anti-inflammatory drugs. Moreover, there is need to put far more emphasis on patient education and participation in the management of this disease.

Common asthma triggers are viral infections; allergens such as domestic dust mites (in bedding, carpets, and fabric-upholstered furnishings), animals with fur, cockroach, pollen, and molds; tobacco smoke; air pollution; exercise; strong emotional expressions; and chemical irritants.

Medication

Two types of medications help control asthma:

a) long-term preventive medications (especially anti-inflammatory agents) that keep symptoms and attacks from starting.

b) quick-relief medications (short-acting bronchodilators) that work fast to stop attacks or relieve symptoms.

See details in the box on facing page.

The National Asthma Council does not recommend specific immunotherapy to any patient suffering from asthma whether during acute attack or in chronic disease.

Opinion pool

Committee on the Safety of Medicines, UK

After re-examination of the efficacy and safety of desensitising vaccines, the CSM has concluded that they should only be used for the following indications:

Seasonal allergic hay fever (which has not responded to anti-allergy drugs) caused by pollen, using licensed products only - patients with asthma should not be treated with desensitising vaccines as they are more likely to develop severe adverse reactions.

Hypersensitivity to wasp and bee venoms since reactions can be life threatening, asthma is not an absolute contra-indication. There is inadequate evidence of benefit from other allergens such as house dust, house dust mite, animal danders and foods and vaccines are not recommended. Desensitising vaccines should be avoided in pregnant women, in children under five years old, and in those taking beta-blockers.

Recent experience indicates that bronchospasm usually develops within 1 hour and anaphylaxis within 30 minutes of injection. Therefore patients need to be monitored for 1 hour after injection. If symptoms or sign of hypersensitivity develop (e.g rash, urticaria, bronchospasm, faintness), even when mild, the patient should be observed until these have completely resolved.

British National Formulary, Number 32 (September 1996) p 141

National Heart, Lung and Blood Institute, USA

The consensus report on diagnosis and management of asthma of National Institute of Health (USA) recommends that allergen immunotherapy should be considered only when asthma is poorly controlled with drug therapy or when it is impossible to avoid allergens.

National Heart, Lung and Blood Institute, National Asthma Education Program, Expert Panel Report

Long term preventive medication

1. Corticosteroids Adrenocorticoids, glucocorticoids	Anti-inflammatory agent
2. Sodium cromoglycate Cromolyn; Cromones Cromolyn sodium	Anti-inflammatory agent
3. Nedocromil Cromones; Nedocromil sodium	Anti-inflammatory agent
4. Long-acting beta2-agonists Long-acting beta-adrenergics Sympathomimetics	Bronchodilator
5. Sustained-releast theophylline Aminophylline, methylxanthine, Xanthine	Bronchodilator with uncertain anti-flammatory effect
6. Ketotifen	Antiallergic agent

Quick relief medications

1. Short-acting beta2-agonists Adrenergics beta2-stimulants Sympathomime-tics	Bronchodilator
2. Anticholinergics	Bronchodilator
3. Short-acting theophylline Aminophylline	Bronchodilator
4. Epinephrine/adrenaline injection	Bronchodilator

Inhalers

Inhalers are a very safe form of treatment of bronchial asthma. They are quick acting because they take the drug exactly where it is needed without circulating through the blood stream first as do other (tablet, syrup or injectable) drugs. Inhalers use drugs in micrograms while tablets are in milligram doses ie tablets are thousand times more concentrated than inhalers. Hence, the side effects are minimized in inhalers. The use of inhalers through a spacer device further enhances the effectiveness of this mode of drug administration. However, studies and observations of doctors show that most patient are unable to properly use inhalers. Educating the patient about the proper use of inhalers is essential as it may save him/her from over use and thereby from side-effects. Experiences of some doctors shows that the inhalers used with a spacer device are as effective and fast acting as the nebulizer.

Guidelines for the Diagnosis and Management of Asthma, NIH Consensus Publication No. 9336, 59A-Dec 93.

Consumer's Association of UK

Hyposensitisation (also known as desensitization or immunotherapy) may help a few people with severe symptoms that cannot be controlled by other medicines. Not everyone will be helped and people who are sensitive to a wide range of allergens will not benefit from hyposensitisation with just one preparation containing varieties of grass pollen, for example.

Anaphylaxis, an acute and severe allergic reaction to the desensitising vaccine, can occur. The Committee on Safety of Medicines warns the doctors that since 1980 (up to 1992) in Britain, 11 people, mostly young, have died from anaphylaxis caused by allergen extract desensitising vaccines. Patients with asthma appear to be particularly sensitive. Treatment should be carried out only where there are adequate facilities for resuscitation and patients should remain under medical observation for at least two hours after the injection.

Grant Rosalind (1992), WHICH? MEDICINE, Publishers of Drug and Therapeutics Bulletin, London.

The New England Journal of Medicine

In January 1997 the journal has published a "A controlled Trial of Immunotherapy for Asthma in Allergic Children" by N. Franklin Adkinson et al. A double-blind, placebo-controlled trial of multiple-allergen immunotherapy was conducted in 121 allergic children with moderate-to-severe perennial (year-round) asthma. The children, who required daily medication in their asthma, were randomly assigned to receive subcutaneous injections of either a mixture of up to seven aeroallergan extracts or a placebo.

The trial concluded that immunotherapy with injections of allergans for over two years was of no discernible benefit in allergic children with perennial asthma who were receiving appropriate medical treatment.

The New England Medical Journal, January 30 1997, p 324.

Ayyaz Kiani of **The Network** points out towards a new expensive ball game of 'modernizing' the health care with the magic of hi-fi diagnostics and argues that it might turn out to be a fatal attraction.

Diagnostics in health care: a developing countries' perspective

Machine infatuation

Optimal use of the diagnostic technology at appropriate levels in the health care system and in the right order of priority contributes a lot in improving health services. An analysis of the state of affairs in our country, and generally in all developing countries, however presents a gloomy picture. Of all the afflictions of our health care system resulting in poor service delivery, the worst are those causing wastage of resources in services which require big capital investment, need elaborate infrastructure and inflict heavy recurrent costs but deliver only marginal health outcomes. Such services bleed the system to the extent that even the primary services suffer badly. And one important area of wastage is diagnostic equipment.

A recently conducted audit of dispensaries run by a metropolitan corporation in Pakistan made some revealing findings. The dispensaries were a few years back provided diagnostic equipment like x-rays, ultrasound, and spectrophotometry etc. Out of a total of twelve dispensaries having laboratories, technicians, microscopes and spectrophotometers etc, only two were doing any tests at all. The x-rays units were poorly maintained, the staff was not following safe operating practices and many patients were x-rayed for conditions which did not warrant such a test. The average cost to the dispensary of one x-ray done is Rs 514 which is five times more than that in the market. Ultrasound was used for reporting on conditions where it was unlikely to contribute to diagnosis or alter treatment.

It was clearly shown in the audit that the equipment is inappropriately placed at this level of health care as it is being inefficiently used and has no positive impact on the health of the users. This equipment could improve diagnosis/treatment of fractures and tuberculosis but at this level of health care no matching clinical services for treatment of TB or fractures were available.

Collecting scientific evidence of effectiveness of diagnostics and using it in decision making could make a big difference. For example, if the NWFP government had done a similar survey of its primary health care facilities before buying for them Rs 320 million worth of hi-tech diagnostic equipment with a loan provided by a foreign bank last year, this money could most likely have been found to be much better spent to buy Essential Drugs or manpower training in improvement of clinical practices.

Diagnostic testing with hi-tech equipment costing colossal amounts of money to the individual as well as the system has become fashionable and plush diagnostic centers are mushrooming almost everywhere in the country. Huge amounts of money are being spent every year to install and operate state of the art invasive imaging technologies like CAT and PET scans, CATH labs, x-rays, mamograms, and others like MRIs, ultrasound etc. A new kind of "investment" opportunity has been created: put up a neat and clean "diagnostics project" entailing minimum hassle compared to an industrial production unit with the similar capital investment. So lucrative are the rewards in this new business that hi-tech diagnostics are installed even in small, remote towns like Dera Ghazi Khan and Rahim Yar Khan where they are advertised on bill boards alongside Pepsi and Nestlé.

The reasons for proliferation of the diagnostic technology in the public sector are not any nobler than those in the private sector. Manufacturers collude with bilateral and multilateral monetary agencies in offering credit packages to the government and attach strings to spend these loans in buying certain gadgets from certain manufacturer in a certain country. Kick backs and commissions are given for the purchase and the specialists use these equipment to glorify themselves and attract larger number of patients to their private practices.

At no occasion in these deals are ques-

tions asked such as: Is the equipment really needed? Can the system afford it? Is there a more cost-effective technology available elsewhere? Is it a priority for system's development? Can this money be spent elsewhere in the system for greater benefit? What are the hidden costs in terms of infrastructure, manpower development, maintenance and system integration?

The results of such influences would be quite obvious. Here are a few examples to illustrate. A 300MA x-ray unit bought with credit money arrives, among a lot of laboratory and operation theater equipment including a sophisticated electrical theater table, for installation at a RHC in a remote place in Balochistan. This equipment needs three phase power supply but the facility has no power supply!

A donor supplies more microscopes in the same province than the total number of health facilities. Some of this equipment is not likely to complete even a tenth of its useful physical life for lack of maintenance and backup. In other cases the consumables are so expensive or scarce that a perfectly operative machine would be lying idle for there is no money to buy those consumables.

A technician of a municipal corporation laboratory sits in his air conditioned laboratory fitted with modern test facilities but has done no microscopy for six months because there is no supply of glass cover slips for the slides.

In the public sector it is a common experience that a medical center has the latest in diagnostic technology but does not even have simple medicines like paracetamol or cotrimaxazole. At a primary health facility if a chest x-ray leads to say positive tuberculosis diagnosis, it would not result in alteration of the patient outcome as there are no TB drugs available. The installation and running cost of one x-ray unit would have alternatively been used to stock many such facilities with Essential Drugs for year long service.

The real beneficiaries of this 'modernization' of health care scam are not the people but the multinational diagnostics manufacturers and their touts, health officials and specialists, involved in procurement and use.

This situation has to be challenged as the scarcity of both public and private resources demand their most judicious use to maximally benefit the society as a whole and especially those existing on the margins of the system. Ways and means should be devised to base the decision to install new diagnostic equipment in a health facility on solid scientific evidence that provision of such a service is the most prudent use of the money and will lead to appropriate improvement in health care.

Manufacturers of diagnostic equipment collude with bilateral and multilateral monetary agencies in offering credit packages to the government and attach strings to spend these loans in buying certain gadgets from certain manufacturer in a certain country.

Where have all the scanners gone?

Three out of a total of four Computerised Tomography (CT) Scanner machines available in Lahore's three government hospitals are out of order. The only CT Scanner working in the public sector is at Services Hospital.

Two CT scanners worth Rs 40 million are rotting at Lahore General Hospital since last year when these were submerged in water after heavy rains. The third machine at Jinnah Hospital got out of order around six months ago. Its tube worth Rs 2.3 million burnt out.

Ironically, one of the two grounded machines at Lahore General Hospital has a tube intact, but the LGH administration has not responded positively to the Jinnah Hospital administration in their request for the tube even after the health secretary's directions in this context. Sir Ganga Ram, Mayo and Lady Willington hospitals do not have these machines. The federally administered Sheikh Zayed Hospital also has a CT Scanner which is out of order. Though the public sector CT Scanners used to be more busy in entertaining VIPs, the poor patients also had access to the facility for Rs 1000. The only working scanner at the Services Hospital is now catering to the poor of the city. The facility is over-worked, to say the least and even the serious patients are being given a booking of at least 45 days or more.

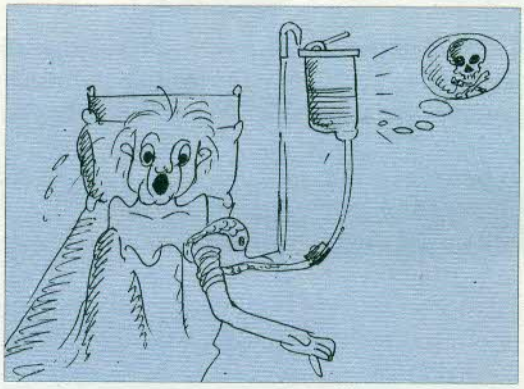
Reliable sources in hospitals revealed that the public sector machines were closed down on purpose since this helped the private facilities enormously. They pointed out that many facilities charging Rs 5,000 to 6,000 for a test were either being run by retired professors or by others working for both the government hospitals and these private facilities.

By Shahab Ansari, coutesy The News, Lahore edition, 27 April, 1997

Dialogue

This is a reader's page. They are invited to write about irrational use of medicines and any other practice that they think is promoting irrationality in prescribing and treatment. Readers can also send their opinions about any article published in this Newsletter.

Cartoons on malpractices



Pyrogens containing infusions playing havoc with people's lives.

Through your newsletter I have come to know why the Ministry of Health did not respond to my letter asking for the National Essential Drugs List - a just right of medical professionals and lay public. I would like to suggest starting a drug related quiz for doctors and allocating some space for cartoons on malpractices in the medical profession in this newsletter. I offer my free services for sketches and cartoons. Space should also be devoted to medications affecting mothers, children and geriatrics and special conditions like depression and schizophrenia etc. I am enclosing a cartoon and a reprint of an article written by me.

Dr Munsif Ali, MBBS, Kalu Khan, Swabi

All these suggestions are very well taken. We would like to get your cartoons and sketches and will include them in our publications when appropriate. Kindly also send us specific examples of questionable practices in the profession and the pharma industry. We look forward to your continued support of our campaign.

Medical supplies and Ehtesab

I am pleased to see every new issue of this Newsletter recruiting new converts. Reading about Tamil Nadu Medical Supply Corporation in the Feb 1997 issue has ignited in me a will to act and I would like to propose a supply system similar to the one in TNMSC but run in private sector and as first step to initiate an exchange of ideas in this regard amongst doctors in the private sector through the forum of this newsletter.

I would also like to hear more doctors speak through this forum to initiate prosecution of all malpracticing pharmaceutical companies in courts of law, such as the Mohtesib-e-Ala and the Ehtesab Commissioner, by The Network or its subsidiary, and then widely publicize these proceedings. I am sure the objectives behind these actions are very close to the hearts of all upright practicing doctors.

Dr Saleem Akhtar Rana, MD, MCPS, Gujranwala

We welcome responses from all our readers to the proposals made in this letter. These are exciting ideas and we would like to expand the idea about prosecution. While Dialogue pages of this newsletter are open to every body to contribute in this regard we would especially invite pharma industry to participate in this discussion.

Technical differentiation

In Vol. 5 ,No. 3, p 7 of the Newsletter, in the chart about "100 Most Sold Drugs" you have mentioned Septran amongst the category of antibiotics. This drug should be categorized separately as 'chemotherapeutic agent' and not antibiotic as it is a misnomer for this class of drugs.

Sardar Shabbir Ahmed, 3rd Professional, B Pharm, Peshawar University

We agree with the technical differentiation as pointed out.

Supportership forms

We have received queries from many of our readers about how can they help others become supporters when they only have one supportership form inserted in the Newsletter.Any interested person can get his/her name on our mailing list either by filling the inserted form and sending it to us or by filling a photocopy of the form or even by simply writing his/her name, address, profession and speciality on a plain piece of paper.

Seminar on "Drug Policy Issues for Developing Countries"

The Executive Coordinator of the Network participated in a recently held seminar on "Drug Policy Issues for Developing Countries" at Boston. The seminar was organized by Boston University School of Public Health in collaboration with WHO and Massachusetts College of Pharmacy and Allied Health Sciences. The course was attended by about 30 senior policy makers, regulators and academics from around 15 countries.

Following is a list of areas covered in the seminar: review of the concept of National Drug Policy (NDP) and WHO guidelines; the process involved in the development of NDP; political analysis of NDP; planning and strategies for NDP implementation; assessment and monitoring of NDP and pharmaceutical systems; selection, formularies and treatment guidelines; investigation and changing drug use; drug pricing issues debate; financing and privatization; procurement and donations; production issues; quality assurance (quality management); regulation and Registration issues; international conference on harmonization; human resource management for the pharmaceutical sector.

The faculty for the seminar comprised of 14 senior academics, researchers, technocrats from universities, WHO, FDA and an NGO. The over all seminar director is Dr. Richard Laing. It was a very educative seminar. The status of participants in their respective countries as senior policy makers makes it more important. The seminar needs some improvements here and there. Consumer perspective in pharmaceutical policies needs to be injected into the course content.

Draft model law for consumer protection

The last caretaker government rekindled the long awaited Consumer Protection Law and initiated its active development. A draft was prepared by few interested in the Federal Monopoly Control Authority and Federal Ministry of Commerce took on the leading role for its fine tuning *and eventual* promulgation through the Presidential Ordinance. The representatives of SDPI (Sustainable Development Policy Institute) and the Network had a detailed meeting with the then Federal Minister of Commerce, Dr Zubair and discussed with him the weaknesses of the draft and two days later a written critique on the draft text was also provided to the Minister. But then the idea could not jump and sit higher on the priority list of "things to do" of the Caretakers and the draft remained a draft.

This was not just symptomatic of the Caretakers, consumer protection has remained a non-priority issue for successive governments in the country. We hope that the present government with historic mandate would eventually legislate on this very important issue for the people - as all the people are consumers and in the absence of any redressal mechanism provided under consumer protection law they are being ripped-off in the market-place through sub-standard goods and services. We hope that apart from waiting for Allah the government would also provide respite to the consumers in this country. Almost all the South Asian neighbors already have such laws in place!

Essential Drugs Program in Balochistan

Work on Essential Drugs Program (EDP) has met with good success in Balochistan and the provincial government has approved the Project Cost Document (PC1). This work was initiated in early 1996 through a consultancy commissioned to The Network by the British Overseas Development Administration (ODA) as a part of health systems strengthening component of the 2nd Family Health Project. An implementation plan is now being formulated with technical support from the Network.

Successful implementation of the program as given in the PC1 is expected to have a major impact in improvement of health care services in the province through universal availability of good quality essential drugs in all government health facilities and their rational use.

Network supporters organize seminars on rational drug use

Since the publication of the invitation "The Network to help its supporters to organize rational drug use seminars/workshops" in the February'97 issue of the newsletter we are continuously receiving invitations, offers and requests from all over the country. Overwhelmed, encouraged and challenged with the response, we have started reaching out and this is fast becoming one of our major operations. Weary of passive and didactic sermonizing through conventional seminars we are thrilled with the prospects of this new approach which is proactive, participatory and action oriented. The very fact that you as a group are interested to discuss the determinants of irrational drug use despite of the moral blackout all around is very stimulating and promising.

Until now we have received invitations and requests to help facilitate these meetings from various parts of the country and we have also gone to three cities i.e. Peshawar, Sialkot and Gujranwala where we had exciting discussions. All those who have contacted us are our long standing supporters and readers of The Network's Newsletter. It is exciting to put faces to the names we knew all through these years. It is also an activity for strengthening solidarity.

Rational drug use workshop in Peshawar.

With each such meeting, we are also fast learning the real ground situation. And accordingly it has set in a whole new thought process about the possibilities for future work at local level and how in different ways we can catalyze, strengthen, channelize and integrate it with the wider national campaign for rational drug use. Apart from listening to each other, sharing our experiences and taking stock of the problems these meetings also need to concentrate on actions and interventions that we as individuals and groups can undertake. We are in the process of developing a list of ideas for possible actions for promoting rational drug use at local level. We will print this list in our June newsletter.

When planning such a meeting please consider the following points so that we can make these most useful and practical:

- number of participants should not be less than 15
- keep it simple, in terms of arrangements i.e. venue, refreshments etc.
- at best we can share only a part of the cost.
- do not consider this meeting as an end in itself, plan it as a start off point
- preferably the group should meet early and discuss the meeting and the possible follow-up activities, for this we can share with you the list of possible follow-up actions before the meeting
- you can also think of a key person from your group who can represent you well and whom we can take as our key contact
- some times you may have to wait for a while because of early commitments, please bear with us, delay would not be intentional
- give us your suggestions for improving these meetings, before or after the meeting

INTERNATIONAL SOCIETY OF DRUG BULLETINS (ISDB)

The Network's Newsletter is a member of the International Society of Drug Bulletins (ISDB), a network of independent drug bulletins which aims to promote international exchange of quality information on drugs and therapeutics.

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