

Health Sans Multinationals : The Bangladesh Crusade

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Dr. Zafarullah Chowdhury, the founder-projects coordinator of Gonoshasthaya Kendra, (a health and development project in Bangladesh) is currently on a visit to India. This is an introduction to the activities of Gonoshasthaya Kendra (GK) and to the Bangladesh health and drug policy which has undeniably been influenced by GK and, more importantly, by Dr. Chowdhury.

Dr. Chowdhury's involvement in social and political issues dates from his student days when he was an active and vocal member of the Dhaka Medical College students union. When war broke out in Bangladesh he was studying in England. Like many other Bangladeshi youth, then working or studying abroad, he returned to work with the Mukti Bahini, helping to set up a field hospital, the Bangladesh Hospital, at the Tripura border. After the war, the Hospital moved to Savar about 60 km from Dhaka and became the Gonoshasthaya Kendra.

The project's bold, innovative and often radical approach has prompted both criticism and admiration. GK was among the earliest health projects to successfully incorporate the idea of training local people to look after their health needs. The women paramedics of Savar have since become a symbol of a plausible alternative to the high-cost, hospital-oriented health care systems. GK is openly committed to improving and enhancing women's skills and its employment policy is biased towards women. Its most recent venture is a pharmaceutical factory, the first in the voluntary sector, set up to produce essential drugs at reasonable prices.

Dr. Zafarullah Chowdhury, with his persistent criticism of anti-people policies and exploitative power structures (Chowdhury, 1977) and his refusal to accept limited but conventional and approved ways of providing solutions to the problems of health, has influenced policy changes at the national level.

During the past year, Bangladesh has been trying to implement a new drug policy which attempts to make essential drugs available to the people at prices they can afford, while at the same time curbing the production and sale of unnecessary, irrational and potentially dangerous formulations. Dr. Chowdhury, who was a member of the expert committee which helped the government formulate the new policy, has been a strong advocate of the policy's main objectives. The policy continues to be under attack from the multinational drug companies and has received little support from the major drug producing nations.

However, the growing consumer movement all over Europe and in Asia has been very vocal in its support of the policy. Much of this international support has been due to Dr. Chowdhury's

personal efforts to forestall the pressure tactics of the multinational companies and drug producing nations — tactics which have in the past sabotaged efforts by other developing countries to gain control of their drug production and sale.

Dr. Chowdhury's visit to India coincides with the beginning of a nation-wide campaign being undertaken by consumer groups, the People's Science Movement, health groups, voluntary organisations and trade union groups. The campaign will highlight the irrational drug production patterns, high prices, artificial scarcities of essential drugs and increasing production of non-essentials, and demand a comprehensive review of drugs.

Health for all : the Savar experience

Gonoshasthaya Kendra began as an attempt by a group of doctors to provide preventive and promotive health care in a rural area, but has now found itself drawn into activities well outside the conventional sphere of health care. Despite this early commitment to preventive health care, the lack of even the most basic health facilities in the area forced them to start clinics. Those were the years of material scarcity, when they were running clinics from tents and had to cope with high death and disease rates and post-war destitution. The first reports from GK talk of the growing realisation that "everything tried so far in the field of health care had miscarried because of a basic fault in the concept of medical care which had been taken over wholesale from the West, in complete disregard of the huge differences in the standards of living, social structure and patterns of health and disease" (GK Report 1972). The transition from these make-shift clinics to the present internationally-acclaimed integrated development project has been slow and fraught with disillusionment, failure and tragedy.

GK's primary health service now covers a population of over 100,000 and its most important functionaries are not doctors but paramedics. A GK paramedic is usually a village woman with a certain level of literacy, between 17 and 25 years old who has been trained in preventive and some curative health work (Chowdhury, 1980). The number of paramedics at any one time varies between 30 and 40.

Paramedics may begin training at any time of the year and are apprenticed to senior personnel for a period of six months to a year. Regular classes are conducted by the seniors and occasionally by doctors in the evenings. A trainee is made a member of the staff only if approved by the villages in which she has worked and by the heads of the various departments such as agriculture, family planning, pathology and village work. In time a paramedic gains enough skills to be allowed to examine patients on her own, run outpatient clinics and prescribe analgesics and antibiotics. Some of them have become department and project heads and many now conduct sterilisation operations on their own. But their primary training is on how to provide advice on antenatal care, family planning methods, nutrition and health education. A paramedic is trained to conduct simple pathological tests on blood, urine and stools and to undertake immunisation such as BCG for children, tetanus toxoid for women in the child-bearing age, and primary smallpox.

GK's paramedics have undertaken far more medical tasks than village health workers elsewhere. Experiments of a similar nature in India have generated strong resentment among the medical profession who often see this as a trespass into an area reserved for 'professionals'.

The GK health service includes four subcentres, each with a staff of five paramedics. The subcentres have little equipment; only two of them have kerosene refrigerators for storing vaccines. For five days of the week, one paramedic runs the subcentre while the others go into the villages, each paramedic being responsible for a population of 3,000 (or approximately 3 villages). Since mobility is so important, all paramedics have to learn to ride a bicycle. In the beginning, women paramedics on bicycles came in for a lot of criticism from the traditional society and from the religious leaders. But now, bicycles are very much a part of the GK health scene.

Another significant feature at GK is that the 'ward' or sick room at the main centre or 'hospital' is also managed by a paramedic and not a doctor. The inpatient unit has eight general beds, one labour bed and one reserved for tetanus cases. The most common causes of admissions are diarrhoeal diseases, self-poisoning (attempted suicide especially among women) and peptic ulcers. Admissions due to the first cause are almost always from areas outside the project limits which is a telling comment on the success of the preventive and promotive work of the paramedic. The infant mortality project area is 120/1000 live births as against the national rate of 140/1000 live births (1981).

Family planning has been an important component of the health service activity. The project area has one of the lowest growth rates in the country. Sterilization and menstrual regulations are done almost exclusively by senior paramedics and, interestingly, for tubectomies people prefer women paramedics to doctors. (Chowdhury and Chowdhury, 1976).

The project began to use the now controversial injectable contraceptive, Depo Provera in 1974 when there were 7,000 acceptors. However, it was found that many of the women experienced menstrual chaos, some had severe bleeding and there was even a case of chorian carcinoma necessitating a hysterectomy. These findings together with Stephen Minkin's now famous article (1980, reprinted) exposing long withheld information about the contraceptive, prompted the health workers to decide to withdraw Depo Provera in 1979. By contrast, the Bangladesh government decided to introduce Depo Provera in their official family planning programme around this time — a move which was highly criticised by GK. (Progress Report, 7).

Dr. Chowdhury has been very vocal in his criticism of the Western attitude to the problem of overpopulation in developing countries. He is also critical of any form of compulsion and even of the incentive scheme introduced to encourage sterilization, which he sees as being degrading and devoid of any human concern for the acceptors. (Chowdhury, 1982).

A health insurance scheme was instituted right at the outset, but had to be drastically modified. Now, the project identifies three categories for the scheme : the first consists of those who are unable to obtain even two meals a day for their families. This group does not pay for registration, but only a fee of half a taka (0.25 p) per patient per visit. The second group is of those who own upto 5 acres of land (arable or otherwise), pays 12 taka for registration, 10 taka for yearly renewal and 2 taka per patient per visit. The third group comprises those who have more than 5 acres of land. They pay the same registration and renewal charges but 5 taka per patient per visit. In 1979-80, 47 percent of the recurrent expenditure of the health programme was met by the insurance fees. (Progress Report, 7).

A characteristic feature of GK has been its ability to assimilate and integrate new experience. It has also survived tragic repercussions of its pioneering zeal. One of GK's most painful periods of self examination, (especially for people like Dr. Chowdhury) came after the brutal murder of Nizam, a paramedic, in 1976. Nizam had succeeded in establishing a subcentre in an area dominated and wholly controlled by the local landlord and political boss. He had also helped the local people to organise a credit cooperative which would have considerably undermined the influence of the landlord. The local doctor, whose exploitative practices had been exposed by Nizam conspired with the landlord to have Nizam murdered. He had been beheaded and his body was discovered days after the event. But inspite of the watchman's eyewitness account of the incident and Dr. Chowdhury's considerable influence in government circles, the murderers although identified, have never been apprehended. (Chowdhury, reprinted 1978).

Nizam's murder has been a constant reminder of the consequences of disturbing the balance of social and political forces. " if there was, perhaps for some months, the unavowed wish among us to forget about the terrifying events surrounding Nizam's death and to pretend it never happened, the anniversary has created an atmosphere of acknowledgement of the dark forces operating in our society and a determination to fight them so that Nizam may not have died in vain." (Progress Report, 6).

The project faces other problems as well. One such problem concerns the GK rule that all the staff, irrespective of their official status or qualification, have to put in a daily quota of work in agriculture. GK believes that "the relation between the landowner and the producer is a main source of conflict and any programme to bring about change cannot function without acknowledging this conflict", and anyone who wishes to work among the people ought to be able to appreciate the main occupation of the people. (Progress Report, 7).

This rule is sometimes resented, partly because many dislike it and are unused to it, but also because their work is extremely heavy even without labouring in the fields. Newer recruits are often unable to see the link between agricultural labour and their work in health. It has led to a high turnover of staff which has, in turn, affected the efficiency of the project.

Another area of friction appears to be the study circles organised for the project staff, where they are expected to undertake a certain amount of general reading in literature, sociology, economics and politics. GK's concept of 'integrated' development has, it would appear, been more successful in the distributive sphere of services. Paramedics have, of course, confronted and helped to solve people's problems falling outside the conventional area of health care. But whether this has meant a genuine understanding among all but the few, of how the socio-economic formation relates to the health picture, is open to debate.

Undoubtedly, the personal zeal and intense commitment of people like Dr. Chowdhury has contributed in great measure to the survival and success of the project and each new venture at GK has been in response to a perceived need, as has been the setting up of the pharmaceutical unit — Gonoshasthaya Pharmaceuticals Limited..

Until recently, the drug production pattern in Bangladesh was similar to that in India or any other developing country — 30-40% of the drugs were vitamins, 15-20% were drugs which have been banned in other developed countries. Less than half of the drugs manufactured and marketed in Bangladesh were essential medicines. Moreover, although there was supposedly a drug-pricing committee, it had had little success in controlling prices. For instance, although the price of a 250 mg ampicillin capsule was no more than 0.95 taka it was being sold under various brand names for as much as 1.90 taka. Deliberate misinformation by drug companies, unethical marketing and advertising practices tended to create a false demand for non-essential drugs. One example was the case of Vitamin B12 in Bangladesh. Although, it is used in developed countries only for specific cases of the vitamin deficiency, it was being advertised to doctors by Glaxo in Bangladesh as being useful for a wide range of symptoms such as poor appetite, sterility etc. (Chowdhury and Chowdhury, 1982). Because of the high cost, only 15 percent of the population had access to modern medicines.

The problem of obtaining inexpensive, good quality drugs for the project first led the GK group to explore the possibilities of starting a manufacturing unit in the project. The factory started production in May 1981, manufacturing paracetamol and ampicillin (Melrose, '82).

The initial investment for GPL was 80 million taka, half of which is a commercial loan from the Bangladesh Shilpa (Industrial) Bank and the GK Trust at interest rates of 16 1/2 and 14 1/2 percent respectively. The rest has come mainly from NOVIB, a Dutch non-government organisation, OXFAM, Christian Aid and others. The factory is owned entirely by the GK Charitable Trust and by its charter, 50 percent of the profits are to be ploughed back for the expansion of the factory and the other 50 percent will go to help volunteer programmes in Bangladesh. The charter also limits the profits to 10/15 percent after payment of duties and bank charges. The company is registered with the joint stock companies and has a nine-member board of directors drawn from the Ministry of Health, GK Trust, Directorate of Industries, the Bangladesh Shilpa bank and NOVIB (Chowdhury and Chowdhury, 1982).

The technical expertise has been provided by the International Dispensary Association (Holland) who also helped to train managers and procure machinery. Automation has been introduced only where it has been necessary for maintaining quality control and most processes are semi-automatic. The buildings were designed and constructed by Bangladeshis. In fact, the window

frames of the factory were produced by the Nari Kendra at their metal and carpentry shop by women who have received training there. (Prakash, July '83).

GPL's employment policy, like that of GK, favours women, who are employed at all levels of production. They work a 48-hour week and the minimum wage at GPL is around 600 taka including a food subsidy. Most of the women are from neighbouring villages and are given a basic education together with the necessary training for operating machines. Women are encouraged to postpone pregnancies again (in keeping with the GK policy) and when pregnant may be moved to a less hazardous or strenuous area of work for the duration.

GPL employs 200 people including 12 at the managerial or executive levels. It also has 50 medical representatives. GPL products are sold only by generic names, the packs being labelled in Bengali. Their promotional expenditure is very small since the drugs 'sell themselves'. The main reasons are GK's admirable record in the field of health care, the consistently high quality of the products, and the low price. A comparison of drug prices in Bangladesh is revealing. (Table 1). In 82-83, the sales turnover was in the range of 31 million taka.

Bangladesh health policies and GK's influence

In the early years of the new nation, Dr. Chowdhury's group had helped to formulate the country's plan for health. But in the ensuing uncertain political climate, social policy was ignored. GK had begun to function on an almost similar model as had been suggested for the country. Their success probably proved encouraging and the government adopted the new scheme, soon afterwards. Currently, the government health care system consists of family welfare centres each covering a population of 20,000 run by medical assistants and field workers. Thus, on paper at least, the Bangladesh programme puts more emphasis on medical assistants and field workers rather than doctors. Only the Thana Health Complex covering a population of 200,000 is staffed by doctors. (Conference Paper, '83).

The staff at GK and other like-minded people have in various conference and seminars pointed to the inadequacy of the government system as well as to the exploitative nature of private practice. Last year, the government attempted to regulate private practice by specifying the consultation fees which could be charged. Unfortunately, this has only been half-heartedly implemented. (Prakash, '83).

Essential drugs for Bangladesh : the new drug policy

The general feeling that GK has considerable influence in government circles received further confirmation, when the Drugs Policy Ordinance was passed after an international conference on drugs and pharmaceuticals had been organised by the Kendra.

In 1981, the country spent more than 1250 million taka on allopathic drugs. Nearly 80 percent of the drugs were manufactured by eight multinationals and the rest by 176 national companies. More than 70 percent of the annual drug sales were on preparations described as useless or therapeutically insignificant by the British National Formulary and the US FDA. Every year, drugs worth 150 million taka were being imported (Table 2). Although the Drugs Administration of the Ministry of Health was responsible for testing and approving the quality of drugs, its meagre staff of 16 superintendents and 7 inspectors was incapable of achieving much. Excessive mark-up on actual value of drugs and on packaging and promotion, had made for exorbitant drug prices. (Chowdhury and Chowdhury, '82).

It was in this climate that the new drug policy was announced in June 1982. It was based on the recommendations of an eight-member Expert Committee, headed by Prof. Nurul Islam, Director of the Institute of Post-Graduate Medicine and Research, Dhaka. The committee submitted its report to the government in May 1982 and it was formally promulgated as the Drugs (Control) Ordinance, 1982.

By this ordinance, the registration of 1,700 unnecessary, harmful and undesirable drugs was suspended. These fell into three categories. Schedule I listed 265 locally manufactured drugs and 40 imported ones. These were considered harmful or unnecessary, and were to be withdrawn from the market within three months. The products in this category were tonics containing alcohol, multivitamin combinations, tetracycline syrup, cough syrups containing alcohol and codeine, analgesic combinations, phenacetin, gripe water, anabolic steroids, appetite stimulants, and 8-hydroxyquinoline derivatives (known to cause SMON — optical nerve damage).

Schedule II comprised drugs which would be allowed only if they were reformulated according to new regulations. These were mostly irrational combinations of antibiotics and corticosteroids which had no superior therapeutic value, but were priced higher. All the 134 drugs in this category were to be reformulated within six months and existing stocks disposed of.

The 1,268 drugs in Schedule III were (i) those which had little or no therapeutic value, (ii) were useful but were imported or manufactured under 'third party' licence (i.e. in units in Bangladesh not owned by the company) or (iii) were simple preparations of antacids or vitamins now only allowed to be produced by national companies. A time limit of nine months was allowed for the withdrawal of these products (Health Protection Committee).

To put it mildly, the new policy caused intense consternation in the world drug industry and there ensued a period of flurried activity. The Bangladesh Aushad Shilpa Samity (the association of manufacturers) urged the government to reconsider. The US Ambassador had lengthy meetings with the Chief Martial Law Administrator urging a reconsideration. The US Pharmaceutical Manufacturers Association appealed to their government to intervene.

In the meanwhile, local vested interests tried to whip up public hysteria by highlighting the temporary and often artificially-created shortages of essential drugs. In short, the reaction and activities of the drug lobby were predictable. Any attempt by developing countries to achieve a more balanced drug production pattern has always been violently attacked by the major drug producing nations. It has happened in Sri Lanka, Costa Rica, Nepal, Mozambique, Lesotho, Pakistan and many other nations which have desperately needed to hold back the spiralling drug costs. In India, the new drug policy (1978) was a show of strength of the drug lobby which succeeded in having the government dilute the Hathi committee's major recommendations.

The Bangladesh government was forced to set up a Review Committee of six military doctors and the Drug (Control) Ordinance Amendment 1982 came into force in September.

The amendment lifted the ban on seven formulations, one anti-diarrhoeal and six misused dental remedies in Schedule I. In Schedule II, four eye preparations which are combinations of analgesics and corticosteroids were reinstated, and illogically, one iron supplement, — Heptuna-plus, was allowed while the ban on other similar combinations was retained! The time limit for withdrawal was extended to 12 months. In Schedule III, 27 drugs being manufactured under licence were allowed to remain as were the 88 balms and vapour rubs which were put in a separate category. The time limit for withdrawal was extended to 18 months.

The fact that the Expert Committee had examined the drugs on the basis of a set of scientific as well as socio-economic criteria before making recommendations was all but ignored by the Review Committee. Of all the amendments the retaining of Heptuna-plus has been heavily criticised. This iron supplement, a Pfizer product containing iron, folic acid, multivitamins and minerals has been claimed as an essential ante-natal drug. It has been said that this drug was 'lobbied' for by Professor Feroze Begum, President of the Bangladesh Medical Association and a shareholder and director of Pfizer (Chowdhury and Chowdhury, 1982).

Reinstating this drug has provided a loophole for the manufacturers of similar drugs to ask for a reconsideration of their product. The amendments in Schedule III have made it possible for companies to apply for limited imports of either raw material or excipients so as to use up prestocked materials. Many of the manufacturers also asked to be allowed to re-export to

other countries. Tetracycline syrup banned in so many developed countries was to be reexported to Saudi Arabia as was Orabolin drops. Clioquinol was to be reexported to India. (Prakash, '83). (The Drugs Controller, however, decided to allow such reexport only if the goods had been marked as having been banned in Bangladesh).

Drug producing nations and multinationals have continued to use well-trying tactics and manoeuvres to sabotage the drug policy and to put pressure on the government in subtle ways.

The fact that Bangladesh has been able to bring off such a major coup in the sensitive area of drug production has surprised many. This fact is even more significant when one considers the cool reaction from international organisations which have often urged developing countries to attempt just what Bangladesh has accomplished. The WHO has been criticised for its long initial silence regarding the policy. Its Director-General even refused to comment on it on the grounds that it was an internal affair. WHO's Dhaka office also proved uncooperative and could not supply the Expert Committee with eight copies of the WHO Essential Drugs List (TRS 641) because they did not have enough copies in the country ! When Dr. Chowdhury and his colleagues offered to reprint, translate it into Bengali and distribute it, it procrastinated and finally refused permission.

Dr. Chowdhury's role in the drug policy drama has been crucial. He was a member of the Expert Committee and if one recalls his earlier writings, he has certainly made his presence felt there. He sent out personal appeals to scientists, doctors, journalists, consumer and voluntary organisations all over the world asking for their support in implementing the policy. This brought in letters and telegrams congratulating the government to withstand pressure. Observers feel that because of the comprehensive nature of the drug policy which has made radical changes in the pattern of production, it has more changes of survival than a policy advocating patchwork measures, such as the banning of certain drugs or making pricing recommendations.

The drug policy has not escaped criticism from even among those who support it. A group of radical doctors in Bangladesh point out that the policy says nothing about contraceptives and the government continues to use (and misuse) Depo Provera. The policy makes no comprehensive statement about the use of generic names nor any recommendations about the control of patents. Dr. Chowdhury's detractors of course, have had a field day pointing out that GPL is likely to reap maximum benefits from the policy !

Another consequence of the policy has been the retrenchment of staff from multinational companies. In the absence of an active and strong trade union in the industry, this has caused concern. By November '82, Fisons, Hoechst, Pfizer and Glaxo had retrenched 1/4 to 1/3 of their staff on the grounds that the policy had forced their hand in the matter. The workers have challenged this. They point out that the reduction in profits is offset in most cases by the introduction of new products which have been allowed (Rahman, '82).

It has also been pointed out that the drug policy has been introduced soon after the liberal New Industrial Policy (NIP) which has virtually denationalised all industries. (Sunday, '82). This apparent contradiction of objectives might also be seen as the government's policy of encouraging the growth of indigenous industry, but not necessarily nationalising them as the drug policy has led people to believe.

At about the same time as the introduction of the drug policy, the government also banned the import of cosmetics. Considering the fact that many of the pharmaceuticals increased their production of cosmetics following the drug policy the cosmetics ban is seen as a concession to multinational interests, in Bangladesh.

Whatever the repercussions, immediate consequences, and drawbacks, it cannot be denied that the Bangladesh drug policy has set a precedent. But its continued survival depends to a great extent on the support it receives, especially from developing countries and from its neighbours.

For us in India, the GK experience is a valuable indicator for groups dealing with health issues. It also reveals what they will come up against in the course of their actions — the pressures and tactics that will be applied by multinational pharmaceutical companies, foreign governments and organisations like the WHO which will subvert, frustrate and impede attempts by people to change the situation. In a country as diverse and large as ours, even a nominal change would necessarily imply concerted and collective action by all health groups in the country as well as other organisations, political or otherwise.

TABLE I

Comparative Prices Of Drugs Being Marketed
(Before The Drug Policy)

<u>Company Name</u>	<u>Product Name</u>	<u>Capsule/Tablet Price</u>
1. Ampicillin		
Fisons	Penbritin	Tk.1.69/cap
Hoechst	Amblosin	1.80
Square	Ampicin	1.70
K.D.H.	Amplin	1.70
Pioneer	Ampicil	1.70
Albert David	Aldapen	1.30
<u>G.P.L.</u>	<u>G-Ampicillin</u>	<u>1.00</u>
2. Amoxicillin		
Fison	Amoxil	3.00/cap
K.D.H.	Amolin	2.47
<u>G.P.L.</u>	<u>G-Amoxicillin</u>	<u>2.25</u>
3. Tetracycline/Oxytetracycline		
Pioneer	Teracin	0.90/cap
Pharmadesh	Oxaline	0.97
Hoechst	Hostacycline	0.90
Albert David	Aldacycline	1.00
Squibb	Sumycin	0.98
I.C.I.	Imperacin	1.05
<u>G.P.L.</u>	<u>G.Tetracycline</u>	<u>0.50</u>
4. Sulphamethoxazole & Trimethoprim		
Burroughs Wellcome	Septtrin	2.30/tab
Square	Cotrin	1.98
Therapeutics	Theratrim	1.80
Opsonin	Chemotrim	1.75
Pioneer	Sephtazol	1.90
<u>G.P.L.</u>	<u>G-Cotrimexazole</u>	<u>1.25</u>

5. Paracetamol

BPI (May & Baker)	Paracetamol	0.25/tab
Square	Cetamol	0.25
Hoechst	Pyralgin	0.27
Fisons	Fitamol	0.25
Nicholas	Paratan	0.25
<u>G.P.L.</u>	<u>G-Paracetamol</u>	<u>0.15</u>

6. Metronidazol

BPI (May & Baker)	Flagyl	0.78/tab
Square	Amodis	0.70
Pioneer	Metazol	0.60
Opsonin	Metril	0.50
<u>G.P.L.</u>	<u>G-Metronidazole</u>	<u>0.40</u>

7. Aspirin (300 mg)

K.D.H.	Aspirin	Tk.0.12/tab
Fisons	Genasprin	0.10
<u>G.P.L.</u>	<u>G-Aspirin</u>	<u>0.75</u>

8. Dizepam (5 mg)

Square	Sedil	0.30/tab
Opsonin	Easium	0.25
Peoples	Sudex	0.20
K.D.H.	Sedalin	0.30
<u>G.P.L.</u>	<u>G-Diazepam</u>	<u>0.125</u>

9. Antacid

I.C.I.	Avlocid	0.45
Squibb	Antacil	0.25
K.D.H.	Nutrakil	0.20
<u>G.P.L.</u>	<u>G-Antacid</u>	<u>0.20</u>

10. Frusemide (40 mg)

Hoechst	Lasix	1.30/tab
<u>G.P.L.</u>	<u>G-Frusemide</u>	<u>0.60</u>

11. Oral Rehydration Salt Sachet (27.5 gm)

Pioneer	Oralite-D	10.00
<u>G.P.L.</u>	<u>Labon Jaler Sarbat (O.R.S.)</u>	<u>2.50</u>

12. Ferrous Fumarate with Folic Acid

Fisons	Folfe Tab	0.60
<u>G.P.L.</u>	<u>G-Iron with Folic Acid</u>	<u>0.05</u>

SOURCE : The War Against Bangladesh :
Part II,
Documents and Background Material.
RUSTIC in association with VHAI.

TABLE II

Drug Production/Importation in Bangladesh

	<u>Name of the Company</u>	<u>Annual Production in Taka*</u>
1. Multinationals :	Pfizer	200 million
	Fisons	140 million
	May & Baker (BPI)	120 million
	Hoechst	115 million
	Glaxo	110 million
	Squibb	105 million
	ICI	50 million
	Organon	50 million
	Others	15 million
		<u>905 million (82.2%)</u>
2. Local Companies :	Square \$	70 million
	Gaco	40 million
	Albert David	35 million
	Pharmadesh	30 million
	Jayson	10 million
	Others	10 million
3. Imported :		<u>150 million</u>
	Grand Total	1250 million

* 1 Taka = .50 paisa (approx.)

\$ Square manufactures drugs mainly under third party licence from Janssen

SOURCE : The War Against Bangladesh, Part II, Documents and Background Material
RUSTIC in association with VHAI.

Bangladesh : A Profile

Population : 92 million

Total land area : 247 hectares

Birth rate : 34.1/1000

Death rate : 11.5/1000

Total annual population increase : 2 million (1980-81)

Literacy : 26 percent

Per capita income : 1,700 taka/year (Re. 1.1 = app. Tk. 2)

Hospitals : 730

Beds : 24379

Persons : hospital bed : 3799

Public Expenditure on Health : 2440 million taka

Public Expenditure on Defence : 3799 million taka

Graduate and post-grad. doctors : 11631 (1980)

Doctor/population

Urban : 1/10,000

Rural : 1/31,000

Allopathic medical colleges : 8

Indigenous medical colleges : 18

Annual output of allopathic graduates : 1031

(Source : Country Paper : Health and Medical Education in Bangladesh distributed at the Conference on 'People and Health', Dhaka, 1983)

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The CED Health Cell specializes in documentation and dissemination of information concerned with health issues. This "Counterfact" was written by Padma Prakash on the eve of Dr. Chowdhury's visit to India to serve as a backgrounder for the meetings and discussions that will be held with him.

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