is the first step in the process that will allow Third World governments the necessary breathing space to establish their own national mechanisms for ensuring a more rational approach to drugs.

Perhaps the most important argument highlighted by the report is the staggering waste of resources in the pharmaceutical market. Study after study has shown that the drugs on the market do not match up with the diseases prevalent in developing countries—or even in some industrialized countries. This, coupled with the failure of the industry to be innovative, has led one group of health experts to suggest that as many as 70% of the drugs available are unnecessary and/or undesirable. By any criteria, such a level of irrelevancy is intolerable. It makes for bad health care, and, ultimately, for bad business.

I have no objection to any company or industry that is trying to get "good medicines at a reasonable cost to the poorest in the world", as Coenen puts it. The sad fact is that the pharmaceutical industry is *not* doing this. One of the most respected companies, Wellcome, which devotes considerable time and expense to tropical disease research—and deserves to be highly praised for this—also deserves to be severely criticized and condemned for developing and marketing an anti-diarrhoeal preparation in East African containing kaolin and pectin—described by authoritative sources as no more effective than a controlled diet. Worse, the company promotes the *pectin*—which is basically gelatin—as the *special* ingredient to deal with diarrhoea. It would not be possible to get away with such quackery in most European countries. Why then would a company even try to do it in developing countries?

Finally Coenen implies in his concluding sentence that there is a political motivation behind the report. Yes, there is. But it is no dark, secret ideology to be feared, but rather the honest desire to encourage *open* debate on this issue, leading to the encouragement of governments, health workers and the industry to have the political will to change those aspects of the trade in pharmaceuticals which are so blatantly irresponsible, irrelevant and unjust.

The pharmaceutical industry is motivated first and foremost by profit, not by philanthropy. There is no sin in that, *provided* its products meet *real* human health needs. I have no problems with an industry which makes a *decent* profit. It's the *indecent* profit that is so disturbing.

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Essential Drugs and Developing Countries: A Review and Selected Annotated Bibliography, by M. MAMDANI and G. WALKER. EPC Publications No. 8, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, 1985. 97 pp. £4.00 (postage included)

This is an admirable review of important issues surrounding the introduction and implementation of essential drug programmes in developing countries. In a concise and clear style the authors treat in turn: (1) inequalities in world drug consumption and production; (2) implications of drug consumption and production; (3) essential drug programmes in the developing world as policy responses to problems described under (1) and (2); (4) the pharmaceutical industry's response to essential drug programmes; (5) implementation of essential drug programmes. Mamdani and Walker's review, based on some 200 publications, forms an excellent bibliography on the issue. It further provides a selected list of 77 annotated references divided among six themes, a glossary, a country and an author index.

This succinct volume makes and extremely useful reference tool for policy-makers, health workers, researchers, industry officials, consumer groups and others interested in drug utilisation in developing countries. One flaw, however, is that references in the text do not bear page numbers, which hampers follow-up reading.

The authors emphasise how pharmaceuticals have assumed great importance as part of people's daily health concerns in developing countries. They also rightly link the quality of drug distribution to the ability of primary health care (phc) to achieve popularity: "The success of phc workers in their promotive and preventive roles depends, to a large extent, on their ability to provide credible first-line curative services. This in turn necessitates a constant timely supply of appropriate drugs in adequate amounts" (p.1). In other words, drug shortages, which undermine the morale of phc workers, have a negative influence both on the quality of drug prescription and on people's overall confidence in phc.

The survey of literature convincingly shows how drug distribution is connected to a considerable number of economic and political factors at the local, national and international level. An important caveat warns against exemption of the private sector from an essential drug policy. In support of this position there is ample evidence to demonstrate that private health care becomes a disruptive factor wherever essential drug policy is applied only in the public sector.

In their conclusion the authors point out that with improvement of the drug supply and subsequent enhancement of the quality of general health care, governments will face a substantial increase in public health costs. They call for further *quantitative* studies of the need and demand for essential drugs, so that realistic estimates can be made of projected costs (p. 49). I would add that research into *qualitative* aspects of drug utilisation also seems urgently needed. This review of the literature makes it only too clear that anthropological micro-study of the use of pharmaceuticals in developing countries has hardly begun. Drafting policy about drugs, even 'essential' ones, does not make much sense unless we know *how* people *perceive* and *use* those drugs. An important 'side-effect' of the bibliography is that it expresses our lack of qualitative insight into drugs in the Third World.

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Pills, Policies and Profits: Reactions to the Bangladesh Drug Policy, by FRANCIS ROLT. War on Want, London, 1985. 110 pp. £2.95

In June 1982, shortly after the coup led by General Ershad, the Bangladesh Ministry of Health announced a controversial new drug policy and the drugs (control) ordinance was enacted giving the legal power to enforce the policy. The new policy closely follows the recommendations of the World Health Organization (WHO) for countries to concentrate on the supply of a limited number of essential drugs.

Included in the statutory provisions and requirements of the drugs (control) ordinance was the phased banning of over 1700 of the then existing 4140 allopathic drugs on the market. At the time of enactment eight western pharmaceutical multinational companies controlled 75% of this market. The ordinance, however, affected drugs being manufactured by 160 companies.

The drugs (control) ordinance divided drugs to be banned into three schedules. Schedule I drugs, which included 265 locally manufactured products and 40 imports, were deemed harmful; production and import were to be stopped immediately and the products had to be destroyed within three months. Drugs listed in Schedule II, 134 locally manufactured products, had to be reformulated and re-registered. These drugs were combinations of similar or incompatible ingredients. A six month period was allowed for disposal of