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The Network's NEWSLETTER

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.

No short cuts for policy making

The caretaker government's 90 days in the office are marked by a show of hyper-activity. The haste and hurry with which it took up every task may be good in many aspects but is harmful and detrimental in many regards as well. Policy making and that too related to health is no joke. It does not just involve some bureaucratic maneuvers. It is not that the Minister utters some magic words like 'open sesame' and here it is the National Drug Policy.

A public policy document has to be a product of a process of debate and discussion involving all the stake-holders of the pharmaceutical sector. The policy could only be successfully implemented if the varied and contrasting opinions of different stake-holders have been duly considered and used to evolve a position of optimal acceptance. But the caretaker set up did not bother to consult any stake-holder, perhaps because the policy is not meant to be implemented. It is a piece of paper that will enable the minister to lay a claim that he accomplished in 90 days what others could not in 50 years.

The document of the National Drug Policy is abysmally poor in the quality of its content, language and presentation. It claims to do things which are opposite to what other departments of the government are dying to achieve. Its contents are self contradictory and even incomprehensible. Its vision is myopic and conventional and the jargon is out of date. It is in no way a document that could help us survive the new corporate onslaught in the name of globalization. Through this document, the Ministry wants its critiques to start believing that it is busy doing a lot.

The Network hopes that the new government which enjoys overwhelming majority in the parliament will kick start the process of drug policy making afresh involving all the stake-holders.

DrugNews

FDA to disapprove Seldane (Teldane)

The Food and Drug Administration of USA (FDA) has announced its intention to withdraw the approval of Seldane (terfenadine), Seldane D (terfenadine and pseudoephedrine) and generic versions of the prescription antihistamine on 12 January 1997. FDA has determined that drugs containing terfenadine are no longer shown to be safe because fexofenadine is now available.

FDA recently approved a brand of fexofenadine, the primary active derivative of terfenadine produced in the body when terfenadine is taken. Fexofenadine provides nearly all of terfenadine's beneficial effects but does not appear to cause a potentially fatal heart condition when taken with some other commonly prescribed medications.

Introduced in 1985, terfenadine was marketed as the first prescription antihistamine to relieve the symptoms of allergic rhinitis without causing drowsiness. Following approval, FDA received reports of serious and sometimes fatal cardiac arrhythmias associated with terfenadine when it was taken with some other medications or by patients with liver disease. These other drugs, such as erythromycin (an antibiotic and ketoconozole (an antifungal drug), can cause terfenadine build up in the blood and result in serious cardiac side effects.

Prior to the approval of fexofenadine, the agency considered the benefits of terfenadine to outweigh its risks despite its known serious cardiac adverse effects when used inappropriately. Now that fexofenadine is available and provides the therapeutic benefits of terfenadine without the associated serious cardiac risks, terfenadine's benefits are no longer considered to outweigh its risks.

In view of these developments, FDA has determined that terfanadine-containing products should be removed from the market. The 12 January Notice of Opportunity for Hearing from the FDA gives the manufacturers 30 days to request a hearing to show why approval of the registration (New Drug Applications or ANDA for the generic version) should not be withdrawn.

In the meantime, FDA is advising patients currently taking Seldane, Seldane-D and generic terfenadine products to talk to their doctor about switching to alternative medications.

Raw materials: From India with ...

The caretaker government has decided to allow the import of raw materials for pharmaceutical industry from India. This is being done to help bring down the prices of medicines in Pakistan.

According to daily *Dawn* the authorities are of the view that Indian chemical and pharmaceutical industry has developed tremendously in the recent past and it can provide the raw materials at very competitive price. Currently, the raw materials imports from India and Israel are banned. Official sources told *Dawn* that the import of finished goods (medicines), however, would not be allowed from India.

The Network welcomes any move to lower the high drug prices in Pakistan but thinks that this particular move may not be very helpful in this regard. The Network has this considered opinion that it is not the price of raw material that has made medicines in Pakistan costlier than in India but the absence of an effective price control. The raw material from China, Brazil or Italy is most of the times as inexpensive as that available from India but the manufacturers either fraudulently show it to be much higher (called transfer pricing) or simply raise their profit margin to thousands of percents. The prices can only be brought down by checking the practice of transfer pricing and setting a formula for fixing the prices.

The drug price situation in Pakistan is worsening because a cartel of multinational companies has monopolized the market. Their monopoly is getting stronger by the mega mergers and take overs. The local companies are either too weak to offer any competition or are dependent on multinationals for contracts or business. The Network considers this situation of no-competition as the major cause of high prices and only the import of raw materials from India would not help bring competition into our market.

Herbal fraud

Ummal Laboratories of Rawalpindi is actively promoting a single dose oral contraceptive that it claims is effective for one whole year. The company boasts, through the glossy brochure it is providing to all the chemists along with the 'medicine', that the product has no side effects whatsoever and is well-tried and popular around the world. The manufacturer has used science and Islam alike in the bid to establish effectiveness of the product but has not even mentioned the contents of the capsule anywhere. The capsule priced Rs 95 is available on chemist shops and general stores.

This is all happening right under the nose of federal health authorities. Such baseless claims of treatment should be treated as a criminal offense by the authorities and immunity of the herbal drugs from Drug Act 1976 should not stand as an excuse.

A consumer group in Ahmedabad, India, complained recently to a consumer court about the promotion of a herbal drug called 'Select'. The manufacturer was claiming that if taken after pregnancy the product will ensure that the baby is a boy. The drug inspector took the plea in the court that he can't do anything as the product is Ayurvedic and enjoys immunity from the regular law. But the court insisted that the law should not be used as an excuse and he should act to remedy the situation. The drug inspector raided the 'Select Laboratories' next day and arrested the quack.

Ruthless ads

The media has become one big avenue for the companies to push all types of trash products. The state television is running ads for cigarettes, baby food, herbal cough and cold preparations and even tonics. The print media has also failed to set any ethical criteria to accept or not the promotional campaigns of professionals and traders, manufacturers of health related products.

Recently a number of supplements have appeared in many newspapers promoting useless or dubious products. The Network wrote to the Ministry of Health about one such product called 'Efamol' but did not receive any response. The company however did respond through a telephone call by the personal secretary of a high up, 'advising' The Network not to take up the issue. Also disappointing is the fact that many senior professionals very easily 'volunteer' to praise the products in newspaper pages.

It seems that the Ministry's advertisement scrutiny committee is on long leave.

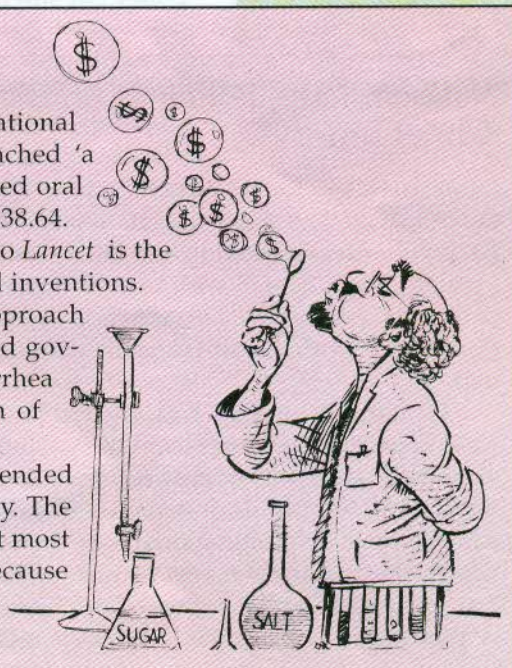
Bubbling profits

Pakistan's second richest pharma company, the 'research based' multinational company Abbott laboratories is bubbling with excitement. It has launched 'a break-through' product for the ailing children of Pakistan — ready-to-feed oral electrolyte solution in an exciting new bubble gum flavor priced just Rs 38.64.

It is a cheap attempt at medicalizing a home remedy that according to *Lancet* is the miracle of the century as it has saved more lives than any of the medical inventions.

The product is bound to confuse people and complicate their approach towards the treatment of diarrhea. All the efforts of the international and government health agencies concentrate on simplifying the treatment of diarrhea which has been complicated by the companies through the promotion of anti-diarrheals and anti-infectives.

The product is priced at Rs 77 per liter and the company recommended daily dose for children of 3 months and beyond is more than a liter a day. The bottled sterile, mineral water of any brand is available at Rs 12 per liter at most and a sachet of ORS for Rs 6. But perhaps the product is priced high because the company had to invest millions of dollars on the research which gave us this brave new 'medicine'!



Dr Zafar Mirza of **The Network** finds out that the new National Drug Policy is at best a placebo prescribed to a seriously ill person.

Caretaker s Drug Policy: good for nothing

The caretaker government has approved the National Drug Policy (NDP) prepared by the Federal Ministry of Health under its new director-general and minister. The hush-hush and haste with which the government approved the draft and the quality of its text both are indicative of the caretakers' disregard to the participatory and democratic process of policy formulation.

Most of the stake-holders of the pharmaceutical sector came to know about the approval of the policy through newspapers as the draft of the document remained a well-guarded 'state secret' till it was approved by the cabinet. This secretive approach alone can fail any policy even if it has some good points. In case of public policy the final product is as important as the process to evolve it. The policy making should be essentially pluralist and all the stake-holders need to be involved in it.

If a policy does not facilitate a consensus working relationship among different stake-holders, it is bound to fail. True, all the stake holders cannot agree on every detail of the policy but still it is imperative for the policy makers to seriously listen to different points of views and try to forge a position of optimal acceptance. Only this process then ensures the implementation and meaningful follow-up of the policy.

This whole episode is missing in the drama staged by the caretakers in the name of National Drug Policy.

South Africa initiated the process of formulating a National Drug Policy in mid-1994, about the same time the Pakistani government took up the task. The South African health minister set up a Drug Policy Committee. The committee compiled and presented a report to the minister in November 1994. The ministry then prepared a discussion document on the basis of the committee report and disseminated it among different stake-holders including consumers, industry and health care providers. Consultative workshops were held in June 1995 which involved provincial health officials, industry representatives, officers of other related government departments (like trade, industry and finance) and professional organizations. Inputs were invited from WHO Action Pro-

National Drug Policy: A brief history

In January 1995 for the first time in the history of the country a National Drug Policy was drafted by the Ministry of Health in line with the recommendations of the Drug Action Program of World Health Organization.

Though the policy had many weak areas, it did attempt to address some basic issues. The three recommendations in the draft regarding joint ventures by multinational companies, the country of origin issue in drug registration and the mandatory production of Essential Drugs by all the companies invited the wrath of industry. The Pharma Bureau of multinationals was on the forefront.

Deputy Chairman Planning Commission Qazi Aleemullah intervened and 'an inter-ministerial committee' headed by Mr Qazi was constituted to 'review' the draft. The committee after performing the ritual of listening to all the parties including The Network issued in June the revised draft of the NDP and all the three important points were omitted.

The Network approached the Standing Committees of Senate and the National Assemblies and made presentations about what points should be included in the policy. The Senate committee took a few months to finalize and forward its comments on the draft. There has been no news about the National Assembly committee making any move on the subject.

Annoyed by the hue and cry raised by The Network , the bureaucracy meanwhile decided to put the issue in the cold storage.

Soon after the dismissal of the Benazir government and the subsequent changes in the Ministry of Health, the caretaker government decided to have a National Drug Policy . A cabinet meeting in January 1997 approved a NDP document.

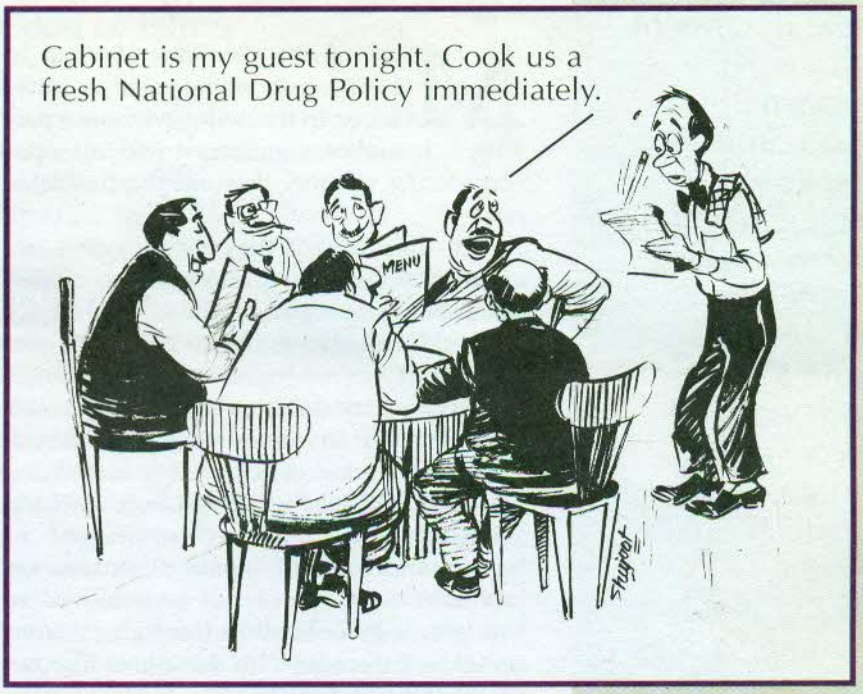
gram on Essential Drugs. A wide range of comments were received after the workshops and were incorporated in the document. The policy document was finalized and distributed in January 1996 after one and half year of national debate and consultations on the subject.

Compare this with the way the National Drug Policy is made in Pakistan. A minister who has only 90 days to make his mark orders a director-general who has just assumed charge to provide him a draft NDP. The DG who is new to many things but has to justify his appointment perhaps passes on the orders to his subordinates who have been witnessing the merry-go-round policy making since the last few years. Some bureaucrat decides to spend a few extra hours in the evenings for some days and comes up with a cocktail of ideas borrowed from different documents. The document is hurriedly passed on to the cabinet and is approved as the National Drug Policy.

The important fact to note is that the Ministry of Health has not even involved other related government departments in the making of the National Drug Policy. The same was the case with the NDP's January 1995 draft which many other government departments found very offending. Deputy Chairman Planning Commission Qazi Aleemullah was so much annoyed that he intervened under the cover of an inter-ministerial committee which he headed and practically dismantled the policy.

The absence of a participatory process makes the new policy document just another gimmick in the political point scoring game. The non-committal approach is more evident in the fact that the policy does not envisage any mechanism to implement the policy and monitor it. A good policy without an implementation plan is like a luxury car without an engine. It only shows that the real objectives of the policy are not those stated in document.

The NDP's section on legislation is literally the anti-thesis. It says that the Drugs Act 1976 is just perfect and there is no real need for any legislation except for the herbal products which are not covered by the Act. If the existing laws are all that we need to improve our pharmaceutical sector, if the NDP does not require any major changes in the legal frame work in which the pharmaceutical sector is today operating, then why do we need a National Drug Policy? In fact a critique of the failures and shortcomings of the existing legal and administrative set up should have been the foundation of the new policy. If the Drugs Act 1976 could not deliver in twenty years or has not been fully implemented since then, logically any policy initiative should address the issues which failed the 1976 Act or made impossible its implementation. But the new NDP does not dare move in this direction.



The South African NDP, which is contemporary to Pakistan's policy, contains within its text a firm promise to put words into action. It established within the Department of Health a comprehensive program, the South African Drug Action Program (SADAP) to coordinate, support and supervise provincial activities and strategies, together with the complimentary roles of different parties and stake-holders. The policy also established a Medicines Control Council (MCC) with very clear mandate and terms of reference. The MCC which is monetarily autonomous is to review legislation and regulation in order to support the objectives of the NDP and liaise frequently with relevant departments and organizations active in implementation of the policy.

A good policy without an implementation plan is like a luxury car without an engine.

The document of the NDP is abysmally poor in its language, sequence and format. Many sentences are incoherent and there are numerous typographical mistakes. The general quality of the document is a shame, it does not deserve to be called a national policy document.

Many of the recommendations in new the policy are in sharp contradiction to the new governance paradigm. It makes suggestions without even considering whether they are practicable or not.

On the one hand the policy suggests creation of more posts to improve the quality assurance system and on the other the government is shedding jobs to reduce its size and cut down on governmental expenditure. The policy does not hint at how will it make possible any investment in infrastructure in this period of resourcelessness.

The NDP talks of technology transfer, self-sufficiency and encouragement of basic manufacturing. These objectives are laudable but these cannot be achieved in this era of globalization through conventional and decades old measures like tax exemptions and shuffling of tariff regimes. These measures as instruments of macroeconomic management are not any more possessed by the governments but are in the hands of global financial institutions and multinational corporations. These objectives had meanings in the fifties and sixties when governments of many Third World companies, like India, were able to dictate their terms to the corporations interested in investing in these countries. Today, however, the governments of countries like Pakistan are ready to do anything to lure investment into their countries.

The desire to be self-sufficient may be justifiable but certainly incentive packages, export processing zones, offers of 100% repatriation of profits and decontrolling of pricing system are not the ways to achieve it. If the policy makers are really sincere to these objectives, they need to be creative otherwise they should know that the jargon they are using is at least a quarter century old and has out lived its meanings.

Under the heading Drug Pricing it says: "The grant of patent protection for drugs shall be only for process and not for the product." Perhaps our policy makers don't know that Pakistan is a signatory to the GATT 94 and a member of WTO which implies that Pakistan has to accept the new patent regime (Trade-Related Intellectual Property Rights -TRIPs) and amend its laws accordingly in next few years. Unlike many other developing countries, Pakistan has never vowed to defy its commitment to accept the new global patent regime. In fact Pakistan has already initiated a move to amend its laws. The NDP however boasts of undoing Pakistan's acceptance of GATT 94 without mentioning how will it accomplish the Herculean task. Or are the policy makers asking us not to take the NDP 'too' seriously?

The quality of the presentation of the NDP document also deserves a few comments. The document is abysmally poor in its language, sequence and format. Many sentences are incoherent and incomprehensible and there are numerous typographical mistakes. The general quality of the document is a shame, it does not deserve to be called a national policy document.

Objectives: inside out

The National Drug Policy of Pakistan has set itself eight objectives. Most of these are just incomprehensible. These are words without meanings and in no relation to each other. One objective is to provide the people of Pakistan 'genuine and pure' drugs. One promises provision to people of 'drugs of acceptable quality'; another is to ensure supply of unadulterated drugs and still another is to 'protect public from hazards of spurious drugs'. What the policy makers are really up to is however the following:

- to have a document — a few pages titled National Drug Policy — in place so that the Ministry cannot be criticized about not having one since last 50 years.
- to add another 'feather' to the caretaker's already over-crowded cap and lengthen the list of 'achievements' of the new team in charge.
- the show of hyper efficiency by the new bosses at the MoH to justify their appointments.

Over the counter

With reference to the editorial, Over the Counter Availability of Medicines, of your Dec. '96 Newsletter, consider the following for an example:

A psoriatic patient took 5mg methotrexate (an anti-cancer, anti-psoriatic drug) per day for one and a half years! He was lucky enough to have developed only gross anemia (Hb 5.0 gm/dl). The average dose is 15mg per week and it has to be used under specialist supervision and regular blood, kidney and liver tests done to monitor toxicity. Once having received the prescription, this patient kept buying the drug from medical stores by showing the outer carton and did not return to the prescriber for all that period.

Dr Irshad Hakim, MBBS, FCPS, MCPS
Dermatologist, Peshawar

Misuse of clomiphene citrate

Over the last almost one decade, I have observed that clomiphene citrate is used by gynecologists, physicians and quacks alike in almost 99% of infertility cases. Since ovalutory failures account for about 20% of all infertility being reported, the use of this drug according to the protocol should not be more than that. I wonder if the promotional tactics employed by the manufacturers have any thing to do with this extreme situation.

Dr S Abdul Manan Bangash,
MBBS, MCPS, BHU Serozai, Hangu

Guide to Good Prescribing

I am interested to have Guide to Good Prescribing by WHO which has been reviewed in the Sept. 1996 issue of the Newsletter. Kindly advise how could I get it. If it is available at The Network could I have a copy made and sent to me. Thanks.

Dr Abdul Ghaffar Khan, General Practitioner,
Mandi Warburton, Sheikhupura

We have requested the Drug Action Program of the WHO to send us some copies. We will let you know as soon as we receive these.

Code of Ethics

I want to suggest about having a Code of Ethics in the medical practice, it will also help a lot in controlling the irrational prescription of drugs.

Dr Abdul Salam, Mardan

We appreciate this suggestion coming from a medical doctor as it emanates from the knowledge of irresponsible attitude of the prescribers. Many studies have convincingly proven the irrational behavior of medical professionals in prescription. Patients are getting quite a rough deal from the profession especially in the private sector. Medical profession in general is quite immune to accountability in our country and lot needs to be done in this area. We think that time has come when medical profession should do some introspection and come up with a voluntary Code of Ethics for Medical Practice. The Pakistan Medical Association should take a lead as any such move will go a long way in improving the deteriorating image of the medical profession.

Is ignorance bliss?

I am not in favor of the proposed newsletter in Urdu. It will add to the miseries of health profession by providing access to vital information to the quacks and homeopaths who are already playing havoc with the lives of the people. Lets abort the fetus before its birth.

Dr Farida Habib, Lahore

We believe that the best way to end quackery of the semi-literate and the 'fully literate' practitioners is to educate the consumers. Limiting the access of the common people to the knowledge will not hamper the growth of quackery, it will in fact promote it. People believe in quacks only because they are ignorant. Our newsletter in Urdu will target common people and will try to improve their knowledge about health, role of medicines and other related issues so that they are able to make an informed choice and are not cheated by quacks, irresponsible professionals and pharmaceutical industry.

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.

Tahir Mehdi of **The Network** sifts through the health indicators provided in Unicef's latest world report to find out why Pakistan lags behind even poorer countries.

Pakistan has little to cherish in health sector on its golden jubilee

Poor show

Unicef's annual report 'The State of the World's Children' provides facts and figures about the status of the child in over 150 countries. The 1997 report ranks in descending order 150 countries according to their under-five mortality rates. The worst country Niger with an under five mortality rate (U5MR) of 320 per thousand live births is ranked first while Sweden with an U5MR of only 5 stands at 150th place.

Pakistan is ranked 33rd worst country with an U5MR of 137 and infant (under one) mortality rate of 95. This means that out of every thousand live births 95 babies in Pakistan die before seeing their first birthday. A baby is born in our country almost every 6th second and one dies every minute. Average U5MR for the South Asian region is 121 and U1MR is 82. Pakistan is second only to the war-torn Afghanistan in the region.

Many believe that the health indicators are directly linked to the economic indicators - better the economy of the country, better the health of its people. This is actually not true. See Table 1. Good health did come with economic prosperity for most of the developed countries, but many developing countries have demonstrated during the last fifty years that health of the people can be improved even without first making all of them rich. Sri Lanka offers the best example in this regard. With a per capita income comparable to that of Pakistan, the U5MR of Sri Lanka matches that of rich countries like Malaysia. Bangladesh with around half the per capita income of Pakistan has better child mortality rates. Both the countries had similar start off points and Bangladesh had graver economic problems than Pakistan.

In 1960, China had an under five mortality rate of 209 which it reduced to 47 in the next 35 years. Similarly, Iran reduced its U5MR from 233 to 40 during the period 1960-95 and Malaysia from 105 to 13. Pakistan however could not even half its 1960 under five mortality rate of 221 in 35 years. See Table 6.

This also shows that good health does not automatically trickle down from an economic boom. It needs sensible planning and sincere implementation to improve the health of the people and if these two things are present the health of the people can be improved even without waiting for the economic miracle to happen.

The differences in the U5MR figures for different countries are surely not accidental as these are confirmed by the differences in other indicators as well. In Iran around 100 per cent and in Malaysia, China and Sri Lanka over 90 per cent children under one year of age are fully immunized against TB, DPT, polio and measles. In Pakistan, however not even half of the children are immunized. See Table 5.

In Bangladesh 44 per cent of the families are consuming iodized salt compared to only 19 per cent in Pakistan. In India 67 per cent, in China 51 and in Iran 82 per cent of the households use iodized salts.

In Pakistan one fourth of the babies are born under weight, while in Bangladesh half and in India one third weigh less at birth. Despite that less babies die in Bangladesh

Table 1

Rank	Country	Under 5 mortality rate	Under 1 mortality rate	GNP per capita (US$)
33	Pakistan	137	95	430
38	Bangladesh	115	85	220
39	India	115	76	320
72	China	47	38	530
79	Iran	40	35	1,033
87	Saudi Arabia	34	29	7,050
110	Sri Lanka	19	15	640
122	Malaysia	13	11	3,480
125	United States	10	8	25,880
130	Korea, Rep. of	9	8	8,260
150	Sweden	5	4	23,530

Table 2

	Adult literacy rate (1995)		Primary school enrolment ratio (1990-94 gross)		% of primary school children reaching grade 5 (1990-95)	Secondary school enrolment ratio (1990-94 gross)	
	male	female	male	female		male	female
Pakistan	50	24	57	30	48	28	13
Bangladesh	49	26	84	73	47	25	13
India	66	38	113	91	62	59	38
China	90	73	120	116	88	60	15
Iran	78	59	109	101	90	74	58
Sri Lanka	93	87	106	105	92	71	78
Malaysia	89	78	93	93	98	56	61
Korea, Rep. of	99	97	97	99	100	97	96

and India than in Pakistan during their first year. Better breastfeeding rates may be one of the reasons. In Bangladesh 54 and in India 51 per cent of the babies are exclusively breastfed during first three months of their life, in Pakistan, however, only 16 per cent are lucky enough to be exclusively breastfed. Similarly in Bangladesh 87 and in India 67 per cent of the babies are breastfed till at least the 20th month of their life while in Pakistan only 56 per cent are found breastfeeding in 20-23rd month.

The difference is also very prominent in fertility and population growth rates. See Table 4. Fewer number of children per women (fertility rate) has a direct effect on women's health. However, some countries, like Iran and Malaysia, where population growth rate has not dropped in last 25 years or so, show lowered fertility rates resulting from an over all improvement in mother and child health.

Most interesting to note is the fact that the indicators related to education have a direct bearing on health indicators. The countries performing better in the field of education also perform better in health. See Table 2.

All of these differences have been made possible by the governments of these countries through pro-people planning and huge investment of their resources. The figures in Table 3 given in the Unicef report are an eye opener. The countries spending more on health and education than on defense are healthier than those following the opposite policy.

Definitions

Under-five mortality rate (U5MR): Probability of dying between birth and exactly five years of age expressed per 1000 live births.

Infant mortality rate: Probability of dying between birth and exactly one year of age expressed per thousand live births.

Adult literacy rate: Percentage of persons aged 15 and over who can read and write.

Primary/secondary enrolment ratios: The gross enrollment ratio is the total number of children enrolled in a schooling level — whether or not they belong in the relevant age group for that level — expressed as a per centage of the total number of children in the relevant age group for that level.

Children reaching grade 5: Percentage of children entering the first grade of primary school who eventually reach grade 5.

Total fertility rate: The number of children that would be born per woman if she were to live to the end of her child bearing age and bear children at each age in accordance with prevailing age - specific fertility rates.

Contraceptive prevalence: Percentage of married women aged 15-49 years currently using contraception.

Table 3

	% of central government expenditure allocated to 1990-95		
	health	education	defense
Pakistan	1	2	31
Bangladesh	5	11	10
India	2	2	15
China	0	3	19
Iran	6	16	7
Sri Lanka	6	11	12
Malaysia	6	22	13
Korea, Rep. of	1	20	18
United States	18	2	18
Australia	13	8	8
United Kingdom	14	3	10
Germany	17	1	7

Table 4

	Pop. in millions	Pop. growth rate(%) 1980-95	Total fertility rate	Contraceptive prevalence (%)
Pakistan	140.5	3.3	5.9	19
Bangladesh	120.4	2.1	4.1	45
India	935.7	2.0	3.6	41
China	1,221.5	1.3	2.0	83
Iran	67.3	3.6	4.8	73
Sri Lanka	18.4	1.4	2.4	66
Malaysia	20.1	2.5	3.4	48

Table 5

	One year old children % fully immunized 1992-95			
	TB	DPT	polio	measles
Pakistan	75	35	37	53
Bangladesh	94	69	69	79
India	96	89	98	78
China	92	92	94	93
Iran	99	97	97	95
Saudi Arabia	93	97	97	94
Sri Lanka	90	93	92	88
Malaysia	97	90	90	81

Table 6

	Under five mortality rate		Infant mortality rate		Pop. annual growth rate		Total fertility rate		Adult literacy 1980		Adult literacy 1995	
	1960	1995	1960	1995	1965-80	1980-95	1960	1995	male	female	male	female
Pakistan	221	137	137	95	2.7	3.3	6.9	5.9	38	15	50	24
Bangladesh	247	115	151	85	2.8	2.1	6.7	4.1	41	17	49	26
India	236	115	144	76	2.2	2.0	5.9	3.6	55	25	66	38
China	209	47	140	38	2.1	1.3	5.5	2.0	79	53	90	73
Iran	233	40	145	35	3.1	3.6	7.2	4.8	61	37	78	59
Saudi Arabia	292	34	170	29	4.6	4.1	7.2	6.2	60	32	72	50
Sri Lanka	130	19	90	15	1.9	1.4	5.3	2.4	91	80	93	87
Malaysia	105	13	73	11	2.5	2.5	6.8	3.4	80	60	89	78
Korea, Rep. of	124	9	88	8	1.9	1.1	5.7	1.8	97	90	99	97

Report of a study conducted by **Drs SQ Nizami and ZA Bhutta** to examine drug prescribing practices of general practitioners and pediatricians for childhood diarrhea in Karachi

Local research

Prescribing for diarrhea

Diarrhea is one of the commonest causes of morbidity and mortality in children in developing countries. Over the past two decades the mortality due to diarrhea in children under 5 years of age has declined by one million deaths per year. This decline, at least in part, is a result of promotion and use of ORS. Although, despite lucid WHO guidelines overuse of antidiarrheals, antiamoebics and antibacterials continue to be reported from developing countries. Pakistan is no exception to this situation.

Drs SQ Nizami and ZA Bhutta have done a study in Karachi with the co-operation of Applied Diarrheal Disease Research Project (ADDR) to investigate the drug prescribing practices of general practitioners and pediatricians for childhood diarrhea. They randomly selected 94 general practitioners (GPs) from a list of 2000 doctors (obtained from a drug company which was not making any antidiarrheal). The authors have mentioned the absence of any complete list of doctors with their practicing addresses. According to their best judgement there are around 5,000 doctors working as GPs in Karachi) and 41 pediatricians from a list provided by Pakistan Pediatric Association. Interestingly, 15 GPs and 11 pediatricians refused to take part in the study and another 13 GPs and a pediatrician refused to allow observation of their practice after their initial consent. Finally 65 GPs and 29 pediatricians were observed between April and December 1992.

The observers (graduates in sociology) sat in the practitioner's office and observed patient-practitioner interactions without any intervention, recording the relevant information on the data collection forms. Each doctor's practice was observed for 3-4 hours during peak hours of practice, for 5-6 days over one week. The information gathered included age and sex of patients, frequency, duration and type of diarrhea, history of vomiting, fever or cough, drugs prescribed and/or dispensed and the duration of encounter between practitioner and patient.

A total of 996 encounters between 90 practitioners and children were observed. ORS was prescribed in more than 50% of encounters by 53% of GPs and 61% of pediatricians. Sixty six percent of GPs and 50% of pediatricians prescribed antibacterials, 60% of GPs and 28% of pediatricians prescribed antidiarrheals and 39% of GPs and 32% of pediatricians prescribed antiamoebics in more than 30% of their encounters. Cotrimoxazloe was the most frequently prescribed antibacterial by both types of practitioners. Antidiarrheals were prescribed more often by the GPs than by the pediatricians. An interesting finding was that in 77% of their encounters, GPs dispensed drug formulations known as "mixtures" made in their own dispensing corners.

The mean duration of encounters between patients and GPs was 3.2 minutes and between patients and pediatricians was 9.4 minutes.

The authors found not only sub-optimal prescribing of ORS but also inadequate explanation to parents about how to prepare it and how much to use. Without the correct preparation and use of ORS, rehydration, prevention of dehydration and mortality reduction cannot be achieved.

The authors have recommended that to reduce high prescribing rates for antibacterials and antidiarrheals, more emphasis should be given to the health education of consumers as well as measures to improve knowledge of practitioners. This is important to reduce the parental demand for drugs and for a quick cure.

Surprisingly, the authors have neither mentioned in the discussion nor in recommended, the deregistration of pediatric formulations of antidiarrheals available in the market. An important policy recommendation could have been the bridging of the gap between the Drug Registration Board which registers these drugs and the National Control for Diarrheal Disease Program which clearly advises against the use of antidiarrheals in any type of diarrhea.

The Network grows

It is good news for The Network supporters that our secretariate has almost doubled during 1996 both in terms of human and material resources. In fact, compared to the very modest beginnings in 1991, The Network secretariate today has grown many times over! But we are not done as yet. This expansion will continue during 1997, and beyond. We have plans to hire more staff, enlarge our library holdings, acquire computers, and other hardware.

Urdu Newsletter

We had an excellent response to our request for names for the Urdu monthly which we are starting from April 97. While taking great interest in naming the baby, our supporters were also very appreciative of the idea and encouraged us to go ahead with it. However, there was one letter urging us against publishing it with the view that it would promote quackery in the country. Our response to this and other such views is very clear. The Declaration of Alma Ata on Primary Health Care seeks to empower individuals and communities with information enabling them to be responsible for their own health and also participate individually and collectively in the planning and implementation of their health care. This publication aims to achieve just that.

Our readers are invited to write to us with their suggestions about the contents and style of this periodical as well as any other idea about it.

Pharma industry's 'Task Force'

Both the indigenous and the overseas pharma companies have joined hands together to press for their demands concerning withdrawal of customs duty, sales tax and pre-shipment inspection fees etc. They have formed a "Task Force" which has been lobbying in Islamabad recently for this purpose. This united front of the two types of manufacturers is a novelty in itself as until recently the two have had conflicting interests and they have been fighting against each other at all fora.

The chairman and a member of the Task Force met The Network staff members on 12th January in Islamabad. The Network impressed upon the industry representatives that we are very seriously concerned about exploitation of the consumers in our country by the industry through high prices and transfer pricing, double standards in information and marketing, and producing useless and/or harmful drugs. The meeting concluded with an agreement that lack of the right information leads to confusion and distortion of facts and that the industry will be more open and willing to provide information to The Network in future.

CI-ROAP meeting

The Consumer International - Regional Office for Asia and Pacific held a conference 'Consumer in the global Age' in New Delhi on January 22-24. The Network representatives attended the conference. Dr Zafar Mirza, the executive coordinator of The Network, also presented a paper 'Time to re-read the Alma Ata Declaration' in the conference. The Network availed the opportunity to interact and share experiences of a number of organizations working in the field of health in different parts of the world.

The Network to help its supporters organize

Rational drug use seminars/workshops

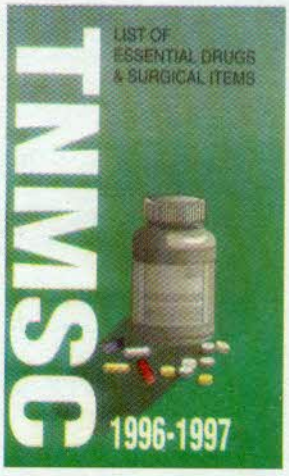
We have been conducting seminars and workshops for teachers and students in medical institutions of the country over the last few years. These activities provided us good opportunity to promote principles of rational therapeutics and essential drugs concept in these institutions and also to make friends during the process.

This year we would like to do these activities differently. Instead of planning at our end, we would like our supporters in medical and pharmacy colleges to tell us to hold similar activities in their institutions. You may write to us about your plans briefly and we'll get back to you to settle the details.

The Network would be able to provide technical resource as well as the expense involved. We may not be able to respond positively to all the requests but only on a first come first served basis. But still we might be able to respond to many of you. You'll have to hurry though.

... there is way

Availability and access to good quality essential drugs in the public sector can be improved significantly through innovative improvements in the procurement and distribution systems. In our June 1996 issue (Vol. 5 No. 2) we mentioned how South African government has committed itself to improve the situation in their country through an assertive and people centred National Drug Policy. Here we describe briefly how an Indian State, Tamil Nadu, has tackled the issue and is beginning to reap the benefits from the changes it has introduced.



For the States population of more than 5.5 million, there has been a plentiful supply of drugs in the private sector but the poor attending the government health facilities suffer due to shortages and supplies management problems. These problems were identified to have to do mainly with inefficient utilization of funds in procurement, poor indenting and inventory management systems. In order to purchase quality Essential Drugs at most competitive prices and bringing in efficient supplies management systems, Tamil Nadu Medical Supplies Corporation (TNMSC) was formed in 19994-95. The Medical Officer of Madras Municipal Corporation, Dr Kannabran, and the Secretary Health & Family Welfare Department of Tamil Nadu, Mr R Poornalingam (IAS), are to be credited for the establishment and eventual success of this courageous venture.

The TNMSC changed the procurement system through a process of discussion and debate amongst the relevant people in the profession. The new system was based on buying only from within a graded Essential Drugs list containing around 240 drugs through open tendering directly from manufacturers of good standing who had Good Manufacturing Practice certificate. Teaching hospitals were allowed 10% of their budgets to be utilized for local purchase of those drugs which were not on the list. A list of all such drugs was also prepared in consultation with the leading professors. The corporation has also started to procure other medical supplies like surgical items. Special packings were introduced to rule out theft. State and district stores were stocked well in order to avoid any stock-outs. An elaborate and fool proof system of quality assurance based on double blind coding allows for adequate guarantees to the prescribers and the consumers alike.

The TMNSC has a Board of Directors, with the State's Secretary of Health as ex-officio Chairman and a full-time Managing Director. The Corporation over the last two years of its formation has been very successful in terms of improving availability of Essential Drugs, and a growing list of other supplies in public sector health facilities, raising cost consciousness amongst the health managers and improving financial efficiency. With the upcoming computerization of the supplies system, the TNMSC hopes to link each health facility's drug consumption to morbidity patterns thus improving rational use of drugs, cost control, and better inventory management and availability of drugs.

It would appear to the casual observer that the problems in the availability and access of medicines that we are facing in our country are probably technical in nature and one can fix them by improving the system through management and technical interventions. But in fact it is not quite so. What we are suffering from is nothing technical. It is only political. What is different with the governments of South Africa and Tamil Nadu is not the technical know-how but the desire to provide the people a better deal. What we really lack is politicians like Dr Zuma, professionals like Dr Kannabran and public servants like Poornalingam to stand up, on the peoples side, and say that enough is enough and they won't take it any more. Putting the system straight is only too simple.

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