Still Hope for the Drug Addict

by Sadaf Noori and Najme Sabina

"FOR 25 years I've smoked almost a truckload of 'ganja' (hashish)," says a 45-year-old 'ganja'-addict patient at 'Deep Clinic' — one of the leading private remedy centres for the drug addict as well as the mentally retarded.

'If you take 'ganja' you'll feel great inside. It makes a person 'mellow' and prevent him from commiting any crime', says the ganja addict now undergoing treatment. 'What an illusionary world you belong to". He was the chief of a 'mastan' group controlling areas around the Dhaka High Court.

"I was never an addict. My disciples used to take 'ganja' but I took it just as a fun", adds he. And once he had an irrestible urge for more, which dragged him into a desperate situation like this.

In this country, it is not at all surprising, therefore, that the number of drug addicts, according to the government — and therefore conservative — estimate is 2,00,000. Among them the male is their teens and 20s make for an alarming majority.

Now, the question arise: why do people get addicted? "People turn to drugs because of peer pressure, break-up of the family, failure of love, lack of job opportunity, and mostly bad association," so says Dr Ezaz. Still the main reason of teen-agers' addiction is the fact of having a fun.

Usually a drug addict never bothers what is going on inside him, though he becomes depressed, starts losing weight and his family life becomes chaotic. But in exceptional cases, a few find themselves in intense pain and volunteer to come for their own treatment.

That happened to one patient who is reluctant to give his name. He was used to take 'phensydyl' as a light dose, but soon this habit compelled his to take at least one and a half bottle a day. As a result, his family ran into desperation. Then he consulted the doctor himself and got admitted into the clinic.

"He has no reason to become a drug addict having a good family life," says Dr Ezaz who along with his friend Dilip Kumar Karmakar has painstakingly shaped up the clinic to its present status with a humble beginning on August 7, 1988 at Lalmatia, Block E, Dhaka. "There are also some other cases which do not hold any explanation," adds he.

For example, a renowned businessman of 45 who has almost everything that is needed for life has turned into an addict from bad association. He received treatment at the clinic for six months and was cured.

"I want to leave these baddies. But whenever I go back home, I feel worse. Then I can tolerate neither my wife nor the children. Again I take refuge in the tranquilising influence of drugs," was the considerate opinion of the patient.

Referring to this case, Dr Ezaz informs, "someone can have pessimistic attitude towards life. Once the people become drug addict, medicine can cure them from addiction, but this mental problem cannot be overcome. So, they again run for this holocaust (Sic)".

In this clinic a patient is usually treated for at least ten days requiring an amount of Tk 5000. But this is not sufficient for a patient. Since "before admission in the clinic, the patient usually takes heavy dose of drug. And to cure him from vomiting, fever, nausea convulsion, itching etc., special treatment is needed which keeps him unconscious for four days," informs Dr Ezaz.

On day five, he is given high dose of oral medicine and liquid food. And gradually on the 8th day of treatment, they are applied lower doses. Going through this process, they come to the end of their primary and basic treatment.

Yet these puffers can be put into right track —Star photo

"When a patient goes back home, it does not mean he is fully cured. What we do here is just try to return him back on the normal track. A complete treatment needs at least six months, which seems impossible to most of the parents," according to Dr Ezaz.

"Usually it is seen that after going back home people stop taking medicine, balanced diet, and due to this, 85% of the cases relapse," adds he.

What type of people usually come into his clinic?

Dr Ezaz sighs and says, "Since 1984, they have mostly belonged to high class. But gradually in the light of experience, they have become conscious. When a child reaches the age of 14 or 15, they start providing them with an extra bit of care and attention, which can be a primary preventive measure against their words terming addict."

A significant point today is that majority of the drug addict are from middle class or lower class.

About them he says, "the prices of any kind of drug have reduced remarkably. Can you imagine, if you have Tk. 15, you could have heroin for once." And Dr Ezaz was quick to add with an edge of sarcasm "though it is not so difficult to manage Tk 15.

Notwithstanding his good work, Dr Ezaz is not free from problems. Mastans in the area often try to compel him to treat their men free of charge. This cannot always be avoided.

Dr Ezaz envisages a plan to expand the clinic and make it more modernised. But "only plan can't translate a dream into reality. The need for active support and cooperation from common people, NGOs and the government cannot be overemphasised just because it is not merely a problem but a threat to the whole nation," says he.

Those who get cured from addiction cannot benefit much from the sympathy showered on them. What they really need is jobs preferably in narcotics department, drug addict rehabilitation centre etc., where they can work with enthusiasm. This would help them build up their career and also avoid the old ways and the stigma of an ex-drug addict. Dr Ezaz's suggestion deserves consideration.

Baby-Friendly Hospital Initiative Takes Off

by Maggie Murray-Lee

'EVERY country should have at least one baby-friendly hospital by the end of 1992.' UNICEF (United Nations Children's Fund) Executive Director James P Grant told the UNICEF representatives of the 12 countries chosen to lead the baby-friendly hospital initiative at a meeting in New York in October 1991.

So far, progress has been impressive, with each of the 12 lead countries (Bolivia, Brazil, Cote d' Ivoire, Egypt, Gabon, Kenya, Mexico, Nigeria, Pakistan, the Philippines, Thailand, Turkey) on schedule in, designating at least one baby-friendly hospital in their country by the end of 1991.

The baby-friendly hospital initiative, a 'global effort' involving 160 countries (95 of them in the developing world), was launched in June 1991 by the World Health Organisation (WHO) and UNICEF. To earn the classification, a hospital must comply with the Ten steps to Successful Breastfeeding developed by the two organisations (see box story.)

The general goal is to reverse a trend of the last few decades, when bottlefeeding has increased throughout the world, and breastfeeding — especially exclusive breastfeeding — has declined. A major concern has been the increasing reliance of hospitals on the infant formula provided to them for free or at low subsidised rates by infant food manufacturers.

The baby-friendly hospital initiative does not stop at the hospital, however. The challenge in many developing countries, where few babies are born in hospital or where their stay is brief, is to extend the principles of breastfeeding throughout the primary health care system, and to encourage communities and villages to support breastfeeding mothers.

In many industrialised countries, the challenge will be to make it possible for mothers to breastfeed, especially working mothers, who for economic reasons are forced to resume work rapidly after childbirth.

The initiative is an outgrowth of years of related work, starting with the first meeting on infant and young child feeding organised by WHO and UNICEF in 1979, when negotiations began with infant formula manufacturers. In 1981, the World Health Assembly adopted the International Code of Marketing of Breast-milk Substitutes to regulate the advertising and promotional techniques used to sell infant formulas.

Then in the early 1980s, breastfeeding was promoted as part of the UNICEF GOBI strategy (Growth monitoring, Oral rehydration, Breastfeeding, Immunisation). In 1990, the Innocenti Declaration, the Convention on the Rights of the Child and the World Summit Declaration all called attention to the importance of breastfeeding.

With the cooperation and active participation of governments and hospitals in various countries, a global project to promote breastfeeding is showing good progress.

The initiative took clearer shape after a meeting in June 1991, when infant formula manufacturers agreed to cooperate actively to achieve the goal of ending the free and low-cost distribution of breastmilk substitutes to hospitals and maternity centres in developing countries by the end of 1992.

Events there moved rapidly, with the heads of WHO and UNICEF sending a joint letter to heads of State or Government, calling for action in support of the baby-friendly hospital initiative. Following this action, the President of the Infant Formula Manufacturers' Association, Dr G P Borasio, addressed a letter to the Ministers of Health of the 12 lead countries, asking for their support in introducing government regulations on the distribution of infant formula in their particular countries.

UNICEF and WHO are also working closely with non-governmental organisations (NGOs) and non-profit professional organisations, like Wellstart, a private non-profit organisation that trains health-care workers in lactation management. In February last year, major international organisations set up the World Alliance for Breastfeeding Action (WABA), with the common goal to 'protect, promote and support breastfeeding'.

To ensure that 'baby-friendly' means the same thing everywhere, a Global Commission, composed of prominent international professionals, was established in December 1991, to adopt and endorse strict guidelines for the designation of baby-friendly hospitals and criteria for an award system. A team of appraisers will also be constituted to work with national authorities on implementation and the training of government and hospital staff.

In Kenya, which has been baby-friendly for several years, most maternity institutions have already halted the supply of milk formula. Last October, the Minister of Health identified Pumwani Hospital and Kenyatta National Hospital as baby-friendly because they had been practising the Ten Steps for at least five years.

At a meeting chaired by President Carlos Salinas de Gortari last November, the Mexican Council of Infant Food Manufacturers publicly announced their decision to suspend the distribution of free and low-cost supplies of infant formula to public and private health-care facilities in Mexico.

In Bangladesh, the Dhaka Declaration, committing the Government to enact legislation on the control of breastmilk substitutes, was signed by several ministers at the country's first national conference on breastfeeding, held in November 1991.

A scientific orientation meeting on the baby-friendly hospital initiative was held in Bangkok last November, which laid the foundations for a national plan of action.

Several National Committees are also actively engaged in baby-friendly activities. At the press conference for The State of the World's Children 1992 report at the Hospital for Sick Children in Toronto, the Canadian Committee for UNICEF seized the opportunity to launch to baby-friendly hospital initiative in Canada.

Earlier in 1991, the UK Committee was instrumental in lobbying British ministers for changes in an internal market directive of the European Commission on infant formula and follow-on formula. The UK Committee also organised a letter to the European Commissioner from the Directors of 11 European Committees. This action, the Committee advises, urgently needs to be repeated, since the European Commission is currently preparing a directive on infant and follow-on formula for export.

Richard Reid, Director of the Division of Public Affairs and coordinator of the baby-friendly hospital initiative at UNICEF headquarters, is encouraged by the progress so far. "From all we can see now, indications are that the tally of hospitals reaching the baby-friendly qualification line will be much higher than our earlier expectations," he said. "The initiative has caught on — the best evidence of that is the large harvest of baby-friendly hospitals yielded by the 12 lead countries at the end of 1991. From here on, the growth could be exponential as we move into the broadening of the challenge to all the countries of the world."

— Third World Network Features/First Call for Children

Maggie Murray-Lee is Global Communications Officer, Division of Information in UNICEF New York.

Ten Steps to Successful Breastfeeding

Every facility providing maternity services care for new-born infants should :

1. **Have a written breastfeeding policy that is routinely communicated to all health care staff.**
2. **Train all health care staff in skills necessary to implement this policy.**
3. **Inform all pregnant women about the benefits and management of breastfeeding.**
4. **Help mothers initiate breastfeeding within a half-hour of birth.**
5. **Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.**
6. **Give newborn infants no food or drink other than breastmilk, unless medically indicated.**
7. **Practise rooming-in — allow mothers and infants to remain together — 24 hours a day.**
8. **Encourage brestfeeding on demand.**
9. **Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.**
10. **Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.**

Plants and Bismuth Stage a Comeback to Cure Ulcers

by T. V. Padma

PLANT extracts and bismuth compounds are staging a comeback to heal peptic ulcers, with recent medical research rediscovering their value.

The virtues of plant extracts in curing ulcers are being appreciated for the second time since the ancient Chinese first used liquorice extracts to treat "inflamed stomachs" centuries ago.

Interest in liquorice continued till the 17th century, and in other plant extracts till 1960s, but waned with the advent of synthetic anti-histamine drugs in the 1970s. Now, it is reviving with scientists identifying some plant compounds that are offering hopes of combating one of the most uncomfortable and long problems in medicine.

Peptic ulcers, which include both duodenal and gastric ulcers, are produced by the self-destruction of the gut wall by pepsin and hydrochloric acid in gastric juice.

Normally, the wall is protected by a waterproof, viscous and elastic mucous layer and any surface acid in the gastric juice is neutralised by bicarbonate ions secreted by the wall. But small perforations in the wall may arise due to what doctors call "aggressive factors" that include reflexion of the gastric juice and bile salts into the stomach, drinking, smoking, stress and certain drugs.

Ulcers start as small erosions which, if they fail to heal, enlarge and penetrate to the underlying muscle to form ulcers.

They tend to run in families and genetic factors make some people more susceptible than others to the aggressive factors.

In the 1960s, doctors ordered bed rest, diet regulation including more intake of easily digestible products such as milk, and reducing smoking and drinking for patients with ulcers.

Some of the prescribed medicines were derived from plants — for example, opium mixed with chalked powder, sucrose, nutmegs, cloves and powdered seeds of the herb Mistura kaolini. Although they did neutralise the acidity that leads to ulcers in stomachs and intestines, they did not offer a permanent cure.

Modern treatment of ulcers started with the use of triterpenoid drug carbenoxolone which was developed in 1960s from boiled extracts of the roots and rhizomes of the liquorice plant Glycyrrhiza glabra.

Various Abrus species which form part of traditional medicines of the Malay peninsula and Indonesia also contain glycyrrhizic acid present in liquorice root.

Carbenoxolone was popular for about 10 years but it led to side-effects such as weight gain, odema, potassium loss and hypertension. Other triterpenoid-containing plants include Calendula, Psychotria ademonphylla, Terminalia sericea and Taraxacum officinale.

Later the most popular choice for ulcer treatment became hydrogen receptor antagonists, more simply called hydrogen blockers, which are considered safe, heal most ulcers in eight weeks and have only mild and reversible side-effects.

In general, doctors treat young patients with antacids and hydrogen blockers, but in older patients who do not respond to these lines, endoscopic surgery may be needed.

The major disadvantage of using hydrogen receptor antagonists is that virtually all ulcers relapse once treatment is stopped — half the ulcers recur within a year and almost all reappear after two years of stopping treatment.

Interest in liquorice reemerged when scientists found that its extract retained its anti-ulcer activity even after glycyrrhizic acid was removed from it.

Subsequent research showed that the anti-ulcer effect was due to flavonoids, aromatic heterocyclic compounds present in some plants.

Flavonoids are attracting interest because of some of their chemical and biological properties. An anti-ulcer flavonoid isolated from the medicinal herb Sideritis mugronensis found in Spain and other parts of southern Europe stimulates the synthesis of prostaglandins — hormones that cause secretion of the protective mucous and bicarbonate ions by the gastric walls.

The most successfully exploited flavonoid is solon from the medicinal plant Sophora subprostrata, the source of an ancient Chinese drug widely used to treat digestive disorders. Solon has been used clinically in Japan since 1984.

Recent work on other plant flavonoids shows that a dry alcohol extract of Vaccinium myrtillus berries, commonly known bilberries, has anti-ulcer activities. The extract has been marketed for long by Italy as a medicine to treat eye problems and microcirculation disorders.

Anti-ulcer properties have also been discovered in the Thai medicinal plant Corton sublyratus and in Solidago, a hardy perennial plant fond in parts of Europe, says a report by David A Lewis, a pharmaceutical scientist from Aston University, Birmingham, in the journal "Chemistry in Britain."

Other drugs of plant origin used in ulcer therapy are alkaloids, the best known of which is the drug atropine found in Atropa belladonia, better known as the deadly nightshade. In modern medicine atropine is classified as an antidholinergic.

The long-held theory that ulcers are caused by erosion of the stomach wall lining by acids is being challenged by recent medical reports that a bacterium, Heliobacter pylori, may be the culprit.

The bacterium is present in about 20 per cent of 20-year-olds and 60 per cent of 60-year-olds, says the medical journal "The Practioner".

Doctors now believe that ulcer relapse occur when the bacteria are not totally eradicated from the system, or when they recolonise the system.

With the spotlight turning on Heliobacter pylori, medical interest in the use of bismuth to treat ulcers has revived.

Drugs based on bismuth may be staging a comeback, says "The Practioner". Bismuth has long been used in the treatment of digestive problems, a typical bismuth drug containing a mixture of bismuth carbonate, magnesium carbonate and sodium carbonate.

Recent interest in bismuth is prompted by evidence that Heliobacter pylori responds to treatment with bismuth drugs. Doctors abroad are suggesting a "triple therapy" regime, consisting of a bismuth-containing chemical tripotassium dicitratobismuthate (TDB) and two antibiotics to heal ulcers.

(PTI Science Service)

Vaccine Fights Haemorrhagic Spticaemia

FOOT-and-mouth disease and rinderpest have been controlled in most of tropical Asia and Africa, but Haemorrhagic Septicaemia (HS), a highly-fatal bacterial disease, still ranks as one of the leading livestock killers.

Once the symptoms have appeared — high fever, dullness and reluctance to move, followed by swelling of the throat and nasal discharges — the mortality rate in affected bovines may run as high as 80-90 per cent of a herd.

The battle against this cattlekiller may soon be fought with better weapons, thanks to a new vaccine being tested in field trials in the union of Myanmar (Burma).

HS's causative agents are two specific serotypes of the bacteria Pasteurella multocida. Numerous experimental vaccines have been tried against it, with researchers trying to produce a live-avirulent vaccine using an avirulent/mutant bacterial seed. A live vaccine using a particular P multocida serotype, locally known as the "deer strain", has been introduced in Myanmar and exhibits promising results in terms both of potency and — equally important in the Third World — cost of production.

Myanmar recently became the newest member of the FAO's Regional Animal Production and Health Commission for Asia and the Pacific (APHCA), which is closely associated with HS research projects of the Australian Centre for International Agricultural Research (ACIAR).

The ACIAR developed the new-generation HS vaccine, using advanced biotechnology (genetically engineered vector vaccine and a vaccine based on purified immunogenic components isolated from P multocida).

Currently, three conventional, inactivated (killed) HS vaccines are used in affected African and Asian countries: Broth Bacterin, Alum-Precipitated Vaccine (APV) and Oil-Adjuvant Vaccine (OVA). Broth Bacterin is for immediate use in case of outbreaks, while the other two are for routine prevention.

APV gives shorter immunity (four to six months) compared to OAV (nine to 12 months). The latter may produce anaphylactic shock, which causes sudden death in some vaccinated animals. It is also found to be too viscous, and thus difficult for field use.

However, several countries have been improving it with less viscosity but still good potency.

— Ceres

A veterinary doctor writes a prescription for farmers with a sick cow in Bangladesh

Moms Turn Health Workers During Market Days

by Lita S Consignado

TIANGGE traditionally means market day in rural Philippines, when farm produce is brought in from the fields and various goods are sold in abundance.

For a number of villages, however, the world has also gained a new meaning. It is "tiangge", too, when the medical team of the Children's Medical Centre Philippines (CMCP) comes to pitch tent.

For one whole day the team — complete with examination tables, weighing scales, supplies — goes about immunising children, examining expectant mothers, treating the sick and teaching the community how to stay well. Then it packs up again for another village.

The roving clinic targets some of the country's more disadvantaged communities not easily reached by public transportation, much less by government health workers. The "tiangge" is used as an entry point.

The roving clinic is actually a continuation of the rural health service started some 25 years ago by well-known pediatrician Dr Fe del Mundo, whose more than 40 years of service to children has earned her the title Mother of Pediatrics in the Philippines.

When the CMCP — of which Dr del Mundo is president and founder — was established in 1959, rural health service was made part of its outreach programme. "Today we reach more underserved areas more readily than some government health workers," she says.

With the help of a grant from the Ramon Magsaysay Award Foundation, the CMCP tiangge project has over two years brought health care to 13 villages in the provinces of Pampanga, Bulacan and Laguna in northern Philippines.

Each village is regularly visited by the CMCP team which is usually composed of four doctors, two junior medical interns, a midwife, a field coordinator from the Philippine Centre for Population and Community Development and staff of the town's Safe Motherhood and Child Survival Clinic. (Both agencies are extensions of the CMCP).

Aside from rendering routine medical service, the team holds a clinic for children from infancy to school age. It also gathers mothers for lectures and tips on the prevention and control of disease prevalent in the area, and gives advice on safe motherhood, child survival, family planning and environmental sanitation.

To better enable the community to take care of itself, the team further conducts a 12-session training course of two hours each for mothers and teachers in a given area.

When the health team is not around, they attend to common minor ailments and simple emergencies.

Not only that. The women are also assigned specific localities where they survey, collect and collate data on population by age groups, married couples of reproductive age, environmental sanitation, common illnesses and the availability and utilisation of medicinal plants.

Another project component is the organisation of village drugstores called Botika sa Barangay, of which there are currently four in Pampanga, five in Bulacan and two in Laguna. Started mostly with seed money solicited by Dr del Mundo herself, each drugstore is run by a mother health worker trained in drugstore management. Many of the drugstores have done well and have started paying back the 500-peso (US $19) seed capital.

— Depthnews Asia.