Trócaire Development Review, Dublin, 1990, pp. 87-104, ISSN 0790-9403

Drugs and the Distortion of Health Priorities in Developing Countries

Vincent Tucker

The main determinants of health in developing countries are social and economic rather than pharmaceutical. Indeed, pharmaceutical abuse is a major problem in many countries, while at the same time essential drugs are often in short supply. This paper examines the role of the international pharmaceutical industry in bringing about this situation. It also looks at some important steps which have been made to rectify the problems, with particular emphasis on the role played by non-governmental organisations.

Introduction

The idea that more doctors, hospitals and drugs means better health is a myth that has gained widespread currency. This belief has led to a distortion of health priorities, especially in developing countries, where scarce resources are spent on drugs and curative services to the detriment of preventive measures such as primary health care programmes. This is not to deny that

doctors, drugs and vaccines play an important role in health care. Drugs such as antibiotics and anti-malarials can play a vital role in improving health and well being. However their role in health care programmes must not be exaggerated. The main determinants of health in underdeveloped countries are social and economic and not pharmaceutical. Indeed, as I will argue, pharmaceuticals, or to be more precise, the abuse of pharmaceuticals, have now become a major health hazard. This is particularly so in countries which do not have the necessary infrastructure and regulatory mechanisms to control them. A further problem arises from the fact that in many countries essential drugs such as antibiotics and anti-malarial drugs are in short supply while useless or dangerous drugs such as 'tonics', vitamins, anti-diarrhoeals, mercury soaps and steroids proliferate.

In this paper I will examine the role of the international pharmaceutical industry in bringing about this situation. I will also look at some important steps which have been made to rectify the problem, with particular emphasis on the role played by non-governmental organisations (NGOs). This last point is important as much of the analysis of Third World problems has tended towards pessimism and even fatalism. It is important, therefore, to identify possible means of tackling these problems.

The use and misuse of drugs

Diarrhoea is one of the leading causes of illness and death in the developing world, where poverty, poor sanitation, contaminated water supplies and exposure to infection are widespread. Nearly five million children die each year from diarrhoea[1]. At least half of these deaths could be prevented by the use of a very simple and cheap but highly effective therapy — oral rehydration (ORT). In many cases death is as a result of dehydration. The replacement of lost body liquids with a drink of water mixed with small amounts of salt and sugar can prevent dehydration and save at least fifty per cent of the lives lost. This is the most important and effective form of therapy for diarrhoea and was described by the British Medical Journal, *The Lancet*, as 'potentially the most important medical breakthrough this century'.[2] Quite literally 'many children are dying for lack of a drink'.[3]

Despite this, more than $430 million is spent each year on anti-diarrhoeal medicines which are ineffective or dangerous. Irrational and expensive combination antibiotics and drugs with well known dangerous side effects such as Lomotil and Immodium, are widely marketed in Third World countries.[4]

During a survey of drug use which I carried out in Nigeria in 1988, among the drugs which I was offered for the treatment of infant diarrhoea were Diapec-Cap produced by Pfizer, an irrational prescription containing two antibiotics and a sulfamoid, and Enterovioform and Mexaform, drugs containing clioquinol produced by Ciba-Geigy. The use of these latter drugs for diarrhoea led to an epidemic which swept Japan between 1956 and 1970 leaving more than 10,000 people suffering from paralysis and partial or total loss of sight. These problems were caused by clioquinol and in 1978 a Tokyo court found Ciba-Geigy responsible and awarded damages to the victims. In 1988, ten years later, I was able to buy these drugs in Nigeria where they are still in use for the treatment of diarrhoea. Surveys of drug use and promotion in Third World countries carried out by NGOs clearly show that the above are not isolated examples but part of a general pattern.[5]

I have dwelled on the case of anti-diarrhoeals in detail because it illustrates the way in which health priorities in the Third World are distorted by the activities of the pharmaceutical industry. In order to understand how scarce resources are spent on ineffective and often useless drugs, when cheap and more effective methods of prevention and treatment are available, it is necessary to examine the objectives and operation of the international pharmaceutical industry.

Drug company strategies

Developing country markets are becoming increasingly important targets for the pharmaceutical industry. The expansion of the pharmaceutical industry to developing countries dates from the 1960s. Before 1950 the top 25 US companies had established only 28 foreign subsidiaries and these were located in Canada, Britain, Mexico and in some Commonwealth countries. During the ten year period between 1950 and 1960 expansion accelerated and 333 foreign subsidiaries were established. In the 1950s the expansion focused primarily on Western Europe, Commonwealth countries and the more industrialised Latin American countries such as Brazil, Mexico and Argentina. In the 1960s the industry expanded to Africa, Asia, and the Middle East.

Since the 1960s the developing countries have increasingly been drawn into the world drug market. According to the United Nations Centre on Transnational Corporations, in 1980 53 per cent of the market was concentrated in North America and

Western Europe and 29 per cent in Africa, Asia, and Latin America.[6]

Since the 1960s developing countries have doubled their expenditure on drugs every four years. The Organisation for Economic Cooperation and Development (OECD) estimates that by the year 2000 developing countries will make up 40 per cent of the world market.[7]

There now exist in excess of 50,000 brand name drugs worldwide. Despite public perception and company propaganda, this proliferation of drugs has little to do with improved health care and is in many cases detrimental to the health of populations. However, innovation and proliferation are vital to the economic interests of the pharmaceutical industry. In this respect the industry's strategies are very successful as profits in the pharmaceutical industry are greater than in any other industry.[8]

More drugs does not mean better health. What most developing countries need is a secure supply of a relatively small number of basic drugs at affordable prices. In practice most doctors in Europe and the US prescribe from a self-imposed list of between 20-100 drugs. Many US hospitals have formularies or restricted lists of approximately 300 drugs which are regarded as sufficient to meet their needs. In 1977 the World Health Organisation (WHO), after careful study, issued an Essential Drugs List of some 200 preparations which are regarded as sufficient to meet more than 90 per cent of the pharmaceutical needs of any country.[9] How then can we explain the vast proliferation of drugs while essential drugs such as antibiotics are often in short supply in developing countries?

(a) Proliferation

The discovery of antibiotics and vaccines represented a radical breakthrough in the health care process. For the first time a compound could be administered to an acutely ill person which would restore them to full health. The impact of the new drugs in treating bacterial infections seemed almost miraculous and contributed to a perception of medicine and of drug companies as leaders in the fight against death and disease. Drug companies now embarked on a search for more magic cures. Between 1950 and 1960 3,800 new products were introduced to the market. However, the success of the antibiotics was not easily replicated in other fields.

Following the considerable therapeutic gains of the drug discoveries between 1930 and 1950 there have been

comparatively few discoveries of significant therapeutic value in the 1960s and 1970s, despite the massive proliferation of new drugs. An official US Government report published in 1974 pointed out that of the 1,500 drugs patented since 1972 only 45 (3 per cent) could claim an 'important therapeutic gain', 150 (10 per cent) could be described as 'modest improvements', and the remaining 87 per cent were merely copies of existing drugs or 'me too' drugs. Since these offered no advantage over existing drugs they were produced for commercial purposes only.[10] A similar study in the UK in 1982 showed that only 4 per cent of the products licensed constituted a therapeutic gain.[11] The drug company rationale for diversification is aptly summed up by a former medical director of an American transnational, E.R. Squibb and Sons: 'The incidence of disease cannot be manipulated and so increased sales volume must depend at least in part on the use of drugs unrelated to their real utility or need.'[12] Clearly profit takes precedence over improved health care.

Despite the growing markets in the developing countries the pharmaceutical industry not only fails to meet the real health needs but in many instances it distorts them. A 1984 study by the UN Centre on Transnational Corporations found that in three countries — Mexico, Malaysia and Kenya — the products marketed 'did not correspond to the major health requirements and priorities of each country.'[13] The exception in each case was antibiotics. The companies' best selling products were vitamins and tonics. Vitamins are widely and inappropriately marketed for the treatment of malnutrition where the money would be better spent on appropriate nutritious food. Yet nearly 18 per cent of all drug imports in North Yemen in 1980 were vitamins. In Nepal one third of all drugs on the market were tonics.[14] Research in the Andean countries of Latin America showed 'brain stimulants' such as E. Merk's Encephabol to be widely promoted and available in public hospitals where life saving antibiotics were out of stock. Anabolic steroids which are known to cause liver tumours, irreversible virilisation, and stunting of growth are promoted for malnutrition because they are known to stimulate appetite. Unfortunately, these are not isolated examples.[15]

(b) Promotion and pricing

The second means through which pharmaceutical companies expand markets and maintain high profits is through intense promotion of their products. Approximately 15 per cent of pharmaceutical companies' costs are accounted for by promotion,

double what they spend on research.[16] These promotional activities have led to a distortion of health care priorities, over-prescribing, and inappropriate use of drugs.

In Britain the pharmaceutical industry spends approximately £150 million a year on promotion. Approximately £5,000 is spent on each GP.[17] However the intensity of promotional activities in developing countries far exceeds anything found in industrialised countries. Whereas Britain has one drug company representative for every twenty doctors, Tanzania has one for every fout doctors, Nepal, Guatemala, Mexico and Brazil one for every three and the Philippines one for every two doctors.[18] In the Philippines doctors are visited by an average of ten drug sales representatives every day. The fact that each doctor in a developing country is responsible for a much larger population than in Eutope and thus controls a larger drug expenditure may explain such intense sales promotion.

Inducements such as free samples are frequently sold by doctors and medical students in developing countries so as to supplement their incomes or help get them through medical school. But gifts are not restricted to free samples. In the Philippines gifts include cars and refrigerators, and in some instances 'a visit during the night' is arranged for speakers at medical conferences.[19] Doctors, especially in developing countries where there are few independent sources of information, are frequently dependent on the drug companies as the sole source of information on the drugs they use. MIMS, the guide to prescribing most widely used by doctors, is published by the pharmaceutical industry. Comparisons between the information given to doctors in MIMS Africa as opposed to European MIMS shows that contraindications listed in the European versions may be omitted from developing country versions. A representative of Abbot/Ross Laboratories summed up the promotional activities as follows: 'In effect we are striving to make the physician a low-pressure salesman of Abbotts'.[20]

The promotional activities of pharmaceutical companies have caused widespread concern, especially in developing countries where legislative controls on promotional literature are often non-existent. The former World Health Organisation Director General, Dr. Mahler summarised some of the problems to the World Health Assembly (WHA: the legislative body of the WHO) in the following way:

> Drugs not authorised for sale in the country of origin — or withdrawn from the market for reasons of safety or lack of efficacy — are sometimes exported and marketed in

> developing countries: other drugs are promoted and advertised in those countries for indications that are not approved by the regulatory agencies of the countries of origin. Products not meeting the quality requirements of the exporting countries, including products beyond their expiry date, may be exported to developing countries that are not in a position to carry out quality control measures. While these practices may conform to legal requirements they are unethical and detrimental to health.[21]

Even a cursory look at which drugs are available and which ones are unavailable in developing countries shows that this manipulation of market demand bears very little relationship to health needs but has to do with attempts to boost the companies' market shares and maximise profits. What most developing countries need is a regular supply of low cost generic drugs but current pharmaceutical strategies militate against this.

At the same time as such ineffective and harmful drugs are vigorously promoted little attention is given to the health priorities of developing countries such a malaria, TB and bilharzia. Out of a total of some £5,000 million spent annually on research by the pharmaceutical industry only one per cent of the total (£50 million) was spent on diseases particular to developing countries.[22] Furthermore drug prices in developing countries are frequently higher than in developed countries. In Colombia between 1967 and 1971 drugs were priced at between 350 - 6,500 per cent higher than international market prices. In Argentina drugs sold by parent companies to subsidiaries ranged in cost from 145 per cent to 3,700 per cent more, in eight therapeutic categories, than if they were purchased from other sources.[23] A further example of the arbitrary nature of drug pricing is illustrated by the case of Bangladesh where Beecham, when faced with competition from the government sponsored national pharmaceutical industry, was forced to reduce the price of ampicillin by 80 per cent.[24]

Implications for health policy

Intensive drug promotion has led to over-prescribing, mis-prescribing and to a dependence on drugs. These problems are more serious in developing countries where regulatory mechanisms are not as extensive or as effective as in developed countries. This in turn has created financial waste and a growing number of drug-related problems. In situations where drugs are

generally available without prescription and where self-medication is the norm, serious misuse of drugs becomes a major problem.

It is common, for example, for users to buy antibiotics in small quantities or in single capsules in the markets of many developing countries. Such use generates resistance to antibiotics and can also be instrumental in breeding more virulent strains of infection.

Pharmaceutical companies disclaim responsibility for such problems and argue that regulation and control are the role of national governments.

> Multinational pharmaceutical companies usually take the view that if it is legal to sell a drug in a particular country, then it is legal to sell it there, preferably in large quantities. In their country of origin many potentially hazardous drugs may be promoted only for a restricted range of uses, and with certain mandatory warnings. If an importing country has no such requirements, the company can omit the warnings and can promote many more uses, no doubt sincerely believing that the local regulatory authority must surely know best what is right for the country, and that it is not for the company to usurp its function.[25]

In addition to selling their products pharmaceutical companies have also played a significant role in the promotion of a notion of health care which is highly drug-dependent. Anyone with even cursory familiarity with developing countries will be struck by the faith which people have in the seemingly magical ability of drugs to save life and treat illness. It is for this reason that parents of severely malnourished children will sacrifice large proportions of their meagre incomes to buy vitamins, 'tonics' or other such preparations for sick children, thereby endangering the health of other members of the family. The money would be much better spent on nutritious food. Such behaviour is often directly encouraged by drug companies. One company took out a full page advertisement for vitamins in an African newspaper which declared that 'the natural way to good health is no big meal'.[26]

In developing countries the financial and economic imperatives of the pharmaceutical industry have come into conflict with and undermined health care priorities. The situation is aptly summed up by Medawar:

> Medicines have brought great benefits to many people — and partly because of it they have also created great problems .... Over-medication and under-medication tend to be treated as

very different problems — though in some ways they are related. Neither is good for health; and both reflect the domination of organisational and economic imperatives over human values.[27]

North American, European and Japanese pharmaceutical companies have come to exercise considerable hegemony in health care systems worldwide. Developing countries have been reduced to a state of dependency with regard to the acquisition of essential drugs. Since many of these problems could be tackled by greatly restricting the plethora of useless and ineffective drugs, and through the production of low cost generic versions of the essential drugs, we might well ask: Why then, do these developing countries not go ahead and produce their own drugs?

The suppression of competition

Attempts by the developing countries to break this dependency and to create greater self-reliance in the provision of essential medicines have met with strenuous opposition. Pharmaceutical industries based in the rich nations have used their considerable economic and political power, not only to take over long established indigenous pharmaceutical industries, as in the case of Mexico and Brazil,[28] but to prevent the emergence of national pharmaceutical industries in developing countries. They have also strongly opposed the marketing of cheaper generic drugs.

In 1976 when the Sri Lanken government attempted to reform the pharmaceutical industry, in order to control the proliferation of drugs, reduce costs and improve prescribing practices, they met with concerted opposition from the established foreign owned transnational corporations (TNCs). The government of Mrs Bandaranaike proposed a new '34 Drug Programme' under which the State Pharmaceuticals Corporation (SPC) would centralise the procurement of chemical intermediaries for the local formulation of 34 essential drugs. This would cut down on the high transfer prices which parent companies were charging their local subsidiaries.

The US Pharmaceutical Manufacturers Association campaigned against the new policy. Their president wrote to Mrs Bandaranaike raising their objections. In the letter it was stated that:

> These actions if implemented, would effectively destroy operations of the modern research-based pharmaceuticals

industry in Sri Lanka by removing all business incentives and internationally respected property rights. By so doing, the plan would call into question the government's attitude towards any future private investment in the country.[29]

The veiled threat contained in the last sentence was further reinforced when the US ambassador personally intervened to support the industry. Further to this a widespread campaign was launched by the industry in which reports were circulated claiming that the cheaper drugs were substandard, ineffective and toxic. No evidence was produced to substantiate these claims. Private practitioners were also drawn into the campaign by the companies.

Up until 1975 the Prime Minister continued to support the Minister of Industry and the SPC in their reforms. However, with growing political problems, food shortages, and the need to obtain US food aid, the Prime Minister backtracked from her former strong stand and the SPC was obliged to compromise, thus losing some of the most important elements of the programme.

In 1982 the Bangladesh government announced a far-reaching drug policy which aimed at reducing the number of non-essential drugs, thus reducing costs and assuring a steady supply of essential drugs. They based their programme on the guidelines laid down by the World Health Organisation (WHO). As was the case in Sri Lanka there was considerable opposition to this policy from the eight pharmaceutical TNCs which had plants in Bangladesh. They opposed the new policy, not primarily for economic reasons, but because the industry was 'worried about the principles which this policy could establish'.[30] In economic terms the Bangladesh market hardly mattered to the companies but they were concerned that the WHO recommendations, embodied in the Bangladesh policy, might be adopted by a large number of Third World countries.

When the new policy was announced in June 1982 it provoked a wave of propaganda from the foreign companies and from some Western governments, suggesting that companies might go out of business or pull out of the country. Asian business journals echoed these fears and characterised the policy as a disaster. The TNC-dominated Bangladesh Pharmaceutical Manufacturers Association took out one and a quarter page advertisements in the national newspapers under the caption 'Conspiracy Against the Nation's Drug Industry Must be Thwarted'. A weekly paper financed by the pharmaceutical industry and distributed free to doctors and drug sellers, also took up the campaign. Foreign

diplomats contributed to the rumours. The West German ambassador argued that the policy had deterred foreign companies from investing in Bangladesh, and that Hoechst, the German pharmaceutical giant, had intended to expand but was now reluctant to do so.[31] The campaign sowed suspicion and confusion in a situation where most people were ill-informed about the issues at stake.

Despite this vigorous campaign against the policy the Bangladesh government succeeded in implementing the programme and none of the threatened pull-outs came to pass. Since then the Bangladesh government has carried the experiment further, greatly limiting the number of drugs available and setting up its own pharmaceutical industry. It has established a precedent which many Third World countries are now attempting to emulate.

Initiatives from the developing world

Despite the weak economic position of the developing countries, significant progress has been made in challenging the hegemony of the pharmaceutical TNCs and in reversing positions of dependency in relation to drug supplies. Increasingly developing countries are fighting to establish an alternative drug production and control system more attuned to their health care needs. Progress had already been made on this front prior to the Sri Lanka and Bangladesh initiatives discussed in the previous section.

In developing countries the movement towards a more rational use of drugs emerged initially as a response to drug shortages and to prices which they could not afford. Later, as information accumulated, problems of massive misuse of drugs and related problems led to worldwide concern. In 1959 Sri Lanka was the first government to draw up a list of essential drugs. This was done so as to reduce costs and ensure a reliable supply of the most essential drugs for its needs. Cuba, in the 1960s, adopted a national formulary, reducing the number of registered drugs from 20,000 to 600. China and later Chile also reorganised their pharmaceutical industries in an attempt to make them more responsive to the health needs of the countries concerned. In 1963, Egypt which was then 80 per cent dependent on imported drugs, nationalised the pharmaceutical industry and now meets more than 70 per cent of its own needs. In 1971 Bangladesh

carried its reforms a step further by removing licenses from all but 600 drugs and made the use of generics compulsory; in 1972 Pakistan's military government followed suit.

The idea was carried a step further when it was taken up by intergovernmental organisations such as the Non-Aligned Movement and the WHO. The Non-Aligned Movement, composed of approximately seventy-seven developing countries, provided a forum for discussion, research and co-operation in tackling mutual problems and interests. At their 1976 meeting in Sri Lanka they agreed to start work on setting up new regional centres for co-operative drug production as well as technology centres. As a result of this initiative the Caribbean countries set up collective purchasing procedures and a regional testing laboratory situated in Jamaica but serving the Caribbean region. The Andean Pact countries together with thirty-three African countries drew up a list of essential drugs as a basis for joint purchasing. The movement also urged the WHO to draw up an international code covering production, prices, distribution, research and the transfer of technology.[32]

The Non-Aligned Movement also drew up a report based on a survey of drug policies in Africa, Asia and Latin America. The report concluded that:

> In spite of the availability of good quality drugs at much cheaper prices, many developing countries are tied to traditional sources of supply — namely transnational corporations. This is mainly due to the fear that these companies may retaliate. There is inadequate appreciation that it is within their power to formulate new policies, which when implemented would enable them to reduce their import bill by as much as 50 per cent.[33]

The Non-Aligned Movement was to play an important role, through its members, in encouraging the WHO to tackle the issues.

The role of the World Health Organisation

Under the direction of the new Director General, Dr Halfdan Mahler, and the urging of the Non-Aligned Movement and various NGOs, the WHO, which had traditionally concerned itself with the relatively non-controversial aspects of drug policy, now began to raise ethical questions regarding the responsibility

of both companies and governments. Mahler denounced the existing drug marketing practices in the developing world as 'unethical and detrimental to health'.[34]

In 1977 the WHO published its influential 'Selection of Essential Drugs' which consisted of some 200 drugs which were considered adequate for meeting the health needs of most countries. This was intended for use by countries in drawing up their own lists. Despite resistance by the pharmaceutical industry the idea of a restricted drugs list was now firmly on the international agenda. In 1978 the World Health Assembly passed a resolution urging member states to adopt an essential drugs list, to use generic names, and to introduce tougher legislation to control the proliferation and misuse of drugs. The WHO received a mandate to assist member states to adopt the new policies. At the urging of developing countries and the group of Nordic countries, the Assembly also voted to give the WHO a mandate to develop a Code of Drug Marketing Practice. The International Federation of Pharmaceutical Manufacturers Associations (IFPMA) reacted by proposing their own Code of Pharmaceutical Marketing Practices, in an effort to promote self-regulation by the industry itself rather than through WHO action.

The proposed WHO marketing code led to a major clash between the pharmaceutical industry, Health Action International (HAI), and the WHO. The pharmaceutical industry had learned important lessons from the baby food campaign.[35] They copied the NGOs' strategy by setting up their own NGOs and gaining representation in every possible UN agency. They were determined to assure that the WHA would not pass a marketing code for drugs similar to the baby food code. They attempted to discredit their critics by portraying them as corporation-haters whose motivation was political, namely the overthrow of the free enterprise system. They also manipulated the political vulnerability of the WHO and its economic dependence on countries such as the US and Japan. Robert Dee, Chairman of Smith Kline, articulated the strategy:

> My second recommendation is that we put intense pressure on the UN — and on its health agencies — to give realistic instead of unrealistic advice to developing countries. For this year [1981] and next, 70 per cent of the WHO's budget will be paid by 13 industrialised countries — 13 out of 156 WHO member countries. Certainly this entitles the industrialised world to stand up to the WHO. We must have the will to do so.[36]

The pharmaceutical industry was successful in eliciting the support of governments in its campaign against the WHO.

The proposed marketing code was resolutely opposed by the US. The Reagan administration, whose hostility to the UN and its various bodies was unconcealed, was more than willing to use its clout to oppose the mandate to draw up a code. They succeeded in preventing the code even from being discussed by threatening to withdraw from the WHO. Japan was also opposed to the idea of a WHO marketing code. To give teeth to their threats the US and Japan delayed payment of their dues for several years. The WHO, fearing that the loss of financial support from its largest donors would threaten the entire Action Programme on Essential Drugs, refrained from pushing through a code despite the overwhelming support of the other member states.

Despite its failure to establish a marketing code the WHO Action Programme on Essential Drugs has played a major role in promoting the idea and practice of essential drugs programmes. Notwithstanding the opposition of the industry it gave considerable legitimacy to the idea of an essential drugs list and promoted the notion of greater self-reliance in the production of cheaper generic drugs. However, the WHA has no power to enforce its decisions. It can make recommendations but it cannot compel members to implement them. If governments do not act it can do nothing. Despite its mandate the WHO does not have the necessary resources to actively promote its essential drugs policy. Its total budget is less than $5 million a year, less than would normally be spent by a pharmaceutical company in promoting one successful drug.[37] However, WHO policies carry considerable moral authority and the idea of an essential drugs policy has now gained widespread international acceptance. In this respect the WHO has out-marketed the pharmaceutical industry.

Since the programme was launched more than eighty countries have drawn up some form of essential drugs lists and started programmes.[38] Some countries including Bangladesh, Lesotho, Mozambique and Zimbabwe, have banned all but the 200 drugs listed by the WHO and an increasing number of countries are following their example. The government of Zimbabwe has set up an impressive drug education programme so as to provide a grass roots support system for the implementation of the new policies. The idea is gaining ground very rapidly in Africa.

The impetus for action, however, falls to national governments and to NGOs such as Third World development agencies, consumer movements and campaign groups. Where transnational

bodies such as the WHO or national governments have been unwilling or unable to tackle the abuses of the pharmaceutical industry the role of NGOs has been decisive.

The role of NGOs

In the late 1970s new and influential actors emerged on the international stage campaigning against the misuse and abuse of drugs and medicines in the Third World. These created an international watchdog network and a countervailing force to the TNCs. The success of this movement in getting the WHO to draw up the 'International Code of Marketing Breast-Milk Substitutes' demonstrated new possibilities, and proved to be a model for other campaigns to follow.[39] The campaign set an important precedent in that for the first time NGOs were allowed to have an input into WHO policy making.

As a result of the success of the baby food campaign the NGOs achieved a new level of moral authority and legitimacy. Members and member organisations also accumulated a considerable body of skills. They now focused these skills and their renewed confidence and commitment on a campaign to tackle the problems of drug marketing.

In order to co-ordinate this campaign a new organisation, Health Action International (HAI), was formed by representatives of a number of NGOs who were attending the 1981 WHO meeting on baby food marketing. The organisation consists of some fifty NGOs, development action groups, consumer groups and other public interest groups. The network extends to Latin America, North America, Africa, Europe and Asia. The organisation has sufficient scientific expertise to enable it to be a formidable critic of both the products and marketing practices of the pharmaceutical industry. It has had considerable influence on the outcomes of WHO and WHA decisions. It has also provided advice and support for governments working towards a more rational drugs policy.

HAI has played a major role in promoting and gaining support for the Action Programme on Essential Drugs. It has used its international network of contacts and expert advisors to monitor drug use, collect information, and present well documented and argued analyses. At WHO meetings and through actions and lobbying campaigns directed at the members of the WHA, HAI activists have decisively influenced outcomes. Teams of HAI members, speaking a variety of languages, have individually lobbied delegates to the World Health Assembly. They presented

them with detailed briefing and documentation kits. They provided slide shows and videos, prepared specially for the occasion, which were attended by large numbers of delegates and industry representatives. During the 1984 WHA meeting HAI issued a conference newspaper, *Health Now*, which appeared at two-day intervals. The paper was produced by a specially assembled team of journalists from India, Canada, Chile, the Philippines and Peru. These journalists were well versed in the issues and were familiar with the conditions in a great many parts of the world. Through actions such as these HAI has had a major impact. Commentaries in the journals of the pharmaceutical industry and in medical journals acknowledge the impact of HAI.

Conclusion

No progress would have been brought about without effective action on the part of the NGOs. The international pharmaceutical industry is a powerful force in the world economic and political system. It has frequently used this power in ways which have maximised its own growth but have had detrimental effects on the health of peoples in developing countries. NGOs, by contrast, lack the power of governments and the economic clout of TNCs yet they can mobilise considerable moral power. Despite their relatively small numbers they can be important sources of information, analysis, and strategies for action. Their research and their ability to present and argue their case has a major influence on government representatives at WHA meetings. In the ongoing struggle to establish health care systems more responsive to the needs of people and to counteract the distortions of the international pharmaceutical industry the expertise of the NGOs, their careful and reliable research, their ability to rapidly mobilise information and evidence from all parts of the world will continue to be decisive.

Footnotes

1. WHO Feature Service, (1982), "Diarrhoeal diseases", Geneva, no. 19
2. The Lancet, "Oral rehydration: the time has come", 30 July 1981
3. N. Hirschorn, (1980), "The treatment of acute diarrhoea in children: an historical and physiological perspective", *American Jnl of Clinical Nutrition* 33, March, 637
4. For a review of the literature on these drugs see "Health Action International (HAI) Problem Drugs Pack", 1986 and Charles Medawar and Barbara Freese, (1982), *Drug Diplomacy*, London, Social Audit

5. HAI, (1985), *Promoting Health or Promoting Drugs?*; HAI, (1986), Problem Drugs Pack, HAI/IOCU, The Hague; Robert Hartog and Hermann Schulte-Sasse, (1990), "German Swiss drug supplies to the Third World: Survey and evaluation of pharmacological rationality", Buko, Erklarung von Bern, HAI
6. UN, (1984), *Transnational Corporations in the Pharmaceutical Industry in Developing Countries*, New York, ST/CTC/49
7. OECD, (1985), *The Pharmaceutical Industry: Trade Related Issues*, Paris
8. William S. Comanor, (1986), "The political economy of the pharmaceutical industry", *Jnl of Economic Literature*, Vol.XXVI, September, 1178-1217
9. WHO, (1983), *The Essential Use of Drugs*, Technical Series Report 685, Geneva; Comanor (1986), op.cit.; Andrew Chetley, (1985), "Drug promotion with a social conscience: The experience of Gonoshasthaya Pharmaceuticals", *Development Dialogue*, Vol.2, 94-107
10. German Valesquez, (1983), *L'Industrie du Medicaments et le Tiers Monde*, Paris, Editions L'Harmattan
11. Charles Medawar, (1984b), *The Wrong Kind of Medicine*, London, Hodder and Stoughton
12. HAI, (1985), op.cit.
13. UN, (1984), op.cit.
14. Diana Melrose, (1982), *Bitter Pills: Medicines and the Third World Poor*, London, Oxfam
15. HAI, (1986), op.cit.
16. Valesquez, (1983), op.cit.
17. Medawar, (1984b), op.cit.
18. Melrose, (1982), op. cit.
19. O. Gonzales, quoted in "Healthy business — The Pharmaceutical Multinationals and the Third World", London, Bebo Film Productions
20. HAI, (1985) op cit., 85
21. WHO, (1975), "Prophylactic and Therapeutic Substances", Report by the Director General, 28th World Health Assembly, Geneva, (A28/11)
22. Leslie Doyal, (1984), "The drug industry and the underdevelopment of health", *Danish Medical Bulletin*, Vol.31, no.1, 8-11
23. UN, (1984), op. cit.
24. Mike Muller, (1982), *The Health of Nations*, London, Faber and Faber, 89
25. Andrew Herxheimer, (1984), "Problem Drugs", *World Health Forum*, Vol 4, no.3, 224-29
26. *Zimbabwe Sunday Mail*, 14 April 1985

27. Charles Medawar, (1984a), *Drugs and World Health*, London, Social Audit
28. Brazil in the 1940s was a world leader in pharmaceuticals equalling if not surpassing the US. The Brazilian industries were displaced by subsidiaries of US multinational corporations, with 75 Brazilian companies disappearing between 1960 and 1962. This process was futther accelerated after the coup in 1964 so that by 1980 there were no Brazilian industries in the top thirty pharmaceutical producers. Likewise in the 1940s Mexico was the leading producer of steroid hormones, produced from the roots of a native plant, the barbasco. By 1950 the country's industry was controlled by half a dozen vertically integrated foreign TNC subsidiaries.
29. S.Lall and S. Bibile, (1977), "The Political economy of controlling transnationals: the pharmaceutical industry in Sri Lanka 1972-6, *Development Dialogue*, Vol.5, no.8, 648
30. Frances Rolt, (1985), *Pills, Politics and Profits*, London, War on Want, 32
31. Rolt, (1985), op.cit., 42
32. Melrose, (1982), op. cit., 160
33. Quoted in Melrose, (1982), op. cit., 150
34. WHO, (1975), op. cit., 1
35. For a detailed account of the baby food campaign see Chetley, (1985), op. cit. and Penny Van Esterik, (1989), *Motherpower and Infant Feeding*, London, Zed Books.
36. Quoted in Chetley, (1985), op. cit., 84
37. Medawar, (1984a), op. cit., 31
38. WHO, (1986), "Green light for WHO drugs strategy", *Essential Drugs Monitor*, Vol.3
39. Cf. Chetley, (1985) and Van Esterik, (1989), op. cit.