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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.

Over-the-counter availability of medicines

All over the country, any pharmaceutical product can be bought by anybody over-the-counter. Generally, neither is any prescription demanded by the sellers (very few of whom are qualified pharmacists) nor do they consider it important. Prescriptions are required only when either the customer/consumer does not remember the name of the drug or cannot pronounce it.

Drugs are special consumer commodities. Owing to their special status they require special handling. Governments regulate the pharmaceutical sector with an objective to ensure the rational use of effective, safe and quality drugs by the consumers. Licensing of pharmaceutical manufacturing units, registration of drugs, control of drug promotion, drug labeling standards, classification of drugs for different purposes, essential drug lists and formularies, development of therapeutic guidelines, drug sale rules etc. are some examples of drug regulation.

Retail selling or dispensing of drugs is the last and one of the most important steps before the use of drugs. To ensure better end-use, one measure is to classify drugs into basically two categories: first, drugs which can be made available to the consumers only after professional advice and second, drugs which can be purchased without such advice. A signed prescription by a qualified health professional containing drug/s from first category forms an evidence that the patient medically needs these drugs and is required to be seen by the seller before these are handed over or dispensed to the patient. The first category includes all those drugs which are to be given only after proper diagnosis has been made and/or which can have serious side-effects including dependence and/or which require complicated instructions to be followed for their use (antibiotics, psychotropics, steroids, hormonal preparations, anti-cancer drugs etc.). These are the very basic principles to be followed for classifying drugs into "prescription-only" and "over-the-counter" drugs.

In all the industrialized and in many developing countries this rule is strictly followed. In Pakistan the situation is "a free for all" and most disturbingly there is no attempt of any kind to improve the situation. The Drug Act 1976 is vague and non-committal about this aspect. Provinces have formulated "Sale Rules" based on Drug Act which are quite out-dated and in some cases ridiculous. The result is that any body can enter a retail medical store and ask for even a anti-cancer drug and it will be provided readily without asking for a prescription. This is also true for Islamabad.

There is a dire need for strengthening the Drug Act, thorough review of provincial Sale Rules, strict enforcement of these rules, training of sellers and education of consumers. We hope that all involved will feel their responsibility. The Network, apart from its own work, is very willing to join in any effort in this direction.

DrugNews

Rhone Poulenc Rorer (RPR): a Rather Poor Reply!

The June 1996 MaLAM international edition focused on the promotion of Flagyl (metronidazole) by Rhone Poulenc Rorer (RPR) in Pakistan exhorting "suspect amoebiasis/giardiasis in all cases of diarrhoea... immediate treatment is vital". RPR's response to MaLAM is one of the worst letters that MaLAM has received in recent years. Dr. Minhaj A. Qidwai, Medical Advisor for RPR (Pakistan) stated that "If you agree that amoebiasis and giardiasis should be treated urgently due to their potential impact on morbidity and mortality, then empirical treatment becomes routine in a community unable to afford the charges for stool examination and other associated laboratory or office costs". Does RPR mean that all children with diarrhoea should receive metronidazole?

Misuse of metronidazole: "a worldwide health problem": A number of studies in developing countries have shown that metronidazole is often misused for the treatment of diarrhoea in children. In her survey of prescribing practice in India, Greenhalgh (1987) found that metronidazole was the most frequently prescribed antimicrobial for diarrhoea in hospitals (26% of cases) and among private general practitioners (36% of cases).[1]

A recent study on health professionals' knowledge of dysentery treatment in Bangladesh has shown that less than half chose the correct treatment as recommended by the WHO.[2] Metronidazole was chosen by 10.9 to 25.6% of the doctors and by 36.8 to 47.3% of the drug dispensers. In Pakistan, in a recent study antiamoebics were prescribed by general practitioners and pediatricians in 26% and 22% of encounters for childhood diarrhoea respectively.[3]

"Suspect drug promotion in all cases of inappropriate prescribing": In the Philippines, an anthropological study focused on the popularity of drugs for diarrhoea among prescribers and dispensers. The author concluded "A review of studies in the Philippines showed that, contrary to popular belief, the general prevalence of amoebiasis is not high, that amoebiasis is not frequently associated with acute or persistent diarrhoea in children and that the first etiological agent to be considered in pediatric dysentery is Shigella, not E. Histolytica. Despite this, metronidazole and other anti-amoebic drugs are frequently prescribed for ordinary cases of watery diarrhoea."

As in the Philippines, RPR's promotion of Flagyl in Pakistan encourages false beliefs about amoebic hyperendemicity. RPR's current promotion for the routine empirical use of metronidazole is in opposition to the World Health Organization (WHO) recommendations and should be strongly condemned. (References available on request)

— MaLAM International News, Nov/Dec 1996

Our readers' comments on this issue are invited for publication in Dialogue section of the newsletter.

Poverty of research

Around 40 per cent of the world's population is at risk from malaria. Half a billion people catch malaria every year, nearly 1.5 million to 2.7 million of them die. This number is continuously rising because of the growing problem of drug resistance. You might think that the multinational companies would be scrambling to concoct new medicines for malaria. No, they are not. Rather the sums spent on research on malaria is painfully low. In 1993 the world spent $84 million on malaria research or $40 per death caused by malaria while on AIDS $3,774 per fatal case were spent. A recent study sponsored by Wellcome Trust failed to produce figures for private investment in malaria research, partly because drug firms are secretive but mainly because there isn't much research.

The real reason why companies are not investing in research on malaria is commercial. Most of the victims are too poor to pay. A vast majority of these live in sub-Saharan Africa, South East and East Asia. For many companies venturing into the area, the real target market are Western visitors of these areas. But the risks are high even in this market of prophylactics as these affluent travellers can easily bring litigation. So the companies have no interest in the search for a drug for malaria.

This situation is alarming for the Third World where governments are, on the prescription of World Bank and IMF, closing down the public sector research organizations.

Source: The Economist, 28 Nov., 1996

Dialogue

From a concerned medical representative

I am a pharmacy graduate, working with a pharmaceutical multinational and am responsible for promoting and selling medicines. The other day I saw your newsletter, it was so inspiring that I decided to extend my support and co-operation to your work for promoting rational use of medication.

I can inform you about the unethical promotional claims of pharmaceutical companies and malpractice in which both companies and medical profession indulge. I shall continue my support for your work.

Name withheld

Thank you very much for your encouraging letter and extension of support. It would be good to hear from you and I hope that with your help we would be able to strengthen our work. The history of pharmaceutical multinationals is rife with such examples where conscientious professionals working in the industry collaborate with consumer organizations/activists and provide them important information regarding safety issues, unethical promotion, flimsy research etc. In many cases these professionals prefer not to be named. As responsible citizens they just cannot ignore what they see - all respect for these men and women for their concern and courage.

Please feel free to contact us wherever you are working. We observe a strict policy of confidentiality where requested and/or required. Looking forward to hearing from you!

Material on rational therapeutics

The Jehad waged by The Network for rational drug use in the country is most commendable. Your Newsletter is contributing greatly in this direction.

In the University Medical Complex we have prepared a formulary and it is being implemented now. We need your help in providing us with scientific materials on rational therapeutics and updating and reviewing the formulary on a regular basis.

Iftikhar Ahmad, M Phill
Hospital Pharmacist,
Punjab University Medical Complex, Lahore

We would like to extend our fullest support to all such efforts anywhere in the country to prepare Essential Drugs lists and formularies in any institution, big or small, and for promotion of rational use of medication at any level. Our readers are most welcome to ask us for our technical assistance in this regard. We'll try our hardest to meet your requirements and expectations.

Supportership forms

Please send me a few more supportership forms for making new supporters for The Network.

Dr Mohammad Ansar
Medical Officer In-Charge
BHU, Jabba, Mansehra Distt.

We appreciate our supporters' help in making new supporters of The Network. However, the forms inserted in the Newsletter are not essential for this purpose. A photocopy of the form and even basic biodata written legibly on a plain paper would suffice.

Plans and expectations

Tell me about your future plans and your expectations from me and my colleagues besides receiving your newsletter.

Nayab A. Barney, Coordinator,
Management Information System,
Baqai University

We keep briefing our supporters about our activities and plans through this Newsletter. We also regularly invite the input/participation of our supporters on our different campaigns. For example in this issue readers' input is invited on

1: Rhone Poulenc Rorer: A Rather Poor Reply, DrugNews, page 2
2: Openness in drug regulation, page 10
3: Suggestions for Urdu newsletter, page 12.

We hope you and your colleagues will respond to these queries/invitations.

Contents

Medical consequences of Ramzan

The month-long Ramzan requires followers to fast during the hours of daylight. What are the medical consequences and what advice should be given to patients?

Islam exonerates the sick from fasting but some Muslims with chronic illnesses nonetheless fast during Ramzan.

Insulin-dependent diabetes: fasting is not recommended

Fasting in diabetic patients was the subject of a consensus meeting in Casablanca in January 1994.[1]

There is a striking lack of studies on insulin-dependent diabetes and Ramzan with only two surveys[2,3] one published series[4] and two personal views.[5,6]

In summary: Despite the lack of data it seems best to advise insulin dependent diabetics not to fast. Those who wish to do so should be advised to check their blood glucose level several times a day to avoid hypoglycaemia during the daytime fast and hyperglycaemia (with or without acidosis and ketosis) from increased food intake at night. Insulin doses should be reduced and administration times shifted.[5,6] A single injection is often sufficient and should be given in the evening with the first meal. When two injections are necessary the two-thirds of the dose should be injected in the evening. Fasting is formally contraindicated in case of unstable diabetes or a history of hypoglycaemia, acidoketosis concurrent cardiovascular disease or infection.[6]

Non-insulin dependent diabetes: few problems

One study in the Middle East found no evidence of weight loss, deterioration in blood glucose control or increase in hospital admissions among fasting non insulin-dependent diabetics[7].

Another study involving 21 well controlled non-insulin dependent diabetics showed that fluctuations in glycaemia during Ramzan depended on food consumption and that control was maintained if food consumption was appropriately adjusted[8]. A similar study compared the effects of Ramzan fasting in 23 non-insulin dependent diabetics and 15 healthy volunteers. Blood glucose glycosylated haemoglobin and fructosamine levels remained stable in both groups.[9]

In a study of patients with uncomplicated non-insulin dependent diabetes who were at least 20% over weight there were no incidents on 1500 calories/24 hours and when medication was taken after the fast was broken.[10]

In summary: Despite conflicting results, available studies suggest that Ramzan fasting is not detrimental to patients with stable non-insulin dependent diabetes. The Moroccan expert consensus considered that fasting was acceptable for non-insulin dependent diabetics with a normal or above body weight whose diabetes was stable and treated by dietary measures, with or without oral hypoglycaemic agents, as long as they were free of intercurrent disease or vascular complications.[1] It was stressed that oral hypoglycaemic agents must be taken with the meals and that their doses must be adjusted in response to test results. In contrast, the Muslim doctors on the consensus panel came down against fasting by persons with poorly controlled non-insulin dependent diabetes, those with vascular complications, elderly, pregnant and breast feeding diabetics, and women with diabetes of pregnancy.[1]

Gastroduodenal ulcer

Experimental studies of healthy volunteers have shown acid and pepsin hypersecretion

This review article is adopted from Prescrire International, August 1996, Volume 5, No 24, p.123 to 126, and is reproduced with their permission. The article is the result of a very large collective effort on the part of the author (Farid Hakkou, pharmacologist in Casablanca (Morocco)); Prescrire's editorial board that, among other things, carried out a thorough literature search (manuals, Medline (1966 - September 1994), Embase (1992 - Sept. 1994), Pascal (1991 - Sept. 1994), Encyclopedia Medico-chirurgicale (1982 - Sept. 1994); and a large, multidisciplinary, international ad hoc review committee.

during Ramzan[11]. More interesting data have been obtained in clinical studies on ulcer disease during Ramzan . There have been four retrospective studies.[12,13,14,15] They compared that incidence of gastroduodenal ulcer complications (mainly bleeding and perforation) over periods of up to 10 years. They all showed a significant increase in perforations of gastroduodenal ulcers among fasting Muslims relative to the rest of that year, regardless of the season during which Ramzan occurred. Experimental data, descriptive studies and surveys all document the risks of fasting (especially perforation) in patients with gastroduodenal ulcers, but these data require confirmation in prospective studies. It would be interesting to determine the incidence of first ulcers in Muslims who observe Ramzan, the incidence of relapse among those with healed ulcers, the incidence of complications and the preventive efficacy of anti-ulcer treatments.

In summary: Patients with active or healing gastroduodenal ulcers should be advised not to fast, while those with recently healed ulcers should be given maintenance treatment and the usual lifestyle advice for ulcer patients (eg not to smoke).

Effects on other diseases

A questionnaire-based survey of patients gave the following rates of complications in a limited number of chronic diseases. Blood pressure fluctuations in 40% of 49 hypertensive patients, and clinical deterioration in 22% of 46 asthmatics and 43% of 18 patients with depression.[3] Another study compared hospital admissions during three consecutive months, the second of which corresponded to Ramzan[16]. The authors found a significant reduction in hospital admissions for angina pectoris and arterial hypertension, and a significant increase in hospital admissions duodenal ulcer and asthma. Hospital admissions for stroke, complications of non-insulin dependent diabetes, hypoglycaemia, dehydration, heart-failure, myocardial infarction, kidney disease and renal colic remained stable through out the 3 month study period.[16] Another study showed an aggravation of respiratory function tests in 65 asthmatic patients at the end of Ramzan.[17] As regards haemodialysis, no change in laboratory finding has been observed, but weight gain can occur in the short term.[18,19] These results require confirmation by medium and long-term follow up studies. No objective published data was found on the influence of fasting on hypertension.

A survey was conducted among Moroccan psychiatrists. 96% of the respondents stated that they had problems managing their patients during Ramzan[20]. 67% of psychiatrists considered that psychotic and epileptic patients frequently relapsed, and 81%, 60% and 51% advised against fasting by patients with psychosis, epilepsy and depression, respectively. Interestingly, in Jordan, where suicides and suicide attempts are registered nation-wide, there were fewer suicide attempts during Ramzan than at other times between 1986 and 1991. Using the attempted suicide rate during Ramzan as a reference, the relative risk was 2.5 in the month preceding Ramzan and 2.4 in that month following it ($p<0.05$).

Attitudes to disease during Ramzan

Although Islam exempt; patients with acute or chronic diseases from fasting, some

شَهْرُ رَمَضَانَ الَّذِيْ أُنْزِلَ فِيْهِ الْقُرْاٰنُ هُدًى
لِّلنَّاسِ وَبَيِّنٰتٍ مِّنَ الْهُدٰى وَالْفُرْقَانِ فَمَنْ شَهِدَ
مِنْكُمُ الشَّهْرَ فَلْيَصُمْهُ وَمَنْ كَانَ مَرِيْضًا اَوْ عَلٰى سَفَرٍ
فَعِدَّةٌ مِّنْ اَيَّامٍ اُخَرَ يُرِيْدُ اللّٰهُ بِكُمُ الْيُسْرَ وَلَا يُرِيْدُ
بِكُمُ الْعُسْرَ وَلِتُكْمِلُوا الْعِدَّةَ وَلِتُكَبِّرُوا اللّٰهَ عَلٰى مَا
هَدٰىكُمْ وَلَعَلَّكُمْ تَشْكُرُوْنَ ﴿١٨٥﴾

The Cow: 185: The month of Ramadan in which was revealed the Qur'an, a guidance for mankind, and clear proofs of the guidance, and the Criterion (of right and wrong). And whosoever of you is present, let him fast the month, and whosoever is sick or on a journey, (let him fast the same) number of other days. Allah desireth for you ease; He desireth not hardship for you; and (He desireth) that ye should complete the period, and that ye should magnify Allah for having guided you, and that peradventure ye may be thankful.

The Koran translated by Marmaduke Pickthall

Effects of Ramzan on pregnant and breastfeeding women

The dominant view in Islam is that pregnant women are exempted from fasting during Ramzan, as are breast-feeding and menstruating women.

Pregnancy: A few studies have been done on the consequence of Ramzan on pregnant women. Some have shown metabolic changes at the end of Ramzan in pregnant women who fast, such as lower glucose and insulin concentrations and higher triglyceride levels.[1,2]

Clinical studies of infants born to women who fast during their pregnancy are cause for concern. In a retrospective study, 250 pregnant women were divided into five equal groups: four groups fasted during Ramzan, which fell during the 6th, 7th, 8th or 9th month of pregnancy, while the 5th group, composed of women who chose not to fast for non medical reasons, served as controls.[3] When Ramzan fell during the 8th and 9th months the Apgar score and birth weight were lower and the neonatal mortality rate was higher. Another retrospective study which included 13, 351 full-term births between 1964 and 1984 concluded that the Ramzan fast had no effect on neonates.[4] In addition, a Saudi Arabian team retrospectively assessed the out come of children with a birth weight below 2500 gram. Among the 5280 children born in the same hospital between March 1985 and January 1987, 345 weighed less than 2500 g at birth. 21% of these births occurred during Ramzan or Hajj (the month-long pilgrimage to Mecca).[5] The risk of having an infant with a birth weight below 2500 g during these months was 1.42 relative to the rest of the year. The perinatal mortality rate was 176.8 per 1000 compared to 25.8 per 1000 in the entire population of infants born during the study period.

Only one prospective study has been published. It was a multicenter study involving 322 pregnant Egyptian Muslims, 167 of whom fasted for a month during the third trimester and 155 of whom did not fast for non-medical reasons.[6] The two groups were otherwise comparable. No difference was found in the mode of delivery, birthweight or Apgar scores. There was even a significant reduction in premature deliveries among the women who fasted (3/164,1.80% versus 10/155, 6.45%; $P<0.05$). This discrepancy in results could only be resolved by a large, prospective, multidisciplinary, multicenter study.

Breast-feeding. Few data are available on breast-feeding during Ramzan. It has been reported that fasting can exhaust maternal milk production, leading to the infant being fed with diluted cow's milk. This early weaning has led to cases of severe diarrhea with dehydration in countries with poor sanitation.[7] One study showed that women who fasted while breast-feeding lost 7.6% of total body fluids during the day, and that milk concentrations of lactose, sodium and potassium changed.[8]

Information for women. Pregnant, breast-feeding and menstruating women are often, unaware of exemptions from fasting during Ramzan.[4,9,10] Theologians, midwives and doctors should bear in mind that Islam authorizes pregnant women to refrain from fasting during Ramzan. It has been shown that many pregnant women choose not to fast when they are informed of this exemption before Ramzan begins.[9]

There is a striking lack of studies relating to medical consequences of Ramzan

patients choose to fast nonetheless. Doctors do not always have access to the information they require to advise their patients, and this translates into highly variable attitudes and practices. A Moroccan survey showed that while doctors were relatively firm on diseases such as insulin-dependent diabetes (all advised against fasting) and gastroduodenal ulcer (88% advising against), this was not the case for depression (53%) or asthma (4%).[3] This variability reveals the need for valid data on the health effects of Ramzan. The same survey showed that patients who fasted did so primarily because of religious convictions (between 50% and 76% according to the disease), while medical approval was only cited in 3% to 23% of cases.[3] This should encourage doctors and religious authorities to explain that Islam allows the sick to abstain from fasting. Indeed one study showed that the number of pregnant women who agreed to postpone their fast increased when the obstetrician worked hand in hand with an Islamic theologian.[22]

Drug treatments must be adjusted during Ramzan

Administration of drugs during Ramzan is not always easy, and adjustments are not always rational. For example, one study of 81 Asia Muslims showed that 47 modified their treatment, 35 stopped it completely, 8 changed the intake times and 4 took all their drugs in a single daily intake.[23] In a study carried out in Kuwait more than 60% of 325

outpatients modified their treatments during Ramzan.[24] Epileptic attacks have been reported in patients who stop taking their prescribed drugs.[25] In the studies the authors stressed that most of the patients were not given special advice on how to modify their treatments during Ramzan.[26]

In the case of diseases considered compatible with fasting, it is possible to find ways of observing Ramzan. First, the route of administration must be compatible, and the efficacy and tolerability of the drug must be affected by the change in intake times.

Antibiotics

No data could be found on antibiotic bioavailibility during Ramzan. A study of 12 healthy volunteers showed that the bioavailibility of trimethoprim (a single 300-mg tablet) was not modified during Ramzan.[26] The day's tablets can all be taken when the fast is broken, before the evening and morning meals.

For the other antibiotics pharmacokinetics should be extrapolated and the intake times shifted to the evening and morning.

Theophylline

A study of 12 asthmatic patients[27] and another study of 10 healthy volunteers[2] assessed the pharmacokinetics and tolerability of a sustained-release theophylline preparation during and outside the Ramzan period. Both showed that blood theophylline concentrations were unaffected by fasting. However, 8 patients in the first study reported gastrointestinal disorders and 6 had to stop fasting because of vomiting.[27] In these latter patients blood theophylline levels were moderately but not significantly higher than in the subjects free of marked gastrointestinal problems. The authors concluded that a longer-acting preparation taken in a single daily dose (preferably at the end of the night) would be a solution during Ramzan for asthmatic patients. However, when the patients clinical condition allows steroid aerosols, with or without beta2 stimulant (immediate or sustained action) would be an alternative for fasting asthmatic patients, as this form of administration is approved by Islamic law during Ramzan.

Common-sense recommendations

The surprising lack of clinical studies on drug therapy during Ramzan may explain the highly different attitudes among doctors.[3] Many drugs are now available in slow-release forms that enable one or two oral administrations after the fast is broken and/or just before sunrise. In addition, on the basis of plasma elimination half-lives of certain drugs it is possible to select those which could be given in only one or two daily doses. Non-steroidal anti inflammatory (NSAIDs) drugs can be taken during the day in forms compatible with Ramzan (suppositories or topical routes).

When no alternative to multiple daily dosing can be found it may be medically indicated to advise the patient to interrupt the fast. The therapeutic effect of certain oral drugs taken in the evening instead of during the day may affect the quality of sleep (the duration of which is shorter during Ramzan). This is notably the case of caffeine, theophylline and diuretics. The treatment may be modified to limit these disturbances, for example by replacing a diuretic by another class of antihypertensive agent, or by replacing theophylline by a long-acting topical steroid or beta2 stimulant given by inhaler.

Doctors do not always have access to the information they require to advise their patients, and this translates into highly variable attitudes and practices

References quoted in the box 'Effects of Ramzan on pregnant and breastfeeding women' are different from those quoted in the main article.
Both are available on request.

Conclusion

There is a striking lack of studies in this area, especially studies with clinical end points. Most available data are retrospective and based on small populations. These methodological weaknesses no doubt explain the wide discrepancies in the results. The attitudes of health professionals, especially doctors, towards Ramzan fasting by the sick still differ widely, no doubt because objective data on which to base their decisions are sparse and inaccessible. Many patients fail to respect medical advice or to take advantage of the exemptions offered by Islam.

Doctors and religious authorities ought to collaborate to ensure that information on the medical impact of Ramzan is available to all followers. Pregnant and breast-feeding women, and all those with serious medical problems which are likely to deteriorate with fasting, must be aware that Islam exempts them from fasting.

One role of doctors and pharmacists is to advise fasters on how to maintain a healthy lifestyle during Ramzan: this means eating (two main meals), limiting carbohydrate intake, eating fruit and vegetables, and taking adequate sleep.

Tahir Mehdi of **The Network** offers an introduction to the worldwide efforts to protect and promote breastfeeding and stop companies from misguiding doctors and mothers

Infant formulas and cereal foods

Substituting mothers

Around 400 human rights activists and legal experts, physicians and feminists, scientists and ecologists flew from 86 countries to Bangkok and for five full days shared experiences, discussed strategies and laid down action plans to protect and promote as natural an act as breastfeeding.

The global forum at Bangkok titled "Children's Health, Chlidren's Rights: Action for the 21st Century" was organized by the World Alliance for Breastfeeding Action (WABA) and participated in by mostly the representatives of non-governmental organizations from around the world. The five-day forum had, besides the daily plenary sessions, 88 workshops or smaller group meetings, many of them held simultaneously, on different aspects of breastfeeding issues.

At first it sounded like making a mountain out of a mole hill. Do we need to tell mothers how they should feed their babies? It's as nonsensical as telling birds how to teach flying to their siblings. But then birds are lucky not being commercial consumers. Mothers are not. Around the world women are under immense commercial pressure to surrender their right to breastfeed and put their babies on packaged milk powders and cereal foods. Who can profit from breastfeeding except babies?

Medical science has no doubt about the fact that a mother's milk is nutritionally perfect and more than enough for her baby. Breastfeeding has been a norm in all societies. It was considered so natural that nobody ever gave it a second thought. The dairy companies came up with the 'bright idea of substituting breastmilk' only when scientific innovations made their cows produce more milk than was needed by consumers.

To create a demand for such an unnatural product — the so-called breastmilk substitutes — the companies undermined the people's basic health beliefs. They have been successful in creating doubts in mothers' minds about their ability to produce enough milk for their babies. This artificial crisis of confidence has proven to be a gold mine for the companies. One of the commonest reasons given by mothers all over the world for stopping breastfeeding or introducing complementary foods early is that they think they do not have enough breastmilk for their baby.

Then the companies have also successfully convinced mothers and families that the packaged food products are nutritionally superior to natural things like breastmilk or family foods. Penny Van Estrik, an anthropologist and advocate of breastfeeding, told the Bangkok meeting about her encounter with a poor Thai working women who was breastfeeding her child and was guilty and apologetic about her act. "I am sorry for breastfeeding my baby. But I have no choice. I can't afford to buy the powder baby milk," she told Penny.

Breastmilk is best

Breastmilk is unequalled in providing infants proper nourishment.

Breastmilk contains antibodies that protect the baby against many common childhood illnesses.

Breastmilk is free and nearly every mother has more than enough for her baby (or babies in cases of twins and triplets, or baby and young child when a mother continues to feed her older child).

Artificially-fed infants have greater incidences of diarrhoea, respiratory and middle ear infections and are 10 to 15 times more at risk of death.

Breastfeeding promotes child spacing; exclusive breastfeeding prevents more births than all other forms of contraception combined.

Breastfeeding promotes bonding between mother and baby.

Mothers who breastfeed are less likely to develop breast and ovarian cancer.

Artificially-fed babies are more likely to develop allergies.

Artificially-fed babies are less intelligent than the breastfed babies.

Bibi Vogel, a Brazilian feminist and actress, interviewed a number of women of her country for her video film on the breastfeeding. The film presented at the global forum showed an indigenous women selling bananas at the road side while her child sitting next to her was eating canned bananas marketed by a multinational company at an exorbitant price. The women told Bibi the bananas 'made by the company' were much more nutritious then the ones she was selling!

Participants from all corners of the world — be it tribal Africa or democratic Scandinavia, Mexican deserts or Latin American forest, big countries like China or tiny islands like Fiji — narrated similar stories.

The use of baby food products has also become a matter of status. Breastfeeding has been made to look old fashioned, a thing of the past or a tradition of lower classes. Mothers giving these products to their babies wrongly think they are doing them a great favor. Besides being a drain on family resources, these products are playing havoc with the health of children.

Pakistan has one of the highest infant mortality rates in the world - around 100 per thousand live births, half of which is contributed by diarrhoea and acute respiratory infections. One of the reasons for the high prevalence of these diseases in our country is the high number of bottle-fed babies. Though there are no exact figures available in this regard, the evidence suggests that bottle-feeding is on the rise. A 1988 report says that Pakistanis bought 4.5 million feeding bottles that year. Statistics show that only 16 per cent of children from 0 to 3 months of age are exclusively breastfed in Pakistan and only half are breastfed up to 20 months of age.

But perhaps, even more grave is the fact that there is little resistance to this ever-growing menace in our country. This is not the case with the rest of the world. Authorities, health professionals and the general public in the majority of countries are concerned over the issue and are working out different ways to fight back.

In the industrialized world the number of women breastfeeding their babies had declined sharply as the companies marched on unhindered until around the seventies, when a number of activists started raising their voice against the way the companies exploit mothers. In 1979 the World Health Organization and UNICEF hosted an international meeting on infant and young child feeding calling for development of an international code on marketing of baby milk products. Subsequently, the World Health Assembly in 1981 adopted an International Code of Marketing Breastmilk Substitutes. But the Code is not binding and countries need to enact national laws on the same lines to stop companies from undermining breastfeeding by promoting milk food products.

Many of the developed countries, especially Scandinavian countries and Japan, have revived the breastfeeding practice (and culture) after losing it all to the companies' propaganda. Many others, including developing and poor countries, have enacted and enforced laws to refrain companies from misguiding health professionals and mothers.

India enacted Infant Milk Substitutes, Feeding Bottles and Infant Foods Act in 1993. Johnson & Johnson and Nestlé have been sued by an NGO for violating this Act. While the case against Nestlé is still in court, Johnson & Johnson had conceded last year and agreed to stop marketing its feeding bottles.

Bangladesh and Sri Lanka have also enacted laws to protect and promote breastfeeding. The Third SAARC Ministerial Conference on Children of South Asia held in Rawalpindi 20-22 August, 1996 adopted a "SAARC Model Code on Breastfeeding and Young Child Nutrition". But Pakistan does not yet have a relevant law that could protect mothers from the companies' exploits.

Baby food companies attempt to undermine women's confidence in their ability to fulfill their baby's nutritional requirements through breastfeeding

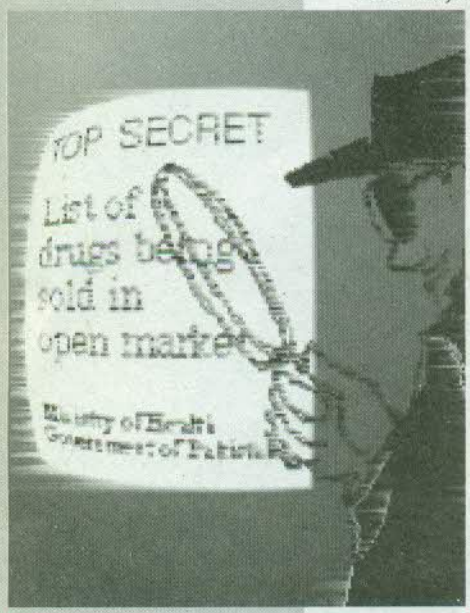
The Network advocates a policy of complete openness in decision making and policy formulation

Campaigning

Openness in drug regulation

Decision making and policy formulation regarding medicines is a very sensitive matter for two obvious reasons. One, these decisions and policies directly effect the lives of the people and two, a number of parties with varying (and many times differing) interests and stakes are involved in these matters.

This sensitivity of the issue demands that policy makers be very careful, vigilant and objective and this in turn requires hardwork and honesty. But there is an inherent tendency in the bureaucracies to avoid all this and cover it by keeping the whole affair secret. This secrecy not only hides the inefficiency of the authorities but also provides a ready, permanent cover-up for the corrupt practices of these officials.



Policies regarding medicines are a contract between the private business interests and the consumers, brokered and guaranteed by the government through laws and its different agencies. Governments, as the bodies elected by the general public, claim to be acting on the people's behalf. But the tradition of secrecy is a major impediment in holding the public representatives and the public servants accountable.

One of the main players in the policy wrangles is the industry and their main objective is simply to maximize profits. The developments in the last two decades have given extra leeway to the companies. The mega mergers have made the companies bigger and stronger than ever. On the other hand, the governments have disinvested or privatized the public sector, abolished the nationalist, protectionist policies and exposed the small local entrepreneurs to the tough competition with multinationals. All this has made the big companies more assertive, if not dictating and blackmailing, in the policy-making process. The situation is compounded by the bureaucratic tradition of secrecy.

It is hard to believe that the Ministry of Health in Pakistan is not willing to hand over to The Network a copy of the list of the 20,000 registered drugs in the country. The names of the medicines that the Ministry has allowed to be sold in the open market in Pakistan are a state secret! The Ministry is also not very forthcoming about the names of the members of the Drug Registration Board. Requests for information about individual drugs are also never answered.

The policy of secrecy has undermined the credibility of the public institutions. If these institutions are to play their role, they will have to adopt a policy of openness to restore public confidence in them. Access to information is people's basic right. It becomes all the more important when the information relates to health and medicines.

The Network advocates for a policy of complete openness in decision making and policy formulation in general and for the health sector in particular and is launching a campaign in this regard. By doing so it is joining Health Action International and other such organizations which are working for greater transparency and accountability in drug regulation worldwide.

Health Action International (HAI) and Dag Hammarskjöld Foundation have recently published the Statement of the International Working Group on Transparency and Accountability in Drug Regulation. The statement has called for greater openness in the way national and international drug regulators handle data regarding drug quality and safety. A copy of the statement can be sent to readers on request.

The Network requests its supporters to write letters to the Ministry of Health asking for;

. the list of pharmaceutical products registered with the Ministry of Health;

. details about the decision making process in Drug Registration Board meetings and the list of its members..

We also ask our readers to bring this issue to the attention of elected officials, office-bearers of Pakistan Medical Association and other professional associations and the press.

Murree training workshop

The Network conducted a Rational Drug Use workshop in Murree from 21 - 24 Oct. 96 for medical and paramedical workers of different Christian mission hospitals in Pakistan. This workshop was organized by the Church World Services and the Rosary Hospital Gujrat. The highlight of this workshop were the presentations by some of the participants who had been trained in a similar workshop conducted in March this year. At the end some participants staged very interesting skits prepared by them during the workshop. It was quite evident that not only were the participants benefitting from the training they had received by being rational themselves about drug use, they were also able to communicate such messages effectively with the communities they work with.

ISDB meeting and workshop

The International Society of Drug Bulletins (ISDB) held its Annual General Meeting at Granada, Spain from Sept. 28 to Oct. 1 this year. The Network's Newsletter, a member of ISDB, was represented by Associate Editor, Ayyaz Kiani. He was one of the 54 members who participated from all the five continents of the world. The AGM was followed by a training workshop for editors. ISDB's main task is to encourage the development of high quality, independent information about drugs and therapeutics and to support the development of new bulletins all over the world. Dr Zafar Mirza was elected as member of the Executive Board of the ISDB in this AGM.

GATT seminar in Germany

While in London for his studies, Dr Zafar Mirza organized a seminar entitled "GATT/WTO, Pharmaceutical Policies and Essential Drugs" in Bielefeld, Germany on 4th October 1996 on behalf of the Health Action International (HAI). The General Agreement on Trade and Tariffs (GATT) and the newly formed World Trade Organization (WTO) have brought sweeping changes in the way in which products and services are traded. The ways in which public health and pharmaceuticals will be affected are lesser known consequences of the trade agreements that most countries, including Pakistan, have already signed. This seminar was organized to provide an opportunity to the health activists in the European continent to deliberate on the consequences of these new developments on the national drug policies and essential drugs. Ayyaz Kiani, Projects Coordinator, also attended the seminar.

Council Meeting

The Network's ninth Council Members' meeting and Annual General Meeting was held in Islamabad on 31st Oct. 1996. The participants were very critical of the deteriorating standard of drugs' registration, non-availability of essential drugs, uncontrolled price increases and the Ministry of Health's unwillingness to regulate the industry. A number of policy decisions were taken for The Network to respond to this situation.

The General Body elected Prof. Akhlaque un Nabi as Chairman and Dr Tasleem Akhtar as the Vice Chairperson of The Network Council.

Quality of Health Care Services: Asia-Pacific Consultation

Recognizing the fact that rational use of medication has to be seen in the broader perspective of health care services, the Federation of Consumer Organizations of Tamil Nadu, India, and the Consumers International, Malaysia organized Quality of Health

Participants of the workshop on Rational Use of Drugs held in Murree on October 21-24, 1996.

Care Services, Asia-Pacific Consultation for health and consumer activists in the South Indian city of Madurai on 11-14 December 1996. Ayyaz Kiani represented The Network in this first of its kind conference in the region. Participants from twelve countries deliberated for four days on the three themes of the conference, namely: Quality of health care series. Privatization of health care series. Charter of patient rights.

Lecture at SDPI

Sustainable Development Policy Institute, an NGO and a think tank, arranged a discussion on November 3, 1996 on the issue of drug price hike . On the occasion The Network was represented by its campaign officer who briefed the audience on the subject and responded to their queries.

WABA Global Forum

The Network's campaign staff, Tahir Mehdi and Tracey Wagner-Rizvi, participated in a global conference organized by World Alliance for Breastfeeding Action held in Bangkok on December 2-6, 1996 on the protection and promotion of breastfeeding. For details of the conference see article on page 8.

Name the new baby

From 1997, The Network is starting publication of a newsletter in Urdu. Its target readers will primarily be general consumers and health workers. It will provide them authentic information in simple language about rational use of drugs, possible rational therapies for common ailments, information about the irrational/dangerous drugs available in the market and health tips. It will have separate sections focusing on issues related to women and children.

We invite our readers to suggest a name for the new Urdu publication.

Any other suggestions about the contents or any other related matters are also welcome. Please send the suggestions before Eid.

Announcement

We are pleased to inform our readers that from 1997 The Network's Newsletter will be a bimonthly publication and not a quarterly. Our next issue is due in late February.

— Editor

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